

Medicare Managed Care Manual

Chapter 17, Subchapter D Medicare Cost Plan Enrollment and Disenrollment Instructions

Updated: *XXXXXXXX XX, 2012*

This guidance update is effective for contract year ~~2010~~2013. All enrollments with an effective date on or after January 1, ~~2010~~2013, must be processed in accordance with the revised guidance requirements, including new model enrollment forms and notices provided. ~~Organizations~~ *Cost plans* may, at their option, implement any aspect of this guidance (e.g. new model forms/notices) prior to the required implementation date *with the exception of reinstatements for “Good Cause” for cost plan contract disenrollments due to failure to pay premiums, which is effective January 1, 2013.*

It is expected that plans will assure that all requirements outlined in this subchapter regarding communications made with beneficiaries/members, including the use of the model notices are also in compliance with standards and guidelines was established in the Medicare Marketing Guidelines.

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10 – ~~Definitions~~ *General Information*

10.1 – *Definitions*

42 CFR 417.1

Application Date – For paper enrollment forms and other enrollment request mechanisms, the application date is the date the enrollment request is initially received by the Medicare cost plan as defined below. Plans must use this date in the appropriate field when submitting enrollment transactions to CMS. For requests sent by mail, the application date is the date the application is received by the cost plan (postmark is irrelevant).

- For requests received by fax, the application date is the date the fax is received on the cost plan's fax machine.
- For requests submitted to sales agents, including brokers, the application date is the date the agent/broker receives (accepts) the enrollment request and not the date the cost plan receives the enrollment request from the agent/broker. For purposes of enrollment, receipt by the agent or broker, employed by or contracting with the cost plan, is considered receipt by the plan, thus all CMS required timeframes for enrollment processing begin on this date.
- For requests accepted by approved telephonic enrollment mechanisms, the application date is the date of the call. The call must have followed the approved script, included a clear statement that the individual understands he or she is requesting enrollment, and have been recorded.
- For requests made via the Medicare.gov Online Enrollment Center (OEC), the application date is the date CMS "stamps" on the enrollment request at the time the individual completed the OEC process. This is true regardless of when the cost plan ultimately retrieves or downloads the request.
- For internet enrollment requests made directly to the cost plan's website, the application date is the date the request is completed through the cost plan's website process. This is true regardless of when a cost plan ultimately retrieves or downloads the request.
- For all enrollments into employer group or union sponsored plans, the application date used on the transaction submitted to CMS will always be the 1st of the month prior to the effective date of enrollment for all mechanisms at all times. For the purposes of providing notices and meeting other timeframe requirements provided in this guidance, use the date the cost plan receives the request. For example, if a valid group enrollment mechanism file is received by the cost plan on January 24th for enrollments effective February 1st, the receipt date for the provision of required notices is January 24th and the application date submitted on the enrollment transactions is January 1st.
- For auto- or facilitated enrollment as provided in Section 40.1.5, the application date is the first day of the month prior to the effective date of the auto/facilitated enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the auto- or facilitated enrollment in CMS systems.

Conversions -For individuals who are enrolled in a health plan offered by the ~~managed care organization~~ *Medicare cost plan* the month immediately before the month of their entitlement to Medicare Parts A and B, or Part B only, their enrollment in a cost plan offered by the same

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organization is referred to as a "conversion" from commercial status to Medicare cost enrollee status. The effective date of conversion enrollments is the first of the month of initial Medicare entitlement.

Enrollment Request Mechanism - A method used by individuals to request to enroll in a Medicare cost plan.

Evidence of Medicare Part A and/or Part B Coverage –*For the purposes of completing a cost plan enrollment request, the Medicare cost plan must verify Medicare entitlement for all enrollment requests using either the BEQ or the MARx online query (M232).*

If CMS systems do not show Medicare entitlement, acceptable forms of evidence are:

- 1. A Medicare identification card;*
- 2. A Social Security award letter that shows the Medicare HICN and effective date of Part A and/or Part B.*

Evidence of Permanent Residence -A permanent residence is normally the enrollee's primary residence. A Medicare cost organization may request additional information such as voter's registration records, driver's license records, tax records, or utility bills to verify the primary residence. Such records must establish the permanent residence address, and not the mailing address, of the individual.

“Good Cause” – *This term refers to the standards established in §60.6.4 under which an individual may be reinstated into his/her cost plan, or optional supplemental Part D benefit, when involuntarily disenrolled for failure to pay the plan’s premium (or co-insurance) or the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA).*

Involuntary Disenrollment ~~-Refers to Medicare cost organization, as opposed to the member, initiates disenrollment from the plan~~*Disenrollments made necessary due to the cost plan’s determination that the individual is no longer eligible to remain in the plan, or when an organization otherwise initiates disenrollment as allowed in this guidance (e.g. failure to pay plan premiums, plan termination). Procedures regarding involuntary disenrollment are found in §50.2 of this chapter.*

Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) – *A premium amount separate from the Part D plan’s monthly premium for individuals who have incomes over a certain amount. The Social Security Administration assesses the amount annually based on the enrollee’s available tax information. The plan does not collect the Part D-IRMAA as part of its premium. Typically, individuals pay the Part D-IRMAA through their Social Security, Office of Personnel Management or Railroad Retirement Board (RRB) benefit withholding. Some enrollees are directly billed for their Part D-IRMAA through invoices sent by CMS or the RRB. All Part D enrollees who are assessed the Part D-IRMAA are required to pay the IRMAA even if the Part D coverage is provided through an EGHP.*

Plan Performance Rating – *A CMS-assigned rating, measured in stars from one to five, which indicates an organization’s quality and performance based on criteria established by CMS. A star rating of one star indicates poor performance, while a star rating of five stars indicates exemplary performance. The Plan Performance Overall Rating (or “overall rating”) is publicly available on Medicare.gov. CMS assigns the rating in October for the following year based on the organization’s most recent quality and performance data.*

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Receipt of Enrollment Request - Medicare Cost organizations may receive enrollment requests through various means, as described in § 40.1. The Medicare cost plan must date as received all enrollment requests as soon as they are initially received. This date will be used to determine the effective date of the request. Please refer to the definition of "Application Date" in this section for specific information regarding the correct date to report as the application date on enrollment transactions submitted to CMS.

Voluntary Disenrollment - Disenrollment initiated by a member or his/her authorized representative.

10.12 – General Requirements

42 CFR 417

Cost contracts generally are limited to existing contractors, who had a cost contract in place before the date of enactment of the Balanced Budget Act of 1997. The only exception to this rule is for entities that currently have an HCPP contract under §1833(a)(1)(A) of the Social Security Act (the Act), and wish to convert to a §1876 cost contract. In order for an HCPP to contract CMS under a cost contract, the entity must meet certain qualifying conditions as outlined in 42 CFR 417, Subpart J. One of these qualifying conditions requires the entity to demonstrate an ability to enroll members and to sustain a membership that ensures effective, efficient and economical care to the plan's Medicare enrollees. Meeting these requirements is also a condition for continuing to contract with CMS as an existing cost contractor.

Operating experience and enrollment requirements are minimum standards. In addition to the plan demonstrating the ability to enroll members, these enrollment levels are necessary to provide a reasonable basis for CMS to establish payment rates for the plan.

10.23 – Cost Plans Offering Medicare Prescription Drug Coverage as an Optional Supplemental Benefit

42 CFR 417.102

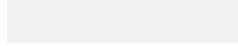
Individuals enrolled in (or newly enrolling in) a cost plan may select that cost plan's optional supplemental Medicare prescription drug benefit (Part D), if one is offered, following the requirements outlined in *Chapter 3 of the Medicare Prescription Drug Benefit Manual*. ~~the CMS enrollment guidance for PDP Sponsors titled: "PDP Guidance; Eligibility, Enrollment and Disenrollment" available at:~~ *It is* important to remember that even though a cost plan is not subject to the Part D enrollment periods, these enrollment periods apply to a cost plan member's (or new enrollee's) ability to enroll in or disenroll from the optional supplemental Part D benefit.

Individuals enrolled in a cost plan, regardless of whether or not the cost plan offers an optional supplemental Part D benefit, may enroll in a separate Prescription Drug Plan (PDP), during applicable enrollment periods and in accordance with CMS Part D eligibility and enrollment guidance. Such individuals will be simultaneously enrolled in both the cost plan (but not the cost plan's optional supplemental Part D benefit) and the separate PDP.

Cost plans offering the optional supplemental Part D benefit must determine if the Part D late enrollment penalty applies, following guidelines in Chapter 4 of the Medicare Prescription Drug Benefit Manual, and if so, apply the LEP amount reported by CMS to the member's monthly premium.

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An individual in a cost plan with an optional supplemental Part D benefit may be subject to a Part D-Part D-IRMAA). The Part D-IRMAA is paid directly to the government and not to the plan. Individuals who fail to pay the Part D-IRMAA within the established grace period will be involuntarily disenrolled. See Section 50.7.5.



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20 – Eligibility for Enrollment in a Medicare Cost Plan

42 CFR 417.422

In general, an individual is eligible to enroll in a cost plan by meeting each of the following requirements. A cost plan that is accepting new members must enroll any Medicare beneficiary who:

- Is entitled to benefits under Medicare Part A and enrolled in Medicare Part B, or is enrolled in Medicare Part B only;
- Permanently resides within the geographic area of the cost plan (see exception in [§20.1.2](#) for persons converting to Medicare Part A and/or Part B who are living outside the service area at the time of enrollment);
- Completes ~~and signs~~ the application form *or mechanism* used to enroll members during the enrollment period and provides all the information required to process the enrollment; and
- Agrees to abide by the membership rules disclosed during the enrollment process.

A cost plan must deny enrollment if:

- The beneficiary has been medically determined to have End Stage Renal Disease (ESRD) prior to applying for enrollment (with some exceptions; see [§20.2](#)).
- The beneficiary is otherwise ineligible to enroll in the cost plan
- CMS has granted a waiver or limitation of the open enrollment requirement (see [§30.1.1](#)) and that limit has been reached

Individuals who have elected Hospice are not precluded from enrolling in a Cost plan per the statutory eligibility criteria in Section [1876\(d\)](#) of The Social Security Act.

A cost plan may choose to wait for the individual's payment of the plan premium, including any premiums or cost sharing due the organization for a prior enrollment, before processing the enrollment.

The organization may not deny enrollment to a Medicare beneficiary who continues to work and who is enrolled in his or her employer's health benefits plan (or that of a spouse). If the individual enrolls in a cost plan and continues enrollment in his/her (or their spouse's) employer health benefits plan, then coordination of benefits rules apply.

If the cost plan offers Medicare prescription drug coverage as an optional supplemental benefit, current cost plan members, as well as individuals newly enrolling in the cost plan, may select this benefit only during Medicare prescription drug coverage enrollment periods, as described in *Chapter 3 of the Medicare Prescription Drug Benefit Manual* ~~the CMS PDP Guidance; Eligibility, Enrollment and Disenrollment.~~

Individuals enrolled in a Medicare Advantage (MA) plan must have a valid MA election period available that would permit their disenrollment from that MA plan upon enrollment into a cost plan (MA election periods are described in detail in the CMS MA enrollment and disenrollment guidance).

Enrollment into a cost plan by an individual who is currently an MA enrollee requires a valid MA enrollment election period type on the cost plan enrollment transaction to effectuate the individual's disenrollment from the MA plan upon enrollment into the cost plan.

20.1 – Conversion Enrollments

42 CFR 417.432

The cost plan must accept as a Medicare member any individual who was enrolled in the organization during the month immediately before the month in which he or she became entitled to both Medicare Parts A and B, or Part B only. *The individual must complete ~~and sign an~~ an application form or ~~complete another~~ other enrollment request mechanism within the standard timeframes.* The application of this provision to individuals with ESRD is discussed in §20.2.2.

Unless the individual chooses to cancel the enrollment request in the Medicare cost plan, the effective date of the conversion is the month in which he or she is entitled to Medicare Parts A and B or Part B only. The Medicare cost organization may not cancel the enrollment of an individual who is converting unless one of the conditions specified in 50.2 and/or 50.3 apply.

The cost plan has the option to also allow individuals who are newly entitled to Medicare Parts A and/or B to elect the cost plan upon conversion even if they reside outside the service area. The cost plan must apply its choice of this option 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 cost plan. Individuals permitted to enroll under this option must also be permitted to enroll in the cost plan's optional supplemental Part D benefit, if one is offered.

A cost plan that is closed to enrollment cannot accept conversion enrollments.

20.2 – End Stage Renal Disease

42 CFR 417.423

Generally, an individual is not eligible to enroll in a cost plan if he or she has been medically determined to have ESRD (see exceptions described under §20.2.2). End Stage Renal Disease (ESRD) is defined as that stage of kidney impairment that appears irreversible and permanent, and requires a regular course of dialysis or a kidney transplant to maintain life.

An individual who receives a transplant that restores kidney function and no longer requires a regular course of dialysis to maintain life is no longer considered to have ESRD for purposes of cost plan eligibility. The individual may elect to enroll in a cost plan if he or she meets the other applicable eligibility requirements indicated in §20. If a beneficiary is only eligible for Medicare on the basis of ESRD (i.e., not based on disability or age), he or she would only be permitted to remain enrolled in a cost plan during his or her remaining months of Medicare eligibility. See §40.3 for additional information.

The cost plan is permitted to ask whether the beneficiary has ESRD at the time of application. This question is permissible since the law does not permit a person with ESRD to join a cost plan. If the applicant answers "yes" to the question of whether he or she requires regular maintenance dialysis, the plan can deny enrollment after ensuring the beneficiary is not eligible for one of the exceptions listed in §20.2.2. CMS will reject the enrollment if Medicare records indicate the applicant has ESRD.

20.2.1 – Background on ESRD Entitlement

42 CFR 406.13

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

The first day of the third month after the month dialysis begins (i.e., the first day of the fourth month of dialysis);

- The first day of the month dialysis began if the individual trains for self-dialysis;
- The month an individual is admitted to a hospital for a kidney transplant or for health care services needed before a transplant if the transplant takes place in the same month or within the 2 following months;
- Up to 12 months prior to the month of filing (if dialysis began more than 12 months before); or
- Prospectively.

The Medicare entitlement date is usually the month an individual is hospitalized for 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.

There are individuals who are approved to perform self-dialysis. If an individual is approved for self-dialysis, the Social Security Administration (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.

20.2.2 – Exceptions to Eligibility Rule for Individuals with ESRD

42 CFR 417.423(2)

- **Conversion:** Individuals who developed ESRD while a member of a health plan offered by an organization and who are converting to Medicare Parts A and B, or Part B only, may enroll in a cost plan in the same organization (within the same state, with exceptions) at the time of conversion. The individuals must meet all other cost plan eligibility requirements and must fill out an enrollment form to enroll.

If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect a cost plan at the time of their conversion. Therefore, these individuals will be allowed to prospectively elect a cost plan offered by the organization, as long as they were in a health plan offered by the same organization the month before their entitlement to Parts A and B, or Part B only, 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 third month after the month dialysis begins.

- If the individual was first medically determined to have ESRD after the date on which the enrollment form was signed but before the effective date of coverage, he can still enroll in that cost plan
- An individual who develops ESRD while enrolled in a cost plan may continue to be enrolled that cost plan. This also can apply to an individual who developed ESRD while enrolled with the organization offering the cost plan, even if the individual was not enrolled under the cost contract, and it is not a conversion situation

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- An individual with ESRD who is a member of a cost plan may enroll in other plans offered by that organization (within the same state, with exceptions)
- 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 cost plan eligibility (see §40.3 for additional instructions).

20.3 – Hospice

42 CFR 417.423

Individuals who have elected Hospice are not precluded from enrolling in a Cost plan per the statutory eligibility criteria in Section 1876(d) of The Social Security Act. When it is determined that a current member of the cost plan has elected to receive hospice care, he or she must waive the right to receive treatment for the terminal condition and related conditions from any provider other than the hospice and the attending physician. **The individual cannot be disenrolled from the cost plan merely because he or she has elected hospice care.**

The beneficiary remains in the cost plan as long as he or she continues payment of the plan premium. This means that the cost plan must provide those services that have not been waived, e.g., the cost plan must continue providing services unrelated to the terminal condition that the cost plan provides or authorizes. The cost plan must also continue to provide services unrelated to the terminal condition under the same conditions that would apply to a member who has not elected hospice (the member continues to be responsible for normal plan cost sharing for these services), and any supplemental benefits for which the beneficiary has paid.

Upon revocation of the hospice election *or when the enrollee exhausts his or her hospice benefits*, the cost plan must immediately reinstate the beneficiary's full enrollment.

30 – Enrollment Periods and Effective Date of Enrollment

42 CFR 417.422

Cost plans are subject to the following requirements to accept enrollment forms from individuals eligible to enroll in the cost plan. Individuals wishing to also enroll in an optional supplemental Part D benefit offered by the cost plan may do so only during applicable Part D enrollment periods (refer to section 10.2).

30.1 – General Open Enrollment Requirements

42 CFR 417.426

The general requirements for open enrollment are that the cost plan:

- Hold an annual open enrollment period of at least 30 or more consecutive days for Medicare beneficiaries;
- Publicize its upcoming enrollment period in appropriate media throughout the service area (this requirement does not apply for Cost Plans that are continuously open for enrollment); and
- Enroll Medicare beneficiaries on a first come, first serve basis.

If the organization has met the 30-day requirement through a longer enrollment period or through continuous open enrollment and it decides to close enrollment, the plan must notify CMS and the general public 30 days in advance of the new limitations on its open enrollment process (refer to Exhibit 12).

If the organization has both a cost contract and a Medicare Advantage contract in the same service area, it may not enroll new individuals in the cost plan (42 CFR 422.503(b)(5)).

This prohibition on enrolling new individuals in the cost plan also applies to enrollments into employer or union sponsored cost plans, including individuals who convert to Medicare (either by age or disability). While CMS has granted exceptions to this prohibition on a limited basis in the past, any such exceptions ~~ended will end as of the date the current employer/union contract terminates or is due for renewal, but no later than~~ on December 31, 2009. As of this date, all employer/union sponsored cost contracts will be prohibited from accepting enrollments.

The cost plan would not be able to retain its Medicare Advantage contract if it were to accept new enrollments in the cost plan at any time of the year. In this instance only, CMS will not enforce the cost plan's obligation to open enrollment. The cost plan must always accept requests for disenrollment.

If a cost plan is voluntarily closed for enrollment, then it is closed to all individuals in the entire plan service area for enrollment. When a cost plan re-opens after being voluntarily closed, there is no requirement for the cost plan to notify the general public. However, the cost plan should notify CMS when this occurs. If this occurs, the plan would no longer be able to offer a Medicare Advantage contract in the area.

A cost plan that offers an optional supplemental Part D benefit must permit plan members to enroll in or disenroll from that benefit during any valid Part D enrollment period, as described in ~~the CMS PDP Guidance; Eligibility, Enrollment and Disenrollment~~ *Chapter 3 of the Medicare Prescription Drug Benefit Manual*, regardless of whether the cost plan is otherwise open for enrollment.

A cost plan that offers an optional supplemental Part D benefit can allow plan members to make changes to their medical (non-prescription) benefits during the general open enrollment period, but those members cannot make changes to their Part D benefit unless a valid Part D enrollment period exists for the member.

30.1.1 – Waivers for Open Enrollment

The organization may obtain a waiver of the open enrollment requirements under one of the following two conditions -(1) Non-representative enrollment, and (2) Limited capacity.

Non-Representative Enrollment (42 CFR 417.413(e)(2))

An open enrollment period will result in a membership substantially non-representative of the population in the geographic area. In this case, the organization may request a selection restriction in writing at least 90 days before the proposed open enrollment period. The organization must provide statistical data that an open enrollment period would cause a particular membership subgroup to exceed its proportion of the geographic area by at least 10 percent. A subgroup is defined as a class of Medicare beneficiaries based on factors such as age, ~~sex~~gender, or other factors that CMS determines significantly affects health care utilization. The organization may not limit enrollment unless and until CMS approves the selection policy. If the organization submits insufficient data to make a decision, CMS will deny the request.

Limited Capacity (42 CFR 417.426(b))

The organization does not have capacity for additional members, or the organization must limit enrollment to a certain number of members. The organization must estimate whether it would reach capacity during its next open enrollment period, and would therefore need a CMS approved capacity waiver. The following sections describe criteria and procedures for capacity waiver applications. An organization must submit all required information to its Regional Office at least (and preferably more than) 90 days prior to the open enrollment period for Medicare beneficiaries. ~~The~~CMS will make every attempt to notify the organization of its decision at least 60 days in advance of the enrollment period. If the waiver is granted, it remains in effect for one year only.

30.1.2 – Determining Enrollment Availability for Medicare Beneficiaries

42 CFR 417.426(c)

The cost plan must verify to CMS the number of vacancies open to Medicare beneficiaries during the open enrollment period. If there are conditions or factors that the organization believes are pertinent to determining its enrollment availability for Medicare beneficiaries, it should submit this information to CMS. Utilizing a worksheet (~~Exhibit 11~~Appendix 2), the plan will determine enrollment availability by:

1. Establishing present capacity;
2. Obtaining current Medicare, Medicaid, and commercial enrollment numbers;
3. Adjusting these enrollment numbers by the following figures:
 - i. Reserved vacancies -add to commercial enrollment the number of members the plan expects to enroll from its existing group contracts and from anticipated new group contracts (see §30.1.5);
 - ii. Subtract expected age-ins (commercial members of the plan who will convert to Medicare status upon becoming eligible for Medicare) from the commercial enrollment total and add to the Medicare enrollment numbers for a new Medicare enrollment total; and

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- iii. Multiply the new Medicare enrollment total by the organization's Medicare utilization factor (see §30.1.4) to obtain an adjusted Medicare enrollment total.
4. Subtracting the adjusted commercial enrollment total and the adjusted Medicare enrollment total from the organization's capacity. The remainder determines the number of vacancies available for open enrollment.

These vacancies must be filled with Medicare beneficiaries up to the point where further enrollment would be substantially non-representative of the population in the geographic area.

30.1.3 – Utilization Adjustment Factor

The CMS recognizes the greater intensity of services and frequency of health care utilization among Medicare beneficiaries than among commercial membership. Since there is no one-to-one equivalence between Medicare and commercial members in this respect, a utilization adjustment factor is incorporated in calculating enrollment capacity. The utilization adjustment factor represents the number of commercial members the organization could serve for every one Medicare member served over the course of the contract year. The organization also provides backup documentation and discussion of the methodology employed in the calculations. For example, if the data show that Medicare utilization is three times that of commercial members, the capacity for new commercial members is three times what it would be for new Medicare members. Therefore, if the available capacity is for 3,000 additional commercial members in the next contract period, and the organization anticipates filling 1,500 of those slots with commercial members, the remaining 1,500 slots must be divided by three. That is, full capacity is reached if the organization enrolls 500 Medicare members in addition to the 1,500 commercial members, based on a ratio of one Medicare vacancy to every three commercial vacancies.

30.1.4 – Reserved Vacancies

42 CFR 417.426

Reserved vacancies are those set aside for members of anticipated new group contracts or for anticipated new members of an existing group contract when these group enrollment periods are held after the cost plan open enrollment period.

If open enrollment(s) for one or more of the organization's group contracts is scheduled after the organization's cost plan open enrollment period, the plan should set aside a reasonable number of slots or vacancies for anticipated new members from these groups. These reserved vacancies should also be used to determine the enrollment availability for Medicare beneficiaries as described in §20.1.

Because these reserved vacancies limit the available spaces for Medicare members, CMS must approve the organization's use and number of reserved vacancies. Therefore, reserved vacancies are included in the calculations outlined in §30.1.5 and on the worksheet shown in Exhibit 12. Reserved vacancies not used within a reasonable time after the group contract enrollment period has begun must be released and made available to Medicare beneficiaries.

30.1.5 – Special Requirements When Reaching Capacity

42 CFR 417.430(b)

If an organization reaches capacity during open enrollment and it has a CMS approved waiver, it has two options: It can refuse further enrollments or continue accepting applications and place them on a waiting list. For example, if the organization opts to continue accepting applications, it must place all

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prospective members who wish to wait for an opening on the waiting list in chronological order. As vacancies occur, the plan should contact the beneficiary, and enroll him or her after ensuring he or she still wants the cost plan to honor the application.

30.2 – Effective Date of Enrollment in Cost Plans

42 CFR 417.450

A Medicare cost plan may choose between the following two Cost Plan Enrollment Effective date options:

1. Cost Plan Enrollment Effective Date Option 1: Follow the traditional cost plan effective date rules found below as Enrollment Effective Date Option 1 (§30.2.1)
- OR-**
2. Cost plan Enrollment Effective Date Option 2: Follow the effective date policy for enrollment outlined below as Enrollment Effective Date Option 2 (§30.2.2).

The organization must choose only one option and must apply that option to all cost plan enrollments.

~~The~~ CMS will assume the organization will follow Cost Plan Enrollment Effective Date **Option 1** unless the organization notifies (or has notified) the appropriate CMS Regional Office and includes this change in the policies and procedures provided to CMS. Organizations offering Medicare cost plans will be expected to follow the chosen enrollment effective date option throughout the contract year. ~~The~~ CMS may permit an organization to change its enrollment effective date option during a contract year by special request for good cause. If the organization plans to change its selection of enrollment effective date options for a new contract year, it must notify the appropriate CMS Regional Office account manager.

30.2.1 – Cost Plan Enrollment Effective Date Option 1

42 CFR 417.450(a)(2)

A Medicare beneficiary's enrollment begins on the first day of the month in which his or her membership in the cost plan is effective, as shown on CMS records. The effective month of coverage may not be earlier than the first month after, or later than the third month after, the month in which the enrollment information is correctly submitted to and received by CMS. *Specifically, if CMS receives the enrollment request data before the CMS monthly plan data due date, the effective date can be as early as the first of the next month and as late as the first of the third month following receipt of the request. If CMS receives the enrollment request data after the CMS monthly plan data due date, the effective date can be as early as the first of the second month following and as late as the fourth month following the receipt of the request. See the example below.* ~~The~~ CMS may approve a later effective date if requested by the plan and the beneficiary.

Enrollment cannot be effective prior to the date entitlement to Medicare Part A and Part B, or Part B only begins. *If an individual attempts to enroll in a Medicare Cost plan before becoming entitled to Medicare Part B benefits, the effective month of coverage for a valid enrollment request is the first month for which he or she becomes entitled to Medicare Part B benefits.*

The cost plan is responsible for submitting accurate and timely records to CMS for new enrollments (*refer to §40.2*). ~~The~~ CMS is responsible for promptly supplying systems verification of the individual's acceptance (or rejection) into the cost plan. Cost plans must adhere to and comply with the

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transaction submission and other systems requirements provided by CMS in the Plan Communications Users Guide.

Enrollment Effective Date Example:

The CMS monthly cut-off date for the submission of records is August 16, 2010. A cost plan enrollment application form that is received on August 12, 2010, could have an effective date of enrollment of September 1, October 1, or November 1, 2010.

If the same cost plan enrollment application form was received on August 17, 2010, (i.e., after the cut-off date for the submission of records) it could have an effective date of enrollment of October 1, November 1, or December 1, 2010.

If the cost plan has informed a beneficiary that his/her enrollment in the plan is effective on a certain date, but then submits an incorrect enrollment record to CMS, the plan must honor its contract with the individual and begin providing coverage on the stated date. If the plan provides services to the member before it can submit the correct enrollment information, the plan may still receive Medicare fee-for-service payments for any services it renders. In order for the cost plan to receive direct payments for physician and supplier services from a Medicare carrier, the cost plan must have a third party billing number, or it can have the physician or supplier ~~directly~~ bill the FFS program *directly*.

Additionally, if the cost plan collects or has waived collection of a premium from the beneficiary which covers the deductible and coinsurance for Medicare covered services for the originally designated month of enrollment, the cost plan is financially responsible for Medicare deductibles and coinsurance amounts not paid by carriers and intermediaries on pre-enrollment claims for services obtained in network or for emergency or urgently needed care. The Medicare beneficiary is liable for any services for which the cost plan has no financial responsibility under the terms of its Medicare contract.

30.2.2 – Cost Plan Enrollment Effective Date Option 2

Cost plans that choose this option must consistently apply the following rules:

1. **First of the Next Month:** Enrollments will be effective the first day of the month after the month the cost plan receives an enrollment form. The cost plan must be open to accept such enrollments.
2. ~~November-October~~ **15 through December 31-7 of every year:** Enrollments received during this time period ~~will~~ *can* be effective January 1 of the following year (except as noted below).
3. **Enrollment Prior to entitlement:** Individuals may enroll in a cost plan during the three months **immediately** before the individual's entitlement to Medicare Part A and/or Part B. The enrollment will be effective the first day of the month of entitlement to Medicare Part A and/or Part B.

Note: These rules are specific to cost plans. While they are similar to Medicare Advantage rules outlined in Chapter 2 of the Medicare Managed Care Manual, the use of Option 2 does not allow the cost plan to enroll individuals using Medicare Advantage methods and rules.

Employer group members only: Cost plans that have contracted with an employer group may offer beneficiaries enrolling through an employer group effective dates of up to three months after the month in which the cost plan receives the enrollment form. However, the effective date may NOT be earlier than the date the cost plan receives the enrollment form; retroactive transactions are not allowed.

30.2.3 – Effective Date of Optional Supplemental Part D Benefit

42 CFR 423.40

New applicants and existing cost plan enrollees who want to also enroll in an optional supplemental Part D benefit offered by a cost plan may do so only during applicable Part D enrollment periods (refer to §10.2). The effective date of this Part D benefit is determined by the Part D enrollment period. Refer to the CMS Guidance; PDP Eligibility, Enrollment and Disenrollment for additional information.

30.3 – Effect of the MA and PDP Five-Star Special Enrollment Period (SEP) on Cost Plans

42 CFR 423.38(c)(8)(ii)

An eligible individual may enroll in an MA plan or PDP with a Plan Performance Rating of five (5) stars anytime during the year in which that plan has the 5-star overall rating, provided the enrollee meets the other requirements to enroll in that plan (e.g., living within the service area as well as requirements regarding end-stage renal disease). Individuals may also use the 5-Star SEP to disenroll from a Medicare Advantage plan by enrolling in a 5-Star cost plan that is open for enrollment.

***Example:** Cost plan Y has an overall rating of 5 stars for 2012 and is open for enrollment. An individual enrolled in a MA plan uses this SEP to enroll in cost plan A. Cost plan Y submits the enrollment transaction to MARx using the “R” election type code, and the MA plan Z accepts and processes the subsequent disenrollment per the TRR.*

As overall ratings are assigned for the plan contract year (January through December), possible enrollment effective dates are the first of the month from January 1 to December 1 during the year for which the plan has been assigned an overall rating of five stars. An individual may use this SEP only one time between December 8 of the year prior to the year in which the cost plan has been granted a 5-star overall rating and November 30 of the year in which the cost plan has been granted a 5-star overall rating. The enrollment effective date is the first of the month following the month in which the plan receives the enrollment request.

***Example 1:** Cost Plan X has an overall rating of 4.5 stars in 2012 and 5 stars for 2013. An individual could use this SEP to request disenrollment from an MA plan for the purpose of enrolling in Cost Plan X starting on December 8, 2012 for an effective date of January 1, 2013. An individual could not use the SEP to disenroll from an MA plan for the purpose of enrolling in Cost Plan X for an effective date on or before December 1, 2012, as the enrollment effective dates available during that period are prior to the calendar year for which Cost Plan X has been assigned a 5-star overall rating.*

***Example 2:** Cost Plan Y has an overall rating of 5 stars for 2013 but has lost that 5-star rating for 2014. A beneficiary could use this SEP to disenroll from an MA plan in order to enroll in Cost Plan Y for the first of the following month until November 30, 2013, with the last possible effective date available being December 1, 2013. The beneficiary could not use the SEP to disenroll from an MA plan for the purpose of enrolling in Cost Plan Y on or after December 1, 2013, as the enrollment effective dates available during that period are after the calendar year for which Cost Plan Y has been assigned a 5-star overall rating.*

Regardless of whether the individual has Part D coverage prior to use of this SEP, any individual who enrolls in a 5-star cost plan is eligible for a coordinating Part D SEP to enroll in either the cost plan’s

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optional supplemental Part D benefit or in a standalone PDP. (See Chapter 3, Section 30.3.8 #8, letter H of the Medicare Prescription Drug Benefit Manual for more information.)

***Note:** An individual in either an MA-PD plan who chooses to use the 5-star SEP to disenroll for the purpose of enrolling in a cost plan with a 5-star overall rating would lose their prior Part D coverage. If that individual does not use the coordinating Part D SEP to obtain Part D coverage, then he or she must wait for a subsequent enrollment period to do so under the normal enrollment rules. Late enrollment penalties might also apply.*

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40 – Enrollment Procedures

The enrollment form is a portion of the cost plan's contract with the beneficiary. There are several requirements regarding the exchange of information between the plan and the prospective member during the application process. There are also requirements regarding who may complete the application form.

Cost plans that offer an optional supplemental Part D benefit must ensure the required elements and language provided on the CMS Model PDP enrollment form are captured on the cost plan form. The CMS model PDP enrollment form is provided in ~~the CMS guidance; PDP Eligibility, Enrollment and Disenrollment.~~ *Chapter 3 of the Medicare Prescription Drug Benefit Manual*. Cost plans may add this information directly to their cost plan enrollment form(s) or use a separate additional sheet that will accompany the cost plan enrollment form. In either format, cost plans must make it clear that beneficiaries are not required to choose the cost plan's optional supplemental Part D benefit, and therefore do not have to complete those items if not enrolling in it. Cost plans offering such a benefit must also provide information about Part D enrollment periods to potential enrollees in the cost plan's marketing materials.

40.1 – Format of Enrollment ~~Forms~~ *Requests*

42 CFR 417.430

A cost plan must accept enrollment requests it receives, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, or through other mechanisms as defined and allowed by CMS. Cost plans may use telephonic, online, and group enrollment mechanisms in addition to accepting paper enrollment requests. Cost plans must always have a method in place to accept paper enrollment requests. Additionally, cost plans have the option to participate in the Medicare Online Enrollment Center (OEC) on www.medicare.gov.

A cost plan that chooses to use any of these mechanisms cannot require beneficiaries to use the new mechanism and must still offer a paper enrollment form process (as described below and approved through the CMS marketing material review process described in the CMS Medicare Marketing Guidelines) for potential enrollees to elect enrollments in the cost plan.

40.1.1 – Paper Enrollment Forms

42 CFR 417.430(a)

The cost plan must use a CMS approved enrollment form that complies with the following guidelines on structure and content. A model CMS enrollment form is provided as Exhibit 1 at the end of this chapter. The enrollment form should include a statement acknowledging that premium and co-payment amounts were stated to the enrollee and may be found in the subscriber agreement or other documents, as well as statements indicating that the enrollee:

- Agrees to abide by the cost plan membership rules as outlined in the material provided to the enrollee;
- Authorizes the plan to disclose and exchange necessary information with CMS;
- Understands that he or she may receive medical services from non-network providers, but will be liable for deductibles, coinsurance, and charges not covered by Medicare;

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- Understands that enrollment in the cost plan automatically disenrolls him/her from any other cost plan or Medicare Advantage plan in which he or she is enrolled; and
- Knows the proposed effective date of coverage, which is the date he/she should begin receiving care through the plan.

The cost plan must obtain the applicant's signature and the date. If the applicant inadvertently fails to include the date of signature on the form, then the date of receipt stamped by the cost plan will serve as the signature date on the form. If an individual submits an enrollment form with a missing signature, the cost plan must ~~return the form and obtain the signature~~ *follow up with applicant and obtain a confirmation of the applicant's intention to enroll (see §40.2.2 below).*

40.1.2 – Enrollment Via Telephone

42 CFR 417.430(a)

Organizations may accept telephonic requests for enrollment into their cost plans only via an incoming (in-bound) telephone call to a plan representative or agent. CMS prohibits conducting outbound telephonic enrollment. Organizations that choose to offer a telephonic enrollment mechanism must follow the requirements below in addition to all other applicable program requirements:

- *The cost plan must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his/her authorized representative and that the plan representative, sales agent or broker is not physically present with the beneficiary or present on the phone at the time of the request.*
- *The telephonic enrollment mechanism must clearly advise individuals that they are completing an enrollment request into the plan.*
- *The cost plan must record the audio of each telephonic enrollment request including a statement of the individual's agreement to be recorded, all required elements necessary to complete the enrollment (as required on the model enrollment form, Exhibit 1 in the cost plan enrollment manual), and a verbal attestation of the intent to enroll. If someone other than the beneficiary makes the request, the recording must include the attestation regarding the individual's authority under State law to complete the request, in addition to the required contact information. All telephonic enrollment recordings must be reproducible and maintained as provided in §60.4 of the cost plan enrollment manual.*
- *The telephonic enrollment mechanism must include a tracking mechanism (e.g., a confirmation number) to provide the individual with evidence that the cost plan received the telephonic enrollment request.*
- *The cost plan must provide a notice of acknowledgement and other required information as described in §40.4.1.*
- *The cost plan may not collect information through the telephonic enrollment mechanism that is also prohibited on the paper enrollment mechanism (e.g., impermissible health screening).*
- *The cost plan may not request or collect financial information (e.g., a credit card or bank account number) or market other lines of business at any time during the enrollment call.*

40.1.3 – Enrollment Via the Internet

42 CFR 417.430(a)

Organizations may accept internet enrollment requests into their cost plans only via the organization's secure internet web site (or through the Medicare Online Enrollment Center as described below).

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Online enrollment via other means, such as a broker's website, is prohibited. Organizations that choose to offer an online enrollment mechanism must follow the requirements below, in addition to all other applicable program requirements:

- At a minimum, the organization's internet enrollment mechanism must comply with CMS' internet security policies (found at: <http://www.cms.hhs.gov/informationsecurity/> on the web). The cost organization may include additional security provisions.*
- The cost organization must advise each individual at the beginning of the online enrollment process that s/he is sending an actual enrollment request to the cost plan.*
- The cost organization must maintain electronic records that are securely stored and readily reproducible for the period as required in §60.4 of the cost plan enrollment manual. The organization's record of the enrollment request must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member and/or CMS. A data extract file alone is not acceptable.*
- As part of the online enrollment process, the cost plan's internet enrollment mechanism must inform the individual that, by clicking on the "Enroll Now" or "I Agree" button, s/he is indicating his/her intent to enroll and agreement to the release and authorization language, (see the model enrollment form, Exhibit 1 in the cost plan enrollment manual, for this language), and attesting to the truthfulness of the data provided. The process must also remind the individual of the penalty for providing false information.*
- The internet enrollment mechanism must inform the individual of the consequences of completing the internet enrollment, including that s/he will be enrolled (if approved by CMS), and that s/he will receive notice (of acceptance or denial) following submission of the enrollment to CMS.*
- The internet enrollment mechanism must also indicate that if a legal representative is completing the enrollment request, s/he must attest that s/he has such authority to make the enrollment request and that proof of this authority is available upon request by CMS.*
- The internet enrollment mechanism must include a tracking mechanism to provide the individual with evidence that the internet enrollment request was received (e.g., a confirmation number).*
- Following the acceptance of an online enrollment request, cost plans must provide a summary of the plan for which the individual has requested enrollment or provide a statement that the individual will receive a notice in the mail in response to the enrollment request – e.g., acknowledging receipt of the completed enrollment request, or requesting additional information or denial of enrollment.*
- The cost plan may not collect information on the online enrollment mechanism that is also prohibited on the paper enrollment mechanism (e.g., impermissible health screening).*
- The cost plan may not request or collect financial information (e.g., a credit card or bank account number) or market or enroll beneficiaries in other lines of business/products as part of the online enrollment process.*

40.1.4 – Medicare Online Enrollment Center (OEC)

42 CFR 417.430(a)

In addition to the processes described above, cost plans, including those plans with optional supplemental Medicare prescription drug plans, may choose to participate with the OEC through the www.medicare.gov web site and the 1-800-MEDICARE Call Center. The date and time "stamped" by the OEC will serve as the application date for purposes of determining the enrollment effective date. Cost plans must promptly retrieve enrollment requests from the OEC and must check for requests at least daily.

Because the effective date for enrollment into a cost plan can vary depending on the method used by cost plans (per §30.2), the cost plan must contact the individual in order to determine his/her desired effective date. To that end, data on the cost plan's OEC report will include a "dummy code" that will not necessarily constitute a valid enrollment effective date. Cost plans must still determine the effective date of enrollment in the cost plan's optional supplemental Part D drug benefit separately from the cost plan enrollment itself (per §30.2.3).

CMS' Requirements for Plans Participating in the OEC

Cost plans participating in the OEC must also meet the following requirements that apply to all plans participating in the OEC.

- With the exception of obtaining the enrollment effective date, as described above, all participating cost plans must accept enrollments received through the OEC as complete in terms of the information that the applicant is required to provide. Plans must follow up with the enrollee to get any optional information that the plan requires, but the cost plan cannot delay processing the enrollment while waiting for the additional information. Plans should refer to the cost plan enrollment guidance for a complete description of enrollment processing requirements.*
- Please refer to the Medicare Online Enrollment Center File Layout document for more information on the file layout and applicable data elements for each of the OEC forms. This document is available in the "Help" section of the OEC's Administrative Console.*
- CMS expects all cost plans participating in the OEC to log into the Administrative Console **at least once every business day** and download any pending enrollment requests. Plans have access to information to validate the confirmation number. When necessary, they can have the enrollment re-set so that they can download the enrollment again. An organization can establish a link to the OEC directly from its web site. This option allows an organization to initiate the OEC enrollment application process but complete the OEC enrollment application on Medicare.Gov. This option is available only to those cost plans participating in the OEC. Information regarding the requirements to link to the OEC is posted in the "Help" section of the Administrative Console.*

NOTE: Plans that have a link to the OEC from an external web site and decide to end participation in the OEC will be required to disable the link in order to avoid having to download enrollments from the OEC received from the external web site.
- If an enrollee has a valid online enrollment center confirmation number, the cost plan can verify the enrollment through the Administrative Console. The URL is: <https://enrollmentcenter.medicare.gov/AdministrativeConsole/PlanFinder/login.aspx>. If the enrollment has not been downloaded, the plan should download the enrollment through its usual procedures and process the enrollment.*
- If the plan is unable to find the enrollment in the Administrative Console, the plan can work via email with its designated regional office. The regional office staff can work with CMS central office to try to locate the record and validate the enrollment.*

40.1.15 – Auto and Facilitated Enrollment

42 CFR 423.34

CMS requires that cost plan organizations offering cost plans with optional Part D supplemental benefits have a process for auto- and facilitated enrollment. Cost plans that offer a Part D optional supplemental benefit effective 2006 or later ~~will~~*must* auto or facilitate enrollment of all Part D Low

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Income Subsidy (LIS) eligible individuals into the plan benefit package (PBP) that includes the Part D benefit, in the same organization, if they are enrolled in the cost plan but have not elected the Part D benefit from the cost plan or another PDP, unless the individual declines the enrollment. CMS *auto-enrolls* and facilitates enrollment for LIS-eligible individuals into PDPs when they are enrolled in a cost plan that does not offer any Part D optional supplemental benefits whatsoever, or in an HCPP plan (as HCPP plans may not offer Part D benefits).

The auto and facilitated enrollment processes will occur monthly. As noted in the preamble to the final regulation for Part D (Federal Register Nol. 70, No. 18, January 28, 2005), the legal authority for both auto-and facilitated enrollment processes is technically termed "facilitated" enrollment, since auto-enrollment is limited to PDPs. However, the term "auto-enrollment" is used here to denote the process that applies to full-benefit dual eligible individuals, and "facilitated enrollment" to others with LIS.

CMS has safeguards in place to prevent existing full-benefit dual eligibles enrolled in a cost plan with Medicare prescription drug coverage from being auto-enrolled by CMS into a PDP. However, there may be instances in which a beneficiary election will not yet be reflected at the point in time when CMS processes auto-or facilitated PDP enrollments. In these cases, the beneficiary will receive a notice from CMS informing him/her that s/he has been enrolled into a PDP. However, once the beneficiary's election into the cost plan with Medicare prescription drug coverage is processed by CMS, it will prevail over the previously processed auto-or facilitated PDP enrollment submitted by CMS.

Starting January 1, 2010, *CMS implemented the Limited Income Newly Eligible Transition (Limited Income NET) demonstration, which modified its procedures for auto/facilitating enrollment of LIS beneficiaries into PDPs for those who have retroactive enrollment effective dates. That demonstration does not impact the auto/facilitated requirements* ~~CMS will conduct a demonstration in which it will modify the procedures for auto/facilitated enrollment of LIS beneficiaries into PDPs for those who have retroactive effective dates. That demonstration will not impact the auto/facilitated enrollment requirement~~ for cost plan organizations as specified in this section.

A. Populations

1. Auto-Enrollment

Full-benefit dual eligibles in cost plans that do not include the Medicare Part D benefit will be auto-enrolled by the cost plan as described in section B below. Full-benefit dual eligible individuals are defined as those eligible for comprehensive Title XIX Medicaid benefits as well as eligible for Medicare Part D. This includes those who are eligible for comprehensive Medicaid benefits plus Medicaid payment of Medicare cost-sharing (sometimes known as QMB-plus or SLMB-plus). Please note that full-benefit dual eligible individuals do not include those eligible *only* for Medicaid payment of Medicare cost-sharing (i.e. QMB-only, SLMB-only, or QI).

Full-benefit dual eligible individuals to be auto-enrolled include those who are full-benefit dual eligible upon initial enrollment into a cost plan without Part D, as well as existing Medicare enrollees of a cost plan without Part D who become newly Medicaid eligible. This includes full benefit dual eligible cost plan enrollees who:

- Live in the 50 states or the District of Columbia.

This excludes full-benefit dual eligibles who:

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- Live in any of the five U.S. territories;
- Live in another country;
- Are individuals for whom the employer or union is claiming the retiree drug subsidy, or are enrolled in an employer-sponsored cost plan;
- Are inmates in a correctional facility;
- Have opted out of auto-enrollment into Part D benefits; or
- Are already enrolled in a stand-alone Prescription Drug Plan (please perform a Beneficiary Eligibility Query to determine this status)

2. Facilitated Enrollment

Other LIS eligibles are defined as those deemed automatically eligible for LIS because they are QMB-only, SLMB-only, QI (i.e., only eligible for Medicaid payment of Medicare *premiums and/or* cost-sharing); SSI-only (Medicare and SSI, but no Medicaid); or those who apply for LIS at the Social Security Administration (SSA) or a State Medicaid Agency and are determined eligible for LIS. This includes those who apply and are determined eligible for either the full or partial level of the LIS.

Other LIS eligible individuals to be facilitated enrolled include those who are Other LIS eligible upon initial enrollment into *a* cost plan without Part D, as well as existing Medicare enrollees of a cost plan without Part D who become newly Other LIS eligible.

This includes Other LIS eligible MA-only enrollees who:

- Live in the 50 states or the District of Columbia.

This excludes Other LIS eligible individuals who:

- Live in any of the five U.S. territories,
- Live in another country,
- Are individuals for whom the employer is claiming the retiree drug subsidy, or are enrolled in an employer-sponsored cost plan without Part D,
- Are inmates in a correctional facility, or
- Have opted out of facilitated enrollment into the Part D benefit.
- Are already enrolled in a stand-alone Prescription Drug Plan (please perform a Beneficiary Eligibility Query to determine this status)

B. Auto/Facilitated Enrollment Process

The procedure for auto/facilitated enrollment is as follows:

1. The cost plan will identify full-benefit dual eligibles to be auto-enrolled, and Other LIS eligibles to be facilitated enrolled. Please see subsection C for details on how to distinguish the two populations.

Auto/facilitated enrollment specifically excludes individuals in employer-sponsored cost plans without Part D, and individuals with an employer which is claiming the retiree drug subsidy. These individuals may be identified by submitting a Batch Eligibility Query (BEQ) transaction or access the BEQ information on-line

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1. The cost plan will exclude those who are already enrolled in a stand-alone PDP. The organization may submit a Batch Eligibility Query (BEQ) transaction or access the BEQ information on-line to determine whether individuals are enrolled in a stand-alone PDP.
2. The cost plan will then identify one of the following:
 - a) The cost plan PBP(s) in the same service area, and in the same organization, with the lowest combined cost plan and Part D optional supplemental premium amount. If more than one cost PBP have the same lowest premium amount, auto-enrollment must be random among the available plans. The selection of plan is without regard to the cost plan premium or cost-sharing.
Note: The beneficiary must be auto/facilitated enrolled in the lowest premium plan available, even if that plan's premiums are above the benchmark.
 - a)b) A stand-alone Prescription Drug Plan with a basic benefit package and premium below the region-specific low-income premium subsidy amount offered by the same organization that offers the cost plan
3. Regardless of which option it chooses, the cost plan must apply the requirement consistently to all auto/facilitated enrollees.
4. Within 10 calendar days of identifying an individual as needing auto/facilitated enrollment, the cost plan sends an auto/facilitated enrollment notice to the beneficiary (see Exhibits 13, 13a, 14, and 14 a.).
5. Submit a ~~71~~ *61* transaction (PBP change enrollment transaction) for the auto/facilitated enrollment into the cost plan PBP that includes the optional supplemental part D benefit and include the appropriate effective date within the timelines specified below (see subsection C). The cost plan will be notified of the accepted enrollment via a transaction reply.
 - a) Auto-enrollment – within 10 calendar days of sending notice
 - b) Facilitated enrollment – by last day before effective date of facilitated enrollment

C. Effective Date of Auto/Facilitated Enrollments

1. Auto-Enrollment

The effective date of auto-enrollment is retroactive to the first day of the month the individual first became a full-benefit dual eligible or January 1, 2006, whichever is later. For individuals who are full-benefit dual eligible upon enrollment into a cost plan without part D, the effective date would be retroactive to the effective date of enrollment in the cost plan. For existing Medicare enrollees of a cost plan without part D who subsequently become Medicaid eligible, the effective date is retroactive to the first day of the month the person became Medicaid eligible. In no case will the effective date of auto-enrollment precede the date that the individual became an enrollee of the cost plan.

There is nothing that prohibits a full-benefit dual eligible from initially electing a cost plan without part D. To ensure they understand the consequences of doing so, marketing material and the acknowledgement letter must emphasize that prescription drugs are not covered

2. Facilitated Enrollment

The effective date of facilitated enrollment for all Other LIS eligible members is the first day of the second month after the person is identified as qualifying for facilitated enrollment. For

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example, if the plan is notified in August 2010 that an existing member of a cost plan without part D has become LIS eligible, the effective date of facilitated enrollment into the PBP that includes the optional supplemental part D benefit is October 1, 2010.

The cost plan may move up the effective date of a facilitated enrollment by one month if an Other LIS beneficiary requests this in a timely fashion, i.e. before *the* start of earlier month. The Special Enrollment Periods (SEP) that permit the individual's enrollment in the optional supplemental part D benefit are described in ~~the CMS PDP Eligibility, Enrollment and Disenrollment Guidance~~, section 20.3 *Chapter 3 of the Medicare Prescription Drug Benefit Manual*.

Example: The cost plan facilitates enrollment of an Other LIS eligible in May, 2010, effective July 1, 2010. The beneficiary receives the facilitated enrollment by the last day in May, and requests that the cost plan makes the facilitated enrollment effective June 1. The cost plan submits an enrollment transaction (~~code 71~~ *code 61*) to do so.

3. Distinguishing Between Full-Benefit Dual Eligible and Other LIS Individuals

Cost plans need to distinguish full benefit dual eligibles from others with LIS for purposes of setting the effective date. The first step is to identify all LIS eligibles in the cost plan PBP(s) that do not include the optional supplemental Part D benefit, e.g. through the LIS bi-weekly report. Please be sure to exclude those who are already enrolled in a stand-alone Prescription Drug Plan. CMS does not transmit a data element to plans that can be used to distinguish full-benefit dual eligibles from other LIS. As a result, CMS sends a monthly "Auto Assignment Full Dual Notification File" (for file format and technical specifications, please see section 8.1 of the Plan Communications User Guide, on the CMS website at <http://www.cms.hhs.gov/mmahelp>). This file identifies full-benefit dual eligibles.

Use the Auto Assignment Full Dual Notification File to identify the subset of the LIS enrollees in the cost plan without the Part D benefit who are full-benefit dual eligibles. To determine the auto-enrollment effective date, identify the LIS copay start date data provided on other files (e.g., monthly LIS history report).

The remaining LIS eligibles in the cost plan without the Part D benefit qualify for facilitated enrollment, and the effective date should be set as noted in item 2 above.

D. Notice

The cost plan will notify the beneficiary in writing that she/he will be auto or facilitated enrolled on the specified effective date. The notice must be sent within 10 calendar days of identifying the individual as qualifying for auto/facilitated enrollment. The notice will inform the beneficiary that they may choose another Part D plan or opt out of auto/facilitated enrollment into the Part D benefit. If the beneficiary does not opt out, or choose another Part D plan within the specified deadline, the person's silence will be deemed consent with the auto/facilitated enrollment, and it will take effect on the effective date. These individuals will also be informed they have a Special Enrollment Period (SEP) that permits them to change Part D plans, even after the auto/facilitated enrollment takes effect.

1. Auto-Enrollment

Please use the appropriate model notice language, as follows:

Exhibit 13 (auto-enroll into cost plan with Part D)

Exhibit 13a (auto-enroll into PDP)

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The deadline for responding is 10 calendar days from when the notice is sent. The SEP available is continuous, i.e. full-benefit dual eligibles may change Part D plans in any month.

2. Facilitated Enrollment

Please use the model notice language, as follows:

Exhibit 14 (facilitated enrollment into cost plan with Part D)

Exhibit 14a (facilitated enrollment into PDP)

The deadline for responding is the last day before the facilitated enrollment effective date. The SEP available is continuous.

E. Opt-Out

Full-benefit dual eligible and Other LIS individuals may opt-out, or affirmatively decline, the Part D benefit. Beneficiaries may opt-out verbally or in writing. For a cost plan enrollee, this primarily means declining auto/facilitated enrollment and maintaining enrollment in the cost plan (without part D). The cost plan may check the common User Interface to see if the individual has previously opted out; if so, the person should not be auto/facilitated enrolled. Once a beneficiary has opted out, the cost plan should document this and not include them in future auto-enroll processing.

The cost plan should counsel the individual to ensure they understand the implications of their request to decline, and should confirm this in writing (see Exhibit 15) within 10 calendar days of the individual's request to opt out. If a beneficiary opts out of auto/facilitated enrollment by the deadline in the auto/facilitated notice, do not submit an enrollment transaction that would move them to a cost plan PBP that includes the optional supplemental Part D benefit. This will have the effect of leaving them in the cost plan without Part D.

If the individual opts-out after the *cost plan has submitted the ~~code 71~~code 61* transaction ~~has been submitted~~, the effective date of returning to the cost plan without the Part D benefit is normally prospective, i.e. first day of the following month. However, through the end of the month after notice was sent, at the beneficiary's request, the cost plan may restore the person to the cost plan without the Part D benefit retroactive to the auto-enrollment effective date. This is accomplished by submitting a ~~code 71~~code 61 transaction with the same effective date, and setting the opt-out flag as noted below.

LIS eligible individuals who want to opt-out of auto/facilitated enrollment must do so with the cost plan, not through 1-800-MEDICARE. This differs from the procedure for LIS eligible individuals full duals who want to opt-out of auto-enrollment into a stand-alone PDP. The cost plan sends a ~~code 71~~code 61 transaction (to move the person back to the cost plan PBP without the optional Part D benefit), setting the Part D Opt-Out Flag (field 38) to Y (opt-out of auto-enrollment)

An LIS eligible individual who opts out does not permanently surrender his or her eligibility for, or right to enroll in, a Part D plan; rather, this step ensures the person is not included in future monthly auto-enrollment processes. To obtain Part D benefits, the beneficiary simply makes a voluntary election into a plan that offers Part D benefits.

F. Special Procedures for Individuals With Employer Coverage with a Retiree Drug Subsidy

When the individual's employer or union-sponsored enrollment, including in "800 series" plans, or Retirement Drug Subsidy (RDS) status is known, the cost plan shall exclude the individual from auto/facilitated enrollment.

It is possible the cost plan will not be aware an individual has RDS until they submit a ~~code 71~~ *code 61* transaction to auto/facilitate his/her enrollment. As with all enrollment transactions for individuals with RDS, MARx will enforce a two-step process, initially rejecting the transaction.

The cost plan must follow normal procedures of confirming with the beneficiary that she/he wants to be enrolled in the Part D benefit and, if confirmed, resubmit the transaction with the employer subsidy override.

G. Information Provided to Auto/facilitated Enrolled Beneficiaries

The cost plan must send a modified version of the pre-and post-enrollment materials required to be provided to all new enrollees. If the effective date is retroactive into the previous calendar year, only send the current year's version of the documents below.

Prior to effective date, the cost plan must send:

- The information required in §40A.1, and
- A Summary of Benefits (those who are auto/facilitated enrolled still need to make a decision whether to stay with the plan into which they have been auto/facilitated enrolled or change to another one that better meets their needs). Providing the Summary of Benefits, which is considered marketing material normally provided prior to making an enrollment election, ensures that those auto/facilitated enrolled have a similar scope of information as those who voluntarily enroll.

H. Summary of Differences Between Auto-and Facilitated Enrollment Processes

	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS
Frequency	Monthly	Monthly
Steps	<ul style="list-style-type: none"> • Identify full dual eligibles in cost plan who need to be enrolled into cost plan PBP that includes Part D benefit • Send notice to beneficiary within 10 calendar days of identifying need for person to be auto-enrolled • If no answer or person does not opt out within 10 calendar days, submit 71-61 transaction to move to the cost plan PBP that includes the Part D benefit 	<ul style="list-style-type: none"> • Identify non-full dual LIS beneficiaries in cost plan who need to be enrolled into the cost plan PBP that includes the Part D benefit • Send notice to beneficiary within 10 calendar days of identifying need for person to be facilitated enrolled • If no answer or person does not opt out by last day before effective date of facilitated enrollment, submit 71-61 transaction to move to the cost plan PBP that includes the Part D benefit

	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS
Who needs to be moved	<ul style="list-style-type: none"> • Full dual who newly enrolls in the cost plan without the Part D benefit • Beneficiary in the cost plan without the Part D benefit who recently became Medicaid eligible and is thus newly full dual 	<ul style="list-style-type: none"> • Non-full dual with LIS who newly enrolls into the cost plan without the Part D benefit • Beneficiary in the cost plan without the Part D benefit who recently became LIS-eligible
Who does not need to be moved	<ul style="list-style-type: none"> • Those who have already opted out • Those with RDS or employer coverage who do not consent to auto-enrollment 	<ul style="list-style-type: none"> • Those who have already opted out • Those with RDS • Those in employer sponsored plans
Data to identify those in MA-only plan who need to be moved to MA-PD plan	Monthly MA full dual file	LIS data (TRR or monthly LIS history report): <ul style="list-style-type: none"> • Premium subsidy = 25%, 50%, 75% OR <ul style="list-style-type: none"> • Premium subsidy = 100 and LIS copay = 4 (15%) • Premium subsidy = 100 and LIS copay = 1-(\$2/5), 2 or 3 and person is not on MA full dual file
Plan Into Which Beneficiary Should be Enrolled	Cost plan PBP that includes the Part D benefit with the lowest combined cost plan and Part D premium-, or PDP	Cost plan PBP that includes the Part D benefit with the lowest combined cost plan and Part D premium-, or PDP
Notice to send	Exhibit 13 or 13a	Exhibit 14 or 14a
Effective date	<ul style="list-style-type: none"> • First day of the month person qualified for LIS (will be retroactive) • Cannot be prior to start of enrollment in the cost plan 	<ul style="list-style-type: none"> • First day of second month after person identified as needing enrollment • Cannot be prior to start of enrollment in the cost plan
Opt out	<ul style="list-style-type: none"> • Document and do not enroll again in future. • Confirm with beneficiary (see Exhibit 15) • If submitting 71-61 transaction to move beneficiary back to cost plan PBP that does not include Part D benefit, set Opt-Out flag to Y (field 38) 	<ul style="list-style-type: none"> • Document and do not enroll again in future. • Confirm with beneficiary (see Exhibit 15) • If submitting 71-61 transaction to move beneficiary back to cost plan PBP that does not include Part D benefit, set Opt-Out flag to Y (field 38)
Application date on transaction	First day of month prior to effective date of the enrollment OR day after current application date on the cost	First day of month prior to effective date of the enrollment

	plan PBP that does not include the Part D benefit, whichever is later.	
Election type code	Z = Special Enrollment Period*	S = Special Enrollment Period
Enrollment source code	E (MA/cost plan submitted auto-enrollment)*	F (MA/cost plan submitted facilitated enrollment)*

* Use of the enrollment period of “Z” and enrollment source code of “E” permits these ~~71-61~~ transactions for retroactive auto-enrollments to bypass normal MARx suspension of processing for retroactive effective dates (i.e. they will process immediately).

40.1.6 –Group Enrollment Request Mechanism for Employer/Union Sponsored Coverage

42 CFR 417.430(a)

Cost plans may choose to accept voluntary enrollment requests directly from the employer or union who sponsors cost plan coverage for its members in any of the enrollment mechanisms described in this guidance (except auto or facilitated enrollment).

It is the cost organization’s responsibility to ensure that all applicable enrollment requirements are met as required by CMS. The enrollment requests provided to the cost plan by the employer or union will reflect the choice of retiree coverage individuals- made using their employer’s or union’s process for selecting a health plan. For enrollments processed using an employer/union sponsored mechanism, the application date on the enrollment transaction submitted to CMS is the first day of the month prior to the effective date of enrollment into the employer or union group-sponsored cost plan. For the purposes of providing notices and meeting other timeframe requirements provided in this guidance, use the date the cost plan received the request.

*CMS will allow a cost plan to accept enrollment requests using a group enrollment process in which beneficiaries enroll in an employer or union sponsored cost plan. Beneficiaries participate in this process through advance notification that provides each individual with all the information necessary to make an informed choice. Furthermore, the process must provide CMS with any information the employer/union has on other insurance coverage for the purposes of coordination of benefits. It is the cost plan’s responsibility to ensure the group enrollment process meets all applicable cost plan enrollment requirements. **Cost plans must ensure that any contracts and other arrangements and agreements with employers and unions intending to use the group enrollment process make these requirements clear.***

*The group enrollment process **must** provide the following information to each beneficiary as follows:*

- Beneficiaries participate in the group enrollment mechanism by receiving an advance notice that the employer/union intends to enroll them for a prospective coverage effective date in a cost plan that the employer/union is sponsoring; and*
- Clear instruction that the beneficiary may affirmatively opt out of such enrollment; explaining the process to opt-out; and any consequences to employer or union benefits opting out would bring; and*
- This notice must be provided by the cost plan, or the employer or union acting on its behalf (as specified in the contract the cost plan has with the employer/union), not less than 21 calendar days prior to the effective date of the beneficiary’s enrollment in the employer/union sponsored cost plan; and*
- Additionally, the information provided to each beneficiary must include a Summary of Benefits offered under the employer/union sponsored cost plan, as well as an explanation of how to get*

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more information about the cost plan, and an explanation on how to contact Medicare for information on other Medicare health plan options that might be available to the beneficiary; and

- *Each individual must also receive in the group enrollment notice materials the information contained in Exhibit 2 under the heading “Please Read & Sign Below.”*

The cost plan must ensure all of the above requirements are met prior to submission of the enrollment transactions to CMS. For enrollments processed using a group enrollment mechanism, the application date on the enrollment transaction submitted to CMS is the first day of the month prior to the effective date of the group enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the group enrollment in CMS systems.

The employer or union must provide in the group enrollment file(s) all the information required for the cost plan to submit a complete enrollment request transaction to CMS, including permanent residence information. Records must be maintained as outlined in §60.4 of this chapter.

40.2 – Verifying Enrollment Information

Whether Medicare beneficiaries are enrolled during a face-to-face interview, ~~or~~ by mail, *via the Medicare Online Enrollment Center (OEC), or through another approved enrollment mechanism*, the plan ~~should~~ *must* verify all information. If the *applicant (or his/her authorized representative) completes the enrollment application request is being completed* in person, the applicant's Medicare card *or Medicare award letter, issued by Social Security*, should be used to verify the spelling of his or her name and to confirm the correct recording of ~~sex~~ *gender*, Health Insurance Claim Number (HICN), and the beneficiary's entitlement to both Parts A and B, or Part B only. The plan must obtain the applicant's permanent residence address and verify that he/she resides within the service contract area. If enrollment assistance is given by telephone, a back-up system should be established for verifying this information. For example, some cost plans direct staff responsible for recording enrollment information to call the applicant and double-check the information.

While desirable, it is not necessary for an individual to prove Medicare Part A entitlement and/or Part B enrollment at the time he/she completes the enrollment form, i.e., the cost plan organization may not deny the enrollment if the individual does not have the evidence when filling out the enrollment form or does not include it with the form when he/she mails it to the organization.

Cost plans may use the CMS Beneficiary Eligibility Query (BEQ, batch submission (or via on-line access to the MARx M232 screen), to verify Medicare entitlement to Part A and/or Part B.

Cost plans offering an optional supplemental Part D benefit must use the BEQ (batch process or on-line inquiry), as described in the Plan Communications User Guide, for individuals electing the cost plan's optional supplemental Part D benefit as permitted in this Chapter to verify eligibility for Part D and obtain important information about Low Income Subsidy status.

40.2.1 – Who May Complete a Cost Plan Enrollment ~~Form~~ or Disenrollment Request

A Medicare beneficiary is generally the only person who may execute a valid *request for enrollment in or disenrollment from a* cost plan ~~enrollment form~~. However, another individual could be the legal representative or appropriate party to execute the cost plan enrollment *or disenrollment* as the law of the State in which the beneficiary resides may allow. ~~The~~ CMS will recognize State laws that authorize persons to take such actions on behalf of a *Medicare* beneficiary. For example, persons authorized under State law may be court appointed legal guardians, persons having durable power of attorney for health care decisions or individuals authorized to make health care decisions under State surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity.

If a Medicare beneficiary is unable to sign an enrollment form or disenrollment request *or is unable to complete an enrollment request mechanism* due to reasons such as physical limitations or illiteracy, State law would again govern whether another individual may execute the ~~form~~ *enrollment/disenrollment request* 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, cost plan organizations should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

Where cost plan organizations are aware that an individual has a representative payee designated by the SSA to handle the individual's finances, the cost plan should contact the representative payee to determine his or her legal relationship to the beneficiary, and to ascertain whether he or she is the appropriate person, under state law, to ~~complete the individual's membership application~~ *execute the enrollment or disenrollment request. Representative payee status alone is not sufficient to enroll a Medicare beneficiary.*

When someone other than the Medicare beneficiary completes an enrollment form (or disenrollment request), he or she must attest to having the authority under State law to do so and confirm that authorization, if any, required by State law that empowers the individual to effect an election on behalf of the applicant is available and can be provided upon request to ~~the cost plan or~~ CMS. *The individual acting on behalf of the Medicare beneficiary must also provide contact information to the cost plan.* The cost plan must retain the record of this attestation, *including the contact information*, as part of the enrollment form. The CMS model enrollment form for cost plans (see Exhibit # 1 of this chapter) includes a sample attestation. Cost plans may not require individuals to provide documentation as a condition of accepting the enrollment ~~form~~ *or disenrollment request.*

If anyone has reason to believe that an individual making an election on behalf of a beneficiary may not be authorized under State law to do so, the cost plan should contact its CMS account manager with all applicable documentation regarding State Law and the case in question. The account manager may request supporting documentation from the individual making the election.

If the cost plan receives an enrollment form that was signed more than 30 calendar days prior to the organization's receipt of the form, the plan is encouraged to contact the individual to confirm intent to enroll prior to processing the enrollment, and to advise the beneficiary of the upcoming effective date.

40.2.2 – When the Enrollment Form Has Missing or Erroneous Information

To obtain information to complete the enrollment request, the cost plan must contact the individual to request the information within ten calendar days of receipt of the enrollment request. When the cost plan receives an enrollment form that cannot be processed because it has missing (or erroneous) information (*including the enrollee's signature or the signature of the enrollee's representative*), it should contact the individual by telephone to obtain the information necessary, and document all efforts to obtain the information needed. *In the case of a missing signature, the cost plan must obtain and document verbal confirmation of the beneficiary's intent to enroll.* The cost plan may also send a letter asking for information to facilitate the enrollment (see Exhibit 3). *The cost plan must explain to the individual that s/he has 30 calendar days in which to submit the additional information or the enrollment will be denied.* If the individual does not respond within 30 days of the request for additional information, the cost plan must deny the enrollment, and must send the appropriate notice to the individual (Exhibit 5) within the 7 business days following this denial.

If the cost plan receives all documentation within allowable time frames, and the enrollment request is complete, the cost plan must transmit the enrollment to CMS within the time frames prescribed in §40.4, and must send the individual the information described in §40.4.1.

40.3 – ESRD and Enrollment

Please refer to §20.2 of this chapter for information on when a beneficiary with ESRD may be eligible to enroll in a cost plan.

If a cost plan is aware that an individual electing a plan has received a kidney transplant (e.g., the individual informs the cost plan this has occurred), then the plan should request that the individual submit medical documentation that he or she no longer has ESRD (i.e., a letter from the physician that states the individual has received a kidney transplant and no longer requires a regular course of dialysis to maintain life). Upon receipt of this documentation, the cost plan should enroll the beneficiary.

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

If the cost plan 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 plan if other applicable eligibility requirements are met. When this occurs, the cost plan 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 cost plan's attempts to enroll the individual and the resulting rejection.

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

40.4 – Processing Applications

The cost plan must maintain a system for receiving, controlling and processing applications for membership in which it:

- Date-stamps each application with the date the form was received;
- Ensures that each beneficiary who enrolls (whether previously a member of the organization or not) receives a signed and dated copy of the *paper* application form *or an identifier (e.g., a tracking number) for a request made through a non-paper enrollment mechanism*;
- Processes applications from beneficiaries in chronological order by received date;
- Contacts the beneficiary if additional information is needed to process the enrollment (see Exhibit 3 and additional information in §40.2.2).
- Notifies the beneficiary in writing of the cost plan's acceptance or denial of his /her application no later than 30 calendar days following the date the application was received;
- If the application is accepted, the plan must inform the beneficiary of the proposed effective date of coverage (see Exhibit 2);
- If the application is denied, the plan must provide the applicant with a written explanation of the reason for denial (see Exhibit 5 and additional detail in §40.5 of this chapter); and

For Cost Plans that have obtained a capacity waiver:

- Places the application on a waiting list as described in §30.1.5 of this chapter, and provides the beneficiary with an explanation of procedures to follow as vacancies occur, and
- Fills vacancies occurring during an enrollment period in chronological order, beginning with the earliest dated application on the list.

Once the plan receives a reply listing report from CMS indicating whether the individual's enrollment has been accepted or rejected, the plan must send written notification to the beneficiary that CMS accepted or rejected his/her enrollment application (*See-see* Exhibit 4 and Exhibit 5).

40.4.1 – Information Provided to the Beneficiary

During the enrollment process, the cost plan must provide the enrollee with all the necessary information about being a member of the cost plan, including the plan rules and the member's rights and responsibilities. The cost plan must ensure that the enrollee is provided with the following:

- A description of the charges for which the beneficiary is liable, e.g. any premiums, coinsurances, fees, or other amounts. For a high option, amounts attributable to the Medicare deductible and coinsurance should be explained in detail.
- An explanation of the beneficiary's authorization for the disclosure and exchange of necessary information between the cost plan and CMS that is generally included on the application form.
- A copy of the signed and dated enrollment form, if the individual does not already have a copy of the form.
- A letter acknowledging receipt of the completed enrollment form and showing the effective date of coverage (Exhibit 2). For cost plans that offer an optional supplemental Part D benefit, this

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notice must include all the information necessary for the individual to obtain pharmacy coverage as of the 1st day of enrollment (commonly referred to as "4 Rx" data).

- Following receipt of the confirmation of enrollment from CMS, notify the enrollee in writing (see Exhibit 4) of the effective date of enrollment within 30 calendar days and send a CMS-approved evidence of coverage that describes the cost plan organization rules, including benefits and enrollee rights and responsibilities (42 CFR 417.436).

40.5 – Cost Plan Denial of Enrollment

§ 417.424

A cost plan must deny an enrollment based on its own determination of the ineligibility of the individual to enroll in the plan. A Medicare cost organization may also deny enrollment to an individual who meets the criteria of §20, if acceptance would:

- *Cause the number of enrollees who have both Medicare and Medicaid to exceed 50% of the cost plan's total enrollment.*
- *Prevent the Medicare cost organization from complying with their contract with CMS.*
- *Require the Medicare cost organization to exceed its enrollment capacity*
- *Cause the enrollment to become substantially non-representative of the general population in the Medicare cost plan's geographic area.*
 - *Disenrollment for non-representative of the general population requires CMS approval.*

Cost plan denials occur before the organization has 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 permanent residence, or that the cost plan is closed for enrollment, etc. This up-front denial determination must be made in a timely manner, within 30 calendar days from the date the organization received the 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 (Exhibit 5). ~~This notice~~ *The cost plan must be sent send this notice* no later than 30 calendar days from the date the organization received the enrollment form.

If the cost plan is following the procedures in §40.2.2 of this chapter to request additional information from a beneficiary, the denial notice should be sent within 7 business days of the denial determination made when the request for additional information period expires.

40.5.1 – Cost Plan Denial of Enrollment in Optional Supplemental Part D Benefit

As described in §10.2 of this chapter, new and existing cost plan enrollees may only enroll in an optional supplemental Part D benefit offered by the cost plan in accordance with the Part D Enrollment requirements including Part D enrollment periods.

If an individual who is eligible to enroll in a cost plan (or who is an enrollee of that plan) requests enrollment in the cost plan's optional supplemental Part D benefit at a time when enrollment in Part D is not permitted, the cost plan must provide the individual with written notice that he or she may only enroll in the Part D optional supplemental benefit at specified times and cannot enroll in it at this time. This notice must be provided within 10 calendar days of the receipt of the request to select the optional supplemental benefit. Refer to Exhibit 5a for a model notice.

40.6 – Transmission of Enrollments to CMS

42 CFR 417.432(e)

Within 30 days of the date of the organization's receipt of the completed enrollment form, the cost plan must transmit information necessary to add the beneficiary to CMS records. In the case of applications that are accepted when the cost plan enrollment is at a capacity limit, it must transmit the information by the earliest plan data due date after a vacancy has become available. However, if a current commercial plan member is converting to Medicare enrollment status, the plan must submit the enrollment information no earlier than the third plan data due date, but no later than the first plan data due date, prior to the individual's Medicare entitlement date. Cost plans are strongly encouraged to submit all enrollment requests to CMS within 7 calendar days ~~in 2008 and going forward~~. If the cost plan enrollment transaction includes the enrollment into an optional supplemental Part D benefit, the cost plan **must** meet this time frame.

40.7 – Re-enrollment

If the Medicare cost organization requires periodic re-enrollment, it must re-enroll Medicare enrollees unless they meet the disenrollment requirements found in §§ 50.2 or 50.3.

~~Some members may disenroll but then wish to re-enroll at a later time. The cost plan must enroll these members following standard enrollment procedures, i.e. the member must meet the requirements of §20 and reapply during an open enrollment period. If there is a waiting list, the former member must be placed on a waiting list with other applicants. New applications from former plan enrollees must be processed in chronological order with all other applications, i.e.; the former member cannot be enrolled ahead of other applicants. A cost plan may choose to wait for the individual's payment of the plan premium, including any premiums or cost sharing due the organization for a prior enrollment, before processing the enrollment. See §20 of this chapter.~~

50 – Disenrollments

417.460

Cost plans must submit disenrollments to CMS no later than the systems cut-off date of the month for which disenrollment is requested. Disenrollment requests can be submitted up to 90 days prospectively. Except as provided for in this section a cost plan may not, either orally or in writing or by any action or inaction, request or encourage a member to disenroll from the plan. Cost plans are strongly encouraged to submit disenrollment requests to CMS within 7 calendar days. ~~(beginning in 2008-2013 and beyond)~~. If the cost plan the individual is disenrolling from includes an optional supplemental Part D benefit, the cost plan **must** meet this timeframe.

50.1 – Voluntary Disenrollments

A Medicare beneficiary may disenroll at any time by mailing, hand delivering, or faxing a signed and dated written notice to the plan. If the member is unable to sign the disenrollment request, his or her legal representative must do so (refer to §40.2.1 for more details on who may sign forms). ~~The~~ CMS systems will generate an automatic disenrollment if a beneficiary elects another cost plan or Medicare Advantage plan without first disenrolling from the current health plan. Note: Enrollment into a Medicare Advantage plan may only be requested by an individual during the enrollment periods applicable to that program.

If a cost plan receives a written disenrollment request without a valid signature, the cost plan may verify with the individual or legal representative with a phone call rather than returning the written request as incomplete, provided the contact is documented and retained.

If a member verbally requests disenrollment from the cost plan, the plan must instruct him or her to make the request in writing. The plan may send a disenrollment form to the member upon request (see Exhibits 6 and Exhibit 6a).

The liability of CMS to make monthly payments on the beneficiary's behalf ends with the close of the last month of membership specified by the beneficiary, with the exception that the last month of payment may not be earlier than the month in which the beneficiary requested disenrollment. However, if the Regional Office has reason to review the disenrollment request, the last month of CMS liability may not follow this guideline, e.g. if the member moved out of the service area and the Regional Office grants an earlier disenrollment date.

Individuals enrolled in a cost plan and an optional supplemental Part D benefit offered by that cost plan, are disenrolled from both upon disenrollment from the cost plan.

When an individual who is enrolled in a cost plan and an optional supplemental Part D benefit offered by that cost plan successfully enrolls in a stand-alone PDP, he or she must be disenrolled from the optional supplemental Part D benefit offered by the cost plan.

50.1.1 – Effective Date of Voluntary Disenrollment

The disenrollment must be effective no later than the first day of the month following receipt of the member's written request for disenrollment, unless the member requests a later date. The plan must date stamp the disenrollment request upon initial receipt. If the member requests a later effective date, it can

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be no later than the third month after the month in which CMS receives an acceptable disenrollment request from the cost plan.

The cost plan must provide the member with a copy of his/her request for termination of enrollment (Exhibit 7 may be used if desired). ~~The~~ CMS encourages cost plans to provide the beneficiary with a final letter once the disenrollment has been confirmed and should send this notice within 7 business days of the availability of the reply listing (Exhibit 8).

If the plan learns of the disenrollment through the CMS Reply Listing Report rather than by written request, the cost plan is strongly encouraged to provide the beneficiary with a final letter within 7 business days of the availability of the reply listing (see Exhibit 8).

50.1.2 – Group Disenrollment for Employer/Union Sponsored Cost Plans

CMS is providing a process for group disenrollment from an employer or union sponsored cost plan. CMS will allow an employer or union to disenroll its retirees from an employer or union sponsored cost plan using a group disenrollment process.

The group disenrollment process must include notification to each beneficiary as follows:

- The cost plan or the employer/union must notify all beneficiaries involved that the employer or union intends to disenroll them from the cost plan that the employer or union is offering; and*
- The cost plan or the employer/union must provide this notice to the affected beneficiaries not less than 21 calendar days prior to the effective date of the beneficiaries' disenrollment from the employer/union sponsored cost plan.*

Additionally, the information provided must include an explanation on how to contact Medicare for information about other Medicare plan options that might be available to the beneficiaries.

The employer/union must have and provide all the information required for the cost plan to submit a complete disenrollment request transaction to CMS, as described in this guidance. Records must be maintained as outlined in §60.4 of this chapter.

50.2 – Required Involuntary Disenrollments

The cost plan must disenroll a member from the plan in the following cases:

- A permanent change in residence out of the plan's *geographic* service area (§50.2.1), or a temporary absence from the plan's service area for more than 90 consecutive days (except as described in §50.2.1.1);
- Death of the member (§50.2.2);
- Member's loss of entitlement to Medicare Part B (§50.2.3); and
- Termination or non-renewal of the cost plan's contract (§50.2.4).

50.2.1 – Permanent Move Out of the Plan's Service Area

A beneficiary must be disenrolled if he or she permanently moves out of the plan's *geographic* service ~~geographic~~ area and does not voluntarily disenroll. The plan must initiate disenrollment as soon as it

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becomes aware that the beneficiary has permanently moved outside the service area. An uninterrupted absence of more than 90 days is deemed to be a permanent move (see the exception in §50.2.1.1). A written statement from the beneficiary or other reasonable evidence establishes that the beneficiary has moved out of the service area. Even if the beneficiary has not informed the plan of his or her new address, the plan must attempt to provide the beneficiary written notice of enrollment termination. ~~The~~ CMS encourages the plan to send final confirmation of disenrollment to the member.

50.2.1.1 – Retention of Members Who Temporarily Leave the Plan's Service Area

Cost plans are allowed to retain a Medicare member under either of the two options described below if the member leaves the plan's service area for an extended absence. An extended absence is one that is over 90 days, but not more than 1 year, and where the member intends to return to the service area within the 1 year period. The extended absence option is available only to members remaining in the United States.

Option 1 -General Retention Option

The cost plan may choose to cover all out-of-area routine services for anyone who leaves the service area for an extended absence. If the plan offers such a service, it must advise all members of its availability. When an individual who has taken advantage of this policy returns to the service area, he or she must resume obtaining medical services through network providers in order for services to be covered in full. However, the member can still elect to obtain services from non-network providers, but he or she will be responsible for any applicable Medicare coinsurance and deductibles. If the member elects to obtain care from non-network providers, those providers can submit bills to Original Medicare for payment consideration.

The cost plan may place restrictions on the services received out-of-area for individuals who take advantage of the extended absence option, as long as the Medicare beneficiary agrees to the restrictions and the full scope of contracted benefits is available to the member in the extended service area. Possible restrictions on services include obtaining medical care through designated providers or requiring prior authorization. Non-designated providers or those seen without prior authorization (where required) would submit bills to Original Medicare.

Additionally, the cost plan remains financially liable for emergency and out-of-area urgently needed services.

Option 2 -Retention of Enrollment With Services Provided Through Affiliated Organization

If the cost plan is affiliated with another organization (by common ownership or control, or written agreement), the plan may make the extended absence option available only to members who move to the affiliate's service area during an extended absence. The members must agree to obtain services exclusively through the affiliated organization. The cost plan may retain such individuals as Medicare members of its plan for up to one year. This option must be made available to anyone moving to the affiliated organization's service area during an extended absence, and all plan members must be advised of the availability of this service.

Also, the cost plan is financially responsible for emergency and out of area urgently needed services. For this extended absence option, urgently needed services obtained while temporarily absent from the geographic area and needed while the member is present in the affiliate organization's service area are the responsibility of the affiliate organization responsible for providing services to the member during the extended absence.

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The CMS approves extended absence options as part of the cost plan's initial Medicare application, or as such options are developed. The CMS also reviews marketing materials and membership rules to ensure that the options are clearly explained and beneficiaries are advised of the distinction between authorized and unauthorized out-of-plan service use.

If a plan wants to offer an extended absence option, CMS suggests that the cost plan have the individual sign an agreement which states any restrictions on services imposed, where and how to obtain services, and how billing is accomplished.

Supplemental benefits for which the member is paying a premium may be discontinued upon his or her leaving the service area, as long as the member is not required to continue paying the premium or portion of a premium that corresponds to these services.

If a member takes advantage of the extended absence option, but fails to return to the service area within one year, the plan must disenroll him or her effective the first day of the month following the 1 year anniversary date of the original departure from the service area. The plan should notify the beneficiary regarding the upcoming disenrollment before it occurs.

50.2.2 – Death

The CMS will disenroll deceased members effective the month immediately following the month of death and notify the cost plan that the member has expired. Monthly interim per capita payments end with that month. The plan should send a notice to the member or his or her estate so that any disenrollment due to an erroneous report of death can be corrected as soon as possible (Exhibit 9).

If the plan obtains reliable information regarding the death of a member from a source other than CMS, such as a copy of an official death certificate, it may notate this in the cost plan's internal systems for customer service purposes, such as to suppress premium billing. The cost plan may not submit a disenrollment transaction to CMS based on a report of death; CMS will obtain this information directly from SSA (or RRB) and take the appropriate action in its systems.

50.2.3 – Loss of Entitlement to Part B

The member is disenrolled by CMS the month immediately following the month that enrollment in Part B ends. Monthly interim per capita payments made on behalf of the beneficiary terminate effective the month immediately following the last month of entitlement to benefits under Part B. The plan should send a notice to the member so that any disenrollment due to erroneous information can be corrected as soon as possible (Exhibit 10). The beneficiary may remain a member of the organization if a non-Medicare option is available.

If a member loses entitlement to benefits under Part A, but remains entitled to benefits under Part B, he or she remains a member of the cost plan. The member is entitled to receive and have payment made for Part B services only, beginning with the month immediately following the last month of his/her entitlement to Part A. The cost plan may offer all or partial Medicare Part A benefits.

50.2.4 – Plan Termination/Non-Renewal or Reduction of Plan Service Area

A cost plan must disenroll members from its plan if the contract is terminated, if the organization discontinues offering the plan, or if the plan does not renew in any portion of the area where it had previously been available.

A member who is disenrolled from a cost plan under these provisions is allowed to choose another cost plan or an MA organization (if one is available and he/she meets applicable eligibility requirements), or original Medicare. If no other choice is made, the individual will automatically return to Original Medicare by default.

Notice Requirements: In most cases, the plan terminating the contract must send a written notice to all Medicare members enrolled in the organization at least 60 days before the effective date. However, if CMS initiates a termination, it notifies members 30 days before the effective date.

The notice must be reviewed by CMS prior to issuance. The plan must submit the proposed notices for review in sufficient time to meet all deadlines, and provide final copies of the notices sent to beneficiaries to the CMS Regional Office account manager.

The termination, non-renewal, or partial non-renewal of a contract between the plan and CMS, whether by mutual consent or by unilateral action of either party, ends the liability of CMS to make monthly interim per capita payments on behalf of Medicare beneficiaries. ~~The CMS~~' liability ends effective the first day of the month following the last month the contract is in effect.

If the cost plan defaults on its contract with CMS prior to the close of the contract year due to bankruptcy or other reasons, CMS will establish the month in which interim per capita payments end for all enrolled Medicare beneficiaries. ~~The CMS~~ will notify the cost plan and all affected Medicare enrollees in writing as soon as practical.

50.2.5 – Failure to Pay Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)

Individuals with Part D-IRMAA must pay this additional amount directly to the government, not to the plan providing the Part D coverage. CMS has established a 3-month initial grace period before individuals who fail to pay their Part D-IRMAA will be disenrolled from their Part D coverage. CMS will report the disenrollments to the organization via the daily TRR using a specific Transaction Reply Code (TRC). The effective date of the Part D coverage disenrollment is the first of the month following the end of the initial grace period.

Individuals, enrolled in a cost contract and an optional supplemental Part D benefit offered by the cost plan, who fail to pay their assessed Part D-IRMAA will be disenrolled from the cost contract, as directed by CMS via the TRR using a specific TRC.

Similar to instances in which a cost plan enrollee is automatically disenrolled when s/he enrolls in a standalone PDP, CMS directs cost plans to submit a transaction to CMS to enroll the individual in the cost contract without the Part D optional supplemental benefit (i.e. "cost-only PBP"). The action the cost plan takes to submit an enrollment transaction to return the individual to the Cost-only plan should be transparent to the individual.

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The cost plan must send each affected individual a written notice of the loss of the Part D optional supplemental benefit within ten (10) calendar days of receipt of the TRR indicating disenrollment for non-payment of the Part D-IRMAA. (see Exhibit 21)

For more information on disenrollment for failure to pay the Part D-IRMAA, see Chapter 3 of the Medicare Prescription Drug Benefit Manual.

***Reinstatement for “Good Cause”** – Individuals involuntarily disenrolled from their optional supplemental Part D benefit for failure to pay Part D-IRMAA have the opportunity to ask CMS for reinstatement into the optional supplemental benefit from which they were disenrolled. CMS may reinstate enrollment, without interruption of coverage, if the individual demonstrates “good cause” and pays all Part D-IRMAA and plan owed amounts (both past due and monthly amounts during the request period) within 3 calendar months after the disenrollment effective date (see §60.6.4).*

50.3 – Other Involuntary Disenrollments

The cost plan may disenroll a member from the plan in the following cases:

- *Fails to pay premiums or other charges (§50.3.1);*
- *Commits fraud or permits abuse of his or her enrollment card (§50.3.2); or*
- *Cause (Disruptive Behavior)(§50.3.3).*

50.3.1 – Failure to Pay Premium

Cost plans have the following options when a member does not pay his/her basic monthly premium (*or other charges for deductible and coinsurance amounts for which the member is liable.*) The cost plan should outline its policy in its policy and procedures and apply the option chosen consistently among all members.

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

The cost plan may disenroll a Medicare beneficiary who fails to pay his/her basic monthly premiums, or other charges imposed by the cost plan for Medicare deductible and coinsurance amounts for which he or she is liable. However, the cost plan must demonstrate to CMS that a reasonable effort was made to collect the unpaid amount and that the plan gave the beneficiary written notice of disenrollment before notifying CMS. Since it is possible that the beneficiary believes that nonpayment of premiums is a way to disenroll, the cost plan may wish to include in its payment reminder notices an explanation of the proper way to disenroll. ~~The~~ CMS will consider the cost plan to have demonstrated reasonable effort in collecting unpaid premiums if the plan mails a notice of disenrollment for nonpayment of premium to the beneficiary at least 20 days before the effective date of disenrollment. This allows 5 days for mailing time and 15 days for the beneficiary to act on the notice. Disenrollment for nonpayment of premium will be effective as of the last day of the month in which the 20-day period expires. The plan should include *in any disenrollment communications* an explanation of the member's rights to a hearing under its grievance procedures *and the ability to request reinstatement for “good cause”*. (See Exhibit 19) The cost plan may not notify CMS until after the plan has notified the

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beneficiary. *The cost plan is strongly encouraged to send the beneficiary a disenrollment confirmation notice. (See Exhibit 20)*

NOTE: If the member fails to pay the premium for optional supplemental benefits, but pays the premium for the basic benefits, the cost plan may not disenroll him or her. The cost plan may discontinue the optional benefits, but may not disenroll the member from the cost plan. If the optional supplement benefit is a Part D benefit, the cost plan must disenroll the individual from that optional supplemental benefit.

If the individual is involuntarily disenrolled for failure to pay premiums, payment of past due premiums after the disenrollment date does not create an opportunity for reinstatement into the plan from which the individual was disenrolled for failure to pay premiums. See §60.6.4 for more information about reinstatements after disenrollment for failure to pay premiums.

50.3.2 – Fraud in Enrollment or Abuse of Membership Cards

A Medicare beneficiary may be disenrolled if he/she commits fraud in connection with his or her enrollment or permits abuse of the membership card, e.g., the beneficiary knowingly provides fraudulent information on the application form, which materially affects eligibility for enrollment, or a Medicare beneficiary permits others to use his/her membership card to receive services. This category includes any abuse relating to cost plan membership or the Medicare program.

In the case of fraud or abuse, the *cost* plan must send the beneficiary written notice of termination prior to submission of the disenrollment notice to CMS. The plan must include an explanation of the member's rights to a hearing under grievance procedures established by the organization, and also notify the RO so that the Office of the Inspector General may initiate its own investigation of the alleged fraud or abuse.

50.3.3 – Disenrollment for Cause (*Disruptive Behavior*)

A cost plan *may request CMS review of a proposed disenrollment of* ~~has the right to initiate procedures to disenroll~~ a Medicare member if his/her behavior is disruptive, unruly, abusive, or uncooperative to the point that his or her continuing membership seriously impairs the ability to furnish services to either him/her or other members. *The cost plan must meet all the requirements of this section.*

The cost plan must ascertain that the enrollee's behavior is not related to the use of medical services or to mental illness. *The cost plan may not disenroll a member because he/she exercises the option to make treatment decisions with which the cost plan disagrees, including the option of no treatment and/or no diagnostic testing. The cost plan may not disenroll a member because he/she chooses not to comply with any treatment regimen developed by the cost plan or any health care professionals associated with the cost plan.*

Before requesting CMS' approval of disenrollment for disruptive behavior, the cost plan must make a serious effort to resolve the problems presented by the member. Such efforts must include providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive

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conditions, including mental illness and developmental disabilities. The cost plan must also inform the individual of his or her right to use the organization's grievance procedures.

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

- Of the disruptive behavior;*
- Of the cost plan's serious efforts to resolve the problem with the individual;*
- Of the cost plan's effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act;*
- Establishing that the member's behavior is not related to the use, or lack of use, of medical services;*
- Describing any extenuating circumstances cited under 42 CFR 417.460(e)(2);*
- That the cost plan provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Notice Requirements); and*
- That the cost plan then provided written notice of its intent to request involuntary disenrollment (see Notice Requirements).*

The cost plan must submit to its CMS Regional Office account manager:

- The above documentation;*
- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the cost plan's ability to arrange for or provide services to the individual or other members of the cost plan;*
- Member information, including age, diagnosis, mental status, functional status, a description of his or her social support systems and any other relevant information;*
- Statements from providers describing their experiences with the member; and*
- Any information provided by the member.*

The cost plan may request that CMS consider prohibiting re-enrollment in the cost plan or other plans offered by the cost plan's parent organization in the service area.

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

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

If the request for involuntary disenrollment for disruptive behavior is approved, CMS may require the cost plan to provide reasonable accommodations to the individual in such exceptional circumstances that CMS deems necessary. An example of a reasonable accommodation in this context is that CMS

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could require the cost plan to delay the effective date of involuntary disenrollment to coordinate with a cost plan enrollment request or Part D enrollment period that would permit the individual an opportunity to obtain other coverage.

Notice Requirements

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

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

Advance Notice

*Prior to forwarding an involuntary disenrollment request to CMS, the cost plan must provide the member with written notice describing the behavior it has identified as disruptive and how it has impacted the cost plan's ability to arrange for or provide services to the member or to other members of the MA plan. The notice must explain that his/her continued behavior may result in involuntary disenrollment and that cessation of the undesirable behavior may prevent this action. The cost plan must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS. **NOTE:** If the disruptive behavior ceases after the member receives notice and then later resumes, the cost plan must begin the process again. This includes sending another advance notice.*

Notice of Intent

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

Planned Action Notice

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

The cost plan can only submit the disenrollment transaction to CMS after providing the notice of disenrollment (Planned Action Notice) to the individual. The disenrollment is effective the first day of the calendar month after the month in which the cost plan gives the member a written notice of the disenrollment, or as provided by CMS. ~~The cost plan must ascertain that the enrollee's behavior is not related to the use of medical services or to mental illness. The cost plan may not initiate disenrollment because the beneficiary exercises his or her option to make treatment decisions with which the cost plan disagrees, e.g. refuses aggressive treatment for cancer. Before beginning the disenrollment for cause process, the plan must make a serious effort to resolve the problem presented by the member. It must inform the member that his/her continued behavior may result in termination of membership in the organization.~~

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~~If the problem cannot be resolved, the plan must give the member written notice of its intent to request disenrollment for cause. In this notice, explain the member's right to a hearing under the organization's grievance procedures.~~

~~50.3.3.1—Notice of Proposed Disenrollment for Cause~~

~~Once the grievance process has been completed or the member has chosen not to use this process, the cost plan must submit a proposed disenrollment notice to the Regional Office stating reasons for the termination of enrollment and the proposed effective date. Also, the cost plan must summarize the case and submit documentation to the Regional Office, including:~~

- ~~• The reason that the plan is requesting disenrollment for cause;~~
- ~~• A summary of plan efforts to explain these issues to the member and the other types of options presented before disenrollment was considered;~~
- ~~• A description of the member's age, diagnosis, mental status, functional status, and social support system; and~~
- ~~• Separate statements from primary providers describing their experiences with the member.~~

~~50.3.3.2—Regional Office Review of Disenrollment for Cause~~

~~The Regional Office will review the cost plan's request based on the documentation submitted and make a decision within 20 business days of receipt of complete documentation. The Regional Office will notify the plan within 5 business days after the decision is made.~~

~~When the cost plan receives the decision it must inform the enrollee of the determination. If membership is being terminated, the cost plan must send a notice that contains the reason for disenrollment, the effective date of termination, and a statement that this action was approved by CMS.~~

~~50.3.3.3—Effective Date of Disenrollments for Cause~~

~~If CMS permits a cost plan to disenroll a member for cause, the disenrollment takes effect on the first day of the calendar month after the month in which the plan serves written notice of termination to the member and the grievance period has expired. The liability of CMS to make payments ends on that date. The cost plan must retain copies of its documentation, the proposed disenrollment notice, the approval letter from CMS, and the notice to the beneficiary in its files for verification purposes.~~

60 – Post-Enrollment/Disenrollment Activities

60.1 – Retroactive Enrollments

In general, retroactive enrollments are not accepted by CMS. If the cost plan has informed a beneficiary that his/her enrollment in the plan is effective on a certain date, but then submits an incorrect enrollment transaction to CMS, the plan must honor its contract with the individual and begin providing coverage on the stated date. If the plan provides services to the member before it can submit the correct enrollment information, the plan may still receive Medicare fee-for-service (FFS) payments for any services it renders. In order for the cost plan to receive direct payments for physician and supplier services from a Medicare carrier, the cost plan must have a third party billing number.

Each month, CMS will make an interim per capita payment to the plan based on the number of members enrolled in the plan. At the end of the contract period, the plan must submit a Cost Settlement Report to CMS (please see [Chapter 17-Subchapter A, §20.2](#), of the Medicare Managed Care Manual for further details on the Report). The report will allow the cost plan to report any underpayments or overpayments due.

However, there are situations where CMS may make an exception. CMS will review these situations on a case-by-case basis and will generally only grant exceptions for incorrect entitlement data or other types of CMS systems problems.

60.1.1 – Enrollment Retroactive to Date of Initial Medicare Entitlement

The effective date of membership as a Medicare beneficiary is the month in which the individual becomes entitled to benefits under Medicare Part A and is enrolled in Medicare Part B, or enrolled in Medicare Part B only if:

- The individual enrolls in Part B of Medicare and applies to the cost plan prior to the month in which he/she is entitled to part B of Medicare; or
- The individual is a member of the cost plan organization prior to his/her entitlement to Medicare benefits and applies to the cost plan prior to the month of entitlement.

Some beneficiaries may not have a record of entitlement to Part B established in the data system at CMS until after the actual date of first entitlement. In such cases, CMS will take action to correct the effective date retroactively.

60.1.2 – Errors in Social Security Administration (SSA) Records and/or CMS Medicare Entitlement Data

In some instances, problems may occur that are related to SSA and/or CMS systems. The cost plan may request a retroactive enrollment when SSA/CMS systems problems delay processing of applications. These include:

1. Application rejection when Part B entitlement is not reflected on Medicare records prior to the first month of entitlement (due to possible lag time when a beneficiary enrolls during a special enrollment period instead of the initial enrollment period);
2. HIC number changes;
3. Erroneous death notifications;

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4. Problems with posting of Medicare Part B premiums; or
5. Any other SSA/CMS systems issue that may cause the Medicare entitlement data to be incorrect or missing or that may result in an erroneous enrollment rejection

The cost plan should submit requests for review of such cases to CMS.

60.2 – Retroactive Disenrollment

In general, CMS does not accept retroactive disenrollments. As discussed in §50.1.1 of this chapter, voluntary disenrollment must be effective no later than the first day of the month following receipt of the member's written request for disenrollment, unless the beneficiary requests a later date. If the beneficiary requests a later date, it can be no later than the third month after the month in which CMS receives an acceptable disenrollment request from the cost plan.

However, CMS may approve retroactive disenrollments for certain situations on a case-by-case basis. The plan should submit retroactive disenrollment requests, including supporting evidence justifying the late disenrollment, to CMS. If CMS approves the cost plan's request for retroactive disenrollment, the plan must reimburse the member for any premium paid for any month for which CMS processes a retroactive disenrollment.

The following are examples of situations where retroactive disenrollment may be permissible. This list contains examples; it is not meant to be all-inclusive, nor does it imply that retroactive disenrollment is assured for any circumstance:

- **Systems Problems** - If the beneficiary submits a proper disenrollment request, but as a result of systems problems the disenrollment is not shown on a timely basis in the cost plan's and/or CMS' records.
- **Organizational Error** - When the organization has not properly processed or acted upon the member's properly made disenrollment request. A disenrollment request will be considered not properly processed or acted upon if the effective date is a date other than as required in §50.1.1 of this chapter.
- **Lack of Intent to Enroll** - The cost plan must submit a retroactive disenrollment request to CMS if there is evidence that the beneficiary did not intend to enroll in the plan (e.g., the beneficiary did not realize he or she ever enrolled in a cost plan).

Evidence that the beneficiary did not intend to enroll may include:

- Continuing supplemental (Medigap) insurance coverage after the effective date of cost plan enrollment;
- Purchasing supplemental insurance immediately after enrolling in the plan; or
- Making an inquiry to CMS questioning cost plan enrollment.

Payment of the plan's premium does not necessarily indicate an informed decision to enroll. The beneficiary may believe that he or she was purchasing a supplemental health insurance policy. In addition, use of a plan doctor does not necessarily indicate an understanding of the cost plan's rules if the doctor also treats non-cost plan members.

60.2.1 – Failure of Employer Group to Notify Plan of Requested Disenrollment

The cost plan must submit a retroactive disenrollment request to CMS if an employer group fails to provide timely notification of a Medicare beneficiary's requested disenrollment. ~~The~~ CMS may process disenrollments up to 90 days retroactively. The employer group's notification is untimely if it does not result in a disenrollment effective for the month following the month the request is received, or for the requested effective date (if later).

Evidence must demonstrate that the beneficiary acted to disenroll in a timely fashion (i.e. prospectively), but the employer group was late in providing the information to the cost plan. Such evidence may include an election or application form signed by the beneficiary and given to the employer group during an open enrollment season.

NOTE: The application form could be the employer group's generic form used during its open enrollment season for all employees and retirees.

60.3 – Multiple Transactions

Multiple transactions occur when CMS receives more than one enrollment transaction for the same individual with the same effective date in the same reporting period. An individual may not be enrolled in more than one MA, cost, PDP or HCPP plan at any given time (however, an individual may be enrolled in a cost plan and a separate PDP plan, or in certain other MA plan types and a separate PDP plan). Generally, the last enrollment action the beneficiary makes during an enrollment period will be accepted as the plan the individual intends to enroll in. The CMS will accept the enrollment action based upon the date that the enrollment application was signed or the enrollment request for MA or PDP plans was received. If the beneficiary does not date the enrollment form, the date the enrollment form was received by the cost plan will be used as the default date.

If an individual elects more than one plan for the same effective date and with the same signature or receipt date, the first transaction successfully processed by CMS will apply. Because simultaneous enrollment in a cost plan and a separate PDP plan is permitted, CMS systems will accept both enrollments.

Generally, given the use of the application date to determine the intended enrollment choice, retroactive enrollments will not be processed for multiple transactions that reject because the elections were signed on the same day.

EXAMPLE 1

- Two Medicare managed care plans receive completed enrollment forms from one individual. Cost plan #1 receives the complete form on May 4th and cost plan #2 receives a complete form on May 10. Both cost plans submit enrollment transactions, including the applicable date. The enrollment in cost plan #2 will be the transaction that is accepted and will be effective on June 1 because the application date on the enrollment transaction is the later of the 2 submitted. Both plans receive the appropriate reply on the reply listing.

EXAMPLE 2

- Two Medicare managed care plans receive completed enrollment forms from one individual on August 13 for an October 1 effective date. Both enrollment forms were signed on August 8, and were transmitted by the August cutoff date with the same application date on the transaction.

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The first transaction successfully processed by CMS will be accepted; the second to arrive (with identical application and effective dates) will be rejected.

In the event a rejection for a multiple transaction is reported to the cost plan, the cost plan may contact the individual. If the individual wishes to enroll in the cost plan, he or she must fill out and sign another enrollment form. The cost plan may transmit the information to CMS using the appropriate effective date as described in §30.

60.4 – Storage of Enrollment Forms

The cost plan must retain enrollment forms while beneficiaries are members of the plan and for one year after disenrollment. Cost plans that offer an optional supplemental Part D benefit must retain the enrollment records for individuals who have elected that benefit for the current contract period and 10 (ten) prior periods (as described in the CMS PDP Enrollment and Disenrollment guidance, section 50.6).

It is appropriate to allow for storage on microfilm or by other technologies, such as optical scanning, as long as all forms and associated documents stored in this manner are legible, including the signature, and easily accessible by reviewers.

60.5 – Cancellations

Cancellations may be necessary in cases of mistaken enrollment or disenrollment made by an individual. Unless otherwise directed by CMS, requests for cancellations can only be accepted prior to the effective date of the enrollment or disenrollment request. For employer or union groups, cancellations properly made to the employer or union prior to the effective date of the election being canceled are also acceptable.

If a cancellation occurs after CMS records have changed, retroactive disenrollment and reinstatement actions may be necessary.

If a beneficiary verbally requests a cancellation of an enrollment or disenrollment request, the cost plan must document the request and process the cancellation. Cost plans may request that the cancellation be made in writing to the plan itself, however, they may not delay processing of a cancellation until the request is made in writing if they have already received a verbal request from the individual of the desire to cancel the enrollment or disenrollment.

60.5.1 – Cancellation of Enrollment

An individual's enrollment can be cancelled only if the request is received prior to the effective date of the enrollment, unless otherwise directed by CMS.

To ensure the cancellation is honored, the cost plan should not transmit the enrollment to CMS. If, however, the organization has already transmitted the enrollment by the time it receives the request for cancellation, it ~~may attempt to~~ **must** submit a ~~corresponding disenrollment~~ **TRC 80 cancellation** transaction to CMS to "cancel out" the ~~now-now~~-void enrollment transaction from the CMS enrollment system. In the event **the cancellation transaction fails or** the cost plan ~~has submitted the enrollment and is unable to submit a corresponding disenrollment transaction,~~ or has other difficulty, the cost plan

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~~should~~**must** contact CMS (or the CMS Retroactive Processing Contractor) in order to cancel the enrollment.

When canceling an enrollment *transaction*, the cost plan must provide a notice to the individual that states that the cancellation is being processed. The organization should send this notice within 10 calendar days of receiving the cancellation request.

If the member's request for cancellation occurs after the effective date of the enrollment in the cost plan, the cancellation generally cannot be processed. The organization must inform the individual that he/she is a member of its cost plan. An individual previously enrolled in an MA plan will have to request enrollment in that plan during a valid enrollment period for a prospective effective date.

Note that if the individual was enrolled in another plan prior to making the enrollment request (and cancelling that request), when the cancellation transaction occurs, CMS will attempt to reinstate the individual into the prior plan. See §60.6.2 for specifics regarding the reinstatement.

60.5.2 – Cancellation of Disenrollment

A voluntary disenrollment request can be cancelled by the individual only if the request for cancellation is received prior to the effective date of the disenrollment unless otherwise directed by CMS.

To ensure the cancellation is honored, the cost plan should not transmit the disenrollment to CMS. If, however, the organization had already transmitted the disenrollment by the time it receives the verbal request for cancellation, it may attempt to submit a ~~corresponding enrollment~~ *TRC 81 cancellation of disenrollment* transaction to CMS to *cancel the now* ~~"cancel out" the now now~~-void disenrollment transaction. In the event the organization has submitted the disenrollment and is unable to submit the ~~"canceling" enrollment transaction~~ *TRC 81*, or has other difficulty, ~~the cost plan~~ then the organization should contact CMS (or the CMS Retroactive Processing Contractor) in order to cancel the disenrollment.

The cost plan must send a letter to the individual that states that the cancellation is being processed and that instructs the member to continue using plan services. This notice should be sent within 10 calendar days of receipt of the cancellation request.

If the member's request for cancellation occurs after the disenrollment effective date, the cancellation cannot be processed. The organization should instruct the member to complete a new enrollment form to enroll in the cost plan for a prospective effective date.

60.6 – Reinstatements

Reinstatements may be necessary under limited circumstances. The most common reasons potentially warranting reinstatements are:

1. *Disenrollment due to erroneous death indicator (§60.6.1);*

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2. *Disenrollment due to erroneous loss of Medicare Part B indicator (§60.6.1);*
3. *Automatic reinstatement~~s~~ based on beneficiary cancellation of subsequent enrollment (§60.6.2);*
4. *Demonstration of “good cause” for failure to pay cost plan premiums (or other costs) or optional supplemental Part D benefit premiums (and/or Part D-IRMAA) timely (§60.6.3).*

When a disenrolled individual contacts the cost plan to state that he/she was disenrolled due to items 1 or 2 listed above, and states that he/she wants to remain a member of the cost plan, the cost plan must instruct the member in writing to continue to use cost plan services (refer to Exhibits 17 and 18). The cost plan must send the notice within ten (10) calendar days of the individual’s contact with the organization to report the erroneous disenrollment. Accordingly, plan systems should indicate active membership as of the date the organization instructs the individual to continue to use plan services.

When a disenrolled individual contacts the Cost plan about either item 3 (reinstatement based on enrollment cancellation) or 4 (“good cause”), plans must follow the guidance outlined below pertaining to those unique situations.

CMS views a reinstatement as a correction necessary to “erase” an invalid disenrollment action. Therefore, reinstatements may be made back to a date when an cost plan was closed for enrollment.

When a cost organization receives notification of an individual’s reinstatement, the organization has ten (10) calendar days to send the individual a notice of reinstatement (Exhibit 16).

It is important to note that for all cases of reinstatement, CMS does not provide payment to cost plans retroactively. For information on cost plan payment, see Chapter 17, Subchapter B of the Medicare Managed Care Manual.

60.6.1 – Reinstatements for Disenrollment Due to Erroneous Death Indicator or Due to Erroneous Loss of Medicare Part B

A member will be reinstated if he/she was disenrolled due to an erroneous death indicator or erroneous loss of Part B, since he/she continues to be eligible. As outlined in 42 CFR 417.460(b), cost plans have the option of sending notification of disenrollment due to death or loss of B to the beneficiary (or to the beneficiary’s estate in the case of disenrollment due to death). CMS strongly suggests that cost plans send these notices, to ensure any erroneous disenrollments are corrected as soon as possible. Refer to Exhibit 17 and Exhibit 18 for model letters. Although organizations may request that individuals provide evidence of Medicare entitlement by a particular date, erroneous disenrollments must be corrected and the corresponding reinstatements processed regardless of the date on which the individual disputes the erroneous disenrollment or provides evidence of Medicare entitlement.

To request consideration for reinstatement following disenrollment due to erroneous death indicator or erroneous loss of Medicare Part B, the cost plan must submit to CMS (or its designee) a copy of the letter to the member informing him/her to continue to use cost plan services until the issue is resolved. The cost plan must indicate the date the letter was sent. Refer to model letters in Exhibit 17 and Exhibit 18.

Within ten (10) calendar days of receipt of TRR confirmation of the individual’s reinstatement, the organization must send the member notification of the reinstatement (Exhibit 16).

CMS will attempt to automatically reinstate beneficiaries that were auto-disenrolled by a report of date of death if there is a subsequent date of death correction that impacts the plan enrollment.

60.6.2 – Reinstatements Based on Beneficiary Cancellation of New Enrollment

As stated in §50.5, deliberate member-initiated disenrollments imply intent to disenroll. Therefore, reinstatements generally will not be allowed if the member deliberately initiated a disenrollment. An exception is made for those members who were automatically disenrolled because they enrolled in another plan but subsequently cancelled the enrollment in the new plan before it becomes effective.

In this situation, the individual must cancel the enrollment into the new plan, as described in section 60.5.2 or other CMS manual guidance. When a cancellation of enrollment in a new plan is properly made, the associated automatic disenrollment from the previous plan becomes invalid. Upon successful cancellation of enrollment in the new plan, CMS systems will attempt to automatically reinstate enrollment in the previous plan. Because this process is automatic, it is generally not necessary to request reinstatement via the Regional Office or CMS contractor. Within ten (10) days of receipt of TRR confirmation of the individual’s reinstatement, the organization must send the member notification of the reinstatement (Exhibit 16).

In cases where the valid, timely cancellation request is not processed correctly, or CMS systems cannot complete the otherwise-valid request, the new plan must submit a request to the CMS Retroactive Processing Center -to cancel the enrollment. This request will require complete documentation, including evidence that the beneficiary requested cancellation of enrollment in the new plan within required timeframes.

If the previous plan becomes aware of an unsuccessful reinstatement, the previous plan may contact the CMS Retroactive Processing Center or CMS Account Manager to investigate the issue with the new plan.

If the disenrolled individual contacts the previous plan requesting to remain a member of that plan, the Cost plan should inform the individual that reinstatement of enrollment is an option only if the individual successfully cancels enrollment in the “new” plan; accordingly, the organization should refer the individual to the “new” plan to inquire about his or her options.

60.6.3 – Reinstatements Based on “Good Cause” Determination for Failure to Pay Cost Plan Premiums, Optional Supplemental Part D Benefit Premiums or Part D-IRMAA

Individuals who lose their cost plan coverage or optional supplemental Part D benefit as a result of failure to pay the premium (or other costs) associated with the basic cost coverage, failure to pay the premium associated with the optional supplemental Part D benefit to the cost plan (under §50.3.1) or failure to pay the assessed Part D-IRMAA amount to CMS (under §50.2.5) may request reinstatement for good cause. This option is available in 2012 only to individuals who fail to pay the premium associated with their optional supplemental Part D benefit but continue to pay the basic plan premium and are therefore not disenrolled from the cost contract. In 2012, reinstatement for good cause is not an option for individuals who are disenrolled from the cost plan for failure to pay the premiums

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associated with the basic benefit(s). Starting with disenrollments effective January 1, 2013, reinstatement for good cause is available to all individuals enrolled in cost contracts, including both those with or without the optional supplemental Part D benefit.

Reinstatement will occur only under the following circumstances:

1. The individual requests reinstatement with CMS within the first 60 days of the disenrollment effective date;
2. CMS determines that the individual meets the criteria specified and receives a favorable determination by CMS;
3. Individual pays all owed premiums (and other costs) and/or Part D-IRMAA amounts in full within the three month grace period (both past due amounts and the premium amounts that accrue for the months during the request for reinstatement).

The timeframe for the good cause reinstatement process is three months from the effective date of disenrollment.

Reinstatement of enrollment for “good cause” is provided only in rare circumstances in which the beneficiary or his/her authorized representative was unable to make timely payment due to circumstances over which they had no control and they could not reasonably have been expected to foresee. Examples of circumstances that may constitute “good cause” include:

- Federal government error caused the payment to be missed or late;
- Prolonged illness, hospitalization or institutionalization of the beneficiary;
- Death or serious illness of spouse or other family member; or
- Loss of the beneficiary’s home or severe impact by fire, or other exceptional circumstance outside the beneficiary’s control (e.g. affected individual resides in a federal disaster area).

Examples of circumstances that would not constitute “good cause” include:

- Allegation that bills or warning notices were not received due to unreported change of address, out of town for vacation, visiting out of town family, etc;
- Authorized representative did not pay timely on member’s behalf;
- Lack of understanding of the ramifications of not paying plan premiums/other costs or Part D-IRMAA;
- Could not afford to pay premiums at the time of delinquency/disenrollment

For the purpose of determining “good cause” for members with authorized representatives, the criteria for both favorable and unfavorable determinations apply as though the authorized representative is the member. Thus, as noted above, failure to make timely payment by an authorized representative alone is not grounds for a favorable “good cause” determination and reinstatement.

An individual who is not assessed Part D-IRMAA remains disenrolled from the cost plan or the optional supplemental Part D benefit and does not have access to services until one of the following occurs:

- The plan receives full payment of all required amounts to satisfy a CMS-determined, favorable good cause case for failure to pay premiums (or other amounts),
- The plan is contacted by the CMS caseworker, or
- The reinstatement occurs and is reported on the TRR.

An individual who is not assessed Part D-IRMAA remains disenrolled from the cost plan or the optional supplemental Part D benefit and does not have access to services until the reinstatement

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occurs and is reported on the TRR or the CMS caseworker contacts the cost plan after the caseworker has successfully updated the individual's enrollment record in MARx. Once a reinstatement occurs, the individual's disenrollment will be cancelled and his/her cost plan coverage and/or optional supplemental Part D coverage will be continuous, assuming the individual continues to be eligible for enrollment in that benefit.

Process for "Good Cause" Determinations:

When a member who has lost his/her optional supplemental Part D benefit contacts the cost plan because s/he was disenrolled due to failure to pay cost plan premiums (or other costs), optional supplemental Part D benefit premiums or Part D-IRMAA and states that s/he "has a good reason for not paying the premiums", the cost plan must advise the individual to contact 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) within 60 calendar days of the disenrollment effective date to make the "good cause" reinstatement request. The cost plan should also inform the individual that in order to be reinstated, s/he must meet specific "good cause" standards and must pay all overdue and current owed premiums (including other costs and, if applicable, both the optional supplemental Part D premium and Part D-IRMAA) within 3 months of the disenrollment date in order for reinstatement may occur.

Note: In cases where the involuntary disenrollment for failure to pay the optional supplemental Part D premium is the result of plan error, cost plans should follow the reinstatement process outlined in §60.2.3 of Chapter 3 of the Medicare Prescription Drug Benefit Manual. Plans should not refer these individuals to 1-800-MEDICARE to request reinstatement for "good cause."

Once a request is made with CMS via 1-800-MEDICARE, a CTM case will be generated for CMS caseworker action. The CMS caseworker will contact the individual and make a "good cause" determination. If the individual provides any documentation to the cost plan regarding the inability to make timely payment, the cost plan must provide that documentation to CMS (through the cost plan's account manager) so that the caseworker may consider it when making the determination. CMS will notify the individual of the determination and, if favorable, explain the general process, including payment responsibilities and timing. Cost plans are required to provide more specific information to the individual, as outlined below. Notes of the "good cause" reinstatement request will be captured in the CTM for CMS and plan viewing. (Note: Requests for reinstatement are not considered complaints against the cost plan, therefore, these types of CTM cases are excluded from tracking for the purposes of cost plan ratings.)

If CMS makes a favorable determination, a note will be made in the CTM "good cause" request case. CMS will communicate directly with cost plans regarding approved good cause determinations. If there are required amounts owed to the cost plan for premiums and other costs (and/or optional supplemental Part D benefit premiums), the cost plan must send notification to the beneficiary within 3 business days of being informed of the approved good cause determination. This notice will specify the amount owed, the date by which the cost plan must receive the payment to allow reinstatement (i.e., last day of the third month following effective date of disenrollment), and where to send payment (or other payment options such as credit card or direct withdrawal from a bank account)(See Exhibit 22 and 22a). Even if an individual has received a favorable good cause determination, the actual reinstatement will not occur until all required payments are made, provided they are received within three months of the disenrollment effective date.

Within ten (10) calendar days of receipt of TRR confirmation of the individual's reinstatement, the cost plan must send the member notification of the reinstatement (See Exhibit 16).

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In cases where an individual pays all cost plan, optional supplemental Part D benefit or Part D-IRMAA premium amounts but does not receive a favorable “good cause” determination or receives a favorable good cause determination but does not pay the required amounts to the plan -and/or the Part D-IRMAA owed within three months of the disenrollment effective date, s/he will not be reinstated. In both of these cases, the plan may re-enroll the individual for a prospective enrollment effective date at the beneficiary’s request (using and appropriate enrollment request mechanism and assuming the cost plan is open for enrollment), following enrollment procedures outlined in Sections 30 and 40. Individuals wanting to re-enroll in the optional supplemental Part D benefit must have a valid Part D election period. See Chapter 3 of the Medicare Prescription Drug Benefit Manual for more information on Part D election periods.

Example A: Mr. Smith is disenrolled from the optional supplemental Part D benefit for failure to pay optional supplemental Part D premiums and remains enrolled in the cost plan’s basic medical benefit on April 1. Mr. Smith contacts Medicare and makes his request on April 15 and receives a favorable good cause determination on April 23. Mr. Smith is not assessed a Part D-IRMAA and only owes the optional supplemental Part D premiums (he has continued to pay the basic cost plan premium). The cost plan notifies Mr. Smith of the amount he owes by June 30 in order to be reinstated into the optional supplemental Part D benefit. Mr. Smith pays the amount due on June 15. Mr. Smith is reinstated into the optional supplemental Part D benefit. (Note: If Mr. Smith did not pay his owed amount by June 30, he would not be reinstated.)

Example B: Mr. Smith is disenrolled from the cost contract (and optional supplemental Part D benefit) for failure to pay the plan’s premiums and co-insurance amounts effective December 1. Mr. Smith contacts Medicare and makes his request on December 20 and receives a favorable good cause determination on January 4. Mr. Smith is also delinquent on his Part D-IRMAA. CMS notifies Mr. Smith of the amount he owes by February 28 for Part D-IRMAA. The cost plan notifies Mr. Smith of the amount he owes by February 28 in order to be reinstated into his cost contract (and the optional supplemental Part D benefit). Mr. Smith pays his Part D-IRMAA owed amount on February 7. Mr. Smith pays his cost plan -owed amounts on February 25. Mr. Smith is reinstated into the cost contract. (Note: If Mr. Smith did not pay either of his owed amounts by February 28, he would not be reinstated. Further, if Mr. Smith paid his cost plan premiums, but not his optional supplemental Part D benefit premiums, he would not be reinstated.)

Example C: Mr. Smith is disenrolled from the optional supplemental Part D benefit for failure to pay the optional supplemental Part D premium and remains enrolled in the cost plan’s basic medical benefit effective July 1. Mr. Smith mails in his past due amounts to the cost plan on July 30. He contacts Medicare and makes his request on August 10, and does not receive a favorable good cause determination. Mr. Smith may not be reinstated.

Example D: Mr. Smith is disenrolled from the cost contract for failure to pay cost plan coinsurance amounts effective November 1. Mr. Smith mails in his owed amounts to the cost plan on December 15, but does not request reinstatement with CMS. Thus, Mr. Smith does not have a favorable good cause determination, and he may not be reinstated in the cost contract.

Example E: Mr. Smith is disenrolled from the optional supplemental Part D benefit for failure to pay Part D-IRMAA and remains enrolled in the cost plan’s basic medical benefit effective August 1. He contacts Medicare and makes his request on September 29 and receives a favorable good cause determination on October 5. Mr. Smith is also delinquent on his optional supplemental Part D benefit premiums. CMS notifies Mr. Smith of the amount he owes by

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October 31 for Part D-IRMAA. The cost plan also notifies Mr. Smith of the amount he owes by October 31 for optional supplemental Part D benefit premiums. Mr. Smith pays his Part D-IRMAA owed amount on October 25. Mr. Smith pays his optional supplemental Part D benefit premium owed amount on November 5. Mr. Smith may not be reinstated. (Note: If Mr. Smith had paid both his owed Part D-IRMAA and optional supplemental Part D benefit premiums by October 31, he would have been reinstated.)

The above examples apply for disenrollments from cost contract and/or the optional supplemental Part D benefit for either failure to pay premiums or failure to pay Part D-IRMAA.

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Appendix 1: Summary of Exhibits

This information provides a summary of the model notices and forms referenced in this chapter. For exact details on requirements and any applicable time frames, refer to the appropriate sections within this Chapter. Please refer to Chapter 17 for information on cost plan marketing material review.

Exhibit	Notice	Section	Required?	Timeframe
1	<i>Model Cost Plan Enrollment Form</i>	40.1	Yes	N/A
2	<i>Model Notice to Acknowledgment of Receipt of Completed Enrollment Form</i>	40.4 40.4.1	Yes	< 30 days from the date the form was received
3	<i>Model Notice for Request for Information</i>	40.2.2	No	N/A
4	<i>Model Notice to Confirmation of Enrollment</i>	40.4.1	Yes	Within 30 days from receipt of CMS confirmation
5	Cost Plan <i>Model Notice for Denial of Enrollment</i>	40.2.2.5	Yes	7 business days following denial made when additional information request period ends
5a	<i>Model Notice for Denial of Enrollment in Optional Supplemental Part D Benefit</i>	40.5.1	Yes	Within 10 calendar days of receipt of selection request.
6 & 6a	Model Notice to Sending Out Disenrollment Form			
6 & 6a	<i>& Disenrollment Form</i>	50.1	No	N/A
6a	<i>Model Disenrollment Form</i>	50.1	No	N/A
7	Model Notice to Acknowledgment Acknowledge of Receipt of Member's Voluntary Disenrollment Request from Member	50.1.1	No ¹	
8	<i>Model Notice to Confirm Voluntary Disenrollment Following Receipt of Identified Through Reply Listing</i>	50.1.1	No	Encouraged to send within 7 days of the availability of the reply listing
9	<i>Model Notice of Disenrollment Due to Death</i>	50.2.2	No	N/A
10	<i>Model Notice of Disenrollment Due to Loss of Medicare Part B</i>	50.2.3	No	N/A
11	Capacity Waiver Calculation Worksheet <i>[Moved to Appendix 2]</i>	30.1.1, 30.1.2 N/A	N/A	N/A
12	<i>Model for Closing Enrollment</i>	30.1.1	N/A	N/A
13	<i>Model Notice to Inform Full Benefit Dual Eligible Member of Auto-Enrollment</i>	40.1.1	Yes	As described in §40.1.1

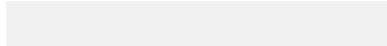
¹ However, the cost plan must provide the member with a copy of his/her disenrollment request.

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Exhibit	Notice	Section	Required?	Timeframe
13a	<i>Model</i> Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in PDP	40.1.1	Yes	As described in §40.1.1
14	<i>Model</i> Notice to Inform Member of Facilitated Enrollment	40.1.1	Yes	As described in §40.1.1
14a	<i>Cost Plan Model</i> Notice to Inform Other LIS Eligible Member of Auto-Enrollment in PDP	40.1.1	Yes	As described in §40.1.1
15	Acknowledgment of Request to Decline Part D	40.1.1	Yes	As described in §40.1.1
16	<i>Model Confirmation of Reinstatement</i>	60.6, 60.6.1, 60.6.2, 60.6.3,	Yes	<i>Within ten (10) days of receipt of TRR confirmation of the individual's reinstatement.</i>
17	<i>Model Notice to Offer Beneficiary Services Pending Correction of Erroneous Death Status</i>	60.6.1	No	<i>As described in §60.6.1</i>
18	<i>Model Notice to Offer Beneficiary Services Pending Correction of Erroneous Medicare Part B Termination</i>	60.6, 60.6.1	No	<i>As described in §60.6.1</i>
19	<i>Notice of Involuntary Disenrollment for Failure to Pay Plan Premium</i>	50.3.1	Yes	<i>At least 20 days prior to the effective date of the disenrollment.</i>
20	<i>Notice of Confirmation of Involuntary Disenrollment for Failure to Pay Premiums</i>	50.3.1	Yes No	<i>Within ten (10) calendar days of the availability of the TRR.</i>
21	<i>Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services for Failure to Pay the Part D-Income Related Monthly Adjustment Amount</i>	50.2.5	Yes	<i>Within ten (10) calendar days of the availability of the TRR.</i>
22	<i>Model Notice on Favorable "Good Cause" Determination – Notification of Premium Amount Due for Reinstatement of Optional Supplemental Part D Benefit</i>	60.6.3	Yes	<i>Within three (3) business days following the notification by CMS of favorable "Good Cause" determination</i>
22a	<i>Model Notice on Favorable "Good Cause" Determination – Notification of Premium Amount Due for Reinstatement of Cost Plan Contract</i>	60.6.3	Yes	<i>Within three (3) business days following the notification by CMS of favorable "Good Cause" determination</i>

Appendix 2: Model Capacity Waiver Calculation Worksheet

1. Start with total capacity for the year that the waiver is requested (i.e., how many slots are available for both commercial and Medicare).
2. Current total (Medicare/Medicaid and commercial) membership, excluding estimated number of "age-ins" (i.e., non-Medicare enrollees of your plan who will convert to Medicare status during the period for which you are seeking a capacity waiver).
3. Projected new Medicaid-only and commercial individual or group members.
4. Add steps (2) and (3) and subtract result from step (1) above to determine remaining slots available.
5. Divide the figure in step (4) above by the utilization factor or factors from the most recent ACR to determine available slots for Medicare enrollees. Use an inpatient factor and ambulatory factor, or both. However, if both are used, the data must be shown separately for each one, or show an acceptable methodology for combining the factors.
6. The resultant figure is the initial number of available Medicare slots.
7. Enter estimated Medicare enrollment from "age-ins." (Current members excluded from (2) above).
8. Subtract step (7) from step (6). The result is the total number of slots available to individual Medicare members.



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Exhibit 1: Model Cost Plan Enrollment Form

To Enroll in <name of plan>, Please Provide the Following Information:			
[Optional Field] Please check which plan you want to enroll in: ____ Product ABC \$XX per month ____ Product XYZ \$XX per month]			
Please indicate your requested enrollment effective date: _____			
LAST name: FIRST Name: Middle Initial		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Birth Date: (____/____/____) (M M/D D/Y Y Y Y)	Sex Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	
Permanent Residence Street Address:			
City:	State:	[Optional: County:]	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:		City:	State: ZIP Code:
[Optional field: Emergency contact: [Optional field] _____]			
[Optional field: Phone Number: [Optional field] _____]			
[Optional field: Relationship to You [Optional field] _____]			
[Optional field] E-mail Address: _____]			
Please Provide Your Medicare Insurance Information			
Please take out your Medicare Card to complete this section. <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare card - OR - Attach a copy of your Medicare card or your letter from the Social Security Administration of Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage-cost plan.		 <p style="text-align: center;">SAMPLE ONLY</p> Name: _____ Medicare Claim Number Sex _____ _____ - _____ - _____ Is Entitled to Effective Date HOSPITAL (Part A) _____ MEDICAL (Part B) _____	

[Optional: (this section applies only to cost plans offering an optional supplemental Part D benefit)]:

Your Plan Premium Payment Options

You can pay your monthly plan premium by mail <insert optional methods: "Electronic Funds Transfer (EFT)", "credit card"> each month <insert optional intervals, if applicable, for example "or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month <optional language in place of "bill each month": "coupon book" or "payment book">.

Please select a premium payment option:

- Receive a bill <option: "coupon"; "payment" book, etc>
<option to include other billing intervals e.g. bi-monthly, quarterly>

[Include other optional methods, such as EFT & credit card as follows:

- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____
Bank routing number: _____ Bank account number: _____
Account type: Checking Saving

- Credit Card. Please provide the following information:

Type of Card: _____
Name of Account holder as it appears on card: _____
Account number:
Expiration Date: __/__/____ (MM/YYYY)]

- Automatic deduction from your monthly SSA/RRB (*Railroad Retirement Board*) benefit check. (The SSA deduction may take two or more months to begin *after Social Security/RRB approves the deduction*. In most cases, *if Social Security/RRB accepts your request for automatic deduction*, the first deduction from your SSA/RRB benefit check will *not* include all premiums due from your enrollment effective date up to the point withholding begins. *We will [insert one of the following or similar billing language: send you a paper bill/send you a coupon book] for those months before deduction from your*

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Social Security/RRB check starts. If Social Security/the RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Do you or your spouse work? Yes No

Do you have health coverage through you or your spouse's current or former employer? Yes No

If "yes," please provide the following information:

Employer Name: _____ Employer Address: _____
Policy Holder Name: _____ Policy Number: _____

3. Are you enrolled in your State Medicaid program? Yes No

If yes, please provide your Medicaid number: _____

[Cost plans offering an optional supplemental Part D benefit only must include:

4. Some individuals may have other drug coverage, including other private insurance such as through an employer or spouse's employer, TRICARE, Federal Employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

Do you or will you have other prescription drug coverage in addition to <plan name>? Yes No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage _____]

[Optional field] **Please choose the name of a Primary Care Physician (PCP), clinic or health center (if required):]**

[Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**

Language A (e.g., Spanish)
 Language B (e.g., Chinese)]

[This box required only for cost plans offering an optional supplemental Part D benefit:]



Please Read This Important Information

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If you currently have health coverage from an employer or union, joining <Cost Plan Name> could affect your employer or union health benefits. If you have health coverage from an employer or union, joining <Cost Plan Name> and selecting the Medicare Prescription Drug benefit may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

<Cost Plan Name> is a Medicare health plan and I will need to keep my Medicare Part B. I can be in only one Medicare Health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to <Cost Plan Name> or by calling I-800-Medicare. TTY users should call 1-877-486-2048.

<Cost Plan Name> serves a specific service area. If I move out of the area that <Cost Plan Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Cost Plan Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of coverage document] from [name] when I receive it to know which rules I must follow in order to receive coverage with this Medicare health plan.

I understand that beginning on the date [name of plan] coverage starts, in order for [Cost Plan Name] to fully cover my medical services (except for emergency or urgently-needed services), all of my health care must be provided or arranged by {<name of plan>. } If obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by [name of plan] and other services contained in my [name of plan] Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. *[If offering an optional supplemental Part D benefit include: I also acknowledge that <Cost Plan name> will release my information, including my prescription drug event data, to Medicare who may release it for research and other purposes which follow all applicable Federal statutes and regulations.]* The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1)

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this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <Cost Plan Name> or by Medicare.

Your Signature: _____

Today's Date: _____

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (____) ____-_____

Relationship to Enrollee _____

Office Use Only:

Name of staff member (if assisted in enrollment): _____

Plan ID #: _____

[Enrollment Period when applicable] IEP: _____ AEP: _____ SEP (type): _____

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Exhibit 2: Model Notice to Acknowledge Receipt of Completed Enrollment Form

Referenced in section(s): 40.5

[Member ID #]

†[Cost plans offering Optional Supplement Part D Benefit must include: [Rx 10], [Rx Group], [Rx Bin], [Rx PCN] †]

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 in order for the plan to fully cover your medical services. You may obtain medical services not provided or arranged by [name of plan/organization], but you will be responsible for payment of all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. ***[Optional language: This letter can serve as evidence of insurance until you receive your membership card from us. You should show this letter to your doctor when you go to your doctor appointments until you receive your membership card.]***

All enrollment forms must be reviewed by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare program. We will send your enrollment form to CMS, and a final review of the enrollment form will be performed. When CMS finishes its review, we will send you a letter to confirm your enrollment with <Plan>. However, you can begin using <Plan> doctors prior to receiving the confirmation letter. 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 B (Medical Insurance) to be a member of <name of plan>. If you do not have Medicare Part B, we will bill you for any health care you receive from us, and neither Medicare nor <name of plan> will pay for those services. Also, if you have End Stage Renal Disease (ESRD), you may not be able to enroll in <Plan>, and you may be billed for Medicare deductibles and coinsurance for any health care you received.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socia/security.gov/prescriptionhelp.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/~~TDD~~ users should call <toll-free TTY number>.

Thank you.

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Exhibit 3: Model Notice to Request Information

Referenced in section(s); 40.2.2

Dear <Name of beneficiary>:

Thank you for your application to <Plan *name*>. We cannot process your application until we receive one or more of the following things from you (please see item checked below):

- _____ Proof of Medicare Part 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.
- _____ Other: _____.

You will need to send this information to <Plan 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. However, if you wish to apply at a later date, you may complete another application and provide the information necessary to process your request.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/~~TDD~~ users should call <toll-free TTY number>.

Thank you.

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Exhibit 4: Model Notice to Confirm Enrollment

Referenced in section(s): 40.3

[Member ID #]

[*Cost plans offering Optional Supplement Part D Benefit must include: <Rx ID>, <Rx Group>, <Rx Bin>, <Rx PCN>*]

Dear <Name of Member>:

This letter is to tell you that the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, has approved your enrollment in <Plan>, beginning <effective date>. You must see your <Plan> doctor(s) for your health care in order for the plan to fully cover your medical services. If you obtain medical care from a non-network provider, you will be responsible for deductibles, coinsurance, or charges for services not covered by Medicare.

As we explained in an earlier letter, you may cancel any Medigap or supplemental insurance that you have now that we have confirmed your enrollment. Before canceling any supplemental insurance, be sure to determine if it is more beneficial to keep additional coverage.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/~~TDD~~ users should call <toll-free TTY number>.

Thank you

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Exhibit 5: Model Notice for Denial of Enrollment

Referenced in section(s): 40.5, 40.5.1

Dear <Name of beneficiary>:

Thank you for applying for membership in <Plan>. We cannot accept your application for enrollment in <Plan> because:

1. ____ You do not have Medicare Part B
2. ____ You have End Stage Renal Disease (ESRD)
3. ____ Your permanent residence is outside of our service area.
4. ____ We did not receive the information we requested from you within 30 days of our request.

If any of the above items are checked, and our information is correct, then you may be billed for any services you received.

If our information is incorrect, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

Thank you.

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Exhibit 5a: Model Notice for Denial of Enrollment in ~~Part D~~ Optional Supplemental *Part D* Benefit

Referenced in section: 40.5.1

Dear <Name of beneficiary>:

Thank you for selecting <name of Cost Plan drug benefit option>. We cannot accept your request for this Medicare prescription drug benefit because you attempted to enroll in it outside of an enrollment period.

You may enroll in or disenroll from Medicare prescription drug coverage only at certain times of the year. Generally, unless you meet certain special circumstances, such as if you move out of a plan service area, you may only make Medicare prescription drug plan choices between November 15 and December 31 of each year.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you believe our information is incorrect, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/~~TDD~~ users should call <toll-free TTY number>.

Thank you.

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Exhibit 6: Model Notice to Send Out Disenrollment Form

Referenced in section(s): 50.1

Dear <Name of member>:

Attached is the disenrollment form you requested. Please complete the entire form, sign it, and return it to us in the enclosed envelope, or mail it to your local Social Security Office or Railroad Retirement Board Office. You can also fax it to us, as long as the signature and date are readable. Our fax number is <fax number>. You can also disenroll by calling 1-800-MEDICARE or <TTY/TDD number> for the hearing impaired.

If you are joining another Medicare managed care plan, it is not necessary for you to complete the enclosed disenrollment form. You will be automatically disenrolled from <name of plan> if you submit an enrollment application for a new Medicare managed care plan. However, please note that you can generally only choose other Medicare health plans, including drug plans, at certain times of the year.

[Cost plans offering an optional supplemental Part D benefit must include]:

If you have selected to have Medicare prescription drug coverage from (name of plan), by disenrolling from (name of plan) you are also disenrolling from Medicare prescription drug coverage. You generally may only change to a new Medicare drug plan during certain times of year. If you do not have Medicare drug coverage, or other coverage that is at least as good as Medicare drug coverage, you may have to pay a penalty in addition to your plan premium for Medicare drug coverage in the future. For information about Medicare drug plans available in your area you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-4862048.

We will mail a copy of the disenrollment form back to you with the date of your disenrollment written on the form.

If you need assistance, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/~~TDD~~ users should call <toll-free TTY number>.

Thank you.

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Exhibit 6a: Model Disenrollment Form

Referenced in section: 50.1

DATE

(Please Print in Ink)

MEMBER'S NAME _____

First Middle Last

ADDRESS _____

City State Zip Code 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:

Note: If you want to return to Original Medicare (also known as the Medicare fee-for-service program), then you must complete this disenrollment form. We will notify you of the effective date of your disenrollment after we have received this form from you.

If you want to join another HMO immediately following termination from (Health Plan), then you do **not** need to complete this form. Once you enroll in another HMO, your current membership in <health plan> will automatically be cancelled. However, please note that you can generally only choose other plans at certain times of the year.

[Cost plans offering an optional supplemental Part D benefit must include:

If you have selected to have Medicare prescription drug coverage from <name of plan>, by disenrolling from <name of plan> you are also disenrolling from Medicare prescription drug coverage. You generally may only change to a new Medicare drug plan during certain times of year. If you do not have Medicare drug coverage, or other coverage that is at least as good as Medicare drug coverage, you may have to pay a penalty in addition to your plan premium for Medicare drug coverage in the future. For information about drug plans available in your area you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.]

Disenrollment from the <health plan> will be effective on the first day of the month after the month <health plan> receives the written request (unless you request a later date of disenrollment). For example, if you complete this form and submit it to <health plan> on April 30, the last day of the month, your disenrollment will be effective the next day, May 1st. If you are requesting a later date, disenrollment cannot take place later than the third month after which you submit a completed disenrollment request to <health plan>. Therefore, if you submit this form on April 30, the latest disenrollment date possible would be July 1.

Requested disenrollment date: _____

Your Signature Date

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Exhibit 7: Model Notice to Acknowledge Receipt of Member's Voluntary Disenrollment Request

Referenced in section(s): 50.1.1

Dear <Name of beneficiary>:

We received your request to disenroll from <Health Plan> and you will be disenrolled effective <date.> Beginning <effective date>, <Health Plan> will not cover any health care you receive. A copy of your disenrollment request is enclosed.

[Cost plans offering an optional supplemental Part D benefit must include:

If you have selected to have Medicare prescription drug coverage from <name of plan>, by disenrolling from <name of plan> you are also disenrolling from Medicare prescription drug coverage. You generally may only change to a new Medicare drug plan during certain times of year. If you do not have Medicare drug coverage, or other coverage that is at least as good as Medicare drug coverage, you may have to pay a penalty in addition to your plan premium for Medicare drug coverage in the future. For information about drug plans available in your area you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.]

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you have any questions, please call us at <phone number> <days and hours of operation>. TTY users should call <TTY/TDD number>.

Enclosure

Exhibit 8: Model Notice to Confirm Voluntary Disenrollment Identified Through Reply Listing

Referenced in section(s): 50.1.1

Dear <Name of beneficiary>: This is to confirm your disenrollment from <Health Plan>. This disenrollment began <effective date>, and <Health 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 <Health Plan> and there may be a short delay in having your records updated.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you think you did not disenroll from <Health Plan>, and you want to remain a member of our plan, please call us right away at <phone number> <days and hours of operation>. TTY users should call <TTY/~~TDD~~ number>.

Thank you.

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Exhibit 9: Model Notice ~~of~~ Disenrollment Due to Death

Referenced in section(s): 50.2.2

Note: Address letter To The Estate of<Member's Name> or To <Member's Name> To The Estate of<Member's Name> (or To <Member's Name>):

The Centers for Medicare & Medicaid Services, the federal agency that administers the Medicare program, has notified us of the death of<Member's Name>. Please accept our condolences. <Member's name>'s coverage in <name of health 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, *or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. ~~TTY~~ TTY users should call <toll-free TTY number>.*

Thank you.

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Exhibit 10: Model Notice of Disenrollment Due to Loss of Medicare Part B

Referenced in section: 50.2.3

Dear <Member's Name>:

The Centers for Medicare & Medicaid Services, the federal agency that administers the Medicare program, has notified us that your Medicare Part B coverage has ended. Without Medicare Part B enrollment, you cannot continue your membership in <name of plan health plan>. Therefore, your coverage in <name of health plan> has ended as of <effective date>. If you paid plan premiums for any month after <effective date>, we will send you a refund within 30 days of this letter.

If this information is incorrect, *or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/~~TDD~~ users should call <toll-free TTY number>.*

Thank you.

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Exhibit 11: Model Capacity Waiver Calculation Worksheet *[Moved to Appendix 2]*

1. Start with total capacity for the year that the waiver is requested (i.e., how many slots are available for both commercial and Medicare).
2. Current total (Medicare/Medicaid and commercial) membership, excluding estimated number of "age-ins" (i.e., non-Medicare enrollees of your plan who will convert to Medicare status during the period for which you are seeking a capacity waiver).
3. Projected new Medicaid-only and commercial individual or group members.
4. Add steps (2) and (3) and subtract result from step (1) above to determine remaining slots available.
5. Divide the figure in step (4) above by the utilization factor or factors from the most recent ACR to determine available slots for Medicare enrollees. Use an inpatient factor and ambulatory factor, or both. However, if both are used, the data must be shown separately for each one, or show an acceptable methodology for combining the factors.
6. The resultant figure is the initial number of available Medicare slots.
7. Enter estimated Medicare enrollment from "age-ins." (Current members excluded from (2) above).
8. Subtract step (7) from step (6). The result is the total number of slots available to individual Medicare members.

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Exhibit 12: Model for Closing Enrollment

Model A: Closing Enrollment for Partial Month(s)

<plan name> [Insert name of health plan] PUBLIC NOTICE

As of [insert date] [health plan] will no longer offer continuous open enrollment under its contract with the Centers for Medicare & Medicaid Services for [insert plan name] <plan name> in [insert service area].

Instead, [insert name of health plan] <plan name> will offer open enrollment for all eligible individuals from the [insert date] to the [insert date] of each month.

Current members of [insert name of plan] <plan name> are not affected by this change. For information regarding this notice, call [insert name of organization] <plan name> at [insert phone number]. TTY users should call [insert number]. We are open [insert days and hours of operation].

Model B: Closing Enrollment for Whole Month(s)

<plan name> [Insert name of health plan] PUBLIC NOTICE

As of [insert date] [insert name of health] <plan name> will no longer offer open enrollment under its contract with the Centers for Medicare & Medicaid Services [insert plan name] in [insert service area].

Current members of [insert name of plan] are not affected by this change. For information regarding this notice, call [insert name of organization] at [insert phone number]. TTY users should call [insert number]. We are open [insert days and hours of operation].

Model C: Closing Enrollment for Capacity Reasons

<Plan name> [Insert name of health plan] PUBLIC NOTICE

As of [insert date], [insert name of health plan] will no longer accept enrollment under its contract with the Centers for Medicaid & Medicaid Services [insert plan name] in [insert service area].

[insert plan] <Plan name> has been approved for a capacity limit by the Centers for Medicare & Medicaid Services. A capacity limit allows a health plan to limit enrollment once a specific number of members joins the plan. This is based in part on the accessibility and availability of providers to provide services to members of the plan.

Current members of [insert name of plan] <plan name> are not affected by this change. For information regarding this notice, call [insert name of organization] <plan name> at [insert phone number]. TTY users should call [insert number]. We are open [insert days and hours of operation].

Exhibit 13: Model Notice to Inform Full Benefit Dual Eligible Member of Auto-Enrollment

Referenced in section: 40.1.1

[Member#]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you have Medicare and Medicaid. [Insert for those with retroactive effective dates: To make sure that you don't lose a day of your drug coverage,] [insert for those with prospective effective dates: To make sure you have prescription drug coverage,] Medicare *has asked us to enroll* you in our <name of cost plan> that offers Medicare prescription drug coverage, beginning <effective date>.

Important: If you (or anyone on your behalf) have filled a prescription *before* <auto-enrollment effective date>, you may be eligible for reimbursement for some of these costs. Please contact *Medicare's Limited Income Newly Eligible Transition (LI NET) Program* <demonstration contractor> at <insert #> 1-800-783-1307 (TTY: 1-877-801-0369) or visit www.humana.com/pharmacists/pharmacy_resources/information.aspx <Plan website> on the web for more information.

This means that starting <effective date> you must see your <Plan> doctor(s) for your health care in order for the plan to fully cover your medical services. You may obtain medical services not provided or arranged by [name of plan/organization], but you will be responsible for payment of all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. **[Optional language:** This letter is proof of insurance that you should show during your doctor appointments.]

With the addition of this Medicare prescription drug coverage, you will pay:

- \$0 for your yearly prescription drug plan deductible,
- [insert appropriate LIS copay amount] copayments when you fill a prescription.

[Include cost of premium less low-income premium subsidy amount, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.

Remember, Medicaid will not pay for your prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover those prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like {<plan name>}.</p></div>

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If you have other types of prescription drug coverage, or if your employer pays for your enrollment in ~~insert~~<name of MA-only plan>, read all the materials you get from your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of veterans Affairs, or a Medigap policy. Talk to your benefits administrator, insurer, or plan provider. Ask them if enrolling in ~~a~~Medicare drug coverage would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan and have the option to stay in ~~insert~~<name of cost plan without Medicare prescription drug coverage>. If you don't want Medicare prescription drug coverage, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/~~TDD~~ users should call <toll-free TTY number>. You will need to tell us if you don't want Medicare prescription drug coverage.

Thank you.

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Exhibit 13a: Cost Plan Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in PDP

Referenced in section: 40.1.1

[Member#]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you have Medicare and Medicaid. *[Insert for those with retroactive effective dates: To make sure that you don't lose a day of your drug coverage,]* *[insert for those with prospective effective dates: To make sure you have prescription drug coverage,]* Medicare has asked us to enroll you in our <name of PDP> that offers Medicare prescription drug coverage, beginning <effective date>.

Important: If you (or anyone on your behalf) have filled a prescription before <auto-enrollment effective date>, you may be eligible for reimbursement for some of these costs. Please contact <demonstrator contractor> *Medicare's Limited Income Newly Eligible Transition (LI NET) Program* at <insert #> 1-800-783-1397 (TTY: 1-877-801-0369) or visit www.humana.com/pharmacists/pharmacy_resources/information.aspx <Plan website> on the web for more information.

This means that starting <effective date>, all of your health care, will continue to be covered under your <current cost plan>, and your pharmacy coverage will be provided through our <PDP> plan. Your medical benefits and member copayments under <current cost plan> will not change. *[Optional language: You will be sent a pharmacy card along with more detailed information about your pharmacy coverage in the next several days. Until you receive your pharmacy card, you can use this letter to purchase your prescriptions. This letter includes the information needed to obtain your prescriptions.]*

With the addition of this Medicare prescription drug coverage, you will pay:

- \$0 for your yearly prescription drug plan deductible,
- *[insert appropriate LIS copay amount]* copayments when you fill a prescription.

There will be no changes to your premium, medical benefits or member copayments under the <Current cost plan>.

Remember, Medicaid will not pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like {<plan name>+>.

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If you have other types of prescription drug coverage, or if your employer pays for your enrollment in ~~insert~~ <name of MA-only plan>, read all the materials you get from your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of veterans Affairs, or a Medigap policy. Talk to your benefits administrator, insurer, or plan provider. Ask them if enrolling in Medicare drug coverage would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan and have the option to stay in <current cost plan>. If you don't want Medicare prescription drug coverage, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/~~TDD~~ users should call <toll-free TTY number>. You will need to tell us if you don't want Medicare prescription drug coverage.

Thank you.

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Exhibit 14: Model Notice to Inform Member of Facilitated Enrollment

Referenced in section: 40.1.2

[Member#]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you qualify for extra help with your prescription drug costs. Medicare *has asked us to enroll you* in our <name of cost plan> that offers Medicare prescription drug coverage, beginning <effective date>. This way, you will pay the lowest possible premium for Medicare prescription drug coverage.

With the addition of this Medicare prescription drug coverage, you will pay:

- [insert appropriate LIS deductible amount] for your yearly prescription drug plan deductible,
- [insert appropriate LIS copay amount] copayments when you fill a prescription.

[Include cost of premium less amount of premium assistance the member is eligible for, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.]

If you have other types of prescription drug coverage, or if your employer pays for your enrollment in [insert name of MA-only plan], read all the materials you get from your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of veterans Affairs, or a Medigap policy. Talk to your benefits administrator, insurer, or plan provider. Ask them if enrolling in ~~a~~ Medicare drug coverage would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan and have the option to stay in [insert name of cost plan without Medicare prescription drug coverage]. If you don't want Medicare prescription drug coverage, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/~~TDD~~ users should call <toll-free TTY number>. You will need to tell us if you don't want Medicare prescription drug coverage.

Thank you.

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Exhibit 14a: Cost Plan Model Notice to Inform Other LIS Eligible Member of Auto-Enrollment in PDP

Referenced in section: 40.1.1

[Member#]

[RxID]

[RxGroup]

[RxBin]

[RxPCN]

Dear <insert member name>

Our records show that you have Medicare and Medicaid. [*Insert for those with retroactive effective dates: To make sure that you don't lose a day of your drug coverage,*] [*insert for those with prospective effective dates: To make sure you have prescription drug coverage,*] Medicare has asked us to enroll you in our <name of PDP> that offers Medicare prescription drug coverage, beginning <effective date>.

This means that starting <effective date>, all of your health care, will continue to be covered under your <current cost plan>, and your pharmacy coverage will be provided through our <PDP> plan. Your medical benefits and member copayments under <current cost plan> will not change. [*Optional language: You will be sent a pharmacy card along with more detailed information about your pharmacy coverage in the next several days. Until you receive your pharmacy card, you can use this letter to purchase your prescriptions. This letter includes the information needed to obtain your prescriptions.*]

With the addition of this Medicare prescription drug coverage, you will pay:

- \$0 for your yearly prescription drug plan deductible,
- [*insert appropriate LIS copay amount*] copayments when you fill a prescription.

There will be no changes to your premium, medical benefits or member copayments under the <current cost plan>.

Remember, Medicaid will not pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like [~~<plan name>~~].

If you have other types of prescription drug coverage, or if your employer pays for your enrollment in [*insert name of MA-only plan*], read all the materials you get from your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap policy. Talk to your benefits administrator, insurer, or plan provider. Ask them if enrolling in Medicare drug coverage would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan and have the option to stay in <current cost plan>. If you don't want Medicare prescription drug coverage, or if you have any

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questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/~~TDD~~ users should call <toll-free TTY number>. You will need to tell us if you don't want Medicare prescription drug coverage.

Thank you.

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Exhibit 15: Acknowledgement of Request to Decline Part D

Referenced in section(s): 40.1.1

Dear <name of member>:

As requested, we have processed your request to decline Medicare prescription drug coverage. You will continue to be a member of <cost plan without Medicare prescription drug coverage> that does not offer Medicare prescription drug coverage.

If you had Medicaid drug coverage, it will no longer pay for your prescription drugs. Our records show you are eligible for extra help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help.

Remember, even if you don't use a lot of prescription drugs now, you still should consider signing up for a Medicare prescription drug plan. For most people, joining now means you will pay your lowest possible monthly premium. If you don't join a prescription drug plan when you are first eligible for one, and you don't currently have prescription drug coverage that covers at least as much as Medicare prescription drug coverage, your premium cost will go up at least 1 % per month for every month that you wait to enroll. You will have to pay this penalty as long as you have Medicare prescription drug coverage.

If you change your mind now or at any time in the future, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

Thank you.

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Exhibit 16: Model Confirmation of Reinstatement

Referenced in section(s): 60.6, 60.6.1, 60.6.2, 60.6.3

Dear <member name>

Please be sure to keep this letter for your records.

Medicare has enrolled you back in <plan name> as of <effective date>.

You should keep using your <plan name> providers for your health care.

[Insert one of the following depending on plan policy: We will send you a new membership card and other important documents for <plan name>. or You can continue to use the <plan name> membership card that you currently have. or If you no longer have your membership card, contact us at the number below to get a new card.]

[Insert information regarding plan premiums required to maintain enrollment, or use the following language: The monthly premium for <plan name> is <monthly premium amount>. You must pay this premium amount each month to remain enrolled in our plan. For more information regarding our disenrollment policy for non-payment of plan premiums, please see our policy written in your <insert "Member Handbook" or "Evidence of Coverage" as appropriate>.]

Please call <plan name> at <phone number> if you have any questions. TTY users should call <TTY phone number>. We are open <days and hours of operation>.

Thank you for your continued membership in <plan name>.

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Exhibit 17: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status

Referenced in section(s): 60.6, 60.6.1

Dear < Name of Member >:

Medicare records incorrectly show you as deceased.

If you haven't already done so, please go to your local Social Security Office and ask them to correct your records. Please send us written proof at <address> after you do this. When we get this proof, we will share it with Medicare.

In the meantime, you should keep using your <plan name> primary care physician for your health care. [Note: If PCP not applicable, omit this sentence. Cost plans may insert "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate.] If you have any questions or need help, please call us at < phone number >. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <plan name>.

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Exhibit 18: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part B Termination

Referenced in section(s): 60.6, 60.6.1

Dear < Name of Member>:

On <date of request> you told us that your enrollment in Medicare Part B was ended in error and that you want to stay a member of <plan name>.

[Organizations that are able to verify current Medicare entitlement may omit the following: To do this, please complete the following three steps no later than <insert date: 60 days from date of disenrollment notice>:

- 1. Contact Social Security at 1-800-772-1213 between 7AM to 7PM, Monday to Friday, to have them fix their records. TTY users should call 1-800-325-0778.*
- 2. Ask Social Security to give you a letter that says they have fixed your records.*
- 3. Send the letter from Social Security to us at: <address of MA Plan> in the enclosed postage-paid envelope. You may also fax this information to us at <fax number>. When we get this letter, we will tell the Medicare to correct its records.]*

[Organizations that are able to verify current Medicare entitlement insert: Social Security corrected the error. We will tell Medicare to correct its records.]

In the meantime, you should keep using your <plan name> primary care physician for your health care. [Note: If PCP not applicable, omit this sentence. Cost plans may insert “physicians” or “doctors” or “providers” instead of “primary care physician,” if that is more appropriate.]

[Organizations that are able to verify current Medicare entitlement omit the following: If we find out that you don’t have Medicare Part “B,” or if we don’t get proof that you have Medicare Part “B” by <insert date: 60 days from date of disenrollment notice>, you will have to pay for any service you got after <disenrollment date>.]

If you have any questions or need help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <plan name>.

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Exhibit 19: Notice of Failure to Pay Premiums – Notification of Involuntary Disenrollment

Referenced in §50.3.1

<Date>

Dear < Member>:

On <date of notification letter>, we sent you a bill for the <insert language regarding purpose for bill: premiums, coinsurance, deductible> you owe. Since we didn't get that payment, we have asked Medicare to disenroll you. Your disenrollment begins <effective date>. As of <effective date>, <plan name> won't cover your medical costs [For cost plans with optional supplemental Part D benefits, insert: or your prescription drug costs].

This letter only applies to your benefits through <plan name>. Your other Medicare benefits aren't affected by your disenrollment from <plan name>.

What if I think there's been a mistake?

If you think that we have made a mistake, please call us at <phone number>. You also have the right to ask us to reconsider your disenrollment through the grievance procedure written in your <insert: "Member Handbook" or "Evidence of Coverage" as appropriate>.

I had an emergency that kept me from sending my payment. What can I do?

You can ask Medicare to review this decision if you can show "good cause" (a good reason) for not paying your premiums. A good reason would have to be an emergency or unexpected situation. If Medicare approves your request, you will have to pay all owed premium amounts within 3 months of your disenrollment in order to get your coverage back. Call Medicare at 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week, to make a request as soon as possible, but no later than <insert the date that is 60 calendar days after the disenrollment effective date>. TTY users should call 1-877-486-2048.

[Cost plans with optional supplemental Part D benefits, add the following four paragraphs:

When can I get Part D coverage?

Medicare limits when you can make changes to your Part D coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of your Part D plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help with your prescription drug costs.

Please remember, if you don't have or get coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know

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it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.]

For more information:

If you have recently sent us a payment, please call <plan name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

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Exhibit 20: Notice of Confirmation of Involuntary Disenrollment for Failure to Pay Premiums

Referenced in §50.3.1

Dear <Name of Beneficiary>:

Medicare has confirmed your disenrollment from <plan name> because you didn't pay your <insert reason for disenrollment, such as: premium, coinsurance, deductible>. Your disenrollment begins <effective date>. You are now in Original Medicare.

What if I think there's been a mistake?

If you think that we have made a mistake, please call us at <phone number>. You also have the right to ask us to reconsider your disenrollment through the grievance procedure written in your <insert: "Member Handbook" or "Evidence of Coverage" as appropriate>.

I had an emergency that kept me from sending my payment. What can I do?

You can ask Medicare to review this decision if you can show "good cause" (a good reason) for not paying your premiums. A good reason would have to be an emergency or unexpected situation. If Medicare approves your request, you will have to pay all owed premium amounts within 3 months of your disenrollment in order to get your coverage back. Call Medicare at 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week, to make a request as soon as possible, but no later than <insert the date that is 60 calendar days after the disenrollment effective date>. TTY users should call 1-877-486-2048.

[Cost plans with optional supplemental Part D benefits, add the following four paragraphs:

When can I get Part D coverage?

Medicare limits when you can make changes to your Part D coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of your Part D plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help with your prescription drug costs.

Please remember, if you don't have or get coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

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If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.]

For more information:

If you have recently sent us a payment, please call <plan name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

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Exhibit 21: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services for Failure to Pay the Part D-Income Related Monthly Adjustment Amount

Referenced in section: 50.2.5

Important – You have been disenrolled from your Medicare Advantage Prescription Drug Plan

<Date>

Dear <Beneficiary Name>:

As of <disenrollment effective date>, Medicare has disenrolled you from <cost plan name's optional supplemental Part D benefit> because you didn't pay the extra amount (called the Part D-Income Related Monthly Adjustment Amount or Part D-IRMAA). As of <effective date>, you will no longer have prescription drug coverage. Since the disenrollment has already happened, you can't pay the owed amounts now to keep your Part D coverage.

Before you were disenrolled, Medicare (or the Railroad Retirement Board) sent you notices that showed the amount that you owed and provided information on how to pay this amount. If your optional supplemental Part D benefit premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter. The decision to disenroll you was made by Medicare, not by <plan name>.

What if I think there's been a mistake?

If you think that we have made a mistake, please call us at <phone number>. You also have the right to ask us to reconsider your disenrollment through the grievance procedure written in your <insert: "Member Handbook" or "Evidence of Coverage" as appropriate>.

I had an emergency that kept me from sending my payment. What can I do?

You can ask Medicare to review this decision if you can show "good cause" (a good reason) for not paying your premiums. A good reason would have to be an emergency or unexpected situation. If Medicare approves your request, you will have to pay all owed premium amounts within 3 months of your disenrollment in order to get your coverage back. Call Medicare at 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week, to make a request as soon as possible, but no later than <insert the date that is 60 calendar days after the disenrollment effective date>. TTY users should call 1-877-486-2048.

When can I get Part D coverage?

Medicare limits when you can make changes to your Part D coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of your Part D plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help with your prescription drug costs.

Who can I call to get more information?

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable

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You can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week if you have questions about your disenrollment because you didn't pay the Part D-IRMAA. TTY users should call 1-877-486-2048. You can also call < plan name> at <phone number> if you have questions about your plan's premium. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

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Exhibit 22: Model Notice on Favorable “Good Cause” Determination – Notification of Premium Amount Due for Reinstatement of Optional Supplemental Part D Benefit

Referenced in section: 60.6.3

Dear <Name of Member>:

Medicare has notified us that you have received a favorable decision regarding your request for reinstatement into <plan name>'s optional supplemental Part D benefit. Our records show that we haven't gotten payment for your optional supplemental Part D benefit premium as of <premium due date>. In order for your coverage to be reinstated, we must receive payment in the amount of <enter amount owed> no later than <date 3 months from the effective date of disenrollment>.

[Cost plans that disenroll members for failure to pay, use the following sentence: If we don't get payment by <date 3 months from the effective date of disenrollment>, you will remain disenrolled from <plan name>.]

[Cost plans may elect to mail a payment coupon with the letter. Cost plans who include the coupon with the letter, insert the following sentences: You can mail your payment to us using the enclosed coupon. Be sure to make full payment of your owed amount and include your member number on the check.]

[Cost plans that do not include a payment coupon with the letter, insert the following sentences: You can mail your payment to us at the following address: <billing address>. Be sure to make full payment of your owed amount and include your name and member number on the check.]

[If disenrollment was due to failure to pay Part D-IRMAA premiums and the beneficiary also owed the cost plan premiums for the optional supplemental Part D benefit, cost plans insert the following sentences: In addition to the optional supplemental Part D benefit premiums you owe, you must also pay <Medicare or RRB> your amount due for the Part D-Income Related Monthly Adjustment Amount. <Medicare or RRB> will send you a letter regarding the amount you owe and how you can pay. You must pay <Medicare or RRB> this amount by <date 3 months from the effective date of disenrollment> to be reinstated.]

If you have any questions or need help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 22a: Model Notice on Favorable “Good Cause” Determination – Notification of Premium Amount Due for Reinstatement into Cost Contract

Referenced in section: 60.6.3

Dear <Name of Member>:

Medicare has notified us that you have received a favorable decision regarding your request for reinstatement into <insert either: plan name or plan name’s optional supplemental Part D benefit>. Our records show that we haven’t gotten payment for your plan <insert all that apply: premium, coinsurance, deductibles> as of <premium due date>. In order for your coverage to be reinstated, we must receive payment in the amount of <enter amount owed> no later than <date 3 months from the effective date of disenrollment>.

[For disenrollments from the cost plan contract, insert: If we don’t get payment by <date 3 months from the effective date of disenrollment>, you will remain disenrolled from <insert as applicable: plan name; plan name’s optional supplemental Part D benefit>. You will be covered by Original Medicare instead of <plan name> [Add if also disenrolled from optional supplemental Part D benefit: and will not have prescription drug coverage].]

[For disenrollments from the optional supplemental Part D benefit, insert: If we don’t get payment by < date 3 months from the effective date of disenrollment >, you will continue to have a reduced amount of health care coverage in <plan name>. This means that you will not have prescription drug coverage.]

[Cost plans may elect to mail a payment coupon with the letter. Cost plans that include the coupon with the letter, insert the following sentences: You can mail your payment to us using the enclosed coupon. Be sure to make full payment of your owed amount and include your member number on the check.]

[Cost plans that do not include a payment coupon with the letter, insert the following sentences: You can mail your payment to us at the following address: <billing address>. Be sure to make full payment of your owed amount and include your name and [insert one: member number/billing number/ID number] on the check.]

[If disenrollment was due to failure to pay Part D-IRMAA premiums and the beneficiary also owes the cost plan premiums, insert the following sentences: In addition to the plan amounts you owe, you must also pay <Medicare or RRB> your amount due for the Part D-Income Related Monthly Adjustment Amount. <Medicare or RRB> will send you a letter regarding the amount you owe and how you can pay. You must pay <Medicare or RRB> this amount by <date 3 months from the effective date of disenrollment> to be reinstated.]

[For disenrollments from the cost plan contract, insert: You generally may only change to a new Medicare drug plan during certain times of year. For information about drug plans available in your area you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.]

[For disenrollments from the optional supplemental Part D benefit, insert: Medicare limits when you can make changes to your Part D coverage. **From October 15 through December 7 each year**, you

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can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of your Part D plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help with your prescription drug costs.

Please remember, if you don't have or get coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

Thank you.

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