Medicare
Managed Care Manual

Department of Health and Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Transmittal No 6 **Date: JANUARY 15, 2002**

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
Manual Table of Contents			
Table of Contents			
2		10 - 60.9	---
Exhibits		1 - 26	---

NEW/REVISED MATERIAL --EFFECTIVE DATE: Not Applicable

IMPLEMENTATION DATE: Not Applicable

Chapter 2, Medicare + Choice Enrollment and Disenrollment, this chapter replaces policy in OPL 100, OPL 104, OPL 105, OPL 109, OPL 111, OPL 113, OPL 122, and OPL 123.

These instructions should be implemented within your current operating budget.

NOTE: Normally red italicized font identifies new material. However, because this is a new chapter, normal text font is used for the initial release.

Medicare Managed Care Manual

Table of Contents

Manual Transmittals through Transmittal Number 4 are included in this update. As new transmittals are included they will be identified on this page. To review individual transmittal cover pages click here.

Medicare Managed Care Manual

Chapter 2 - Medicare+Choice Enrollment and Disenrollment

Table of Contents

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

10 - Definitions

(Rev. 6, 01-15-02)

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+CO) (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 Exhibit 25 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+CO may also choose to wait for the individual's payment of the plan premium, including any premiums due the M+CO 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+COs should conduct the required activities within the time frames specified by the State. If no time frame is specified, then the M+CO 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+CO 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+CO furnishes or arranges for furnishing of services to the M+C plan's continuation of enrollment members. M+COs have the option of establishing continuation areas.

Conversions - When 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+CO 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+CO, 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) to make the election in place of the comprehensive individual enrollment form. In addition, M+COs may want to collaborate with 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. 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+CO 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+CO 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+CO, 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+CO) - Refer to Chapter 1 (General Administration of the Managed Care/Medicare+Choice Program) for a definition of a M+C organization (M+CO)."

M+CO Error - An error or delay in election processing made under the full control of the M+CO personnel, and 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+CO 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+CO. An election is considered received and must be date stamped by the M+CO when the M+CO (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+CO. The rejection could be due to the M+CO 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. 6, 01-15-02)

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 Exhibit 25 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+CO that were provided during the election process; and

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

An M+CO 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.

20.1 - Entitlement to Medicare Parts A and B

(Rev. 6, 01-15-02)

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

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

While desirable, it is not necessary for an individual to prove Medicare Part A entitlement or Part B enrollment **at the time** he/she completes the enrollment form, i.e., the M+CO may not deny the enrollment if the individual does not have the evidence when filling out the enrollment form or does not include it with the form when he/she mails it to the organization. However, the organization may consider the enrollment form to be incomplete until it can verify such entitlement or enrollment. Section 40.2.2 provides more information on the steps the organization can take to verify Medicare coverage. In addition, the definition of "Evidence of Part A and Part B Coverage" in §10 lists some of the type of information that can be used to verify coverage.

20.2 - End Stage Renal Disease (ESRD)

(Rev. 6, 01-15-02)

Except as provided under exceptions discussed below, an individual is not eligible to elect an M+C plan if he/she has been medically determined to have ESRD.

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

The M+CO is permitted to ask at the time of the election whether the applicant has ESRD. This question is not considered impermissible health screening since the law does

not permit a person with ESRD to elect an M+C plan, except as provided in the following paragraphs. An M+CO must deny enrollment to any individual medically determined to have ESRD, except as provided in the following paragraphs. CMS will reject the enrollment if Medicare records indicate the applicant has ESRD, and no exception permitting enrollment applies.

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

20.2.1 - Background on ESRD Entitlement

(Rev. 6, 01-15-02)

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

- The first day of the third month after the month dialysis begins (i.e., the first day of the fourth month of dialysis), or
- The first day of the month dialysis began if the individual trains for self-dialysis, or
- Up to 12 months prior to the month of filing (if dialysis began more than 12 months before) or
- Prospectively.

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

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

EXAMPLE:

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

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

Individuals sometimes elect a prospective effective date to coordinate with the end of their 30-month coordination period. In the case of an **individual in a group health plan**,

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

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

20.2.2 - Exceptions to Eligibility Rule for Persons Who Have ESRD

(Rev. 6, 01-15-02)

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

- **Conversions other than ICEP:**

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

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

    2. Individuals who are members of a group health plan and are in their 30-month coordination period will have the opportunity to elect an M+C plan at any time during this 30-month period if certain conditions are met. The individual must have been a member of a health plan offered by the M+C organization the month before his/her entitlement to Parts A and B, and must continue to be enrolled in that health plan. The individual must also choose to elect an M+C plan offered by that M+C organization, and must meet all other M+C eligibility requirements.

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

- An individual who elects an M+C plan and who is medically determined to first have ESRD **after** the date on which the enrollment form is signed (or receipt date stamp if no date is on the form, per §40.2), but **before** the effective date of coverage under the plan is still eligible to elect the plan.

- An individual who develops ESRD while enrolled in an M+C plan may continue to be enrolled in the M+C plan.

- Once enrolled in an M+C plan, a person who has ESRD may elect other M+C plans in the same M+CO (and during allowable election periods, as described under §30.0). However, the member would not be eligible to elect an M+C plan in a different M+CO or a plan in the same M+CO in a different State (with exceptions).

- An individual with ESRD whose enrollment in an M+C plan was terminated on or after December 31, 1998 as a result of a contract termination, non-renewal, or service area reduction can make one election into a new M+C plan following such termination. The individual must meet all other M+C eligibility requirements, and must enroll during an M+C election period. Once an individual has exhausted his one election, he will not be permitted to join another M+C plan, unless his new plan is terminated.

20.3 - Place of Permanent Residence

(Rev. 6, 01-15-02)

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

EXCEPTIONS

- A member who permanently moves from the service area of the M+C plan to an approved continuation area of the M+CO, and who chooses the continuation of enrollment option offered by the M+CO, may continue to be enrolled in the M+C plan (refer to §60.7 for more detail on the requirements for the continuation of enrollment option).

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

- A member who was enrolled in an M+C plan covering the area in which the member permanently resides at the time the plan was terminated in that area, may

remain enrolled in the M+C plan while living outside the plan's new reduced service area if:

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

2. The M+CO offers this option; and

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

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

Individuals who do not meet the above requirements may not elect the M+C plan. The M+CO must deny enrollment to these individuals.

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

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

20.4 - Completion of Enrollment Form

(Rev. 6, 01-15-02)

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+CO 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+CO within required time frames, and submits the properly completed form to the M+CO 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+CO, 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+CO 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 Exhibit 25. Refer to §10 for a definition of "completed election form."

20.5 - Agreeing to Abide By M+CO Rules

(Rev. 6, 01-15-02)

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

20.6 - Grandfathering of Members on January 1, 1999

(Rev. 6, 01-15-02)

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

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

The M+CO must identify all Medicare Part B-only "grandfathered" individuals and inform them of their status annually. This notification may be included as part of the Evidence of Coverage. The notice must inform these individuals that if they disenroll

from the M+CO, they cannot elect another M+C plan unless they become entitled to Medicare Part A (by enrolling in Medicare Part A at SSA and by paying the appropriate premium to CMS) and remain enrolled in Medicare Part B.

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

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

20.7 - Eligibility and the Hospice Benefit

(Rev. 6, 01-15-02)

An M+CO must not deny enrollment to any individual who has elected the hospice benefit. Until the M+CO acknowledges that it has received the completed enrollment form and gives a coverage effective date to the individual (refer to Exhibit 4 and §40), the M+CO must not ask any questions related to the existence of a terminal illness or election of the hospice benefit. Such questions will be considered impermissible health screening.

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

20.8 - Continuation of Enrollment Option

(Rev. 6, 01-15-02)

With CMS approval, an M+CO may establish continuation areas, separate and apart from an M+C plan's service area. Refer to Chapter 11 (Contracts with Medicare+Choice Organizations) regarding CMS approval of continuation areas. As defined in §10, the CMS-approved continuation area is an additional area outside an M+C plan's service area within which the M+CO furnishes or arranges for furnishing of services to the M+C

plan's members. Members may only choose to continue enrollment with the M+C plan if they have permanently moved from the service area into the continuation area.

As described in Chapter 11, if an M+CO wants to offer a continuation of enrollment option under one or more of the M+C plans it offers, then it must obtain CMS's approval of the continuation area, and the marketing materials that describe the continuation of enrollment option. The M+CO must also describe the enrollment option(s) in member materials and make the option available to all members of the M+C plan in question who make a permanent move to the continuation area. A M+CO may require members to give advance notice of their intent to use the continuation of enrollment option. If the M+CO has this requirement, then it must fully describe the required notification process in the CMS-approved marketing materials. In addition, the M+CO must fully explain any continuation option to all potential members of the M+C plan, current members of any other health plan of the M+CO and current risk and/or M+C members who reside in the M+C plan service area and/or M+CO continuation area.

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

20.9 - Additional Eligibility Requirements for M+C Religious Fraternal Benefit (RFB) Plans

(Rev. 6, 01-15-02)

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

20.10 - Eligibility Requirements for Medicare MSA Plans

(Rev. 6, 01-15-02)

Although an individual may meet all the requirements to elect an M+C plan, there are additional requirements and limitations on the individuals who may wish to elect to enroll in a Medicare Medical Savings Account (MSA) plan, should such a plan become available (currently, no such plans are offered). An individual is not eligible to elect a Medicare MSA plan if any one of the following applies:

- The number of individuals enrolled in all Medicare MSA plans has reached 390,000;
- The individual will reside in the United States for fewer than 183 calendar days during the year in which the election is effective;

- Initial enrollment is on or after January 1, 2003 (i.e., no new enrollees may be accepted beginning January 1, 2003). Individuals whose enrollment is already in effect on January 1, 2003, including those who elected a Medicare MSA for a January 1, 2003 effective date, may remain members of that Medicare MSA after January 1, 2003);

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

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

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

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

30 - Election Periods and Effective Dates

(Rev. 6, 01-15-02)

In order for an M+CO 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+COs 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+COs 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 service area who are making OEP elections.

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+CO 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+CO 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+CO 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+COs 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. 6, 01-15-02)

The AEP occurs in November of every year.

30.2 - Initial Coverage Election Period (ICEP)

(Rev. 6, 01-15-02)

The ICEP is the three months immediately before the individual's entitlement to **both** Medicare Part A and Part B.

EXAMPLE:

- If an individual is entitled to Medicare Part A effective July, 2001, and enrolls in Medicare Part B effective July, 2001, then the ICEP is April, May, and June of 2001.

- If an individual is entitled to Medicare Part A effective November, 2000, but waits to enroll in Medicare Part B for an effective date of July, 2001, then the ICEP is April, May and June of 2001.

Please note that the ICEP will frequently relate to either the individual's 65th birthday or the 25th month of disability, but it must **always** relate to the individual's entitlement to **both** Medicare Part A and Part B.

30.3 - Open Enrollment Period (OEP)

(Rev. 6, 01-15-02)

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+COs are not required to open their plans for enrollment during an OEP (or OEPI or OEPNEW). However, M+COs 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+CO has more than one M+C plan, the M+CO is not required to open each plan for enrollment during the same time frames, nor is it required to be open for all OEP-type (i.e., OEP, OEPI, OEPNEW) elections.

If an M+CO opens a plan during part of an OEP, it is not required to open the plan for the entire OEP. For example, in 2001 an M+CO may open a plan only during March and April, or it may choose to open the plan only during the first 25 days of each month.

Beginning in 2002, except as described for newly eligible individuals in §30.3.4, an individual may make only **one** election during each OEP, not including any elections made during an SEP, ICEP, or OEPNEW. Beginning in 2003, only the individual's first OEP election will be processed by CMS. All subsequent OEP elections made by that individual will be rejected.

30.3.1 - OEP Through 2001

(Rev. 6, 01-15-02)

The OEP is continuous through 2001. If an M+CO 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+CO 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+COs must accept requests for disenrollment from M+C plans during the OEP since Original Medicare is open continuously through 2001.

An M+C eligible individual can make an unlimited number of elections during the OEP in 2001.

30.3.2 - OEP in 2002

(Rev. 6, 01-15-02)

In 2002, the OEP is from January through June. During this period an individual may make only one OEP election.

After June 30, 2002, M+COs must deny elections of individuals unless they are eligible for an ICEP, OEPNEW, OEPI, SEP, or AEP. This includes enrollments, disenrollments to another M+CO, and disenrollments to Original Medicare.

If an M+CO has a plan that is open for enrollment any time between January and June 2002, then it must accept all elections into that plan made during the plan's open enrollment period.

M+COs must accept requests for disenrollment from M+C plans during the OEP since Original Medicare is open January through June in 2002.

EXAMPLE:

- If an M+CO has a plan that is open for enrollment in 2002 in January and February only, then it must accept OEP elections into the plan made in January and February, but it does not accept OEP elections into the plan in March through June.

- If an M+CO has a plan that is not open for enrollment outside of the AEP, then it cannot accept OEP elections into the plan between January and June of 2002.

- Since Original Medicare is always open during the OEP, beneficiaries may disenroll at any time to Original Medicare between January and June 2002.

Counting Elections - If an individual enrolls in a new M+C plan, thereby automatically disenrolling from their old M+C plan, this counts as one election. If an individual disenrolls from an M+C plan and enrolls in a new M+C plan - making two distinct elections - for the **same effective date,** this counts as one election. If an individual disenrolls to the Original Medicare Plan, this counts as an election.

30.3.3 - OEP in 2003 and Beyond

(Rev. 6, 01-15-02)

In 2003, the OEP is from January through March. During this period an individual may make only one OEP election. Once an individual has exercised their 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, 2003, M+COs must deny elections of individuals unless they are eligible for an ICEP, OEPNEW, OEPI, SEP, or AEP. This includes enrollments, disenrollments to another M+CO, and disenrollments to Original Medicare.

If an M+CO 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+COs must accept requests for disenrollment from M+C plans during the OEP since Original Medicare is open January through March every year beginning in 2003.

EXAMPLE:

- If an M+CO has a plan that is open for enrollment in 2003 in January and February only, then it must accept OEP elections into the plan made in January and February, but it does not have to accept OEP elections into the plan in March.

- If an M+CO has a plan that is not open for enrollment outside of the AEP, it cannot accept OEP elections into the plan between January and March.

- Since Original Medicare is always open during the OEP, beneficiaries may disenroll at any time to Original Medicare between January and March.

Counting Elections - If an individual enrolls in a new M+C plan, thereby automatically disenrolling from their old M+C plan, this counts as one election. If an individual disenrolls from an M+C plan and enrolls in a new M+C plan - making two distinct elections - for the **same effective date**, this counts as one election. If an individual disenrolls to the Original Medicare Plan, this counts as an election.

30.3.4 - Open Enrollment for Newly Eligible Individuals (OEPNEW)

(Rev. 6, 01-15-02)

Beginning in 2002, an OEPNEW exists for newly eligible individuals. In 2002, 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 2003 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, 2003, his/her OEPNEW lasts from February 1 through April 30, 2003.

- If an individual becomes entitled to Medicare Parts A and B on November 1, 2003, his/her OEPNEW lasts from November 1 through December 31, 2003.

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

An M+CO 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+CO 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)

(Rev. 6, 01-15-02)

Beginning January, 2002, 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 2002. An M+CO 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 2002. Therefore, M+COs 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. 6, 01-15-02)

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+CO'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+CO offering the M+C plan substantially violated a material provision of its contract under M+C in relation to the individual, or the M+CO (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+CO 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.**

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+CO 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.

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

30.4.1 - SEPs for Changes in Residence

(Rev. 6, 01-15-02)

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

Permanent Move Out of the Service or Continuation Area

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

Outside the Service or Continuation Area for Over Six Months

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

In Either Case:

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

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

EXAMPLE:

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

A. If an M+CO in Arizona receives a completed enrollment form from the beneficiary in May, the beneficiary can choose an effective date of June 1, July 1, or August 1.

B. If the M+CO receives the completed enrollment form from the beneficiary in June (the month of the move), the beneficiary can choose an effective date of July 1, August 1, or September 1.

C. If the M+CO receives the completed enrollment form in July, the beneficiary could choose an effective date of August 1, September 1, or October 1.

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

Disenrollment from Previous M+C Plan

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

We have established an SEP that allows an individual adequate time to choose a new M+C plan, given the fact that the individual will no longer be enrolled in the original M+C plan after the month of the move or after the sixth month (whichever is appropriate). Unless an individual enrolls in a new M+C plan with an effective date of the month after the move or the beginning of the seventh month (e.g., the individual moves

on June 18 and enrolls in a new plan effective July 1), he/she will be enrolled in Original Medicare until he/she elects the new M+C plan.

30.4.2 - SEPs for Contract Violation

(Rev. 6, 01-15-02)

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

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

- A SEP exists such that an individual may elect another M+C plan or Original Medicare during the last month of enrollment in the M+CO, for an effective date of the month after the month the new M+CO receives the completed enrollment form.

  EXAMPLE:

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

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

EXAMPLE:

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

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

30.4.3 - SEPs for Nonrenewals or Terminations

(Rev. 6, 01-15-02)

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

In particular:

- **Contract Nonrenewals -** A SEP exists for members of M+C plans that will be affected by contract nonrenewals that are effective January 1 of the contract year (42 CFR §422.506). For this type of nonrenewal, M+COs are required to give notice to affected members at least 90 calendar days prior to the date of nonrenewal (42 CFR §422.506(a)(2)(ii)). To help coordinate with the notification time frames, the SEP begins October 1 and ends on December 31 of that year.

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

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

proposed termination effective date, and ends 1 month after the month in which the termination occurs.

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

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

EXAMPLE:

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

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

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

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

  EXAMPLE:

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

- **Immediate Terminations By CMS -** CMS will establish the SEP during the termination process for immediate terminations by CMS (§422.510(b)(2)), where

CMS provides notice of termination to an M+C plan's members and the termination may be mid-month.

30.4.4 - SEPs for Exceptional Conditions

(Rev. 6, 01-15-02)

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.

   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+CO 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+CO, and an enrollee disenrolls in connection with the matter that gave rise to that sanction.

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+CO 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.

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.

   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.

7. **SEP for M+C Plans that Open in (or Expand into) an Abandoned County Mid -Year -** In 2002, individuals who live in areas with no other M+C options will have an SEP if an M+CO opens a plan, or expands the service area of an

existing plan, in their area. This SEP allows for a one-time election into the new (or expanded) M+C plan.

The SEP starts when CMS approves the new contract (typically 1 or 2 months before the contract begins) and continues through the end of the calendar year. 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 May 1 through December 31, 2002.

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, as long they were in a health plan offered by the same M+C organization the month before their entitlement to Parts A and B, developed ESRD while a member of that health plan, and are still enrolled in that health plan. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who performs self-dialysis will have his/her entitlement date adjusted to begin at the time of dialysis, rather than the customary 3-month period AFTER dialysis begins.

   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.

30.4.5 - SEPs for Beneficiaries Age 65 (SEP65)

(Rev. 6, 01-15-02)

Beginning January 1, 2002, 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. 6, 01-15-02)

With the exception of some SEPs and when election periods overlap, beneficiaries 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+CO. 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+CO **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+CO.

Once the election period is identified by the M+CO, the M+CO 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+COs 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 (including the OEPNEW, OEPI)	First day of the month after the month the M+CO receives a completed enrollment form.	No, the M+CO 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. For example, until 2002, the AEP and the OEP will coincide every November if an M+C plan has continuous open enrollment. Therefore, if an individual makes an enrollment election when more than one election period applies, an M+CO 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).

EXAMPLE:

- If an M+CO receives a completed enrollment form in November 2001 for enrollment in an M+C plan that has continuous open enrollment, the individual can choose a December 1, 2001 effective date for the OEP or a January 1, 2002 effective date for the AEP.

  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+CO receives a completed enrollment form from that individual in November (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.

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+CO must assign an effective

date according to the following ranking of election periods (1 = Highest, 4 = Lowest). The election period with the **highest rank** determines the effective date.

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

1. ICEP
2. AEP
3. OEP (including OEPNEW and OEPI)
4. SEP

EXAMPLE:

An M+C plan with continuous open enrollment may receive a completed enrollment form on November 5, but the individual does not choose an effective date. In this scenario, the effective date should be January 1 (for the AEP), and not December 1 (for the OEP), because the AEP is ranked higher than the OEP.

30.6 - Effective Date of Voluntary Disenrollment

(Rev. 6, 01-15-02)

With the exception of some SEPs and when election periods overlap, 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+CO, 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. For example, since Original Medicare is always open during the OEP, the AEP and the OEP will overlap in November 2001. Therefore, in order to determine the proper effective date, the M+CO **must** determine which election period applies to each member **before** the disenrollment may be transmitted to CMS.

If an M+CO receives a completed disenrollment request when more than one election period applies, the M+CO 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+CO 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+COs have to accept elections in this election period?
Open Enrollment Periods (including OEPNEW and OEPI)	First day of the month after the month the M+CO 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.

30.7 - Election Periods and Effective Dates for Medicare MSA Plans

(Rev. 6, 01-15-02)

Individuals may only enroll in Medicare MSA plans (should one be offered in their area) during the ICEP or the AEP; they may not enroll in Medicare MSA plans during an OEP. The effective date of coverage when an election is made under the ICEP is on the first day of the month of entitlement to **both** Medicare Part A **and** Part B. The effective date of coverage when an election is made under the AEP is January 1 of the following year (refer to §30.5 to determine when the ICEP effective date should take precedence over the AEP effective date).

With one exception, individuals may only disenroll from Medicare MSA plans during the AEP or SEP. The effective date of disenrollment during the AEP is January 1. The effective date of disenrollment during an SEP depends on the type of SEP and the reason members must disenroll.

EXCEPTION:

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

40 - Enrollment Procedures

(Rev. 6, 01-15-02)

An M+CO must accept elections it receives, regardless of whether they are received in a face-to-face interview, by mail, or by facsimile. M+COs 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 to enroll in an M+C plan, **even if that individual is electing an M+C plan in the same M+CO in which he/she is enrolled**. If an individual wishes to elect another M+C plan in the same M+CO, 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) to make the election in place of the comprehensive individual enrollment form. With the exception of forms that are faxed to the M+CO, individuals should submit original, not photocopied, forms.

An M+CO must send the beneficiary written notice of M+CO denial of enrollment, CMS confirmation of enrollment, or CMS rejection of enrollment, as described in §§40.2.3 and 40.4.2.

40.1 - Format of Enrollment Forms

(Rev. 6, 01-15-02)

The M+CO 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.

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

- Agrees to abide by the M+CO'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 will 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+CO, must include statements that the member:

- Agrees to abide by the M+CO'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.

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.

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

40.2 - Completing the Enrollment

(Rev. 6, 01-15-02)

If the enrollment form is filled out during a face-to-face interview, the M+CO 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+CO, the M+CO 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.

Exhibit 25 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, and 3. If the M+CO receives an enrollment form that contains all these elements, the M+CO must consider the enrollment form complete even if all other data elements on the enrollment form are not filled out. If an M+CO has received CMS approval for an enrollment form that contains data elements in addition to those included in Exhibit 1, 2, or 3, then the election form is considered complete even if those additional elements are incomplete.

If an M+CO 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+CO must follow the procedures outlined in §40.2.2 in order to complete the enrollment. Where possible, the M+CO 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+CO 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+CO 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+CO 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+CO should consult the State law in which the M+CO 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+CO 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+CO 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+CO 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+CO to confirm the actual effective date. The M+CO 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+CO is responsible for assigning the appropriate effective date based on the election period. During face-to-face enrollments, the M+CO 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+CO allowed the beneficiary to choose an unallowable prospective effective date, the M+CO 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+COs 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+CO, in which the M+CO would already have this type of information, the M+CO 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+CO'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+CO must apply the policy consistently. If the M+CO requires the initials and the beneficiary fails to initial his/her understanding of each item listed, the M+CO may contact the beneficiary to clarify the M+CO rules in order to complete the enrollment form. The M+CO must document the contact and annotate the outcome of the contact. If the M+CO 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+CO places on the enrollment form may serve as the signature date of the form.

- **Other Signatures -** If the M+CO representative, or any other person, helps the individual fill out the enrollment form, then the M+CO representative or person must also sign the enrollment form and indicate his/her relationship to the individual. However, the M+CO 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+CO 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+CO receives an enrollment form that was signed more than 30 calendar days prior to the M+CO's receipt of the form, the M+CO 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+CO must date stamp all enrollment forms as soon as they are initially received at the M+CO'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+CO for the purposes of determining the effective date.

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

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

40.2.1 - Who May Sign An Election Form

(Rev. 6, 01-15-02)

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

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

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

When someone other than the Medicare beneficiary completes an enrollment form or disenrollment request, M+COs must maintain documentation showing how the determination was made that another individual was authorized to act on behalf of the beneficiary.

40.2.2 - When The Enrollment Form is Incomplete

(Rev. 6, 01-15-02)

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

Entitlement Information - If the individual has not provided evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment form, the organization may choose to consider an enrollment form complete by obtaining evidence through available

systems within seven business days of receipt of the enrollment form to determine if the individual is entitled to Medicare Part A and enrolled in Part B.

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

If the systems do not provide evidence of entitlement, then the M+CO must promptly contact the individual to obtain such evidence.

Requesting Information from the Beneficiary - To obtain information to complete the enrollment form, the M+CO must contact the individual to request the information (see Exhibit 5 for a model letter). If the contact is made orally, the M+CO must document the contact and retain the documentation in its records. The M+CO must explain to the individual that the individual has 30 calendar days in which to submit the additional information or the enrollment will be denied. Since an incomplete election form is an invalid enrollment (as explained in §40.6), if the additional documentation is not received within 45 calendar days of request (i.e., after allowing for the 30 days plus an additional 15 days for information to be received and logged in by the M+CO), the M+CO must send a denial of enrollment letter (see Exhibit 7 for a model denial of enrollment letter).

If all documentation is received within allowable time frames and the enrollment form is complete, the M+CO must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4.

40.2.3 - M+CO Denial of Enrollment

(Rev. 6, 01-15-02)

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

Based on information provided by the beneficiary, the M+C organization may determine that the individual is not eligible to enroll and deny the election upfront. The M+C organization should explain to the beneficiary why he/she is not eligible, and advise him/her to contact 1-800-MEDICARE for further information/assistance or to request a copy of "New Rules for Switching Medicare Health Plans."

If the beneficiary insists that the application be submitted, the M+C organization has the option to:

- Deny the application and send the individual a denial of disenrollment letter. This letter should include language that refers the beneficiary to 1-800-MEDICARE if they want further information on why they are not eligible to enroll; or

- Process the application and wait to see if the transaction will reject on the transaction reply report. If so, then the M+C organization would send the beneficiary an official CMS rejection letter.

After the OEP, if the M+C organization is sure that the individual is not eligible to make an election (i.e., they are not making an SEP, ICEP, OEPNEW election) the M+C organization would deny the individual's application.

M+CO 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, the individual is making an election outside of the allowable election period time frames, 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+CO 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+CO 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.

40.2.4 - ESRD and Enrollment

(Rev. 6, 01-15-02)

ESRD and Kidney Transplants

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

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

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

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

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

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

ESRD and M+C Plan Terminations

Certain individuals with ESRD who have been impacted by M+C terminations will be permitted to make one election into a new M+C plan (refer to §20.2 for a discussion of who is eligible to make an election). Beneficiaries will be instructed to save their notification letters to present, if requested, to M+COs as proof of their eligibility to join a plan. CMS's system will edit incoming enrollment transactions for ESRD beneficiaries to determine: (1) If they were a member of a terminating or terminated M+C plan, and (2) If they have already used their one election. Enrollments for these individuals should be submitted as normal transactions with all other transactions. The enrollment will be allowed if the individual is eligible, and will be rejected if not.

40.3 - Transmission of Enrollments to CMS

(Rev. 6, 01-15-02)

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

information within 30 calendar days after a vacancy has become available.

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

M+COs are encouraged to submit transactions by the earliest possible M+CO processing cutoff date (refer to Chapter 19 - Managed Care and M+C Systems Requirements). However, if the organization misses the cutoff date, it must still submit the transactions within the required 30-day time frame.

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

More detail on how M+COs must submit transmissions to CMS are contained in Chapter 19 and the Enrollment and Payment User's Guide.

40.4 - Information Provided to Member

(Rev. 6, 01-15-02)

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

40.4.1 - Prior to the Effective Date of Coverage

(Rev. 6, 01-15-02)

Prior to the effective date of coverage the M+CO must provide the member with all the necessary information about being a Medicare member of the M+CO, the M+CO rules, and the member's rights and responsibilities. (An exception to this requirement is described in §40.4.2.)

The M+CO must also provide the following to the individual:

- A copy of the completed enrollment form, if the individual does not already have a copy of the form;
- A letter acknowledging receipt of the completed enrollment form (refer to Exhibit 4 for a model letter) and showing the effective date of coverage; and
- Evidence of health insurance coverage so that he/she may begin using plan services as of the effective date

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

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

NOTE: If the M+CO does not provide the member card prior to the effective date, it must provide it as soon as possible after the effective date.

Regardless of whether an election is made in a face-to-face interview, by fax, or by mail, the M+CO must explain:

- The charges for which the prospective member will be liable, e.g., any premiums, co-insurance, fees or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance.
- The prospective member's authorization for the disclosure and exchange of necessary information between the M+CO and CMS.
- The lock-in requirement. The M+CO must also obtain an acknowledgment by the individual that he/she understands that care will be received through designated providers except for emergency services and urgently needed care.
- The potential for member liability if it is found that the member is not entitled to Medicare Part A and Part B at the time coverage begins and the member has used M+C plan services after the effective date.
- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the M+CO has not yet provided the ID cards).

40.4.2 - After the Effective Date of Coverage

(Rev. 6, 01-15-02)

CMS recognizes that for some election periods, the M+CO 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+CO, and the effective date is the first of the upcoming month. In these cases, the M+CO 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+CO 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+CO rules.

Acceptance/Rejection of Enrollment - Once the M+CO receives a reply listing report from CMS indicating whether the individual's enrollment has been accepted or rejected, the M+CO 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 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+CO 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+CO 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+CO rejects an enrollment and later receives additional information from the individual showing entitlement to Medicare Part A and enrollment in Part B, the M+CO 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.

40.5 - Enrollment Processing During Closed Periods

(Rev. 6, 01-15-02)

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

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

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

40.5.1 - Procedures After Reaching Capacity

(Rev. 6, 01-15-02)

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

If an M+CO 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+CO 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+CO 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+CO has similar options for handling any additional enrollment requests received while the plan is closed for enrollment. The M+CO 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+COs 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+CO 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+CO 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+CO receives approval from CMS to limit enrollment (Exhibit 7). Please note that CMS encourages M+COs 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+CO 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+CO receives the enrollment form or after the M+CO 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+CO must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The M+CO 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+CO 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+CO 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+CO 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 B 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.

40.5.2 - Procedures After Closing During the OEP

(Rev. 6, 01-15-02)

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

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

1. Deny the enrollment;

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

If the M+CO uses option #1 above - It must notify the individual in writing that it is denying the enrollment, and should do so within seven business days after it receives the enrollment form (Exhibit 7). Please note that CMS encourages M+COs 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+CO uses option #2 above - it must notify the individual in writing that he/she has been placed on a waiting list. The notice must inform the individual that the enrollment request will not be processed until the plan re-opens for enrollment, must include the date the plan will re-open, and must inform the individual that he/she may cancel the request for enrollment before the plan re-opens. All individuals who wish to wait for an opening must be placed on the waiting list.

After the M+C plan re-opens, if the plan was closed for more than 30 calendar days since the M+CO received the enrollment form, it must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The M+CO may make this contact even if the plan was closed for less than 30 days.) The M+CO 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, and should do so within seven business days after contacting the individual.

For individuals who indicate their continued interest in enrollment, the M+CO must document the individual's expressed interest to continue enrollment. This may be done via phone contact report, notation on the enrollment form, etc. The date the M+C plan re-opened 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.

40.6 - Enrollments Not Legally Valid

(Rev. 6, 01-15-02)

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

An enrollment that is not complete, as defined in §10, is not legally valid. In addition, an enrollment is not legally valid if it is later determined that the individual did not meet eligibility requirements at the time of enrollment. For example, an enrollment is not legally valid if an M+CO determines at a later date that the individual provided an incorrect permanent address at the time of enrollment and the actual address is outside the M+C plan's service area.

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

- Continuing supplemental (Medigap) insurance coverage after receipt of the confirmation of enrollment letter from the M+CO (refer to Exhibit 6 for a model confirmation letter);
- An enrollment form signed by the member when a legal representative should be signing for the member;

- Request by the individual for cancellation of enrollment before the effective date (refer to §60.2 for procedures for processing cancellations);
- Enrolling in a supplemental insurance program immediately after enrolling in the M+CO; or
- Receiving non-emergency or non-urgent services out-of-plan immediately after the effective date of coverage under the plan.

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

40.7 - Enrollment Procedures for Medicare MSA Plans

(Rev. 6, 01-15-02)

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

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

50 - Disenrollment Procedures

(Rev. 6, 01-15-02)

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

All notice requirements are summarized in Exhibit 24.

50.1 - Voluntary Disenrollment by Member

(Rev. 6, 01-15-02)

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 giving or faxing a signed written notice to the M+CO, by giving a signed written notice to any SSA or RRB office

(refer to §50.6 for procedures for Medicare MSA plans), or by calling 1-800-MEDICAR(E). An individual who elects another Medicare managed care plan will automatically be disenrolled from his/her current plan.

If a member verbally requests disenrollment from the M+C plan, the M+CO must instruct the member to make the request in writing. The M+CO 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+CO's business offices.

Request Signature and Date - 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+CO 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+CO 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+CO 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+CO allowed the beneficiary to choose an unallowable prospective effective date, the M+CO 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 written request, the M+CO 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+CO 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+CO, M+COs 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+CO 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+CO learns of the voluntary disenrollment from the CMS reply listing (as opposed to through written request from the member), the M+CO 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+COs 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 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+CO may provide such a notice to the beneficiary upon request (see Exhibit 26).

50.2 - Required Involuntary Disenrollment

(Rev. 6, 01-15-02)

The M+CO **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+CO contract is terminated, or the M+CO 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+CO 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+CO 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+CO'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+COs.)

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

M+COs 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 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+CO may provide such a notice to the beneficiary upon request (see Exhibit 26).

50.2.1 - Members Who Change Residence

(Rev. 6, 01-15-02)

General Rule

The M+CO **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+CO 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.

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). Disenrollment for reasons 5 and 6 above is effective the first day of the calendar month after six months have passed.

M+COs 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+CO of when he/she left the service area, then the M+CO 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+COs 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+COs may receive a notice of a change of address from the member, the member's representative, a CMS reply listing, or another source. M+COs 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+CO applies the policy consistently among all members.

If the M+CO 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+CO 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+CO may not initiate disenrollment. The M+CO must retain documentation from the member or member's representative of the notice of the change in address.

If the M+CO 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+CO may **not** assume the move is permanent until it has received confirmation from the member or member's representative. CMS suggests that the M+CO contact the member directly or in writing to verify address information in order to determine whether disenrollment is appropriate. The M+CO must give the member at least 20 calendar days to respond to the verification request. The M+CO 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+CO determines a member's move **is** permanent, then the M+CO 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+CO determines the change in address is temporary, then the M+CO may not initiate disenrollment until six months have passed from the date the M+CO 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+CO, then the M+CO must assume the move is not permanent and may not disenroll the member. The M+CO 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+CO learned of the change in address.

Notice Requirements - The M+CO 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+CO must give the member at least 20 calendar days to respond to the request for verification.

The M+CO must provide written notification of disenrollment to the member upon the M+CO'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+CO's learning of the permanent move before the disenrollment transaction is submitted to CMS.

In the notice, the M+CO 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+CO 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+CO learned of the change in address (or the date the member stated that his address changed, if that date is earlier), the M+CO 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+CO 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+CO must disenroll the member effective with the first day of the month following the 20-day notice. CMS strongly encourages that M+COs send final confirmation of disenrollment to the member to ensure the individual does not continue to use M+CO services.

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

(Rev. 6, 01-15-02)

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

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

Notice Requirements - CMS strongly suggests that notices be sent when the disenrollment is due to the loss of entitlement to either Medicare Part A or Part B (see

Exhibit 14) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §60.3.1.

50.2.3 - Death

(Rev. 6, 01-15-02)

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

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

50.2.4 - Terminations/Nonrenewals

(Rev. 6, 01-15-02)

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

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

EXCEPTION:

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

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

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

50.3 - Optional Involuntary Disenrollments

(Rev. 6, 01-15-02)

An M+CO may disenroll a member from an M+C plan it offers if:

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

In situations where the M+CO disenrolls the member involuntarily for any of the reasons addressed above, the M+CO must send notice of the upcoming disenrollment that meets the following requirements:

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

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

50.3.1 - Failure to Pay Premiums

(Rev. 6, 01-15-02)

M+COs may not disenroll a member who fails to pay M+C plan cost sharing, other than premiums. However, an M+CO 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+CO must take action consistently among all members, i.e., an M+CO may have different policies among its plans, but it may not have different policies within a plan.

The M+CO **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+CO chooses to disenroll the member or reduce coverage, the action may only be accomplished by the M+CO 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+CO 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+CO 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+CO 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+CO may require the individual to pay any outstanding premiums owed to the M+CO before considering the enrollment to be "complete."

Calculating the 90-Day Grace Period

M+COs 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+COs 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+CO) are not paid in full by the end of 90 days following the date of the first notice, the M+CO can terminate or reduce the member's coverage. Under this scenario, M+COs 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+CO 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+CO. 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+CO could then terminate or reduce the member's coverage, after giving proper notice, effective May 1.

In short, the M+CO 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+CO 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+CO must state so in its initial delinquency notice to the member.

B. M+COs 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+CO 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+CO could terminate or reduce the member's coverage.

EXAMPLE A

A member fails to pay his January premium due January 1. The M+CO 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+CO 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+CO 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+CO could terminate or reduce the member's coverage, after giving proper notice, effective June 1.

Notice Requirements - If the M+CO chooses to disenroll the member or to reduce coverage when a member has not paid premiums, the M+CO 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+CO 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+CO policy;
- Advise the member that failure to pay the premiums within the 90-day grace perioc will result in termination or reduction of M+C coverage, whichever is appropriate according to the M+CO policy;
- Explain whether the M+CO 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+CO 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+CO policy is to disenroll the member, the M+CO must notify the member in writing that the M+CO 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+COs send final confirmation of disenrollment to the member after receiving the reply listing report to ensure the individual does not continue to access M+CO 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+CO policy is to reduce coverage, the M+CO must notify the member in writing prior to the effective date that the M+CO 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+COs have the **option** to retain dually eligible members who fail to pay premiums even if the M+CO 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+CO 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+CO 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+CO 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+COs 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.

50.3.2 - Disruptive Behavior

(Rev. 6, 01-15-02)

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

Before beginning the disenrollment for cause process, the M+CO must make a serious effort to resolve the problems presented by the member. This includes making an effort to provide reasonable accommodations for individuals with disabilities, in accordance with the Americans with Disabilities Act. It must inform the member, in writing, that his/her continued behavior may result in termination of membership in the plan. Such efforts must include the use (or attempted use) of the organization's grievance procedures. In this process, the member has a right to submit any information or explanation that he/she may wish to the M+CO.

If the problem cannot be resolved, the M+CO must give the member written notice of the M+CO's intent to request, from CMS, permission to disenroll for cause.

The M+CO must establish that the member's behavior is not related to the use, or lack of use, of medical services or to diminished mental capacity. The organization must document the member's behavior, the efforts it has taken to resolve any problems, and any extenuating circumstances cited under 42 CFR §422.74(d)(2)(iii) and (iv). In addition to a summary of the case and a reason for the disenrollment request, the M+CO must submit to the CMS RO a description of the member's age, diagnosis, mental status, functional status, and social support systems, as well as statements from primary providers describing their experiences with the member.

After a review of this documentation, the CMS RO will decide whether the organization may disenroll the member on this basis. Such review will include any documentation or information provided either by the organization or the member (information provided by the member must be forwarded by the organization to the CMS RO) and CMS will make the decision within 20 calendar days after receipt of this information. The M+CO will be notified within seven business days after CMS's decision. The disenrollment is effective the first day of the calendar month after the month in which the organization gives the member a written notice of the disenrollment. Any disenrollment processed under these provisions will always result in a change of election to Original Medicare.

Notice Requirements - The M+CO must inform the member, in writing, that his/her continued behavior may result in termination of membership in the plan. If the problem cannot be resolved, the M+CO must give the member written notice of the M+CO's intent to request disenrollment for cause. This notice must include an explanation of the organization's grievance procedures. In this process, the member has a right to submit any information or explanation that he/she may wish to the organization. Refer to Chapter 13 (Grievances, Organizations Determinations, and Appeals) for the appropriate procedures for grievances.

If CMS permits an M+CO to disenroll a member for disruptive behavior, the M+CO must provide the member with a written notice that contains, in addition to the notice requirements outlined in §50.3, a statement that this action was approved by CMS and meets the requirements for disenrollment due to disruptive behavior described above.

50.3.3 - Fraud and Abuse

(Rev. 6, 01-15-02)

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

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

Notice Requirements - The M+CO must give the member a written notice of the disenrollment that contains the information required at §50.3.

50.4 - Processing Disenrollments

(Rev. 6, 01-15-02)

50.4.1 - Voluntary Disenrollments

(Rev. 6, 01-15-02)

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

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

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

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

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

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

- For disenrollment requests received by the M+CO, assuring that each individual who disenrolls receives a signed copy of the completed disenrollment request; and

- For disenrollment requests received by the M+CO, notifying the member in writing within seven **business** days after receiving the member's written request, to acknowledge receipt of the completed disenrollment request, and to provide the effective date (see Exhibit 11 for a model letter). M+COs are encouraged, but not

required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the reply listing;

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

50.4.2 - Involuntary Disenrollments

(Rev. 6, 01-15-02)

The M+CO is responsible for submitting involuntary disenrollment transactions to CMS in a timely, accurate fashion.

The M+CO must maintain a system for controlling and processing involuntary disenrollments from the M+CO. This includes:

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

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

In addition, CMS strongly encourages M+COs to send confirmation of involuntary disenrollment to ensure the member discontinues use of M+CO services after the disenrollment date.

50.5 - Disenrollments Not Legally Valid

(Rev. 6, 01-15-02)

When a disenrollment is not legally valid, a reinstatement action may be necessary (refer to §60.3 for more information on reinstatements). In addition, the reinstatement may result in a retroactive disenrollment from another plan.

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

CMS also does not regard a voluntary disenrollment as actually complete if the member or his/her representative did not intend to disenroll from the M+CO. If there is evidence that the member did not intend to disenroll from the M+CO, the M+CO should submit a

reinstatement request to the CMS RO. Evidence that a member did not intend to disenroll may include:

- A disenrollment request signed by the member when a legal representative should be signing for the member; or
- Request by the member for cancellation of disenrollment before the effective date (refer to §60.2 for procedures for processing cancellations).

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

In contrast, we believe that a member's deliberate attempt to disenroll from a plan (e.g., filing a CMS-566 with SSA, sending a written request for disenrollment to the M+CO, or calling 1-800-MEDICAR(E)) implies intent to disenroll. Therefore, unless other factors indicate that this disenrollment is not valid, what appears to be a deliberate, member-initiated disenrollment should be considered valid.

50.6 - Disenrollment of Grandfathered Members

(Rev. 6, 01-15-02)

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

Disenrollment procedures for grandfathered members are the same as those for other members. The M+CO must disenroll any grandfathered member if:

- The member dies;
- The member loses entitlement to either Medicare Part A or Part B (or for Part B only members, enrollment in Medicare Part B ends for the member);
- The member permanently moves into the continuation area, but does not choose to continue enrollment or moves to an area that is out of the service or continuation area

  NOTE: A subsequent permanent move into an area that is not in the service or continuation area is grounds for disenrollment

- The M+CO contract is terminated, or if the service area or continuation area is reduced with respect to all M+C individuals who live in the area where the individual resides.

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

50.7 - Disenrollment Procedures for Employer Group Health Plans

(Rev. 6, 01-15-02)

When an employer group terminates its contract with an M+CO, the M+CO has the option to follow one of two procedures to disenroll beneficiaries. The M+CO 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+CO 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 their employer. If the beneficiary is disenrolling to Original Medicare, they would submit a disenrollment request to the original M+CO. If the beneficiary is enrolling in a different M+C plan as an individual member, they would submit an enrollment form to their newly chosen M+CO. As with any disenrollment, the old M+CO is obligated to send a confirmation of disenrollment to the beneficiary.

c. If the beneficiary does not elect a new employer-contracting M+CO, 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+CO even after the employer group nonrenewal has gone into effect. The beneficiary would become a member of the individual plan on which his/her employer group coverage was based. The M+CO 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+CO, CMS will permit mass disenrollments to be submitted by the M+CO providing:

The employer agrees to the following:

- Send a letter/notification to their 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.

The M+CO must:

- Inform the individual at least 30 days prior to the contract termination that he/she has the option to remain as an individual member of the M+CO.
- 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+CO 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+CO since these individuals are generally not allowed to join new M+C organizations.

50.8 - Disenrollment Procedures for Medicare MSA Plans

(Rev. 6, 01-15-02)

Members of Medicare MSA plans may only disenroll in writing through the M+CO offering the Medicare MSA plan; they may not disenroll through the Social Security office or the RRB. Election periods and effective dates for disenrollment from Medicare MSA plans are outlined in §30.7.

M+COs offering Medicare MSA plans must otherwise follow the disenrollment policies and procedures outlined in §§50.2 through 50.5.

60 - Post-Election Activities

(Rev. 6, 01-15-02)

Post-election activities begin after the M+CO receives the election from the individual (e.g., cancellations), and last until a decision is made with respect to an individual's election (e.g., retroactive transactions).

60.1 - Multiple Transactions

(Rev. 6, 01-15-02)

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. In addition, if an individual elects more than one plan for the same effective date, it is not always clear which plan the individual truly intended to be enrolled. Therefore, M+COs will occasionally receive reply listings that show rejections for multiple transactions.

To ensure an individual's intent is identified when he/she elects multiple plans, and to educate individuals on the impact of multiple transactions, retroactive enrollments will not be processed for multiple transactions. When a multiple transaction occurs, 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 for the M+COs that received the multiple transaction rejections. Only current enrollments will be

allowed for correction of multiple transactions (i.e., no retroactive enrollments will be allowed under these circumstances).

If a Medicare eligible individual has used M+C plan services and the enrollment is rejected for multiple transactions, then the M+CO may bill Medicare for the services if the individual is in Original Medicare. The M+CO 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. MC+Os 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+CO 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 (to serve as supporting documentation to the original enrollment form signed by the individual), The M+CO may transmit the information to CMS with a current effective date, using the appropriate effective date as prescribed in §30.5.

EXAMPLE

- Two M+COs receive completed enrollment forms from one individual on May 2 for a June 1 effective date. Both elections are transmitted by the May 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+CO no later than May 31, then the effective date of coverage is June 1.

- Two M+COs 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+CO no later than August 31, then the effective date of coverage is September 1.

60.2 - Cancellations

(Rev. 6, 01-15-02)

Cancellations may be necessary in cases of mistaken enrollment made by an individual and/or mistaken disenrollment made by a member. Requests for cancellations can only be accepted prior to the effective date of the election.

If a cancellation occurs after CMS records have changed, retroactive disenrollment and reinstatement actions may be necessary. Refer to §§60.3 and 60.5.

If a beneficiary verbally requests a cancellation, the M+CO should document the request. M+COs have the right to request that a cancellation be in writing. However, they may not

delay processing of a cancellation until the request is made in writing if they have already received verbal confirmation from the beneficiary of the desire to cancel the election.

60.2.1 - Cancellation of Enrollment

(Rev. 6, 01-15-02)

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+CO 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+CO must send a letter to the individual that states that the cancellation is being processed. 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+CO if he/she wishes to remain a member of the M+C plan in that M+CO.

If the member's request for cancellation occurs after the effective date of the enrollment, then the cancellation cannot be processed. The M+CO 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+CO, 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) 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. 6, 01-15-02)

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+CO 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+CO 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.

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+CO should instruct the member to fill out and sign a new enrollment form to re-enroll with the M+CO during an election period (described in §30), and with a current effective date, using the appropriate effective date as prescribed in §30.5.

60.3 - Reinstatements

(Rev. 6, 01-15-02)

Reinstatements may be necessary if a disenrollment is not legally valid (refer to §50.5 to determine whether a disenrollment is not legally valid). The most common reasons warranting reinstatements are:

1. Disenrollment due to erroneous death indicator,

2. Disenrollment due to erroneous loss of Medicare Part A or Part B indicator, and

3. Mistaken disenrollment. In unique circumstances, an organization may consult with the RO to reinstate members.

The RO will approve such reinstatements on a case-by-case basis.

A reinstatement is viewed as a correction necessary to "erase" a disenrollment action and to ensure no gaps in coverage occur. Therefore, reinstatements may be made back to a date when an M+C plan was closed for enrollment.

When a disenrolled member contacts the M+CO to state that he/she was disenrolled due to any of the reasons listed above, and states that he/she wants to remain a member of the M+C plan, then the M+CO must instruct the member in writing as soon as possible to continue to use M+C plan services (refer to Exhibits 15, 16, and 17 for model letters).

60.3.1 - Reinstatements for Disenrollment Due to Erroneous Death Indicator or Due to Erroneous Loss of Medicare Part A or Part B Indicator

(Rev. 6, 01-15-02)

A member can be reinstated if he/she was disenrolled due to an erroneous death or loss of Part A or Part B indicator since he/she was always entitled to membership. As outlined in 42 CFR §422.74(c), M+COs have the option of sending notification of disenrollment due to death or loss of Part A or B. CMS strongly suggests that M+COs send these notices, to ensure any erroneous disenrollments are corrected as soon as possible. Refer to Exhibits 13 and 14 for model letters.

To request reinstatement from the CMS RO, the M+CO should submit the following information to its RO:

- A copy of the reply listing showing the disenrollment (include the system run date);
- A copy of any disenrollment letter that the M+C plan may have sent to the individual (see §§50.2.2 and 50.2.3). Refer to model letters in Exhibits 13 and 14;
- A copy of any correspondence from the member disputing the disenrollment. Member correspondence could include a summary of the dispute, phone contact reports, and copies of letters;
- A copy of the letter to the member informing him/her to continue to use M+C plan services until the issue is resolved. Refer to model letters in Exhibits 15 and 16; and
- Verification that the disenrollment was erroneous. This verification can be shown via documentation from SSA stating its records have been corrected or that its records never showed the member as being deceased or having lost entitlement. It may also be shown by a CMS or CMS subcontractor print screen supporting the uninterrupted existence of Medicare Part A or B enrollment.

60.3.2 - Reinstatements Due to Mistaken Disenrollment Made By Member

(Rev. 6, 01-15-02)

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. The only exception is 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+CO, which resulted in automatic disenrollment from the original M+CO in which he/she was enrolled, and who was unable to cancel the enrollment in the second M+CO (as outlined in §60.2.1). However, these reinstatements will only be granted if 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 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+CO 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+CO must instruct the member to notify the M+CO in writing of the desire to remain enrolled in the plan within 30 calendar days after the M+CO sent the notice of disenrollment to the individual (i.e., the notices shown in Exhibit 12). Regardless of whether the request for reinstatement is verbal or in writing, the M+CO 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+CO 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+CO.

To request reinstatement from the CMS RO, the M+CO 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).

60.4 - Retroactive Enrollments

(Rev. 6, 01-15-02)

The CMS ROs will only process requests for retroactive enrollments when the M+CO has notified the member that he/she must use M+C plan services during the period covered by the retroactive enrollment request. Retroactive enrollments will be approved by the CMS RO when an individual has fulfilled all election and eligibility requirements for an M+C plan, but the M+CO or CMS is unable to process the election for the statutorily required effective date (as outlined in §30.5).

Unlike a reinstatement, which is a correction of records to "erase" an action, a retroactive enrollment is viewed as an action to enroll a beneficiary into a plan for a new time period. Therefore, retroactive enrollments may NOT be made back to a date when an M+C plan was closed for enrollment.

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

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

1. Copy of signed completed enrollment form.

   NOTE: The form must have been signed by the applicant prior to the requested effective date of coverage, in order to effectuate the requested effective date of coverage.

2. Copy of M+CO's letter to the member acknowledging receipt of the completed enrollment form and notifying the member to begin using the M+C plan's services as of the effective date (refer to Exhibit 4 for the model letter). The letter must be dated prior to the requested retroactive effective date of coverage (or, when appropriate as outlined in §40.4.2, within seven business days after the effective date of coverage), in order to effectuate the requested effective date of coverage.

3. One or more of the examples of "evidence of Medicare Part A and Part B coverage" cited in §10.

4. For cases of erroneous indicator of no Medicare entitlement - Copies of two reply listings, including a copy of the system run date, indicating the M+CO's attempts to correctly enroll the individual and the resulting rejections. One reply listing will be considered acceptable if the M+CO would be unable to obtain a second reply listing and still submit the retroactive enrollment request within 45 calendar days of the availability of the first reply listing; however, two reply listings are preferred. The M+CO may submit the McCoy exception report in place of the reply listing. The effective date on the first reply listing must correspond with the requested effective date, in order to effectuate the retroactive effective date of coverage.

5. For cases of erroneous indicator of ESRD, either because the individual has never had ESRD or because ESRD status has been terminated:

A. Evidence of contact with the individual after the first systems rejection, including the individual's explanation for rejection. If the individual reports that he/she no longer has ESRD or that he/she has had a kidney transplant or no longer receives dialysis services, then provide medical documentation, for example a letter from the physician or dialysis facility that documents date of transplant or last month of dialysis. If the individual reports that he/she never had ESRD, provide a statement signed by the individual (or his/her physician) to that effect.

B. A copy of the reply listings or print screens indicating the M+CO's attempts to correctly enroll the individual and the resulting rejection. The effective date on the reply listing must correspond with the requested effective date, in order to effectuate the retroactive effective date.

In the event that CMS determines that the M+CO did not notify the member that he/she must use M+C plan services during the period covered by the retroactive enrollment request, a retroactive enrollment request will be denied. In this case, if the Medicare eligible individual has used M+C plan services during the period covering the retroactive enrollment request, the M+CO may bill Medicare for the services. The M+CO may bill for Medicare Part B services from the Medicare carrier

NOTE: The M+CO must have an indirect billing number from CMS).

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

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

- CMS central office, for a CMS or SSA computer system problem involving multiple members, or
- CMS RO, for individual cases or situations when the organization is experiencing internal problems.

If the CMS RO is not able to resolve system errors, the recommendation is submitted to CMS central office for correction.

60.5 - Retroactive Disenrollments

(Rev. 6, 01-15-02)

CMS may grant a retroactive disenrollment if an enrollment was never legally valid (§40.6) or if a valid request for disenrollment was properly made, but not processed or acted upon (as outlined in the following paragraph), which includes not only system error, but plan error (see §10 for a definition of "system error" and "plan error"). CMS

may also grant a retroactive disenrollment if the reason for the disenrollment is related to a contract violation (as outlined in 42 CFR §422.62(b)(3)). Retroactive disenrollments can be submitted to CMS by the beneficiary or an M+CO. Requests from an M+CO must include supporting evidence justifying a late disenrollment. M+COs must submit retroactive disenrollment requests to CMS RO as soon as possible. If CMS approves a request for retroactive disenrollment, the M+CO must return any premium paid by the member for any month for which CMS processed a retroactive disenrollment. In addition, CMS will retrieve any capitation payment for the retroactive period.

Individuals who permanently move out of the service area are no longer eligible to be enrolled in the M+C plan (see §§20.3 and 50.2.1); therefore, the enrollment is no longer considered to be legally valid. The CMS RO will approve requests for retroactive disenrollment made by the beneficiary (or the M+C organization) when beneficiaries permanently move out of the plan's service area. In most cases, statements made by the beneficiary will be sufficient evidence to process such retroactive requests. Disenrollments due to a change in permanent residence are effective the first day of the calendar month after the date the member began residing outside of the plan's service area (see §50.2.1).

A retroactive request must be submitted by the M+CO to CMS by the member in cases in which the M+CO has not properly processed or acted upon the member's request for disenrollment as required in §50.4.1 of these instructions. A disenrollment request would be considered not properly acted upon or processed if the effective date is a date other than as required in §30.6.

If an M+CO is making a retroactive request that is a result of M+CO error or system problems (as defined in §10) in which the disenrollment is not recorded on a timely basis by the M+CO or in CMS records, the M+CO must submit the request to:

- CMS central office, for a CMS or SSA computer system problem involving multiple members, or
- CMS RO, for individual cases or situations when the organization is experiencing internal problems.

If the CMS RO is not able to resolve system errors, the recommendation is submitted to CMS central office for correction.

The M+CO should submit a retroactive disenrollment request to the CMS RO for errors made by SSA in submitting plan disenrollments. CMS makes an adjustment of the dates. If the M+CO is uncertain which CMS office should process the request, the M+CO should contact the CMS RO.

60.6 - Retroactive Transactions for Employer Group Health Plan (EGHP) Members

(Rev. 6, 01-15-02)

In some cases an M+CO that has both a Medicare contract and a contract with an EGHP, arranges for the employer to process elections for Medicare-entitled group members who wish to make elections under the Medicare contract. However, there can be a delay between the time the member makes the election through the EGHP, and when the election is received by the M+CO. Therefore, retroactive transactions may be necessary.

60.6.1 - EGHP Retroactive Enrollments

(Rev. 6, 01-15-02)

CMS will allow the M+CO to submit the EGHP enrollment to CMS with retroactive enrollment dates. However, the effective date cannot be prior to the signature date on the election form. The effective date may be adjusted to reflect a retroactive adjustment in payment of up to, but not exceeding, 90 days **payment** adjustment, to conform with the adjustments in payment described under §422.250(b).

EXAMPLE:

In March 2001, the CMS system processing date was March 10, 2001. Elections processed by CMS for the March 10, 2001 due date were for the prospective April 1, 2001 payment. For EGHPs, an effective date of March 1, February 1, or January 1 would reflect 30-, 60-, and 90-days of retroactive payment adjustment, respectively. Therefore, if a completed EGHP election were to be received on 3/5/01, the retroactive effective date could be January 1, February 1, or March 1.

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

No retroactive enrollments may be made unless the individual certifies that the M+CO (or EGHP) provided him/her with the explanation of enrollee rights (including the lock-in requirement) at the time of enrollment. The M+CO should submit such enrollments using a number 60 enrollment code. Refer to Chapter 19 (Managed Care and M+C Systems Requirements) and the Enrollment and Payment User's Guide for more detail on the use of code 60.

60.6.2 - EGHP Retroactive Disenrollments

(Rev. 6, 01-15-02)

The M+CO must submit a retroactive disenrollment request to the CMS RO if an employer does not provide the M+CO with timely notification of a member's requested disenrollment. Up to 90 day's retroactive **payment** adjustment is possible in such a case to conform with the adjustments in payment described under §422.250(b). The employer notification is considered untimely if it does not result in a disenrollment effective date as outlined in §30.6.

The M+CO must submit a disenrollment notice (i.e., documentation) to CMS demonstrating that the member acted to disenroll in a timely fashion (i.e., prospectively), but that the employer was late in providing the information to the M+CO. Such documentation may include an enrollment form for a new M+C plan signed by the member and given to the employer during an open enrollment season. The documentation may not include a copy of a Medicare supplemental plan or Medigap plan enrollment form unless the member indicated on that form that he/she has cancelled any other insurance. Such documentation should be sent to the CMS RO as soon as possible.

60.7 - Election of the Continuation of Enrollment Option

(Rev. 6, 01-15-02)

When a member permanently moves into the M+CO's continuation area, the member must make a positive choice to continue enrollment in the M+C plan. The member must make this choice in writing, but does not have to complete and sign a new enrollment form in order for the continuation to occur.

The M+CO must verify that the member has established permanent residence in the continuation area. Proof of permanent residence is normally established by the address of the residence, but the M+CO may request additional information such as voter's registration records, driver's license records, tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual.

The effective date of a continuation of enrollment change generally is the first day of the month after the individual moves into the continuation area.

60.8 - Storage of Election Forms

(Rev. 6, 01-15-02)

As stated at 42 CFR §422.60(c)(2), M+COs are required to file and retain election forms. 42 CFR §422.502(e)(1)(iii) further states that M+COs must have available for evaluation enrollment and disenrollment records for the current contract period and six prior periods. Therefore, all M+COs must retain enrollment forms and disenrollment requests for the current contract period and six prior periods.

It is appropriate to allow for storage on microfilm, as long as microfilm versions of enrollment forms and disenrollment requests showing the signature and the date are available to reviewers. Similarly, other technologies that would allow the reviewer to access signed forms may also be allowed, such as optically scanned forms stored on disk.

60.9 - Medicare MSA Plans

(Rev. 6, 01-15-02)

M+COs offering Medicare MSA plans must follow the procedures outlined in §§60.1 through 60.8.

Exhibits - Table of Contents

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

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 Center for Medicare and 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 _____

3. Have you changed your Medicare coverage in the past 6 months?

   Yes _____ No _____

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

4. 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 _____

5. Do you receive Medicaid benefits?

   Yes_____ (If yes, Medicaid Number:_____) No _____

6. 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? _____

7. 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 canceled and I will have to fill out a new enrollment form to become a member of a Medicare+Choice plan. _____(Initials)

5. I understand that, in general, I can change health plans or return to the Original Medicare plan only during **certain times of the year**. _____ (Initials)

6. I understand that, in general, there are limitations to the **number of times** I can change my health plan choices during the year. _____ (Initials)

7. 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)

8. 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)

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

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

Exhibit 2: Model Employer Group Health Plan Enrollment (the term "Election" may also be used) Form (5 Pages)

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

Medicare +Choice Plan Name: _____

Effective Date (to be filled in by the plan): _____

Employer Name: _____ Group Number: _____

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 Individual** [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)

Are you the retiree? _____ Yes _____ No

If yes, retirement date (month/date/year) _____

If no, name of retiree _____

Are you covering a spouse or dependents under this Employer Plan? ___ Yes ____ No

If yes, name of spouse _____ Name of dependent(s) _____

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: _____

Are you currently a member of the Health Plan selected? _____Yes _____No

If yes, Plan Member Identification Number_____

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 Center for Medicare and 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 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 individual fill out this form (with the exception of the effective date), 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 don't need dialysis or have had a successful kidney transplant.

Your answers to the following questions will <u>not</u> keep you from enrolling in this plan.

2. 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 _____

3. Do you receive Medicaid benefits?

   Yes_____ No_____

   If yes, Medicaid Number:_____

4. 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? _____

5. 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 continuing to pay 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 canceled and I will have to fill out a new enrollment form to become a member of a Medicare+Choice plan. _____ (Initials)

5. I understand that I may **disenroll** from this plan by sending a written request to the employer benefits office, 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 the Medicare managed care plan. _____ (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)

8. I understand that if I disenroll from this employer-sponsored plan, I will be automatically transferred to the Original Medicare Plan (fee-for-service program). Also, I understand that if I choose to enroll in a different Medicare managed care plan (whether or not it is sponsored by my employer), I will be automatically disenrolled from this employer-sponsored plan. _____ (Initials).

Exhibit 3: Model Short Enrollment Form ("Election" may also be used) (2 Pages)

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 Center for Medicare and 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, in general, I can **change my health plans** or return to the Original Medicare plan only during **certain times of the year** and that there are limitations to the **number of times** I can change my health plan choices during the year.

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 4: Model Notice to Acknowledge Receipt of Completed Enrollment Form

Referenced in section(s): 40.4.1, 60.4

Dear <Name of Member>:

Thank you for filling out a form to enroll in <Plan name>. Starting <effective date>, you must see your <Plan> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <Plan> doctor(s). You will need to pay our copayments when you get health care. **Optional language:** This letter can serve as evidence of insurance until you get your member card from us. Until you get a member card from us, you should show this letter to your doctor when you go to your doctor appointments**.**

All enrollments have to be reviewed by the Center for Medicare and Medicaid Services (CMS), the federal agency that runs the Medicare program. We will send your enrollment to CMS, and they will do a final review of the enrollment. When CMS finishes its review, we will send you a letter to confirm your enrollment with <Plan>. But, you should not wait to get this letter before you begin using <Plan> doctors. You should begin using <Plan> doctors on <effective date>. Also, you should not cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the letter.

You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you do not have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <Plan> will pay for those services. Also, if you have end stage renal disease (ESRD), you may not be able to be a member of <Plan>, and we may have to send you a bill for any health care you received.

Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services,** if you get health care from a non-<Plan> doctor without prior authorization, you will have to pay for the health care yourself.

** Insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain M+C Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc. **

If you have any questions, please call our Member Services Department at <phone number> 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

.

Exhibit 5: Model Notice to Request Information

Referenced in section(s): 40.2.2

Dear <Name of Beneficiary>:

Thank you for your application to <M+C Plan>. We cannot process your application until we get the following things from you:

_____ Proof of Medicare Part A and B coverage. You can send us a copy of your Medicare card or a letter from Social Security or the Railroad Retirement Board as evidence of your Medicare coverage.

_____ A copy of your legal papers authorizing another person to act on your behalf.

_____ Other: _____

You will need to send this information to <M+C Plan name and address> by <date - 30 days from date letter provided to the beneficiary>. If you cannot send this information by <date listed above>, we will have to deny your request to enroll in our plan.

If you have any questions, please call our Member Services Department at <phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 6: Model Notice to Confirm Enrollment

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

This letter is to tell you that the Center for Medicare and 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 7: Model Notice for M+CO Denial of Enrollment

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.

6. _____ You are not eligible to enroll in another Medicare+Choice plan at this time. You will be able to change your health plan choice during the Annual Election Period in November with an effective date of January 1, <insert year>. If you have further questions regarding when you are eligible to enroll in a Medicare+Choice plan, please contact 1-800-MEDICARE.

Medicare MSA plans add #7:

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

(**This paragraph is optional for M+C plans that do not send notice prior to this letter instructing the individual to use plan services as of a certain date.**) 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

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 Center for Medicare and 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.

5. _____ You are not eligible to enroll in another Medicare+Choice plan at this time. You will be able to change your health plan choice during the Annual Election Period in November with an effective date of January 1, <insert year>. If you have further questions regarding when you are eligible to enroll in a Medicare+Choice plan, please contact 1-800-MEDICARE.

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

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 before June 30, 2002 <after 2002 use: March 31, year>. 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).

If we do not receive your disenrollment form before June 30, 2002 <after 2002 use: March 31, year>, you will generally have to wait until the Annual Election Period in November to disenroll from <M+C Plan>. This disenrollment will be effective January 1, <insert year>.Certain exceptions may apply as explained below.

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.

In some cases you **can** disenroll after June 30, 2002 <after 2002 use: March 31, year>, and, in fact, if you move out of <M+C Plan>'s service area you **must** disenroll from <M+C Plan>. In addition, you may disenroll if you are in a "trial period" and you wish to return to Original 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 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.

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 9a: Model Letter for Sending Out Disenrollment Form After the Open Enrollment Period

Referenced in section(s): 50.1

Dear <Name of Member>:

Attached is the disenrollment form you asked for. At this time, you may only disenroll from <M+C Plan> if:

- You move outside <M+C Plan>'s service area. If you move, you must disenroll from <M+C Plan>.
- You are in a trial period. If this is the case, you will have a right to disenroll from (M+C Plan> and return to Original 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) and ask them to check Medicare records to determine whether you might be in a trial period.

If none of the above applies to you, you may not disenroll from <M+C Plan> until the Annual Election Period in November for an effective date of January 1, <insert year>. You may hold on to this disenrollment form until then.

If any of the above do apply to you, complete this disenrollment form, send it back to us in the enclosed envelope, or mail it to your local Social Security Office or Railroad Retirement Board Office. You may also fax it to us, as long as the signature and date are readable at <fax number>. You may also disenroll by calling 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

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.

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

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.

Starting January 1, 2002, there are certain times of the year when you will be unable to disenroll from <M+C Plan> unless there are special circumstances. Before you complete this form, please check your Evidence of Coverage or call <M+C Plan> to make sure you are eligible to disenroll at this time. You can call us at <phone number> 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 }.

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.

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

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. If you want to change your enrollment status again this year, you will have to wait until the Annual Election period in November, unless there are special circumstances.

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 11a: Model Letter for Acknowledgment of Receipt of Voluntary Disenrollment Request from Member and Denial of that Request

Referenced in section(s): 50.1, 50.4.1

Dear <Name of Beneficiary>:

We received your request to disenroll from <M+C Plan>, however we cannot grant you your request due to the following reason:

____ You are not eligible to disenroll from <M+C Plan> at this time. The Open Enrollment Period during which you may disenroll from <M+C Plan> begins January 1 and ends June 30, 2002 <after 2002 use: March 31>. You may only disenroll during those months or during the Annual Election Period in November. We did not receive your election during these months.

____ You already made one election during the Open Enrollment Period, which begins January 1 and ends June 30, 2002 <after 2002 use March 31>. During these months, you may change your enrollment status only one time.

You may disenroll from <M+C Plan> during the Annual Election Period in November for an effective date of January 1, <insert year>. If you wish to disenroll during November, you will need to submit another disenrollment form at that time. If you believe that this denial is an error, please contact us. You may have certain grievance rights.

Please call Member Services at <phone number> or, for the hearing impaired, at <TDD/TTY number> for assistance. We are open <insert days/hours of operation and, if different, TTY/TDD hours of operation >.

Exhibit 12: Model Notice to Confirm Voluntary Disenrollment Identified Through Reply Listing

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. If you want to change your enrollment status again this year, you will have to wait until the Annual Election period in November, unless there are special circumstances.

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 have 60 days before your coverage ends until 63 days after your coverage ends to apply for a Medigap policy. For the first two circumstances described above, some people have up to 24 months during which they are guaranteed the right to buy certain Medigap policies. You may contact your State Health Insurance Program to get more information about the availability of Medigap insurance in your State.

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

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 for Medicare and 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 Loss of Medicare Part A and/or Part B

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

Dear <Name of Member>:

We have been told by the Center 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

Referenced in section(s): 60.3, 60.3.1

Dear< Name of Member>:

The Center for Medicare and 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

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 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 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 17: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another M+CO

Referenced in section(s): 60.3, 60.3.2

Dear <Name of Member>:

Thank you for letting us know you want to keep being a member of <M+C Plan> after we sent you a letter that said we had disenrolled you from our plan.

Based on what you told us, we understand that you canceled your membership in the other plan and want to keep being a member of <M+C Plan>. Please send us a letter within <insert date: 30-days from the effective date of the original disenrollment>, that says you want to keep being a member of <M+C Plan>. Your letter must also say whether or not you got services from non <M+C Plan> doctors since <original effective date of disenrollment>. If you did not get any services from non <M+C Plan> doctors since <original effective date of disenrollment>, we will fix our records after we receive your letter.

In the meantime, you should keep seeing your <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. This sentence is optional for plans that do not require PCPs)**

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

Exhibit 18: Model Notice to Close Out Request for Reinstatement

Referenced in section(s): 60.3.2

Dear <Name of Beneficiary>:

This letter is in response to your request that your membership in <M+C Plan> be reinstated. We cannot process your request because you have not sent us a letter asking for reinstatement. On <date of letter> we told you that you needed to send us a letter by <date placed on notice in exhibit 19>. Your letter has not been received.

The <effective date> date of disenrollment remains in effect. If you have used <M+C Plan> services after this disenrollment date, we will have to bill you for any services you received.

If you have any questions, please call <phone number> 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

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 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 Railroad Retirement Board Office, or by calling 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Please note that beginning January 1, 2002, you may be able to voluntarily join or leave a plan only at certain times of the year, unless there are special circumstances. This could affect your ability to join another Medicare+Choice plan. Call <M+C Plan> for more information.

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

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 Center for Medicare and 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 must wait until the Annual Election Period in November to select another Medicare+Choice Plan, unless there are special circumstances. Any enrollment changes made during the Annual Election period will be effective January 1, <insert year>.

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

Referenced in section(s): 50.3.1

Dear <Name of Beneficiary>:

We have received confirmation from the Center for Medicare and 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 must wait until the Annual Election Period in November to select another Medicare+Choice plan, unless there are special circumstances. Any enrollment changes made during the Annual Election period will be effective January 1, <insert year>.

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

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>

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).

Please note that beginning January 1, 2002, you may be able to voluntarily join or leave a plan only at certain times of the year, unless there are special circumstances. This could affect your ability to join another Medicare+Choice plan. Call <M+C Plan> for more information. 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 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 23: Model Notices For Closing Enrollment (2 pages)

Referenced in section(s): 30

Model A: Closing Enrollment for Partial Month(s)

[Insert name of M+C organization] PUBLIC NOTICE

As of [insert date] [insert name of M+C organization] will no longer offer continuous open enrollment under its Medicare +Choice contract with the Center for Medicare and Medicaid Services for [insert plan name] in [insert service area].

Instead, [insert name of M+C organization] will offer open enrollment for all eligible individuals from the [insert date] to the [insert date] of each month.

[Insert name of M+C organization] will continue to accept enrollments during an entire month into [insert plan name] from eligible individuals who are in a Special Election Period or an Initial Coverage Election Period.

Also, during the Annual Election Period in November, [insert name of M+C organization] will continue to accept enrollments into [insert plan name] from all eligible individuals during the entire month.

Current members of [insert name of plan] are not affected by this change. For information regarding this notice, call [insert name of M+C organization] at [insert phone number] or, for the hearing impaired, at TDD/TTY [insert number] between [insert time frames].

Model B: Closing Enrollment for Whole Month(s)

[Insert name of M+C organization] PUBLIC NOTICE

As of [insert date] [insert name of M+C organization] will no longer offer open enrollment under its Medicare +Choice contract with the Center for Medicare and Medicaid Services for [insert plan name] in [insert service area].

However, [insert name of M+C organization] will continue to accept enrollments into [insert plan name] from eligible individuals who are in a Special Election Period or an Initial Coverage Election Period.

Also, during the Annual Election Period in November, [insert name of M+C organization] will continue to accept enrollments into [insert plan name] from **all** eligible individuals.

Current members of [insert name of plan] are not affected by this change. For information regarding this notice, call [insert name of M+C organization] at [insert phone number] or, for the hearing impaired, at TDD/TTY [insert number] between [insert time frames].

Model C: Closing Enrollment for Capacity Reasons

[Insert name of M+C organization] PUBLIC NOTICE

As of [insert date], [insert name of M+C organization] will no longer accept enrollment under its Medicare +Choice contract with the Center for Medicare and Medicaid Services for [insert plan name] in [insert service area].

The [insert plan] has been approved for a capacity limit by the Center for Medicare and Medicaid Services. A capacity limit allows a Medicare +Choice Organization to limit enrollment in a plan once a specific number of people join the plan. This is based primarily on the accessibility and availability of providers to provide services to members of the plan.

Current members of [insert name of plan] are not affected by this change. Also, individuals who are enrolled in other [insert organization name] plans may still be able to enroll in [insert name of plan] when they become eligible for Medicare.

For information regarding this notice, call [insert name of M+C organization] at [insert phone number] or, for the hearing impaired, at TDD/TTY [insert number] between [insert time frames].

Exhibit 24: Summary of Notice Requirements (3 Pages)

Referenced in sections(s): 50

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 Form (Exh. 3)	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)	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 and 11a)	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
Confirmation of Voluntary Disenrollment Identified Through Reply Listing (Exh.	50.1, 50.4.1.	Yes	7 business days of reply listing

12)	60.3.2		
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
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
Medicare MSA Plan Enrollment Form (Exh. 23)	40.7	Yes	NA
Medicare MSA Trustee/Custodian Account Application (Exh. 24)	40.7	Yes	NA
Public Notices For Closing Enrollment (Exh. 24)	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

Exhibit 25: 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
2	Effective date of coverage**{**tc \l1 "Effective date of coverage**}**	No[1]	1, 2, 3
3	Beneficiary name	Yes	1, 2, 3
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
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

[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
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
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
20	Signature and Relationship of any individual who helped beneficiary fill out form (if applicable)	Yes	1, 2, 3
21	Date of signatures	No[3]	1, 2, 3
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

[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 Acomplete@ 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, 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.

	Data Element	Required before enrollment complete?	Exhibit # in which data element appears
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

[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.

Exhibit 26 - Model Notice for Medigap Rights Per Special Election Period

Referenced in section(s): 50.1 and 50.2

Dear <Name of Beneficiary>:

This is to confirm that you disenrolled effective <insert date> as a result of special circumstances. You requested disenrollment from our plan to return to Original Medicare because:

1. _____ You permanently moved.
2. _____ You receive assistance from the Medicaid program.
3. _____ You wanted to disenroll to Original Medicare to access certain Medigap protections associated with your trial period.
4. _____ You joined an M+C plan when you turned 65 and wanted to return to Original Medicare during your 12-month trial period.
5. _____ Other circumstance defined as eligible for a Special Election Period.

Please save this letter as proof of your Medigap rights.

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