# CMS Medicare Manual System
# Pub. 100-16 Managed Care

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

**Transmittal 12** **Date: AUGUST 15, 2002**

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Exhibit 3a
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*Red italicized font identifies new material.*

**NEW/REVISED MATERIAL - EFFECTIVE DATE:**
**IMPLEMENTATION DATE:**

**Chapter Heading -** Special "Note" has been added at the heading of the chapter announcing the new legislation enacted on 6/12/02 that delayed the implementation of "lock-in" until 2005.

**Table of Contents**

1. Added an Appendix section for items that are more appropriate as reference items rather than as exhibits.

2. Exhibit 24 becomes Appendix 1,

3. Exhibit 25 becomes Appendix 2, and

4. Exhibit 26 becomes Exhibit 24.

5. Exhibits 3, 3a, 6a, 25 and 26 have been added.

6. In addition, section heading names have been changed for sections 30.3.1, 30.3.2, and 30.3.3.

**Section 10 - Definitions**

1. For the definition "Completed Election", replaced the reference to "Exhibit 25" with "Appendix 2" in the third bulleted paragraph.

2. For the definition "Election Form", added reference to the new "selection" form for switching M+C plans within an M+C organization and referred the reader to the new Exhibit 3a.

**Section 20 - Eligibility for Enrollment in M+C Plans -** Item number 4, replaced "Exhibit 25" with "Appendix 2".

**Section 20.4 - Completion of Enrollment Form -** Third paragraph - replaced "Exhibit 25" with "Appendix 2".

**Section 30 - Election Periods and Effective Dates**

1. Added note regarding the new legislation enacted on 6/12/02 that delayed the implementation of "lock-in" until 2005.

2. In the sixth paragraph, inserted the word "plan" to say "entire plan service area".

**Section 30.1 - Annual Election Period (AEP)** - Specified that the AEP occurs between November 15th and December 31st, instead of November.

**Section 30.3 -Open Enrollment Period (OEP)**

1. In the first paragraph, deleted OEPI and OEPNEW from the periods that an M+C organization are required to open their plans for enrollment.

2. Updated text throughout the section regarding this change.

**Section 30.3.1 - OEP Through 2004 -** Changed "2001" to "2004" as a result of the new law in section title, and "2001" to "years 2002, 2003, and 2004" in the last sentence of the section.

**Section 30.3.2 - OEP Through 2005**

1. Changed "2002" to "2005", changed "2002" to "2005" in section title and text.

2. Added a sentence to the first paragraph indicating that once an individual has exercised one OEP election, subsequent elections in the calendar year will be rejected.

3. In addition, the paragraphs containing the example and "Counting Elections" were deleted.

**Section 30.3.3 - OEP in 2006 and Beyond**

1. Changed "2003" to "2006" in the text and the section heading.

2. Changed "their" to "his/her".

3. In addition, the paragraphs containing the example and "Counting Elections" were deleted.

**Section 30.3.4 - Open Enrollment for Newly Eligible Individuals in 2005 and Beyond (OEPNEW)**

1. Changed section heading indicating this section applies to the year 2005 and beyond, and updated years "2002" to "2005" and "2003" to "2006.

2. Added the word "always" to the third bulleted paragraph.

**Section 30.3.5 - Open Enrollment for Newly Eligible Individuals in 2005 and Beyond (OEPI) -** Changed section heading indicating this section applies to the year 2005 and beyond, and updated years "2002" to "2005".

**Section 30.4 - Special Election Period - (SEP) -** Added "unless specified otherwise with an SEP" to the end of the first paragraph.

**Section 30.4.4 - SEPS for Exceptional Conditions -**

1. Item 1 - SEP EGHP - Added a sentence indicating the SEP EGHP may be used during the OEP under certain conditions.

2. Item 7 - SEP for M+C Plans that Open in (or Expand into) a Rural Non-M+C Area - Changed abandoned to “non-M+C” in Item title, and added a reference to the list of MSAs and the web address for this reference.

**Section 30.4.5 - SEPs for Beneficiaries Aged 65 (SEP65)** - Updated years "2002" to "2005".

**Section 30.5 - Effective Date of Coverage**

1. Changed the Effective Date Table to exclude OEPNEW and OEPI from the second item, "Open Enrollment Period".

2. Text was changed in the example to explain why that individual must be given an effective date of February 1 for the ICEP "because January 1st is earlier than the month of entitlement to Medicare Part A and Part B."

3. Items 5, OEPNEW, and 6, OEPI, were deleted from the list of "Ranking of Election Periods".

**Section 30.6 - Effective Date of Voluntary Disenrollment -** Changed Effective Date Table to exclude OEPNEW and OEPI from the second item, "Open Enrollment Period".

**Section 40 - Enrollment Procedures**

1. Inserted language to allow M+C organizations the option of using a CMS approved “selection” form or method in lieu of the short enrollment form for changes between M+C plans within an M+CO (new Exhibit 3a).

2. Added reference to summary of notice requirements, which is now Appendix 1.

**Section 40.1 - Format of Enrollment Forms**

1. In the first paragraph, added reference to new “selection” form option (Exhibit 3a).

2. The word "will" was changed to "may" in the fifth bulleted paragraph to indicate multiple enrollment forms "may" cause all to be cancelled.

3. Text was added to establish three requirements an M+C organization must satisfy when using the model change form for elections from one M+C plan to another M+C plan within the same organization.

4. In the second to last paragraph, nursing home status is added to ESRD status as an exception of questions that may be included on an enrollment form.

**Section 40.2** - In the second paragraph, replace reference to “Exhibit 25” with “Appendix 2” and added references to Exhibit 3a and 3b.

**Section 40.2.3 - M+C Organization Denial of Enrollment**

1. Deleted the second through the fourth paragraph containing the explanation of an M+C organization's rights and responsibilities when denying elections based on ineligibility.

2. Also, in the fifth paragraph deleted the third example in the second sentence of an individual making an election outside the allowable election period.

**Section 40.4.2 - After the Effective Date of Coverage** - In second paragraph, added reference to new Exhibits 6a and 8a.

**Section 40.5.1 - Procedures After Reaching Capacity -** Corrected spelling in last paragraph.

**Section 50 - Disenrollment Procedures -** Changed reference from "Exhibit 24" to "Appendix 1" in last paragraph.

**Section 50.1 - Voluntary Disenrollment by Member**

1. Revised the second bulleted item regarding “e-mail” to "via Internet".

2. In unnumbered section "Requests Submitted via Internet", the word "E-mail" in the section title was changed to read "via Internet," and language was revised to state that receiving disenrollment requests via the Internet is at the option of the

M+C organization. The M+C organization may designate specific sites and must use additional security provisions required under CMS security policies.

3. Spelling of the word “recipient” and "identification" has been corrected.

4. In unnumbered section "Medigap Guaranteed Issue Notification Requirements" inserted “Exhibit 24” in place of “Exhibit 26” second paragraph.

**Section 50.2 - Medigap Guaranteed Issue Notification Requirements -** Insert “Exhibit 24” in place of “Exhibit 26” in the second paragraph.

**Section 50.2.1 - Members Who Change Residence -** Added “or his/her authorized representative” to the end of the first sentence after the numbered list (AAHP comment.)

**Section 50.3.1 - Failure to Pay Premiums -** In unnumbered section “Notice Requirements”, corrected spelling of "period" in third bullet item of bulleted list.

**Section 50.7 - Disenrollment Procedures for Employer Group Health Plans**

1. Added “or determines that an enrollee in its program is no longer eligible to participate in the employer group plan” in the first paragraph as a situation where an employer group determines an individual is ineligible to participate in the employer group plan.

2. Clarified this point throughout section 50.7.

3. In unnumbered section "Option 1" bulleted paragraph "b.", changed the word "they" to "he/she" throughout.

4. In unnumbered section "Option 2", a third bullet was added to the list of employer responsibilities to indicate that the employer must provide timely notice of enrollee ineligibility or contract termination.

**Section 60.1 - Multiple Transactions**

1. Deleted sentence regarding multiple elections from first paragraph. The policy for multiple transactions is that in cases of multiple elections, the enrollment with the latest signature date will determine which plan the individual will be enrolled in. If the signature dates are the same on, then all elections are rejected. This policy has been communicated to plans over the past year and inclusion of the policy in these instructions coincides with the system changes for July 1 that will implement this policy, i.e., “signature date”.

2. In addition, the first example was replaced by an example to better illustrate the policy.

**Section 60.2.1 - Cancellation of Enrollment -** In the second paragraph added reference to the new Exhibit 25 which contains a sample letter and clarified that the letter must be sent "within 7 business days" of the request.

**Section 60.2.2** - In the third paragraph, added reference to the new Exhibit 26 created for the notification requirement under 60.2.2, clarified that the letter must be sent "within 7 business days" of the request.

**Section 60.3.2 - Reinstatements Due to Mistaken Disenrollment Made By Member -** Clarified policy regarding disenrollment made in error by the member. An automatic disenrollment from the first M+C organization is erroneous and invalid where a cancellation of enrollment in a second M+C organization is properly made.

**Appendices and Exhibits**

Appendices - The Appendices is a new section, which better reflects the information included in the documents - i.e., summaries, lists, etc. - rather than model notices.

> **Appendix 1 - Summary of Notice Requirements** was previously Exhibit 24 and has become Appendix 1. This summary has been revised and updated to include references to the new exhibits.
>
> **Appendix 2 - Data Elements Required to Complete the Enrollment Form** was previously Exhibit 25. This summary has been revised and updated to include references to the new exhibits.
>
> **Appendix 3 - Timeframes for Required Enrollment & Disenrollment Monitoring Elements** - Will be added at a later date.

Exhibits:

> **Exhibit 1 - Model Individual Enrollment Form -** Deleted Item 3 from page 3 and renumbered the remaining questions, deleted sentence 5 and 6 from page 4 and renumbered the remaining sentences.
>
> **Exhibit 3** - Model Short Enrollment Form - Deleted paragraph containing lock-in language in all models.
>
> **Exhibit 3a - Model Selection Form -** Inserted a new exhibit containing a model letter and a "Plan Benefit Selection Form."
>
> **Exhibit 6 - Model Notice to Request Information -** Corrected full spelling of "Centers for Medicare & Medicaid Services".
>
> **Exhibit 6a - Model Notice to Confirm Enrollment - Plan to Plan within M+C Organization** - Inserted a new exhibit of a model letter confirming member enrollment by CMS.
>
> **Exhibit 7 - Model Notice for M+C Organization Denial of Enrollment**

1. Deleted denial reason 6, and changed 7 to 6.

2. Also the first sentence in the paragraph following item 6 was deleted to indicate that this paragraph is not optional.

**Exhibit 8 - Model Notice for CMS Rejection of Enrollment -** Deleted reason number 5, and corrected full spelling of "Centers for Medicare & Medicaid Services".

**Exhibit 9 - Model Notice to Send Out Disenrollment Form**

1. In the first paragraph deleted deadline of June 30, 2002, and "March 31, year" and also second paragraph and fourth paragraph pertaining to these deadlines.

2. Under "Important Note About Medigap Rights", added two situations to bulleted list indicating if these situations apply, an individual might have a guaranteed right to buy a Medicare supplement. Text was added regarding definitions of trial period.

**Exhibit 9a - Model Letter for Sending Out Disenrollment Form After the Open Enrollment Period -** is deleted.

**Exhibit 10 - Model Disenrollment Form**

1. Deleted first full paragraph regarding lock-in language.

2. Under "Important Note About Medigap Rights", added two situations to bulleted list indicating if any of these situations apply, an individual might have a guaranteed right to buy a Medicare supplement policy. These situations are if an individual is receiving or no longer receiving Medicaid to pay for Medicare premiums and "other special circumstances" defined by Medicare."

3. Paragraph was added regarding definitions of trial period.

**Exhibit 11 - Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member** - In second paragraph deleted lock-in language.

**Exhibit 11a - Model Letter for Acknowledgement of Receipt of Voluntary Disenrollment Request From Member and Denial of that Request -** is deleted.

**Exhibit 12 - Model Notice to Confirm Voluntary Disenrollment Identified through Reply Listing**

1. In the first paragraph deleted last sentence regarding deleted lock-in language.

2. Under "Important Note About Medigap Rights", added "or no longer receiving" to Medicaid situations where member may be eligible to buy a Medicare supplement policy.

**Exhibit 13 - Model Notice of Disenrollment Due to Death -** corrected full spelling of "Centers for Medicare & Medicaid Services".

**Exhibit 14 - Model Notice of Disenrollment Due to Loss of Medicare Part A and/or Part B -** Corrected full spelling of "Centers for Medicare & Medicaid Services".

**Exhibit 15 - Model Notice to Offer Beneficiary Services Pending Correction of Erroneous Death Status -** Corrected full spelling of "Centers for Medicare & Medicaid Services".

**Exhibit 16 - Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination -** corrected full spelling of "Centers for Medicare & Medicaid Services".

**Exhibit 19 - Model Notice on Failure to Pay Plan Premiums - Advanced Notification of Disenrollment or Reduction in Coverage -** In the third paragraph changed "want" to "are eligible," and added "to Original Medicare" after "(M+C Plan)". The fourth paragraph text was deleted regarding lock-in language.

**Exhibit 20 - Model Notice on Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment -** Corrected full spelling of "Centers for Medicare & Medicaid Services" in first paragraph. In the second paragraph, text was deleted regarding lock-in language.

**Exhibit 21 - Model Notice on Failure to Pay Plan Premiums -** Confirmation of Involuntary Disenrollment - Corrected full spelling of "Centers for Medicare & Medicaid Services" in first paragraph. In the second paragraph, text was deleted regarding lock-in language.

**Exhibit 22 - Model Notice on Failure to Pay Plan Premiums - Notice of Reduction in Coverage -** The fourth paragraph regarding lock-in language and text reminding the member that he or she must keep using plan doctors except for emergency or urgent care unless the member disenrolls from the plan was moved to the third paragraph.

**Exhibit 25 - Acknowledgement of Request to Cancel Enrollment -** Added model letter to acknowledge to member that a request to cancel an enrollment has been received.

**Exhibit 26 - Acknowledgement of Request to Cancel Disenrollment -** Added model letter to acknowledge to member that a request to cancel a disenrollment has been received.

# Medicare Managed Care Manual

## Chapter 2 - Medicare + Choice Enrollment and Disenrollment

***Special note: A new law enacted on June 12, 2002, has delayed the implementation of enrollment "lock-in" until 2005. Please see section 30 of this chapter for important changes.***

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*Appendices*

*Appendix 1: Summary of Notice Requirements (3 pages)*

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Exhibits

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*Exhibit 24 - Model Notice for Medigap Rights per Special Election Period*

*Exhibit 25 - Model Notice to Acknowledge Request to Cancel Enrollment*

*Exhibit 26 - Model Notice to Acknowledge Request to Cancel Disenrollment*

## 10 - Definitions - (Rev. 12, 08-15-02)

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.

**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);

2. For enrollments, evidence of entitlement to Medicare Part A and enrollment in Medicare Part B is obtained by the Medicare+Choice Organization (M+C organization) (see below for definition of "evidence of Medicare Part A and Part B coverage");

3. All necessary elements on the form are completed (for enrollments, see *Appendix 2* for a list of elements that must be completed), and, when applicable;

4. Supporting documentation for a representative's signature is obtained.

For enrollments, an M+C organization may also choose to wait for the individual's payment of the plan premium, including any premiums due the M+C organization for a prior enrollment that ended when the beneficiary was disenrolled for nonpayment of basic and supplementary premiums, before considering an enrollment "complete."

Some States have additional requirements before an enrollment is considered complete. For example, some States require phone verification prior to enrollment. Unless otherwise directed by CMS, M+C organizations should conduct the required activities within the time frames specified by the State. If no time frame is specified, then the M+C

organization should complete the required activities as quickly as possible, but within the time frames specified in §40.2.2. The election will not be considered complete until the M+C organization has completed the State-required activities.

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

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

**Denial of Election -** Occurs when an M+C organization determines that an individual is not eligible to make an election (e.g., the individual is not entitled to Medicare Parts A or B, the individual has ESRD, the individual is not making the election during an election period, etc.), and therefore decides not to submit the election transaction to CMS.

**Election -** Enrollment in, or voluntary disenrollment from, an M+C 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 M+C 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 -** The form used by individuals to request to enroll in, or disenroll from, M+C plans. A model individual enrollment form is provided in Exhibit 1. **An individual who is a member of an M+C plan and who wishes to elect another M+C plan, even if it is in the same M+C organization, must complete a new election form to enroll in the new M+C 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, M+C organizations may want to collaborate with employer group health plans *(EGHPs)* to use a single enrollment form for EGHP members; a model EGHP enrollment form for this purpose is provided in *Exhibit 2*. Beneficiaries or their authorized representatives must complete enrollment forms to enroll in M+C plans.

Beneficiaries are not required to use a specific form to disenroll from an M+C plan, but if they do not use a form they must submit a signed and written request for disenrollment to the M+C organization. A model disenrollment form is provided in Exhibit 10.

**Election Period -** The time during which an eligible individual may elect an M+C plan or Original Medicare. The type of election period determines the effective date of M+C 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 form, the M+C 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's 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.

**Evidence of Permanent Residence -** A permanent residence is normally the enrollee's primary residence. An M+C 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.

**Institutionalized Individual -** An individual who moves into, resides in, or moves out of an institution specified in §30.3.5.

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

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

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

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

**Out-of-Area Members -** Members of an M+C plan who live outside the service area and who elected the M+C 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 form has been received by the M+C organization. An election is considered received and must be date stamped by the M+C organization when the M+C 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" form is defined above.

**Reinstatement of Election -** An action that may be taken by CMS after an individual disenrolls from an M+C plan. The reinstatement corrects an individual's records by canceling a disenrollment to reflect no gap in enrollment in an M+C 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 M+C organization. The rejection could be due to the M+C organization incorrectly submitting the transactions, to system error, or to an individual's ineligibility to elect the M+C 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 M+C Plans - (Rev. 12, 08-15-02)

In general, an individual is eligible to elect an M+C plan when each of the following requirements are met. More specific detail regarding these requirements is as follows.

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 form (see exceptions described under §20.2);

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

4. The individual or his/her legally authorized representative completes an enrollment form 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);

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

6. The individual makes the election during an election period, as described in §30.

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

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

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## 20.4 - Completion of Enrollment Form - (Rev. 12, 08-15-02)

An eligible individual or authorized individual must fill out an election form to enroll in an M+C plan, **even if that individual is electing an M+C plan in the same M+C organization in which he/she is enrolled**. Unless otherwise specified by CMS, an eligible individual can elect an M+C plan only if he/she completes and signs an enrollment form, provides required information to the M+C organization within required time frames, and submits the properly completed form to the M+C organization for enrollment. Model enrollment forms are included in Exhibits 1, 2, and 3.

An individual who is a member of an M+C plan, and who wishes to elect another M+C plan offered by the same M+C organization, must complete a new enrollment form to enroll in the new M+C plan; however, that individual may use a short enrollment form (refer to Exhibit 3 for a model short enrollment form) to make the election in place of the comprehensive individual enrollment form.

An M+C organization must deny enrollment to any individual who does not properly complete the enrollment form 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 form."

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## 30 - Election Periods and Effective Dates - (Rev. 12, 08-15-02)

***Special Note: A new law enacted on June 12, 2002, has delayed the implementation of enrollment "lock-in" provisions until January 2005. Please take note of the changes to this section.*

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.

For the OEP, M+C organizations are required to process elections into any of their M+C plans that they choose to open to enrollment during an OEP. If an M+C plan is closed for enrollment, then it is closed to all individuals in the entire *plan* service area who are making OEP elections. 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.

**NOTE:** If an M+C plan is closed based on a capacity limit, this closure would apply to all types of enrollment. 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.

**Notice to Close Enrollment -** 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 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.

## 30.1 - Annual Election Period (AEP) - (Rev. 12, 08-15-02)

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

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## 30.3 - Open Enrollment Period (OEP) - (Rev. 12, 08-15-02)

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

If an M+C organization opens a plan during 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.*

### 30.3.1 - OEP Through 200*4* - (Rev. 12, 08-15-02)

The OEP is continuous through 200*4*. If an M+C organization has a plan that is open for enrollment at any time during the OEP, then it must accept all OEP elections into that plan made during the plan's open enrollment period. If an M+C organization has a plan that is not open for enrollment outside of the AEP, then it cannot accept any OEP elections into that plan.

**NOTE:** M+C organizations must accept requests for disenrollment from M+C plans during the OEP since Original Medicare is open continuously through 200*4*.

An M+C eligible individual can make an unlimited number of elections during the OEP in *years 2002, 2003 and 2004.*

## 30.3.2 - OEP in 2005 - (Rev. 12, 08-15-02)

In 2005, the OEP is from January through June. During this period an individual may make only one OEP election. *Once an individual has exercised his/her one OEP election, subsequent elections made during the remaining calendar year (unless made through an ICEP, OEPNEW, OEPI, SEP, or AEP) will be denied or rejected.*

After June 30, 2005, M+C organizations must deny elections of individuals unless they are eligible for an ICEP, OEPNEW, OEPI, SEP, or AEP. This includes enrollments, disenrollments to another M+C organization, and disenrollments to Original Medicare.

If an M+C organization has a plan that is open for enrollment any time between January and June 2005, then it must accept all elections into that plan made during the plan's open enrollment period.

M+C organizations must accept requests for disenrollment from M+C plans during the OEP since Original Medicare is open January through June in 2005.

## 30.3.3 - OEP in 2006 and Beyond - (Rev. 12, 08-15-02)

In 2006, the OEP is from January through March. During this period an individual may make only one OEP election. Once an individual has exercised *his/her* one OEP election, subsequent elections made during the calendar year (unless made through an ICEP, OEPNEW, OEPI, SEP, or AEP) will be denied or rejected.

After March 31, 2006, M+C organizations must deny elections of individuals unless they are eligible for an ICEP, OEPNEW, OEPI, SEP, or AEP. This includes enrollments, disenrollments to another M+C organization, and disenrollments to Original Medicare.

If an M+C organization has a plan that is open for enrollment any time between January and March of a particular year, then it must accept all OEP elections into the plan made during its open enrollment period for that same year. M+C organizations must accept requests for disenrollment from M+C plans during the OEP since Original Medicare is open January through March every year beginning in 2006.

## 30.3.4 - Open Enrollment for Newly Eligible Individuals *in 2005 and Beyond* (OEPNEW) - (Rev. 12, 08-15-02)

Beginning in 2005, an OEPNEW exists for newly eligible individuals. In 2005, the OEPNEW is the 6-month period beginning with the month of entitlement to both Medicare Part A and Part B, but not extending past December 31 of the same calendar year. In 2006 and thereafter, the OEPNEW is the 3-month period beginning with the month of entitlement to both Medicare Part A and Part B, but not extending past December 31 of the same calendar year.

**EXAMPLE:**

- If an individual first becomes entitled to Medicare Parts A and B on February 1, 2006, his/her OEPNEW lasts from February 1 through April 30, 2006.

- If an individual becomes entitled to Medicare Parts A and B on November 1, 2006, his/her OEPNEW lasts from November 1 through December 31, 2006.

Since Original Medicare is always open during an OEPNEW, beneficiaries may *always* disenroll to Original Medicare during their OEPNEW.

An M+C organization is not required to accept elections into its plan in the OEPNEW but if it is open for these elections, it must accept all OEPNEW elections into the plan. An individual is allowed one change of election during the OEPNEW. If the M+C organization accepts elections into its plan during the OEPNEW, only the individual's first OEPNEW election should be processed. All subsequent OEPNEW elections made by the individual will be rejected. An election made during any SEP, AEP, or OEP will not count towards this limit of one election in this period.

## 30.3.5 - Open Enrollment Period for Institutionalized Individuals (OEPI) *in 2005 and Beyond*- (Rev. 12, 08-15-02)

Beginning January, 2005, the OEPI is continuous for institutionalized individuals. For purposes of enrollment, 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).

Therefore, an M+C eligible institutionalized individual can make an unlimited number of elections during the OEPI beginning 2005. An M+C 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.

**NOTE:** Since the OEPI is continuous, Original Medicare is open continuously for institutionalized individuals beginning 2005. Therefore, M+C organizations must accept requests for disenrollment from their M+C plans during the OEPI since Original Medicare is open continuously for institutionalized individuals.

## 30.4 - Special Election Period - (SEP) - (Rev. 12, 08-15-02)

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 M+C plan;

2. CMS or the organization has terminated the M+C organization's contract for the M+C 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 M+C organization offering the M+C plan substantially violated a material provision of its contract under M+C in relation to the individual, or the M+C 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 M+C plan offered by an M+C organization and change to a different M+C plan or Original Medicare. If the individual disenrolls from (or is disenrolled from) the M+C plan and changes to Original Medicare, the individual may subsequently elect a new M+C plan within the SEP time period. Once the individual has elected the new M+C 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 M+C 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 M+C organization must receive a completed election form 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 M+C 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 M+C plan during an SEP - only those who disenroll to Original Medicare. M+C organizations are required to notify members of theses 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 frame and effective dates for SEPs are discussed in the following sections.

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## 30.4.4 - SEPs for Exceptional Conditions - (Rev. 12, 08-15-02)

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 form or disenrollment request. However, the effective date may not be earlier than the date the EGHP receives the completed enrollment form 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 form.

**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 two 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 Social Security Act (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 list of* MSAs at www.hcfa.gov/medicare/mgd-rept.htm. 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 form.

**9. SEP for Individuals with ESRD who are Members of a Group Health Plan and in their 30-month Coordination Period -** This SEP provides certain individuals with ESRD who are in group health plans the opportunity to elect select M+C plans at any time during the 30-month period **provided:**

a. The individual is a member of a health plan offered by the M+C organization at the time of Medicare entitlement;

b. Continues to be enrolled in the health plan offered by the M+C organization; and

c. Chooses to elect an M+C plan offered by that M+C organization, assuming the individual meets all other M+C eligibility requirements.

In order to be eligible for this SEP, there must be no break in coverage between the commercial health plan offered by an M+C organization, and coverage in the M+C plan offered by the same organization. This SEP continues throughout the duration of the 30-month coordination period and allows the individual one election from the commercial health plan to the M+C product offered by the same organization. The effective date is dependent upon the situation.

**10. 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 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 form.

**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 -** In 2002, individuals enrolled in an M+C plan with a monthly premium will have an SEP to elect a zero premium plan in the same M+C organization, if such a plan is offered. The election is effective the first day of the month after the M+C plan receives an election form (an abbreviated election form can be used).

## 30.4.5 - SEPs for Beneficiaries Age 65 (SEP65) - (Rev. 12, 08-15-02)

Beginning January 1, 200*5*, M+C eligible individuals who elect an M+C plan during the initial enrollment period (IEP) surrounding their 65th birthday have an SEP. This SEP65 allows the individual to disenroll from the M+C plan and elect the Original Medicare plan any time during the 12-month period that begins on the effective date of coverage in the M+C plan.

The IEP is **not** the same as the ICEP and relates to Medicare, not M+C, enrollment. The IEP isestablished by Medicare and begins three months before, and ends three months after the month of the individual's 65th birthday.

## 30.5 - Effective Date of Coverage - (Rev. 12, 08-15-02)

With the exception of some SEPs and when election periods overlap, generally *b*eneficiaries may not request their effective date. Furthermore, except for EGHP elections, the effective date can never be prior to the receipt of a complete election form by the M+C organization. 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 M+C 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 form is received by the M+C organization.

Once the election period is identified by the M+C organization, the M+C 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 M+C 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 | Yes - unless capacity limit applies |
| Open Enrollment Period | First day of the month after the month the M+C organization receives a completed enrollment form. | No the M+C organization can choose to be "opened" or "closed" to accept enrollments during this period. |
| Annual Election Period | January 1 of the following year | Yes - unless capacity limit applies |
| Special Election Period | Varies, as outlined in §30.4 | Yes - unless capacity limit applies |

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 M+C 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 both Medicare Part A and Part B.

**EXAMPLE:**

- If an individual's ICEP is November, December and January (i.e., he will be entitled to Medicare Part A and Part B in February) and an M+C organization receives a completed enrollment form 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 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 M+C organization CO 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 M+C organization should use the following ranking of election periods (1 = Highest, 4 = Lowest). The election period with the highest rank generally determines the effective date.

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

1. ICEP
2. SEP
3. AEP
4. OEP

## 30.6 - Effective Date of Voluntary Disenrollment - ((Rev. 12, 08-15-02) 9, 04-01-02)

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not select their effective date. 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 M+C organization, SSA, the RRB, or 1-800-MEDICAR(E), the election will return the member to Original Medicare. If a member elects a new M+C 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 M+C organization **must** determine which election period applies to each member **before** the disenrollment may be transmitted to CMS.

If an M+C organization receives a completed disenrollment request when more than one election period applies, the M+C 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 M+C 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 M+C organizations have to accept elections in this election period?** |
|---|---|---|
| Open Enrollment Periods | First day of the month after the month the M+C organization receives a completed disenrollment request. | Yes (because Original Medicare is always open during this election period) |
| 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.

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## 40 - Enrollment Procedures - (Rev. 12, 08-15-02)

An M+C organization must accept elections it receives, regardless of whether they are received in a face-to-face interview, by mail, or by facsimile. M+C organizations must never delay processing of enrollment forms unless the beneficiary's election is being placed on a waiting list, as allowed under §40.5.

An individual must complete and sign an enrollment form*, or another CMS accepted form or CMS approved method,* to enroll in an M+C plan, **even if that individual is electing an M+C plan in the same M+C organization in which he/she is enrolled**. If an individual wishes to elect another M+C plan in the same M+C organization, he/she must complete a new enrollment form to enroll in the new M+C plan. However, that individual may use a short enrollment form (refer to Exhibit 3 for a model short enrollment form) *OR model selection form for changes between M+C plans within an M+CO (Exhibits 3a)* to make the election in place of the comprehensive individual enrollment form. With the exception of forms that are faxed to the M+C organization, individuals should submit original, not photocopied, forms.

An M+C organization must send the beneficiary written notice of M+C 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.*

## 40.1 - Format of Enrollment Forms - (Rev. 12, 08-15-02)

The M+C organization must use an enrollment form that complies with CMS's 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; and a model short enrollment form is included as Exhibit 3*; and a model form for changes from plan to plan within an M+CO is included as Exhibit 3a.*

The M+C organization's individual and/or EGHP enrollment form must include statements that the member:

- Agrees to abide by the M+C organization's membership rules as outlined in material provided to the member, including the lock-in provisions;
- Authorizes the disclosure and exchange of necessary information with CMS;
- Understands that enrollment in the M+C plan automatically disenrolls him/her from any other M+C, HCPP, or cost plan in which he/she is enrolled;
- Understands that if enrollment forms are submitted for more than one plan with the same effective date, all attempted enrollments *may* be cancelled;
- Knows that the effective date is the date he/she must begin receiving care through the M+C plan; and
- Knows he/she has the right to appeal service and payment denials made by the organization.

The short enrollment form, if used by the M+C organization, must include statements that the member:

- Agrees to abide by the M+C organization's membership rules as outlined in material provided to the member, including the lock-in provisions;
- Authorizes the disclosure and exchange of necessary information with CMS; and
- Knows that the effective date is the date he/she must begin receiving care through the M+C plan.

*The model change form for elections from one M+C plan to another M+C plan within an organization, if used by the organization, must include:*

- *A description of the M+C plan option's benefits, costs, and premiums;*
- *Statements that the member understands the lock-in rules that apply under the plan; and*
- *The signature from the beneficiary or beneficiary's representative (proof of authorized representative should be on file).*

No enrollment form 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.*

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

## 40.2 - Completing the Enrollment - (Rev. 12, 08-15-02)

If the enrollment form is filled out during a face-to-face interview, the M+C 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 both Medicare Parts A and B. If the form is mailed or faxed to the M+C organization, the M+C 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 the enrollment form "complete." This list is based on the data elements contained in Exhibits 1, 2, 3 and 3a. If the M+C organization receives an enrollment form that contains all these elements, the M+C organization must consider the enrollment form complete even if all other data elements on the enrollment form are not filled out. If an M+C organization has received CMS approval for an enrollment form that contains data elements in addition to those included in Exhibit 1, 2, ,*3 and 3a,* then the election form is considered complete even if those additional elements are incomplete.

If an M+C organization receives an enrollment form that does not have all necessary elements required in order to consider the application complete, it must not deny the enrollment. Instead, the enrollment is considered incomplete and the M+C organization must follow the procedures outlined in §40.2.2 in order to complete the enrollment. Where possible, the M+C 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 M+C organization could obtain this information via available systems rather than request the information from the beneficiary.

The following should also be considered when completing an enrollment:

- **Permanent Residence Information -** The M+C organization should obtain the individual's permanent residence address to determine that he/she resides within the M+C plan's service area. If an individual puts a Post Office Box as his/her place of residence on the enrollment form, the M+C organization may consider the enrollment form 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 M+C organization should consult the State law in which the M+C 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.

- **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. For example, the M+C 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. Section 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 the individual does not provide evidence of Medicare coverage with the enrollment form and the organization is not able to obtain or verify entitlement through available systems, refer to §40.2.2 for additional procedures.

- **Effective Date of Coverage -** The M+C organization must fill out the effective date of coverage block on the enrollment form according to the effective dates outlined in §30.5. If the individual fills out the enrollment form in a face-to-face interview, then the M+C 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 M+C organization to confirm the actual effective date. The M+C 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.

  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 M+C organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face enrollments, the M+C 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 mails in an enrollment form with an unallowable prospective effective date, or if the M+C organization allowed the beneficiary to choose an unallowable prospective effective date, the M+C 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.

- **Health Related Information -** M+C organizations may not ask health screening questions during completion of the enrollment form. With the exception of elections from one M+C plan to another M+C plan in the same M+C organization, in which the M+C organization would already have this type of information, the M+C organization must obtain information on 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. Responses to 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 M+C plan.

- **Statement of Understanding -** As outlined in §20.5, a beneficiary must understand and agree to abide by the rules of the M+C plan in order to be eligible to enroll. It is at the M+C 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 to signify that the individual has read and understands the statements.

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

- **Enrollee Signature and Date -** The individual must sign the enrollment form. If the individual is unable to sign the form, a legal representative must sign the enrollment form (refer to §40.2.1 for more detail). If a legal representative signs

the form for the individual, then 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 must be attached to the form.

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

- **Other Signatures -** If the M+C organization representative, or any other person, helps the individual fill out the enrollment form, then the M+C organization representative or person must also sign the enrollment form and indicate his/her relationship to the individual. However, the M+C organization representative does not have to co-sign the form when:

    1. 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,

    2. He/she fills in the "office use only" block, and/or

    3. He/she corrects information on the enrollment form after verifying information (see "final verification of information" below).

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

- **Old Signature Dates -** If the M+C organization receives an enrollment form that was signed more than 30 calendar days prior to the M+C organization's receipt of the form, the M+C 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.

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

- **Final Verification of Information -** Some M+C organizations verify information before enrollment information has been transmitted to CMS. In these cases the M+C organization may find that it must make corrections to an individual's enrollment form. The M+C 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 M+C 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 M+C organization having to co-sign the enrollment form.

- **Completed Enrollment Forms -** Once the enrollment form is complete, the M+C 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.

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## 40.2.3 - M+C organization Denial of Enrollment - (Rev. 12, 08-15-02)

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

M+C 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, the M+C 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 form.

**Notice Requirement -** The organization must send written 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 M+C organization receives an enrollment form 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 written notice of denial within seven business days from January 7.

- An M+C 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 written notice of denial within seven business days from February 24.

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## 40.4.2 - After the Effective Date of Coverage - (Rev. 12, 08-15-02)

CMS recognizes that for some election periods, the M+C 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 SEP or an ICEP, when a completed enrollment form is received by the M+C organization, and the effective date is the first of the upcoming month. In these cases, the M+C organization should mail the member all materials described above no later than seven business days after receipt of the completed enrollment form. In these cases, the M+C organization is also strongly encouraged to call the member within one business day after the effective date to provide the effective date and explain the M+C organization rules.

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

The one 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. In this case, the M+C 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 M+C 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 M+C organization rejects an enrollment and later receives additional information from the individual showing entitlement to Medicare Part A and enrollment in Part B, the M+C organization must obtain a new enrollment form 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.

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## 40.5.1 - Procedures After Reaching Capacity - (Rev. 12, 08-15-02)

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

If an M+C organization receives completed enrollment forms 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 M+C organization process enrollments from individuals who elected the M+C plan prior to CMS's determination that the capacity has been exceeded, in order based on date of receipt of the completed enrollment form, 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 M+C organization must take the same action for all enrollment forms received. See below for procedures for following options 1 or 2.

After the enrollments discussed in the above paragraph are acted upon, the M+C organization has similar options for handling any additional enrollment requests received while the plan is closed for enrollment. The M+C 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 M+C 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 M+C 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 M+C 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 forms received in April is May 1. See below for procedures for following options 1 or 2.

**If the M+C 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 form or after the M+C organization receives approval from CMS to limit enrollment (Exhibit 7). Please note that CMS encourages M+C 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 M+C plan while waiting for the original M+C plan to re-open.

**If the M+C 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 M+C organization receives the enrollment form or after the M+C 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 M+C organization must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The M+C 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 M+C 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 M+C plan.

For individuals who indicate their continued interest in enrollment, the M+C 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 M+C 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 M+C 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 M+C plans are closed (see §40.5.2 below). Further, it must take those individuals based upon enrollments received in chronological order.

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## 50 - Disenrollment Procedures - (Rev. 12, 08-15-02)

Except as provided for in this section, an M+C organization may not, either orally or in writing or by any action or inaction, request or encourage any member to disenroll. While an M+C organization may contact members to determine the reason for disenrollment, the M+C organization must not discourage members from disenrolling after they indicate their desire to do so. The M+C 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. 12, 08-15-02)

A member may only disenroll from an M+C plan during one of the election periods outlined in §§30.0 and 30.7. The member may disenroll by:

1. Giving or faxing a signed written notice to the M+C organization;

2. *Submitting a request via Internet to* the M+C organization *(if the M+C organization offers such an option)*;

3. Giving a signed written notice to any SSA or RRB office (refer to section 5.6 for procedures for Medicare MSA plans); or

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

If a member verbally requests disenrollment from the M+C plan, as mentioned in #1 and #2 above, the M+C organization must instruct the member to make the request in writing. The M+C organization may send a disenrollment form to the member upon request (see Exhibits 9 and 10).

The disenrollment request must be date stamped when it is initially received at the M+C organization's business offices.

**Requests Submitted *via Internet***

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 *www.hcfa.gov/security/isecplcy.htm*. *However, the M+CO may also include additional security provisions. The CMS* policies indicate that with regard to receiving such *disenrollments via 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. 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 disenrollment request would be based upon the date the *request* is received by the *specified site designated by the* M+C organization.

**Request Signature and Date**

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 a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law must be attached to the request.

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 stamped date of receipt that the M+C organization places on the request form may serve as the signature date.

**Effective Dates**

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 M+C 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 M+C 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 prospective effective date, or if the M+C organization allowed the beneficiary to choose an unallowable prospective effective date, the M+C 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.

**Notice Requirements**

After the member submits a request, the M+C organization must provide the member a copy of the request for disenrollment and a disenrollment letter, and should do so within seven business days of receipt of the request to disenroll. The disenrollment letter 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 M+C 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 M+C organization, M+C 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.

Since Medicare beneficiaries have the option of disenrolling through SSA, RRB, 1-800-MEDICAR(E), or by enrolling in another Medicare managed care plan, the M+C organization will not always receive written request for disenrollment from the member and will instead learn of the disenrollment through the CMS Reply Listing Report. If the M+C organization learns of the voluntary disenrollment from the CMS reply listing (as opposed to through written request from the member), the M+C organization must send written confirmation of the disenrollment to the member, and should do so within seven business days of the availability of the reply listing (see Exhibit 12).

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

M+C 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 M+C organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

## 50.2 - Required Involuntary Disenrollment - (Rev. 12, 08-15-02)

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

- A change in residence makes the individual ineligible to be a member of the plan (§50.2.1);
- The member loses entitlement to either Medicare Part A or Part B (§50.2.2.);
- The member dies (§50.2.3); or
- The M+C organization contract is terminated, or the M+C 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.

In situations where the M+C 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 M+C 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 M+C organization's grievance procedures. (This explanation is not required if the disenrollment is a result of the M+C 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 M+C organizations.)

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

M+C 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 M+C organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

## 50.2.1 - Members Who Change Residence - (Rev. 12, 08-15-02)

**General Rule**

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

3. 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);

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. The member's temporary absence from the service area (or continuation area, for continuation of enrollment members) exceeds six consecutive months. The M+C organization may not disenroll members whose absence from the service area (or continuation area, for continuation of enrollment members) lasts for six months or less; or

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

Generally disenrollments for reasons 1 - 4 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 authorized representative*. Disenrollment for reasons 5 and 6 above is effective the first day of the calendar month after six months have passed.

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).

**NOTE:** CMS is currently in the process of developing a notice of proposed rulemaking in which we expect to address the issue of "extended enrollment" or visitor/traveler programs. Directions on this matter will be available in a subsequent update to this chapter. M+C organizations that offer a visitor/traveler benefit allowing out of area enrollment for up to 12 months at this time should contact their plan manager for further guidance.

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.

**Researching and Acting on a Change of Address**

M+C organizations may receive a notice of a change of address from the member, the member's representative, a CMS reply listing, or another source. 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.

If the M+C organization receives notice of a permanent change in address from the member or the member's 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). If the change in address is temporary (i.e., not expected to exceed six months), then the M+C organization may not initiate disenrollment. The M+C organization must retain documentation from the member or member's representative of the notice of the change in address.

If the M+C organization receives notice of a new address from a source other than the member or the member's 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 representative. CMS suggests that the M+C

organization contact the member directly or in writing to verify address information in order to determine whether disenrollment is appropriate. The M+C organization must give the member at least 20 calendar days to respond to the verification request. The M+C organization must retain documentation from the member or member's representative of the notice of the change in address, including the determination of whether the move is temporary or permanent.

- If, based on this verification, the M+C organization determines a member's move is permanent, then the M+C organization must disenroll the member and provide written notice of disenrollment to the member. The only exception is if the member has moved into and chosen the continuation of enrollment option (procedures for electing a continuation of enrollment option are outlined in §60.7).

- 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 member does not respond to the request for verification within the time frame given by the M+C organization, then the M+C organization must assume the move is not permanent and may not disenroll the member. The M+C organization may continue its attempts to verify address information with the member, but may not initiate disenrollment unless it verifies a move is permanent or until the member has been out of the service area (or continuation area, for continuation of enrollment members) for over six months from the date the M+C organization learned of the change in address.

**Notice Requirements -** The M+C organization is strongly encouraged to contact a member directly or in writing when it learns of a change of address from a source other than the member or the member's representative, in order to verify the change of address and determine whether disenrollment is necessary. The M+C organization must give the member at least 20 calendar days to respond to the request for verification.

The M+C organization must provide written notification of disenrollment to the member upon the M+C organization's learning through the member or a member's representative of the permanent move. 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.

If the member has left the service area (without having chosen a continuation area) or continuation area (for continuation of enrollment members) for six months after the date the M+C organization learned of the change in address (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. 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 notice 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 must advise the member to notify the M+C organization within 20 calendar days of the date of the notice if the information is incorrect. The notice must also state that if the member has not responded after the 20 days have passed, or if the member indicates that he/she will not be returning to the service/continuation area before the six months have passed, the M+C organization must disenroll the member effective with the first day of the month following the 20-day notice. 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.

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## 50.3.1 - Failure to Pay Premiums - (Rev. 12, 08-15-02)

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 a notice of non-payment was sent to the member. 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 from the date the first notice of non-payment is sent.**

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 following the date of the first notice, the M+C organization can 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, but the 90-day grace period still begins to run from the date the first notice was sent. Subsequent notices, therefore, should determine the expiration date of the grace period by reference to the date of the first notice.

**EXAMPLE**

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 (as the case may be) if the outstanding premium is not paid within 90 days of the date of notice, along with all premiums that become due during that 90-day period. The member fails to pay his February and March premiums, and receives a second and third notice from the M+C organization. The member pays the January premium by the April

13th, the 90th day. However, the premium payments for February, March, and April are still outstanding. The M+C organization could then terminate or reduce the member's coverage, after giving proper notice, effective May 1.

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 the first notice of non-payment is sent, 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 that the second notice was sent. (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 of the date of notice. 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 on February 15th, the date the second notice was sent. 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 on May 13th. 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 13. 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; Advise 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;
- Advise 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;
- 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 90 calendar days of the date of the initial notice, and the M+C organization policy is to disenroll the member, the M+C organization must notify the member in writing 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 90 calendar days of the date of the initial notice, and the M+C organization policy is to reduce coverage, the M+C organization must notify the member in writing prior to the effective date 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. 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.

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## 50.7 - Disenrollment Procedures for Employer Group Health Plans - (Rev. 12, 08-15-02)

When an employer group terminates its contract with an M+C organization, *or determines that an enrollee in its program is no longer eligible to participate in the employer group plan,* the M+C organization has the option to follow one of two procedures to disenroll beneficiaries. The M+C organization should outline its policy in its policy and procedures guide.

**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 M+C plan offered by the employer during the employer's open season. As with any disenrollment, the old M+C 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 M+C plan as an individual member instead of electing the new M+C plan offered by *his/her* employer. If the beneficiary is disenrolling to Original Medicare, *he/she* would submit a disenrollment request to the original

M+C organization. If the beneficiary is enrolling in a different M+C plan as an individual member, *he/she* would submit an enrollment form to *his/her* newly chosen M+C organization. As with any disenrollment, the old M+C organization is obligated to send a confirmation of disenrollment to the beneficiary.

c. If the beneficiary does not elect a new employer-contracting M+C organization, does not disenroll to Original Medicare, or does not join a new M+C plan as an individual member, the beneficiary would remain a member of the original M+C 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 the individual plan on which his/her employer group coverage was based. The M+C organization should notify the beneficiary that his/her benefits, premiums, and/or copayments are changing.

**Option 2**: If an employer group is terminating its contract with an M+C 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 M+C 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 M+C options, the beneficiary must go through the usual process to select a M+C plan by filling out an election form with his/her employer group; and

- *Provide timely notice (i.e., not retroactive) of enrollee ineligibility or contract termination to the M+C organization to facilitate the notice requirements as described below.*

The M+C 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 M+C organization.

- If the beneficiary chooses to remain as an individual member, the beneficiary would be given instructions on what action he/she would need to take to choose an available M+C plan. The M+C organization should notify the beneficiary of any benefit, premium, or copayment 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 M+C organization since these individuals are generally not allowed to join new M+C organizations.

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## 60.1 - Multiple Transactions - (Rev. 12, 08-15-02)

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 M+C, cost, or HCPP plan at any given time.

*Generally, the last election the beneficiary makes during the month will be the M+C plan the individual intends to enroll in. The beneficiary's enrollment will be based upon the date that the enrollment application was signed. If the beneficiary does not date the enrollment form, the date the enrollment form was received by the M+C organization will be used as the default date.*

*However, if an individual elects more than one plan for the same effective date and with the same signature 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 application signature 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 managed care plan in which the beneficiary was enrolled before he/she applied *to* the M+C organizations that received the multiple transaction rejections.

If a Medicare eligible individual has used M+C plan services and the enrollment is rejected for multiple transactions, then the M+C organization may bill Medicare for the services if the individual is in Original Medicare. The M+C organization may be able to bill for Medicare Part B services from the Medicare carrier, and its certified M+C plan providers may be able to bill the Medicare fiscal intermediary for Medicare Part A services. *M+C 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 M+C organization may contact the individual to determine in which M+C plan the individual wishes to enroll. Once the individual has chosen one M+C plan, he/she must either fill out and sign another enrollment form or send written notice of his/her intent to enroll in the plan . The M+C 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 M+C organizations (M+COs) receive completed enrollment forms from one individual on May 20th for a June 1st effective date. The form received by M+CO #1 was signed on May 10th and the form received by M+CO #2 was signed on May 12th. Both M+COs submit enrollment transactions, including the applicable signature date. The enrollment in M+CO #2 will be the transaction that is accepted and will be effective on June 1st.*

- Two M+C organizations receive completed enrollment forms from one individual on August 15 for a September 1 effective date. Both elections are transmitted by the August cutoff date and are subsequently rejected, and the individual fills out a new enrollment form for the M+C plan of choice. If that completed enrollment form is received by the M+C organization no later than August 31, then the effective date of coverage is September 1.

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## 60.2.1 - Cancellation of Enrollment - (Rev. 12, 08-15-02)

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 M+C 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, then the organization should contact the CMS RO in order to cancel the enrollment.

When cancelling an enrollment the M+C 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 7 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 M+C 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 M+C organization if he/she wishes to remain a member of the M+C plan in that M+C organization.

If the member's request for cancellation occurs after the effective date of the enrollment, then the cancellation cannot be processed. The M+C organization must inform the member that he/she is a member of its M+C plan. If he/she wants to get back into the other M+C plan he/she will have to fill out an enrollment form to enroll in that M+C 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 in writing with the M+C organization, SSA, or the RRB, or to call 1-800-MEDICAR(E). 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. 12, 08-15-02)

A member's disenrollment can only be cancelled if the request is made prior to the effective date of the disenrollment.

To ensure the cancellation is honored, the M+C 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, then the organization should contact the CMS RO in order to cancel the disenrollment.

The M+C organization must send a letter to the member that states that the cancellation is being processed and instructs the member to continue using M+C plan services *(see Exhibit 26). This notice should be sent within 7 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 M+C organization should instruct the member to fill out and sign a new enrollment form to re-enroll with the M+C organization during an election period (described in §30), and with a current effective date, using the appropriate effective date as prescribed in §30.5.

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## 60.3.2 - Reinstatements Due to Mistaken Disenrollment Made By Member - (Rev. 12, 08-15-02)

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 M+C organization, which resulted in *an erroneous* automatic disenrollment from the

original M+C organization in which he/she was enrolled, and who was able to cancel the enrollment in the second M+C organization (as outlined in §60.2.1). *When a cancellation of enrollment in a second M+C organization is properly made, the associated automatic disenrollment from the first M+C organization becomes invalid. Generally*, these reinstatements will 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)* M+C 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 M+C organization to state that he/she mistakenly disenrolled, and states that he/she wants to remain a member of the M+C plan, then the M+C organization must instruct the member to notify the M+C organization in writing of the desire to remain enrolled in the plan within 30 calendar days. Regardless of whether the request for reinstatement is verbal or in writing, the M+C organization must also instruct the member as soon as possible to continue to use M+C plan services (refer to Exhibit 17 for a model letter).

If the M+C 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 M+C organization.

To request reinstatement from the CMS RO, the M+C 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 M+C 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 M+C plan and has not used non-plan services (except for emergency or urgently needed services).

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## *Appendix 1: Summary of Notice Requirements (3 Pages)*

*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* |
|---|---|---|---|
| *Individual Enrollment Form (Exh. 1)* | *10, 40.1, 40.2, 40.4.1* | *Yes* | *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 Form (Exh. 4)* | *40.4.1, 60.4* | *Yes* | *Before effective date, or if late in election period, 7 business days of receipt of completed enrollment form* |
| *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* |
| *M+CO 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. 9-10)* | *50.1* | *No* | *NA* |
| *Acknowledgment of Receipt of Voluntary Disenrollment Request from Member (Exh. 11)* | *50.1, 50.4.1* | *Yes* | *7 business days of receipt of written request to disenroll* |
| *Final Confirmation of Voluntary Disenrollment Request from Member (no exhibit)* | *50.1* | *No* | *NA* |

| *Notice* | *Section* | *Required?* | *Timeframe* |
|---|---|---|---|
| *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* |
| *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 exhibit)* | *50.3.2* | *Yes* | *NA* |
| *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* |

| *Notice* | *Section* | *Required?* | *Timeframe* |
|---|---|---|---|
| *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 M+C 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 M+C organization* |
| *Failure to Pay Plan Premiums - Advanced Notification of Disenrollment or Reduction in Coverage (Exh. 19)* | *50.3.1* | *Yes* | *Within 20 days after 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* | *NA* |
| *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 (Exh. 23)* | *40.5* | *Yes* | *30 calendar days before closure (15 days if related to CMS approved capacity limit)* |
| *Notice that Election Placed on Waiting List* | *40.5.1, 40.5.2* | *Yes* | *7 business days of receiving enrollment form or of approval from CMS to limit enrollment* |
| *Re-affirming Intent to Not Enroll* | *40.5.1, 40.5.2* | *No* | *NA* |
| *Intent to Not Process Enrollment* | *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* |

| Notice | Section | Required? | Timeframe |
|---|---|---|---|
| *Request to Cancel Disenrollment (Exh. 26)* | *60.2.2* | *Yes* | *7 business days of request* |

## *Appendix 2: Data Elements Required to Complete the Enrollment Form (2 Pages)*

*Referenced in section(s): 20, 20.4, 40.2*

*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 | M+C Plan name | Yes | 1, 2, 3, 3a |
| 2 | Effective date of coverage | No[1] | 1, 2, 3, 3a |
| 3 | Beneficiary name | Yes | 1, 2, 3, 3a |
| 4 | Beneficiary Medicare number | Yes | 1, 2, 3 |
| 5 | Beneficiary Date of Birth | Yes | 1, 2 |
| 6 | Beneficiary Sex | Yes | 1, 2 |
| 7 | Permanent Residence Address | Yes | 1, 2, 3 |
| 8 | Mailing Address | No | 1, 2, 3 |
| 9 | Beneficiary Telephone Number | No | 1, 2, 3 |
| 10 | Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field) | No | 1, 2 |

[1] While it is true the effective date must be established in order to complete the election, it is not the beneficiary who fills out this data element. As indicated in section 40.2, the effective date of coverage is filled in by the M+C organization. Therefore, the "no" in this column is simply intended to mean that the beneficiary does not have to fill in this data element in order to complete the election.

| | Data Element | Required before enrollment complete? | Exhibit # in which data element appears |
|---|---|---|---|
| *11* | *Language preferences (Optional Field)* | *No* | *1, 2* |
| *12* | *Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)* | *No* | *2* |
| *13* | *Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents* | *No* | *2* |
| *14* | *Medicare information contained on sample Medicare card, or copy of card* | *No*[2] | *1, 2* |
| *15* | *M+C Plan/Product choice* | *Yes* | *1, 2, 3a* |
| *16* | *M+C Product/Premium Choice* | *Yes* | *3* |
| *17* | *Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number* | *No* | *2* |
| *18* | *Name of chosen Primary Care Physician, clinic or health center (Optional Field)* | *No* | *1, 2, 3* |
| *19* | *Beneficiary signature and/or Beneficiary Representative Signature* | *Yes* | *1, 2, 3,3a* |
| *20* | *Signature and Relationship of any individual who helped beneficiary fill out form (if applicable)* | *Yes* | *1, 2, 3, 3a* |
| *21* | *Date of signatures* | *No*[3] | *1, 2, 3, 3a* |

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[2] As stated in section 40.2, an M+C organization may 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 M+C organization has obtained evidence of entitlement to Medicare Part A and enrollment in Part B. We recognize that the M+C 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.

[3] As explained in section 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,

| | Data Element | Required before enrollment complete? | Exhibit # in which data element appears |
|---|---|---|---|
| *22* | *Response to question 1 on page 3 ("Please read and answer these questions")* | *Yes* | *1, 2* |
| *23* | *Response to questions 2 - 5 on page 3 ("Please read and answer these questions")* | *No* | *1, 2* |
| *24* | *Initials/annotation next to all statements on page 4 ("Please read these sentences and put your initials next to them")* | *M+CO decision*[4] | *1, 2* |
| *25* | *Employer Name and Group Number* | *Yes* | *2* |
| *26* | *Question of which M+C plan/premium the beneficiary is currently a member of and to which M+C plan/premium the beneficiary is changing* | *Yes* | *3* |

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then the stamped date of receipt that the M+C organization places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is not a necessary element.

[4] As explained in section 40.2, the M+C organization should decide whether it will require the beneficiary□s initials on this section of the form or consider the beneficiary signature to be adequate. If initials are required, Item #24 must be completed by the beneficiary. If the M+C organization uses the signature and not initials, Item #24 need not be completed by the beneficiary.

## *Appendix 3: Timeframes for Required Enrollment & Disenrollment Monitoring Elements*

*To be added in a future update.*

## *Exhibit 1: Model Individual Enrollment Form ("Election" may also be used) (4 Pages) - (Rev. 12, 08-15-02)*

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 Information:**

Please fill in these blanks so they look the same as what is on your Medicare card. You need to fill this out, or you can attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

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

**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)

**Your Medicare +Choice plan choice :**

**Please check which product you want to enroll in:** [Optional field for plans with 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 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 the individual fill out this form, s/he must sign the following line:

Signature _____ Date: _____ Relationship to Individual:

**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 can not 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 <u>not</u> 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/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 will be cancelled 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 (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). 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:_____

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## *Exhibit 3: Model Short Enrollment Form ("Election" may also be used) (2 Pages) - (Rev. 12, 08-15-02)*

This form may be used in place of the model individual enrollment form when a member of a M+C plan is enrolling into another M+C plan in the same M+CO

Referenced in section(s): 10, 20.4, 40, 40.1

**If you are changing plans within {M+CO name} you should use this form. This form may not be used to enroll in {M+CO name} for the first time.**

**Name of Plan You are Enrolling In**:

**Name**: _____ **Medicare Number:**

(Note: may use "member number" instead of "Medicare number")

**Permanent 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

**Please fill out the following:**

I am currently a member of the _____ plan in _____{M+CO name} with a monthly premium of $_____ .

I would like to change to the _____ plan in _____ {M+CO name}. I understand that this plan has different health benefits and a monthly premium of $ _____ .

Have you recently **moved** into this plan's service area? Yes_____ No_____

Have you **changed** your Medicare coverage in the past 6 months? Yes _____ No _____

Optional field, if M+CO will require the member to name a new PCP:

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

**Release of Information:** By joining this plan, I allow the Centers for Medicare &Medicaid Services 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.

**<u>Lock-In:</u> I understand that, beginning on the date my Medicare+Choice plan coverage begins, I must get all of my health care from my new 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 plan 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.

Enrollee's Signature*_____ Date:

*If the individual is unable to sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law, must sign the following line. **Attach a copy of the proof of Legal Guardian, DPAHC, or proof of authorization by state law**

Signature _____ Date: _____

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

Signature _____ Date: _____ Relationship to Beneficiary: _____

**Office Use Only:**
Plan ID #:_____
Effective Date of Coverage:_____
ICEP:_____ OEP:_____ AEP:_____ SEP(type):_____

## *Exhibit 3a - Model Selection Form - Switch from plan to plan within M+CO - (Rev. 12, 08-15-02)*

*Referenced in section(s): 10, 40, 40.1, 40.2*

*Dear <plan name> Member:*

*<Introduction - In the introduction of cover letter, M+CO may include language regarding plan choices, description of plans, differences, etc.>.*

*If you wish to make a change in the M+C plan you have with <name of M+CO> just fill out the enclosed plan benefit selection form to make your choice. Remember to check off which of the plans you want and sign the form. Then mail the completed form back to us <optional: in the postage-paid envelope> by <date>.*

*If you select another and we receive your completed selection form by <date>, your new benefit plan will begin in <month/year>. Your monthly plan premium will <insert premium> and you may continue to see any <current plan> primary care doctors and specialists.*

*The attached form should only be completed 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 > or, for the hearing impaired, at <TDD/TTY number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}. Thank you.*

# *Plan Benefit Selection Form*

*Date:*

*Member Name:*

*Member Number:*

*I wish 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, it generally will 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. )*

*Signature:*_____ *Date:*_____

***Please mail this form to:***

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## *Exhibit 6: Model Notice to Confirm Enrollment - (Rev. 12, 08-15-02)*

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

This letter is to tell you that the Center*s* for Medicare *&* Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <M+C Plan>, beginning <effective date>.

As we said in a letter we gave you before, now that your enrollment is confirmed, 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 + Choice plan, you may have a trial period during which you have certain rights to disenroll from <M+C Plan> and purchase a Medigap policy. Please contact 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for further information.)

Please feel free to call our Member Services at <phone number> or, for the hearing impaired, at <TDD/TTY number> if you have any questions. We are open <days and hours of operation>.

## *Exhibit 6a: Model Notice to Confirm Enrollment - plan to plan within M+CO (Rev. 12, 08-15-02)*

*Referenced in section(s): 40.40.2, 40.6*

*Dear <Name of Member>:*

*This letter is to tell you that the Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <M+C Plan>, beginning <effective date>.*

*Please feel free to call our Member Services at <phone number> or, for the hearing impaired, at <TDD/TTY number> if you have any questions. We are open <days and hours of operation>.*

## *Exhibit 7: Model Notice for M+CO Denial of Enrollment - (Rev. 12, 08-15-02)*

Referenced in section(s): 40.2.3

Dear <Name of Beneficiary>:

Thank you for applying for membership in <M+C Plan>. We cannot accept your application for enrollment in <M+C 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. _____ We did not receive the information we requested from you within 30 days of our request.

Medicare MSA plans add #*6*:

*6.* _____ National enrollment in Medicare Medical Savings Accounts has reached the maximum amount allowed under law

If we checked item 1 or 2, and it is correct, then we will send you a bill for any services you received. If we checked anything else and it is correct, then we may send you a bill for any services you received.

If what we checked is wrong, or if you have any questions, please call us at <phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

## *Exhibit 8: Model Notice for CMS Rejection of Enrollment - (Rev. 12, 08-15-02)*

Referenced in section(s): 40.4.2

Dear <Name of Beneficiary>:

Thank you for your recent application to <M+C Plan>. We are sorry to say that the Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has denied your enrollment in <M+C 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 signed a form to enroll in a different plan for the same effective date, which canceled your application with <M+C Plan>. This may mean that you are still enrolled in the Original Medicare Plan or in the Medicare +Choice plan that you were enrolled in before you applied for membership in our plan.

If we checked number 1 or 2, and it is right, then we will send you a bill for any services you received from us.

If we checked number 3 or 4, and it is right, then we may send you a bill for any services you received from us.

If what we checked is not right, or if you have any questions, please call us at <phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

## *Exhibit 9: Model Notice to Send Out Disenrollment Form - (Rev. 12, 08-15-02)*

Referenced in section(s): 50.1

Dear <Name of Member>:

Attached is the disenrollment form you asked for. Please fill out the whole form, sign it, and send it back to us in the enclosed envelope, or mail it to your local Social Security Office or Railroad Retirement Board Office. You can also fax it to us, as long as the signature and date are readable. Our fax number is <fax number>. You can also disenroll by calling 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

You must keep using <M+C Plan> doctors until your disenrollment date. 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 <M+C plan>'s network. We will mail a copy of the disenrollment form back to you with the date of your disenrollment written on the form.

You might be in a trial period if you have been enrolled in <M+C Plan> less than 12 months and you have never before been enrolled in another Medicare+Choice plan OR if you enrolled in <M+C plan> immediately after losing coverage under another health plan, and you were still in a trial period under the other plan when you lost coverage. Call 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for more information about trial periods.

**IMPORTANT NOTE ABOUT MEDIGAP RIGHTS**

If you return to Original Medicare, and any of the following situations apply to you, you might have a guaranteed right to buy a Medicare supplement (Medigap) insurance policy, even if you have health problems.

- **Trial Periods -** If you are in a trial period and you disenroll from <M+C Plan> before the trial period ends.
- **Moving -** If you move out of the <M+C Plan>'s service area.
- **Medigap Open Enrollment -** If you are age 65 or older and you enrolled in Part B within the past 6 months, federal law guarantees your right to purchase any Medigap policy sold in your State.
- ***Medicaid*** *- If you are receiving, or no longer receiving, financial assistance from the State (Medicaid) to pay for your Medicare premiums.*
- *Other special circumstances defined by Medicare.*

*You might be in a trial period if you have been enrolled in <M+C Plan> less than 12 months and you have never before been enrolled in another Medicare+Choice plan, OR you enrolled in <M+C plan> immediately after losing coverage under another health plan, and you were still in*

*a trial period under the other plan when you lost coverage. Call 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for more information about trial periods.*

Under Federal law, if you are in a trial period or you move out of the service area, you will need to apply for a Medigap policy no later than 63 days after you disenroll from <M+C Plan>. If you are still within your six-month open enrollment period, you must apply before the period ends.

**Your State may have laws that provide additional Medigap protections.** Contact your State Health Insurance Program <insert name of SHIP> to get more information about open enrollment and trial periods; the availability of Medigap insurance in your State; which policies you have the right to buy; the rules you must follow when applying for a policy; and any more generous protections that may apply under State law.

**Your enrollment in a Medigap policy is not automatic.** You must contact an insurance company that sells Medigap insurance and request an application.

If you need any help, please call us at <phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Attachment

## *Exhibit 10: Model Disenrollment Form - (Rev. 12, 08-15-02)*

Referenced in section(s): 10

**NOTE TO BENEFICIARY:** If you have already joined or intend to join a new Medicare managed care plan, you do not have to complete this form.

DATE_____

(Please Print in Ink)
Member's Name _____
First Middle Last
Address_____
City State Zip County
Telephone _____
Male _____ Female_____ Date of Birth_____
Medicare #_____

DISENROLLMENT RESPONSIBILITIES: **Please carefully read and complete the following information before signing and dating this disenrollment form:**

Upon the effective date of enrollment in another Medicare managed care plan, your current membership in <M+C plan name> will automatically be canceled.

Members who have requested disenrollment must continue to receive all medical care from <M+C plan name> until the effective date of disenrollment. To avoid any unanticipated expenses, you may want to contact us to verify your disenrollment before you seek medical services outside of <M+C plan>'s network. We will notify you of your effective date after we have received this form from you.

Requested disenrollment date:_____

_____ _____

Beneficiary Signature Date

OR

_____ _____

Beneficiary Guardian Signature Date

## *IMPORTANT NOTE ABOUT MEDIGAP RIGHTS*

If you return to Original Medicare, and any of the following situations apply to you, you might have a guaranteed right to buy a Medicare supplement (Medigap) insurance policy, even if you have health problems.

- **Trial Periods -** If you are in a trial period and you disenroll from <M+C Plan> before the trial period ends.
- **Moving -** If you move out of the <M+C Plan>'s service area
- **Medigap Open Enrollment -** If you are age 65 or older and you enrolled in Part B within the past 6 months, federal law guarantees your right to purchase any Medigap policy sold in your State.
- ***Medicaid*** *- If you are receiving, or no longer receiving, financial assistance from the State (Medicaid) to pay for your Medicare premiums.*
- *Other special circumstances defined by Medicare.*

*You might be in a trial period if you have been enrolled in <M+C Plan> less than 12 months and you have never before been enrolled in another Medicare+Choice plan, OR you enrolled in <M+C plan> immediately after losing coverage under another health plan, and you were still in a trial period under the other plan when you lost coverage. Call 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for more information about trial periods.*

You might be in a trial period if you have been enrolled in <M+C Plan> less than 12 months and you have never before been enrolled in another Medicare+Choice plan, OR you enrolled in <M+C plan> immediately after losing coverage under another health plan, and you were still in a trial period under the other plan when you lost coverage. Call 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for more information about trial periods.

Under Federal law, if you are in a trial period or you move out of the service area, you will need to apply for a Medigap policy no later than 63 days after you disenroll from <M+C Plan>. If you are still within your six-month open enrollment period, you must apply before the period ends.

**Your State may have laws that provide additional Medigap protections.** Contact your State Health Insurance Program <insert name of SHIP> to get more information about open enrollment and trial periods; the availability of Medigap insurance in your State; which policies you have the right to buy; the rules you must follow when applying for a policy; and any more generous protections that may apply under State law.

**Your enrollment in a Medigap policy is not automatic.** You must contact an insurance company that sells Medigap insurance and request an application

If you need any help, please call us at <phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Attachment

## *Exhibit 11: Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member - (Rev. 12, 08-15-02)*

Referenced in section(s): 50.1, 50.4.1

Dear <Name of Beneficiary>:

We received your request to disenroll from <M+C Plan> and you will be disenrolled starting <effective date.> Beginning <effective date>, <M+C Plan> will not cover any health care you receive.

Until <effective date>, you must keep using <M+C Plan> doctors, except for emergencies and urgently needed care and out-of-area dialysis services. Beginning <effective date>, you can see any doctor through the Original Medicare Plan, unless you have enrolled in another Medicare+Choice plan.

Please be patient. It will take a few weeks for us to process your disenrollment and update Medicare's records. You may want to tell your doctors that if they need to send Medicare claims, you just disenrolled from <M+C Plan> and there may be a short delay in having your records updated.

**IMPORTANT NOTE ABOUT MEDIGAP RIGHTS**

If you return to Original Medicare, and any of the following situations apply to you, you might have a guaranteed right to buy a Medicare supplement (Medigap) insurance policy, even if you have health problems.

- **Trial Periods -** If you are in a trial period and you disenroll from <M+C Plan> before the trial period ends.
- **Moving -** If you move out of the <M+C Plan>'s service area.
- **Medigap Open Enrollment -** If you are age 65 or older and you enrolled in Part B within the past 6 months, federal law guarantees your right to purchase any Medigap policy sold in your State.
- **Medicaid -** If you are receiving financial assistance from the State (Medicaid) to pay for your Medicare premiums.
- Other special circumstances defined by Medicare.

You might be in a trial period if you have been enrolled in <M+C Plan> less than 12 months and you have never before been enrolled in another Medicare+Choice plan, OR you enrolled in <M+C plan> immediately after losing coverage under another health plan, and you were still in a trial period under the other plan when you lost coverage. Call 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for more information about trial periods.

Under Federal law, if you are in a trial period or you move out of the service area, you will need to apply for a Medigap policy no later than 63 days after you disenroll from <M+C Plan>. If you are still within your six-month open enrollment period, you must apply before the period ends.

**Your State may have laws that provide additional Medigap protections.** Contact your State Health Insurance Program <insert name of SHIP > to get more information about open enrollment and trial periods; the availability of Medigap insurance in your State; which policies you have the right to buy; the rules you must follow when applying for a policy; and any more generous protections that may apply under State law.

**Your enrollment in a Medigap policy is not automatic.** You must contact an insurance company that sells Medigap insurance and request an application.

If you need any help, please call us at <phone number> or, for the hearing impaired, at <TDD/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. 12, 08-15-02)*

Referenced in section(s): 50.1, 50.4.1, 60.3.2

Dear <Name of Beneficiary>:

This is to confirm your disenrollment from <M+C Plan.> This disenrollment began <effective date,> and <M+C Plan> will not cover any health care you receive after that date. Please note that you may want to tell your doctors that if they need to send Medicare claims, you just disenrolled from <M+C Plan> and there may be a short delay in having your records updated.

## *IMPORTANT NOTE ABOUT MEDIGAP RIGHTS*

If you return to Original Medicare, and any of the following situations apply to you, you might have a guaranteed right to buy a Medicare supplement (Medigap) insurance policy, even if you have health problems.

- **Trial Periods**. If you are in a trial period and you disenroll from <M+C Plan> before the trial period ends.
- **Moving.** If you move out of the <M+C Plan>'s service area.
- **Medigap Open Enrollment.** If you are age 65 or older and you enrolled in Part B within the past 6 months, federal law guarantees your right to purchase any Medigap policy sold in your State.
- **Medicaid**. If you are receiving*, or no longer receiving,* financial assistance from the State (Medicaid) to pay for your Medicare premiums.
- Other special circumstances defined by Medicare.

You might be in a trial period if you have been enrolled in <M+C Plan> less than 12 months and you have never before been enrolled in another Medicare+Choice plan, OR you enrolled in <M+C plan> immediately after losing coverage under another health plan, and you were still in a trial period under the other plan when you lost coverage. Call 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) for more information about trial periods.

Under Federal law, if you are in a trial period or you move out of the service area, you will need to apply for a Medigap policy no later than 63 days after you disenroll from <M+C Plan>. If you are still within your six-month open enrollment period, you must apply before the period ends.

**Your State may have laws that provide additional Medigap protections.** Contact your State Health Insurance Program <insert name of SHIP > to get more information about open enrollment and trial periods; the availability of Medigap insurance in your State; which policies

you have the right to buy; the rules you must follow when applying for a policy; and any more generous protections that may apply under State law.

**Your enrollment in a Medigap policy is not automatic.** You must contact an insurance company that sells Medigap insurance and request an application.

If you think you did not disenroll from <M+C 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 <TDD/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 13: Model Notice of Disenrollment Due to Death - (Rev. 12, 08-15-02)*

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 Center*s* 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 <M+C Plan> has ended as of <effective date>. If membership premiums were paid for any month after <effective date>, we will refund the Estate within 30 days of this letter.

If this information is wrong, please call us at <phone number> or, for the hearing impaired, at <TDD/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. 12, 08-15-02)*

Referenced in section(s): 50.2.2, 50.4.2, 60.3.1

Dear <Name of Member>:

We have been told by the Centers for Medicare & Medicaid Services (CMS) that you no longer have Medicare Part <insert A and/or B, as appropriate (cost plans may only insert "B")> insurance. Therefore, your membership in <M+C Plan> was ended beginning <date>. If this information is wrong, and you want to keep being a member of our plan, please contact us right away so we can make sure you stay a member of our plan. 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> or, for the hearing impaired, at <TDD/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. 12, 08-15-02)*

Referenced in section(s): 60.3, 60.3.1

Dear< Name of Member>:

The Center*s* for Medicare *&* Medicaid Services has told us that their records show that you have a deceased status. But, based on our contact with you, we understand that you are alive! Obviously, there has been an error.

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 <M+C Plan> written proof once this is done. When we receive this proof, we will tell the Center for Medicare and Medicaid Services to correct its records.

In the meantime, 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 any questions or need help, please call us at < phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>.

## *Exhibit 16: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination - (Rev. 12, 08-15-02)*

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 keep being a member of <M+C Plan>. As we told you, you will need to contact the Social Security Administration (SSA) to have them fix their records. You will also need to have SSA give you a letter that says the records have been fixed. Then, send the letter from SSA to us at: <address of M+C Plan>. A postage-paid envelope has been provided for your convenience. When we receive this proof,we will tell the Centers for Medicare & Medicaid Services to correct its records.

In the meantime, 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 enrollment in the <M+C Plan>. In the event that 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> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>.

## *Exhibit 19: Model Notice on Failure to Pay Plan Premiums - Advanced Notification of Disenrollment or Reduction in Coverage - (Rev. 12, 08-15-02)*

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+COs who will disenroll all members (and not use the downgrade option) use the following sentence:** If we do not get payment by <90 days from date of this letter>, we will have to disenroll you from <M+C Plan>. After the disenrollment you will be covered by the Original Medicare plan instead of <M+C Plan>. **Note: As required in section 50.3.1, the M+CO must state whether full payment of premiums is due to prevent disenrollment.**

**M+COs 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>. What this means is 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+CO must state whether full payment of premiums is due to prevent the downgrade.**

If you *are eligible* to disenroll from <M+C Plan> *to Original Medicare* now, you must tell us in writing and send your request to <M+C Plan address>. Or, you may disenroll by contacting your local Social Security District Office or Railroad Retirement Board Office, or by calling 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

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> or, for the hearing impaired, at <TDD/TTY number> between <days and hours of operation>.

## *Exhibit 20: Model Notice on Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment - (Rev. 12, 08-15-02)*

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 disenroll you from <M+C Plan>. Unfortunately, since we did not receive that payment, we have asked the Centers for Medicare & Medicaid Services to disenroll you from <M+C Plan> beginning <date>.

Due to your disenrollment from <M+C Plan>, you are now covered by the Original Medicare plan.

You have the right to ask us to re-think this decision through the grievance procedure written in your Member Handbook.

Please note that until <disenrollment effective date>, you must keep using <M+C 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 another Medicare managed care plan.

If you think that we have made a mistake or if you have any questions, please call us at <phone number> or, for the hearing impaired, at <TDD/TTY number> between <days and hours of operation>.

## *Exhibit 21: Model Notice on Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment - (Rev. 12, 08-15-02)*

Referenced in section(s): 50.3.1

Dear <Name of Beneficiary>:

We have received confirmation from the Centers for Medicare & Medicaid Services, the federal agency that runs the Medicare program, of your disenrollment from <M+C Plan> due to non-payment of plan premium. Your disenrollment begins <effective date>.

Due to your disenrollment from <M+C Plan>, you are now covered by the Original Medicare plan.

You have the right to ask us to re-think your disenrollment through the grievance procedure written in your Member Handbook.

If you have any questions about this action, or need help in any way, please call us at <phone number> or, for the hearing impaired, at <TDD/TTY number> between <days and hours of operation>.

## *Exhibit 22: Model Notice on Failure to Pay Plan Premiums --Notice of Reduction in Coverage - (Rev. 12, 08-15-02)*

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 <M+C Plan>. Our records show that we did not get payment from you as of <Date>. Therefore, we have reduced your coverage in <M+C Plan>, beginning <effective date.>

Your new benefits <Explain lower level of benefits, e.g., prescription drugs or routing dental care will not be covered>

*Please note that unless you disenroll from <M+C Plan>, you must keep using <M+C Plan> doctors except for emergency or urgently needed care or out-of-area dialysis services.*

If you want to disenroll from <M+C Plan> now, you must tell us in writing and send your request to <M+C Plan address>. Or, you may disenroll by contacting your local Social Security District Office or by calling 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

If you think we have made a mistake, or if you have any questions, please call us at <phone number> or, for the hearing impaired, at <TDD/TTY number> between <days and hours of operation>.

## *Exhibit 25 - Acknowledgement of Request to Cancel Enrollment - (Rev. 12, 08-15-02)*

*Referenced in section(s): 60.2.1*

*Dear <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 Original Medicare, you may want to tell your providers that if they need to submit Medicare claims for any health care you received from them, there may be a short delay in having your records updated.*

*If you were enrolled in another Medicare+Choice 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 (xxx)xxx-xxxx or TDD (xxx)xxx-xxxx, Monday through Friday between the hours of <hours>.*

## *Exhibit 26 - Acknowledgement of Request to Cancel Disenrollment - (Rev. 12, 08-15-02)*

*Referenced in section(s): 60.2.2*

*Dear <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>.*

*Please be patient. It may take up to 45 days for Medicare to update your records. You may want to tell your providers that if they need to submit Medicare claims for any health care you received from them, there may be a short delay in having your records updated.*

*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 maintain enrollment in <our plan>, you will need to notify them that you are cancelling enrollment in their plan. They may request you write them a letter for their records.*

*If you have any questions, please contact <plan> customer service at (xxx)xxx-xxxx or TDD (xxx)xxx-xxxx, Monday through Friday between the hours of <hours>.*