CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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I. SUMMARY OF CHANGES:

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 9, 2004

Section 20.2.3 - Optional Employer Group Waiver for ESRD Enrollees - Added text to clarify under which conditions M+C organizations may choose to accept enrollees with ESRD who are enrolling in an M+C plan through an employer or union group.

Section 30.8 - Capacity Limit - Added new section regarding conditions for an M+C organization to reserve spaces for individual and employer group commercial members for conversion enrollments.

Section 30.8.1 - M+C Plan Closures - Added new section regarding plan closures for an M+C organization.

CLARIFICATION – EFFECTIVE: Not Applicable.

Table of Contents - Addition of line items for new §§20.2.3, 30.8, and 30.8.1.

Section 20.2 - End-Stage Renal Disease - Text added to clarify the definition End-Stage Renal Disease (ESRD), and to clarify how a beneficiary can be assigned ESRD status.

Section 20.2.2 - Exceptions to Eligibility Rule for Persons Who Have ESRD - Replaced bullets with numbers and letters in the list.

Section 20.3 - Place of Permanent Residence - Added last bulleted item regarding "visitor" or "traveler" programs for those individuals consecutively out of the area for up to 12 months.

Section 30 - Election Periods and Effective Dates - At end of the second paragraph after the bulleted list, added sentence to refer reader to new §§30.8 and 30.8.1 for information on Open Enrollment Period (OEP) plan closures, capacity limits and reserved vacancies. Deleted remainder of the section regarding processing of elections in any of the plans open during the OEP.

Section 30.4.4 - SEPs for Exceptional Conditions - In list item number 7, updated web address for Metropolitan Statistical Areas (MSAs). Deleted item 9 regarding SEP for individuals with ESRD who are members of a group health plan and in their 30-month

coordination period. Renumbered previous item 10, “SEP for Individuals Whose Medicare Entitlement Determination Made Retroactively,” to 9. Deleted item 11, SEP for current M+C organization members who wish to enroll in a zero premium plan offered by the same M+C organization in 2002.

Section 50.1.1 - Requests Submitted via Internet - Added “determined by the date the request is” to the last sentence of the section regarding the effective date of a disenrollment request submitted by the Internet.

Section 50.2.1 - Members Who Change Residence - Added introductory material to a previously empty section - it was a section header only.

Section 50.2.1.1 - **General Rule** - Added bullet number 3 regarding disenrollment of a member from a visitor/traveler program where his/her absence exceeds twelve consecutive months. Renumbered subsequent items in the list.

Section 50.2.1.2 - Effective Date - Clarified the effective dates for each disenrollment reason listed in the previous section, §50.2.1.1.

Section 50.2.1.3 - Researching and Acting on a Change of Address - Added a paragraph to item 3 regarding a requirement to initiate disenrollment if the individual continues to remain out of the area during the length of the M+C organization’s visitor/traveler program

Section 50.2.1.4 - Notice Requirements - Added information regarding Visitor/Traveler Program Option.

Section 50.3.1 - Failure to Pay Premiums - Added “the premium was due” to the first sentence after the bulleted list.

In unnumbered section “Calculating the 90-Day Grace Period,” subheading A, changed the words from “first notice of nonpayment is sent” to “the first delinquent premium was due,” and made changes in this section in keeping with this word change. Two examples were added.

Like changes are made in subsection “B - M+C organizations may use a ‘rollover’ approach in determining how to calculate the 90-day period,” regarding beginning the 90-day grace period with the day the delinquent premium is due. In example B, added “and the proposed effective date of this action” to the second bulleted item. Deleted the third bulleted item regarding a requirement to advise the member that failure to pay the premium within the 90-day grace period will result in termination or reduction in coverage. Added “after the expiration of the grace period and prior to submission of the transaction to CMS” to the second paragraph after the bulleted list.

Section 50.3.2 - Disruptive Behavior - Made miscellaneous word changes. Also, changed “beginning the disenrollment” to “requesting CMS’ approval of for-cause

disenrollment" and listed documentation accepted for this purpose. In the following two paragraphs, clarified CMS RO's tasks in this process. Added text to clarify the notice requirement for disenrollment for disruptive behavior.

Section 60.2 - Cancellations - In the first paragraph, added last sentence describing acceptable cancellations in the case of employer groups.

Section 60.4 - Retroactive Enrollments - Changed two instances of "The CMS ROs" to "The CMS" in the first paragraph. Corrected "type" to "types" in the "**NOTE:**" paragraph.

Exhibit 1 - Model Individual Enrollment Form ("Election" may also be used) (4 Pages) - In the questionnaire section, corrected numbering beginning at 3.

Exhibit 19: Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage - Made miscellaneous word changes, as well as added "the delinquent premium was due," to the language required in this notice.

Exhibit 26: Acknowledgement of Request to Cancel Disenrollment - Deleted second paragraph beginning "Please be patient…." from this model letter. In the current second paragraph, added "before that enrollment takes effect."

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 2 / Table of Contents
R	Chapter 2 / Section 20.2 / End-Stage Renal Disease
R	Chapter 2 / Section 20.2.2 / Exceptions to Eligibility Rule for Persons Who Have ESRD
N	Chapter 2 / Section 20.2.3 / Optional Employer Group Waiver for ESRD Enrollees
R	Chapter 2 / Section 20.3 / Place of Permanent Residence
R	Chapter 2 / Section 30 / Election Periods and Effective Dates
R	Chapter 2 / Section 30.4.4 / SEPs for Exceptional Conditions
N	Chapter 2 / Section 30.8 / Capacity Limit
N	Chapter 2 / Section 30.8.1 / M+C Plan Closures
R	Chapter 2 / Section 50.1.1 / Requests Submitted via Internet
R	Chapter 2 / Section 50.2.1 / Members Who Change Residence
R	Chapter 2 / Section 50.2.1.1 / General Rule
R	Chapter 2 / Section 50.2.1.2 / Effective Date

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 2 / Section 50.2.1.3 / Researching and Acting on a Change of Address
R	Chapter 2 / Section 50.2.1.4 / Notice Requirements
R	Chapter 2 / Section 50.3.1 / Failure to Pay Premiums
R	Chapter 2 / Section 50.3.2 / Disruptive Behavior
R	Chapter 2 / Section 60.2 / Cancellations
R	Chapter 2 / Section 60.4 / Retroactive Enrollments
R	Chapter 2 / Exhibit 1 / Model Individual Enrollment Form ("Election" may also be used) (4 Pages)
R	Chapter 2 / Exhibit 19 / Model Notice on Failure to Pay Plan Premiums / Advance Notification of Disenrollment or Reduction in Coverage
R	Chapter 2 / Exhibit 26 / Acknowledgement of Request to Cancel Disenrollment

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

Medicare Managed Care Manual

Chapter 2 - Medicare + Choice Enrollment and Disenrollment

(Rev. 41, 01-09-04)

NOTE: This chapter replaces policy outlined in OPL 100, OPL 104, OPL 105, OPL 109, OPL 111, OPL 113, OPL 122, and OPL 123.

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Exhibit 26: Acknowledgement of Request to Cancel Disenrollment

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20.2 - End-Stage Renal Disease (ESRD)

(Rev. 41, 01-09-04)

Except as provided under exceptions discussed below, an individual is not eligible to elect an M+C 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 2728-U3. For purposes of M+C 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 M+C eligibility. Such an individual may elect to enroll in a M+C 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 M+C enrollee during his or her remaining months of Medicare eligibility.

The M+C 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 M+C plan, except as provided in the following paragraphs. An M+C 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.

20.2.2 - Exceptions to Eligibility Rule for Persons Who Have ESRD

(Rev. 41, 01-09-04)

1. Conversions upon ICEP: Individuals who developed ESRD while a member of a health plan offered by an M+C organization and who are converting to Medicare Parts A and B, can elect an M+C 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 M+C eligibility requirements and must fill out an election form or complete an alternate enrollment election to join the M+C 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 M+C plan during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an M+C plan offered by the M+C organization, as long they were enrolled in a health plan offered by the same M+C 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, Medicaid plan) offered by the M+C organization are eligible to elect an M+C 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 M+C organization, and the start of coverage in the M+C plan offered by the same organization.*

3. An individual who elects an M+C 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 M+C plan may continue to be enrolled in the M+C plan.

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

6. An individual with ESRD whose enrollment in an M+C 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 M+C plan. The individual must meet all other M+C eligibility requirements, and must enroll during an M+C 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 M+C plan, unless his new plan is terminated.

20.2.3 - Optional Employer Group Waiver for ESRD Enrollees

(Rev. 41, 01-09-04)

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

1. *If an employer or union group offers an M+C 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 M+C 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 M+C plan that is offered by the group.*

3. *If an employer or union group has contracted locally with an M+C 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 M+C organization in the local employer or union M+C plan.*

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

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

20.3 - Place of Permanent Residence

(Rev. 41, 01-09-04)

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

EXCEPTIONS

- A member who permanently moves from the service area of the M+C plan to an approved continuation area of the M+C organization, and who chooses the continuation of enrollment option offered by the M+C organization, may continue to be enrolled in the M+C plan (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 M+C organization and are converting to Medicare Parts A and B can elect an M+C plan offered by the same M+C organization during their ICEP even if they reside in the M+C 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 M+C 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 M+C plan while living outside the plan's new reduced service area if:

    - There is no other M+C plan serving the area;

    - The M+C organization offers this option; and

    - The member agrees to receive services through providers in the M+C plan's service area.

- The M+C organization has the **option** to also allow individuals who are converting to Medicare Parts A and B to elect the M+C 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 M+C access requirements in 42 CFR 422.112 are met for that individual through the M+C plan's established provider network providing services in the M+C 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 M+C organization.

- *The M+C 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 M+C plan. The M+C 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 M+C 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 M+C 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 M+C organization should determine whether, according to the law of the M+C 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.

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30 - Election Periods and Effective Dates

(Rev. 41, 01-09-04)

In order for an M+C 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).

During the AEP, SEP, and OEP, individuals may enroll in and disenroll from M+C plans, or may move between M+C plans, or between an M+C plan and Original Medicare. Individuals may elect to enroll in M+C plans during an ICEP.

Unless a CMS-approved capacity limit applies, all M+C organizations must accept elections into their M+C plans (with the exception of M+C MSA plans) during the AEP, an ICEP, and an SEP. (Refer to §30.7 for election periods for Medicare MSA plans.) When an M+C plan is closed due to a capacity limit, the M+C 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.*

30.4.4 - SEPs for Exceptional Conditions

(Rev. 41, 01-09-04)

The 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 electing M+C plans through their employer groups; disenrolling from their employer group-sponsored M+C plan to Original Medicare; or disenrolling from their employer group-sponsored M+C plan and electing a new M+C plan. The SEP EGHP may be used during the OEP if a plan is closed for enrollment during the OEP. Additionally, the SEP EGHP may be used when the EGHP would otherwise allow the individual to make changes in their elections due to "life changes," e.g., changes in marital status, for the newly employed, etc.

For elections into M+C plans, the SEP may only be used if the EGHP provides notice to the individual at the time of enrollment stating that he/she understands the network and authorization requirements of the plan - also referred to as "lock-in" language. This language is included on the model enrollment forms in Exhibits 1, 2, and 3.

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 M+C organization may process the election with a retroactive effective date, as outlined in §60.6. Keep in mind that all M+C eligible individuals, including those in EGHPs, may elect M+C 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 M+C 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 - For calendar years through 2004 (or, if later, for so long as authority for cost contracts is extended), 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 M+C plan via this SEP must meet M+C 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 M+C 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 M+C 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 M+C 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. This SEP lasts from the time the individual becomes dually-eligible and exists as long as they receive Medicaid benefits, provided the Medicaid program allows for a change. The effective date would be dependent upon the situation.

In addition, M+C-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 M+C 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 M+C plan, §1882(s)(3)(B)(v) of the Act provides a guaranteed right to purchase another Medigap policy if they disenroll from the M+C 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 M+C 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 M+C 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 M+C 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 M+C plan in which they are enrolled. This SEP allows a qualified individual to make a one-time election to disenroll from their first M+C 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 M+C Plans that Open in (or Expand into) a Rural Non–M+C Area - This SEP permits individuals to enroll in a plan that enters a rural non-M+C area at any time during that M+C plan’s first 12 months of operation. In this case, “rural” is defined in accordance with §1886(d)(2)(D)(ii) of the Act and further defined in the regulation at 42 CFR 412.62(f). In general, any area outside a Metropolitan Statistical Area (as defined by the Office of Management and Budget) is considered rural. Refer to a list of MSAs at http://www.cms.hhs.gov/healthplans/reportfilesdata . This SEP allows for a one-time election into the new M+C plan. The effective date is the first day of the month after the M+C plan receives the completed election form. The SEP would end if and when another M+C plan entered the area before the end of the 12-month period.

For example, if CMS approves a new M+C plan on May 1, 2002, for a start date of June 1, 2002, the SEP would last from June 1, 2002, through May 31, 2003. However, if another M+C plan entered that same service area before May 31, 2003 - for example, January 1, 2003 - the SEP would end.

8. 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 M+C plan during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an M+C plan offered by the M+C organization, provided:

a. They were in a health plan offered by the same M+C 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 M+C plan receives the completed election.

9. 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 M+C plan during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an M+C plan offered by the M+C 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 election may only be made prospectively and the effective date is the first day of the month after the M+C plan receives the completed election.

30.8 – Closed Plans, Capacity Limits, and Reserved Vacancies

(Rev. 41, 01-09-04)

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

All M+C plans (with the exception of M+C 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 M+C organization set aside openings for the enrollment of conversions (i.e., ICEP elections).

Unlike the mandatory election periods (AEP, ICEP and SEP), an M+C organization has the option to be open for elections made during the OEP. An M+C organization may voluntarily close one or more of its M+C plans during any portion of the OEP. If an M+C 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 M+C plans must accept OEP disenrollment elections whether or not it is open for enrollment.*

30.8.1 – M+C Plan Closures

(Rev. 41, 01-09-04)

The decision to be open or closed for OEP enrollment elections rests with the M+C organization and does not require CMS approval. However, if an M+C organization has an M+C 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 M+C organization has more than one M+C plan, those plans may be open or closed independent of one another, as the M+C organization determines. Further, each M+C plan may be open for all or only part of the OEP. For example, an M+C 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 M+C 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 M+C 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 M+C organization cannot accept any new enrollees into the M+C 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 M+C organization has an M+C 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 M+C 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 M+C 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 M+C 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 M+C organization to notify the general public. However, the M+C organization should notify CMS when this occurs.

50.1.1 - Requests Submitted via Internet

(Rev. 41, 01-09-04)

The M+C organization has the option to allow members to submit disenrollment requests via the Internet; however, certain conditions must be met. The M+C organization must, at a minimum, comply with the CMS security policies - found at http://cms.hhs.gov/it/security/. However, the M+C 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 M+C 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 M+C organization is complying with the required encryption, authentication, and identification requirements. The CMS reserves the right to audit the M+C organization to ascertain whether it is in compliance with the security policy. The effective date of the request is *determined by the date the request is* received by the specified site designated by the M+C organization.

50.2.1 - Members Who Change Residence

(Rev. 41, 01-09-04)

On August 22, 2003, CMS clarified that M+C 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 M+C 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)****, M+C organizations must make this option available to all enrollees who are absent for an extended period from the M+C plan's service area.*

However, M+C organizations may limit this option to enrollees who travel to certain areas, as defined by the M+C organization and who receive serves from qualified providers.

The M+C organizations without these programs must continue to disenroll members who have been out of the area for more than 6 months.

50.2.1.1 - General Rule

(Rev. 41, 01-09-04)

The M+C 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 M+C 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 and his/her new residence is not in the service area or another continuation area;

6. The member permanently moves out of the service area (or continuation area, for continuation of enrollment members) and into a continuation area, but chooses not to continue enrollment in the M+C 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. 41, 01-09-04)

Generally disenrollments for **reasons 1, 3, 4, and 5** above are effective the first day of the calendar month after the date the member begins residing outside of the M+C plan's service area (or continuation area, as appropriate) AND after the M+C 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 M+C organization can submit this request to the RO for consideration of retroactive action.

Disenrollment for **reasons 2 and *6*** above is effective the first day of the calendar month after 6 months have passed. *Disenrollment for reason 4 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 M+C plan, or Original Medicare, during this SEP. The rules for this SEP will determine the effective date in the new M+C plan or Original Medicare.

50.2.1.3 - Researching and Acting on a Change of Address

(Rev. 41, 01-09-04)

M+C 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 M+C 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. M+C 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 M+C organization applies the policy consistently among all members.

The M+C 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 M+C organization receives notice of a **permanent change** in address **from the member or the member's legal representative**, and that address is outside the M+C plan's service area (or continuation area, for continuation of enrollment members), then the M+C 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 M+C 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 M+C plan's service area (or continuation area, for continuation of enrollment members), then the M+C organization may not assume the move is

permanent until it has received confirmation from the member or member's legal representative.

M+C 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 M+C organization of when he/she left the service area, then the M+C 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 M+C organization, the M+C organization cannot assume the move is permanent and may not disenroll the member until six months have passed. The M+C organization may continue its attempts to verify address information with the member.

The M+C 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 M+C organization learned of the change in address.

3. **Temporary moves** - If the M+C organization determines the change in address is temporary, then the M+C organization may not initiate disenrollment until six months have passed from the date the M+C 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 M+C organization offers a visitor/traveler program, the M+C 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. 41, 01-09-04)

1. **M+C 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 written notification of disenrollment to the member. This notice must be sent within seven business days of the M+C organization's learning of the permanent move before the disenrollment transaction is submitted to CMS.

   In the notice, the M+C 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 M+C organization ends. The M+C 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 M+C 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 M+C organization must provide written notification of the upcoming disenrollment to the member.

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

   This written notice must also be sent 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 M+C organizations send final confirmation of disenrollment to the member to ensure the individual does not continue to use M+C organization services.

   EXAMPLE

   M+C 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 M+C organization sends a notice to the member in February. The M+C organization continues to receive reply listings, however, has not received any response from the member indicating this information is incorrect. Therefore, the M+C organization will proceed with the disenrollment, effective August 1. The M+C 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 M+C organization must provide written notification of the upcoming disenrollment to the member.*

   The notice of disenrollment must be sent 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 sent before the disenrollment transaction is submitted to CMS. The notice should advise the member to notify the M+C organization as soon as possible if the information is incorrect.

The CMS strongly encourages that M+C organizations send final confirmation of disenrollment to the member to ensure the individual does not continue to use M+C organization services.

50.3.1 - Failure to Pay Premiums

(Rev. 41, 01-09-04)

M+C organizations may not disenroll a member who fails to pay M+C plan cost sharing, other than premiums. However, an M+C organization has three options when a member fails to pay the M+C plan's basic and supplementary premiums.

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

The M+C organization **may**:

1. Do nothing, i.e., allow the member to remain enrolled in the same premium plan;

2. Disenroll the member after 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 M+C 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 M+C 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 M+C organization chooses to disenroll the member or reduce coverage, the action may only be accomplished by the M+C organization when payment has not been received within 90 calendar days after the date *the premium was due*. The M+C organization must send a notice of non-payment of premiums **within** 20 calendar days after the delinquent premiums were due, and must notify the member if he/she will be disenrolled or if coverage will be reduced.

While the M+C organization may accept partial payments, it has the right to ask for full payment within the 90-day grace period. If the member does not pay the required amount within the 90-day grace period, the effective date of disenrollment or reduction in coverage is the first day of the month after the 90-day period ends. Unless the member elects another M+C plan during an applicable election period, any disenrollment processed under these provisions will always result in a change of election to Original Medicare. **The M+C 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 M+C organization may require the individual to pay any outstanding premiums owed to the M+C organization before considering the enrollment to be "complete."

Calculating the 90-Day Grace Period

M+C organizations have the following options in calculating the 90-day grace period. The organization must apply the same option for all members of a plan.

A - M+C organizations may consider the 90-day grace period to end 90 days *after* the date the *first delinquent premium was due.*

If the overdue premium and all other premiums that become due during the 90-day period (in accordance with the terms of the member's agreement with the M+C organization) are not paid in full by the end of 90 days *after* the date *the first delinquent premium was due*, the M+C organization *may* terminate or reduce the member's coverage. Under this scenario, M+C 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: *Mr. Stone's premium was due on February 1, 2003. He did not pay this premium and on February 17, the M+C organization sent an appropriate notice. Mr. Stone ignores this notice and subsequent premium bills. To calculate the 90-day grace period, add February 2 -28 (27 days), March (31 days), April (30 days) and May 1-2 (2 days) for a total of 90 days. In this example, the disenrollment notice required following the expiration of the 90-day period could be sent on May 3 with an effective date of June 1st for disenrollment.*

Example B: *Mrs. Monsoon's premium was due on July 1, 2003. She did not pay this premium and on July 14, the M+C organization sent an appropriate notice. Mrs. Monsoon ignores this notice and subsequent premium bills. To calculate the 90-day grace period, add July 2-31 (30 days), August (31 days) and September 1 –29 (29 days) for a total of 90 days. In this example, the disenrollment notice required following the expiration of the 90-day grace period could be sent on September 30 with an effective date of October 1 for disenrollment.*

In short, the M+C organization may require that the member pay the overdue premiums in full within the 90-day grace period, as well as all other payments becoming due within that 90-day period, in order to avoid disenrollment or a reduction in coverage. If the M+C organization requires the member to make full payment within the 90-day grace period and pay all premiums falling due within that period, however, the M+C organization must state so in its initial delinquency notice to the member.

B - M+C organizations may use a "rollover" approach in determining how to calculate the 90-day period.

Under this scenario, the 90-day grace period would begin on the date *after the date the delinquent premium was due*, but if the member makes a premium payment within the 90-day period, the 90-day grace period stops, and the M+C organization would then send another notice informing the member of any overdue payments. The member would then have a new 90-day grace period, beginning on the date *after the next unpaid premium was due*. (The subsequent notice also would have to be sent within 20 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 a 90-day grace period expired with no premium payments being made, at which time the M+C organization could terminate or reduce the member's coverage.

EXAMPLE A

A member fails to pay his January premium due January 1. The M+C organization sends a notice to the member on January 15 stating that his coverage will be terminated or reduced if the outstanding premium is not paid within 90 days *after the date the premium was due*. The member fails to pay his February premium, and receives a second notice from the M+C organization on February 15. The member pays the January premium, but does not pay the February premium. The 90-day grace period is recalculated to begin *after* the date the *next unpaid premium became due (after February 1).* The M+C organization sends a notice to the member reflecting the new 90-day grace period. The member pays off his balance in full before the second 90-day time frame expires; *the* member's coverage in the M+C plan remains intact.

EXAMPLE B

Same scenario as above, except the member does not make any more premium payments during the second 90-day grace period expiring on May *2*. The M+C organization could terminate or reduce the member's coverage, after giving proper notice, effective June 1.

Notice Requirements - If the M+C 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 20 calendar days** after the date

the delinquent premiums were due (see Exhibit 19). The M+C 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;

- Provide the member with an explanation of disenrollment procedures *advising* the member that failure to pay the premiums within the 90-day grace period will result in termination or reduction of M+C coverage, whichever is appropriate according to the M+C organization policy, *and the proposed effective date of this action;*

- Explain whether the M+C organization requires full payment within the 90-day grace period (including the payment of all premiums falling due during the intervening 90 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 M+C organization policy is to reduce coverage.

If a member does not pay within *the* 90-*day grace period*, and the M+C organization's policy is to disenroll the member, the M+C 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 M+C 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 M+C organizations send final confirmation of disenrollment to the member after receiving the reply listing report to ensure the individual does not continue to access M+C organization services (refer to Exhibit 21 for a model letter).

If a member does not pay within *the* 90-*day grace period*, and the M+C organization policy is to reduce coverage, the M+C 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 M+C 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

M+C organizations have the **option** to retain dually eligible members who fail to pay premiums even if the M+C 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 M+C organization has the discretion to offer this option to dually eligible individuals within each of its M+C plans. The only stipulation is that if the M+C organization offers this option in one of its plans, it must apply the policy to all dual eligible individuals in that M+C plan.

The policy to retain individuals is based upon non-payment of premium for the standard benefit package of the M+C plan. If the M+C 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 M+C plan.

Members of an M+C plan must be informed at least 30 days before a policy changes within the plan. M+C 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. 41, 01-09-04)

The M+C organization **may** disenroll a member if *his/her* behavior is disruptive, unruly, abusive, or uncooperative to the extent that his/her continued enrollment in the plan seriously impairs the M+C organization's ability to furnish services to either *that* particular member or other members *of* the plan. However, the M+C organization may only disenroll a member for disruptive behavior *with CMS'* approval. The M+C organization may not disenroll a member because *he/she* exercises the option to make treatment decisions with which the M+C organization disagrees, including the option of no treatment and/or no diagnostic testing. The M+C organization may not disenroll a member *because he/she* chooses not to comply with any treatment regimen developed by the M+C organization or any health care professionals associated with the M+C organization.

Before *requesting CMS' approval of* for-cause *disenrollment*, the M+C organization must make a serious effort to resolve the problems presented by the member. This includes *documentation:*

- *Of the disruptive behavior;*
- *Of the M+C organization's efforts to resolve the problem;*

- *Of the M+C 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;

- *Establishing that the member's behavior is not related* to diminished mental capacity*;*

- *Describing* any extenuating circumstances cited under 42 CFR 422.74(d)(2)(iii) and (iv);

- *That the M+C organization provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Notice Requirements); or*

- *That the M+C organization then provided written notice of its intent to request involuntary disenrollment (see Notice Requirements).*

The M+C organization must submit to the CMS Regional Office:

- *The above documentation;*

- *The reason for the request;*

- *Member information, including* age, diagnosis, mental status, functional status, and *a description of their* social support systems;

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

- *Any information provided by the member.*

The CMS Regional Office will *review this documentation, consult with CMS Central Office (CO), 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). The CMS will make the decision within *20* business days after receipt of this information. *The CMS will notify the M+C 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. Any disenrollment processed under these provisions will always result in a change of election to Original Medicare.

Notice Requirements

The disenrollment for disruptive behavior process requires 3 (three) 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 M+C organization's request.*

Advance Notice

Prior to forwarding an involuntary disenrollment request to CMS, the M+C 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 M+C 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 M+C organization must begin the process again. This includes sending another advance notice.*

Notice of Intent

If the *member's disruptive behavior continues despite the M+C organization's efforts* , *then* the M+C organization must *notify him/her* of *its* intent to request *CMS' permission to disenroll them* for cause. 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 M+C 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 M+C organization to disenroll a member for disruptive behavior, the M+C 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. While there is no required timeframe in which the M+C organization must provide notice to the member, the M+C organization may provide the

member the required notice as soon as CMS notifies the M+C organization of the *approval*.

The M+C organization can only submit the *disenrollment* transaction to CMS after *providing* the notice of disenrollment to the individual. The disenrollment is effective the first day of the calendar month after the month in which the *M+C organization* gives the member a written notice of the disenrollment.

60.2 - Cancellations

(Rev. 41, 01-09-04)

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 M+C organization should document the request. M+C 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.

60.4 - Retroactive Enrollments

(Rev. 41, 01-09-04)

The CMS will only process requests for retroactive enrollments when the M+C organization has notified the member that he/she must use M+C 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 M+C plan, but the M+C 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 M+C plan was closed for enrollment.

NOTE: Keep in mind that unless a capacity limit applies, all M+C plans are open for ICEP, AEP, and SEP elections; therefore, all M+C plans are open for retroactive enrollments for these *types* of elections.

The following documentation must be submitted to the RO for all retroactive enrollment requests. The retroactive enrollment request should be made within 45 calendar days of the availability of the first reply listing.

1. 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

   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. Copy of M+C organization's letter to the member acknowledging receipt of the completed enrollment election and notifying the member to begin using the M+C 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 M+C organization's attempts to correctly enroll the individual and the resulting rejections. One reply listing will be considered acceptable if the M+C 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 M+C organization may submit the McCoy 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 M+C 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 M+C organization did not notify the member that he/she must use M+C 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 M+C plan services during the period covering the retroactive enrollment request, the M+C organization may bill Medicare for the services. The M+C organization may bill for Medicare Part B services from the Medicare carrier.

NOTE: The M+C organization must have an indirect billing number from CMS.

Or, the M+C organization may have its certified M+C plan providers bill for Medicare Part B services. The certified M+C plan providers may bill the Medicare fiscal intermediary for Medicare Part A services. M+C organizations may not bill for Medicare Part A services. The beneficiary would remain responsible for any co-insurance and deductible.

If an M+C organization is making a retroactive request that is a result of M+C organization error or system problems (as defined in §10) in which the enrollment is not recorded on a timely basis by the M+C organization or in CMS records, the M+C 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.

Exhibit 1: Model Individual Enrollment Form ("Election" may also be used) (4 Pages)

(Rev. 41, 01-09-04)

Referenced in section(s): 10, 40.1, 40.2, 50.1

Medicare +Choice Plan Name: _______________________________

Your Name:_________________________**Your Medicare Number:** ____________

Date of Birth (month/day/year): ___________________ **Male** _____**Female** _____

Permanent Residence Address:

____________________________	_________	_________	_____	__________
Number, Street, Apartment #	City	County	State	Zip Code

Telephone Number: _____ __________________

Area Code Number

Mailing Address (if different from permanent address)

____________________________	_________	_________	_____	__________
Number, Street, Apartment #	City	County	State	Zip Code

Name of person to contact in case of emergency [Optional field] _________________

Phone Number: [Optional field]________**Relationship to You** [Optional field]______

[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., Chinese)

____ Language B (e.g., Spanish)

Medicare Health Insurance

Social Security Act

Name of Beneficiary:

Medicare Claim Number _________ Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To Effective Date

__ Hospital Insurance (Part A)______________

__ Medical Insurance (Part B)______________

- Medicare Information: Fill in these blanks so they match your Medicare card, or
- Attach a copy of your Medicare card or your Letter from the Social Security Administration or Railroad Board.

We cannot call this enrollment form "finished" until you have given us this information.

Your Medicare +Choice plan choice:

Please check which product you want to enroll in: [Optional field for plans with more than 1 product]

____ Product ABC [optional] Premium = $XX per month

____ Product XYZ [optional] Premium = $XX per month

Name of chosen Primary Care Physician (PCP), clinic or health center (if required):

[This field is not necessary for PPOs]

Release of Information: By joining this plan, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

Lock-In: I understand that, beginning on the date my Medicare +Choice plan coverage begins, I must get all of my health care from the Medicare +Choice plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the Medicare +Choice organization and other services contained in my Medicare +Choice plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE MEDICARE + CHOICE PLAN WILL PAY FOR THE SERVICES. [Note: POS and PPO plans need to add a statement regarding financial liability when using non-contracted providers]

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this Medicare +Choice plan.

Your Signature* ____________________________ Date: ________________

*If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law; or another person who is authorized by State law, must sign the following line. **Attach a copy of proof of Legal Guardian, DPAHC, or proof of authorization by state law**

Signature __________________________________ Date: ________________

*If anyone helped you fill out this form, s/he must sign the following line:

Signature _____________________ Date: ________ Relationship:__________________

Please read and answer these questions:

1. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive.

   Yes ______________ No ______________

Note: If you have ESRD, you cannot enroll in this plan unless you are already enrolled in the Medicare + Choice organization as a commercial member or you were affected by the non-renewal of another Medicare + Choice plan after December 31, 1998. If 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. Have you recently moved into this plan's service area?

   Yes ______________ No ______________

Your answer to the following questions will not keep you from enrolling in this plan.

3. Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?

   Yes ______________ No ______________

   If yes, Name of Institution ______________________________

   Address of Institution (number and street) ______________________________

   Phone Number of Institution ______________________________

   Your Date of Admission into Institution ______________________________

4. Do you receive Medicaid benefits?

   Yes________ (If yes, Medicaid Number: __________________) No __________

5. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits?

   Yes ______________ No ______________

   If yes, what kind of insurance do you have? ______________________________

   What is the name of your insurance? ______________________________

6. Do you or your spouse work?

   Yes ______________ No ______________

Please read these sentences and put your initials next to them:

1. I understand that while the "effective date of coverage" on the first page of this form is when I should begin using the plan's services, the plan will still send me final approval of my enrollment in the plan. I understand that I should not disenroll from **any Medicare supplement plan, or Medigap or Medicare Select plan** until I get that approval from the plan. ______ (Initials)

2. I understand that I must keep my **Medicare Part A and Part B insurance** by paying the Part B premiums and the Part A premiums, if applicable. ______ (Initials)

3. I understand that I can be a member of only **one Medicare + Choice plan at a time**. By enrolling in this plan, I will automatically be disenrolled from any other Medicare + Choice plan of which I am currently a member. ______ (Initials)

4. I understand that since I can be a member of only one Medicare +Choice plan at a time, I **cannot enroll in more than one Medicare + Choice plan** with the same effective date of coverage. If I do this, my enrollments may be canceled and I will have to fill out a new enrollment form to become a member of a Medicare + Choice plan. _____(Initials)

5. I understand that I may **disenroll** from this plan by sending a written request to the plan, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Until the effective date of disenrollment, I must keep getting health care from the plan doctors. ______ (Initials)

6. I understand that as a member of the plan, I have the right to **ask about the plan's decision** about payment or services if I disagree. _______ (Initials)

7. I understand that it is my job to tell the plan before I **move** out of the service and/or continuation area. I understand that if I move permanently out of the service and continuation area, Medicare requires the plan to disenroll me. ______ (Initials)

Office Use Only:
Plan ID #:______________________________
Effective Date of Coverage: ________________
ICEP: __________ OEP: __________ AEP: __________ SEP (type): __________

Exhibit 19: Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage

(Rev. 41, 01-09-04)

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>. **M+C organizations who will disenroll all members (and not use the downgrade option) use the following sentence:** If we do not get payment by <90 days *after the* date *the delinquent premium was due*>, we will have to disenroll you from <M+C Plan>. After the disenrollment you will be covered by the Original Medicare *P*lan instead of <M+C Plan>.

Note: As required in section 50.3.1, the M+C organization must state whether full payment of premiums is due to prevent disenrollment.

M+C 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 <M+C plan name> that will reduce the amount of health care coverage you have in <M+C plan name>. *T*his means that (describe lower level of benefits, e.g., prescription drugs or routing dental care will not be covered) beginning <date>.

Note: As required in section 50.3.1, the M+C 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 <M+C Plan> and change to the Original Medicare Plan now, you should do one of these three things:

1. Send us a written request at <M+C Plan address>.

2. Contact your local Social Security Office or Railroad Retirement Board Office.

3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You must keep using <M+C Plan name> doctors except for emergency or urgently needed care or out-of-area dialysis services until you are no longer a member.
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 26: Acknowledgement of Request to Cancel Disenrollment

(Rev. 41, 01-09-04)

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 <M+C Plan> primary care physician for your health care. (Note: 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 <M+C Plan>.

If you have also submitted an enrollment with another Medicare + Choice 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].