

# Medicare Managed Care Manual

## Chapter 17, Subchapter D

### Medicare Cost Plan Enrollment and Disenrollment Instructions

(Rev. 38, 10-31-03)

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#### Table of Contents

#### 10 - Definitions

##### 10.1 - General Requirements

#### 20 – Eligibility for Enrollment in a Medicare Cost Plan

##### 20.1 – Conversion Enrollments

##### 20.2 - End Stage Renal Disease

###### 20.2.1 – Background on ESRD Entitlement

###### 20.2.2 - Exceptions to Eligibility Rule for Individuals with ESRD

##### 20.3 - Hospice

#### 30 – Enrollment Periods and Effective Date of Enrollment

##### 30.1 – General Open Enrollment Requirements

###### 30.1.1 – Waivers for Open Enrollment

###### 30.1.2 – Determining Enrollment Availability for Medicare Beneficiaries

###### 30.1.3 – Utilization Adjustment Factor

###### 30.1.4 – Reserved Vacancies

###### 30.1.5 – Special Requirements When Reaching Capacity

##### 30.2 – Effective Date of Enrollment in Cost Plans

###### 30.2.1 – Cost Plan Enrollment Effective Date Option 1

###### 30.2.2 – Cost Plan Enrollment Effective Date Option 2

#### 40 - Enrollment Procedures

##### 40.1 – Format of Enrollment Forms

##### 40.2 – Verifying Enrollment Information

###### 40.2.1 – Who May Complete a Cost Plan Enrollment Form

40.2.2 – When the Enrollment Form Has Missing or Erroneous Information

40.3 - ESRD and Enrollment

40.4 - Processing Applications

40.4.1 – Information Provided to the Beneficiary

40.5 – Cost Plan Denial of Enrollment

40.6 – Transmission of Enrollments to CMS

40.7 – Re-enrollment

50 – Disenrollments

50.1 – Voluntary Disenrollments

50.1.1 - Effective Date of Voluntary Disenrollment

50.2 – Required Involuntary Disenrollments

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

50.2.1.1 - Retention of Members Who Temporarily Leave the Plan’s Service Area

50.2.2 – Death

50.2.3 – Loss of Entitlement to Part B

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

50.3 – Other Involuntary Disenrollments

50.3.1 – Failure to Pay Premium

50.3.2 – Fraud in Enrollment or Abuse of Membership Cards

50.3.3 – Disenrollment for Cause

50.3.3.1 – Proposed Notice for Disenrollment for Cause

50.3.3.2 – Regional Office Review of Disenrollment for Cause

50.3.3.3 – Effective Date of Disenrollments for Cause

60 - Post-Enrollment/Disenrollment Activities

60.1 – Retroactive Enrollments

60.1.1 – Enrollment Retroactive to Date of Initial Medicare Entitlement

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

60.2 – Retroactive Disenrollment

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

### 60.3 - Multiple Transactions

### 60.4 – Storage of Enrollment Forms

#### Appendix 1: Summary of Exhibits

Exhibit 1: Model Individual Enrollment Form (3 Pages)

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

Exhibit 3: Model Notice to Request Information

Exhibit 4: Model Notice to Confirm Enrollment

Exhibit 5: Model Notice for Denial of Enrollment

Exhibit 6: Model Notice to Send Out Disenrollment Form

Exhibit 6a: Model Disenrollment Form

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

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

Exhibit 9: Model Notice of Disenrollment Due to Death

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

Exhibit 11: Model Capacity Waiver Calculation Worksheet

Exhibit 12: Model for Closing Enrollment

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## 10 - Definitions

**(Rev. 38, 10-31-03)**

**Conversions** - For individuals who are enrolled in a health plan offered by the managed care organization 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 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.

**Evidence of Medicare Part A and/or Part B Coverage** – Acceptable forms of evidence are:

1. A Medicare card;
2. Social Security Administration (SSA) award notice;
3. A Railroad Retirement Board (RRB) letter of verification;

4. A statement from SSA or RRB verifying the individual's entitlement to Medicare Part A and enrollment in Part B;
5. Verification of Medicare Part A and Part B through one of CMS's systems, including CMS data available through CMS subcontractors; or
6. For individuals enrolling when they first become entitled to Medicare, an SSA application for Medicare Part A and/or B showing the effective date for both Medicare Parts A and B or Part B only.

**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.

**Involuntary Disenrollment** - Refers to when a Medicare Cost organization, as opposed to the member, initiates disenrollment from the plan. Procedures regarding involuntary disenrollment are found in [§50.2](#) of this chapter.

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

## 10.1 - General Requirements

**(Rev. 38, 10-31-03)**

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.

## **20 – Eligibility for Enrollment in a Medicare Cost Plan**

**(Rev. 38, 10-31-03)**

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 service area of the cost plan (see exception in [§20.1](#) 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 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](#)).

In addition, a cost plan is permitted to deny enrollment if CMS has granted a waiver or limitation of the open enrollment requirement (see [§30.1.1](#)), and that limit has been reached.

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.

### **20.1 – Conversion Enrollments**

**(Rev. 38, 10-31-03)**

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 application of this provision to individuals with ESRD is discussed in [§20.2.2](#).

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.

## **20.2 - End Stage Renal Disease**

**(Rev. 38, 10-31-03)**

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](#). The CMS will reject the enrollment if Medicare records indicate the applicant has ESRD.

### **20.2.1 – Background on ESRD Entitlement**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

- **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.

- 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**

**(Rev. 38, 10-31-03)**

When it is determined that a current member of the cost plan has a terminal illness and life expectancy is 6 months or less, he or she may elect to receive care through a Medicare-certified hospice. If the current member elects 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 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, the cost plan must immediately reinstate the beneficiary's full enrollment.

## **30 – Enrollment Periods and Effective Date of Enrollment**

**(Rev. 38, 10-31-03)**

### **30.1 – General Open Enrollment Requirements**

**(Rev. 38, 10-31-03)**

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+Choice contract in the same service area, it may not enroll new individuals in the cost plan ([42 CFR 422.501\(b\)\(4\)](#)). In this case, the cost plan would not be able to retain its Medicare+Choice 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 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 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+Choice contract in the area.

### **30.1.1 – Waivers for Open Enrollment**

**(Rev. 38, 10-31-03)**

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**

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, 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

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

(Rev. 38, 10-31-03)

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](#)), 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
  - 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**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

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 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 plan to honor the application.

### **30.2 – Effective Date of Enrollment in Cost Plans**

**(Rev. 38, 10-31-03)**

A Medicare cost plan may choose between the following two 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 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.

#### **30.2.1 – Cost Plan Enrollment Effective Date Option 1**

**(Rev. 38, 10-31-03)**

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. 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.

The cost plan is responsible for submitting accurate and timely records to CMS for new enrollments. The CMS is responsible for promptly supplying written verification of the individual's acceptance (or rejection) in the plan. Generally, CMS does not accept records received after the monthly cut-off date for submission of records (as announced by CMS periodically), or that are incomplete or incorrect.

**Enrollment Effective Date Example:**

The CMS monthly cut-off date for the submission of records is August 14, 2002. A cost plan enrollment application form that is received on August 12, 2002, could have an effective date of enrollment of September 1, October 1, or November 1, 2002.

If the same cost plan enrollment application form was received on August 15, 2002, (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, 2002.

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.

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**

**(Rev. 38, 10-31-03)**

Cost plans who choose this option will follow 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 15 through December 31 of every year:** Enrollments received during this time period will be effective January 1 of the following year (except as noted below).

(NOTE: Enrollments made between November 15 and November 30 may be effective December 1 or January 1. The cost plan must allow the individual to choose the effective date. If no choice is made, January 1 will be the effective date.)

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.

**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.

## **40 - Enrollment Procedures**

**(Rev. 38, 10-31-03)**

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.

### **40.1 – Format of Enrollment Forms**

**(Rev. 38, 10-31-03)**

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 copayment 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;
- Understands that enrollment in the plan automatically disenrolls him/her from any other cost plan or Medicare+Choice 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 may serve as the signature date on the form.

## **40.2 –Verifying Enrollment Information**

**(Rev. 38, 10-31-03)**

Whether Medicare beneficiaries are enrolled during a face-to-face interview or by mail, the plan should verify all information. If the enrollment application is being completed in person, the applicant's Medicare card should be used to verify the spelling of his or her name and to confirm the correct recording of sex, Health Insurance Claim Number (HICN), and the beneficiary's type of entitlement, i.e. whether entitled 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.

## **40.2.1 – Who May Complete a Cost Plan Enrollment Form**

**(Rev. 38, 10-31-03)**

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

If a Medicare beneficiary is unable to sign an enrollment form, or disenrollment request, due to reasons such as physical limitations or illiteracy, state law would again govern whether another individual may execute the form on behalf of the beneficiary. Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, 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.

When someone other than the beneficiary completes the application or submits the disenrollment request, the plan must retain documentation showing how the determination was made that another entity or person was legally authorized to enroll the Medicare beneficiary.

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**

**(Rev. 38, 10-31-03)**

When the cost plan receives an enrollment form that cannot be processed because it has missing (or erroneous) information, it should contact the individual by telephone to obtain the information necessary, and document all efforts to obtain the information needed. The cost plan may also send a letter asking for information to facilitate the enrollment (see [Exhibit 3](#)). If the individual does not respond within 30 days of the

request for additional information, the cost plan must deny the enrollment, and should send the appropriate notice to the individual ([Exhibit 5](#)) within the 7 business days following this denial.

### **40.3 - ESRD and Enrollment**

**(Rev. 38, 10-31-03)**

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 15” 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**

**(Rev. 38, 10-31-03)**

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 application form;
- Processes applications from beneficiaries in chronological order by received date;
- 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
- Contacts the beneficiary if additional information is needed to process the enrollment (see [Exhibit 3](#) and additional information in [§40.2.2](#)).

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 should send written notification to the beneficiary that CMS accepted or rejected his/her enrollment application. (See [Exhibit 4](#) and [Exhibit 6](#).)

### **40.4.1 – Information Provided to the Beneficiary**

**(Rev. 38, 10-31-03)**

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](#)).
- Following receipt of the confirmation of enrollment from CMS promptly (within 14-30 calendar days) notify the enrollee in writing of the effective date of enrollment and send a CMS-approved evidence of coverage that describes M+C organization rules, including benefits and enrollee rights and responsibilities ([42 CFR 417.436](#)).

## **40.5 – Cost Plan Denial of Enrollment**

**(Rev. 38, 10-31-03)**

A cost plan must deny an enrollment based on its own determination of the ineligibility of the individual to enroll in the plan.

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 should be made in a timely manner, but no later than 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 should be sent 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.

## **40.6 – Transmission of Enrollments to CMS**

**(Rev. 38, 10-31-03)**

Within 30 days of the date of the organization's receipt of the completed enrollment form, the 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.

## **40.7 – Re-enrollment**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

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.

### **50.1 – Voluntary Disenrollments**

**(Rev. 38, 10-31-03)**

A Medicare beneficiary may disenroll at any time by mailing, hand delivering, or faxing a signed and dated written notice to the plan, SSA, or the Railroad Retirement Board (if the member is an annuitant). 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+Choice plan without first disenrolling from the current health plan.

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.

### **50.1.1 - Effective Date of Voluntary Disenrollment**

**(Rev. 38, 10-31-03)**

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 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).

### **50.2 – Required Involuntary Disenrollments**

**(Rev. 38, 10-31-03)**

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

- A permanent change in residence out of the plan's 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**

**(Rev. 38, 10-31-03)**

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

**(Rev. 38, 10-31-03)**

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.

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**

**(Rev. 38, 10-31-03)**

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](#)).

## **50.2.3 – Loss of Entitlement to Part B**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

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 M+C plan (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 Plan 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.

### **50.3 – Other Involuntary Disenrollments**

**(Rev. 38, 10-31-03)**

#### **50.3.1 – Failure to Pay Premium**

**(Rev. 38, 10-31-03)**

Cost plans have the following options when a member does not pay his/her basic monthly premium. 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 an explanation of the member's rights to a hearing under its grievance

procedures. The cost plan may not notify CMS until after the plan has notified the beneficiary.

**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.

### **50.3.2 – Fraud in Enrollment or Abuse of Membership Cards**

**(Rev. 38, 10-31-03)**

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 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**

**(Rev. 38, 10-31-03)**

A cost plan 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 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. 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 – Proposed Notice for Disenrollment for Cause**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

### **60.1 – Retroactive Enrollments**

**(Rev. 38, 10-31-03)**

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 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 (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**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

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;
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**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

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**

**(Rev. 38, 10-31-03)**

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 M+C, cost, or HCPP plan at any given time. Generally, the last enrollment action the beneficiary makes during the month 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. 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 date, an assumption cannot be made as to which plan the individual truly intended to be enrolled in. Therefore, if multiple transactions are received for the same effective date with the same application signature date, they will all be rejected. The reply listings will show rejections for these types of multiple transactions.

In these cases, the beneficiary's enrollment will remain with Original Medicare or with the Medicare health plan in which the beneficiary was enrolled before he/she applied to the plans that received the multiple transaction rejections.

Upon availability of the reply listing from CMS showing a rejection for a multiple transaction, the cost plan should contact the individual to determine in which plan the individual wishes to enroll. Once the individual has chosen one plan, he/she must either fill out and sign another enrollment form or send written notice of his/her intent to enroll in the plan. The cost plan may transmit the information to CMS using the appropriate effective date as described in [§30](#).

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

#### **EXAMPLE**

- Two Medicare managed care plans receive completed enrollment forms from one individual on May 11 for a June 1 effective date. The form received by cost plan #1 was signed on May 4th and the form received by cost plan #2 was signed on May 10. Both cost plans submit enrollment transactions, including the applicable signature date. The enrollment in cost plan #2 will be the transaction that is

accepted and will be effective on June 1. Both plans receive the appropriate reply on the reply listing.

- 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. Both enrollments will be rejected. The individual must complete a new enrollment form to enroll in either plan.

## **60.4 – Storage of Enrollment Forms**

**(Rev. 38, 10-31-03)**

The cost plan must retain enrollment forms while beneficiaries are members of the plan and for one year after disenrollment.

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.

## Appendix 1: Summary of Exhibits

(Rev. 38, 10-31-03)

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       | Enrollment Form  | 40.1            | Yes             | N/A   |
| 2       | Acknowledgment of Receipt of Enrollment Form                             | 40.4,<br>40.4.1 | Yes             | < 30 days from the date the form was received   |
| 3       | Request for Information  | 40.2.2          | No              | N/A   |
| 4       | Confirmation of Enrollment   | 40.4.1          | Yes             | Within 14-30 days from receipt of CMS confirmation                                    |
| 5       | Cost Plan Denial of Enrollment   | 40.2.2          | Yes             | 7 business days following denial made when additional information request period ends |
|         |  | 40.5            |                 | Within 30 days of date of receipt   |
| 6 & 6a  | Sending Out Disenrollment Form & Disenrollment Form                      | 50.1            | No              | N/A   |
| 7       | Acknowledgment of Receipt of Voluntary Disenrollment Request from Member | 50.1.1          | No <sup>1</sup> |   |
| 8       | Notice to Confirm  | 50.1.1          | No              | Encouraged to send within 7   |

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

| <b>Exhibit</b> | <b>Notice</b>  | <b>Section</b>    | <b>Required ?</b> | <b>Timeframe</b>                                 |
|----------------|--|-------------------|-------------------|--|
|                | Voluntary Disenrollment<br>Following Receipt of Reply<br>Listing |                   |                   | days of the availability of the<br>reply listing |
| 9              | Notice of Disenrollment<br>Due To Death                          | 50.2.2            | No                | N/A  |
| 10             | Notice of Disenrollment<br>Due To Loss of Part B                 | 50.2.3            | No                | N/A  |
| 11             | Capacity Waiver<br>Calculation Worksheet                         | 30.1.1,<br>30.1.2 | N/A               | N/A  |



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

\_\_\_\_\_ Language A (e.g., Chinese)

\_\_\_\_\_ Language B (e.g., Spanish)

**Medicare Information:**

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

Your enrollment form cannot be processed without this information.

|                                  |                |
|----------------------------------|----------------|
| <b>Medicare Health Insurance</b> |                |
| Social Security Act              |                |
| Name of Beneficiary:             |                |
| Medicare Claim Number            | Sex            |
| ___ - ___ - _____                | _____          |
| Is Entitled To                   | Effective Date |
| ___ Hospital Insurance (Part A)  | _____          |
| ___ Medical Insurance (Part B)   | _____          |

**Please read and answer these questions:**

1. Are you currently enrolled in another Medicare health plan? By enrolling in (Health Plan), you will be canceling your membership in your current plan.

Yes \_\_\_\_\_ No \_\_\_\_\_

2. Do you have insurance through your spouse's employer?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

(Note: You cannot enroll in this plan if you have ESRD, unless you are already enrolled in <name of plan organization> as a non-Medicare member and you developed ESRD while a member of <name of plan organization> or unless you have had a successful kidney transplant and no longer

require dialysis. Please attach a note or records from your doctor showing you no longer need dialysis or have had a successful kidney transplant.)

4. By enrolling in this plan, I authorize:

- a) The Centers for Medicare & Medicaid Services to furnish information to the plan confirming my entitlement to Medicare Hospital Insurance Benefits (Part A) and/or Supplementary Medical Insurance Benefits (Part B); and,
- b) The plan's providers, clinics, or anyone else with medical or other relevant information about me to give CMS or CMS' agents the information needed to run the Medicare program.

Yes \_\_\_\_\_ No \_\_\_\_\_

5. I understand that it is my responsibility to tell the plan before I permanently move or leave the service area for more than 90 consecutive days, and that my absence means that the plan may take action to disenroll me and return me to traditional Medicare coverage.

Yes \_\_\_\_\_ No \_\_\_\_\_

6. I understand that the plan will send me written notification of the effective date of my enrollment.

7. I understand that once my enrollment is effective, in order for [name of plan] to fully cover my medical services (except for emergency or urgently-needed services), they must be provided or arranged by the plan. If I 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 any charges not covered by Medicare.

Signature:

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

Your Signature\* \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature \_\_\_\_\_ Date: \_\_\_\_\_

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

**(Rev. 38, 10-31-03)**

*Referenced in section(s): 40.5*

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.

If you have any questions, please call our Member Services Department at <phone number>. TTY users should call <TDD/TTY number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}. Thank you.

### **Exhibit 3: Model Notice to Request Information**

**(Rev. 38, 10-31-03)**

*Referenced in section(s): 40.2.2*

Dear <Name of Beneficiary>:

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

\_\_\_\_\_ 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.

\_\_\_\_\_ A copy of the legal document that authorizes another person to act on your behalf.

\_\_\_\_\_ 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 call our Member Services Department at <phone number>. TTY users should call <TTY/TDD number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}. Thank you.

## **Exhibit 4: Model Notice to Confirm Enrollment**

**(Rev. 38, 10-31-03)**

*Referenced in section(s): 40.3*

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.

Please feel free to call our Member Services at <phone number>. TTY users should call <TTY/TDD number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}. Thank you.

## **Exhibit 5: Model Notice for Denial of Enrollment**

**(Rev. 38, 10-31-03)**

*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 call us at <phone number>. TTY users should call <TTY/TDD number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}. Thank you.

## **Exhibit 6: Model Notice to Send Out Disenrollment Form**

**(Rev. 38, 10-31-03)**

*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.

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, please call us at <phone number>. TTY users should call <TTY/TDD number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}. Thank you.

Attachment

## Exhibit 6a: Model Disenrollment Form

(Rev. 38, 10-31-03)

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.

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. -We will notify you of the effective date of your disenrollment after we have received this form from you.

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

\_\_\_\_\_  
Your Guardian's Signature Date

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

**(Rev. 38, 10-31-03)**

*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.

If you have any questions, please call us at <phone number>. TTY users should call <TTY/TDD number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}.

Enclosure

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

**(Rev. 38, 10-31-03)**

*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.

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>. TTY users should call <TTY/TDD number>.

We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}.  
Thank you.

## **Exhibit 9: Model Notice of Disenrollment Due to Death**

**(Rev. 38, 10-31-03)**

*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, please call us at <phone number>. TTY users should call <TTY/TDD number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}. Thank you.

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

**(Rev. 38, 10-31-03)**

*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, please contact us immediately at <phone number>. TTY users should call <TTY/TDD number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}. Thank you.

## Exhibit 11: Model Capacity Waiver Calculation Worksheet

(Rev. 38, 10-31-03)

- 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. \_\_\_\_\_

## **Exhibit 12: Model for Closing Enrollment**

**(Rev. 38, 10-31-03)**

### **Model A: Closing Enrollment for Partial Month(s)**

[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] in [insert service area].

Instead, [insert name of health plan] 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] are not affected by this change. For information regarding this notice, call [insert name of M+C organization] 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)**

[Insert name of health plan] PUBLIC NOTICE

As of [insert date] [insert name of health] 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 M+C 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**

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