# Medicare Managed Care Manual

## Chapter 2 - Medicare Advantage Enrollment and Disenrollment

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## 10 - Definitions

*(Rev. 66, Issued: 08-05-05, Effective Date: 08-05-05)*

**For Chapter 2, a reference to an "MA plan" includes MA local plans, MA Regional Preferred Provider Organization (PPO) plans and MA-PD plans unless otherwise specified.**

**The instructions provided in this chapter apply to MA plans, including MA-PD plans. Instructions for enrollment (and disenrollment) in a Prescription Drug Plan (PDP) is provided in a separate guidance.**

The following definitions relate to topics addressed in this Chapter.

**Cancellation of Election -** An action initiated by the beneficiary to cancel an election before the effective date of the election. A cancelled election has not been used and remains available for use during the applicable election period.

**Completed Election -** An election is considered complete when:

1. The form/request is signed by the beneficiary or legal representative (refer to §40.2.1 for a discussion of who is considered to be a legal representative), or the election mechanism (described by CMS) is completed;

2. For enrollments, evidence of entitlement to Medicare Part A and enrollment in Medicare Part B is obtained by the Medicare Advantage organization (see below for definition of "evidence of Medicare Part A and Part B coverage.") There are situations at the end of the month when the MA organization receives an election form from the beneficiary without any evidence of entitlement to Medicare Part A and Medicare Part B (e.g., copy of a Medicare card, SSA letter). The MA organization is then required to obtain verification of the beneficiary's entitlement through other means. In these cases, CMS will allow for a grace period of **three business days** after the end of the month to obtain such verification. If it is confirmed during the grace period that the beneficiary was entitled to both Medicare Part A and Part B when the election form was received by the MA organization, the date of entitlement will suffice as the evidence and the election form will be considered complete upon receipt.

   For example, if an otherwise complete enrollment form was received on September 30, the MA organization has until October 3 to verify Medicare Part A entitlement and Part B enrollment to provide the enrollee with an October 1 effective date.

3. All necessary elements on the form are completed (for enrollments, see Appendix 2 for a list of elements that must be completed) or when the election mechanism is completed as CMS directs, and, when applicable;

4. Certification of a legal representative's authority to make the election is obtained by attestation (refer to §40.2).

For enrollments into an MA-only (non MA-PD) plan, an MA organization may also choose to wait for the individual's payment of the plan premium, including any premiums due the MA organization for a prior enrollment before considering an enrollment "complete." This does not apply when the individual has chosen to have plan premiums withheld from SSA/RRB/OPM benefits.

**Continuation Area/Continuation of Enrollment Option -** A continuation area is an additional CMS-approved area outside the MA local plan's service area within which the MA organization furnishes or arranges for furnishing of services to the MA local plan's continuation of enrollment members. MA organizations have the option of establishing continuation areas for MA local plans.

**Conversions -** For individuals who are enrolled in a health plan offered by the MA organization the month immediately before the month of their entitlement to Medicare Parts A and B, their enrollment in an MA plan offered by the same organization is referred to as a "conversion" from non-Medicare status to MA enrollee status. In order for the individual's enrollment with the organization as an MA enrollee to take effect upon becoming eligible for Medicare, conversions must take place during the individual's Initial Coverage Election Period (ICEP).

**Denial of Election -** Occurs when an MA organization determines that an individual is not eligible to make an election (e.g., the individual is not entitled to Medicare Part A or enrolled in Part B, the individual has ESRD, the individual is not making the election during an election period, etc.), and therefore determines it should not submit the election transaction to CMS.

**Election -** Enrollment in, or voluntary disenrollment from, an MA plan or the traditional Medicare fee-for-service program ("Original Medicare") constitutes an election. (Disenrollment from Original Medicare would only occur when an individual enrolls in an MA plan.) The term "election" is used to describe either an enrollment or voluntary disenrollment. If the term "enrollment" is used alone, however, then the term is used deliberately, i.e., it is being used to describe only an enrollment, and not a disenrollment. The same applies when the term "disenrollment" is used alone, i.e., the term is being used to describe only a disenrollment, and not an enrollment.

**Election Form -** An election mechanism used by individuals to request to enroll in, or disenroll from, MA plans. A model individual enrollment form is provided in Exhibit 1. **An individual who is a member of an MA plan and who wishes to elect another MA plan, even if it is in the same MA organization, must complete a new election to**

**enroll in the new MA plan**. However, that individual may use a short enrollment form (refer to Exhibit 3 for a model short enrollment form) or a "selection" form (refer to Exhibit 3a) to make the election in place of the comprehensive individual enrollment form. In addition, MA organizations may want to collaborate with employer group health plans (EGHPs) to use a single enrollment form (or other CMS approved method, if available) for EGHP members; a model EGHP enrollment form for this purpose is provided in Exhibit 2. Beneficiaries or their legal representatives must complete enrollment elections (e.g. enrollment forms) to enroll in MA plans.

Beneficiaries are not required to use a specific form to disenroll from an MA plan, however a model disenrollment form is provided in Exhibit 10.

Other election mechanisms are discussed in §20.4 of this chapter.

**Election Period -** The time(s) during which an eligible individual may elect an MA plan or Original Medicare. The type of election period determines the effective date of MA coverage. There are several types of election periods, all of which are defined under §30.

**Evidence of Medicare Part A and Part B Coverage -** For the purposes of completing an enrollment election, the MA organization must accept any of the following as acceptable evidence of entitlement to Medicare Part A and enrollment in Part B:

1. A Medicare card;

2. A Social Security Administration (SSA) award notice;

3. A Railroad Retirement Board (RRB) letter of verification;

4. A statement from SSA or RRB verifying the individual's entitlement to Medicare Part A and enrollment in Part B;

5. Verification of Medicare Part A and Part B through one of CMS' systems, including CMS data available through CMS subcontractors; or

6. For individuals enrolling in their ICEP, an SSA application for Medicare Part A and B showing the effective date for both Medicare Parts A and B.

**NOTE:** CMS will allow for a grace period of three business days after the end of the month to obtain such verification. If it is confirmed during the grace period that the beneficiary was entitled to Medicare Part A and enrolled in Part B when the election was received by the MAO, the date of entitlement will suffice as the evidence and the election form will be considered complete upon receipt.

**Evidence of Permanent Residence -** A permanent residence is normally the enrollee's primary residence. An MA organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills to verify

the primary residence. Such records must establish the permanent residence address, and not the mailing address, of the individual.

**Full-Benefit Dual Eligible Individual** – For purposes of Medicare Prescription Drug benefits (Part D), is a Medicare beneficiary who is determined eligible by the state for medical assistance for full benefits under title XIX of the Social Security Act for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under section 1115 of the Act, or medical assistance under section 1902(a)(10)(C) of the Act (medically needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

**Institutionalized Individual -** An individual as defined in §30.3.4.

**Involuntary Disenrollment -** Refers to when an MA organization, as opposed to the member, initiates disenrollment from the plan. Procedures regarding involuntary disenrollment are found in §§50.2 and 50.3.

**Medicare Advantage Organization (MA organization) -** Refer to Chapter 1 (General Administration of the Managed Care/Medicare + Choice Program) for a definition of an "MA organization."

**MA Organization Error -** An error or delay in election processing made under the full control of the MA organization personnel and one that the organization could have avoided.

**Medicare Advantage Plan -** Refer to Chapter 1 for a definition of "MA plan." Elections are made at the MA **plan level**, not at the **MA organization level.**

**Other Low Income Subsidy (LIS) Eligible Individuals** – For purposes of Medicare Part D benefits, individuals who are determined eligible for the Part D low-income subsidy (LIS) who are not full-benefit dual eligible individuals as defined above. This includes individuals deemed eligible for LIS by virtue of having QMB-only, SLMB-only, QI, SSI-only; as well as those who apply and are determined eligible for LIS.

**Out-of-Area Members -** Members of an MA plan who live outside the service area and who elected the MA plan while residing outside the service area (as allowed in §§20.0, 20.3, 50.2.1, and 50.2.4).

**Receipt of Election -** According to 42 CFR 422.60(d), an election has been made when a completed election (such as an enrollment application form, written request for disenrollment, or alternate election mechanism as described by CMS) has been received by the MA organization. An election is considered received and must be date stamped by the MA organization when the MA organization (or any entity authorized by CMS to process election forms, such as SSA or the RRB) comes into possession of a **completed** election form signed by the enrollee (or as may be the situation in the case of a

disenrollment, a written request or other CMS-approved method described in §50.1). A "completed election" is defined above.

**Reinstatement of Election -** An action that may be taken by CMS after an individual disenrolls from an MA plan. The reinstatement corrects an individual's records by canceling a disenrollment to reflect no gap in enrollment in an MA plan. A reinstatement may result in retroactive disenrollment from another Medicare managed care plan.

**Rejection of Election -** Occurs when CMS has rejected an election submitted by the MA organization. The rejection could be due to the MA organization incorrectly submitting the transactions, to system error, or to an individual's ineligibility to elect the MA plan.

**System Error -** A "system error" is an unintended error or delay in election processing that is clearly attributable to a specific Federal government system (e.g., the Rail Road Benefit (RRB) system), and is related to Medicare entitlement information or other information required to process an election.

## 20 - Eligibility for Enrollment in MA Plans

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

In general, an individual is eligible to elect an MA plan when each of the following requirements is met:

1. The individual is entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan (see exceptions described under §20.6);

2. The individual has not been medically determined to have ESRD prior to completing the enrollment election (see exceptions described under §20.2);

3. The individual permanently resides in the service area of the MA plan (see exceptions in §20.3 for persons living outside the service area at the time of election);

4. The individual or his/her legal representative completes an enrollment election and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS (refer to Appendix 2 for a list of items required to complete the enrollment form, and §40.2.1 for who may sign election forms or complete other election mechanisms);

5. The individual is fully informed of and agrees to abide by the rules of the MA organization that were provided during the election process; and

6. The individual makes a valid election during an election period, as described in §30;

7. For a Special Needs Plan (SNP) additional requirements apply as described in §20.11 and §70 of this chapter.

An MA organization must not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in an MA plan and continues to be enrolled in his/her employer's or spouse's health benefits plan, then coordination of benefits rules apply.

An MA eligible individual may not be enrolled in more than one MA plan at any given time. Procedures for handling multiple transactions, cancellations, and reinstatements are described under §60.

Individuals enrolled in an MA plan may not concurrently enroll in a PDP except for individuals enrolled in an MSA plan or individuals enrolled in a PFFS plan that does not offer Medicare prescription drug coverage.

## 20.1 - Entitlement to Medicare Parts A and B

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

To be eligible to elect an MA plan, an individual must be entitled to Medicare Part A and enrolled in Part B, and must be entitled to Medicare Part A and Part B benefits as of the effective date of coverage under the plan. Exceptions for Part B-only "grandfathered" members are outlined in §20.6. Part B only individuals currently enrolled in a plan created under §1833 or §1876 of the Social Security Act (the Act) are not considered to be "grandfathered" individuals, and must purchase Medicare Part A through the Social Security Administration to become eligible to enroll in an MA plan.

An MA organization has the option to continue to offer Part A-equivalent coverage to Medicare Part B-only "grandfathered" members, as described in §20.6. However, an MA organization may not offer Part A-equivalent coverage to other individuals enrolled only in Medicare Part B (and not entitled to Part A) in order to make them "eligible" for enrollment in an MA plan. Eligibility requirements are met based on Part A entitlement through Medicare and not through the purchase of Part A-equivalent benefits through the MA organization. The MA organization may refer the individual to SSA if the individual wishes to enroll in Medicare Part A in order to be eligible to enroll in the MA plan.

While desirable, it is not necessary for an individual to prove Medicare Part A entitlement or Part B enrollment **at the time** he/she completes the enrollment election, i.e., the MA organization may not deny the enrollment if the individual does not have the evidence when filling out the enrollment form or does not include it with the form when he/she mails it to the organization. However, the organization may consider the enrollment election to be incomplete until it can verify such entitlement or enrollment.

Section §40.2.2 provides more information on the steps the organization can take to verify Medicare coverage. In addition, the definition of "Evidence of Part A and Part B Coverage" in §10 lists some of the types of information that can be used to verify coverage.

## 20.2 - End-Stage Renal Disease (ESRD)

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Except as provided under exceptions discussed below, an individual is not eligible to elect an MA plan if he/she has been medically determined to have ESRD. ESRD means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. A Medicare beneficiary will be assigned ESRD status by the Medicare ESRD system as a result of the attending physician certifying the ESRD status of the enrollee and completing a CMS Form CMS-728-U3. For purposes of MA eligibility, an individual's ESRD status begins:

- The date regular dialysis begins, as reported on the Form CMS-2728-U3; or
- The month an individual is admitted to a hospital for a kidney transplant, or for health care services needed before a transplant if the transplant takes place in the same month or within the two following months; or
- The first day of the month dialysis began if the individual trained for self-dialysis.

An individual who receives a kidney transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of MA eligibility. Such an individual may elect to enroll in a MA plan, if he/she meets other applicable eligibility requirements. If an individual is only eligible for Medicare on the basis of ESRD (i.e., not based on disability or age), the individual would only be permitted to remain enrolled as an MA enrollee during his or her remaining months of Medicare eligibility.

In addition, an individual who initiated dialysis treatments for ESRD, but subsequently recovered native kidney function and no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of MA eligibility. Such an individual may also elect to enroll in a MA plan, if he/she meets other applicable eligibility requirements.

The MA organization is permitted to ask at the time of the election whether the applicant has ESRD. This question is not considered impermissible health screening since the law does not permit a person with ESRD to elect an MA plan, except as provided in the following paragraphs. If a beneficiary no longer requires regular dialysis or has had a successful transplant, the beneficiary should obtain a note or records from the beneficiary's physician showing that the ESRD status has changed and submit it with the enrollment election. An MA organization must deny enrollment to any individual medically determined to have ESRD, except as provided in the following paragraphs. The

CMS will reject the enrollment if Medicare records indicate the applicant has ESRD, and no exception permitting enrollment applies.

Procedures for identifying whether an individual is medically determined to have ESRD are included in §40.2.4.

## 20.2.1 - Background on ESRD Entitlement

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

When an individual files for Medicare based upon ESRD, entitlement can begin:

- The first day of the third month after the month dialysis begins (i.e., the first day of the fourth month of dialysis);
- The first day of the month dialysis began if the individual trains for self-dialysis;
- The month an individual is admitted to a hospital for a kidney transplant, or for health care services needed before a transplant if the transplant takes place in the same month or within the two following months;
- Up to 12 months prior to the month of filing (if dialysis began more than 12 months before); or
- Prospectively.

The Medicare entitlement date is usually the month an individual receives a transplant or three months after the month the individual begins dialysis (i.e., the first day of the fourth month of dialysis). For example, if an individual begins dialysis in January, Medicare entitlement is effective April 1. Therefore, for these individuals, the initial coverage election period (ICEP) would be the time between when dialysis begins and the Medicare entitlement date - the 3-month waiting period for Medicare entitlement.

There are individuals who are approved to perform **self-dialysis**. If an individual is approved for self-dialysis, SSA will waive the 3-month waiting period to begin Medicare entitlement. In cases of self-dialysis, Medicare entitlement is effective the month dialysis begins, rather than the customary 3 months from the month the individual begins dialysis.

**EXAMPLE**

A Medicare record is established in January for an April 1 entitlement effective date. Since the individual has 3-month waiting period waived, SSA submits a changed record for a January 1 Medicare entitlement effective date.

Medicare pays nothing until the individual files for benefits and Medicare coverage becomes effective.

Individuals sometimes elect a prospective effective date to coordinate with the end of their 30-month coordination period. In the case of an **individual in a group health plan**, the group plan is required to be the primary payer for the first 30 months of Medicare eligibility or entitlement (also known as the 30-month coordination of benefits period), as long as the individual chooses to be enrolled in the group health plan. There is nothing to require an individual to file for Medicare immediately upon starting dialysis. The group health plan is primary during the coordination of benefits period, without regard to the number of individuals employed and irrespective of current employment status.

Since an ICEP generally relates to when an individual becomes entitled to Medicare Part A and B, when possible the group or MA organization should coordinate with the individual so that he/she will not be adversely impacted if he/she has the option to elect an MA plan.

## 20.2.2 - Exceptions to Eligibility Rule for Persons Who Have ESRD

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

1. Conversions upon ICEP: Individuals who developed ESRD while a member of a health plan offered by an MA organization and who are converting to Medicare Parts A and B, can elect an MA plan in the same organization (within the same State, with exceptions) as their health plan during their ICEP. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2.) The individuals must meet all other MA eligibility requirements and must fill out an election form or complete an alternate enrollment election to join the MA plan.

2. Conversions other than ICEP:

   (a.) If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an MA plan during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an MA plan offered by the MA organization, as long they were enrolled in a health plan offered by the same MA organization the month before their entitlement to Parts A and B, developed ESRD while a member of that health plan, and are still enrolled in that health plan. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who performs self-dialysis will have his/her entitlement date adjusted to begin at the time of dialysis, rather than the customary 3-month period **after** dialysis begins.

   These individuals will be given a special election period. See §30.4.4 for additional instructions.

(b.) Individuals who develop ESRD while enrolled in a health plan (e.g., a commercial or group health plan, or a Medicaid plan) offered by the MA organization are eligible to elect an MA plan offered by that organization. In order to be eligible, there must be no break in coverage between enrollment in the health plan offered by an MA organization, and the start of coverage in the MA plan offered by the same organization.

3. An individual who elects an MA plan and who is medically determined to first have ESRD **after** the date on which the enrollment form is signed (or receipt date stamp if no date is on the form, per §40.2), or the election is made by alternate means provided by CMS, but **before** the effective date of coverage under the plan is still eligible to elect the plan.

4. An individual who develops ESRD while enrolled in an MA plan may continue to be enrolled in the MA plan.

5. Once enrolled in an MA plan, a person who has ESRD may elect other MA plans in the same MA organization (and during allowable election periods, as described under §30.). However, the member would not be eligible to elect an MA plan in a different MA organization or a plan in the same MA organization in a different State (with exceptions).

6. An individual with ESRD whose enrollment in an MA plan was terminated on or after December 31, 1998, as a result of a contract termination, non-renewal, or service area reduction can make one election into a new MA plan. The individual must meet all other MA eligibility requirements, and must enroll during an MA election period described in §30, which includes the SEP associated with that specific termination, non-renewal or service area reduction. Once an individual has exhausted his one election, he/she will not be permitted to join another MA plan, unless his new plan is terminated.

7. Individuals with ESRD may enroll in an SNP that has obtained a waiver to be open for enrollment to individuals with ESRD.

## 20.2.3 - Optional Employer Group Waiver for ESRD Enrollees

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The MA organizations may choose to accept enrollees with ESRD who are enrolling in an MA plan through an employer or union group under the following circumstances:

1. If an employer or union group offers an MA plan as a new option to its employees and retirees, regardless of whether it has been an option in the past, ESRD retirees may select this new MA plan option as the employer or union's open enrollment rules allow.

2. If an employer or union group that has been offering a variety of coverage options consolidates its employee/retiree offerings (i.e., it drops one or more plans), current enrollees of the dropped plans may be accepted into an MA plan that is offered by the group.

3. If an employer or union group has contracted locally with an MA organization in more than one geographic area (for example, in two or more states), an ESRD retiree who relocates permanently from one geographic location to another may remain with the MA organization in the local employer or union MA plan.

In order to accommodate these three scenarios, we are waiving the regulations at 42 CFR 422.50(a)(2).

The MA organizations that choose to apply this waiver must agree to apply it consistently. Each year, MA organizations may choose whether or not to apply this waiver at the time of their renewal.

## 20.3 - Place of Permanent Residence

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An individual is eligible to elect an MA plan if he/she permanently resides in the service area of the MA plan. A temporary move into the MA plan's service area does not enable the individual to elect the MA plan; the MA organization must deny such an election.

**EXCEPTIONS**

- An MA organization may offer a continuation of enrollment option to MA local plan enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the MA organization as a continuation area (refer to §60.7 for more detail on the requirements for the continuation of enrollment option).

- Conversions: Individuals who are enrolled in a health plan of the MA organization and are converting to Medicare Parts A and B can elect an MA local plan offered by the same MA organization during their ICEP even if they reside in the MA organization's continuation area. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2.)

- A member who was enrolled in an MA plan covering the area in which the member permanently resides at the time the plan was terminated in that area, may remain enrolled in the MA plan while living outside the plan's new reduced service area if:

    - There is no other MA plan serving the area at that time;

- The MA organization offers this option; and
- The member agrees to receive services through providers in the MA plan's service area.

- The MA organization has the **option** to also allow individuals who are converting to Medicare Parts A and B to elect the MA plan during their ICEP even if they reside outside the service **and** continuation area. This option may be offered provided that CMS determines that all applicable MA access requirements in 42 CFR 422.112 are met for that individual through the MA plan's established provider network providing services in the MA plan service area, and the organization furnishes the same benefits to the individual as to members who reside in the service area. The organization must apply the policy consistently for all individuals. These members will be known as "out-of-area" members. This option applies both to individual members and employer group members of the MA organization.

- The MA organization has the **option** to offer "visitor" or "traveler" programs for individuals who are consecutively out of the area for up to 12 months, provided the plan includes the full range of services available to other members (refer to §50.2.1 for more detail on the requirements for the "visitor/traveler" option).

Individuals who do not meet the above requirements may not elect the MA plan. The MA organization must deny enrollment to these individuals.

A permanent residence is normally the primary residence of an individual. Proof of permanent residence is normally established by the address of an individual's residence, but an MA organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual. If an individual puts a Post Office Box as his/her place of residence on the enrollment form, the MA organization must contact the individual to determine the place of permanent residence, unless the person is homeless (see below). If there is a dispute over where the individual permanently resides, the MA organization should determine whether, according to the law of the MA organization's State, the person would be considered a resident of that State.

In the case of homeless individuals, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) may be considered the place of permanent residence.

## 20.3.1 - State and County Code (SCC) Corrections

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

In order to validate a request for a retroactive payment adjustment, the MA organization is required to provide evidence that establishes an individual's place of permanent residence for that specific period of time. This is different from the process outlined in §20.3 above that provides instructions for establishing current residence for the purposes of eligibility to enroll, or remain enrolled, in an MA plan.

Some evidence items that are acceptable for establishing current residence may not be acceptable for establishing residence for a past period of time. For example, a driver's license generally does not specify a period of time in which the address presented on it is or was valid, and there are variances among the states regarding updating their records when a change of address occurs. Since a driver's license may not provide adequate verification of residence for a specific, past period of time in all states, it is not considered acceptable documentation for retroactive payment adjustment requests. In contrast, a signed statement from the beneficiary, or his or her representative, that confirms the residence for the specific period, or a tax record covering the period in question are examples of documents that do address the specific period of time associated with a retroactive payment adjustment for SCC discrepancies and as such, constitute acceptable documentation.

Information on SCC discrepancies and payment corrections, including evidence requirements for retroactive payment adjustments, is provided in Chapter 19 of this manual.

## 20.4 - Completion of Enrollment Election

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An eligible individual or the individual's legal representative (as described in §40.2.1) must complete an election to enroll in an MA plan, **even if that individual is electing an MA plan in the same MA organization in which he/she is enrolled**. Unless otherwise specified by CMS, an eligible individual can elect an MA plan only if he/she completes an enrollment election, provides required information to the MA organization within required time frames, and submits the properly completed election to the MA organization for enrollment. Model enrollment forms are included in Exhibits 1, 2, and 3.

An individual who is a member of an MA plan, and who wishes to elect another MA plan offered by the same MA organization, must complete a new enrollment election to enroll in the new MA plan; however, that individual may use a short enrollment form (refer to Exhibit 3 for a model short enrollment form or Exhibit 3a for a model selection form) to make the election in place of the comprehensive individual enrollment form, or, may complete the election by telephone as described in §20.4.4 of this chapter, if the MA organization offers this option.

An MA organization must deny enrollment to any individual who does not properly complete the enrollment form or other mechanism within required time frames.

Procedures for completing the enrollment form are provided in §40.2 and Appendix 2. Refer to §10 for a definition of "completed election."

## 20.4.1 - Alternate Employer Group Election Mechanism

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Beginning April 1, 2003, MA organizations that offer MA plans to employer groups may choose to accept voluntary elections directly from an employer group (or its TPA) without obtaining an MA election form from each individual. The elections reported to the MA organization will reflect the choice of retiree coverage individual enrollees made using their employer's process for selecting a health plan. This election mechanism is optional for MA organizations, and may not be required. Therefore, MA organizations may specify the employer groups, if any, from which they will accept this election format and may choose to accept enrollment and/or voluntary disenrollment elections.

The record of an individual's choice of health plan submitted by the employer effectively replaces the MA election form(s). All eligibility, processing and notice requirements, as outlined in this chapter of the Medicare Managed Care Manual (MMCM) and other references, that pertain to election forms are applicable to this election mechanism. This process does not require the MA organization to obtain a signature. Detailed information and instruction is provided in §40.1.2 for enrollments and §50.1.5 for disenrollments.

Notices of disenrollment, cancellation or termination of coverage not initiated by an enrollee election (i.e. involuntary disenrollment) are not included in this mechanism. Guidance for these situations is available in §50.1.5.

## 20.4.2 - Passive Elections

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Under Medicare laws and regulations, Medicare beneficiaries must make an election to enroll in an MA plan, and CMS specifies the form and manner in which such elections are made. CMS has determined that it is legally permissible to provide for enrollment in an MA plan under a passive election process in specific, limited circumstances generally associated with the MA plan renewal process. A passive election is defined as a process by which a beneficiary is informed that he or she may make an election of a new MA plan by taking no action.

**MA Plan Renewal and Non-Renewal**

When a passive election is used in connection with a Service Area Reduction (SAR) or plan termination, the MA Organization must send a modified Annual Notice Of Change (ANOC) to the enrollees setting forth the available options, including Medigap rights. Although the ANOC information ordinarily may not be due until a later date, the MA organization must provide the ANOC information for the new MA Plan by October 2 of

the current calendar year for the following year's plan(s). This will satisfy the MA Plan termination notification requirements and give the enrollees time to decide whether to elect the new plan by taking no action.

When a passive election is used in an MA plan renewal that **does not** include a termination or SAR, there are no Medigap rights. The MA Organization should use the regular ANOC and include passive enrollment language to inform enrollees about their respective plans and other choices for the upcoming year.

## 20.4.3 - Enrollment via the Internet

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Beginning with the Annual Coordinated Election Period (AEP) for 2006 that begins on November 15, 2005, MA organizations may offer enrollment into an MA plan via a secure internet web site. MA organizations must adhere to the guidelines outlined in §40.1.3, as well as all other program requirements, in developing and implementing internet enrollment election processes.

## 20.4.4 - Enrollment Via Telephone for Current MA Plan Enrollees

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Beginning with the Annual Coordinated Election Period (AEP) for 2006 that begins on November 15, 2005, an MA organization may offer enrollment into an MA plan via the telephone for individuals already enrolled in another MA plan offered by the MA organization. MA organizations that choose to implement this election mechanism option must adhere to the guidelines outlined in §40.1.4 of this chapter as well as all other program requirements.

## 20.4.5 - Seamless Conversion Enrollment Option for Newly Medicare Eligible Individuals

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

MA organizations may develop processes to provide seamless enrollment in an MA plan for newly Medicare eligible individuals who are currently enrolled in other health plans offered by the MA organization (such as commercial or Medicaid plans) at the time of their conversion to Medicare. CMS will review an organization's proposal and must approve it before use. Any such proposal must be sent to the MA organization's Regional Office plan manager with a copy to the Central Office plan manager and must meet the conditions provided in §40.1.5 of this chapter before the process may be used.

## 20.4.6 - Auto-enrollment of Full-Benefit Dual Eligible Individuals

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Full-benefit dual eligible individuals enrolled in an MA plan without Medicare prescription drug benefits ("MA-only plan") effective 2006 will be auto-enrolled into an MA-PD plan in the same organization. CMS will delegate auto-enrollment of this population to MA organizations. The only exception will be MA Private Fee for Service (MA-PFFS) plans that do not offer a Part D benefit. CMS will auto-enroll full-benefit dual eligible individuals in MA-PFFS plans into a stand-alone Prescription Drug Plan (PDP).

The auto-enrollment process will begin in September 2005, with notification to beneficiaries in October 2005. The monthly auto-enrollment process will start October 2005, and continue monthly thereafter. The effective date of auto-enrollment taking place prior to January 1, 2006, will be January 1, 2006. The effective date of subsequent auto-enrollments will be the first day of the second calendar month following the month of auto-enrollment.

Full-benefit dual eligible individuals who will be auto-enrolled pursuant to this section include those in MA plans in 2005 that are not deemed into an MA-PD plan for 2006 (i.e., because their MA plan in 2005 did not have any prescription drug coverage, or did not convert to an MA-PD plan in 2006), as well as individuals who newly enroll in an MA-only plan effective January 1, 2006 or thereafter. The purpose of this auto-enrollment is to ensure no gap in prescription drug coverage between the end of the Medicaid coverage and the beginning of eligibility for Medicare prescription drug coverage. Refer to §40.1.6 for more information.

## 20.4.7 - Facilitated Enrollment of Other LIS Eligible Individuals

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Enrollment of other LIS eligible individuals enrolled in MA-only plans will be facilitated into an MA-PD plan in the same organization. CMS will delegate facilitated enrollment of this population to MA organizations. The only exception will be MA Private Fee for Service (MA-PFFS) plans that do not offer a Part D benefit. CMS will auto-enroll full-benefit dual eligible individuals in MA-PFFS plans into a stand-alone Prescription Drug Plan (PDP). Facilitated enrollment will first occur at the end of the Initial Enrollment Period for Part D, and take place monthly thereafter. Since this population is not losing Medicaid prescription drug coverage, CMS intends to provide maximum opportunity for them to choose a Part D plan before facilitating their enrollment.

The process is similar to the auto-enrollment process for full-benefit dual eligible individuals. Refer to §40.1.7 for more information.

## 20.4.8 - Group Enrollment for Employer or Union Sponsored Plans

**PENDING**

## 20.5 - Agreeing to Abide by MA Organization Rules

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An individual is eligible to elect an MA plan if he/she is fully informed of and agrees to abide by the rules of the MA organization that were provided during the enrollment process (refer to §§40.4, 40.4.1, and 40.4.2 regarding what information must be provided to the individual during the enrollment process). "Fully informed" means that the individual must be provided with the applicable rules of the MA organization, as described in §40.4. The MA organization must deny enrollment to any individual who does not agree to abide by the rules of the MA organization. Agreement to abide by the rules of the MA organization in this context is made through the completion of the enrollment election.

## 20.6 - Grandfathering of Members on January 1, 1999

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An individual who was enrolled on December 31, 1998, in an HMO with a risk contract under §1876 of the Social Security Act was deemed to be enrolled on January 1, 1999, in an MA plan offered by the same organization if he/she did not choose to disenroll from the organization effective on the latter date. This deemed enrollment applied even if the enrollee was not entitled to Medicare Part A or did not live in an MA plan service area or continuation area. The MA organization was not permitted to disenroll such individuals because they were not entitled to Part A, or did not live in the service or continuation area. However, if these individuals elect to disenroll from the MA organization, they are not eligible to enroll in any MA plan until or unless they meet all MA eligibility requirements.

If enrollment in Medicare Part B ends for an individual, the individual may not continue as a member of the MA plan and must be disenrolled as described in §§50.2.2 and 50.6.

The MA organization must identify all Medicare Part B-only "grandfathered" individuals and inform them of their status annually. This notification may be included as part of the Evidence of Coverage. The notice must inform these individuals that if they disenroll from the MA organization, they cannot elect another MA plan unless they become entitled to Medicare Part A (by enrolling in Medicare Part A at SSA and by paying the appropriate premium to CMS) and remain enrolled in Medicare Part B.

MA organizations may continue to provide Part A-equivalent benefits to Medicare Part B-only grandfathered members. In addition, if an MA organization offers Part A-equivalent coverage as a supplemental benefit in an MA plan, then the MA organization may disenroll a Medicare Part B-only grandfathered member who fails to pay the organization's Part A-equivalent premium, just as any member of the MA organization could be disenrolled for nonpayment of premiums (refer to §50.3.1).

Grandfathered members may enroll in other MA plans in the same MA organization (within the same State, with exceptions). However, if grandfathered members disenroll from the MA organization (i.e., they switch to Original Medicare), they will not be eligible to enroll in any MA plan in any MA organization until or unless they meet all MA eligibility requirements. If the out-of-area grandfathered members disenroll from the MA organization (i.e., they switch to Original Medicare or attempt to enroll in another MA organization), they will only be able to enroll in other MA organizations if they meet all MA eligibility requirements, including, but not limited to, that of living in the service area of the MA plan.

## 20.7 - Eligibility and the Hospice Benefit

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An MA organization must not deny enrollment to any individual who has elected the hospice benefit (except in the case of an MSA plan; see §20.10 for additional eligibility requirements for MSA plans). Until the MA organization acknowledges that it has received the completed enrollment election and gives a coverage effective date to the individual (refer to Exhibit 4, Exhibit 4a, and §40), the MA organization must not ask any questions related to the existence of a terminal illness or election of the hospice benefit. Such questions will be considered impermissible health screening.

The MA organization may not disenroll any member on the basis of the member electing the hospice benefit either before or after becoming a member of the MA plan. Instead, the MA organization must provide, or continue to provide, services unrelated to the terminal condition, including any additional benefits provided for in the MA plan. If the member chooses to revoke the hospice election, the MA organization again becomes responsible for providing all covered services and benefits included in the MA plan. Refer to Chapter 7, “Payments to Medicare + Choice Organizations” for an explanation of special payment provisions for hospice members.

## 20.8 - Continuation of Enrollment Option for MA Local Plans

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

With CMS approval, an MA organization may establish continuation areas, separate and apart from an MA local plan’s service area. Refer to Chapter 11 (Contracts with Medicare + Choice Organizations) regarding CMS approval of continuation areas. As defined in §10, the CMS-approved continuation area is an additional area outside an MA local plan’s service area within which the MA organization furnishes or arranges for furnishing of services to the MA plan’s members. Members may only choose to continue enrollment with the MA local plan if they have permanently moved from the service area into the continuation area.

As described in Chapter 11, if an MA organization wants to offer a continuation of enrollment option under one or more of the MA local plans it offers, then it must obtain

CMS' approval of the continuation area, and the marketing materials that describe the continuation of enrollment option. The MA organization must also describe the enrollment option(s) in member materials and make the option available to all members of the MA local plan in question who make a permanent move to the continuation area. An MA organization may require members to give advance notice of their intent to use the continuation of enrollment option. If the MA organization has this requirement, then it must fully describe the required notification process in the CMS-approved marketing materials. In addition, the MA organization must fully explain any continuation option to all potential members of the MA local plan, current members of any other health plan of the MA organization and current risk and/or MA members who reside in the MA local plan service area and/or MA organization continuation area.

If a member does not choose the continuation of enrollment option when he/she is eligible for the option, then the individual is no longer eligible to be a member of the MA local plan, and the MA organization must initiate the individual's disenrollment. Procedures for continued enrollment are in §60.7 and procedures describing disenrollment for permanent change of residence are described in §50.2.1.

## 20.9 - Additional Eligibility Requirements for MA Religious Fraternal Benefit (RFB) Plans

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An MA RFB plan is a plan that *a*n RFB society may offer only to members of the church, or convention or group of churches with which the society is affiliated. The requirement for membership can be met by any documentation establishing membership issued by the church, or by using the church's records of membership. An individual must also meet all the other requirements to elect an MA plan.

## 20.10 - Eligibility Requirements for Medicare Medical Savings Account (MSA) Plans

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Although an individual may meet all the requirements to elect an MA plan, there are additional requirements and limitations on the individuals who may wish to elect to enroll in a Medicare Medical Savings Account (MSA) plan. An individual is not eligible to elect a Medicare MSA plan if any one of the following applies:

- The individual will reside in the United States for fewer than 183 calendar days during the year in which the election is effective;

- The individual is enrolled in a Federal Employees Health Benefits program, or is eligible for health care benefits through the Department of Veterans Affairs or the Department of Defense;

- The individual is entitled to coverage of Medicare cost-sharing under a Medicaid State plan;

- The individual is receiving hospice benefits under the Medicare benefit prior to completing the enrollment election; or

- The individual receives health benefits that cover all or part of the annual Medicare MSA deductible such as through insurance primary to Medicare, supplemental insurance policies not specifically permitted under 42 CFR 422.104, or retirement health benefits.

## 20.11 - Additional Eligibility Requirements for MA Special Needs Plans

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

MA Special Needs Plans (SNP) may limit enrollment to individuals who meet specified eligibility requirements in addition to the eligibility requirements in §20 of this chapter. To be eligible for enrollment in an SNP an individual must meet the eligibility requirements for the specific SNP. Refer to §70 of this chapter for more information.

## 30 - Election Periods and Effective Dates

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

In order for an MA organization to accept an election, the individual must make the election during an election period (see §10 for the definition of "election"). There are four types of election periods during which individuals may make elections. They are:

- The Annual Election Period (AEP);

- The Initial Coverage Election Period (ICEP);

- All Special Election Periods (SEP); and

- The Open Enrollment Period (OEP).

Unless a CMS-approved capacity limit applies, all MA organizations must accept elections into their MA plans (with the exception of MA MSA plans) during the AEP, an ICEP, and any SEP that allows enrollment into the specific plan. (Refer to §30.7 for election periods for Medicare MSA plans.) When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all prospective enrollees (with the exception of reserved vacancies) until the limit is lifted. Refer to §30.8 and §30.8.1 for more information on OEP plan closures, capacity limits and reserved vacancies.

## 30.1 - Annual Election Period (AEP)

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

During the AEP, MA eligible individuals may enroll in or disenroll from an MA plan. The last election made, determined by the date the election was received by the MA organization, will be the election that takes effect (refer to §60.1 for information on multiple transactions).

The AEP occurs November 15 through December 31 of every year.

**Special Note for 2006:** The AEP will be extended to begin on November 15, 2005 and continue through May 15, 2006. There is one AEP election (that takes effect) for use during this period.

## 30.2 - Initial Coverage Election Period (ICEP)

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The ICEP is the period during which an individual newly eligible for MA may make an initial election to enroll in an MA plan. This period begins three months immediately before the individual's entitlement to **both** Medicare Part A and Part B and ends on the later of:

1. The last day of the month preceding entitlement to both Part A and Part B, or;

2. After May 15, 2006, the last day of the individual's Part B initial enrollment period.

The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility. See 42 CFR 407.14 for additional information.

Once an ICEP election is made and enrollment takes effect, the ICEP election has been used.

**EXAMPLES**

- Mrs. Smith's 65th birthday is April 20, 2006. She is eligible for Medicare Part A and Part B beginning April 1, 2006 and has decided to enroll in Part B beginning on April 1. Her ICEP begins on January 1, 2006 and ends on July 31, 2006.

- Mrs. Smith's 65th birthday is April 20, 2006. She is eligible for Medicare Part A and Part B beginning April 1, 2006. Because she is still working and has health insurance provided by her employer, she has decided not to enroll in Part B

during her initial enrollment period for Part B. Upon retiring, she will have the opportunity to enroll in Part B (through a Part B SEP). She has enrolled in Part B effective May 1, 2007. Her ICEP would be February 1 through April 30, 2007.

Please note that the ICEP for an MA enrollment election will frequently relate to either the individual's 65th birthday or the 25th month of disability, but it must **always** relate to the individual's entitlement to **both** Medicare Part A and Part B. When an individual enrolls in an MA-PD plan, s/he has used both the ICEP and the IEP for Part D.

## 30.2.1 - Initial Enrollment Period for Part D (IEP for Part D)

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

At the beginning of the Medicare prescription drug coverage program, all current Part D eligible individuals have an Initial Enrollment Period for Part D (the IEP for Part D) that begins on November 15, 2005 and ends on May 15, 2006. Individuals may make one Part D enrollment choice, including enrollment in an MA-PD plan.

Individuals who become eligible for Medicare on February 1, 2006 or later will have an Initial Enrollment Period for Part D that is the same period as the Initial Enrollment Period for Medicare Part B. The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility. See 42 CFR 407.14 for additional information.

In MA context, this election period applies only to MA-PD enrollment elections.

## 30.3 - Open Enrollment Period (OEP)

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Individuals have an opportunity to make an MA election during the OEP, in addition to their opportunities during the AEP, SEP, or ICEP. MA organizations are not required to open their MA plans for enrollment during an OEP. However, MA organizations must accept valid requests for disenrollment from MA plans during the OEP since Original Medicare is always open during an OEP. In addition, if an MA organization has more than one MA plan, the MA organization is not required to open each plan for enrollment during the same time frames.

If an MA organization opens a plan during part of an OEP, it is not required to open the plan for the entire month – it may choose to open the plan for only part of the month.

The OEP (also including the OEP NEW and OEPI described below) is not available for MSA elections. Please refer to §30.7 for more information on MSA elections.

## 30.3.1 - OEP Through 2005

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The OEP is continuous through 2005. If an MA organization has a plan that is open for enrollment at any time during the OEP, then it must accept all valid OEP enrollment elections into that plan made during the plan's open enrollment period. If an MA organization has a plan that is not open for enrollment during the OEP, then it cannot accept any OEP enrollment elections into that plan.

**NOTE:** MA organizations must accept valid requests for disenrollment from MA plans during the OEP since Original Medicare is open continuously through 2005.

An MA eligible individual can make an unlimited number of OEP elections through 2005.

## 30.3.2 - OEP in 2006 and Beyond

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

In **2006**, an MA eligible individual may make **one** MA OEP election from January 1st through June 30th.

In **2007 and each year thereafter**, an MA eligible individual may make **one** MA OEP election from January 1st through March 31st.

**OEP Limitation:**

OEP (including OEPNEW) elections must be made to the same type of plan (regarding Medicare prescription drug coverage) in which the individual is already enrolled, as follows:

(1) An individual who is enrolled in an MA-PD plan may elect another MA-PD plan or disenroll from the MA-PD by enrolling in a PDP (there is a corresponding SEP to permit this Part D enrollment). To effectuate this election, the individual must elect an MA-PD plan or enroll in a PDP. Either action will generate an automatic disenrollment from the current MA-PD plan. An individual enrolled in a PDP may elect an MA-PD.

Such individual may not elect an MA plan that does not provide qualified prescription drug coverage.

(2) An individual who is enrolled in an MA plan and who does not have qualified prescription drug coverage may elect another MA plan that does not provide drug coverage or may elect to disenroll from the MA plan.

An individual enrolled in Original Medicare (or a non-MA Medicare health plan, such as a cost plan) but not in a PDP may elect an MA plan that does not provide qualified prescription drug coverage. Such individual may not elect an MA-PD plan during this period.

**NOTE:** An OEP enrollment election into another MA plan that results in an automatic disenrollment from a current plan will count as 1 OEP election.

## 30.3.3 - Open Enrollment for Newly Eligible Individuals (OEPNEW)

***(Rev. 66, Issued: 08-05-05; Effective: 08-05-05)***

In 2006, an individual who becomes MA eligible during 2006 may make **one** MA OEP NEW election during the period that begins the month the individual is entitled to both Part A and Part B and ends on the last day of the 6th month of entitlement, or on December 31, 2006, whichever occurs first, subject to the limitations described in §30.3.2 above.

Beginning in 2007 and going forward, the OEPNEW period begins with the month of entitlement to both Part A and Part B and ends on the last day of the 3rd month of entitlement, or on December 31st of the same year, whichever occurs first, subject to the limitations described in §30.3.2 above.

An OEPNEW election is separate from an OEP election. An MA organization is not required to accept elections into its plan during the OEPNEW, but if it is open for these elections, it must accept all OEPNEW elections into the plan.

## 30.3.4 - Open Enrollment Period for Institutionalized Individuals (OEPI)

***(Rev. 66, Issued: 08-05-05; Effective: 08-05-05)***

Beginning January 2006, the OEPI is continuous for institutionalized individuals. For purposes of enrollment under the OEPI election period, an institutionalized individual is defined as an individual who moves into, resides in, or moves out of a:

- Skilled nursing facility (SNF) as defined in §1819 of the Act (Medicare);
- Nursing facility (NF) as defined in §1919 of the Act (Medicaid);
- Intermediate care facility for the mentally retarded (ICF/MR) as defined in §1905(d) of the Act;
- Psychiatric hospital or unit as defined in §1886(d)(1)(B of the Act);
- Rehabilitation hospital or unit as defined in §1886(d)(1)(B) of the Act;
- Long-term care hospital as defined in §1886(d)(1)(B) of the Act; or

- Hospital which has an agreement under §1883 of the Act (a swing-bed hospital).

**Special Note for SNP enrollment:**

In addition, the OEPI is available for individuals who meet the definition of "institutionalized" provided in the guidance for SNP plans (refer to §70 for more information) to enroll in or disenroll from an MA SNP.

An MA eligible institutionalized individual can make an unlimited number of MA elections during the OEPI beginning in 2006. An MA organization is not required to accept elections into its plan during the OEPI, but if it is open for these elections, it must accept all OEPI elections into the plan.

Since the OEPI is continuous, Original Medicare is open continuously for institutionalized individuals beginning in 2006. Therefore, MA organizations must accept requests for disenrollment from their MA plans during the OEPI since Original Medicare is open continuously for institutionalized individuals.

## 30.4 - Special Election Period - (SEP)

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

SEPs include those situations where:

1. The individual has made a change in residence outside of the service area or continuation area or has experienced another change in circumstances as determined by CMS (other than termination for non-payment of premiums or disruptive behavior) that causes the individual to no longer be eligible to elect the MA plan;

2. CMS or the organization has terminated the MA organization's contract for the MA plan in the area in which the individual resides, or the organization has notified the individual of the impending termination of the plan or the impending discontinuation of the plan in the area in which the individual resides;

3. The individual demonstrates that the MA organization offering the MA plan substantially violated a material provision of its contract under MA in relation to the individual, or the MA organization (or its agent) materially misrepresented the plan when marketing the plan; or

4. The individual meets such other exceptional conditions as CMS may provide.

During an SEP, an individual may discontinue the election of an MA plan offered by an MA organization and change to a different MA plan or Original Medicare. Corresponding Part D Special Enrollment Periods (also called SEPs), where appropriate, are provided in PDP enrollment guidance. If the individual disenrolls from (or is disenrolled from) the MA plan and changes to Original Medicare, the individual may

subsequently elect a new MA plan within the SEP time period. Once the individual has elected the new MA plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, **the SEP for the individual ends when the individual elects a new MA plan or when the SEP time frame ends, whichever comes first, unless specified otherwise within an SEP.**

Please note that the time frame of an SEP denotes the time frame during which an individual may make an election. **It does not necessarily correspond to the effective date of coverage.** For example, if an SEP exists for an individual from May - July, then an MA organization must receive a completed election from that individual some time between May 1 and July 31 in order to consider the election an SEP election. However, the type of SEP will dictate what the effective date of coverage may be, and that effective date of coverage may be some time after July 31. The following discussion of SEPs and their corresponding effective dates will demonstrate this concept more fully.

Individuals who disenroll from an MA plan to Original Medicare during an SEP are provided Medigap guaranteed issue rights. These rights are not afforded to those individuals who enroll into an MA plan during an SEP. MA organizations are required to notify members of these guaranteed issue rights when members disenroll to Original Medicare during a SEP. See §§50.1 and 50.2 for the additional information regarding these notification requirements

The time frames and effective dates for SEPs are discussed in the following sections.

SEPs apply to local, regional and MA-PD plans unless otherwise specifically stated. Corresponding SEPs for enrollment in Prescription Drug Plans (PDPs) are provided in separate PDP Enrollment guidance.

## 30.4.1 - SEPs for Changes in Residence

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

A SEP exists for individuals who are no longer eligible to be enrolled in the MA plan due to a change in residence outside of the MA plan's service or continuation area.

**Permanent Move Out of the Service or Continuation Area**

If the individual is no longer eligible to be a member of the plan based on a permanent move out of the service or continuation area, the SEP begins the month prior to the month of the individual's permanent move and continues during the month of the move and up to two months after the move.

**Outside the Service or Continuation Area for Over Six Months**

If the individual is no longer eligible to be a member of the plan based on having left the service or continuation area for over six months, this SEP begins at the beginning of the sixth month of being out of the area and continues through to the end of the eighth month.

**In Either Case**

This SEP is associated with the actual **date of the permanent move** (or, in the case of an individual who has left the service or continuation area for over six months, the date the sixth month ends). Therefore, if the beneficiary notifies the MA organization more than two months after the permanent move or the eighth month has passed, the individual is no longer eligible for an SEP. This will not impact those who have already been disenrolled to fee-for-service by any previous action.

The effective date of enrollment is associated with the **date the MA organization receives the completed election**. The individual may choose an effective date of up to three months after the month in which the MA organization receives the enrollment election. However, the effective date may not be earlier than the date the individual moves to the new service area (or the end of the sixth month, as appropriate) and the MA organization receives the completed enrollment election.

**EXAMPLE**

A beneficiary is a member of an MA plan in Florida and intends to move to Arizona on June 18. A SEP exists for this beneficiary from May 1 - August 31.

A. If an MA organization in Arizona receives a completed enrollment election from the beneficiary in May, the beneficiary can choose an effective date of July 1, August 1, or September 1.

B. If the MA organization receives the completed enrollment election from the beneficiary in June (the month of the move), the beneficiary can choose an effective date of July 1, August 1, or September 1.

C. If the MA organization receives the completed enrollment election in July, the beneficiary could choose an effective date of August 1, September 1, or October 1.

At the time the individual makes the election into an MA plan, the individual must provide the specific address where the individual will permanently reside upon moving into the service area, so that the MA organization can determine that the individual meets the residency requirements for enrollment in the plan.

**Disenrollment from Previous MA Plan**

Please keep in mind that a member of an MA plan who moves permanently out of the service area must be disenrolled from the plan, unless continuation of enrollment applies. A member of an MA plan who is out of the area for over six months must be disenrolled from the plan.

We have established an SEP that allows an individual adequate time to choose a new MA plan, given the fact that the individual will no longer be enrolled in the original MA plan after the month of the move or after the sixth month (whichever is appropriate). Unless an individual enrolls in a new MA plan with an effective date of the month after the move or the beginning of the seventh month (e.g., the individual moves on June 18 and enrolls in a new plan effective July 1), he/she will be enrolled in Original Medicare until he/she elects the new MA plan.

## 30.4.2 - SEPs for Contract Violation

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

In the event an individual is able to demonstrate to CMS that the MA organization offering the MA plan of which he/she is a member substantially violated a material provision of its contract under MA in relation to the individual, or the MA organization (or its agent) materially misrepresented the plan when marketing the plan, the individual may disenroll from the MA plan and elect Original Medicare or another MA plan. The SEP will begin once CMS determines that a violation has occurred. Its length will depend on whether the individual immediately elects a new MA plan upon disenrollment from the original MA plan or whether the individual initially elects Original Medicare before choosing a new MA plan.

We note that in some case-specific situations, CMS may process a retroactive disenrollment for these types of disenrollments. If the disenrollment is not retroactive:

- A SEP exists such that an individual may elect another MA plan or Original Medicare during the last month of enrollment in the MA organization, for an effective date of the month after the month the new MA organization receives the completed enrollment election.

  **EXAMPLE**

  On January 16, CMS determines, based on a member's allegations, that the MA organization substantially violated a material provision of its contract. As a result, the member will be disenrolled from the MA plan on January 31. A SEP exists for this beneficiary beginning January 16 and lasting until the end of January. The beneficiary promptly applies for a new MA plan, and the new MA organization receives the completed enrollment form on January 28 for a February 1 effective date.

- If the individual in the above example elected Original Medicare during the last month of enrollment in the MA organization (either by choosing Original Medicare or by not choosing an MA plan and therefore defaulting to Original Medicare), the individual will be given an additional 90 calendar days from the effective date of the disenrollment from the MA organization to elect another MA plan. During this 90-day period, and until the individual elects a new MA plan, the individual will be enrolled in Original Medicare. The individual may choose an effective date into a new MA plan beginning any of the three months after the month in which the MA organization receives the completed enrollment election. However, the effective date may not be earlier than the date the MA organization receives the completed enrollment election.

  **EXAMPLE**

  On January 16, CMS determines, based on a member's allegations that the MA organization substantially violated a material provision of its contract. The member decides to return to Original Medicare. As a result, the member is disenrolled from the MA plan on January 31 and enrolled in Original Medicare with a February 1 effective date. A 90-day SEP continues to exist for the beneficiary from February 1 through April 30. In this example, a new MA organization then receives a completed enrollment election from the individual on April 15. The beneficiary can choose an effective date of May 1, June 1, or July 1.

If the disenrollment is retroactive, the Regional Office (RO) that grants the retroactive disenrollment will provide the beneficiary with the time frame for his/her SEP to elect another MA plan. However, the individual will not be allowed to choose an effective date into a new MA plan of more than three months after the month the new MA organization receives the completed enrollment election, and the effective date may not be earlier than the date the new MA organization receives the completed enrollment election.

## 30.4.3 - SEPs for Nonrenewals or Terminations

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

In general, SEPs are established to allow members affected by nonrenewals or terminations ample time to make a choice of their new election. Effective dates during these SEPs are described below. The CMS has the discretion to modify this SEP as necessary for any nonrenewals or terminations when the circumstances are unique and warrant a need for a modified SEP.

In particular:

- **Contract Nonrenewals -** A SEP exists for members of MA plans that will be affected by contract nonrenewals that are effective January 1 of the contract year (42 CFR §422.506). For this type of nonrenewal, MA organizations are required

to give notice to affected members at least 90 calendar days prior to the date of nonrenewal (42 CFR §422.506(a)(2)(ii)). To help coordinate with the notification time frames, the SEP begins October 1 and ends on December 31 of that year.

During this SEP, a beneficiary may choose an effective date of November 1, December 1, or January 1; however, the effective date may not be earlier than the date the new MA organization receives the completed enrollment election .

- **MA organization Termination of Contract and Terminations/Contract Modifications by Mutual Consent -** A SEP exists for members of plans who will be affected by a termination of contract by the MA organization or a modification or termination of the contract by mutual consent (42 CFR §§422.512 and 422.508(a)(1)). For this type of termination, MA organizations are required to give notice to affected members at least 60 calendar days prior to the proposed date of termination (§422.512(b)(2)). To help coordinate with the notification time frames, the SEP begins two months before the proposed termination effective date, and ends one month after the month in which the termination occurs.

  Please note that if an individual does not elect an MA plan before the termination effective date, he/she will be defaulted to Original Medicare on the effective date of the termination. However, the SEP will still be in effect for one month after the effective date of the termination should the individual wish to subsequently elect an MA plan (for a current, not retroactive, effective date).

  Beneficiaries affected by these types of terminations may request an effective date of the month after notice is given, or up to two months after the effective date of the termination. However, the effective date may not be earlier than the date the new MA organization receives the completed enrollment election.

  **EXAMPLE**

  If an MA organization contract terminates for cause on April 30, an SEP lasts from March 1 through May 31. In this scenario, a beneficiary could choose an effective date of April 1, May 1, or June 1; however, the effective date may not be earlier than the date the new MA organization receives the completed enrollment election.

- **CMS Termination of MA organization Contract -** A SEP exists for members of plans that will be affected by MA organization contract terminations by CMS (42 CFR 422.510). For this type of termination, MA organizations are required to give notice to affected members at least 30 calendar days prior to the effective date of the termination (422.510(b)(1)(ii)). To help coordinate with the notification time frames, the SEP begins 1 month before the termination effective date and ends 2 months after the effective date of the termination.

Please note that if an individual does not elect an MA plan before the termination effective date, he/she will be defaulted to Original Medicare on the effective date of the termination. However, the SEP will still be in effect for two months after the effective date of the termination should the individual wish to subsequently elect an MA plan (for a current, not retroactive, effective date).

Beneficiaries affected by these types of terminations may select an effective date of up to three months after the month of termination. However, the effective date may not be earlier than the date the new MA organization receives the completed election.

**EXAMPLE**

If CMS terminates an MA organization contract effective June 30, an SEP lasts from June 1 through August 31. In this scenario, a beneficiary could choose an effective date of July 1, August 1, or September 1; however, the effective date may not be earlier than the date the new MA organization receives the completed election.

- **Immediate Terminations By CMS -** CMS will establish the SEP during the termination process for immediate terminations by CMS (§422.510(b)(2)), where CMS provides notice of termination to an MA plan's members and the termination may be mid-month.

## 30.4.4 - SEPs for Exceptional Conditions

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

CMS has the legal authority to establish SEPs when an individual meets exceptional conditions specified by CMS. Currently CMS has established the following SEPs for exceptional conditions:

**1. SEP EGHP -** An SEP exists for individuals making MA elections into or out of employer sponsored MA plans and for individuals to disenroll from an MA plan to take employer sponsored coverage of any kind and for individuals disenrolling from employer sponsored coverage to elect an MA plan. The SEP EGHP may be used when the EGHP allows the individual to make changes in their health coverage choices, such as during the employer's annual "open season," or due to "life changes," e.g., changes in marital status, for the newly employed, etc.

The individual may choose an effective date of up to three months after the month in which the EGHP receives the completed enrollment election or disenrollment request. However, the effective date may not be earlier than the date the EGHP receives the completed enrollment election or disenrollment request.

**NOTE:** If necessary, the MA organization may process the election with a retroactive effective date, as outlined in §60.6. Keep in mind that all MA eligible individuals, including those in EGHPs, may elect MA plans during the AEP and ICEP, during any other SEP, and during the OEP if the plan is open for enrollment. The SEP EGHP does not eliminate the right of these individuals to make elections during these time frames.

**2. SEP for Individuals Who Disenroll in Connection with a CMS Sanction -** On a case by case basis, CMS will establish an SEP if CMS sanctions an MA organization, and an enrollee disenrolls in connection with the matter that gave rise to that sanction. The start/length of the SEP, as well as the effective date, are dependent upon the situation.

**3. SEP for Individuals Enrolled in Cost Plans that are Nonrenewing their Contracts -** An SEP will be available to enrollees of HMOs or CMPs that are not renewing their §1876 of the Act cost contracts for the area in which the enrollee lives.

This SEP is available only to Medicare beneficiaries who are enrolled with an HMO or CMP under a §1876 of the Act cost contract that will no longer be offered in the area in which the beneficiary lives. Beneficiaries electing to enroll in an MA plan via this SEP must meet MA eligibility requirements.

This SEP begins 90 calendar days prior to the end of the contract year (i.e., October 1) and ends on December 31 of the same year.

During this SEP, a beneficiary may choose an effective date of November 1, December 1, or January 1; however, the effective date may not be earlier than the date the new MA organization receives the completed election.

**4. SEP for Individuals in the Program of All-inclusive Care for the Elderly (PACE) -** Individuals may disenroll from an MA plan at any time in order to enroll in PACE. In addition, individuals who disenroll from PACE have an SEP for up to 2 months after the effective date of PACE disenrollment to elect an MA plan. The effective date would be dependent upon the situation.

**5. SEP for Dual-eligible Individuals or Individuals Who Lose Their Dual-eligibility -** There is an SEP for individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program including full-benefit dual eligible individuals, as well as those eligible only for the Medicare Savings Programs (QMB-only , SLMB-only, and QI). This SEP lasts from the time the individual becomes dually-eligible and exists as long as they receive Medicaid benefits. The effective date of an election made using this SEP would be dependent upon the situation.

In addition, MA-eligible individuals who are no longer eligible for Title XIX benefits have a 3-month period after the date it is determined they are no longer eligible to make an election.

**6. SEP for Individuals Who Dropped a Medigap Policy When They Enrolled For the First Time in an MA Plan, and Who Are Still in a "Trial Period" -** For Medicare beneficiaries who dropped a Medigap policy when they enrolled for the first time in an MA plan, §1882(s)(3)(B)(v) of the Act provides a guaranteed right to purchase another Medigap policy if they disenroll from the MA plan while they are still in a "trial period." In most cases, a trial period lasts for 12 months after a person enrolls in an MA plan for the first time. Such individuals would not be eligible for the special election period provided for in the last sentence of §1851(e) of the Act, because they did not enroll in an MA plan immediately upon becoming Medicare eligible, but instead had been in the Original Medicare Plan for some period of time. The right to "guaranteed issue" of a Medigap policy under §1882(s)(3)(B)(v) of the Act would be meaningless if individuals covered by this provision could not disenroll from the MA plan while they were still in a trial period.

Accordingly, there is an SEP for individuals who are eligible for "guaranteed issue" of a Medigap policy under §1882(s)(3)(B)(v) of the Act upon disenrollment from the MA plan in which they are enrolled. This SEP allows a qualified individual to make a one-time election to disenroll from their first MA plan to join the Original Medicare Plan at any time of the year. The effective date would be dependent upon the situation.

**7. SEP for Individuals with ESRD Whose Entitlement Determination Made Retroactively -** If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an MA plan during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an MA plan offered by the MA organization, provided:

a. They were in a health plan offered by the same MA organization the month before their entitlement to Parts A and B;

b. Developed ESRD while a member of that health plan; and

c. Are still enrolled in that health plan.

This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who performs self-dialysis will have his/her entitlement date adjusted to begin at the time of dialysis, rather than the customary 3-month period AFTER dialysis begins.

The SEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for 2 additional months after the month the notice is received. The election may only be made prospectively and the effective date is the first day of the month after the MA plan receives the completed election.

**8. SEP for Individuals Whose Medicare Entitlement Determination Made Retroactively -** If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an MA plan during his/her

ICEP. Therefore, these individuals will be allowed to elect an MA plan offered by the MA organization. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely.

The SEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for two additional months after the month the notice is received. The effective date depends on the situation but is not earlier than the first day of the month in which the notice of the Medicare entitlement determination is received by the individual.

**9. SEP for Other LIS Eligible Individuals Who are Not Dual Eligible Individuals Whose Part D Enrollment is Facilitated** – If CMS facilitates enrollment for Other LIS Eligible individuals (who are not dual eligible individuals) enrolled in an MA-only plan into an MA-PD plan, the individual has an SEP to change to a different MA plan in the same organization. The SEP begins with the effective date of the facilitated enrollment, and ends on December 31st of the same year.

**10. Part D Coordinating SEPs –** Individuals eligible for an SEP under the guidance for Part D enrollment and disenrollment may use that SEP to make an election into or out of an MA-PD plan (as applicable). Most Part D SEPs are duplicated in the MA program as described above. Those that are not included above are provided here:

A. Involuntary loss of creditable coverage, including a reduction in the level of coverage so that it is no longer creditable, not including any such loss or reduction due to a failure to pay premiums. The SEP permits enrollment into a Part D plan and begins with the month in which the individual is advised of the loss of creditable coverage and ends 60 days after either the loss (or reduction) occurs or the individual received notice, whichever is later.

B. Individuals who are not adequately informed of a loss of creditable coverage, or that s/he never had creditable coverage have an SEP to enroll in a Part D plan. The SEP applies only once; at the time the individual enrolls in a Part D plan.

C. Individuals whose enrollment or non-enrollment in a Part D plan is erroneous due to an action, inaction or error by a Federal Employee. The SEP permits disenrollment and/or enrollment in a Part D plan on a case-by-case basis. Requests for this SEP must be developed and presented to the CMS Regional Office serving the MA-PD plan for which the SEP will apply. Following CMS approval of the SEP, it will remain available for 90 days following notification to the individual.

These Part D coordinating SEPs apply only to MA-PD elections. For more information about PDP enrollment and disenrollment, please refer to the CMS guidance for PDPs.

## 30.4.5 - SEPs for Beneficiaries Age 65 (SEP65)

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Beginning January 1, 2006, MA eligible individuals who elect an MA plan during the initial enrollment period (IEP) surrounding their 65th birthday have an SEP. This "SEP65" allows the individual to disenroll from the MA plan and elect the Original Medicare plan any time during the 12-month period that begins on the effective date of coverage in the MA plan.

The IEP is established by Medicare and begins 3 months before and ends 3 months after the month of the individual's 65th birthday.

## 30.5 - Effective Date of Coverage

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not request their effective date. Furthermore, except for EGHP elections, the effective dateis generally not prior to the receipt of a complete election by the MA organization. An enrollment cannot be effective prior to the date the beneficiary or their legal representative signed the enrollment form or completed the enrollment election. Section 40.2 includes procedures for handling situations when a beneficiary chooses an enrollment effective date that is not allowable based on the requirements outlined in this section.

To determine the proper effective date, the MA organization must determine which election period applies to each individual before the enrollment may be transmitted to CMS. The election period may be determined by reviewing information such as the individual's date of birth, Medicare card, a letter from SSA, or by the date the completed enrollment *election* is received by the MA organization.

Once the election period is identified by the MA organization, the MA organization must determine the effective date. Refer to §60.7 to determine the effective date for a continuation of enrollment. In addition, EGHP enrollments may be retroactive. (Refer to §60.6 for more information on EGHP retroactive effective dates.)

Effective dates are as follows:

| **Election Period** | **Effective Date of Coverage** | **Do MA organizations have to accept elections in this election period?** |
|---|---|---|
| Initial Coverage Election Period | First day of the month of entitlement to Medicare Part A and Part B – or- The first of the month following the month the election was made if after entitlement has occurred. | Yes – unless capacity limit applies |
| Open Enrollment Periods (OEP, OEPNEW, OEPI | First day of the month after the month the MA organization receives a completed enrollment election. | No the MA organization can choose to be "opened" or "closed" to accept enrollments during these periods. |
| Annual Election Period | January 1 of the following year<br>For the 2005 AEP, elections made from January 1, 2006 through May 15, 2006 are effective the first of the month following the month the election was made. | Yes – unless capacity limit applies |
| Special Election Period | Varies, as outlined in §30.4 | Yes – unless capacity limit applies |
| Initial Enrollment Period for Part D | First day of the month of entitlement to Medicare Part A and Part B – or- The first of the month following the month the election was made if after entitlement has occurred.<br>Note: For 2006, IEP for Part D enrollment requests made from January 1, 2006 through May 15, 2006 are effective the first of the month following the month the election was made. | Yes – unless capacity limit applies (see §30.8 for capacity limit information) This period is applicable only to MA-PD enrollment elections. |

It is possible for an individual to make an enrollment election when more than one election period applies, and therefore it is possible that more than one effective date could be used. Therefore, if an individual makes an enrollment election when more than one election period applies, an MA organization must allow the individual to choose the election period (and therefore the effective date) in which he/she is enrolling (see exception in the next paragraph regarding the ICEP).

If the individual's ICEP and another election period overlap, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and enrollment in Part B.

**EXAMPLE**

- If an individual will be entitled to Medicare Part A and Part B in February his ICEP is November through May. If an MA organization receives a completed enrollment election from that individual during the AEP, then the individual may NOT choose a January 1 effective date for the AEP and must be given a February 1 effective date for the ICEP because January 1st is earlier than the month of entitlement to Medicare Part A and enrollment in Part B.

If an individual makes an enrollment election when more than one election period applies but does not indicate or select an effective date, then the MA organization should assign an effective date that benefits the individual and should attempt to contact the individual to determine the individual's preference. If unsuccessful, the MA organization must use the following ranking of election periods (1 = Highest, 4 = Lowest). The election period with the highest rank generally determines the effective date of enrollment (refer to §30.6 for procedures to determine the effective date of voluntary disenrollment).

Ranking of Election Periods: (1 = Highest, 4 = Lowest)

1. ICEP

2. SEP

3. AEP

4. OEP / OEPNEW / OEPI

## 30.5.1 - Effective Date of Auto- and Facilitated Enrollments

**(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)**

The effective dates for auto-enrollment and facilitated enrollment are described in §40.1.6 and 40.1.7 of this chapter.

## 30.6 - Effective Date of Voluntary Disenrollment

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not select their effective date of disenrollment. Section 50.1 includes procedures for handling situations when a beneficiary chooses a disenrollment effective date that is not allowable based on the requirements outlined in this section.

When a member disenrolls through the MA organization, SSA, the RRB, or 1-800-MEDICAR(E), the election will return the member to Original Medicare. If a member elects a new MA plan while still a member of a different plan, he/she will automatically be disenrolled from the old plan and enrolled in the new plan by CMS systems with no duplication or delay in coverage.

As with enrollments, it is possible for a member to make a disenrollment request when more than one election period applies. Therefore, in order to determine the proper effective date, the MA organization **must** determine which election period applies to each member **before** the disenrollment may be transmitted to CMS.

If an MA organization receives a completed disenrollment request when more than one election period applies, the MA organization must allow the member to choose the effective date of disenrollment. If the member does not make a choice of effective date, then the MA organization must give the effective date that results in the **earliest** disenrollment.

Effective dates for voluntary disenrollment are as follows. (Refer to §§50.2 and 50.3 for effective dates for involuntary disenrollment.)

| **Election Period** | **Effective Date of Disenrollment*** | **Do MA organizations have to accept elections in this election period?** |
|---|---|---|
| Open Enrollment Periods | First day of the month after the month the MA organization receives a completed disenrollment request. | Yes -because Original Medicare is always open during this election period. Refer to §30.3 for information on OEP limitations. |
| Annual Election Period | January 1 of the following year. | Yes |
| Special Election Period | Varies, as outlined in §30.4 | Yes |

***NOTE:** ROs may allow up to 90 days retroactive payment adjustments for EGHP disenrollments. Refer to §60.6 for more information.

## 30.7 - Election Periods and Effective Dates for Medicare MSA Plans

***(Rev. 66, Issued: 08-05-05; Effective: 08-05-05)***

Individuals may only enroll in Medicare MSA plans (should one be offered in their area) during the ICEP or the AEP; they may not enroll in Medicare MSA plans during the OEP. The effective date of coverage is determined by the election period in which an election is made. Effective dates are provided in §30.5 of this chapter.

Individuals may only disenroll from Medicare MSA plans during the AEP or SEP. The effective date of disenrollment during an SEP depends on the type of SEP and the reason members must disenroll.

**CANCELLATION OF MA MSA ELECTION:**

An individual who elects an MA MSA plan during an AEP, and who has never before elected an MA MSA plan, may revoke (i.e., "cancel") that election, but must do so by December 15 of the year in which they elected the Medicare MSA plan. This cancellation will ensure the election does not go into effect on January 1.

## 30.8 - Closed Plans, Capacity Limits, and Reserved Vacancies

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An MA organization may specify a capacity limit for one or all of the MA plans it offers and reserve spaces for individual and employer group commercial members who are converting from a commercial product to an MA product at the time the member becomes eligible (i.e., conversion enrollments). When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all prospective enrollees (with the exception of reserved vacancies) until space becomes available.

All MA plans (with the exception of MA MSA plans; see §30.7) must accept elections made during the AEP, ICEP and SEP unless an approved capacity limit applies. Only with an approved number of reserved vacancies may an MA organization set aside openings for the enrollment of conversions (i.e., ICEP elections).

Unlike the mandatory election periods (AEP, ICEP and SEP), an MA organization has the option to be open for elections made during the OEP. An MA organization may voluntarily close one or more of its MA plans during any portion of the OEP. If an MA plan is closed for OEP enrollment, then it is closed to all individuals in the entire plan service area who are making OEP elections. All MA plans must accept OEP disenrollment elections, subject to the OEP limitation described in §30.3.2, whether or not it is open for enrollment.

**NOTE**: When transitioning Medicaid beneficiaries in 2006, MA organizations must ensure that the MA-PD plans into which beneficiaries are deemed to have

enrolled have the capacity to accept them. Should a capacity limit be proposed for an MA-PD plan, it must be set high enough to ensure all beneficiaries may be transitioned.

## 30.8.1 - MA Plan Closures

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The decision to be open or closed for OEP enrollment elections rests with the MA organization and does not require CMS approval. However, if an MA organization has an MA plan that is open during an OEP, and decides to change this process, it must notify CMS and the general public 30 calendar days in advance of the new limitations on the open enrollment process.

If an MA organization has more than one MA plan, those plans may be open or closed independent of one another, as the MA organization determines. Further, each MA plan may be open for all or only part of the OEP. For example, an MA plan may be open:

1. Only some months of the OEP (such as only during March and April);

2. Some portion of certain months; and/or

3. During the first 25 days (or any part) of each month.

When an MA plan is voluntarily closed for the OEP, it is closed to **ALL** OEP enrollment elections, but must still accept elections made during the ICEP and SEP as well as be open for the AEP, unless an approved capacity limit applies and has been reached (excluding reserved vacancies). The CMS may approve a partial service area closure for capacity reasons. If a plan is closed in a portion of its service area for capacity reasons, that plan may be open during the OEP in the remaining portion of the service area.

When an MA plan is closed due to an approved capacity limit that has been reached, it may continue to accept ICEP (i.e., conversion) enrollments only if there are reserved vacancies set aside. If there are no reserved vacancies, or once all of these vacancies have been filled, the MA organization cannot accept any new enrollees into the MA plan until space becomes available. Refer to §40.5.1 for more information on enrollment processing after reaching capacity.

Refer to §40.5 of this chapter for additional information on enrollment processing during closed periods.

If an MA organization has an MA plan that is approved by CMS for a capacity limit, it should estimate when a capacity limit will be reached and notify CMS and the general public 30 calendar days in advance of the closing of the open enrollment process. If CMS approves the capacity limit for immediate closing of enrollment, the MA organization

must notify the general public within 15 calendar days of CMS approval that it has closed for enrollment.

Exhibit 23 contains three model notices that MA organizations can use to notify the public when they are closing for enrollment. **NOTE:** Public notices must receive CMS approval under the usual marketing review process.

When an MA organization has a plan that re-opens after being closed during an OEP or as a result of a capacity limit, there is no requirement for the MA organization to notify the general public. However, the MA organization should notify CMS when this occurs.

## 40 - Enrollment Procedures

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An MA organization must accept elections it receives, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, or through other mechanisms defined by CMS.

An individual must complete and sign an enrollment election form, or complete another CMS accepted form or CMS approved election method, to enroll in an MA plan, **even if that individual is electing an MA plan in the same MA organization in which he/she is enrolled**. If an individual wishes to elect another MA plan in the same MA organization, he/she must complete a new enrollment election to enroll in the new MA plan. In addition to other CMS approved election methods, a short enrollment form (refer to Exhibit 3 for a model short enrollment form) OR a model selection form (Exhibit 3a) may be used to make the election of another plan in the same organization in place of the comprehensive individual enrollment form. With the exception of forms that are faxed to the MA organization, individuals should submit original, not photocopied, forms. Individuals who are currently MA enrollees in an organization may also elect to enroll in another MA plan in the same MA organization via telephone as described in §20.4.4, if the MA organization offers this option. Enrollment may also be made enroll via Auto- and Facilitated enrollment processes as described in §20.4.6 and 20.4.7 of this chapter.

An MA organization must send the beneficiary notice of an MA organization denial of enrollment, CMS confirmation of enrollment, or CMS rejection of enrollment, as described in §§40.2.3 and 40.4.2. All notice requirements are summarized in Appendix 1.

MA organizations may not delay the processing of enrollment elections unless the beneficiary's election is being placed on a waiting list, as allowed under §40.5. However, in 2005 we recognize that MA organizations may receive an enrollment election for a January 1, 2006 enrollment prior to November 15th. While MA organizations are not allowed to request such enrollment elections, and are required to remind beneficiaries that they cannot submit such elections until November 15, in 2005 the following

procedure will be allowed if enrollment elections for a January 1, 2006 effective date are received prior to November 15, 2005:

1. Prior to submitting the enrollment transaction to CMS, the MA organization must contact the beneficiary (via phone or mail) AND confirm that s/he still intends to enroll in the plan. The MA organization can combine approaches, e.g., by sending a follow-up letter in writing, and then allowing the beneficiary to contact the MA organization via phone to confirm.

2. The MA organization must document this contact (either verbally or in writing), i.e., by retaining a copy of the written confirmation, or noting in the beneficiary's record that confirmation was obtained, and the details of that conversation.

3. For those enrollments received and "held" prior to November 15, 2005, MA organizations will be required to submit these transactions to CMS systems (MARx) as if received on November 15th. The application receipt date will be November 15, 2005, or the date the beneficiary provides confirmation, if this occurs after November 15th.

4. On November 15, 2005, the MA organization must begin providing all the information required to be given to each enrollee prior to the effective date (refer to §40.4.1) including the following specific items:

    - Acknowledgement letter notifying the beneficiary that the MA organization has submitted the transaction to CMS for processing. This notice must be sent within 7 business days of November 15, 2005.

    - Confirmation letter notifying the beneficiary that s/he is enrolled in the plan. This must be sent within seven (7) business days of receipt of confirmation by CMS' systems.

**<u>Special note for MA-PD enrollment when an individual has other qualified prescription drug coverage through an employer or union group:</u>**

CMS systems will compare MA-PD enrollment transactions to information CMS has regarding the existence of employer or union sponsored qualified prescription drug coverage. If there is a match indicating that the individual may have such other coverage, the enrollment will be conditionally rejected by CMS systems as incomplete.

The MA organization must contact the individual to confirm the individual's intent to enroll, and that the individual has discussed and understands the implications of enrollment in a Part D plan on his or her employer coverage. The MA organization must document this contact and retain it with the record of the individual's enrollment request. If the individual indicates that s/he is fully aware of any consequence to his/her employer/union coverage brought about by enrolling in the Part D Plan, and confirms s/he still wants to enroll, the MA organization must update the transaction with the

appropriate "flag" (detailed instructions for this activity are included with CMS systems guidance) and re-submit it for enrollment. The effective date of enrollment will be based upon the individual's initial enrollment request. This effective date may be retroactive in the event that the confirmation step occurs after the effective date.

## 40.1 - Format of Enrollment Elections

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

MA organizations must have, at minimum, a paper enrollment form process (as described in this chapter and approved through the CMS marketing material review process described in Chapter 3 of this manual) available for potential enrollees to elect enrollment in an MA plan. MA organizations will also process auto- and facilitated enrollment elections into MA-PD plans as described in §40.1.6 and §40.1.7 of this section.

MA organizations have the option to accept enrollment elections as described in §§40.1.2, 40.1.3, 40.1.4 and 40.1.5 below.

## 40.1.1 - Enrollment Form

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The MA organization must use an enrollment form that complies with CMS' guidelines in format and content. A model individual enrollment form is included as Exhibit 1; a model EGHP enrollment form is included as Exhibit 2. For elections into another plan within the same MA organization, a model short form is included as Exhibit 3; and a model selection form is included as Exhibit 3a.

Enrollment forms must include the "statements of understanding" which are the statements as shown on the model form(s) that the beneficiary initials to signify understanding of each statement. These include information on enrollment election limitations, consequence of enrollment, the requirement to continue to keep Medicare Part A and B, etc. Please refer to Exhibits 1 – 3 for complete information on the required statements.

No enrollment form or other enrollment election mechanism may include a question regarding whether the individual receives hospice coverage or any other health screening information, with the exception of questions regarding ESRD status and nursing home status (some additional exceptions apply for SNPs; please refer to §40.2, item "D" and §70 of this chapter).

Refer to §60.8 for requirements regarding retention of enrollment forms.

## 40.1.2 - Optional Employer Group MA Enrollment Election

***(Rev. 66, Issued: 08-05-05; Effective: 08-05-05)***

As described in §20.4.1 of this chapter, beginning April 1, 2003, MA organizations that offer MA plans to employer groups may choose to accept voluntary enrollment elections directly from an employer group (or its TPA) without obtaining an MA election form from each individual. The elections reported to the MA organization will reflect the choice of retiree coverage individual enrollees made using their employer's process for selecting a health plan. This election mechanism is optional for MA organizations, and may not be required. Therefore, MA organizations may specify the employer groups, if any, from which they will accept this election format and may choose to accept these enrollment elections. It is the MA organization's responsibility to ensure that the process it uses, as well as the process used by the employer, meets the following requirements:

- The MA organization must inform its Regional Office Plan Manager of its intent to use this mechanism and identify the employer group(s) for which it will be accepting enrollments, made in this manner.

- The enrollment information (i.e., the electronic file) submitted to the MA organization by an employer (or TPA) must accurately reflect the employer's record of the election of coverage made by each individual according to the processes the employer has in place, and may be accepted without a hard-copy MA election form.

- Sales package minimum information requirements are not changed by using this option. These include, but are not limited to, providing the applicable rules of the MA organization. Each individual's enrollment election must clearly denote his/her agreement to abide by the MA organization rules, certify his/her receipt of required disclosure information and include authorization by the beneficiary for the disclosure and exchange of necessary information between the U.S. Department of Health and Human Services (and its designees) and the MA organization. The requirements for all other information provided to enrollees, both pre- and post-enrollment, are unchanged by this option and must be satisfied.

- The enrollment election transaction must include all the data necessary for the MA organization to determine each individual's eligibility to make an election as described in §20 of this chapter of the MMCM. Agreements with employer groups should identify required data elements. A detailed list of these elements is provided as Appendix 2.

- This alternate election mechanism is used in place of paper MA election forms, and does not require a signature. For purposes of compatibility with existing instructions in this chapter, the "signature" date of elections made in this manner will be the date the retiree completes his/her employer's coverage choice process, as recorded by the employer. The MA organization "receipt" date will be the date the employer's record of an individual's choice is received by the MA organization. MA organizations must record these dates.

- Effective date calculation of voluntary elections and the collection and submission of elections to CMS will follow existing procedures.

- To accept electronic records of employer group elections, the MA organization must, at minimum, comply with the CMS security policies regarding the acceptable method of encryption utilized to provide for data security, confidentiality and integrity, and authentication and identification procedures to ensure both the sender and recipient of the data are known to each other and are authorized to receive and decrypt the information. (See the CMS web site at: http://www.cms.hhs.gov/it/security for additional information.)

- The employer's record of the election must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, the MA organization and/or CMS as necessary, and be maintained (by the employer or the MA organization, as they agree) for at least 6 years following the effective date of the individual's disenrollment from an MA plan. The MA organization must maintain its record of information received from the employer following the guidelines for MA election forms (see §60.8).

## 40.1.3 - Enrollment via the Internet

***(Rev. 66, Issued: 08-05-05; Effective: 08-05-05)***

As described in §20.4.3, beginning November 15, 2005, MA organizations may develop and offer enrollment elections into an MA plan via a secure internet web site. The following guidelines must be applied in addition to all other program requirements:

- Inform the CMS Regional Office plan manager of the intent to offer this enrollment election option

- Submit all materials and web pages for CMS approval following the established process for the review and approval of marketing materials

- Provide beneficiaries with all the information required by CMS' marketing guidelines for the MA program

- At a minimum, comply with CMS' internet security policies (found at:

  http://www.cms.hhs.gov/it/security on the web)

- Advise each individual at the beginning of the online enrollment process that he/she is sending an actual enrollment election to the MA organization

- Capture the same data as required on the paper enrollment form (see Appendix 2)

- As part of the online enrollment process include a separate screen or page that includes an "enroll now," or "I agree," type of button, that the individual must

click on to indicate his/her intent to enroll and agreement to the release and authorization language (as provided on the model enrollment form, see Exhibit 1) and attest to the truthfulness of the data provided. The process must also remind the individual of the penalty for providing false information

- If a legal representative is completing this election mechanism, s/he must attest that s/he has such authority to make the election and that proof of this authority is available upon request by the MA organization or CMS

- Inform the individual of the consequences of completing the internet enrollment, including that s/he will be enrolled (if approved by CMS), and that s/he will receive notice (of acceptance or denial) following submission of the enrollment to CMS

- While an internet enrollment process must provide the enrolling individual with the opportunity to choose premium payment withhold from Social Security, Railroad Retirement or Office of Personnel Management benefit checks, it may not request or collect premium payment or other payment information, such as a bank account number or credit card numbers.

- Maintain electronic records that are readily reproducible for the period required in §60.8 of this chapter.

**Medicare Online Enrollment Center**

In addition to the process described above, CMS will provide an on-line enrollment center through the www.medicare.gov web site and the 1-800-Medicare call center for enrollment into Medicare prescription drug plans – including MA-PD plans. MA organization participation for MA-PD plans is encouraged, but not required. Additional information will be provided by CMS as this project is developed and implemented.

## 40.1.4 - Enrollment Via Telephone for Current MA Plan Enrollees

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

As described in §20.4.4, beginning November 15, 2005, MA organizations may offer enrollment into an MA plan via the telephone limited only to individuals already enrolled in another MA plan offered by the organization.

The MA organization must ensure that all MA eligibility and election requirements provided in this chapter are met. Individuals electing to enroll in this manner must be advised that they are completing an MA enrollment election during this process and before the election can be considered to have been made. Audio recording of the call is not required however MA organizations offering this enrollment mechanism must keep a record of the call as part of its enrollment records for the individual. For example, the

organization may employ a form that the organization staff person completes to create a record.

Scripts for completing an enrollment election in this manner must be developed by the MA organization and obtain CMS approval, following existing marketing material approval procedures, prior to use.

## 40.1.5 - Seamless Conversion Enrollment Option for Newly Medicare Eligible Individuals

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

As described in §20.4.5, MA organizations may develop processes to provide seamless enrollment in an MA plan for newly Medicare eligible individuals who are currently enrolled in other health plans offered by the MA organization (such as commercial or Medicaid plans) at the time of their conversion to Medicare. CMS will review an organization's proposal and must approve it before use. Any such proposal must be sent to the MA organization's Regional Office plan manager with a copy to the Central Office plan manager and must meet the conditions provided in §40.1.5 of this chapter before such a process may be used.

- A description of the MA organizations process to identify individuals currently enrolled in a health plan offered by the organization. Such process must be able to identify these individuals no later than 120 days prior to the date of initial Medicare eligibility (the conversion date).

- A description of the outreach activity associated with the seamless conversion process including a written notice provided to each individual at least 90 days prior to the date of conversion. The notice must include clear information instructing the individual on how to opt-out, or decline, the seamless conversion enrollment.

- The process to opt-out or decline the seamless conversion enrollment must include both the opportunity to contact the MA organization in writing or by telephone to a toll-free number. The MA organization is prohibited from discouraging declination.

- Enrollment transactions submitted to CMS for these cases must always use the first day of an individual's ICEP as the application date in the transaction record. Doing so ensures that any subsequent action taken by the individual will take precedence in systems processing.

## 40.1.6 - Auto-enrollment of Full-Benefit Dual Eligible Individuals

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

As described in §20.4.6, full-benefit dual eligible individuals enrolled in an MA plan without Medicare prescription drug benefits ("MA-only plan") effective 2006, will be auto-enrolled into an MA-PD plan in the same organization. The auto-enrollment process will begin in September 2005, and continue monthly thereafter. As noted in the preamble to the final regulation for Part D (Federal Register/Vol. 70, No. 18, January 28, 2005), the legal authority for this process is technically termed "facilitated" enrollment, since auto-enrollment is limited to PDPs. However, the term "auto-enrollment" is used here to denote the process that applies to full-benefit dual eligible individuals.

The procedure for auto-enrollment is as follows:

1. The MA organization will identify full-benefit dual eligible individuals who are in an MA-only plan. For individuals who are Medicaid eligible first and then become Part D eligible, the MA organization will make every effort to identify and auto-enroll them prior to the effective date of Part D eligibility. This includes full-benefit dual eligible MA-only enrollees who:

    - Live in the 50 states or the District of Columbia; and

    - Regardless of whether the employer is claiming the retiree drug subsidy for that individual, or whether the individual is enrolled in an employer-sponsored MA-only plan, including MA-only "800" plans.

    This excludes full-benefit dual eligibles who:

    - Live in any of the six U.S. territories;
    - Live in another country;
    - Are inmates in a correctional facility; and
    - Have affirmatively declined Part D benefits

2. The MA organization will then identify MA-PD plans in the same service area, and in the same MA organization, with the lowest Part D premium amount. If more than one MA-PD plan have the same lowest premium amount, auto-enrollment must be random among the available MA-PD plans. The selection of MA-PD plan is without regard to the Part C premium or cost-sharing. If an MA Special Needs Plan (SNP) meets these criteria, the MA organization must ensure that the individual meets the eligibility criteria for the SNP.

3. The MA organization will create and process an enrollment transaction for the auto-enrollment into the MA-PD plan. The new MA-PD plan will be notified via a transaction reply of the auto-enrollment.

**<u>Effective Date of Auto-enrollment for Full-Benefit Dual Eligible Individuals</u>**:

For those who are full-benefit dual eligible individuals in 2005, the effective date will be January 1, 2006. For full-benefit dual eligible individuals who newly enroll in an MA-

only plan after January 1, 2006, marketing material and the acknowledgement letter will emphasize that prescription drugs are not covered. The MA-only plan is required to submit an enrollment transaction to auto-enroll these full-benefit dual eligibles into an MA-PD plan. The auto-enrollment notice will explain the option to remain with the MA-only plan and the consequences of doing so (no Part D benefits). The effective date of the auto-enrollment transaction will be the first day of the second month after the individual is identified. This gives the person time to confirm she/he wants to remain with the MA-only plan and that they affirmatively decline Part D benefits prior to auto-enrollment taking effect. The effective date will be included on the enrollment transaction.

**Notice**:

The MA organization will notify the beneficiary that she/he will be enrolled in the given MA-PD plan on the auto-enrollment effective date unless the person chooses another Part D plan (either another MA-PD plan, or Original Medicare with a PDP), or affirmatively declines Part D benefits altogether. If the beneficiary does not affirmatively decline, or choose another Part D plan by the last day of the month before the effective date, the person's silence will be deemed consent with the auto-enrollment, and it will take effect on the effective date. These individuals will also be informed they have a Special Enrollment Period (SEP) that permits them to change Part D plans at any time, even after the auto-enrollment takes effect. For the initial round of auto-enrollment in the fall of 2005, please use the model Annual Notice Of Change (ANOC) that CMS will provide specifically for auto-enrollment situations (refer to Chapter 3 of this manual). For subsequent auto-enrollment, please use the model notice language CMS will provide in this chapter.

**Affirmatively Decline**:

Full-benefit dual eligible individuals may affirmatively decline the Part D benefit. For an MA-only plan enrollee, this primarily means declining auto-enrollment into an MA-PD plan in the same organization and maintaining enrollment in the MA-only plan. The MA plan should counsel the individual to ensure they understand the implications of their request to decline, and should confirm this in writing (please see model notice). However, a full-benefit dual eligible individual who affirmatively declines does not permanently surrender his or her eligibility for, or right to enroll in, a Part D plan; rather, this step ensures the person is not included in future monthly auto-enrollment processes.

**Information Provided to Auto-Enrolled Beneficiaries:**

The MA-PD plan into which the beneficiary has been auto-enrolled must send a modified version of the pre- and post-enrollment materials required to be provided to new enrollees.

Prior to effective date, the MA-PD plan must send:

- The information required in Section 40.4.1, and

- A Summary of Benefits (those who are auto-enrolled still need to make a decision whether to stay with the plan into which they have been auto-enrolled or change to another one that better meets their needs). Providing the Summary of Benefits, which is considered marketing material normally provided prior to making an enrollment election, ensures that those auto-enrolled have a similar scope of information as those who voluntarily enroll).

After the effective date of coverage:

- The guidance in Section 40.4.2 applies, including guidance on what to do if the MA-PD is not notified early enough of an auto-enrollment to meet the timelines in Section 30.4.1 on materials required to be provided prior to the effective date.

The requirement on informing the beneficiary of whether the enrollment was accepted or rejected does not apply to auto-enrollments, since CMS generates these transactions.

## 40.1.7 - Facilitated Enrollment of Other LIS Eligible Individuals

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

As described in §20.4.7, enrollment of other LIS eligible individuals enrolled in MA-only plans will be facilitated at the end of their respective Initial Enrollment Period for Part D. CMS will delegate facilitated enrollment of this population to MA organizations. Facilitated enrollment for this population will first occur at the end of the Initial Enrollment Period for Part D (May 15, 2005), and take place monthly thereafter. Since this population is not losing Medicaid prescription drug coverage, CMS intends to provide maximum opportunity for them to choose a Part D plan before facilitating their enrollment.

The procedure for facilitated enrollment of other LIS eligible individuals as follows:

1. The MA organization will identify other LIS eligible individuals who are enrolled in an MA-only plan in its MA organization.

   This includes Other LIS eligible MA-only enrollees who:
   - Live in the 50 states or the District of Columbia.

   This excludes Other LIS eligible individuals who:
   - Live in any of the six U.S. territories, or
   - Live in another country, or
   - Are individuals for whom the employer is claiming the retiree drug subsidy, or are enrolled in an employer-sponsored MA-only plan, including MA-only “800” plans, or
   - Are inmates in a correctional facility, or

- Have affirmatively declined Part D benefits.

2. The MA organization will then identify the MA-PD plan(s) in the same service are and in the same MA organization with the lowest Part D premium amount. If more than one MA-PD plan have the same lowest premium amount, enrollment must be random among these MA-PD plans. The selection of MA-PD plan is without regard to the Part C premium or cost-sharing. If an MA Special Needs Plan (SNP) meets these criteria, the MA organization must ensure that the individual meets the eligibility criteria for the SNP.

3. The MA organization will create and submit an enrollment transaction for the facilitated enrollment into the MA-PD plan.

**Effective Date of Facilitated Enrollment for Other LIS Eligible Individuals**:

The effective date for individuals whom are newly eligible for Medicare will be the first of the month after the end of the individuals' Initial Enrollment Period for Part D. When an individual's Initial Enrollment Period for Part D ends May 15, 2006, the effective date will be June 1, 2006. The MA organization must include the appropriate effective date on the enrollment transaction.

Other LIS eligibles who are QMB-only, SLMB-only, or QI have a Special Enrollment Period that not only allows them to switch Part D plans at any time, but also permits them to enroll at any time (see Section 30.3.4.5). For these individuals, the effective date of facilitated enrollment is the first day of the second month after the MA-only plan identifies the person.

For those deemed eligible for LIS because they are SSI-only, or apply and are determined eligible for LIS by SSA or a State, the effective date of facilitated enrollment will be the first of the month after the end of the individuals' next valid enrollment period. This could be the individual's Initial Enrollment Period (IEP) or the Annual Election Period (AEP). If the MA organization identifies the person no later than the third month prior to the end of the person's IEP, then the facilitated enrollment effective date is the first day of the month after the end of the IEP; otherwise, it will be the first day after the end of the next AEP. This lead time is necessary to meet the requirement that facilitated enrollment give the person enough time to change Part D plans or affirmatively decline prior to facilitated enrollment taking effect.

**EXAMPLE:** A person who is already SSI-only or applied and been determined LIS eligible becomes Medicare eligible May 2007. Facilitated enrollment is effective September 1.

**EXAMPLE:** A person becomes newly Medicare eligible May 1, 2007, and their Part D IEP ends August 31, 2007. They submit an application for LIS to SSA in July, 2007, and SSA notifies CMS in August that the person is retroactively eligible for LIS back to July 1, 2007 (LIS is effective the first day of the month the application is received). Since the IEP ends August 31, 2007, there is not enough time to notify the

person and give them a chance to change or affirmatively decline if facilitated enrollment took effect the first day of the month after the IEP ends. The facilitated enrollment is effective January 1, 2008 (first day after end of AEP).

**Notice**:

The MA organization will notify each individual that she/he will be enrolled in the given MA-PD plan on the facilitated enrollment effective date unless the person chooses another Part D plan, or affirmatively declines Part D benefits altogether. If the beneficiary does not affirmatively decline, or choose another Part D plan by the last day of the month before the effective date, the person's silence will be deemed consent with the facilitated enrollment, and it will take effect on the effective date. They will also be informed they have an SEP that permits them to change MA-PD plans once after facilitated enrollment takes effect (see §30.4). CMS will provide model notice language.

**Affirmatively Decline**:

Other LIS eligible individuals may affirmatively decline the Part D benefit. For an MA-only plan enrollee, this primarily means declining the facilitated enrollment into an MA-PD plan in the same organization and maintaining enrollment in the MA-only plan. The MA plan should counsel the individual to ensure they understand the implications of their request to decline, and should confirm this in writing (please see model notice). However, individuals who affirmatively decline do not permanently surrender their eligibility for, or right to enroll in, a Part D plan; rather, this step ensures the person is not included in future monthly facilitated enrollment processes.

**Information Provided to Facilitated-Enrolled Beneficiaries:**

The MA-PD plan into which the beneficiary has been enrolled must send a modified version of the pre- and post-enrollment materials required to be provided to new enrollees.

Prior to effective date, the MA-PD plan must send:

- The information required in Section 40.4.1, and

- A Summary of Benefits (those who are facilitated-enrolled still need to make a decision whether to stay with the plan into which they have been auto-enrolled or change to another one that better meets their needs). Providing the Summary of Benefits, which is considered marketing material normally provided prior to making an enrollment election, ensures that those enrolled have a similar scope of information as those who voluntarily enroll).

After the effective date of coverage:

- The guidance in §40.4.2 applies, including guidance on what to do if the MA-PD is not notified early enough of an enrollment to meet the timelines in §30.4.1 on materials required to be provided prior to the effective date.

## 40.1.8 - Group Enrollment for Employer or Union Sponsored Plans

**PENDING**

## 40.2 - Completing the Enrollment

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

If an enrollment form is filled out during a face-to-face interview, the MA organization should use the individual's Medicare card to verify the spelling of the name, and to confirm the correct recording of sex, Health Insurance Claim Number, and dates of entitlement to Medicare Part A and enrollment in Part B. If the form is mailed or faxed to the MA organization, or the election is made through another CMS approved method, the MA organization should verify this information with the individual via telephone or other means, or request that the individual include a copy of his/her Medicare card when mailing in the enrollment form.

Appendix 2 lists all the elements that must be filled out in order to consider an enrollment election "complete." If the MA organization receives an enrollment election that contains all these elements, the MA organization must consider the enrollment complete even if all other data elements on the enrollment election are not filled out. If an MA organization has received CMS approval for an enrollment election that contains data elements in addition to those included in Appendix 2, then the election is considered complete even if those additional elements are incomplete.
If an MA organization receives an enrollment election that does not have all necessary elements required in order to consider it complete, it must not deny the enrollment. Instead, the enrollment is considered incomplete and the MA organization must follow the procedures outlined in §40.2.2 in order to complete the enrollment. Where possible, the MA organization should check available systems for information to complete an enrollment before requiring the beneficiary to provide the missing information. For example, if a beneficiary failed to fill out the "sex" field on the enrollment, the MA organization could obtain this information via available systems rather than request the information from the beneficiary.

For employer group health plan enrollees, the MA Organization may choose to accept enrollment elections as described in §40.1.1 or §40.1.8. All required elements as listed in Appendix 2 must be included in the election record for the election to be considered complete (except signature). Follow the procedures outlined in §40.2.2 to address incomplete election records.

For enrollment elections via the Internet, as described in §40.1.3, all required elements as listed in Appendix 2 must be included except a pen-and-ink signature. The individual

enrolling via this method indicates his or her intent to enroll by completing the on-line process (as described). Follow the procedures outlined in §40.2.2 to address incomplete elections.

The following should also be considered when completing an enrollment:

A. **Permanent Residence Information -** The MA organization should obtain the individual's permanent residence address to determine that he/she resides within the MA plan's service area. If an individual puts a Post Office Box as his/her place of residence on the enrollment election, the MA organization may consider the enrollment election incomplete and must contact the individual to determine place of permanent residence. If the applicant claims permanent residency in two or more states or if there is a dispute over where the individual permanently resides, the MA organization should consult the State law in which the MA organization operates and determine whether the enrollee is considered a resident of the State.

   Refer to §10 for a definition of "evidence of permanent residence," and §20.3 for more information on determining residence for homeless individuals.

B. **Entitlement Information -** While desirable, it is not necessary for an individual to prove Medicare Part A entitlement or Part B enrollment **at the time** he/she signs the enrollment form or completes the enrollment election. For example, the MA organization may not deny the enrollment if the individual does not have the evidence when filling out the enrollment form or does not include it with the form when he/she mails it to the organization. §10 contains a list of items that can be considered entitlement evidence under the definition of "evidence of Medicare Part A and Part B coverage."

   If, at the end of the month, the MA organization receives an election form from the beneficiary without any evidence of entitlement to Medicare Part A and enrollment in Medicare Part B (e.g., copy of Medicare card, SSA letter, etc), CMS will allow for a grace period of 3 business days after the end of the month to obtain such verification. If it is confirmed during the grace period that the beneficiary was entitled to Medicare Part A and enrolled in Part B when the election was received by the MAO, the date of entitlement will suffice as the evidence and the election will be considered complete upon receipt.

   For example, if an otherwise complete enrollment election was received on September 30, 2002, the MA organization has until October 3 to verify Medicare Part A entitlement and Part B enrollment to provide the enrollee with an October 1 effective date.

   If the individual does not provide evidence of Medicare coverage with the enrollment election and the organization is not able to obtain or verify entitlement

through available systems by the end of the 3-business day "grace period," refer to §40.2.2 for additional procedures.

For Auto and Facilitated enrollments, as described in §20.4.6 and §20.4.7 of this chapter, entitlement verification is deemed complete, as the individual is already an MA enrollee.

C. **Effective Date of Coverage -** The MA organization must determine the effective date of coverage as described in §30.5 for all enrollment elections. If the individual fills out an enrollment form in a face-to-face interview, then the MA organization representative may advise the individual of the proposed effective date, but must also stress to the individual that it is only a proposed effective date and that the individual will hear directly from the MA organization to confirm the actual effective date. The MA organization must notify the member of the effective date of coverage prior to the effective date (refer to §40.4 for more information and a description of exceptions to this rule), and must write the actual effective date on the enrollment form where applicable.

With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date (effective dates are described in §30.5). Instead, the MA organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face enrollments, the MA organization staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed under the requirements outlined in §30.5.

If a beneficiary completes an enrollment election with an unallowable effective date, or if the MA organization allowed the beneficiary to choose an unallowable effective date, the MA organization must notify the beneficiary in a timely manner and explain that the enrollment must be processed with a different effective date. The organization should resolve the issue with the beneficiary as to the correct effective date, and the notification must be documented. If the beneficiary refuses to have the enrollment processed with the correct effective date, the beneficiary can cancel the election according to the procedures outlined in §60.2.1.

**For auto and facilitated enrollments,** refer to §40.1.6 and §40.1.7 of this chapter for more information.

D. **Health Related Information -** MA organizations may not ask health screening questions during completion of the enrollment election. MA organizations are only permitted to send health assessment forms after enrollment. However, MA organizations may ask very limited health status questions related to a beneficiary's eligibility to join an MA plan such as whether the individual has ESRD, is enrolled in Medicaid, or is currently admitted to a certified Medicare/Medicaid institution. Queries for this information are included on the model individual enrollment form in Exhibit 1, and the model EGHP form in

Exhibit 2. These queries are not considered to be health screening questions. With the exception of information obtained on ESRD status, the responses to these questions must not have an affect on eligibility to enroll in an MA plan.

**Exception for certain MA-SNPs -** An SNP that is being offered to individuals with certain medical conditions (i.e. an SNP for chronic and disabling conditions), as permitted by CMS, will need to establish that the individual has such a condition to determine eligibility for enrollment in that specific SNP. Refer to §70. for more information.

**E. Statements of Understanding -** As outlined in §20.5, a beneficiary must understand and agree to abide by the rules of the MA plan in order to be eligible to enroll. It is at the MA organization's discretion to decide whether it will:

- Have fields next to the statements and require the beneficiary's initials next to each statement (as shown on the last page of Exhibits 1 and 2); or

- List the statement of understanding and consider the beneficiary signature on the form (or completion of the election process) to signify that the individual has read and understands the statements.

The MA organization must apply the policy consistently. If the MA organization requires the initials and the beneficiary fails to initial his/her understanding of each item listed on the enrollment form, the MA organization may contact the beneficiary to clarify the MA organization rules in order to complete the enrollment form. The MA organization must document the contact and annotate the outcome of the contact. If the MA organization is unable to contact the beneficiary to ensure their understanding, the enrollment form would be considered incomplete.

**F. Enrollee Signature and Date -** The individual must sign the enrollment form or complete the enrollment election mechanism. If the individual is unable to do so, a legal representative must sign the enrollment form (refer to §40.2.1 for more detail) or complete the election mechanism. If a legal representative enrolls an individual, the legal representative must attest to having the authority under State law to do so, and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effect an election on behalf of the applicant is available and can be presented upon request by the MA organization or CMS.

The individual and/or legal representative should also include the date he/she signed the enrollment form or completed the enrollment election; however, if he/she inadvertently fails to include the date on the enrollment election, then the date of receipt that the MA organization places on the election may serve as the signature date of the form.

Certain election mechanisms do not include a pen-and-ink, or "wet," signature. Follow the specific procedures provided for the other election mechanism in this chapter, for example see §40.1.3 for information about enrollment via the internet.

For auto and facilitated enrollment as described in §§40.1.6 and 40.1.7, an enrollee signature is not required.

**G. Other Signatures -** If the MA organization representative helps the individual fill out the enrollment form, then the MA organization representative must also sign the enrollment form and indicate his/her relationship to the individual. However, the MA organization representative does not have to co-sign the form when:

- He/she pre-fills the individual's name and mailing address when the individual has requested that an enrollment form be mailed to him/her,
- He/she fills in the "office use only" block, and/or
- He/she corrects information on the enrollment form after verifying information (see "final verification of information" below).

The MA organization representative does have to co-sign the form if he/she pre-fills any other information, including the individual's phone number.

**H. Old Signature Dates -** If the MA organization receives an enrollment form that was signed more than 30 calendar days prior to the MA organization's receipt of the form, the MA organization is encouraged to contact the individual to re-affirm intent to enroll prior to processing the enrollment and to advise the beneficiary of the upcoming effective date.

**I. Determining the Receipt Date -** The MA organization must date all enrollment elections as soon as they are initially received at the MA organization's business offices. If the enrollment election is completed at the time it is dated, then this date is equivalent to the "receipt date" (refer to §10 for definitions of "receipt of election" and "completed election"). If the enrollment election is not complete at the time it is dated, then the additional documentation required for the enrollment election to be complete must be dated as soon as it is received. The date on the last piece of additional documentation received will then serve as the "receipt date." Once the enrollment election is "complete" (based on the definition in §10), then the enrollment election is considered to be "received" by the MA organization for the purposes of determining the effective date.

For the Employer Group MA Election mechanism the receipt date will be the date the employer's record of an individual's health plan choice is received by the MA organization (see §40.1.1).

For enrollment elections made via the Internet, the receipt date will be the date the individual completed the on-line enrollment process that resulted in the complete enrollment request being sent to the MA organization.

For auto- or facilitated enrollment (as described in §40.1.6 and 40.1.7 of this chapter), the receipt date will be 10/15/2005 to ensure that any subsequent beneficiary-generated enrollment request will supersede the auto- or facilitated enrollment in CMS systems.

**J. Final Verification of Information -** Some MA organizations verify information before enrollment information has been transmitted to CMS. In these cases the MA organization may find that it must make corrections to an individual's enrollment form. The MA organization should make those corrections, and the individual making those corrections must place his/her initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, may be used by the MA organization (in place of the initialing procedure described in the prior sentence), and should become a part of the enrollment file. These types of corrections will not result in the MA organization having to co-sign the enrollment form.

**K. Premiums Owed to the MAO -** An MA organization may choose to wait for the individual's payment of the plan premium, including any premiums due the MA organization for a prior enrollment before considering an enrollment in an MA-only (non MA-PD) plan "complete." However, if the individual has indicated that he or she wants plan premiums withheld from a Social Security, Railroad Retirement Board or Office of Personnel Management check, the MA organization may only apply this option to premiums due to the organization from a prior enrollment.

**L. Completed Enrollment Elections -** Once the enrollment election is complete, the MA organization must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4 within the prescribed time frames. There are instances when a complete enrollment can turn out to be legally invalid. These instances are outlined in §40.6.

**M. Option to have plan premiums withheld from Social Security, Rail Road Retirement Board (RRB) or Office of Personnel Management (OPM) payments.** Individuals may choose to have their MA plan premiums withheld from these payments or to have these premiums billed directly. The enrollment election mechanism will capture each individual's preference for premium payment and the MA organization will submit this information with the enrollment transaction it sends to CMS.

**N. Additional Information for MA-PD Enrollment Elections** – Additional information is necessary for enrollment in an MA-PD plan:

a. Information on creditable coverage. After May 15, 2006, a beneficiary enrolling in a Part D plan in any period after his or her ICEP must provide information about his or her coverage history in order to determine if the Part D late enrollment penalty applies. This question will be a required element to consider an enrollment request complete. CMS will update this manual with additional information.

b. Information on other existing coverage. The enrolling beneficiary must disclose any other existing coverage for prescription drugs.

This data will be collected via the enrollment mechanism(s) and submitted to CMS as part of the enrollment transaction.

## 40.2.1 - Who May Sign An Election Form or Complete an Election Method

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

A Medicare beneficiary is generally the only individual who may execute a valid election for enrollment in or disenrollment from an MA plan. However, another individual could be the legal representative or appropriate party to execute an election form if a court has designated that individual as the proper party to take such an action on behalf of the Medicare beneficiary. The CMS will recognize State laws that authorize persons to effect an election for Medicare beneficiaries. Persons authorized under State law may be court-appointed legal guardians or persons having durable power of attorney for health care decisions, provided they have authority to act for the beneficiary in this capacity.

If a Medicare beneficiary is unable to sign an enrollment form or disenrollment request or complete an enrollment mechanism due to reasons such as physical limitations or illiteracy, State law would again govern whether another individual may execute the election on behalf of the beneficiary. Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, MA organizations should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

Where MA organizations are aware that an individual has a representative payee designated by SSA to handle the individual's finances, MA organizations should contact the representative payee to determine his/her legal relationship to the individual, and to ascertain whether he/she is the appropriate person, under State law, to execute the enrollment or disenrollment. Representative payee status alone is not sufficient to enroll or disenroll a Medicare beneficiary.

When someone other than the Medicare beneficiary completes an enrollment election or disenrollment request, he or she must attest to having the authority under State law to do so, and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effect an election on behalf of the applicant is available and can be provided upon request to the MA organization or CMS. The MA organization must retain the record of this attestation as part of the record of the enrollment election. CMS will provide a sample attestation as part of the model MA enrollment form (exhibit 1).

## 40.2.2 - When the Enrollment Election Is Incomplete

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

When the enrollment election is incomplete, the MA organization must document all efforts to obtain additional documentation to complete the enrollment election and have an audit trail to document why the enrollment election needed additional documentation before it could be considered complete. If additional documentation needed to make the election "complete" is not received within 45 days of the request, the organization must deny the enrollment using the procedures outlined in §40.2.3.

**Entitlement Information -** If the individual has not provided evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment election, the organization may choose to consider an enrollment form complete by obtaining such evidence through available systems within seven business days of receipt of the enrollment election.

If the systems indicate that the individual is entitled to Medicare Part A and enrolled in Part B, and the MA organization has all the other information it needs to complete the enrollment election, then no further documentation from the individual would be needed and the enrollment election is considered complete.

If the systems do not provide evidence of entitlement, then the MA organization must promptly contact the individual to obtain such evidence.

**NOTE*:*** CMS will allow for a grace period of 3 business days after the end of the month to obtain such verification. If it is confirmed during the grace period that the beneficiary was entitled to both Medicare Part A and Part B when the election was received by the MAO, the date of entitlement will suffice as the evidence and the election will be considered complete upon receipt.

**Requesting Information from the Beneficiary -** To obtain information to complete the enrollment election, the MA organization must contact the individual to request the information (see Exhibit 5 for a model letter). If the contact is made orally, the MA organization must document the contact and retain the documentation in its records. The MA organization must explain to the individual that the individual has 30 calendar days in which to submit the additional information or the enrollment will be denied. Since an incomplete election is an invalid enrollment (as explained in §40.6), if the additional

documentation is not received within 45 calendar days of request (i.e., after allowing for the 30 days plus an additional 15 days for information to be received and logged in by the MA organization), the MA organization must send a denial of enrollment letter (see Exhibit 7 for a model denial of enrollment letter).

If all documentation is received within allowable time frames and the enrollment election is complete, the MA organization must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4

## 40.2.3 - MA Organization Denial of Enrollment

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An MA organization must deny an enrollment based on (1) Its own determination of the ineligibility of the individual to elect the MA plan and/or, (2) An individual not providing information to complete the enrollment election within the time frames described in §40.2.2.

MA organization denials occur before the organization has even transmitted the enrollment to CMS. For example, it may be obvious that the individual is not eligible to elect the plan due to place of residence or the MA plan is closed for enrollment, etc. This up-front denial determination should be made in a timely manner, but no later than seven business days of receipt of the completed enrollment election.

**Notice Requirement -** The organization must send notice of the denial to the individual that includes an explanation of the reason for denial (refer to Exhibit 7 for a model notice). This notice should be sent within seven business days of the organization's denial determination.

**EXAMPLE**

- An MA organization receives an enrollment election from an individual on January 7 and determines on that same day that the individual is ineligible due to place of residence. The organization should send notice of denial within seven business days from January 7.

- An MA organization receives an enrollment form on January 7 from an individual, identifies the enrollment form as incomplete, and notifies the individual of the need for additional information, on January 10. The beneficiary does not submit the information by February 24 (as required under §40.2.2), which means the organization must deny the enrollment. The organization should send notice of denial within seven business days from February 24.

## 40.2.4 - ESRD and Enrollment

*(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)*

If an MA organization is aware that an individual electing a plan no longer requires regular dialysis or has received a kidney transplant (e.g., the individual informs the MA organization that this has occurred), then the MA organization should request that the individual submit medical documentation (i.e., a letter from the physician that documents that the individual has received a kidney transplant or no longer requires a regular course of dialysis to maintain life), using the procedures outlined in §40.2.2. Upon receipt of this documentation, the MA organization should enroll the beneficiary using the override procedures described in Chapter 19 (Managed Care and MA Systems Requirements).

If an individual indicates on the enrollment election that he/she does not have ESRD, but the MA organization receives a reply listing containing a "code 45" or "code 15" rejection (an explanation of reply listing codes is contained in Chapter 19), the MA organization should investigate further to determine whether the individual is eligible to enroll. To determine eligibility, the MA organization should contact the individual to request medical documentation using the procedures outlined in §40.2.2. Contact can be made orally, in which case the MA organization must document the contact and retain the documentation in its records.

If the MA organization learns that the individual has received a kidney transplant which has restored kidney function or that the individual no longer requires a regular course of dialysis to maintain life, then the individual must be permitted to enroll in the MA plan if other applicable eligibility requirements are met. When this occurs, the MA organization must contact its RO to override the system rejection. The following documentation must be submitted to the RO:

1. Evidence of contact with the individual after the system rejection, including the individual's explanation for rejection (i.e., successful transplant), and medical documentation, i.e., a letter from the physician.

2. A copy of the Reply Listing or, if using the services of a CMS subcontractor, a report indicating the MA organization's attempts to enroll the individual and the resulting rejection.

Once received and approved, the RO will override the enrollment rejection for the individual.

**ESRD and MA Plan Terminations**

Certain individuals with ESRD who have been impacted by MA terminations will be permitted to make one election into a new MA plan (refer to §20.2 for a discussion of who is eligible to make an election). Beneficiaries will be instructed to save their notification letters to present, if requested, to MA organizations as proof of their

eligibility to join a plan. The CMS' system will edit incoming enrollment transactions for ESRD beneficiaries to determine:

1. If they were a member of a terminating or terminated MA plan; and

2. If they have already used their one election.

Enrollments for these individuals should be submitted as normal transactions with all other transactions. The enrollment will be allowed if the individual is eligible, and will be rejected if not.

## 40.3 - Transmission of Enrollments to CMS

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

For all enrollment requests that the organization is not denying per the requirements in §40.2.3, the MA organization must submit the information necessary for CMS to add the beneficiary to its records as an enrollee of the MA organization within 30 calendar days of receipt of the **completed** enrollment election. In the case of elections that are accepted after the MA organization is enrolled to capacity, but as a vacancy occurs, the MA organization must submit the information within 30 calendar days after a vacancy has become available.

All enrollment elections must be processed in chronological order by date of receipt of completed enrollment elections (refer to §40.5 for procedures when the MA plan is closed for enrollment).

MA organizations are encouraged to submit transactions by the earliest possible MA organization processing cutoff date (refer to Chapter 19). However, if the organization misses the cutoff date, it must still submit the transactions within the required 30-day time frame.

**NOTE:** The 30-day requirement to submit the transaction does not delay the effective date of the individual's coverage under the plan, i.e., the effective date must be established according to the procedures outlined in §§30.5 and 30.7.

More detail on how MA organizations must submit transmissions to CMS are contained in Chapters 19 and 20 of this manual.

## 40.4 - Information Provided to Member

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Much of the enrollment information that an MA organization must provide to the member must be sent prior to the effective date of coverage. However, some information will be sent after the effective date of coverage.

## 40.4.1 - Prior to the Effective Date of Coverage

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Prior to the effective date of coverage the MA organization must provide the member with all the necessary information about being a Medicare member of the MA organization, the MA organization rules, and the member's rights and responsibilities. (An exception to this requirement is described in §40.4.2.) The MA organization must also provide the following to the individual:

- A copy of the enrollment form, where applicable, if the individual does not already have a copy of the form;

- A notice acknowledging receipt of the completed enrollment election (refer to Exhibit 4 and Exhibit 4a for a model letter) and showing the effective date of coverage; and

- Evidence of health insurance coverage so that he/she may begin using plan services as of the effective date

  **NOTE:** This is not the same as the Evidence of Coverage document described in Chapter 3 - Marketing.

  This evidence may be in the form of member cards, the enrollment form, and/or a notice to the member (refer to Exhibit 4 and Exhibit 4a, which is a model letter with optional language that would allow the member to use the letter as evidence of health insurance coverage until he/she receives a member card).

  **NOTE:** If the MA organization does not provide the member card prior to the effective date, it must provide it as soon as possible after the effective date.

Regardless of whether an election is made in a face-to-face interview, by fax, by mail, or by other mechanisms defined by CMS, the MA organization must explain:

- The charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance. For those eligible for the low-income subsidy, the notice must specify the limits applicable to the level of subsidy to which the person is entitled.

- The prospective member's authorization for the disclosure and exchange of necessary information between the MA organization and CMS.

- The lock-in requirement. The MA organization must also obtain an acknowledgment by the individual that he/she understands that care will be

received through designated providers except for emergency services and urgently needed care.

- The potential for member liability if it is found that the member is not entitled to Medicare Part A and Part B at the time coverage begins and the member has used MA plan services after the effective date.

- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the MA organization has not yet provided the ID cards).

## 40.4.2 - After the Effective Date of Coverage

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The CMS recognizes that for some election periods, the MA organization will be unable to mail the materials and notification of the effective date to the individual prior to the effective date, as required in §40.4.1. These cases will only occur in the last few days of an election period, when a completed enrollment election is received by the MA organization, and the effective date is the first of the upcoming month. In these cases, the MA organization should mail the member all materials described above no later than 7 business days after receipt of the completed enrollment election. In these cases, the MA organization is also strongly encouraged to call the member within 1 business day after the effective date to provide the effective date and explain the MA organization rules.

**Acceptance/Rejection of Enrollment -** Once the MA organization receives a reply listing report from CMS indicating whether the individual's enrollment has been accepted or rejected, the MA organization must notify the individual in writing of CMS' acceptance or rejection of his/her enrollment within seven business days of the availability of the reply listing (see Exhibits 6, Exhibit 6a, and Exhibit 8 for model letters).

An exception is if the organization receives the initial CMS reply listing that rejects the individual's enrollment due to no Medicare Part A and/or no Medicare Part B and the MA organization has evidence to the contrary. In this case, the MA organization should request a retroactive enrollment from the RO within 45 days from the availability of the initial reply listing. If the RO is unable to process the retroactive enrollment due to its determination that the individual does not have Medicare Part A and/or Part B, the MA organization must reject the enrollment and should notify the individual of the rejection in writing within seven business days after the RO determination. Retroactive enrollments are covered in more detail in §60.4.

If an MA organization rejects an enrollment and later receives additional information from the individual showing entitlement to Medicare Part A and enrollment in Part B, the MA organization must obtain a new enrollment election from the individual in order to enroll the individual, and must process the enrollment with a current (i.e., not retroactive)

effective date. Refer to §60.4 for more information regarding retroactive enrollments and the 45-day requirement.

## 40.5 - Enrollment Processing During Closed Periods

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

As described in §40.3, an MA organization must process elections in order by date of receipt of completed enrollment election when it is open for enrollment. However, an MA organization may close an MA plan during the OEP (as described in §30.3) or when it reaches a CMS-approved capacity limit. This section addresses procedures for handling enrollments that arrive at the MA organization when an MA plan is closed for enrollment, and for processing those enrollments when the MA plan re-opens or a vacancy occurs.

If an MA organization believes its MA plan does not have the capacity to accept additional members, or as the MA plan enrollment grows and the MA organization estimates it may reach capacity during its next open enrollment period, the MA organization may request a CMS-approved limit on enrollment.

A capacity limit allows an MA organization to close or limit enrollment during the AEP, ICEP, and SEP. Only with a reserved vacancy may an MA organization set aside vacancies for enrollment of conversions. Refer to Chapter 1 (General Administration) of the Managed Care/Medicare Advantage Program for more detail on how and when to request a capacity limit.

### 40.5.1 - Procedures After Reaching Capacity

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

If the number of individuals who elect to enroll in an MA plan exceeds a CMS-approved capacity limit, then the MA organization may limit enrollment of these individuals, but only if it provides priority in acceptance.

If an MA organization receives completed enrollment elections between the time it reaches its limit and the time CMS approves the limit, it may follow one of two options **after it receives approval from CMS to limit enrollment:** (1) Deny the enrollment due to the onset of the capacity limit, or (2) Place the enrollment on a waiting list to be processed as vacancies occur in the priority of acceptance. This priority requires that the MA organization process enrollments from individuals who elected the MA plan prior to CMS' determination that the capacity has been exceeded, in order based on date of receipt of the completed enrollment election, and in a manner that does not discriminate on the basis of any factor related to health as described in 42 CFR §422.110.

The MA organization must take the same action for all enrollment elections received. See below for procedures for following options 1 or 2.

After the enrollments discussed in the above paragraph are acted upon, the MA organization has similar options for handling any additional enrollment requests received while the plan is closed for enrollment. The MA organization may follow one of two options: (1) Deny the enrollment due to the capacity limit, or (2) Place the enrollment on a waiting list to be processed when the plan re-opens for enrollment. However, to ensure no discrimination is applied to applications processed, all MA organizations that use option 1 (i.e., deny enrollment) for enrollments discussed in the above paragraph, must continue to deny all enrollments received while the plan is closed for enrollment, and may not use option 2. The MA organization must take the same action for all enrollment forms received. In the case of enrollments received after the plan closes for enrollment, the date the MA plan re-opens becomes the "receipt date" of enrollment forms received when the plan was closed.

**EXAMPLE**

If the plan was closed in April and re-opens on May 1, then the receipt date of enrollment elections received in April is May 1. See below for procedures for following options 1 or 2.

**If the MA Organization Uses Option 1 -** It must notify the individual in writing that it is denying the enrollment, and should do so within seven business days after it receives the enrollment election or after the MA organization receives approval from CMS to limit enrollment (Exhibit 7). Please note that CMS encourages MA organizations to use this option if they expect that there will be no enrollment opportunities for longer than one month. This reduces the likelihood of multiple transactions and/or mistaken disenrollments that would occur if a potential applicant enrolls in another MA plan while waiting for the original MA plan to re-open.

**If the MA Organization Uses Option 2 -** It must notify the individual in writing that he/she has been placed on a waiting list, and should do so within seven business days after the MA organization receives the enrollment election or after the MA organization receives approval from CMS to limit enrollment. The notice must also provide an estimated length of time that the individual will be on a waiting list and instruct the individual that he may cancel his enrollment before a vacancy occurs.

As enrollment spaces become available, if the plan was closed for more than 30 calendar days since the receipt of the enrollment form, the MA organization must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The MA organization may make this contact even if the plan was closed for less than 30 days.) Within seven business days after contacting the individual, the MA organization must send written notice of intent to not process the enrollment to all individuals who state they are no longer interested in being enrolled in the MA plan.

For individuals who indicate their continued interest in enrollment, the MA organization must document the individual's expressed interest to continue enrollment. This may be done via phone contact report, notation on the enrollment form, etc.

There may be situations in which the MA organization has closed enrollment in a service area, yet receives an approval for a capacity limit for a portion of that same service area. Given that MA plans are either open or closed for an ENTIRE service area, any vacancies which may open up may only be filled by individuals in their ICEP or SEP by applying the rules of accepting enrollments when MA plans are closed (see §40.5.2 below). Further, it must take those individuals based upon enrollments received in chronological order.

## 40.5.2 - Procedures After Closing During the OEP

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

As stated in §30, an MA organization must accept all elections for its MA plans made during the AEP, ICEP, or SEP. However, an MA organization may not process **OEP** enrollments for a plan when the plan is closed for enrollment during the OEP.

If an MA plan is closed during the OEP and receives new OEP enrollment forms or documentation to complete OEP enrollment forms already received by the MA organization, then the MA organization may do one of the following. The MA organization must take the same action for all enrollment forms received while the plan is closed:

1. Deny the enrollment;

2. Continue to accept the completed enrollment forms to be placed on a waiting list.

**If the MA Organization uses option #1 above -** It must notify the individual in writing that it is denying the enrollment, and should do so within seven business days after it receives the enrollment election (Exhibit 7). Please note that CMS encourages MA organizations to use this option if they expect that there will be no enrollment opportunities for longer than one month. This reduces the likelihood of multiple transactions and/or mistaken disenrollments that would occur if a potential applicant enrolls in another MA plan while waiting for the original MA plan to re-open.

**If the MA Organization uses option #2 above -** it must notify the individual in writing that he/she has been placed on a waiting list. The notice must inform the individual that the enrollment request will not be processed until the plan re-opens for enrollment, must include the date the plan will re-open, and must inform the individual that he/she may cancel the request for enrollment before the plan re-opens. All individuals who wish to wait for an opening must be placed on the waiting list.

After the MA plan re-opens, if the plan was closed for more than 30 calendar days since the MA organization received the enrollment election, it must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The MA organization may make this contact even if the plan was closed for less than 30 days.) The MA organization must send written notice of intent to not process the enrollment to all individuals who state they are no longer interested in being enrolled in the MA plan, and should do so within seven business days after contacting the individual.

For individuals who indicate their continued interest in enrollment, the MA organization must document the individual's expressed interest to continue enrollment. This may be done via phone contact report, notation on the enrollment form, etc. The date the MA plan re-opened becomes the "receipt date" of enrollment forms received when the plan was closed.

**EXAMPLE**

If the plan was closed in February and re-opens on March 1, then the receipt date of enrollment forms received in February is March 1.

## 40.6 - Enrollments Not Legally Valid

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

When an enrollment is not legally valid, a retroactive cancellation of enrollment action may be necessary (refer to §60.5 for more information on retroactive disenrollments). In addition, a reinstatement to the plan in which the individual was originally enrolled may be necessary if the invalid enrollment resulted in an individual's disenrollment from his/her original plan of choice.

An enrollment that is not complete, as defined in §10, is not legally valid. In addition, an enrollment is not legally valid if it is later determined that the individual did not meet eligibility requirements at the time of enrollment. For example, an enrollment is not legally valid if an MA organization determines at a later date that the individual provided an incorrect permanent address at the time of enrollment and the actual address is outside the MA plan's service area. A second example could be an instance where an individual not authorized by State law to make an election on another's behalf attempts to complete an election.

There are also instances in which an enrollment that appears to be complete can turn out to be legally invalid. In particular, CMS does not regard an enrollment as actually complete if the member or his/her legal representative did not intend to enroll in the MA organization. If there is evidence that the individual did not intend to enroll in the MA organization, the MA organization should submit a retroactive disenrollment request to the CMS RO. Evidence of lack of intent to enroll by the individual may include:

- An enrollment election signed by the individual when a legal representative should have signed for the individual;

- Request by the individual for cancellation of enrollment before the effective date (refer to §60.2 for procedures for processing cancellations);

- Enrolling in a supplemental insurance program immediately after enrolling in the MA organization; or

- Receiving non-emergency or non-urgent services out-of-plan immediately after the effective date of coverage under the plan.

Payment of the premium does not necessarily indicate an informed decision to enroll. For example, the member may believe that he/she was purchasing a supplemental health insurance policy, as opposed to enrolling in an MA organization. In addition, use of an MA plan doctor does not necessarily indicate an understanding of the lock-in requirement if the doctor also treats non-plan members.

## 40.7 - Enrollment Procedures for Medicare MSA Plans

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

MA organizations offering a Medicare MSA plan must follow the procedures outlined in §§40.2, 40.3, 40.4, 40.5.1, and 40.6. However, with respect to §40.2, the MA organization plans may ask whether an individual has hospice coverage during the enrollment process, since hospice patients are not eligible to enroll in a Medicare MSA plan.

MA organizations offering Medicare MSA plans should not use the enrollment form outlined in §40.1, and should instead develop their own Enrollment Form and Trustee/Custodian Account Application. Applications for Medicare MSAs may include a question regarding use of hospice benefits on the enrollment form.

## 50 - Disenrollment Procedures

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Except as provided for in this section, an MA organization may not, either orally or in writing, or by any action or inaction, request or encourage any member to disenroll. While an MA organization may contact members to determine the reason for disenrollment, the MA organization must not discourage members from disenrolling after they indicate their desire to do so. The MA organization must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

All notice requirements are summarized in Appendix 1.

## 50.1 - Voluntary Disenrollment by Member

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

A member may only disenroll from an MA plan during one of the election periods outlined in §§30 and 30.7. The member may disenroll by:

1. Giving or faxing a signed written notice to the MA organization, or through their employer, where applicable;

2. Submitting a request via the Internet to the MA organization (if the MA organization offers such an option);

3. Until November 15, 2005, giving a signed written notice to any SSA or RRB office (refer to §50.8 for procedures for Medicare MSA plans); or

4. By calling 1-800-MEDICAR(E).

If a member verbally requests disenrollment from the MA plan, , the MA organization must instruct the member to make the request in one of the ways described above. The MA organization may send a disenrollment form to the member upon request (see Exhibits 9 and 10 ).

The disenrollment request must be dated when it is initially received at the MA organization's business offices.

## 50.1.1 - Requests Submitted via Internet

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The MA organization has the option to allow members to submit disenrollment requests via the Internet; however, certain conditions must be met. The MA organization must, at a minimum, comply with the CMS security policies - found at http://cms.hhs.gov/it/security/. However, the MA organization may also include additional security provisions. The CMS policies indicate that with regard to receiving such disenrollments via the Internet, an acceptable method of encryption must be utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information.

In addition, CMS policies also require MA organizations to provide the CMS Office of Information Services with a pro forma notice of intent to use the Internet for these purposes. The notice is essentially an attestation that the MA organization is complying with the required encryption, authentication, and identification requirements. The CMS reserves the right to audit the MA organization to ascertain whether it is in compliance with the security policy. The effective date of the request is determined by the election

period in which the valid request was made. The election period is determined by the date the request is received by the specified site designated by the MA organization.

## 50.1.2 - Request Signature and Date

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

When providing a written request, the individual must sign the disenrollment request. If the individual is unable to sign, a legal representative must sign the request (refer to §40.2.1 for more detail on who may sign election forms). If a legal representative signs the request for the individual, then he or she must attest to having the authority under State law to do so, and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effect an election on behalf of the applicant is available and can be presented upon request to the MA organization or CMS.

The individual and/or legal representative should write the date he/she signed the disenrollment request; however, if he/she inadvertently fails to include the date, then the date of receipt that the MA organization places on the request form will serve as the signature date.

## 50.1.3 - Effective Dates

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The election period will determine the effective date of the disenrollment; refer to §§30.6 and 30.7 for information regarding disenrollment effective dates.
With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date. Instead, the MA organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face disenrollments, or when a beneficiary calls about a disenrollment, the MA organization staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed under the requirements outlined in §§30.6 and 30.7.

If a beneficiary mails in a disenrollment request with an unallowable effective date, or if the MA organization allowed the beneficiary to choose an unallowable effective date, the MA organization must call or write the beneficiary to explain that the disenrollment must be processed with a different effective date. The organization should resolve the issue with the beneficiary as to the correct effective date, and the call must be documented. If the beneficiary refuses to have the disenrollment processed with the correct effective date, the beneficiary can cancel the election according to the procedures outlined in §60.2.2.

## 50.1.4 - Notice Requirements

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

After the member submits a request, the MA organization must provide the member with a disenrollment notice within seven business days of receipt of the request to disenroll. The disenrollment notice must include an explanation of the lock-in restrictions for the period during which the member remains enrolled in the organization, and the effective date of the disenrollment (see Exhibit 11). The MA organization may also advise the disenrolling member to hold Original Medicare claims for up to one month so that Medicare computer records can be updated to show that the person is no longer enrolled in the plan. For these types of disenrollments, i.e., disenrollments in which the member has disenrolled directly through the MA organization, MA organizations are encouraged, but not required, to follow up with a confirmation of disenrollment notice after receiving CMS confirmation of the disenrollment from the reply listing.

Since Medicare beneficiaries have the option of disenrolling through sources other than the MA organization (such as 1-800-MEDICARE or by enrolling in another Medicare managed care plan or PDP), the MA organization will not always receive a request for disenrollment directly from the member and will instead learn of the disenrollment through the CMS Reply Listing Report. If the MA organization learns of the voluntary disenrollment from the CMS reply listing (as opposed to through written request from the member), the MA organization must send a written confirmation notice of the disenrollment to the member within seven business days of the availability of the reply listing (see Exhibit 12).

## 50.1.5 - Optional Employer Group MA Disenrollment Election

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

As described in §20.4.1 of this chapter, beginning April 1, 2003, MA organizations that offer MA plans to employer groups may choose to accept voluntary disenrollment elections directly from an employer group (or its TPA) without obtaining an MA disenrollment form from each individual. This disenrollment election mechanism is optional for MA organizations, and may not be required. Therefore, MA organizations may specify the employer groups, if any, from which they will accept this election format and may choose to accept these disenrollment elections.

- The MA organization must inform its Regional Office Plan Manager of its intent to use this mechanism and identify the employer group(s) for which it will be accepting disenrollments, made in this manner.

- The disenrollment information (i.e., the electronic file) submitted to the MA organization by an employer (or TPA) must accurately reflect the employer's record of the disenrollment made by each individual according to the processes the employer has in place, and may be accepted without a hard-copy MA election form.

- This alternate election mechanism is used in place of paper MA election forms, and does not require a signature. For purposes of compatibility with existing instructions in this chapter, the MA organization receipt date will be the date the employer's record of an individual's disenrollment choice is received by the MA organization. MA organizations must record these dates.

- Effective date calculation of voluntary disenrollments and the collection and submission of disenrollments to CMS will follow existing procedures.

- To accept electronic records of employer group elections, the MA organization must, at minimum, comply with the CMS security policies regarding the acceptable method of encryption utilized to provide for data security, confidentiality and integrity, and authentication and identification procedures to ensure both the sender and recipient of the data are known to each other and are authorized to receive and decrypt the information. (See the CMS Web site at: http://www.cms.hhs.gov/it/security for additional information.)

- The employer's record of the election must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, the MA organization and/or CMS as necessary, and be maintained (by the employer or the MA organization, as they agree) for at least 6 years following the effective date of the individual's disenrollment from an MA plan. The MA organization must maintain its record of information received from the employer following the guidelines for MA election forms (see §60.8).

## 50.1.6 - Group Disenrollment for Employer or Union Sponsored Plans

**PENDING**

## 50.1.7 - Medigap Guaranteed Issue Notification Requirements for Disenrollments to Original Medicare during a SEP

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

MA organizations are required to notify members of their Medigap guaranteed issue rights when members disenroll to Original Medicare during a SEP. Model language discussing these Medigap rights has been provided in Exhibit 11 and Exhibit 12.

There may be cases when a Medigap issuer requires the beneficiary to provide additional documentation that they disenrolled as a result of an SEP and are eligible for such guaranteed issue rights. A beneficiary may contact you for assistance in providing such documentation. The MA organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

## 50.2 - Required Involuntary Disenrollment

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The MA organization **must** disenroll a member from an MA plan in the following cases. Refer to §50.6 for some exceptions to required disenrollment for grandfathered members.

*1.* A change in residence makes the individual ineligible to remain enrolled in the plan (§50.2.1)

*2.* The member loses entitlement to either Medicare Part A or Part B (§50.2.2.);

*3.* The member dies (§50.2.3); or

*4.* The MA organization contract is terminated, or the MA organization discontinues offering the plan in any portion of the area where the plan had previously been available. There is an exception to this rule, which is described in §50.2.4.

**Notice Requirements -** In situations where the MA organization disenrolls the member involuntarily on any basis except death or loss of entitlement, notices of the upcoming disenrollment meeting the following requirements must be sent. All disenrollment notices must:

1. Advise the member that the MA organization is planning to disenroll the member and why such action is occurring;

2. Be mailed to the member before submission of the disenrollment transaction to CMS; and

3. Include an explanation of the member's right to a hearing under the MA organization's grievance procedures. (This explanation is not required if the disenrollment is a result of the MA plan termination or service area or continuation area reduction, since a hearing would not be appropriate for that type of disenrollment. There are different notice requirements for terminations and area reductions, which are provided in separate instructions to MA organizations.)

**Medigap Guaranteed Issue Notification Requirements for Disenrollments to Original Medicare during a SEP**

MA organizations are required to notify members of their Medigap guaranteed issue rights when members disenroll to Original Medicare during a SEP. Model language discussing these Medigap rights has been provided in Exhibit 11 and Exhibit 12.

There may be cases when a Medigap issuer requires the beneficiary to provide additional documentation that they disenrolled as a result of an SEP and are eligible for such guaranteed issue rights. A beneficiary may contact you for assistance in providing such documentation. The MA organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

## 50.2.1 - Members Who Change Residence

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

MA organizations may offer (or continue to offer) extended "visitor" or "traveler" programs to members who have been out of the service area for up to 12 months. The MA organizations that offer such programs do not have to disenroll members in these extended programs who remain out of the service area for more than 6 months but less than 12 months. As mentioned at 42 CFR 422.74(d)(4)(iii), MA organizations must make this option available to all enrollees who are absent for an extended period from the MA plan's service area. However, MA organizations may limit this option to enrollees who travel to certain areas, as defined by the MA organization and who receive serves from qualified providers.

**The MA organizations without these programs must disenroll members who have been out of the area for more than 6 months.**

## 50.2.1.1 - General Rule

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The MA organization must disenroll a member if:

1. He/she permanently moves out of the service area and his/her new residence is not in a continuation area;

2. The member's temporary absence from the service area (or continuation area, for continuation of enrollment members) exceeds 6 consecutive months;

3. The member is enrolled in an MA plan that offers a visitor/traveler program and his/her temporary absence exceeds 12 consecutive months (or the length of the visitor/traveler program if less than 12 months);

4. The member is an out-of-area member (as defined in §10), and permanently moves to an area that is not in the service area or continuation area;

5. He/she permanently moves out of the continuation area of an MA local plan and his/her new residence is not in the service area or another continuation area of the MA local plan;

6. The member permanently moves out of the service area (or continuation area, for continuation of enrollment members in MA local plans) and into a continuation area, but chooses not to continue enrollment in the MA local plan (refer to §60.7 for procedures for choosing the continuation of enrollment option);

7. The member is an out-of-area member (as defined in §10), who leaves his/her residence for more than 6 months.

## 50.2.1.2 - Effective Date

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Generally disenrollments for **reasons 1, 4, 5, and 6** above are effective the first day of the calendar month after the date the member begins residing outside of the MA plan's service area (or continuation area, as appropriate) AND after the MA organization has been notified by the member or his/her legal representative. However, if the member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the 1st of the month after the move), the MA organization can submit this request to the RO for consideration of retroactive action.

Disenrollment for **reasons 2, 3 and 7** above is effective the first day of the calendar month after 6 months have passed. Disenrollment for reason 3 is effective the 1st day of the 13th month (or the length of the visitor/traveler program if less than 12 months) after the individual left the service area.

Unless the member elects another Medicare managed care plan during an applicable election period, any disenrollment processed under these provisions will result in a change of election to Original Medicare.

A SEP, as defined in §30.4.1, applies to members who are disenrolled due to a change in residence. A member may choose another MA plan, or Original Medicare, during this SEP. The rules for this SEP will determine the effective date in the new MA plan or Original Medicare.

## 50.2.1.3 - Researching and Acting on a Change of Address

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

MA organizations may receive a notice of a change of address from the member, the member's legal representative, a CMS reply listing, or another source. The MA organization must make an attempt to contact the member to verify address information in order to determine whether disenrollment is appropriate and document their efforts. MA organizations may require members to provide written verification of changes in address, but they may also choose to allow verbal verification, as long as the MA organization applies the policy consistently among all members.

The MA organization must retain documentation from the member or member's legal representative of the notice of the change in address, including the determination of whether the move out of the service area is temporary or permanent.

1. If the MA organization receives notice of a **permanent change** in address **from the member or the member's legal representative**, and that address is outside the MA plan's service area (or continuation area, for continuation of enrollment members), then the MA organization must disenroll the member and provide proper notification. The only exception is if the member has permanently moved into the continuation area and chosen the continuation of enrollment option (procedures for electing a continuation of enrollment option are outlined in §60.7).

2. If the MA organization receives notice of a new address **from a source other than the member or the member's legal representative**, and that address is outside the MA plan's service area (or continuation area, for continuation of enrollment members), then the MA organization may not assume the move is permanent until it has received confirmation from the member or member's legal representative.

   MA organizations may consider the six months to have begun on the date given by the beneficiary as the date that he/she will be leaving the service area. If the beneficiary did not inform the MA organization of when he/she left the service area, then the MA organization can consider the six months to have begun on the date the change in address is identified (e.g. through the reply listing report).

   If the member does not respond to the request for verification within the time frame given by the MA organization, the MA organization cannot assume the move is permanent and may not disenroll the member until six months have passed. The MA organization may continue its attempts to verify address information with the member.

   The MA organization must initiate disenrollment when it verifies a move is permanent or when the member has been out of the service area (or continuation area, for continuation of enrollment members) for six months from the date the MA organization learned of the change in address.

3. **Temporary moves -** If the MA organization determines the change in address is temporary, then the MA organization may not initiate disenrollment until six months have passed from the date the MA organization learned of the change in address (or from the date the member states that his address changed, if that date is earlier).

   If the MA organization offers a visitor/traveler program, the MA organization must initiate disenrollment if it learns that the individual continues to remain out of the area during the 12 months (or the length of its visitor/traveler program if less than 12 months).

## 50.2.1.4 - Notice Requirements

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

1. **MA organization notified of out-of-area permanent move -** When the organization receives notice of a permanent change in address from the member or the member's legal representative, it must provide notification of disenrollment to the member. This notice must be provided within seven business days of the MA organization's learning of the permanent move before the disenrollment transaction is submitted to CMS.

   In the notice, the MA organization is encouraged to inform the member who moves out of the service area that he/she may have certain Medigap enrollment opportunities available to them. These opportunities end 63 days after coverage with the MA organization ends. The MA organization can direct the beneficiary to contact the State Health Insurance Assistance Program (SHIP) for additional information on Medigap insurance.

2. **Out of area for 6 months -** When the member has been out of the service area for 6 months after the date the MA organization learned of the change in address from a source other than the member or the member's legal representative (or the date the member stated that his address changed, if that date is earlier), the MA organization must provide notification of the upcoming disenrollment to the member.

   The notice of disenrollment must be provided some time during the sixth month, or no later than seven business days after the sixth month as long as the notice is provided before the disenrollment transaction is submitted to CMS. The notice should advise the member to notify the MA organization as soon as possible if the information is incorrect.

   This notice must also be provided to out-of-area members (as defined in §10) who leave their residence for a location outside the service area, and that absence exceeds six months.

   The CMS strongly encourages that MA organizations send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MA organization services.

   **EXAMPLE**

   MA organization receives a reply listing on January 20 that indicates that the member is "out of area". The 6-month period ends on July 20. The MA organization sends a notice to the member in February. The MA organization continues to receive reply listings, however, has not received any response from the member indicating this information is incorrect. Therefore, the MA

organization will proceed with the disenrollment, effective August 1. The MA organization sends a notice to the member July 21 notifying him that he will be disenrolled.

3. **Visitor/Traveler Program Option -** When the member has been out of the service area for 12 months (or the length of its visitor/traveler program if less than 12 months), the MA organization must provide notification of the upcoming disenrollment to the member.

   The notice of disenrollment must be provided some time during the 12th month (or the length of its visitor/traveler), or no later than 7 business days after the 12th month (or the length of its visitor/traveler program) as long as the notice is provided before the disenrollment transaction is submitted to CMS. The notice should advise the member to notify the MA organization as soon as possible if the information is incorrect.

   The CMS strongly encourages that MA organizations send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MA organization services.

## 50.2.2 - Loss of Entitlement to Medicare Part A or Part B

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

With the exception of Medicare Part B-only grandfathered members (as described in §§20.6 and 50.6), the MA organization cannot retain a member in an MA plan if the member is no longer entitled to both Medicare Part A and Part B benefits. The organization will be notified by CMS that entitlement to either Medicare Part A or Part B has ended, and CMS will make the disenrollment effective the first day of the month following the last month of entitlement to either Medicare Part A or Part B benefits (whichever occurred first).

If a member loses entitlement to Medicare Part A, the MA organization may not allow the member to remain a member of the plan and receive Medicare Part B-only services. In addition, the MA organization may not offer Part A-equivalent benefits and charge a premium for such coverage to members who lose entitlement to Medicare Part A. Likewise, if a member loses entitlement to Medicare Part B at any time, the MA organization may not allow the member to remain in the MA plan.

**Notice Requirements -** CMS strongly suggests that notices be provided when the disenrollment is due to the loss of entitlement to either Medicare Part A or Part B (see Exhibit 14) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §60.3.1.

## 50.2.3 - Death

*(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)*

The CMS will disenroll a member from an MA organization upon his/her death and CMS will notify the MA organization that the member has died. This disenrollment is effective the first day of the calendar month following the month of death.

**Notice Requirements -** In cases where the disenrollment is based on an apparent death, CMS strongly suggests that a notice be sent to the member or the estate of the member (see Exhibit 13) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §60.3.1.

## 50.2.4 - Terminations/Nonrenewals

*(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)*

The MA organization must disenroll a member from an MA plan if the MA organization contract is terminated, or if the MA organization discontinues offering the plan or non-renews the MA plan in any portion of the area where the plan had previously been available.

A member who is disenrolled under these provisions has an SEP, as described in §30.4.3, to elect a different MA plan or Original Medicare. A member who fails to make an election during this SEP is deemed to have elected Original Medicare.

**EXCEPTION**

MA organizations can offer an option to continue enrollment in an MA local plan in the organization to members affected by MA plan service area reductions in areas where no other MA plans are available at that time. If the organization chooses to offer this option, it must notify CMS, and must notify members in the beneficiary non-renewal notification letter.

Members must indicate their desire to take advantage of this option. Members who take this option to continue enrollment become known as “out-of-area members,” as defined in §10. The organization may require individuals who choose to continue enrollment in an MA local plan in the organization to agree to receive the full range of basic benefits (excluding emergency and urgently needed care, renal dialysis, and post stabilization) exclusively at facilities designated by the MA organization within the MA local plan service area.

**Notice Requirements -** The MA organization must give each Medicare member a written notice of the effective date of the termination or service area or continuation area reduction, and include a description of alternatives for obtaining benefits under the Medicare program. Required time frames for these notices are outlined in 42 CFR 422.506 - 422.512.

## 50.3 - Optional Involuntary Disenrollments

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An MA organization may disenroll a member from an MA plan it offers if:

- Premiums are not paid on a timely basis (§50.3.1);
- The member engages in disruptive behavior (§50.3.2); or
- The member provides fraudulent information on an election form, or if the member permits abuse of an enrollment card in the MA plan (§50.3.3).

**Notice Requirements** - In situations where the MA organization disenrolls the member involuntarily for any of the reasons addressed above, the MA organization must send notice of the upcoming disenrollment that meets the following requirements:

- Advises the member that the MA organization is planning to disenroll the member and why such action is occurring;
- Provides the effective date of termination; and
- Includes an explanation of the member's right to a hearing under the MA organization's grievance procedures.

Unless otherwise indicated, all notices must be mailed to the member before submission of the disenrollment transaction to CMS.

## 50.3.1 - Failure to Pay Premiums

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

MA organizations may not disenroll a member who fails to pay MA plan cost sharing under this provision. However, an MA organization has three options when a member fails to pay the MA plan's basic and supplementary premiums.

For each of its MA plans, the MA organization must take action consistently among all members, i.e., an MA organization may have different policies among its plans, but it may not have different policies within a plan.

The MA organization **may**:

1. Do nothing, i.e., allow the member to remain enrolled in the same premium plan;
2. Disenroll the member after a grace period and proper notice; or

3. If the member fails to pay the premium for optional supplemental benefits (that is, a package of benefits that the member is not required to accept), but pays the premium for basic and mandatory supplemental benefits, reduce the member's coverage (also known as "downgrade") by discontinuing the optional supplemental benefits and retaining the member in the **same** plan after proper notice. Given these requirements for a downgrade, this option clearly is only available for MA plans that have optional supplemental benefits offered at a higher premium than the basic benefit package. Such an action would be considered an addendum to the member's original election in the MA plan, and would not be considered a new election. Refer to Chapter 4 (Benefits and Beneficiary Protections) for a definition of "basic benefit," "mandatory supplement," and "optional supplemental benefits."

If the MA organization chooses to disenroll the member or reduce coverage, the action may only be accomplished by the MA organization when payment has not been received within a grace period of a minimum of 1 calendar month that begins on the 1st day of the month for which the premium was not paid. The MA organization must send a notice of non-payment of premiums **within** 7 business days after the delinquent premiums were due, and must notify the member if he/she will be disenrolled (or if coverage will be reduced where applicable).

While the MA organization may accept partial payments, it has the right to ask for full payment within the grace period. If the member does not pay the required amount within the grace period, the effective date of disenrollment or reduction in coverage is the first day of the month after the period ends. Unless the member elects another MA plan during an applicable election period, any disenrollment processed under these provisions will always result in a change of election to Original Medicare. **The MA organization has the right to take action to collect the unpaid premiums from the beneficiary at any point during or after this process.**

If a member is disenrolled for failure to pay premiums and attempts to re-enroll in the organization, the MA organization may require the individual to pay any outstanding premiums owed to the MA organization before considering the enrollment to be "complete."

**Calculating the Grace Period**

An MA organization must provide plan enrollees with a grace period of not less than 1 calendar month, however it may provide a grace period that is longer than 1 month, at its discretion. MA organizations have the following options in calculating and applying the grace period. The organization must apply the same option for all members of a plan.

**A - MA organizations may consider the grace period to end not less than 1 calendar month after the first day of the month for which premium is unpaid.**

If the overdue premium and all other premiums that become due during the grace period (in accordance with the terms of the member's agreement with the MA organization) are not paid in full by the end of the grace period, the MA organization may terminate or reduce the member's coverage. Under this scenario, MA organizations are encouraged to send subsequent notices as reminders or to show that additional premiums are due. Subsequent notices, therefore, should determine the expiration date of the grace period by reference to this date. Notice requirements are summarized in this section under the heading "notice requirements."

**Example A:** Plan XYZ has a 1-month grace period for premium payment. Plan member Mr. Stone's premium was due on February 1, 2005. He did not pay this premium and on February 7th , the MA organization sent an appropriate notice. Mr. Stone ignores this notice and any subsequent premium bills. The grace period is the month of February. If Mr. Stone does not pay his plan premium before the end of February, he will be disenrolled as of March 1, 2005.

**Example B:** Plan QRS has a 2-month grace period for premium payment. Plan member Mrs. Monsoon's premium was due on July 1, 2005. She did not pay this premium and on July 6th , the MA organization sent an appropriate notice. Mrs. Monsoon ignores this notice and subsequent premium bills. The grace period is the months of July and August. If Mrs. Monsoon does not pay her premiums in full by the end of this period (August 31st ), she will be disenrolled effective September 1, 2005.

In short, the MA organization may require that the member pay the overdue premiums in full within the grace period, as well as all other payments becoming due within that period, in order to avoid disenrollment (or a reduction in coverage where applicable). If the MA organization requires the member to make full payment within the grace period and pay all premiums falling due within that period, however, the MA organization must state so in its initial delinquency notice to the member.

**B - MA organizations may use a "rollover" approach in applying the grace period.**

Under this scenario, the grace period would begin on the first of the month for which the premium was is unpaid, but if the member makes a premium payment within the grace period, the grace period stops, and the MA organization would then send another notice informing the member of any overdue payments. The member would then have a new grace period beginning on the 1st day of the next month for which the premium is unpaid. (The subsequent notice also would have to be sent within 7 business days of the date the subsequent premiums became delinquent and the notice otherwise would have to comply with the requirements for such notices, discussed below.) This process would continue until the member's balance for overdue premiums was paid in full or until the grace period expired with no premium payments being made, at which time the MA organization could terminate (or reduce, if applicable) the member's coverage.

**EXAMPLE**

Plan WXY has decided to offer a 2 –month grace period for non-payment of plan premiums and has chosen the "rollover" approach to calculating the grace period. A member fails to pay his January premium due January 1. The MA organization sends a notice to the member on January 7th stating that his coverage will be terminated if the outstanding premium is not paid within the grace period. The notice advises him that his termination date would be March 1. The member fails to pay his February premium, and receives a second notice from the MA organization on February 9th . The member then pays the January premium, but does not pay the February premium. The grace period is recalculated to begin on the 1st of the next month for which the premium is unpaid (February 1). The MA organization sends a notice to the member reflecting the new grace period, and the new anticipated termination date of April 1st . The member pays off his balance in full before the grace period expires, therefore the member's coverage in the MA plan remains intact.

**Notice Requirements -** If the MA organization chooses to disenroll the member or to reduce coverage when a member has not paid premiums, the M+C organization must send an appropriate written notice to the member **within 7 business days** after the date the delinquent premiums were due (see Exhibit 19). The MA organization may send interim notices after the initial notice.

In addition to the notice requirements outlined in §50.3, this notice must:

- Alert the member that the premiums are delinquent, and;
- Provide the member with an explanation of disenrollment procedures advising the member that failure to pay the premiums within the grace period that began on the 1st of the month for which premium was unpaid will result in termination or reduction of MA coverage, whichever is appropriate according to the MA organization policy, and the proposed effective date of this action;
- Explain whether the MA organization requires full payment within the grace period (including the payment of all premiums falling due during the intervening days, when and as they become due, according to the terms of the membership agreement) in order to avoid termination of membership or reduction in benefits; and,
- Explain the implications of a reduction in coverage (e.g., description of lower level of benefits), if the MA organization policy is to reduce coverage for the nonpayment of optional supplemental benefit premiums.

If a member does not pay within the grace period, and the MA organization's policy is to disenroll the member, the MA organization must notify the member in writing after the

expiration of the grace period and prior to submission of the transaction to CMS that the MA organization is planning on disenrolling him/her and provide the effective date of the member's disenrollment (refer to Exhibit 20 for a model letter). In addition, CMS strongly encourages that MA organizations send final confirmation of disenrollment to the member after receiving the reply listing report to ensure the individual does not continue to access MA organization services (refer to Exhibit 21 for a model letter).

If a member does not pay within the grace period, and the MA organization policy is to reduce coverage for the nonpayment of optional supplemental benefit premiums, the MA organization must notify the member in writing after the expiration of the grace period and prior to submission of the transaction to CMS that the MA organization is reducing the coverage and provide the effective date of the change in benefits (refer to Exhibit 22 for a model letter).**Optional Exception for Dual-Eligible Individuals**

MA organizations have the **option** to retain dually eligible members who fail to pay premiums even if the MA organization has a policy to disenroll members or reduce their coverage for non-payment of premiums. (Dually eligible individuals are defined as individuals who are entitled to Medicare Part A and Part B, and receive any type of assistance from the Title XIX (Medicaid) program.)

The MA organization has the discretion to offer this option to dually eligible individuals within each of its MA plans. If the MA organization offers this option in one of its plans, it must apply the policy to all dual eligible individuals in that MA plan.

The policy to retain individuals is based upon non-payment of premium for the standard benefit package of the MA plan. If the MA organization chooses this option, any dually individual who fails to pay premiums for any optional supplemental benefit offered would be downgraded to the standard benefit package within that MA plan.

Members of an MA plan must be informed at least 30 days before a policy changes within the plan. MA organizations will have the discretion as to how it will notify its members of the change, e.g. in an upcoming newsletter or other member mailing, such as the Annual Notice of Change. The CMS recommends a general statement in such notifications to avoid confusing other members for whom the policy does not apply.

**Example:** "If you receive medical assistance and are having difficulty paying your plan premiums or cost sharing, please contact us."

The plan must document this policy internally and have it available for CMS review.

## 50.3.2 - Disruptive Behavior

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The MA organization **may** disenroll a member if his/her behavior is disruptive to the extent that his/her continued enrollment in the MA plan substantially impairs the MA

organization's ability to arrange for or provide services to either that particular member or other members of the plan. However, the MA organization may only disenroll a member for disruptive behavior after it has met the requirements of this section and with CMS' approval. The MA organization may not disenroll a member because he/she exercises the option to make treatment decisions with which the MA organization disagrees, including the option of no treatment and/or no diagnostic testing. The MA organization may not disenroll a member because he/she chooses not to comply with any treatment regimen developed by the MA organization or any health care professionals associated with the MA organization.

Before requesting CMS' approval of disenrollment for disruptive behavior, the MA organization must make a serious effort to resolve the problems presented by the member. Such efforts must include providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. The MA organization must also inform the individual of his or her right to use the organization's grievance procedures.

The MA organization must submit documentation of the specific case to CMS for review. This includes documentation:

- Of the disruptive behavior;
- Of the MA organization's serious efforts to resolve the problem with the individual;
- Of the MA organization's effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act;
- Establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Describing any extenuating circumstances cited under 42 CFR 422.74(d)(2)(iii) and (iv);
- That the MA organization provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Notice Requirements); and
- That the MA organization then provided written notice of its intent to request involuntary disenrollment (see Notice Requirements).

The MA organization must submit to the CMS Regional Office:

- The above documentation;

- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the MA organization's ability to arrange for or provide services to the individual or other members of the MA plan;

- Member information, including age, diagnosis, mental status, functional status, a description of his or her social support systems and any other relevant information;

- Statements from providers describing their experiences with the member; and

- Any information provided by the member.

- The MA organization may request that CMS consider prohibiting re-enrollment in the MA plan (or plans) offered by the MA organization in the service area.

The MA organization's request for involuntary disenrollment for disruptive behavior must be complete, as described above. The CMS Regional Office will review this documentation and consult with CMS Central Office (CO), including staff with appropriate clinical or medical expertise, and decide whether the organization may involuntarily disenroll the member. Such review will include any documentation or information provided either by the organization and the member (information provided by the member must be forwarded by the organization to the CMS RO). CMS will make the decision within 20 business days after receipt of all the information required to complete its review. The CMS will notify the MA organization within 5 (five) business days after making its decision.

The Regional Office will obtain Central Office concurrence before approving an involuntary disenrollment. The disenrollment is effective the first day of the calendar month after the month in which the organization gives the member a written notice of the disenrollment, or as provided by CMS. Any disenrollment processed under these provisions will always result in a change of election to Original Medicare.

If the request for involuntary disenrollment for disruptive behavior is approved, CMS may require the MA organization to provide reasonable accommodations to the individual in such exceptional circumstances that CMS deems necessary. An example of a reasonable accommodation in this context is that CMS could require the MA organization to delay the effective date of involuntary disenrollment to coordinate with an MA election or Part D enrollment period that would permit the individual an opportunity to obtain other coverage. If necessary, CMS will establish an SEP on a case-by-case basis.

**Notice Requirements**

The disenrollment for disruptive behavior process requires 3 (three) written notices:

- Advance notice to inform the member that the consequences of continued disruptive behavior will be disenrollment;
- Notice of intent to request CMS' permission to disenroll the member; and
- A planned action notice advising that CMS has approved the MA organization's request.

**Advance Notice**

Prior to forwarding an involuntary disenrollment request to CMS, the MA organization must provide the member with written notice explaining that his/her continued behavior may result in involuntary disenrollment, and that cessation of the undesirable behavior may prevent this action. The MA organization must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS. **NOTE:** If the disruptive behavior ceases after the member receives notice and then later resumes, the MA organization must begin the process again. This includes sending another advance notice.

**Notice of Intent**

If the member's disruptive behavior continues despite the MA organization's efforts, then the MA organization must notify him/her of its intent to request CMS' permission to disenroll him/her for disruptive behavior. This notice must also advise the member of his/her right to use the organization's grievance procedures and to submit any information or explanation. Refer to Chapter 13, "Grievances, Organizations Determinations, and Appeals," for the appropriate procedures for grievances. The MA organization must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS.

**Planned Action Notice**

If CMS permits an MA organization to disenroll a member for disruptive behavior, the MA organization must provide the member with a written notice that contains, in addition to the notice requirements outlined in §50.3, a statement that this action was approved by CMS and meets the requirements for disenrollment due to disruptive behavior described above. The MA organization may only provide the member with this required notice after CMS notifies the MA organization of its approval of the request.

The MA organization can only submit the disenrollment transaction to CMS after providing the notice of disenrollment (Planned Action Notice) to the individual. The disenrollment is effective the first day of the calendar month after the month in which the

MA organization gives the member a written notice of the disenrollment, or as provided by CMS.

## 50.3.3 - Fraud and Abuse

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An MA organization **may** disenroll a member who knowingly provides, on the election form or by another election mechanism, fraudulent information that materially affects the member's eligibility to enroll in the plan. The organization may also disenroll a member who intentionally permits others to use his/her enrollment card to obtain services or supplies from the plan or any authorized plan provider. Such a disenrollment is effective the first day of the calendar month after the month in which the organization gives the member the written notice.

When such a disenrollment occurs, the organization must immediately notify the CMS RO so the Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse. Any disenrollment processed under these provisions will always result in a change of election to Original Medicare.

**Notice Requirements -** The MA organization must give the member a written notice of the disenrollment that contains the information required at §50.3.

## 50.4 - Processing Disenrollments

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

## 50.4.1 - Voluntary Disenrollments

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

After receipt of a completed disenrollment request from a member, the MA organization is responsible for submitting disenrollment transactions to CMS in a timely, accurate fashion. Such transmissions must occur within 30 calendar days of receipt of the completed disenrollment request, in order to ensure the correct effective date.

The MA organization must maintain a system for receiving, controlling, and processing voluntary disenrollments from the MA organization. This system should include:

- Dating each disenrollment request as of the date it is received (regardless of whether the request is complete at the time it is received by the MA organization) to establish the date of receipt;

- Dating supporting documents for disenrollment requests as of the date they are received, with the last piece of information establishing the "date of receipt" of disenrollment forms that were incomplete when originally received;

- Processing disenrollment requests in chronological order by date of receipt of completed disenrollment requests;

- Transmitting disenrollment information to CMS within 30 calendar days of the receipt of the completed disenrollment request from the individual or the employer (whichever applies). If the disenrollment information is received through the employer, the MA organization must obtain the member's written request to the EGHP to disenroll;

- For disenrollment requests received by the MA organization, notifying the member in writing within seven business days after receiving the member's written request, to acknowledge receipt of the completed disenrollment request, and to provide the effective date (see Exhibit 11 for a model letter). MA organizations are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the reply listing;

- For all other voluntary disenrollments (i.e., voluntary disenrollments made by the beneficiary through 1-800-MEDICAR(E), or by enrolling in another MA plan or PDP, which the MA organization would not learn of until receiving the reply listing), and notifying the member in writing to confirm the effective date of disenrollment within seven **business** days of the availability of the reply listing (see Exhibit 12 for a model letter).

## 50.4.2 - Involuntary Disenrollments

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The MA organization is responsible for submitting involuntary disenrollment transactions to CMS in a timely, accurate fashion.

The MA organization must maintain a system for controlling and processing involuntary disenrollments from the MA organization. This includes:

- Maintaining documentation leading to the decision to involuntarily disenroll the member; and

- For all involuntary disenrollments except disenrollments due to death and loss of entitlement to Medicare Parts A and/or B, notifying the member in writing of the upcoming involuntary disenrollment, including providing information on grievances rights.

In addition, CMS strongly encourages MA organizations to send confirmation of involuntary disenrollment to ensure the member discontinues use of MA organization services after the disenrollment date.

## 50.5 - Disenrollments Not Legally Valid

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

When a disenrollment is not legally valid, a reinstatement action may be necessary (refer to §60.3 for more information on reinstatements). In addition, the reinstatement may result in a retroactive disenrollment from another plan. Since optional involuntary disenrollments (as stated in §50.3) are considered legal and valid disenrollments, individuals would not qualify for reinstatements in these cases.

A voluntary disenrollment that is not complete, as defined in §10, is not legally valid. In addition, there are instances in which a disenrollment that appears to be complete can turn out to be legally invalid. For example, automatic disenrollments due to an erroneous death indicator or an erroneous loss of Medicare Part A or Part B indicator are not legally valid.

The CMS also does not regard a voluntary disenrollment as actually complete if the member or his/her legal representative did not intend to disenroll from the MA organization. If there is evidence that the member did not intend to disenroll from the MA organization, the MA organization should submit a reinstatement request to the CMS RO. Evidence that a member did not intend to disenroll may include:

- A disenrollment request signed by the member when a legal representative should be signing for the member; or

- Request by the member for cancellation of disenrollment before the effective date (refer to §60.2 for procedures for processing cancellations).

Discontinuation of payment of premiums does not necessarily indicate that the member has made an informed decision to disenroll.

In contrast, CMS believes that a member's deliberate attempt to disenroll from a plan (e.g. sending a written request for disenrollment to the MA organization, or calling 1-800-MEDICARE) implies intent to disenroll. Therefore, unless other factors indicate that this disenrollment is not valid, what appears to be a deliberate, member-initiated disenrollment should be considered valid.

## 50.6 - Disenrollment of Grandfathered Members

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

As discussed in §20.6, any individual who was enrolled in a §1876 risk plan effective December 1, 1998 or earlier, and remained enrolled with the risk plan on December 31, 1998, automatically continued to be enrolled in the MA organization on January 1, 1999, even if he/she was not entitled to Medicare Part A or did not live in an MA plan service area or MA organization continuation area.

Disenrollment procedures for grandfathered members are generally the same as those for other members. The MA organization must disenroll any grandfathered member if:

- The member dies;
- The member loses entitlement to either Medicare Part A or Part B (or for Part B only members, enrollment in Medicare Part B ends for the member);
- The member permanently moves into the continuation area, but does not choose to continue enrollment or moves to an area that is out of the service or continuation area;
- The member permanently moves out of the vicinity making continued enrollment no longer reasonable. For example, a move of only a short distance may not affect the member's ability to continue to access the plan therefore continued enrollment would be reasonable.
- The MA organization contract is terminated, or if the service area or continuation area is reduced with respect to all MA individuals who live in the area where the individual resides;

  **NOTE:** The member may be offered the option to continue enrollment, as described in §50.4.2.

## 50.7 - Disenrollment Procedures for Employer Group Health Plans

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

When an employer group terminates its contract with an MA organization, or determines that an enrollee in its program is no longer eligible to participate in the employer group plan, the MA organization has the option to follow one of two procedures to disenroll beneficiaries. The MA organization should outline its policy in its policy and procedures guide and must notify the Regional Office plan manager of its choice. It is the MA organization's responsibility to ensure that the process it has chosen is understood by the employer or union group and part of the agreement with the employer.

**NOTE:** The employer establishes criteria for its retirees to participate in the employer group sponsored MA plan. These criteria are exclusive of the eligibility criteria for MA enrollment. Eligibility criteria to participate and receive employer sponsored benefits may include spouse/family status, payment to the employer

of the individual's part of the premium, or other criteria determined by the employer.

**Option 1:** Follow the basic requirements outlined in this chapter for individual disenrollments:

a. Using the SEP provided to individuals who are making elections through their employer group, beneficiaries may elect another MA plan offered by the employer during the employer's open season. As with any disenrollment, the old MA organization is obligated to send a notice of disenrollment to the beneficiary.

b. Using the SEP authority, the beneficiary may choose to disenroll to Original Medicare or join another MA plan as an individual member instead of electing the new MA plan offered by his/her employer. If the beneficiary is disenrolling to Original Medicare, he/she would submit a disenrollment request to the original MA organization. If the beneficiary is enrolling in a different MA plan as an individual member, he/she would submit an election to his/her newly chosen MA organization. As with any disenrollment, the old MA organization is obligated to send a confirmation of disenrollment to the beneficiary.

c. If the beneficiary does not elect a new employer-contracting MA organization, does not disenroll to Original Medicare, or does not join a new MA plan as an individual member, the beneficiary would remain a member of the original MA organization even after the employer group nonrenewal has gone into effect, or after the date the individual is no longer eligible to participate in the employer group plan. The beneficiary would become a member of an individual plan within the same MAO that provided his/her employer group coverage. The MA organization must notify the beneficiary that his/her benefits, premiums, and/or copayments are changing prior to the effective date of the new enrollment election.

**Option 2**: If an employer group is terminating its contract with an MA organization, or determines that an enrollee in its program is no longer eligible to participate in the employer group plan, CMS will permit mass disenrollments to be submitted by the MA organization providing:

The employer agrees to the following:

- Send a letter/notification to its members alerting them of the termination event and other insurance options that may be available to them through their employer.

- If the employer offers other MA options, the beneficiary must go through the appropriate process to make an election in a MA plan with his/her employer group.

- Provide timely notice (i.e., not retroactive) of enrollee ineligibility or contract termination to the MA organization to facilitate the notice requirements as described below.

The MA organization must:

- Inform the individual at least 30 days prior to the contract termination date, or the date an enrollee will become ineligible for participation in the employer group plan that he/she has the option to remain as an individual member of the MA organization.

- If the beneficiary chooses to remain as an individual member, the beneficiary would be given instructions on what action (or inaction) he/she would need to take to remain enrolled with the MA organization as an individual member. The MA organization should notify the beneficiary of any benefit, premium, or co-payment changes. The plan MUST accept the individual, even if closed or at capacity. For example, individuals with ESRD or only Part B may choose to retain their coverage with the MA organization since these individuals are generally not allowed to join new MA organizations.

## 50.8 - Disenrollment Procedures for Medicare MSA Plans

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Members of Medicare MSA plans may only disenroll in writing through the MA organization offering the Medicare MSA plan; they may not disenroll through the Social Security office or the RRB. Election periods and effective dates for disenrollment from Medicare MSA plans are outlined in §30.7.

MA organizations offering Medicare MSA plans must otherwise follow the disenrollment policies and procedures outlined in §§50.2 through 50.5.

## 60 - Post-Election Activities

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Post-election activities begin after the MA organization receives the election from the individual (e.g., cancellations), and last until a decision is made with respect to an individual's election (e.g., retroactive transactions).

## 60.1 - Multiple Transactions

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Multiple transactions occur when more than one election for the same individual with the same effective date in the same reporting period is received by CMS. An individual may not be enrolled in more than one MA, cost, or HCPP plan at any given time.

Generally, the last election the beneficiary makes during the month will be the plan the individual intends to enroll in. The beneficiary's enrollment will be based upon the date that the enrollment application was signed (for employer group MA elections as described in §40.1.1, the date the election process was completed will be used). If the beneficiary does not date the enrollment election, the date the enrollment election was received by the MA organization will be used as the default date. Facilitated enrollments as described in §40.1.6 and 40.1.7 of this chapter will have an administratively set early application receipt date, to ensure that any subsequent beneficiary election will have a later application date and thus supersede the facilitated enrollment.

However, if an individual elects more than one plan for the same effective date and with the same signature (or completion) date, an assumption cannot be made as to which plan the individual truly intended to be enrolled in. Therefore, if multiple transactions are received with the same signature (or completion) date, they will all be rejected. The reply listings will show rejections for these types of multiple transactions.

In these cases, the beneficiary's enrollment will remain with Original Medicare or with the Medicare health plan in which the beneficiary was enrolled before he/she applied to the MA organizations that received the multiple transaction rejections.

If a Medicare eligible individual has used MA plan services and the enrollment is rejected for multiple transactions, then the MA organization may bill Medicare for the services if the individual is in Original Medicare. The MA organization may be able to bill for Medicare Part B services from the Medicare carrier, and its certified MA plan providers may be able to bill the Medicare fiscal intermediary for Medicare Part A services. MA organizations should refer to the Medicare Carriers Manual and Medicare Fiscal Intermediaries Manual for more information. The individual should be billed for any applicable co-insurance or non-Medicare covered services.

Upon availability of the reply listing from CMS showing a rejection for a multiple transaction, the MA organization may contact the individual to determine in which MA plan the individual wishes to enroll. Once the individual has chosen one MA plan, he/she must either fill out and sign another enrollment form (or complete another enrollment election mechanism) or send written notice of his/her intent to enroll in the plan (to serve as supporting documentation to the original enrollment election signed (or completed) by the individual), The MA organization may transmit the information to CMS with a current effective date, using the appropriate effective date as prescribed in §30.5. The individual must be eligible to make an election in an available election period, as described in §30.

Generally, given the use of signature date to determine the intended election, retroactive enrollments will not be processed for multiple transactions that reject because the elections were signed on the same day.

**EXAMPLE**

- Two MA organizations (MAOs) receive completed enrollment forms from one individual on March 20 for an April 1 effective date. The form received by MAO #1 was signed on March 10th and the form received by MAO #2 was signed on March 12. Both MAOs submit enrollment transactions, including the applicable signature date (application date). The enrollment in MAO #2 will be the transaction that is accepted and will be effective on April 1.

## 60.2 - Cancellations

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Cancellations may be necessary in cases of mistaken enrollment made by an individual and/or mistaken disenrollment made by a member. Requests for cancellations can only be accepted prior to the effective date of the election. For employer groups, cancellations properly made to the employer prior to the effective date of the election being canceled are also acceptable.

If a cancellation occurs after CMS records have changed, retroactive disenrollment and reinstatement actions may be necessary. Refer to §§60.3 and 60.5.

If a beneficiary verbally requests a cancellation, the MA organization should document the request. MA organizations have the right to request that a cancellation be in writing. However, they may not delay processing of a cancellation until the request is made in writing if they have already received verbal confirmation from the beneficiary of the desire to cancel the election.

For facilitated enrollment as described in §40.1.6 and 40.1.7 of this chapter, a beneficiary may cancel the enrollment and affirmatively decline Part D benefits by telephone. The MA organization may not require these cancellations in writing.

### 60.2.1 - Cancellation of Enrollment

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

An individual's enrollment can only be cancelled if the request is made prior to the effective date of the enrollment.

To ensure the cancellation is honored, the MA organization should not transmit the enrollment to CMS. If, however, the organization had already transmitted the enrollment by the time it receives the request for cancellation, it may attempt to submit a

corresponding disenrollment transaction to CMS to "cancel out" the now void enrollment transaction. In the event the MA organization has submitted the enrollment and is unable to submit a corresponding disenrollment transaction, or has other difficulty, the MA organization should contact the CMS RO in order to cancel the enrollment.

When canceling an enrollment the MA organization must send a letter to the individual that states that the cancellation is being processed (see Exhibit 25). This notice should be sent within seven business days of the request. The language in the notice will depend upon whether the organization has already sent the enrollment transaction to CMS.

- If the enrollment transaction was not sent to CMS, then the notice must inform the member that the cancellation will result in the individual remaining enrolled in the health plan he/she originally was enrolled in.

- If the enrollment transaction was sent to CMS (in which the RO has been contacted to cancel the enrollment), then the notice must inform the member that if he/she was already enrolled in another MA plan, then the current enrollment action will have caused him/her to be disenrolled from the health plan he/she originally was enrolled in. The notice must also instruct the individual to contact the original MA organization if he/she wishes to remain a member of the MA plan in that MA organization.

If the member's request for cancellation occurs after the effective date of the enrollment, then the cancellation cannot be processed. The MA organization must inform the member that he/she is a member of its MA plan. If he/she wants to get back into the other MA plan he/she will have to fill out an enrollment form to enroll in that MA plan during an election period, and with a current effective date.

If the member wants to return to Original Medicare, the member must be instructed to disenroll from the plan as described in §50.1 of this chapter. The member must be informed that the disenrollment must be made during an election period (described in §30.5) and will have a current effective date (as prescribed in §30.5), and must be instructed to continue to use plan services until the disenrollment goes into effect.

## 60.2.2 - Cancellation of Disenrollment

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

A member's disenrollment can only be canceled if the request is made prior to the effective date of the disenrollment.

To ensure the cancellation is honored, the MA organization should not transmit the disenrollment to CMS. If, however, the organization had already transmitted the disenrollment by the time it receives the verbal request for cancellation, it may attempt to submit a corresponding enrollment transaction to CMS to "cancel out" the now void disenrollment transaction. In the event the MA organization has submitted the

disenrollment and is unable to submit the "canceling" enrollment transaction, or has other difficulty, the MA organization then the organization should contact the CMS RO in order to cancel the disenrollment.

The MA organization must send a letter to the member that states that the cancellation is being processed and instructs the member to continue using MA plan services (see Exhibit 26). This notice should be sent within seven business days of the request.

If the member's request for cancellation occurs after the effective date of the disenrollment, then the cancellation cannot be processed. In some cases, reinstatement due to a mistaken disenrollment will be allowed, as outlined in §60.3.2. If a reinstatement will not be allowed, the MA organization should instruct the member to fill out and sign a new enrollment form to re-enroll with the MA organization during an election period (described in §30), and with a current effective date, using the appropriate effective date as prescribed in §30.5.

## 60.3 - Reinstatements

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

Reinstatements may be necessary if a disenrollment is not legally valid (refer to §50.5 to determine whether a disenrollment is not legally valid). The most common reasons warranting reinstatements are:

1. Disenrollment due to erroneous death indicator;

2. Disenrollment due to erroneous loss of Medicare Part A or Part B indicator; and

3. Mistaken disenrollment. In unique circumstances, an organization may consult with the RO to reinstate members.

The RO will approve such reinstatements on a case-by-case basis.

A reinstatement is viewed as a correction necessary to "erase" a disenrollment action and to ensure no gaps in coverage occur. Therefore, reinstatements may be made back to a date when an MA plan was closed for enrollment.

When a disenrolled member contacts the MA organization to state that he/she was disenrolled due to any of the reasons listed above, and states that he/she wants to remain a member of the MA plan, then the MA organization must instruct the member in writing as soon as possible to continue to use MA plan services (refer to Exhibit 15, Exhibit 16, and Exhibit 17 for model letters).

### 60.3.1 - Reinstatements for Disenrollment Due to Erroneous Death Indicator or Due to Erroneous Loss of Medicare Part A or Part B Indicator

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

A member can be reinstated if he/she was disenrolled due to an erroneous death or loss of Part A or Part B indicator since he/she was always entitled to membership. As outlined in 42 CFR 422.74(c), MA organizations have the option of sending notification of disenrollment due to death or loss of Part A or B. The CMS strongly suggests that MA organizations send these notices, to ensure any erroneous disenrollments are corrected as soon as possible. Refer to Exhibit 13 and Exhibit 14 for model letters.

To request reinstatement from the CMS RO, the MA organization should submit the following information to its RO:

- A copy of the reply listing showing the disenrollment (include the system run date);
- A copy of any disenrollment letter that the MA plan may have sent to the individual (see §§50.2.2 and 50.2.3). Refer to model letters in Exhibits 13 and 14;
- A copy of any correspondence from the member disputing the disenrollment. Member correspondence could include a summary of the dispute, phone contact reports, and copies of letters;
- A copy of the letter to the member informing him/her to continue to use MA plan services until the issue is resolved. Refer to model letters in Exhibits 15 and 16; and
- Verification that the disenrollment was erroneous. This verification can be shown via documentation from SSA stating its records have been corrected or that its records never showed the member as being deceased or having lost entitlement. It may also be shown by a CMS or CMS subcontractor print screen supporting the uninterrupted existence of Medicare Part A or B enrollment.

## 60.3.2 - Reinstatements Due to Mistaken Disenrollment Made By Member

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

As stated in §50.5, deliberate member-initiated disenrollments imply intent to disenroll. Therefore, reinstatements generally will not be allowed if the member deliberately initiated a disenrollment. An exception is made for those members who are able to cancel the disenrollment before the effective date of the disenrollment (as outlined in §60.2.2), given that this type of cancellation generally results in no changes to CMS records.

Reinstatements will be allowed at the request of a member who enrolled in a second MA organization, which resulted in an erroneous disenrollment from the original MA

organization in which he/she was enrolled, and who was able to cancel the enrollment in the second MA organization (as outlined in §60.2.1). When a cancellation of enrollment in a second MA organization is properly made, the associated automatic disenrollment from the first MA organization becomes invalid. Generally, these reinstatements will only be granted when the member submits the request for reinstatement in writing in the time frames described in the next paragraph, and has only used health care services from providers in the original (first) MA plan (not including emergency or urgently needed services) since the original effective date of the disenrollment.

In these cases, when a disenrolled member verbally contacts the original MA organization to state that he/she mistakenly disenrolled, and states that he/she wants to remain a member of the MA plan, the MA organization must instruct the member to notify the MA organization in writing of the desire to remain enrolled in the plan within 30 calendar days after the MA organization sent the notice of disenrollment to the individual (i.e., the notices shown in Exhibit 12). Regardless of whether the request for reinstatement is verbal or in writing, the MA organization must also instruct the member as soon as possible to continue to use MA plan services (refer to Exhibit 17 for a model letter).

If the MA organization does not receive the written statement requested from the member within the required time frame, then it must close out the reinstatement request by notifying the individual of the denial of reinstatement (refer to Exhibit 18 for a model letter), and should do so within seven business days after the date the member's written request was due at the MA organization.

To request reinstatement from the CMS RO, the MA organization must submit the following information to its RO:

- A copy of the reply listing showing the disenrollment (include the system run date);

- A copy of the disenrollment letter sent to the individual. Refer to model letter in Exhibit 12 (or Exhibit 11, if appropriate);

- A copy of any correspondence from the member disputing the disenrollment and indicating that he/she wants to remain enrolled in the plan. Member correspondence could include a summary of the facts, phone contact reports, and copies of letters;

- A copy of the letter to the member informing him/her to continue to use MA plan services until the issue is resolved and instructing him/her to state the intent to continue enrollment in writing. Refer to model letter in Exhibit 17; and

- A copy of the written statement from the member indicating he/she wants to remain enrolled in the MA plan and has not used non-plan services (except for emergency or urgently needed services).

## 60.4 - Retroactive Enrollments

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The CMS will only process requests for retroactive enrollments when the MA organization has notified the member that he/she must use MA plan services during the period covered by the retroactive enrollment request. Retroactive enrollments will be approved by CMS when an individual has fulfilled all election and eligibility requirements for an MA plan, but the MA organization or CMS is unable to process the election for the statutorily required effective date (as outlined in §30.5).

Unlike a reinstatement, which is a correction of records to "erase" an action, a retroactive enrollment is viewed as an action to enroll a beneficiary into a plan for a new time period. Therefore, retroactive enrollments may NOT be made back to a date when an MA plan was closed for enrollment.

**NOTE:** Keep in mind that unless a capacity limit applies, all MA plans are open for ICEP, AEP, and SEP elections; therefore, all MA plans are open for retroactive enrollments for these types of elections.

The retroactive enrollment request should be made within 45 calendar days of the availability of the first reply listing. The following documentation must be submitted to the RO for all retroactive enrollment requests:

1. A copy of signed completed enrollment form;

   **NOTE:** The form must have been signed by the applicant prior to the requested effective date of coverage, in order to effectuate the requested effective date of coverage;

   Or

   A copy of the enrollment election record (the election record must show that the election was made prior to the requested effective date of coverage).

2. A copy of MA organization's letter to the member acknowledging receipt of the completed enrollment election and notifying the member to begin using the MA plan's services as of the effective date (refer to Exhibit 4 or Exhibit 4a for the model letter). The letter must be dated prior to the requested retroactive effective date of coverage (or, when appropriate as outlined in §40.4.2, within seven business days after the effective date of coverage), in order to effectuate the requested effective date of coverage.

3. One or more of the examples of "evidence of Medicare Part A and Part B coverage" cited in §10.

4. For cases of an erroneous indicator of no Medicare entitlement - Copies of two reply listings, including a copy of the system run date, indicating the MA organization's attempts to correctly enroll the individual and the resulting rejections. One reply listing will be considered acceptable if the MA organization would be unable to obtain a second reply listing and still submit the retroactive enrollment request within 45 calendar days of the availability of the first reply listing; however, two reply listings are preferred. The MA organization may submit the exception report in place of the reply listing. The effective date on the first reply listing must correspond with the requested effective date, in order to effectuate the retroactive effective date of coverage.

5. For cases of an erroneous indicator of ESRD, either because the individual has never had ESRD or because ESRD status has been terminated:

    - Evidence of contact with the individual after the first systems rejection, including the individual's explanation for rejection. If the individual reports that he/she no longer has ESRD or that he/she has had a kidney transplant or no longer receives dialysis services, then provide medical documentation, for example a letter from the physician or dialysis facility that documents date of transplant or last month of dialysis. If the individual reports that he/she never had ESRD, provide a statement signed by the individual (or his/her physician) to that effect.

    - A copy of the reply listings or print screens indicating the MA organization's attempts to correctly enroll the individual and the resulting rejection. The effective date on the reply listing must correspond with the requested effective date, in order to effectuate the retroactive effective date.

In the event that CMS determines that the MA organization did not notify the member that he/she must use MA plan services during the period covered by the retroactive enrollment request, a retroactive enrollment request will be denied. In this case, if the Medicare eligible individual has used MA plan services during the period covering the retroactive enrollment request, the MA organization may bill Medicare for the services. The MA organization may bill for Medicare Part B services from the Medicare carrier.

**NOTE:** The MA organization must have an indirect billing number from CMS.

Or, the MA organization may have its certified MA plan providers bill for Medicare Part B services. The certified MA plan providers may bill the Medicare fiscal intermediary for Medicare Part A services. MA organizations may not bill for Medicare Part A services. The beneficiary would remain responsible for any co-insurance and deductible.

If an MA organization is making a retroactive request that is a result of MA organization error or system problems (as defined in §10) in which the enrollment is not recorded on a timely basis by the MA organization or in CMS records, the MA organization must submit the request to:

- The CMS central office, for a CMS or SSA computer system problem involving multiple members, or

- The CMS RO, for individual cases or situations when the organization is experiencing internal problems.

If the CMS RO is not able to resolve system errors, the recommendation is submitted to CMS central office for correction.

**SPECIAL NOTE**: For auto-enrollment for full-benefit dual eligible as described in §40.1.6 of this chapter may be retroactive to ensure no coverage gap between the end of Medicaid and beginning of Medicare drug coverage.

## 60.5 - Retroactive Disenrollments

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The CMS may grant a retroactive disenrollment if an enrollment was never legally valid (§40.6) or if a valid request for disenrollment was properly made, but not processed or acted upon (as outlined in the following paragraph), which includes not only system error, but plan error (see §10 for a definition of "system error" and "plan error"). The CMS may also grant a retroactive disenrollment if the reason for the disenrollment is related to a permanent move out of the plan service area (as outlined in §50.2.1.2), or a contract violation (as outlined in 42 CFR 422.62(b)(3)). Retroactive disenrollments can be submitted to CMS by the beneficiary or an MA organization. Requests from an MA organization must include supporting evidence justifying a late disenrollment. MA organizations must submit retroactive disenrollment requests to CMS RO as soon as possible. If CMS approves a request for retroactive disenrollment, the MA organization must return any premium paid by the member for any month for which CMS processed a retroactive disenrollment. In addition, CMS will retrieve any capitation payment for the retroactive period.

A retroactive request must be submitted by the MA organization to CMS by the member in cases in which the MA organization has not properly processed or acted upon the member's request for disenrollment as required in §50.4.1 of these instructions. A disenrollment request would be considered not properly acted upon or processed if the effective date is a date other than as required in §30.6.

If an MA organization is making a retroactive request that is a result of MA organization error or system problems (as defined in §10) in which the disenrollment is not recorded

on a timely basis by the MA organization or in CMS records, the MA organization must submit the request to:

- The CMS central office, for a CMS or SSA computer system problem involving multiple members; or
- The CMS RO, for individual cases or situations when the organization is experiencing internal problems.

If the CMS RO is not able to resolve system errors, the recommendation is submitted to CMS central office for correction.

The MA organization should submit a retroactive disenrollment request to the CMS RO for errors made by SSA in submitting plan disenrollments. The CMS makes an adjustment of the dates. If the MA organization is uncertain which CMS office should process the request, the MA organization should contact the CMS RO.

## 60.6 - Retroactive Transactions for Employer Group Health Plan (EGHP) Members

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

In some cases an MA organization that has both a Medicare contract and a contract with an EGHP arranges for the employer to process elections for Medicare-entitled group members who wish to make elections under the Medicare contract. However, there can be a delay between the time the member makes the election through the EGHP, and when the election is received by the MA organization. Therefore, retroactive transactions for these routine delays may be necessary and are provided for under this section. Errors made by an EGHP, such as failing to forward a valid enrollment or disenrollment election within the timeframes described below, must be submitted to the CMS RO for review. Repeated errors may indicate an ongoing problem and therefore will be forwarded to the MA organization's CMS Plan Manager for compliance monitoring purposes. The MA organization's agreement with the EGHP should include the need to meet the requirements provided in this chapter that ensure timely MA elections to help avoid such errors.

### 60.6.1 - EGHP Retroactive Enrollments

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

CMS will allow the MA organization to submit EGHP enrollment elections to CMS with retroactive enrollment dates. However, the effective date cannot be prior to the signature date on the election form, or prior to the date the enrollment election was completed by the beneficiary. The effective date may be adjusted to reflect a retroactive adjustment in payment of up to, but not exceeding, 90 days **payment** adjustment, to conform with the adjustments in payment described under 42 CFR 422.250(b).

**EXAMPLE**

In March 2002, the CMS system processing date was March 13, 2002. Elections processed by CMS for the March 13, 2002 due date were for the prospective April 1, 2002, payment. For EGHPs, an effective date of March 1, February 1, or January 1 would reflect 30-, 60-, and 90-days of retroactive payment adjustment, respectively. Therefore, if a completed EGHP election were to be received on March 5, 2002, the retroactive effective date could be January 1, February 1, or March 1.

**NOTE:** Keep in mind that unless a capacity limit applies, all MA plans are open for ICEP, AEP, and SEP elections. Therefore, all MA plans are open for retroactive enrollments for these type of elections.

No retroactive enrollments may be made unless the individual certifies that the MA organization (or EGHP) provided him/her with the explanation of enrollee rights (including the lock-in requirement) at the time of enrollment. The MA organization should submit such enrollments using a number 60 enrollment code. Refer to Chapter 19, "Managed Care and MA Systems Requirements", and the Enrollment and Payment User's Guide for more detail on the use of code 60.

## 60.6.2 - EGHP Retroactive Disenrollments

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

The MA organization must submit a retroactive disenrollment request to the CMS RO if an employer does not provide the MA organization with timely notification of a member's requested disenrollment. Up to 90 day's retroactive **payment** adjustment is possible in such a case to conform with the adjustments in payment described under 42 CFR 422.250(b). The employer notification is considered untimely if it does not result in a disenrollment effective date as outlined in §30.6.

The MA organization must submit a disenrollment notice (i.e., documentation) to CMS demonstrating that the member acted to disenroll in a timely fashion (i.e., prospectively), but that the employer was late in providing the information to the MA organization. Such documentation may include an enrollment form for a new MA plan signed by the member and given to the employer during an open enrollment season. The documentation may not include a copy of a Medicare supplemental plan or Medigap plan enrollment form unless the member indicated on that form that he/she has canceled any other insurance. Such documentation should be sent to the CMS RO as soon as possible.

## 60.7 - Election of the Continuation of Enrollment Option for MA Local Plans

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

When a member permanently moves into the MA organization's continuation area, the member must make a positive choice to continue enrollment in the MA local plan. The member does not have to complete and sign a new enrollment form in order for the continuation to occur but must make this choice in a manner described in the MA organization's policy and procedure documents.

The MA organization must verify that the member has established permanent residence in the continuation area. Proof of permanent residence is normally established by the address of the residence, but the MA organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual.

The effective date of a continuation of enrollment change generally is the first day of the month after the individual moves into the continuation area.

## 60.8 - Storage of Enrollment and Disenrollment Records

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

As stated at 42 CFR 422.60(c)(2), MA organizations are required to file and retain election forms. MA organizations must retain and have available for evaluation enrollment and disenrollment records for the current contract period and ten (10) prior periods (42 CFR 422.504(e)(4)).

It is appropriate to allow for storage on microfilm, as long as microfilm versions of enrollment forms and disenrollment requests showing the signature and the date are available to reviewers. Similarly, other technologies that would allow the reviewer to access signed forms and other enrollment elections may also be allowed, such as optically scanned forms stored on disk.

Records of MA enrollment and disenrollment elections made by any other election mechanism (as described in §40.1) must also be retained as above.

## 60.9 - Medicare MSA Plans

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

MA organizations offering Medicare MSA plans must follow the procedures outlined in §§60.1 through 60.8.

## 70.0 - Special Needs Plans (SNPs)

***(Rev. 66, Issued: 08-05-05, Effective: 08-05-05)***

MA organizations may offer SNPs that serve the special needs of certain groups of individuals including; institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and other chronically ill or disabled beneficiaries as provided by CMS.

Guidance for these plans, including a complete **SNP Question &Answer document** that addresses frequently-asked-questions regarding the offering of MA SNPs, is available at the following web address:
www.cms.hhs.gov/healthplans/specialneedsplans/default.asp

# Chapter 2
# Appendices

Summary of Notice and Data Element Requirements

## Appendix 1: Summary of Notice Requirements

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in sections: 10,30, 40, 50, and 60

**This Exhibit is intended to be a summary of notice requirements. For exact detail on requirements and time frames, refer to the appropriate sections within this Chapter.**

| Notice | Section | Required? | Timeframe |
|---|---|---|---|
| Model Enrollment Form (Exh. 1) | 10, 40.1, 40.2, 40.4.1 | Yes[1] | NA |
| EGHP Enrollment Form (Exh. 2) | 10, 40.1, 40.2, 40.4.1 | No | NA |
| Short Enrollment Forms (Exh. 3 and 3a) | 10, 40.1, 40.2, 40.4.1 | No | NA |
| Acknowledgment of Receipt of Completed Enrollment Election (Exh. 4 and 4a) | 40.4.1, 60.4 | Yes | Before effective date, or if late in election period, 7 business days of receipt of completed enrollment election |
| Request for Information (Exh. 5) | 40.2.2 | No | NA |
| Confirmation of Enrollment (Exh. 6 and 6a) | 40.4.2, 40.6 | Yes | 7 business days of reply listing |
| Notice to Individuals Identified on CMS Records As Members of Employer Group Receiving Subsidy (Exh. 6b) | 40 | Yes | 7 business days of reply listing |
| MAO Denial of Enrollment (Exh. 7) | 40.2.3 | Yes | 7 business days of denial determination |
| CMS Rejection of Enrollment (Exh. 8) | 40.4.2 | Yes | 7 business days of reply listing (one exception described in §40.4.2) |
| Sending Out Disenrollment Form/Disenrollment Form (Exh. 9- | 50.1 | No | NA |

[1] Other CMS approved enrollment election mechanisms may take the place of an enrollment form

| Notice | Section | Required? | Timeframe |
|---|---|---|---|
| 10) | | | |
| Acknowledgment of Receipt of Voluntary Disenrollment Request from Member (Exh. 11) | 50.1, 50.4.1 | Yes | 7 business days of receipt of request to disenroll |
| Final Confirmation of Voluntary Disenrollment Request from Member (no exhibit) | 50.1 | No | NA |
| Confirmation of Voluntary Disenrollment Identified Through Reply Listing (Exh. 12) | 50.1, 50.4.1. 60.3.2 | Yes | 7 business days of reply listing |
| Denial of Disenrollment (Exh. 12a) | 40.2.3 | Yes | 7 business days of denial determination |
| Rejection of Disenrollment (Exh. 12b) | 50.1 | Yes | 7 business days of reply listing |
| Verification of Change in Address (no exhibit) | 50.2.1 | No | NA |
| Disenrollment Due to Permanent Move (no exhibit) | 50.2.1 | Yes | Within 7 business days of learning of the permanent move and no later than before the disenrollment transaction is submitted to CMS |
| Notice of Upcoming Disenrollment Due to Out of Area > 6 Months (no exhibit) | 50.2.1 | Yes | Any time during the 6th month, or no later than 7 business days after the 6th month as long as the notice is sent before the disenrollment transaction is submitted to CMS |
| Final Confirmation of Disenrollment Due to Out of Area > 6 Months (no exhibit) | 50.2.1 | No | NA |
| Disenrollment Due to Death (Exh. 13) | 50.2.3, 50.4.2, 60.3.1 | No | NA |
| Disenrollment Due to Loss of Part A and/or Part B Coverage (Exh. 14) | 50.2.2, 50.4.2, 60.3.1 | No | NA |
| Notices on Terminations/Nonrenewals | 50.2.4 | Yes | Follow requirements in 42 CFR 422.506 - 422.512 |
| Warning of Potential Disenrollment Due to Disruptive Behavior (no | 50.3.2 | Yes | NA |

| Notice | Section | Required? | Timeframe |
|---|---|---|---|
| exhibit) | | | |
| Disenrollment for Disruptive Behavior (no exhibit) | 50.3.2 | Yes | Before the disenrollment transaction is submitted to CMS |
| Disenrollment for Fraud and Abuse (no exhibit) | 50.3.3 | Yes | Before the disenrollment transaction is submitted to CMS |
| Offering Beneficiary Services, Pending Correction of Erroneous Death Status (Exh. 15) | 60.3, 60.3.1 | Yes | 7 business days of initial contact with member |
| Offering Beneficiary Services, Pending Correction of Erroneous Part A/B Termination (Exh. 16) | 60.3, 60.3.1 | Yes | 7 business days of initial contact with member |
| Offering Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another MA organization (Exh. 17) | 60.3, 60.3.2 | Yes | 7 business days of initial contact with member |
| Closing Out Request for Reinstatement (Exh. 18) | 60.3.2 | Yes | 7 business days after information was due to MA organization |
| Failure to Pay Plan Premiums - Advanced Notification of Disenrollment or Reduction in Coverage (Exh. 19) | 50.3.1 | Yes | Within 7 business days after the 1st of the month for which delinquent premiums due |
| Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment (Exh. 20) | 50.3.1 | Yes | Before the disenrollment transaction is submitted to CMS |
| Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment (Exh. 21) | 50.3.1 | No | |
| Failure to Pay Plan Premiums - Notice of Reduction in Coverage (Exh. 22) | 50.3.1 | Yes | Prior to effective date of reduction in coverage |
| Public Notices For Closing Enrollment due to Capacity Limit (Exh. 23) | 40.5 | Yes | 15 days if related to CMS approved capacity limit |
| Notice that Election Placed on Waiting List (no exhibit) | 40.5.1, 40.5.2 | Yes | 7 business days of receiving enrollment election or of approval from CMS to limit enrollment |

| Notice | Section | Required? | Timeframe |
|---|---|---|---|
| Re-affirming Intent to Not Enroll (no exhibit) | 40.5.1, 40.5.2 | No | |
| Intent to Not Process Enrollment (no exhibit) | 40.5.1, 40.5.2 | Yes | 7 business days of learning beneficiary no longer wants to enroll |
| Medigap Rights per Special Election Period (Exh. 24) | 50.2, 50.1 | No | Upon request. |
| Request to cancel enrollment (Exh. 25) | 60.2.1 | Yes | 7 business days of request |
| Request to cancel disenrollment (Exh. 26) | 60.2.2 | Yes | 7 business days of request |
| Inform Member of Auto-Enrollment (Exh. 27) | 20.4.6, 40.1.6 | Yes | 7 business days of reply listing |
| Inform Member of Facilitated Enrollment (Exh. 28) | 20.4.7, 40.1.7 | Yes | 7 business days of reply listing |
| Request to Decline Part D (Exh. 29) | 40.1.6 40.1.7 | Yes | 7 business days of request |

## Appendix 2: Data Elements Required to Complete the Enrollment Election

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 20, 20.4, 40.2, 40.4.1

All data elements with a "Yes" in the "Required before enrollment complete" column are necessary in order for the enrollment to be considered complete.

| Data Element | | Required before enrollment complete? | Exhibit # in which data element appears |
|---|---|---|---|
| 1 | MA Plan Name | Yes | 1, 2, 3, 3a |
| 2 | MA Plan/Product/premium choice (if included) | Yes | 1, 2, 3a |
| 3 | Beneficiary Name | Yes | 1, 2, 3, 3a |
| 4 | Beneficiary Date of Birth | Yes | 1, 2 |
| 5 | Beneficiary Sex | Yes | 1, 2 |
| 6 | Social Security Number | No | 1,2 |
| 7 | Beneficiary Telephone Number | No | 1, 2, 3 |
| 8 | Permanent Residence Address | Yes | 1, 2, 3 |
| 9 | Mailing Address | No | 1, 2, 3 |
| 10 | Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field) | No | 1, 2 |
| 11 | E-mail Address | No | 1,2,3 |
| 12 | Beneficiary Medicare number | Yes | 1, 2, 3 |
| 13 | Additional Medicare information contained on sample Medicare card, or copy of card | No[2] | 1, 2 |
| 14 | Plan Premium Payment Option | Yes | 1,3,3a |
| 15 | Response to ESRD Question | Yes | 1, 2 |
| 16 | Response to long term care question | No | 1, 2 |
| 17 | Response to other insurance COB information | Yes | 1, 2 |

[2] As stated in §40.2, an MA organization can not refuse to accept an enrollment form when an individual does not have his/her Medicare card available at the time s/he fills out an enrollment form; however, the enrollment form will not be considered complete until the MA organization has obtained evidence of entitlement to Medicare Part A and enrollment in Part B. We recognize that the MA organization needs, at a minimum, the Medicare number in order to verify entitlement to Part A and enrollment in Part B; we have accounted for the need for this data element under data element number 4.

| Data Element | | Required before enrollment complete? | Exhibit # in which data element appears |
|---|---|---|---|
| 18 | Response to Medicaid question | No | 1, 2 |
| 19 | Language preferences (Optional Field) | No | 1, 2 |
| 20 | Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary) | No | 2 |
| 21 | Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents | No | 2 |
| 22 | Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number | No | 2 |
| 23 | Name of chosen Primary Care Physician, clinic or health center (Optional Field) | No | 1, 2, 3 |
| 24 | Beneficiary signature and/or Authorized Representative Signature | Yes[3] | 1, 2, 3,3a |
| 25 | Date of signature | No[4] | 1, 2, 3, 3a |
| 26 | Authorized representative contact information | Yes | 1,2,3, 3a |
| 27 | Employer Name and Group Number | Yes | 2 |
| 28 | Question of which MA plan/premium the beneficiary is currently a member of and to which MA plan/premium the beneficiary is changing | Yes | 3 |
| 29 | Information regarding creditable coverage | Coming Fall 2006 | |

[3] For Employer Group MA enrollment elections as described in §40.4.1, and some other CMS approved enrollment elections, a signature is not required.

[4] As explained in §40.2, the beneficiary and/or legal representative should write the date s/he signed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment form, then the stamped date of receipt that the MA organization places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is not a necessary element. For employer group MA elections as described in §40.4.1, the "signature date" is the date the employer's process was completed as recorded.

# Chapter 2
# EXHIBITS:

Model Medicare Advantage Enrollment Form & Notices

## Exhibit 1: Model MA Individual Enrollment Form ("Election" may also be used)

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 10, 40.1, 40.2, 50.1

### To Enroll in <plan>, Please Provide the Following Information:

[Optional Field] **Please check which plan you want to enroll in:**

____ Product ABC $XX per month ____ Product XYZ $XX per month

| LAST name: | FIRST Name: | Middle Initial | ☐ Mr. ☐ Mrs. ☐ Ms. |
|---|---|---|---|
| Birth Date:<br>(__ __/__ __/__ __ __ __)<br>(M M / D D / Y Y Y Y) | Sex:<br>☐ M ☐ F | Social Security Number:<br>*(providing this information is optional)* | Home Phone Number:<br>( ) |

Permanent Residence Street Address:

| City: | State: | ZIP Code: |
|---|---|---|

**Mailing Address** (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

**Emergency contact:** [Optional field] _____

**Phone Number**: [Optional field]_____**Relationship to You** [Optional field]_____

[optional field] **E-mail Address:**

### Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To Effective Date

**HOSPITAL (Part A)** _____

**MEDICAL (Part B)** _____

## Your Plan Premium Option

You can have the monthly premium for this Medicare plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by electronic Funds Transfer (EFT). *<Optional – insert other billing interval options, if available>* Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

**Would you like the premium for this plan deducted from your SSA monthly benefit check.** ☐ Yes ☐ No

**Please read and answer these important questions:**

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <MA plan>? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes" please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street):_____

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

**[Optional field ] Please choose the name of a Primary Care Physician (PCP), clinic or health center (if required):**

[Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**

____ Language A (e.g., Spanish)

____ Language B (e.g., Chinese)

*[Following box only required for MA-PD plans*:

## Please Read This Important Information

**If you currently have health coverage from an employer or union, joining <MA-PD Name> could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining <MA-PD Name> may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

## Please Read and Sign Below:

**By completing this enrollment application, I agree to the following:**

<Name> is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to <Name> or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

<Name> serves a specific service area. If I move out of the area that <Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from [name] when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

[*MA PFFS do not include the following paragraph]* I understand that beginning on the date [name of plan] coverage begins, I must get all of my health care from [name of plan], with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by [name of plan] and other services contained in my [name of plan] Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR [NAME OF PLAN] WILL PAY FOR THE SERVICES.**

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <MA Plan> or by Medicare.

| **Your Signature:** | **Today's Date:** |
|---|---|
| If you are the authorized representative, you must provide the following information:<br><br>**Name :** _____<br>**Address:** _____<br>**Phone Number**: (___) ____- _____<br>**Relationship to Enrollee** _____ | |

**Office Use Only**:
Name of staff member (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____

## Exhibit 2: Model Employer Group Health Plan Enrollment Form ("Election" may also be used)

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 10, 40.1, 40.2, 50.1

| **To Enroll in <plan>, Please Provide the following Information:** | | | |
|---|---|---|---|
| Employer Name: | | Group #: | |
| [Optional Field] **Please check which plan you want to enroll in:**<br>____ Product ABC $XX per month ____ Product XYZ $XX per month | | | |
| LAST name: | FIRST Name: | Middle Initial | ☐ Mr. ☐ Mrs. ☐ Ms. |
| Birth Date:<br>(__ __/__ __/__ __ __ __)<br>(M M / D D / Y Y Y Y) | Sex:<br>☐ M ☐ F | Social Security Number:<br>*(providing this information is optional)* | Home Phone Number:<br>( ) |
| Permanent Residence Street Address: | | | |
| City: | State: | ZIP Code: | |
| **Mailing Address** (only if different from your Permanent Residence Address):<br>Street Address: City: State: ZIP Code: | | | |
| [optional field] **E-mail Address:** | | | |

| **Please Provide Your Medicare Insurance Information** | |
|---|---|
| Please take out your Medicare Card to complete this section.<br>• Please fill in these blanks so they match your red, white and blue Medicare card<br>- OR -<br>• Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.<br><br>You must have Medicare Part A and Part B to join a Medicare Advantage plan. | MEDICARE HEALTH INSURANCE<br>SAMPLE ONLY<br>Name: _____<br>Medicare Claim Number Sex ___<br>__ __ __ - __ __ - __ __ __ __ ___<br>Is Entitled To Effective Date<br>**HOSPITAL (Part A)** _____<br>**MEDICAL (Part B)** _____ |

| Please read and answer these important questions: |
|---|
| 1. Are you the retiree? ☐ Yes ☐ No<br>If yes, retirement date (month/date/year): _____<br>If no, name of retiree: _____ |
| 2. Are you covering a spouse or dependents under this employer plan? ☐ Yes ☐ No<br>If yes, name of spouse: _____<br>Name of dependents: _____ |
| 3. Do you or your spouse work? ☐ Yes ☐ No |
| 4. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No<br>If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant. |
| 4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.<br><br>Will you have other prescription drug coverage in addition to <PDP plan>? ☐ Yes ☐ No<br>If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:<br><br>Name of other coverage: ID # for Coverage:<br>_____ _____ |
| 5. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No<br>If "yes" please provide the following information:<br>Name of Institution: _____<br>Address & Phone Number of Institution (number and street):_____ |
| 6. Do you receive Medicaid benefits? ☐ Yes ☐ No<br>If yes, please provide your Medicaid number: _____ |
| [Optional field] **Please Choose the Name of chosen Primary Care Physician (PCP), clinic or health center (if required):**<br>*[This field is not necessary for PPOs]* |
| [Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**<br>____ Language A (e.g., Chinese)<br>____ Language B (e.g., Spanish) |

## Please Read and Sign Below:

**By completing this enrollment application, I agree to the following:**

<Name> is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.] Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to <Name> or by calling

1-800-Medicare. TTY users should call 1-877-486-2048.

<Name> serves a specific service area. If I move out of the area that <Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from [name] when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

[*MA PFFS do not include the following paragraph]* I understand that beginning on the date [name of plan] coverage begins, I must get all of my health care from [name of plan], with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by [name of plan] and other services contained in my [name of plan] Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR [NAME OF PLAN] WILL PAY FOR THE SERVICES.**

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <Name> or by Medicare.

| **Your Signature:** | **Today's Date:** |
|---|---|
| | |

If you are the authorized representative, you must provide the following information:

**Name :** _____
**Address:** _____
**Phone Number**: (___) ____- _____
**Relationship to Enrollee** _____

**Office Use Only**:
Name of staff member (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____

## Exhibit 3: Model Short Enrollment Form ("Election" may also be used)

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

This form may be used in place of the model individual enrollment form when a member of a MA plan is enrolling into another MA plan in the same MAO

Referenced in section(s): 10, 20.4, 40, 40.1

| | | |
|---|---|---|
| **Name of Plan You are Enrolling In:** _____ | | |
| **Name**: _____ | **Medicare Number:**_____<br>(Note: may use "member number" instead of "Medicare number") | |
| Home Phone Number: | | |
| Permanent Street Address | | |
| City: | State: | ZIP Code: |
| **Mailing Address** (only if different from your Permanent Street Address):<br><br>Street Address: City: State: ZIP Code: | | |
| **Please fill out the following:**<br><br>I am currently a member of the _____ plan in _____{MAO name} with a monthly premium of $_____ .<br><br>I would like to change to the _____ plan in _____ {MAO name}. I understand that this plan has different health benefits and a monthly premium of $_____ . | | |
| **Name of chosen Primary Care Physician (PCP), clinic or health center (if required):**<br>Optional field, if MAO will require the member to name a new PCP: | | |

| Your Plan Premium Option |
|---|
| You can have the monthly premium for this Medicare plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by electronic Funds Transfer (EFT). *<Optional – insert other billing interval options, if available>* Generally you must stay with the option you choose for the rest of the year.<br><br>If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.<br><br>**Would you like the premium for this plan deducted from your SSA monthly benefit check.** ☐ Yes ☐ No |

| Please Read and Sign Below: |
|---|
| **Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care |

operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

[*MA PFFS do not include the following paragraph]* I understand that beginning on the date [name of plan] coverage begins, I must get all of my health care from [name of plan], with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by [name of plan] and other services contained in my [name of plan] Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR [NAME OF PLAN] WILL PAY FOR THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <Name> or by Medicare.

| **Your Signature:** | **Today's Date:** |
|---|---|
| | |

If you are the authorized representative, you must provide the following information:

**Name :** _____
**Address:** _____
**Phone Number**: (___) ____- _____
**Relationship to Enrollee** _____

**Office Use Only**:
Name of staff member (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____

## Exhibit 3a: Model Selection Form for MA-PD - Switch From Plan to Plan Within MA Organization

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 10, 40, 40.1, 40.2

Dear <plan name> Member:

*<Introduction - In the introduction of cover letter, MAO may include language regarding plan choices, description of plans, differences, etc.>.*

To make a change in the Medicare Advantage plan you have with <name of MAO>, fill out the enclosed plan benefit selection form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us <optional: in the postage-paid envelope> by <date>.

Please be aware that you can change health plans only at certain times during the year. Between November 15, 2005 and May 15, 2006, anyone can join our plan.

If you select another plan and we receive your completed selection form by <date>, your new benefit plan will begin in <month/year>. Your monthly plan premium will be <insert premium> and you may continue to see any <current plan> primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included <year> <summary of benefits or benefit overview> for the available options.

If you have any questions, please call our Member Services Department at <phone number - if plan is planning to have informational meetings - include information about time/place of meetings >. TTY users should call <TTY number>. We are open {insert days/hours of operation and, if different, TTY hours of operation}. Thank you.

**Plan Benefit Selection Form**

Date:
Member Name:
Member Number:

I want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month.

Please check the appropriate box below <list all available plans>:

____ <Name of Plan>
<cost of premium>
<brief description of benefit - include items such as: visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. )

____ <Name of Plan>
<cost of premium>
<brief description of benefit - include items such as: visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. )

| Your Plan Premium Option |
| --- |
| You can have the monthly premium for this Medicare plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by electronic Funds Transfer (EFT). *<Optional – insert other billing interval options, if available>* Generally you must stay with the option you choose for the rest of the year.<br><br>If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.<br><br>**Would you like the premium for this plan deducted from your SSA monthly benefit check?** ☐ Yes ☐ No |

Signature:_____ Date:_____

**Please mail this form to:**

**<Insert mailing address>**

## Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Election

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 40.4.1, 60.4

**[Member # - if member # is SSN, only use last 4 digits]**
**[RxID]**
**[RxGroup]**
**[RxBin]**
**[RxPCM]**

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must see your <Plan> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <Plan> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor' appointments until you get your member card from us.]

[*MA PPO should use the following paragraph in place of 1st paragraph above:*]

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must receive your health care as provided in your [*insert either "Member handbook" or "evidence of coverage''*]. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor' appointments until you get your member card from us.]

[*MA PFFS plans should use the following paragraph in place of 1st paragraph above:*

Thank you for enrolling in <Plan name>. Beginning <effective date>, you will begin to receive your healthcare from <plan>, which allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment, as provided in your [*insert either "Member handbook" or "evidence of coverage"*]. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor' appointments until you get your member card from us.]

The Centers for Medicare & Medicaid Services (CMS), the federal agency that runs the Medicare program, must review all enrollments. We will send your enrollment to CMS, and they will do a final review. When CMS finishes its review, we will send you a letter to confirm

your enrollment with <Plan>. But, you should not wait to get this letter before you begin using <Plan> doctors on <effective date>. Also, do not cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

[*MA plans without a premium – do not use the following paragraph*] If you have chosen to have your monthly premium for this plan withheld from your Social Security payment, remember that your benefit check will reflect this deduction. Generally you must stay with the option you choose for the rest of the year. If you did not choose this option, we will send you a bill each month for your monthly premium.

You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you do not have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <Plan> will pay for those services. Also, if you have end stage renal disease (ESRD), you may not be able to be a member of <Plan>, and we may have to send you a bill for any health care you've received.

[*MA PPO and PFFS plans do not use the following paragraph*] Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services,** if you get health care services from a non-<Plan> doctor without prior authorization, you will have to pay for these services yourself.

Once enrolled in our plan, you can only make changes during certain times of the year. [*Plans open for the OEP in 2006, insert the following*: Between January and June, you have an opportunity to make changes, but you can only join a plan that has prescription drug coverage or does not have prescription drug coverage, depending on whether you have such coverage.] Between November 15, 2005, and May 15, 2006, anyone can make any type of change. If you have more questions about this, please feel free to call our member services department at phone number.

[*If applicable, please insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain Medicare Advantage Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc.]*

If you have any questions, please call our Member Services Department at <phone number>. TTY users should call <*TTY* number>. We are open {insert days/hours of operation and, if different, *TTY* hours of operation}. Thank you.

## Exhibit 4a: Model Notice to Acknowledge Receipt of Completed Enrollment Election – Enrollment in another Plan Within the Same MA Organization

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 40.4.1, 60.4

[Member # - if member # is SSN, only use last 4 digits]
[RxID]
[RxGroup]
[RxBin]
[RxPCM]

Dear <Name of Member>:

Thank you for your request to change your enrollment from <old Plan name> to <new Plan name>. Starting <effective date>, you must see your <new Plan> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <Plan> doctor(s). You will need to pay your plan copayments at the time you get health care services. **[***Optional language***:** This letter is proof of insurance that you should show during your doctor's appointments**. ]**

[*MA PPO should use the following paragraph in place of 1st paragraph above:*]

Thank you for your request to change your enrollment from <old Plan name> to <new plan name>. Beginning <effective date>, you must receive your health care as provided in your [*insert either "Member handbook" or "evidence of coverage''*]. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor' appointments until you get your member card from us.]

[*MA PFFS plans should use the following paragraph in place of 1st paragraph above:*

Thank you for your request to change your enrollment from <old Plan name> to <new plan name>. Beginning <effective date>, you will begin to receive your healthcare from <plan>, which allows you to go to any Medicare-approved doctor or hospital that is willing to give you are and accept our plan's terms of payment, as provided in your [*insert either "Member handbook" or "evidence of coverage"*]. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor' appointments until you get your member card from us.]

The Centers for Medicare & Medicaid Services (CMS), the federal agency that runs the Medicare program, must review all enrollments. We will send your enrollment to CMS, and they will do a final review. When CMS finishes its review, we will send you a letter to confirm your enrollment with <new Plan>. But, you should not wait to get this letter before you begin using <Plan> doctors on <effective date>.

[*MA plans without a premium – do not use the following paragraph*] If you have chosen to have your monthly premium for this plan withheld from your Social Security payment, remember that your benefit check will reflect this deduction. Generally you must stay with the option you choose for the rest of the year. If you did not choose this option, we will send you a bill each month for your monthly premium.

[*MA PPO and PFFS plans do not use the following paragraph*] Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services,** if you get health care services from a non-<new Plan> doctor without prior authorization, you will have to pay for these services care yourself.

Once enrolled in our plan, you can only make changes during certain times of the year. [*Plans open for the OEP in 2006, insert the following*: Between January and June, you have an opportunity to make changes, but you can only join a plan that has prescription drug coverage or does not have prescription drug coverage, depending on whether you have such coverage.] Between November 15, 2005, and May 15, 2006, anyone can make any type of change. If you have more questions about this, please feel free to call our member services department at phone number.

If you have any questions, please call our Member Services Department at <phone number>. TTY users should call <TTY number>. We are open {insert days/hours of operation and, if different, *TTY* hours of operation}. Thank you.

## Exhibit 5: Model Notice to Request Information

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 40.2.2

Dear <Name of Member>:

Thank you for applying with <MA Plan>. We cannot process your application until we get the following things from you:

_____ Proof of Medicare Part A and B coverage. You can send us a copy of your Medicare card or a letter from Social Security or the Railroad Retirement Board as proof of your Medicare coverage.

_____ Other: _____

You will need to send this information to <MA Plan name and address> by <date>. If you cannot send this information by this date, we will have to deny your request to enroll in our plan.

If you have any questions, please call our Member Services Department at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>. Thank you.

## Exhibit 6: Model Notice to Confirm Enrollment

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 40.40.2, 40.6

[Member # - if member # is SSN, only use last 4 digits]
[RxID]
[RxGroup]
[RxBin]
[RxPCM]

Dear <Name of Member>:

The Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <MA Plan> beginning <effective date>.

[*MA-PD insert the following if no low-income subsidy:* The premium for your plan is: [insert premium].

*[MA-PD, if low-income subsidy applicable:]* Because you qualify for extra help with your prescription drug costs, you will pay:

- [insert premium less amount of premium assistance for which the individual is eligible],
- [insert either $0 or $50] for your yearly prescription drug plan deductible,
- [insert copay amount: $0, $1/$3. $2/$5, or 15%] copayment when you fill a prescription.

Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. (Please note that if this is the first time that you are a member of a Medicare Health Plan (Medicare Advantage or Medicare Cost plan), you may have a trial period during which you have certain rights to *leave (*disenroll from*)* <MA Plan> and purchase a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) for further information. TTY users should call 1-877-486-2048.

Please call our Member Services at <phone number> if you have any questions. TTY users should call <*TTY* number>.We are open <days and hours of operation>.

## Exhibit 6a: Model Notice to Confirm Enrollment - Plan to Plan Within MA Organization

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

The Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <MA Plan> beginning <effective date>.

[*MA-PD insert the following if no low-income subsidy:* The premium for your plan is: [insert premium].

*[MA-PD, if low-income subsidy applicable:]* Because you qualify for extra help with your prescription drug costs, you will pay:

- [insert premium less amount of premium assistance for which the individual is eligible],
- [insert either $0 or $50] for your yearly prescription drug plan deductible,
- [insert copay amount: $0, $1/$3. $2/$5, or 15%] copayment when you fill a prescription.

Please call our Member Services at <phone number> if you have any questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

## Exhibit 6b: Model Notice for MA-PD Plans for Individuals Identified on CMS Records As Members of Employer Group Receiving Subsidy

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 40

Dear <Name of Member>:

Thank you for applying with <Plan Name>. To finalize your enrollment, we would like you to confirm that you want to be enrolled in <plan>.

The Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has informed us you belong to an employer group health plan whose drug coverage is as good as the Medicare prescription drug plan.

It is important that you consider your decision to enroll in our plan carefully, since enrollment in <plan> could affect your employer health benefits. If you have not already done so, please contact your benefits administrator to discuss your decision to enroll in a Medicare prescription drug plan.

If you have already discussed this decision with your benefits administrator and have decided that you would still like to be a member of <plan>, **please confirm this by calling our members services department at phone number**>. TTY users should call <*TTY* number>. Your enrollment will not be complete until you call and confirm this information. Your effective date will be the 1st of the month after we hear from you.

We must hear from you to enroll you in our plan - if we do not hear from you within 30 days from the date of this notice, we will not process your enrollment.

If you have any questions, please feel free to contact us at < number>. We are open {insert days/hours of operation and, if different, *TTY* hours of operation}.

Thank you.

## Exhibit 7: Model Notice for MA Organization Denial of Enrollment

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 40.2.3

Dear <Name of Beneficiary>:

Thank you for applying with <MA Plan>. We cannot accept your request for enrollment in <MA Plan> because:

1. _____ You do not have Medicare Part A.
2. _____ You do not have Medicare Part B.
3. _____ You have End Stage Renal Disease (ESRD).
4. _____ Your permanent residence is outside our service or continuation area.
5. _____ You attempted to enroll outside of an enrollment period.
6. _____ You are not eligible to enroll in prescription drug coverage at this time.
7. _____ We did not receive the information we requested from you within the timeframe listed in our request.

If this information is correct, then we may send you a bill for any services you may have already received.

If item 5 is checked, remember that you can make changes only at certain times during the year. [*Plans open for the OEP in 2006, insert the following*: Between January and June, you have an opportunity to make changes, but you can only join a plan that has prescription drug coverage or does not have prescription drug coverage, depending on whether you have such coverage.] Between November 15, 2005, and May 15, 2006, anyone can make any type of change. If you have more questions about this, please feel free to call our member services department at phone number.

If any of the checked items are wrong, or if you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>. Thank you.

## Exhibit 8: Model Notice for CMS Rejection of Enrollment

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 40.4.2

Dear <Name of Beneficiary>:

The Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has denied your enrollment in <MA Plan> due to the reason(s) checked below:

1. _____ You do not have Medicare Part A

2. _____ You do not have Medicare Part B

3. _____ You have End Stage Renal Disease (ESRD)

4. _____ You attempted to enroll outside of an enrollment period.

5. _____ You requested to enroll in a different plan for the same effective date, which canceled your application with <MA Plan>. This may mean that you are still enrolled in the Original Medicare Plan or in the Medicare Health Plan (Medicare Advantage or Medicare Cost plan) that you were enrolled in before you applied for membership in our plan.

If this information is correct, we may send you a bill for any services you may have already received.

If any of the checked items are wrong, or if you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>. Thank you.

## Exhibit 9: Model Notice to Send Out Disenrollment Form

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.1

Dear <Name of Member>:

Attached is the disenrollment form you requested. Fill out this disenrollment form if you would like to disenroll from our plan to Original Medicare. Beginning in 2006, you can make plan changes only at certain times during the year. In 2006, you can disenroll between January and June, 2006. However, the way you disenroll depends on type of prescription drug coverage you have through our plan.

Please read the important information below regarding these changes.

DO NOT FILL OUT THE ATTACHED FORM IF:

1) You are planning to enroll, or have enrolled in another Medicare Advantage or other Medicare Health Plan. Enrolling in another Medicare plan will automatically disenroll you from our plan.

OR

2) You are enrolling in a Medicare prescription drug plan. Enrolling in such a plan will automatically disenroll you from our plan to Original Medicare. **If you have prescription drug coverage through our plan,** you must enroll in a Medicare prescription drug plan.

[*MA PFFS without drugs use the following in place of the above paragraph:*

DO NOT FILL OUT THE ATTACHED FORM IF you are planning to enroll, or have enrolled in, another Medicare Advantage or other Medicare Health Plan. **If you have prescription drug coverage through our plan,** you must enroll in a Medicare prescription drug plan.]

Until your disenrollment date, you must keep using <MA Plan> doctors. To avoid any unexpected expenses, you may want to contact us to make sure you've been disenrolled before you seek medical services outside of <MA plan>'s network.

If you do NOT have prescription drug coverage through our plan, you may fill out the attached form, sign it, and send it back to us in the enclosed envelope. You can also fax the form with a readable signature and date to us at <fax number>. You can also call 1-800-MEDICARE (1-800-633-4227). For information about drug plans available in your area. TTY users should call 1-877-486-2048.

## A NOTE ABOUT MEDIGAP RIGHTS

If you will be changing to the Original Medicare Plan you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or any special temporary rights you may have, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number> to get more information about Medigap policies in your State. Call 1-800-MEDICARE (1-800-633-4227) for more information about trial periods. TTY users should call 1-877-486-2048.

If you need any help, please call us at <phone number>. *TTY users should call <TTY* number>. We are open <insert days and hours of operation>.

Thank you.

Attachment

## Exhibit 10: Model Disenrollment Form

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 10

If you request disenrollment, you must continue to receive all medical care from <MA plan name> until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of <MA plan>'s network. We will notify you of your effective date after we have received this form from you.

| Last name: First Name: Middle Initial | | | ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. |
|---|---|---|---|
| Medicare # | | | |
| Birth Date: | Sex: ☐ M ☐ F | Home Phone Number: ( ) | |

**Please carefully read and complete the following information before signing and dating this disenrollment form:**

On the effective date of enrollment in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will automatically cancel my current membership in <MA plan name>. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and do not enroll in such coverage at this time, I may have to pay a higher premium for this coverage in the future.

**Your Signature*: _____ Date: _____**

*Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by <plan name> by Medicare.

If you are the authorized representative, you must provide the following information:

**Name :** _____
**Address:** _____
**Phone Number**: (___) ____- _____
**Relationship to Enrollee** _____

## Exhibit 11: Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.1, 50.4.1

Dear <Name of Beneficiary>:

We received your request to disenroll from <MA Plan>. You will be disenrolled starting <effective date.> Beginning <effective date>, <MA Plan> will not cover any health care you receive. Beginning <effective date>, you can see any doctor through the Original Medicare Plan, unless you have enrolled in another Medicare Advantage plan.

Please be patient. It will take a few weeks for us to process your disenrollment and update Medicare's records. If your doctors need to send Medicare claims, you may want to tell them that you just disenrolled from <MA Plan> and there may be a short delay in updating your records.

**A NOTE ABOUT MEDIGAP RIGHTS**

If you will be changing to the Original Medicare Plan you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or any special temporary rights you may have, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number> to get more information about Medigap policies in your State. Call 1-800-MEDICARE (1-800-633-4227) for more information about trial periods. TTY users should call 1-877-486-2048.

If you need any help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>. Thank you.

## Exhibit 12 Model Notice to Confirm Voluntary Disenrollment Identified Through Reply Listing

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.1, 50.4.1, 60.3.2

Dear <Name of Beneficiary>:

The Centers for Medicare & Medicaid Services, the federal agency that runs the Medicare program, has confirmed your disenrollment from <MA Plan>. Beginning <effective date,> <MA Plan> will not cover any health care you receive. If your doctor needs to send Medicare claims, you may want to tell them that there may be a short delay in updating your records since you just disenrolled from <MA Plan>.

**A NOTE ABOUT MEDIGAP RIGHTS**

If you will be changing to the Original Medicare Plan you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or any special temporary rights you may have, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number> to get more information about Medigap policies in your State. Call 1-800-MEDICARE (1-800-633-4227) for more information about trial periods. TTY users should call 1-877-486-2048.

If you think you did not disenroll from <MA Plan>, and you want to keep being a member of our plan, please call us right away at <phone number> or, for the hearing impaired, at <TTY number> so we can make sure you stay a member of our plan. We are open <insert days and hours of operation>. Thank you.

## Exhibit 12a: Model Notice for MA Organization Denial of Disenrollment

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 40.2.3

Dear <Name of Beneficiary>:

We recently received your request to disenroll from <MA Plan>. We cannot accept your request for disenrollment because:

1. _____ You have attempted to make a change outside of an enrollment period.

2. _____ You have already made a change to how you get Medicare (see discussion on limits to changes below.)

Beginning in 2006, there are limits to when and how often you can change the way you get Medicare.

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.

- **From November 15, 2005 and May 15, 2006,** anyone with Medicare can switch from one way of getting Medicare to another.

Generally, you may not make any other changes during the year unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

If you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>. Thank you.

## Exhibit 12b: Model Notice for CMS Rejection of Disnerollment

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.1

Dear <Name of Beneficiary>:

The Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has denied your enrollment in <MA Plan> due to the reason(s) checked below:

1. _____ You have attempted to make a change outside of an enrollment period.

2. _____ You have already made a change to how you get Medicare (see discussion on limits to changes below.)

Beginning in 2006, there are limits to when and how often you can change the way you get Medicare.

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.

- **From November 15 through December 31**, anyone with Medicare can switch from one way of getting Medicare to another for the following year.

Generally, you may not make any other changes during the year unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

If you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>. Thank you.

If the item(s) we checked <is> <are> wrong, or if you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>. Thank you.

## Exhibit 13: Model Notice of Disenrollment Due to Death

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.2.3, 50.4.2, 60.3.1

Note: Address letter “To The Estate of <Member’s Name>“ or “To <Member’s Name>

To the Estate of <Member’s Name> (or To <Member’s Name>):

The Centers for Medicare & Medicaid Services, the federal agency that runs the Medicare program, has told us of the death of <Member’s Name>. Please accept our condolences.

<Member’s name>’s coverage in <MA Plan> has ended as of <effective date>. If membership premiums were paid for any month after <effective date>, we will issue a refund to the Estate within 30 days of this letter.

If this information is wrong, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

## Exhibit 14: Model Notice of Disenrollment Due to Loss of Medicare Part A and/or Part B

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.2.2, 50.4.2, 60.3.1

Dear <Name of Member>:

The Centers for Medicare & Medicaid Services (CMS) has told us that you no longer have Medicare Part <insert A and/or B, as appropriate>. You need to have coverage under both Medicare Part A and Part B to remain enrolled in a Medicare Advantage plan. Therefore, your membership in <MA Plan> ended on <date>. If this information is wrong, and you want to stay a member of our plan, please contact us. Also, if you have not already done so, please contact your local Social Security office to have their records corrected.

If you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>. Thank you.

## Exhibit 15: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 60.3, 60.3.1

Dear< Name of Member>:

The Centers for Medicare & Medicaid Services' (CMS) records incorrectly show you as deceased.

If you have not already done so, please go to your local Social Security Office and ask them to correct your records. Please send us <MA Plan> written proof at <address> after you do this. When we receive this proof, we will tell CMS to correct its records.

In the meantime, you should keep using your <MA Plan> primary care physician for your health care. **(Note: If PCP not applicable, omit this sentence. MA plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate. )** If you have any questions or need help, please call us at < phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <MA Plan>.

## Exhibit 16: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 60.3, 60.3.1

Dear < Name of Member>:

On <Date of request> you told us that your enrollment in Medicare was ended in error and that you wanted to stay a member of <MA Plan>. To do this, please complete the following steps:

1. Contact the Social Security Administration (SSA) at 1-800-772-1213 between 7AM to 7PM, Monday to Friday, to have them fix their records TTY users should call 1-800-325-0778.

2. Ask SSA to give you a letter that says they have fixed your records.

3. Send the letter from SSA to us at: <address of MA Plan> in the enclosed postage-paid envelope. You may also fax this information to us at [insert fax number]. When we receive this letter, we will tell the Centers for Medicare & Medicaid Services (CMS) to correct its records.

In the meantime, you should keep using your <MA Plan> primary care physician for your health care. (**Note: If PCP not applicable, omit this sentence. MA plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate.)** If we find out that you do not have Medicare Part <insert "A" and/or "B" as appropriate>, you will have to pay for any service you received after the disenrollment date.

If you have any questions or need help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <MA Plan>.

## Exhibit 17: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another MA Organization

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 60.3, 60.3.2

Dear <Name of Member>:

Thank you for letting us know you want to remain a member of <MA Plan> after we sent you a letter that said we had disenrolled you from our plan.

Based on what you told us, we understand that you canceled your membership in the other plan and want to stay a member of <MA Plan>. Please send us a letter by <insert date: 30-days from date of disenrollment notice>, that says you want to stay a member of <MA Plan>. Your letter must also say whether or not you got services from non- <MA Plan> doctors since <original effective date of disenrollment>. If you did not get any services from non- <MA Plan> doctors since <original effective date of disenrollment>, we will fix our records after we receive your letter.

In the meantime, you should keep seeing your <MA Plan> primary care physician for your health care.(**Note: If PCP not applicable, omit this sentence. MA plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate. This sentence is optional for plans that do not require PCPs)**

If you have any questions or need help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

## Exhibit 18: Model Notice to Close Out Request for Reinstatement

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 60.3.2

Dear <Name of Beneficiary>:

We cannot process your request to be reinstated in <MA Plan> because we have not received your letter asking for reinstatement. As discussed in our letter of <date of letter> you must send us a letter by <date placed on notice in exhibit 19>.

The <effective date> date of disenrollment remains in effect. If you have used <MA Plan> services after this disenrollment date, we will have to bill you for any services you received.

If you have any questions, please call <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

## Exhibit 19: Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.3.1

Dear <Name of Member>:

Our records show that we have not received payment for your plan premium as of <Date>. **MA organizations who will disenroll all members (and not use the downgrade option) use the following sentence:** If we do not receive payment by <insert premium due date>, we will have to disenroll you from <MA Plan>, effective <insert disenrollment date>. After the disenrollment you will be covered by the Original Medicare Plan instead of <MA Plan>.

**Note: As required in section 50.3.1, the MA organization must state whether full payment of premiums is due to prevent disenrollment.**

**MA organizations who will downgrade the membership for all members use the following sentences:** If we do not get payment, we will make some changes to your membership in <MA plan name> that will reduce the amount of health care coverage you have in <MA plan name>. *T*his means that (describe lower level of benefits, e.g., routine dental care will not be covered) beginning <date>.

**Note: As required in section 50.3.1, the MA organization must state whether full payment of premiums is due to prevent the downgrade.**

If you have been receiving any form of medical assistance (Medicaid) from the State (including paying your premiums, deductibles, or coinsurance), you should check with the State Medicaid Agency to find out if they have been paying for, or have stopped paying for, you plan premium. If you are no longer eligible for assistance from Medicaid, you may have a special temporary right to buy a Medigap policy if you voluntarily disenroll from our plan. If you have questions, you should contact your State Health Insurance Program, <name of SHIP>, at <SHIP phone number(s)> to get more information.

If you wish to disenroll from <MA Plan> and change to the Original Medicare Plan now, you should do one of these three things:

1. Send us a written request at <MA Plan address>.

2. Call 1-800-MEDICARE(1-800-633-4227). TTY users should call 1-877-486-2048.

Remember, beginning in 2006, there are limits to when and how often you can change the way you get Medicare:

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.

- **From November 15, 2005, through May 15, 2006**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

Generally, you will only be able to make changes during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

If you think we have made a mistake, or if you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

## Exhibit 20: Model Notice on Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.3.1

Dear <Name of Member>:

On <date> we sent you a letter that said your plan premium was overdue. The letter said that if we did not get payment from you, we would disenroll you from <MA Plan>. Since we did not receive that payment, we asked the Centers for Medicare & Medicaid Services (CMS) to disenroll you from <MA Plan> beginning <date>.

*Due to your disenrollment from <MA Plan>, you will be covered by the Original Medicare Plan, beginning <effective date>.*

You have the right to ask us to reconsider this decision through the grievance procedure written in your [insert "Member Handbook" or "Evidence of Coverage", as appropriate].

*[MA PFFS do not include this paragraph]*Please note that until <disenrollment effective date>, you must keep using <MA Plan> doctors except for emergency or urgently needed care or out-of-area dialysis services. After that date, you can see any doctor through the Original Medicare Plan, unless you join Medicare Advantage or another Medicare health plan.

Once in Original Medicare, there are limits to when and how often you can change the way you get Medicare:

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.

- **From November 15, 2005, through May 15, 2006**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

Generally, you will only be able to make changes during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

If you think that we have made a mistake or if you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

## Exhibit 21: Model Notice on Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.3.1

Dear <Name of Beneficiary>:

The Centers for Medicare & Medicaid Services (CMS), the federal agency that runs the Medicare program, has confirmed your disenrollment from <MA Plan> due to non-payment of plan premium. Your disenrollment begins <effective date>.

Due to your disenrollment from <MA Plan>, you are now enrolled in the Original Medicare plan. As mentioned in our previous letter to you, there are limits to when and how often you can change the way you get Medicare:

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.

- **From November 15, 2005, through May 15, 2006,** anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

Generally, you will only be able to make changes during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

You have the right to ask us to reconsider your disenrollment through the grievance procedure written in your [insert "Member Handbook" or "Evidence of Coverage", as appropriate].

If you have any questions, or need help, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

## Exhibit 22: Model Notice on Failure to Pay Plan Premiums - Notice of Reduction in Coverage Within Plan

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.3.1

Dear <Name of Member>:

We recently sent you a letter dated <date> that said your plan premium was overdue. The letter said that if we did not get payment from you, we would have to make some changes in your membership in <MA Plan>. Our records show that we did not get payment from you as of <Date>. Therefore, we have reduced your coverage in <MA Plan>, beginning <effective date>.

<Explain in simple terms lower level of benefits, e.g., routine dental care will not be covered>

You have the right to ask us to reconsider this change through the grievance procedure written in your [insert "Member Handbook" or "Evidence of Coverage", as appropriate].

If you want to disenroll from <MA Plan> and return to the Original Medicare Plan now, you should do one of these three things:

1. Send us your written request to <MA Plan or fax it to us at <fax number>.

2. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (1-800-633-4227).

Remember, beginning in 2006, there are limits to when and how often you can change the way you get Medicare:

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.

- **From November 15, 2005, through May 15, 2006,** anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

Generally, you will only be able to make changes during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

If you think we have made a mistake, or if you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

## Exhibit 23: Model Notices for Closing Enrollment Due to Capacity Limits

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 30

[Insert name of MA organization] PUBLIC NOTICE

As of [insert date], [insert name of MA organization] will no longer accept enrollment under its Medicare Advantage contract with the Centers for Medicare & Medicaid Services (CMS) for [insert plan name] in [insert service area].

The [insert plan] has been approved for a capacity limit by CMS. A capacity limit allows a Medicare Advantage Organization to limit enrollment in a plan once a specific number of people join the plan. This is based primarily on the accessibility and availability of providers to provide services to members of the plan.

Current members of [insert name of plan] are not affected by this change. Also, individuals who are enrolled in other [insert organization name] plans may still be able to enroll in [insert name of plan] when they become eligible for Medicare.

For information regarding this notice, call [insert name of MA organization] at [insert phone number] between [insert time frames]. TTY users should call [insert TTY number].

## Exhibit 24: Model Notice for Medigap Rights Per Special Election Period

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 50.1 and 50.2

Dear <Name of Beneficiary>:

This is to confirm that you disenrolled from <MA Plan> effective <insert date> and returned to the Original Medicare Plan because of the special circumstances indicated below:

_____ You permanently moved.

_____ You receive assistance from the Medicaid program.

_____ You wanted to use certain Medigap protections while in your trial period.

_____ Other circumstances defined as eligible for a Special Election Period.

**Please save this letter as proof of your Medigap rights.**

If you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

## Exhibit 25: Acknowledgement of Request to Cancel Enrollment

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 60.2.1

Dear <name of member>:

As requested, we have processed your request to cancel your enrollment with <name of plan>.

Please be patient. It may take up to 45 days for Medicare to update your records. If you are in the Original Medicare Plan, you may want to tell your doctors that if they need to submit Medicare claims, there may be a short delay in updating your records.

If you were enrolled in another Medicare Advantage Plan before enrolling with <plan>, you may appear on their records as being disenrolled. If your intent is NOT to disenroll with that plan, you will need to notify them that you enrolled in <plan> and have cancelled your enrollment. They may request a copy of this letter for their records.

If you have any questions, please contact <plan> customer service at <number>, Monday through Friday between the hours of <hours>. TTY users should call [insert TTY number].

## Exhibit 26: Acknowledgement of Request to Cancel Disenrollment

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 60.2.2

Dear <name of member>:

As requested, we have processed your request to cancel your disenrollment with <insert name of plan>. You should keep using your <MA Plan> primary care physician for your health care. **(Note: If PCP not applicable, omit this sentence. MA plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate)** Thank you for your continued membership in the <MA Plan>.

If you have also submitted an enrollment to another Medicare Health Plan (Medicare Advantage Plan or Medicare Cost Plan) or Medicare Prescription Drug Plan, you may appear on their records as being enrolled. If your intent is NOT to enroll with that plan and stay enrolled in <our plan>, you will need to notify them that you are canceling enrollment in their plan before that enrollment takes effect. They may request you write them a letter for their records.

If you have any questions, please contact <plan> customer service at <number>, Monday through Friday between the hours of <hours>. TTY users should call [insert TTY number].

## Exhibit 27: MA Model Notice to Inform Dually Eligible Member of Auto-Enrollment in MA-PD

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section: 40.1.6

**[Member # - if member # is SSN, only use last 4 digits]**
**[RxID]**
**[RxGroup]**
**[RxBin]**
**[RxPCM]**

Dear <insert member name>
Our records show that you have Medicare and Medicaid and your Medicaid prescription drug coverage is ending. To make sure that you don't lose a day of your drug coverage, Medicare is enrolling you in our <name of MA-PD plan> that offers Medicare prescription drug coverage, beginning <effective date>.

This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <Plan> doctor(s). You will need to pay our copayments when you get health care. **Optional language:** This letter is proof of insurance that you should show during your doctor's appointments**.**

With the addition of this Medicare prescription drug coverage, you will pay:

- $0 for your yearly prescription drug plan deductible,
- [insert copay amount $0, up to $1 and $3, or up to $2 and $5] copayments when you fill a prescription.

[Include cost of premium less low-income premium subsidy amount, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.

[*MA PPO and PFFS plans do not use the following paragraph*] Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services,** if you get health care from a non-<new Plan> doctor without prior authorization, you will have to pay for the health care yourself.

Remember, your Medicaid prescription drug coverage is ending. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover those prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like [plan name].

You are not required to be in our Medicare prescription drug plan and have the option to stay in [insert name of MA-only plan]. If you decide not to be enrolled and don't have other drug coverage at least as good as Medicare prescription drug coverage, you may have to pay more for this coverage at a later time. If you don't want Medicare prescription drug coverage, call our Member Services Department at <phone number>. TTY users should call <TTY number>. We are open {insert days/hours of operation and, if different, TTY hours of operation}. You will need to tell us you don't want Medicare prescription drug coverage.
Thank you.

## Exhibit 28: MA Model Notice to Inform Member of Facilitated Enrollment

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section: 40.1.7

**[Member # - if member # is SSN, only use last 4 digits]**
**[RxID]**
**[RxGroup]**
**[RxBin]**
**[RxPCM]**

Dear <insert member name>

Our records show that you qualify for extra help with your prescription drug costs. Medicare is helping you enroll in our <name of MA-PD plan> that offers Medicare prescription drug coverage, beginning <effective date>. This way, you will pay the lowest possible premium for Medicare prescription drug coverage.

[*MA PPO and PFFS plans do not use the following paragraph*] Starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <Plan> doctor(s). You will need to pay our copayments when you get health care. **Optional language:** This letter is proof of insurance that you should show during your doctor's appointments**.**

With the addition of this Medicare prescription drug coverage, you will pay:

- [insert either $0 or $50] for your yearly prescription drug plan deductible,
- [insert copay amount: up to $2 and $5; or 15%] copayments when you fill a prescription.

[Include cost of premium less amount of premium assistance the member is eligible for, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.

Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services,** if you get health care from a non-<new Plan> doctor without prior authorization, you will have to pay for the health care yourself.

You are not required to be in our Medicare prescription drug plan and have the option to stay in [insert name of MA-only plan]. If you decide not to be enrolled and don't have other drug coverage at least as good as Medicare prescription drug coverage, you may have to pay more for this coverage at a later time. If you don't want Medicare prescription drug coverage, call our Member Services Department at <phone number>. TTY users should call <TTY number>. We

are open {insert days/hours of operation and, if different, TTY hours of operation}. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

## Exhibit 29: Acknowledgement of Request to Decline Part D

**(Rev. 70, Issued: 09-30-05, Effective Date: 09-30-05)**

Referenced in section(s): 40.1.6 and 40.1.7

Dear <name of member>:

As requested, we have processed your request to decline Medicare prescription drug coverage. You will continue to be a member of <MA Plan> that does not offer Medicare prescription drug coverage.

If you had Medicaid drug coverage, it will no longer pay for your prescription drugs. Our records show you are eligible for extra help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help.

Remember, even if you don't use a lot of prescription drugs now, you still should consider signing up for a Medicare prescription drug plan. For most people, joining now means you will pay your lowest possible monthly premium. If you don't join a plan by May 15, 2006, and you don't currently have prescription drug coverage that covers at least as much as Medicare prescription drug coverage, your premium cost will go up at least 1% per month for every month that you wait to enroll. You will have to pay this penalty as long as you have Medicare prescription drug coverage.

If you change you mind now or at anytime in the future, you can call <MA Plan> customer service at <number>, Monday through Friday between the hours of <hours>. TTY users should call [insert TTY number].