

Medicare-Medicaid Plan Enrollment and Disenrollment Guidance

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This guidance provides detailed instructions for enrollment into Medicare-Medicaid plans, including processes that ensure beneficiaries are informed at each step. Passive enrollment is permitted but must follow rigorous procedures to ensure beneficiaries retain their rights, including opting out and choosing other Medicare options. This guidance only pertains to enrollment in Medicare-Medicaid Plans (MMPs) participating in CMS' Financial Alignment Demonstration for Medicare-Medicaid enrollees. It assumes that States will administer the enrollment process, including enrollments, disenrollments, cancellations, and opting-out of passive enrollment. This includes any enrollment broker with whom the State contracts.

In limited instances, and with CMS prior approval, States may defer some of these activities to the MMPs. States cannot delegate to MMPs the following: approval of requests for optional involuntary disenrollments (§ 40.3), the collection of health-related information (§ 30.1.1) and passive enrollments (§ 30.1.4), although the submission of the passive enrollment transactions may be delegated in limited, pre-approved circumstances. Regardless of who administers the enrollment functions, this guidance applies when the person is enrolled for both Medicare and Medicaid benefits.

This document is a national model. States may append certain items in Appendix 5, such as State-specific variations, Medicaid-specific requirements, and delegated functions to MMPs. Appendix 5 should also include any state-specific terms used to refer to Medicaid. Only functions clearly identified in Appendix 5 can be delegated to the MMPs, and the MMPs are not allowed to delegate the identified functions to anyone else, including their contracted sales agents or other entities, without approval from CMS.

States will issue their own guidance when an individual opts out of the demonstration, but remains enrolled solely for Medicaid benefits, e.g., when a State mandates enrollment for Medicaid. At State discretion, this guidance may be in a separate document, or may be included in Appendix 5 of this document. Any additional State-specific requirements or modifications to the policies outlined in this guidance as derived from the MOU or the three-way contract must be specified in the Appendix 5 of this document.

This guidance is effective starting contract year 2013. All enrollments with an effective date on or after the launch of the demonstration within each State must be processed in accordance with the guidance requirements, including important beneficiary protections such as rules around accepting elections, timeframes for submitting them to CMS, and using model enrollment forms and notices.

It is expected that States will assure that all requirements outlined in this guidance regarding communications made with beneficiaries/members, including the use of model notices, are also in compliance with the standards and guidelines as established within the State-specific Demonstration Marketing Guidelines.

While States are assumed to have the lead on administering enrollments, disenrollments, cancellations, and opt-out requests, MMPs will still be responsible for other required data

exchanges required by Medicare, including updates to Medicare Part D Low Income Subsidy (LIS) status. Please also refer to the CMS Plan Communication User Guide (PCUG) for related information on files that must be exchanged, including:

- File formats and valid values for data elements
- Transaction Codes (TC) – See page I-1 of the Appendices of PCUG
- Daily Transaction Reply Report (DTRR) Detailed Record Layout - See page F-81 of the Appendices of PCUG
- Transactions Reply Codes (TRC) - See page I-2 (Table I-2) of the Appendices of PCUG
- Disenrollment Reason Codes – See page I-108 (Table I-7) of the Appendices of PCUG

The PCUG may be found on the CMS website at: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelphdesk/Plan_Communications_User_Guide.html

The State-specific Demonstration Marketing Guidelines may found on the CMS website at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

States (or delegated MMPs) must use the CMS enrollment vendor to submit enrollment-related transactions to CMS; and to receive CMS response files, including the Daily Transaction Reply Report. For additional detail on the CMS demonstration enrollment vendor that is available to assist States with submitting enrollment-related files to CMS, please see: www.medicare-solution.com

For MMP enrollment records requiring corrections or retroactive adjustments, States (or MMPs) must send their request to the CMS Retroactive Processing Contractor (RPC). For general information about the RPC, please see: <http://reedassociatescpas.com/pages/cms.asp>

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10 - Eligibility for Enrollment in Medicare-Medicaid Plans

In general, an individual is eligible to elect a Medicare-Medicaid plan (MMP) when each of the following requirements is met:

1. The individual is entitled to or enrolled in Medicare Part A, enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B and eligible to enroll in a Part D plan as of the effective date of coverage under the MMP;
2. The individual permanently resides (as defined by the State in Appendix 5) in the service area of the MMP;
3. The individual or his/her legal representative (as defined in Appendix 3), or the State or CMS on behalf of the individual, completes an enrollment request and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS (refer to Appendix 1 for a list of items required to complete the enrollment request and §30.2.1 for who may sign enrollment forms); and
4. The individual is eligible for Medical Assistance under a State plan under title XIX of the Social Security Act or under a waiver of such plan, and meets other criteria established by the State in the Memorandum of Understanding, the three-way contract, or as further detailed in Appendix 5.

Note: Separately from this demonstration, some States are seeking section 1915(b) waiver authority to mandatorily enroll dual-eligible individuals in a Medicaid-only managed care program. This waiver authority does not extend to Medicare, so the individual's Medicare benefits are not affected. For example, an individual may be enrolled in a Medicaid-only Managed Long Term Services and Supports (MLTSS) plan that has the same parent organization as the MMP. The Medicaid-only program is different and it is not to be confused with the three-way MMP contract as States have separate contracts with plans for the Medicaid-only managed care product.

An MMP may not impose any additional eligibility requirements as a condition of enrollment other than those described in the Memorandum of Understanding (MOU), by the three-way contract among the MMP, State, and CMS, or established by the State and CMS in this guidance.

A State must not deny a request for voluntary enrollment to otherwise eligible individuals covered under an employee benefit plan, but the State must follow the requirements in §§ 30.2.5 and 30.2.6 to ensure the beneficiary understands the potential consequences of doing so. If the individual enrolls in a MMP and continues to be enrolled in his/her employer/union or spouse's group health benefits plan, then coordination of benefits rules apply.

An individual may not be enrolled in more than one MMP at any given time. Procedures for handling multiple transactions, cancellations, and reinstatements are described in §§ 50.1, 50.2 and 50.3.

Individuals enrolled in an MMP may not concurrently enroll in a Medicare prescription drug plan (PDP) a Medicare Advantage plan, a Medicare cost plan, a PACE organization or another MMP or other coordinated care delivery systems.

10.1 - Entitlement to Medicare Parts A and B and Eligibility for Part D

To be eligible to elect an MMP, an individual must be entitled to or enrolled in Medicare Part A, enrolled in Part B and eligible to enroll in a Part D plan as of the effective date of coverage under the MMP. Individuals who are eligible but not enrolled in Part A and/or Part B should, as appropriate, be screened by the State for Medicare Savings Programs, and/or be referred to the Social Security Administration (SSA) to learn when and how they can enroll in Part A and/or Part B in order to become eligible for enrollment into the MMP.

Eligibility for Part D does not exist:

- When the beneficiary is incarcerated.
- When the beneficiary lives abroad.
- For any month prior to the month of notification of the entitlement determination when the entitlement determination for Medicare Part A and B is made retroactively.

Beneficiaries who are not eligible for Part D may not enroll in an MMP.

10.2 - Place of Permanent Residence

An individual is eligible to elect an MMP if he/she permanently resides in the service area of the MMP. A temporary move into the MMP's service area does not enable the individual to elect the MMP; the State must deny such an enrollment request. Incarcerated individuals are to be considered as residing out of the plan service area, even if the correctional facility is located within the plan service area. Individuals who are confined in Institutions for Mental Disease (IMDs) such as state hospitals, psychiatric hospitals or the psychiatric unit of a hospital, are not considered to be "incarcerated" as CMS defines the term, and are therefore not excluded on that basis from the service area of the plan unless denoted as ineligible under the Memorandum of Understanding, the three-way contract, or in Appendix 5.

A permanent residence is normally the primary residence of an individual. Proof of permanent residence is normally established by the address of an individual's residence, but a State may use additional criteria. Note that there is no minimum residency period required for enrollment into an MMP.

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

10.3 - Completion of Enrollment Request

Enrollment in an MMP is predicated on a beneficiary completing an enrollment request. The enrollment request may be made by the eligible individual or the individual's legal representative (as described in §30.2.1). In passive enrollments, the State or CMS notifies the MMP eligible individual that he or she will be considered to have made a request to enroll in an MMP by taking no additional action.

An enrollment request must be made even if that individual is voluntarily electing an MMP offered by the organization offering the Medicare Advantage plan or Medicaid Managed Care Organization in which the person is currently enrolled. The individual may use a short enrollment form in place of the comprehensive individual enrollment form (see Exhibit 2).

Unless otherwise specified by the State and CMS, an eligible individual can voluntarily elect an MMP only if he/she completes an enrollment request, provides required information to the State within required time frames, and submits the properly completed enrollment request to the State. Model enrollment forms are included as Exhibits 1 and 2.

An individual who is a member of an MMP and who wishes to elect another MMP offered by the same parent organization must complete a new enrollment request; however, that individual may use a short enrollment form in place of the comprehensive individual enrollment form. See Exhibit 2.

A State must deny enrollment to any individual who does not properly complete the voluntary enrollment request within required time frames. Procedures for completing the enrollment request are provided in §30.2. Refer to Appendix 3 for a definition of “completed election.”

10.4 - Agreeing to Abide by Medicare-Medicaid Plan Rules

An individual is eligible to elect an MMP if he/she is fully informed of and agrees to abide by the rules of the MMP that were provided during the enrollment process (refer to §§30.4, 30.4.1 and 30.4.2 regarding what information must be provided to the individual during the enrollment process). “Fully informed” means that the individual must be provided the applicable rules of the MMP, as described in §30.4.1 of this guidance and in the State-specific Demonstration Marketing Guidelines. The MMP must deny enrollment to any individual who does not agree to abide by the rules of the MMP. Agreement to abide by the rules of the MMP in this context is made through the completion of the enrollment request. In the case of passive enrollment, agreement to abide by the rules is made by not declining passive enrollment.

10.5 – Medicaid Eligibility and Additional State-Specific Eligibility Requirements for Enrollment in Medicare-Medicaid Plans

States must limit enrollment to individuals who meet State-specific eligibility requirements as outlined in Appendix 5.

Before processing an enrollment into an MMP, the State must confirm MMP eligibility, including both Medicare eligibility and Medicaid eligibility.

20 - Elections and Effective Dates

Elections include both enrollment and disenrollment requests.

On an ongoing (i.e., month to month) basis, individuals who meet the criteria for enrollment in MMPs may:

- Switch from Original Medicare to an MMP
- Switch from a Medicare health or drug plan to an MMP
- Switch from an MMP to a Medicare health or drug plan
- Switch from one MMP to another MMP
- Switch from an MMP to Original Medicare
- Switch from an MMP to a PACE organization
- <if applicable> Additional options specific to Medicaid benefit, as specified in Appendix 5.

It is generally the responsibility of the State to determine whether the individual is eligible for enrolling in an MMP. All enrollment requests are processed by the State. This includes passive enrollments.

In the Medicare Advantage program, most beneficiaries have specific periods (called “election periods”) during which they can request to enroll into, or disenroll from, a MMP. The election periods are applicable to enrollment in MMPs. For the Initial Coordinated Election Period, individuals may elect a plan up to three months in advance of the month in which their entitlement to Medicare Part A and enrollment into Medicare Part B are effective.

There are “Special Enrollment Periods” that permit changes at additional times during the year. Medicare-Medicaid enrollees who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program have a continuous Medicare Special Enrollment Period (SEP) to request enrollment in or disenrollment from a Medicare health or drug plan. This SEP begins the month the individual becomes dually-eligible and exists as long as he/she is eligible for both Medicare and Medicaid. This SEP permits individuals to enroll into or disenroll from MMPs in any month, including switching MMPs. The effective date of an election made using this SEP is the first of the month following receipt of the enrollment or disenrollment request.

States may establish a cutoff date for accepting voluntary enrollment requests under the two scenarios noted above, but the cutoff may be no more than five calendar days before the end of the month. The effective date for individuals who submit a voluntary enrollment request after the cutoff date will be the first day of the second month after receipt of the request.

Individuals who are no longer eligible for Title XIX benefits have an SEP beginning the month they receive notice of the loss of eligibility plus two additional months to make an enrollment choice in an Medicare Advantage or Part D plan, even if the loss of eligibility is determined retroactively by the State. Please see §40.2.3 regarding involuntary disenrollment from the MMP based on loss of Medicaid eligibility.

20.1 - Effective Date of Coverage for Voluntary Enrollments

Generally, beneficiaries may not request their enrollment effective date when voluntarily requesting enrollment. Furthermore, the effective date is generally not prior to the receipt of an enrollment request by the State. An enrollment cannot be effective prior to the date the beneficiary or his/her legal representative signed the enrollment form or submitted the enrollment request. Section 30.2 includes procedures for handling situations when a beneficiary chooses an enrollment effective date that is not allowable based on the requirements outlined in this section.

The effective date may not be earlier than the first day of the individual's entitlement to Medicare Part A and Part B and Medicaid, as well as eligibility for Part D and other demonstration eligibility criteria. States may obtain this information from CMS through the "TBQ" query (<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/TBQData.pdf>) or through the CMS enrollment vendor.

Generally, the effective date for voluntary enrollment requests is the first day of the month following the State's receipt of the enrollment request. Exceptions include:

- Individuals whose Medicaid and/or Medicare effective date is in the future; in those instances, the effective date for enrollment into the MMP is the first day of the month the individual meets MMP eligibility criteria, e.g., is eligible for both Medicaid and Medicare.
 - For Medicare, this includes the Initial Coordinated Enrollment Period, in which an individual may request enrollment up to three months before the start of their Medicare eligibility.
- In addition, if a State establishes a cutoff date for receiving voluntary enrollments per §20, then the effective date for enrollment requests received after the effective date is the first day of the second month after the month of receipt.

The effective dates for passive enrollment are described in §30.1.4 of this guidance.

20.2 - Effective Date of Voluntary Disenrollment

Generally, beneficiaries may not select their effective date of disenrollment.

When a member voluntarily disenrolls from an MMP, he/she will remain in the MMP until the last day of the month in which the disenrollment request was received, and will return to Original Medicare the first day of the following month. If eligible for the Medicare Part D Low Income Subsidy, and he/she did not elect a Part D plan, CMS will auto-enroll him/her into a Medicare Prescription Drug Plan. If a member elects a Medicare health or drug plan while still a member of an MMP, he/she will automatically be disenrolled from the MMP upon successful submission of the enrollment in the new Medicare plan to CMS.

Individuals have until the last calendar day of the month to request disenrollment (please note this differs from the earlier cutoff permitted under § 20.2 for enrollment requests). The effective

date for all voluntary disenrollments is the first day of the month following the State's receipt of the disenrollment request.

30 - Enrollment Procedures

States will be responsible for accepting enrollment, and opt out requests related to MMPs. States may accept enrollments via a range of mechanisms. Options include accepting enrollments during a face-to-face interview in which a paper form is completed by the applicant, on-line, by mail, by facsimile, through other mechanisms outlined in this guidance or defined by the State and approved by CMS. A State may encourage the use of mechanisms other than a paper form, but must accept paper enrollment requests (which may be received in person, by mail, or facsimile) if beneficiaries choose to use one. Regardless of mechanism, the State must collect certain information necessary for CMS to process related transactions, and to notify beneficiaries of certain rights.

For voluntary enrollment requests, an individual (or his/her legal representative) must complete an enrollment form or other CMS-approved enrollment request mechanism to enroll in an MMP and must submit the enrollment request to the State. Please note that in this guidance, “voluntary” is used to mean beneficiary-initiated elections; this is distinguished from passive enrollments, which are considered voluntary in that beneficiary’s silence is considered agreement with the election. If an individual currently enrolled in a Medicare health or prescription drug plan wishes to elect an MMP offered by the same parent organization, he/she must complete a new enrollment request to enroll in the MMP.

Enrollment may also be made via the passive enrollment process as described in §30.1.4 of this guidance.

An MMP must accept enrollment and opt-out requests it receives through the State. MMPs may not accept enrollment and opt-out requests directly from individuals and process such requests themselves, but instead, must forward the request to the State, unless the State has deferred enrollment activities to the MMP. MMPs will receive enrollment-related notifications from both the State, as well as from CMS or its contractor, via the Daily Transaction Reply Report (DTRR). Please note that the DTRR will also include other notifications from CMS, e.g., changes in Low Income Subsidy copayment level. Please see the CMS Plan Communication User Guide (PCUG) for additional details.

Upon receiving an enrollment request, the State (or the MMP on its behalf) must determine eligibility for enrollment into the MMP and provide within 10 calendar days of receiving the enrollment request, one of the following:

- Acknowledgement notice – Exhibit 3 (as described in section 30.4.1);
- Request for additional information - Exhibit 6 (as described in 30.2.2); or
- Notice of denial – Exhibit 9 (as described in 30.2.3).

As described in §30.4, the State may use a combined acknowledgment/confirmation notice instead of separate acknowledgement (i.e., that request is received) and confirmation (i.e., that request is successfully processed) notices (see Exhibit 4). If a combined notice is used, it must be provided within 7 calendar days of receiving the confirmation of enrollment via the CMS Daily Transaction Reply Report (DTRR). If the enrollment transaction is rejected by CMS, the State (or the MMP on its behalf) must send the notice of rejection within 7 calendar days of receiving the DTRR (see Exhibit 10).

States will notify CMS of enrollment and opt-out requests it has processed, using standard MARx transaction formats. Enrollments will be submitted on TC 61 transactions, and opt-out requests on TC 83 transactions. CMS will process these transactions and InfoCrossing, the MMP enrollment vendor, will send the DTRR to the MMP and the State. InfoCrossing will ensure all applicable reports are provided to the MMP and/or the State. Should the State or the MMP identify discrepancies between State and CMS notification, the State may submit corrections to MARx, or may work with the CMS' Retroactive Processing Contractor (RPC) to process any needed corrections to CMS' systems. Unless otherwise directed in this guidance, required notices must be provided in response to information received from CMS on the DTRR that contains the earliest notification.

Please refer to §30.2.5 and §30.2.6 for additional instructions on processing enrollments in which an individual has other qualified prescription drug coverage through an employer or union group.

30.1 - Format of Enrollment Requests

At a minimum, the State must have a paper enrollment form process (as described in this guidance and approved by CMS) available for potential enrollees to request enrollment in an MMP. However, as noted in §30, States may use other mechanisms outlined in this guidance or as approved by CMS.

States must also process passive enrollments as described in §30.1.4 of this section.

30.1.1 - Enrollment Request Mechanism

The State must use an enrollment mechanism that is approved by CMS. A specific model enrollment form has been developed for enrollment into MMPs (see Exhibit 1).

States should utilize the model to ensure all required elements are included. States may develop their own materials using these models, subject to CMS approval. All enrollment mechanisms must include the applicant's acknowledgement of the following:

- Understanding of the requirement to continue to keep Medicare Parts A and B;
- Agreement to abide by the MMP's membership rules, as outlined in member materials;
- Consent to the disclosure and exchange of information necessary for the operation of the Medicare and Medicaid programs;
- Understanding that he/she can be enrolled in only one Medicare health plan and that enrollment in the MMP automatically disenrolls him/her from any other Medicare health plan and Medicare prescription drug plan;
- Understanding of the right to appeal service and payment denials made by the MMP; and
- Other state-specific requirements.

Please note that for passive enrollments, when the beneficiary does not decline passive enrollment, this is determined to be agreement with the items above.

Please refer to Appendix 1 for a complete listing of required elements that must be included on enrollment mechanisms and Exhibit 1 for complete information on the required statements.

States must include elements on the enrollment mechanism that correspond to the unique eligibility criteria (e.g., required Medicaid status) of the plan.

No enrollment mechanism may include a question regarding binding arbitration, whether the individual receives hospice coverage or any other health screening information, with the exception of questions regarding ESRD status and nursing home status for the purpose of determining eligibility for enrollment in the MMP. However, the States may ask health related questions during completion of the enrollment request for the purpose of successful transition of care. These questions must be asked subsequent to the required enrollment request elements and clearly indicate that the information is only being collected to help in the successful transition of the individual's care in the MMP and is not to be used to determine if an individual can enroll in the MMP. The individual is not required to answer the health related questions in order for the enrollment request to be processed or submitted to the MMP. If the State receives an enrollment request without the health related information, they may follow up with the individual to obtain coordination information, however, the individual is not required to answer and the State may not delay in processing the request due to not having such information. The collected health information is to be securely and electronically forwarded to MMPs to start the care management and transition of care activities.

Refer to §50.7 for requirements regarding retention of enrollment request mechanisms.

30.1.2 - Enrollment via the Internet

States may develop and offer the option for individuals to submit enrollment requests into an MMP via the State's secure internet web site. The following guidelines must be applied, in addition to all other program requirements:

- Submit all materials and web pages related to the online enrollment process for CMS approval.
- Provide beneficiaries with all the information required by State-specific Demonstration Marketing Guidelines.
- At a minimum, comply with CMS' internet security policies (found at: <http://www.cms.hhs.gov/informationsecurity/>). The State may also include additional security provisions.
- Advise each individual at the beginning of the online enrollment process that he/she is sending an actual enrollment request to the State.
- Capture the same data as required on the model enrollment form (see Exhibit 1 and Appendix 1).

- As part of the online enrollment process include a separate screen or page that includes an “Enroll Now,” or “I Agree,” type of button, that the individual must click on to indicate his/her intent to enroll and agreement to the release and authorization language, as provided on the model enrollment form (see Exhibit 1), and attest to the truthfulness of the data provided. The process must also remind the individual of the penalty for providing false information.
- If a legal representative is completing this enrollment request mechanism, he/she must attest that he/she has such authority to make the enrollment request and that proof of this authority is available upon request by CMS.
- Inform the individual of the consequences of completing the internet enrollment, including that he/she will be enrolled (if approved by CMS), and that he/she will receive notice (of acceptance or denial) following submission of the enrollment to CMS.
- Include a tracking mechanism to provide the individual with evidence that the internet enrollment request was received (e.g. a confirmation number).
- Maintain electronic records that are securely stored and readily reproducible for the period required in §50.7 of this guidance. The State’s record of the enrollment request must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member and/or CMS. A data extract file alone is not acceptable.
- The option of online enrollment is limited to requests submitted via the State’s website. Online enrollment via other means, such as a plan broker or plan website, is not permitted.

Note that enrollments into MMPs will not be accepted by the Medicare Online Enrollment Center.

30.1.3 - Enrollment via Telephone

States may accept requests for enrollment into an MMP via an inbound telephone call. In limited situations and with CMS approval, a State may accept an enrollment request via an outbound call when, during the course of a call made to a beneficiary for the purpose of outreach and education regarding the demonstration, the beneficiary expresses a desire to request enrollment in one of the available MMPs. The requirements outlined in this section are applicable to telephonic enrollment requests based on both inbound and outbound calls:

- Enrollment requests may be accepted during an incoming (or in-bound) telephone call from a beneficiary. This includes inbound calls to an incorrect department or extension transferred internally.
- Enrollment requests received from a beneficiary during an outbound telephone call must adhere to all requirements applicable to telephonic enrollment requests received via an inbound call.
- The State must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his/her authorized representative.
- Individuals must be advised that they are completing an enrollment request.
- Each telephonic enrollment request must be recorded (audio) and include a statement of the individual’s agreement to be recorded, all required elements necessary to complete the

enrollment (as described in Appendix 1), and a verbal attestation of the intent to enroll. Here is a sample script the interviewer may use to get verbal consent from the individual: “For this interview, we will ask you questions to process your (/or name of person’s) application for Medicare-Medicaid Plan. Your response will be recorded. At the end of the interview, we will ask you to confirm the accuracy and truthfulness of your answers.”

- If the request is made by someone other than the beneficiary, the recording must include the attestation regarding the individual’s authority under State or other applicable law to complete the request, in addition to the required contact information, e.g., Name and Address. All telephonic enrollment recordings must be reproducible and maintained as provided in section §50.7.
- Include a tracking mechanism to provide the individual with evidence that the telephonic enrollment request was received (e.g. a confirmation number).
- An acknowledgement notice and other required information must be provided to the individual as described in §30.4.1.

The State must ensure that all MMP eligibility and enrollment requirements provided in this guidance are met. Scripts for completing an enrollment request in this manner must be developed by the State, must contain the required elements for completing an enrollment request as described in Appendix 1, and must receive CMS approval.

30.1.4 - Passive Enrollment

CMS and a State may offer eligible individuals passive enrollment into MMPs. Passive enrollment is a process by which a beneficiary is informed that he or she will be considered to have made a request to enroll in an MMP by taking no action.

Passive enrollment into MMPs will be coordinated with CMS activities, such as LIS auto enrollment and reassignment, to ensure that enrollment changes not initiated by eligible individuals are generally limited to one per benefit year. Individuals will not be passively enrolled by CMS or the State into an MMP more than once per benefit year (see section H below), except with CMS’ prior approval in the following limited situations:

- MMP terminations; and
- if CMS and the State jointly determine that remaining in the MMP poses potential harm to members.

The State may not passively enroll an individual more than once per benefit year for any other reasons, including when the person voluntarily disenrolls (even if they have not explicitly requested to opt out of future passive enrollments) or if they are involuntarily disenrolled for the reasons outlined in §40. Such individuals retain the option to voluntarily enroll in an MMP at any time during that benefit year. Individuals who opt out of passive enrollment are not eligible for future passive enrollments (see section E below) for the life of the demonstration.

A. Individuals Subject to Passive Enrollment

Individuals eligible for passive enrollment must:

- Be entitled to both Medicare Part A and Part B (See positions 1152-1331 in MMA response file or TBQ response);
- Be eligible to enroll in a Part D plan;
- Be entitled to Medicaid;
- Permanently reside in the service area of the MMP; and
- Meet additional criteria applicable to his/her state.

States may not passively enroll individuals who:

- Are enrolled with a PACE organization;
- Have employer or union sponsored health or drug coverage;
- Are being claimed by an employer for the Medicare Part D Retiree Drug Subsidy;
- Are confined in a correctional facility;
- Have opted out of passive enrollment into an MMP;
- Have opted out of auto-enrollment into a Part D plan (since MMPs qualify as a Part D plan); or
- <if applicable>Meet additional state-specific requirements in Appendix 5.

B. Passive Enrollment Process

The procedure for passive enrollment is as follows:

1. The State must identify individuals meeting all applicable MMP eligibility criteria. States may send general outreach letters prior to the notification of plan assignment; however States must send notices with plan assignments, as outlined below. States must provide CMS an opportunity to review and approve all beneficiary communications prior to their use.
2. The State must identify the MMP into which each individual will be passively enrolled.
 - a) States must attempt to assign beneficiaries to an MMP that best meets the current circumstances of the individual's needs by using the most recent 12 months of Medicare and Medicaid claim history data to identify the individual's most frequently utilized providers and medical facilities, e.g., physicians, medical groups, clinics, long-term care facility, etc. Note that claims data for individuals previously enrolled in Medicare health plans may not be available.
 - i) For individuals already enrolled in a Medicare Advantage plan or a Medicaid Managed Care Organization that also offers an MMP in the individual's service area, the State may fulfill this requirement by passively enrolling these individuals into the MMP offered by that organization.

- b) States may not passively enroll individuals into an MMP offered by an organization that is either an outlier in CMS' past performance analysis and/or has a "consistently low performing" icon on the Medicare Plan Finder website.
 - i) The only exception is when the individual to be passively enrolled is currently enrolled in a Medicaid Managed Care Organization or a Medicare Advantage plan sponsored by the same organization. Under this exception, the State may passively enroll the individual into the MMP sponsored by that same organization.
 - ii) When the organization is no longer considered by CMS to be a past performance outlier and/or no longer has a "consistently low performing" icon on the Medicare Plan Finder, the MMP may qualify to receive other passive enrollments.
3. No less than 60 calendar days and no more than 90 days prior to the enrollment effective date, the State:
 - Sends a passive enrollment notice to the individual informing him/her of his/her assigned plan and providing instructions to opt out of (i.e., decline) the passive enrollment .
 - Submits an enrollment transaction (TC 61) to CMS' MARx enrollment system to passively enroll the individual into the MMP. Please note:
 - 1.States may omit "4Rx data" (four data elements issued by plans that permit on-line, real time billing by pharmacists) from enrollment transactions (TC 61), and instead direct MMPs to submit them to CMS directly after receiving a Daily Transaction Reply Report that confirms enrollment.
 - 2.States should use the enrollment source code "J", indicating passive enrollment by the State.
4. The State sends an address file to MMPs of those passively enrolled with them (See Appendix 5 for details).
5. The State sends a second reminder notice at least 30 days prior to the effective date.
6. For individuals who opt out at any point prior to the passive enrollment effective date, the State must send an enrollment cancellation transaction (TC 82) to cancel the passive enrollment and an opt-out transaction (TC 83) within 3 business days to register on CMS systems the request to opt out of future passive enrollments into an MMP.

C. Effective Date of Passive Enrollments

The effective date of passive enrollment is determined by the State, subject to the following conditions:

1. The effective date shall always be prospective, no less than 60 calendar days from the date the passive enrollment notice is sent to the individual and the passive enrollment is submitted to CMS' systems.
2. The effective date shall always be the first day of a month.

D. Required Notices

The State must notify the beneficiary in writing that he/she will be passively enrolled in the MMP on the specified effective date if he/she does not opt out of the enrollment prior to the enrollment effective date. The notice must be sent no less than 60 calendar days prior to the enrollment effective date and must inform the beneficiary that she/she may opt out of passive enrollment into the MMP (see Exhibit 4). If the beneficiary does not respond or does not opt out prior to the enrollment effective date, the person's silence will be deemed to be an election of the MMP. These individuals will be informed of their eligibility for a Medicare Special Enrollment Period (SEP) that allows them to request prospective enrollment in a Medicare health plan (Medicare Advantage plan, cost plan or PACE Program) or into Original Medicare and a Medicare Part D plan, even after the passive enrollment takes effect.

Beneficiaries who have been passively enrolled will receive a second notice no later than 30 days prior to the effective date of their coverage, reminding individuals of the passive enrollment effective date, their options (including opt out) and where to seek assistance (see Exhibit 5).

E. Opt-Out

Individuals may opt -out of (i.e., affirmatively decline) passive enrollment into the MMP. Individuals who choose to opt out of passive enrollment into an MMP must do so by contacting the State or 1-800-MEDICARE,. If the individual calls the MMP, the MMP will refer them to the State. Individuals who elect to call 1-800-MEDICARE to opt out may have their requests accepted and processed by CMS. States and MMPs will learn of any opt outs processed by CMS via the DTRR. Beneficiaries may opt out verbally or in writing. Once a beneficiary has opted out, the State must document this and exclude him/her from future passive enrollment processing.

The State should counsel the individual to ensure he/she understands the implications of the request to decline passive enrollment, and must acknowledge the individual's request in writing (see Exhibit 28) within 10 calendar days of receipt of the individual's request to opt out or receipt of the DTRR.

If the individual opts out after the enrollment transaction (TC 61) has been submitted, but prior to the passive enrollment effective date, the State must cancel the passive enrollment with an enrollment cancellation transaction (TC 82) showing an MMP Opt- Out Flag data element as "Y" = Opted out of passive enrollment into MMP Plan in position 202. CMS systems will attempt to restore the individual to his/her previous coverage; if that is not possible, CMS' systems will revert the individual to Original Medicare and will auto-enroll him/her into a Medicare Prescription Drug Plan. The individual will have access to the LI NET prescription drug plan during any coverage gap.

If the individual opts out after the effective date of a passive enrollment, the State must disenroll the individual prospectively by submitting a disenrollment transaction (TC 51) showing an MMP Opt- Out Flag data element as "Y" = Opted out of passive enrollment into MMP Plan in position 202. CMS' systems will revert the individual to Original Medicare and will auto-enroll him/her into a Medicare Prescription Drug Plan. The individual will have access to the LI NET prescription drug plan during any coverage gap.

An individual who opts out does not permanently surrender his or her eligibility for, or right to enroll in, an MMP; rather, this step ensures that CMS and the State do not include the person in future MMP passive enrollment processes for the life of the demonstration. Such individuals may voluntarily enroll into a MMP.

The Part D opt -out flag indicates that the beneficiary has opted out of the Part D auto enrollment and reassignment process. If this flag is on, it will prevent CMS from auto enrolling or reassigning a beneficiary into a Part D plan. The MMP opt-out only indicates that the beneficiary does not wish to be passively enrolled into an MMP. It will not prevent CMS auto enrollment of the beneficiary into non-MMP Part D plans. Beneficiaries who have the Part D opt-out flag should be excluded from all passive enrollments into MMP plans.

- Opting Out of Part D Auto enrollment. Since MMPs offer the Medicare Part D benefit, individuals opting out of future passive enrollments into the MMP may also want to opt out of future autoenrollments by CMS into Medicare Part D plans (e.g., if they have employer coverage and the employer will terminate benefits if the individual has drug coverage elsewhere). The State should inform the beneficiary of the difference between opting out of the MMP passive enrollment and the Part D auto enrollment process, and if the beneficiary has specific questions about the Part D auto enrollment process, or wants to opt out of it, refer the beneficiary to 1-800-MEDICARE.

F. Excluding Individuals with Employer or Union Coverage from Passive Enrollment

Individuals with employer- or union-sponsored coverage shall be excluded from passive enrollment. This includes Medicare “800 series” plans (i.e., Medicare Advantage or Part D plan benefit package ID numbers that start with “8”), employer-Sponsored plans (i.e., contract numbers that start with “E”), as well as individuals for whom an employer or union claims the Medicare Retirement Drug Subsidy (RDS).

When selecting individuals for passive enrollment in the MMP, the State (or the State enrollment broker) must actively check all available systems (e.g., State systems or CMS’ Territory Beneficiary Query (TBQ)) to ensure that individuals with employer or union sponsored coverage are excluded. There are three indicators in the MMA response file or the TBQ to verify if the individuals are enrolled in an employer or union sponsored plan accompanying with **or** without RDS:

1. Beneficiary’s Group Health Organization (GHO) Contract Number (position 1479-1483)
2. RDS Start/End Dates (positions 2903-2910 and 2911-2918)
3. Plan Benefit Package (PBP) Number (positions 1681-1688 and 1689-1696)

For individuals for whom an employer or union is claiming the Medicare Part D RDS, it is possible the State will not be aware an individual has RDS until it submits an enrollment transaction (TC 61) and receives notification of RDS status on the DTRR. CMS’ MARx system will enforce a two-step process, initially rejecting the transaction, which will be indicated on the DTRR with a Transaction Reply Code of 127 – Part D Enrollment Rejected; Employer Subsidy Status (see §30.2.5 for additional detail). If the enrollment was a passive one, the State must let the rejection stand and not override it.

There are individuals (e.g., former school teachers, local government employees, etc.) who are enrolled in an employer or union sponsored plan, which the State may be aware of but CMS does not have a record, either because they are not being claimed by the employer or union for the Part D RDS or because they are enrolled in a Medicare Part C or D plan that is not indicated in CMS systems as being an employer or union sponsored plan. Inclusion of these individuals in passive enrollment activities may result in the unintended loss of the individuals' employer or union sponsored coverage, including for their dependents. States must attempt to identify and exclude these individuals from passive enrollment in the MMP, including checking applicable data sources within the State's systems before doing passive enrollment, and preparing enrollment staff/brokers to appropriately advise those who are included in passive enrollment if they call with questions.

G. Information to Provide to Passively Enrolled Beneficiaries

The State must send the pre- and post-enrollment materials required to be provided to new enrollees. Please see §30.4.1.

H. Coordinating enrollment into Medicare-Medicaid Plan (MMP) with Medicare Prescription Drug Plan (PDP) Reassignment

On an annual basis, Medicare reassigns certain individuals who qualify for Extra Help (including Medicare-Medicaid enrollees) into PDP plans with premiums at or below the regional low income premium subsidy benchmark amount to make sure these individuals continue to pay "zero" premium for their prescription drug coverage (note that MMPs will have zero Part D premiums); individuals who qualify for Extra Help and are enrolled in terminating Medicare Advantage plans or PDPs are also reassigned. Reassignment occurs in October each year, with enrollment into a new PDP effective the first of the following January. Passive enrollment into MMPs must be coordinated with CMS' annual reassignment process to avoid assigning an individual to a new PDP plan and then moving him or her to an MMP in the same year.

To ensure beneficiaries are not reassigned or passively enrolled more than once per benefit year:

CMS provides data relating to the beneficiaries selected for reassignment to the State (based on the address of record) in September each year (i.e., the month before reassignment is actually processed in CMS' systems). An individual included in Medicare reassignment effective January of a given year may NOT be passively enrolled into an MMP any earlier than January of the following year. If a beneficiary will be reassigned, the State may do one of the following:

1. Passively enroll the beneficiary effective January 1 following receipt of the record from CMS that indicates that the beneficiary will be reassigned. For example, the State receives the record from CMS indicating that the beneficiary will be reassigned effective January 1, 2014. The State may passively enroll, per CMS guidance below, the beneficiary effective January 1, 2014, effectively canceling the reassignment.

States phasing in passive enrollment may adjust the passive enrollment effective date of individuals who would otherwise be reassigned January 1 of that year, to take precedence over reassignment. For example, if a Medicare-Medicaid beneficiary is subject to reassignment effective January, 2014, and is also scheduled to be included in MMP

passive enrollment effective March, 2014, the State may move up the passive enrollment effective date of this individual from March, 2014, to January, 2014.

OR

2. Passively enroll the beneficiary one year or more following the date of reassignment. Following the example above, this would be January 1, 2015 or later. Once the beneficiary has been reassigned, the State may not passively enroll that beneficiary until the following year (effective January).

To effectuate this process of ensuring passive enrollments take precedence, CMS and the State should use the steps below:

- a) CMS provides data relating to the individuals selected for reassignment to the State (based on the SSA mailing address of record) in September each year;
- b) Using the data provided in item a), the State identifies those whom they will passively enroll effective January 1 of the following year;
- c) State submits passive enrollment transactions to CMS during a specific time period in October that CMS will announce annually. If a State misses the time period for submitting passive enrollments, the State must wait until the following year to passively enroll affected beneficiaries into an MMP (as outlined in option 2 above); and
- d) Once the State has submitted its passive enrollments per CMS' guidance, CMS will conduct its annual re-assignment for all states. Beneficiaries that have been enrolled into an MMP with an effective date of January 1 of the coming year, prior to CMS performing its annual reassignment, will not be reassigned into a Medicare Part D plan because they will have equivalent prescription drug coverage under the MMP.

I. Application Date

States must enter the application date specified below on enrollment transactions (TC 61) for passive enrollments. (See Appendix 2 for more information about the application date).

- For passive enrollments effective January 1, the application date will be October 14 of the current year. Medicare has an open enrollment period each year, which lasts from October 15 through December 7. When there are multiple enrollments for the same effective date, the one with the later application date “trumps.” By setting the application date to October 14, any Medicare election a beneficiary makes during Medicare’s open enrollment period “trumps” the passive enrollment.
- For passive enrollments with an effective date of February through December, the application date will be the date the transaction is submitted to CMS (which must be no later than 60 days before the effective date).

These dates are set artificially early so that any subsequent voluntary election by an individual will “trump” the passive enrollment transaction.

J. 4Rx Data

“4Rx data” are four data elements issued by Medicare Part D plans indicating billing codes that facilitate real time billing by pharmacists. CMS requires prompt submission of 4Rx data to ensure steady flow of pharmacy billing information to the True Out-of-Pocket (TrOOP) Facilitator so that beneficiary can access their prescriptions without delay and billing/claims are processed timely. Please note that the MMP is the source of the 4Rx data – States that want to submit these data to CMS will first need to obtain them from the MMP.

The four Rx data elements are:

RxBIN – Benefit Identification Number
RxPCN – Processor Control Number
RxID – Identification Number
RxGRP – Group Number

States may opt to submit 4Rx data on the enrollment transaction (TC 61), or may leave those fields blank. (Note that States are strongly encouraged to use the same 4Rx submission process across all enrollments and MMPs within the state.) If an MMP receives a CMS Daily Transaction Reply Report (DTRR) with confirmation of successfully processed enrollment transaction that is missing 4Rx data (whether left blank intentionally or unintentionally by the State), the MMP is required to submit a 4Rx transaction (TC 72) to CMS’ enrollment vendor within 72 hours of that DTRR .

30.2 - Processing the Voluntary Enrollment Request

If an enrollment form is completed during a face-to-face interview, the State should use the individual’s Medicare card to verify the spelling of the name, and to confirm the correct recording of sex, Health Insurance Claim Number, and dates of entitlement to Medicare Part A and enrollment in Part B. If the form is mailed or faxed, the State should verify this information with the individual via telephone or other means, or request, but not require, that the individual include a copy of his/her Medicare card when mailing in the enrollment form. Regardless of whether or not the State has reviewed the Medicare Identification card, the State must still validate and verify Medicare entitlement as described in item “B” below in this section.

Appendix 1 lists all the elements that must be provided by the applicant in order to consider an enrollment request “complete.” If the State receives an enrollment request that contains all these elements, it must consider the enrollment complete even if all other data elements on the enrollment request are not provided. If a State has received CMS approval for an enrollment request that contains data elements in addition to those included in Appendix 1, the enrollment request is considered complete even if those additional elements are not provided.

If a State receives an enrollment request that does not have all necessary elements required in order to consider it complete, it must not immediately deny the enrollment. The State must always check available systems (e.g., State systems; CMS’ demonstration enrollment vendor query; or TBQ [a MARx online query for States]) for information to complete an enrollment before requiring the beneficiary to provide the missing information. For example, if a beneficiary failed to fill out the “sex” field on the enrollment and the State has access to this information via available systems, it must use that source to complete the application instead of requesting the

information from the beneficiary. If the required but missing information is not available via State or CMS systems, the enrollment request is considered incomplete and the State must follow the procedures outlined in §30.2.2 in order to complete the enrollment request.

The following must also be considered when processing an enrollment:

- A. Permanent Residence Information** - The State must determine whether or not the individual resides within the MMP service area. If an individual provides a Post Office Box as his/her place of residence on the enrollment request, the State must consider the enrollment request incomplete and must consult other sources, including State address data or contact with the individual to determine place of permanent residence. If the applicant claims permanent residency in two or more states or if there is a dispute over where the individual permanently resides, the State should consult the laws of the State in which the MMP is offered and determine whether the enrollee is considered a resident of the State.

Refer to Appendix 3 for a definition of “evidence of permanent residence,” and §10.2 for more information on determining residence for homeless individuals.

- B. Entitlement Information** - Following the procedures outlined in the Plan Communication User Guide (PCUG), States must verify Medicare entitlement using the Batch Eligibility Query (BEQ) process, MARx online query (M232 screen) or MAPDIUI (Medicare Advantage Prescription Drug Interactive User Interface) for all enrollment requests.

Individuals are not required to provide evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment request. If the systems indicate that the individual is entitled to Medicare Part A and is enrolled in Part B, no further documentation of Medicare entitlement is needed from the individual.

When neither the BEQ, the MARx online query, nor MAPDIUI beneficiary eligibility query show Medicare entitlement, the State must consider the individual’s Medicare ID card to be evidence of Medicare entitlement. When neither the BEQ/MARx/MAPDIUI query nor the Medicare ID card is available, the State must consider an SSA Award Letter that shows Medicare entitlement (including start dates) as evidence of Medicare entitlement.

If the State is not able to verify entitlement as described above, refer to §40.2.2 for additional procedures.

- C. Effective Date of Coverage** - As described in §20.1, the State must determine the effective date of coverage for all voluntary enrollment requests. If the individual fills out an enrollment form in a face-to-face interview, the representative may advise the individual of the proposed effective date, but must also stress to the individual that it is only a proposed effective date and that the individual will hear directly from the State to confirm the actual effective date. The State must notify the enrollee of the effective date of coverage prior to the effective date (refer to §30.4 for more information and a description of exceptions to this rule).

States/MMPs must ensure enrollees have access to plan benefits as of the enrollment effective date and may not delay providing plan benefits while processing the enrollment request for submission to CMS systems or while awaiting confirmation of the enrollment from CMS systems via DTRR (see §30.4 for a description of an exception to this rule). State should also send an address file to MMPs for all voluntary enrollment requests.

- D. Health Related Information** – Prior to submitting the enrollment to CMS, States may ask very limited health status questions, such as whether the individual has ESRD (if this is an eligibility criterion). Queries for this information are included on the model individual enrollment form in Exhibit 1. These queries are not considered to be health screening questions. With the exception of information obtained on ESRD status, where applicable, the responses to these questions must not have an effect on eligibility to enroll in an MMP.

Apart from collecting necessary health related information to determine eligibility for enrollment in the MMP, the State and their enrollment brokers may ask health related questions during completion of the enrollment request for the purpose of successful care management and transition of care activities. These questions should be asked subsequent to the required enrollment request elements. Further, the State or enrollment broker must clearly indicate to the individual that the information is only being collected to help in the successful transition of the individual’s care in the MMP and will not to be used to determine if an individual can enroll in the MMP. The individual is not required to answer the health related questions in order for the enrollment request to be processed or submitted to the MMP. The collected health information is to be securely and electronically forwarded to MMPs to start the care management and transition of care activities. The personally identifiable information (PII) and protected health information (PHI) must be safeguarded and any electronic data sharing or transmission of PII or PHI must abide by Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security rules.

The optional collection of health-related information by the State or enrollment broker does not eliminate the MMP’s requirement to conduct health assessments for their members. It also does not preclude MPs from conducting health assessments for individuals prior to the effective date of enrollment, as long as the transaction has been processed by CMS, as evidenced by receipt of an enrollment record on the CMS’ Daily Transaction Reply Report (DTRR).

- E. Statements of Understanding** - As outlined in §10.4, a beneficiary must understand and agree to abide by the rules of the MMP in order to be eligible to enroll. If the applicant fails to indicate his/her understanding of all plan rules listed on the enrollment form, the State may contact the applicant to clarify the MMP rules in order to complete the enrollment form. The State must document the contact and annotate the outcome of the contact. If the State is unable to contact the applicant to ensure his/her understanding, the enrollment form would be considered incomplete. For enrollments made by phone, the State shall provide the information verbally and annotate the beneficiary’s understanding.
- F. Applicant Signature and Date** – For paper enrollment requests, the individual must sign the enrollment form. If the individual is unable to do so, a legal representative must sign the enrollment form (refer to §30.2.1 for more detail). If a legal representative enrolls an individual, the legal representative must attest to having the authority under State or other

applicable law to do so, and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effect an enrollment request on behalf of the applicant is available and can be presented upon request by CMS.

The individual and/or legal representative must indicate his/her relationship to the individual and date he/she signed the enrollment form or completed the enrollment request; however, if he/she inadvertently fails to include the date on the enrollment request, then the date the State receives the enrollment request may serve as the signature date of the form.

If a paper enrollment form is submitted and the signature is not included, the State may verify the individual's intent to enroll with a phone call and document the contact, rather than return the paper enrollment form as incomplete. The documentation of this contact will complete the enrollment request (assuming all other required elements are complete).

For passive enrollments and opt out of passive enrollments, as described in §30.1.2, an enrollee signature is not required.

G. Other Signatures - If the State representative helps the individual fill out the enrollment form, the representative must clearly indicate his/her name on the enrollment form. This includes pre-filling out any information on the enrollment form, such as the individual's phone number.

There are limited exceptions to this rule:

- If an individual requests that an enrollment form be mailed to him/her, the State representative may pre-fill only the individual's name and mailing address onto the form,
- The State representative's only additions to the enrollment form are to complete the "office use only" block, and/or
- The State representative needs to correct information on the enrollment due to an error found while verifying information (see "final verification of information" below).

H. Old Enrollment Requests - If the State receives an enrollment request that was executed more than 30 calendar days prior to the State's receipt of the request, the State is encouraged to contact the individual to re-affirm intent to enroll prior to processing the enrollment and to advise the beneficiary of the upcoming effective date.

I. Determining the Application Date - The State must date all enrollment requests as soon as they are initially received. The date the enrollment request is initially received is equivalent to the "application date" (refer to Appendix 3 for definitions of "receipt of enrollment request," "completed enrollment request" and "application date"). If the enrollment request is not complete at the time it is received, the additional documentation required for the enrollment request to be complete must be dated as soon as it is received.

Appendix 2 describes the appropriate application date to include in the enrollment transaction submitted to CMS under various conditions.

- J. Final Verification of Information** - States that verify information before enrollment information has been transmitted to CMS may find that they must make corrections to an individual's enrollment request, including paper enrollment form, or election made by phone or internet. The State should make those corrections, and the individual making those corrections must place his/her initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, may be used by the State (in place of the initialing procedure described in the prior sentence), and must become a part of the enrollment file. These types of corrections will not result in the State having to co-sign the enrollment form.
- K. Completed Enrollment Requests** - Once the enrollment request is complete, the State must transmit the enrollment to CMS within the time frames prescribed in §30.3, and must send the individual the information described in §30.4 within the prescribed time frames. There are instances when a complete enrollment can turn out to be legally invalid. These instances are outlined in §30.5.
- L. Additional Information for MMP Enrollment Requests** – Individuals enrolling in an MMP must disclose any other existing coverage for prescription drugs.
- M. 4Rx Data** - States may opt to submit 4Rx data (four data elements issued by Part D plans indicating billing codes that facilitate real time billing by pharmacists) on the enrollment transaction (TC 61), or may leave those fields blank and instead instruct MMPs to submit a 4Rx transaction (TC 72) directly to CMS' MARx system once confirmation of enrollment is received on the CMS Daily Transaction Reply Report.

If the State submits enrollments, but delegates submission of 4Rx data to the MMP, the MMP must submit the 4Rx data within 72 hours of receiving the Daily Transaction Reply Report. If the State delegates submission of enrollment transactions (TC 61) themselves, then the State must include the 4Rx data on the enrollment transaction (TC 61).

30.2.1 - Who May Complete an Enrollment or Disenrollment Request

A Medicare-Medicaid beneficiary is generally the only individual who may execute a valid request for enrollment in or disenrollment from an MMP. However, another individual could be the legal representative or appropriate party to execute an enrollment or disenrollment request as the law of the State in which the beneficiary resides may allow. CMS will recognize State or other applicable laws that authorize persons to make such requests for Medicare beneficiaries. For example, persons authorized under State law may be court-appointed legal guardians, persons having durable power of attorney for health care decisions or individuals authorized to make health care decisions under State surrogate consent laws, provided they have authority to act on behalf of 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 govern whether another individual may execute the enrollment request on behalf of the beneficiary. Usually, a court-

appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, States should check their laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

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

When someone other than the Medicare beneficiary completes an enrollment or disenrollment request, he or she must:

- 1) Attest to having the authority under State or other applicable law to do so;
- 2) Confirm that proof of authorization, if any, required by State or other applicable law that empowers the individual to make an enrollment or disenrollment request on behalf of the individual is available and can be provided upon request by CMS. States cannot require such documentation as a condition of enrollment or disenrollment; and
- 3) Provide contact information.

The State must retain the record of this attestation as part of the record of the enrollment or disenrollment request for 10 years per the federal records retention guidance. CMS will provide a sample attestation as part of the model enrollment form (Exhibit 1).

If anyone has reason to believe that an individual making an election on behalf of a beneficiary may not be authorized under State or other applicable law to do so, the State should notify the Contract Review Team (the "Team") with all applicable documentation regarding State or other applicable law and the case in question. The Team may request supporting documentation from the individual making the election.

When an authorized representative completes an enrollment request on behalf of a beneficiary, the MMP should inquire regarding the preference for the delivery of required notifications and other plan materials (i.e., sending mail to the beneficiary directly or to the representative, or both) and make reasonable accommodations to satisfy these wishes.

30.2.2 - When the Enrollment Request Is Incomplete

When the enrollment request is incomplete, the State must document all efforts to obtain additional documentation to complete the enrollment request and have an audit trail to document why the enrollment request needed additional documentation before it could be considered complete. The State must make this determination and, within 10 calendar days of receipt of the enrollment request, must notify the individual that additional information is needed, unless the required but missing information can be obtained via CMS or State systems.

For incomplete enrollment requests received prior to the month of entitlement to Part A and enrollment in Part B, additional documentation to make the request complete must be received by the end of the month immediately preceding the individual's Part A and Part B effective date,

or within 21 calendar days of the request for additional information (whichever is later). For incomplete enrollment requests received during the month of entitlement to Part A and enrollment in Part B or later, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).

When the State receives an incomplete enrollment request near the end of either a month or an enrollment period, the use of the full 21 calendar day period to complete the request may extend beyond CMS systems plan submission “cut-off” date (these dates are provided in the PCUG). States may utilize an enrollment transaction (TC 61) to directly submit the request to CMS, as provided in the PCUG.

If additional documentation needed to make the enrollment request “complete” is not received within allowable time frames, the State must deny the enrollment using the procedures outlined in §30.2.3.

Requesting Information from the Beneficiary - To obtain information to complete the enrollment request, the State must contact the individual to request the information within 10 calendar days of receipt of the enrollment request. The State may contact the beneficiary either in writing (see Exhibit 6 for a model letter) or orally. If the contact is made orally, the State must document the contact and retain the documentation in its records. The State must explain to the individual that he/she has 21 calendar days in which to submit the additional information or the enrollment will be denied in writing. Since an incomplete enrollment request is an invalid enrollment (as explained in §30.5), if the additional documentation is not received within allowable time frames, the State must send a denial of enrollment letter (see Exhibit 9).

If all documentation is received within allowable time frames and the enrollment request is complete, the State must transmit the enrollment to CMS within the time frames prescribed in §30.3, and must send the individual the information described in §30.4.

30.2.3 - Denial of Enrollment

Enrollment denials occur before the State has transmitted the enrollment to CMS – A State must deny an enrollment within 10 calendar days of receiving the enrollment request based on its own determination of the ineligibility of the individual to elect the MMP. For an incomplete enrollment request that requires information from the applicant and for which the applicant fails to provide the information within the required time frame, a State must deny the enrollment within 10 calendar days of the expiration of the time frames described in §30.2.2.

Notice Requirement - The State must send notice of the denial to the individual that includes an explanation of the reason for denial (see Exhibit 9). This notice must be sent within 10 calendar days of either 1) receipt of the enrollment request or 2) expiration of the time frame for receipt of requested additional information.

30.2.4 - ESRD and Enrollment (applicable to States for which an individual's ESRD status is an enrollment eligibility criterion)

While Medicare Advantage normally prohibits individuals with ESRD from enrolling in an MA plan, States may opt to permit individuals with ESRD to enroll in an MMP, and may include individuals with ESRD in passive enrollment into an MMP.

If the State excludes individuals with ESRD from enrolling in MMPs and the State receives an enrollment request from an individual that shows active ESRD status from CMS or State systems, the State must check if the ESRD information is current since the individual may no longer require regular dialysis treatment or has received a kidney transplant (e.g., the individual informs the plan that this has occurred), thus making the individual eligible to enroll in an MMP. In these instances, the State should request that the individual submit medical documentation (e.g., a letter from the physician that documents that the individual has received a kidney transplant or no longer requires a regular course of dialysis to maintain life), using the procedures outlined in §30.2.2, as the enrollment request is considered incomplete. Upon receipt of this documentation, the State must enroll the beneficiary using the override procedures described in the PCUG.

If an individual indicates on the enrollment request that he/she does not have ESRD, but the State receives a CMS systems reply containing a “Code 45” or “Code 15” rejection (an explanation of transaction reply codes is contained in the PCUG), the State must investigate further to determine whether the individual is eligible to enroll. This could be because the State permits enrollment of ESRD individuals into MMPs (as outlined in their MOU), or because they meet any one of the exceptions outlined in §20.2.2 of Chapter 2 of the Medicare Managed Care Manual. To determine eligibility, the State may contact the individual to request medical documentation using the procedures outlined in §30.2.2. Contact can be made orally, in which case the State must document the contact and retain the documentation in its records.

If the State learns that the individual is eligible to enroll for any of the exceptions provided in §20.2.2 of Chapter 2 of the Medicare Managed Care Manual, the individual must be permitted to enroll in the MMP if other applicable eligibility requirements are met. The State must submit the enrollment transaction with the ESRD Override field completed as instructed in the PCUG if the effective date of enrollment is within the current operating month for direct submission of the transaction. If the effective date of enrollment is “retroactive” (for CMS systems submission purposes) the request must be submitted to the CMS’ Retroactive Processing Contractor (RPC) with the following documentation:

1. Copy or record of the completed enrollment request, and
2. A description of the individual’s circumstances related to at least one of the exceptions in §20.2.2 of Chapter 2 of the Medicare Managed Care Manual by which the individual has been determined eligible to enroll by the State.

30.2.5 - Enrollment of Individuals with Medicare Employer Group Health Plan Coverage or Individuals Being Claimed for the Retiree Drug Subsidy (RDS)

Individuals enrolled in employer or union-sponsored plans, including Medicare “800 series” plans (i.e., Medicare Advantage or Part D plan benefit package ID numbers that start with “8”), employer-Sponsored plans (i.e., contract numbers that start with “E”), or for whom their employer or union is claiming the Medicare Retiree Drug Subsidy (RDS), will have special procedures to be followed to assure the individual is fully aware of the impact their enrollment into the MMP will have to their employer/union benefits.

CMS systems will compare State enrollment transactions to information CMS has regarding the whether the beneficiary is currently enrolled or being claimed for the Retiree Drug Subsidy (RDS). If there is a match indicating that the individual is being claimed for RDS, the enrollment will be conditionally rejected by CMS systems, and the State will receive a Code 127 on the DTRR.

Within 10 calendar days of receipt of the Code 127 conditional rejection, the State must contact the individual to confirm that the individual wants to be enrolled in the MMP, including the risk that the person may lose other employer benefits, including health benefits for her/himself and/or spouse/dependents, and other employer benefits, including pension. Individuals will have 30 calendar days from the date they are contacted to respond.

The MMP must ensure that plan benefits are available to the individual as of the effective date of the initial enrollment request and must not delay providing plan benefits while awaiting reply of the applicant’s confirmation of intent to enroll. The State may contact the individual in writing (see Exhibit 6) or by phone and must document this contact and retain it with the record of the individual’s enrollment request.

If the individual confirms he/she wants to enroll in the MMP, the State must resubmit the enrollment transaction (TC 61) with the employer subsidy enrollment override flag field set to “Y”. The effective date of enrollment will be based upon the individual’s initial enrollment request. This effective date may be retroactive in the event that the confirmation step occurs after the effective date.

States are strongly encouraged to closely monitor their outreach efforts and to follow up with applicants prior to expiration of the 30 day timeframe. If the individual does not respond in 30 days, or responds and declines the enrollment, the enrollment must be denied. A denial notice must be provided (see Exhibit 9).

30.2.6 –Individuals with Employer/Union Coverage – Other Sources

There are individuals (e.g., former school teachers, local government employees) who are enrolled in an employer or union sponsored plan of which CMS does not have a record, either because they are not being claimed by the employer or union for the Part D Retiree Drug Subsidy (RDS) or because they are enrolled in a Medicare Part C or D plan that is not indicated in CMS systems as being an employer or union sponsored plan. Unlike individuals being claimed for the RDS, CMS systems will not initially reject enrollment transactions for

individuals who have non-RDS employer or union sponsored coverage. If the beneficiary voluntarily requests enrollment in the MMP, States should check State and CMS' systems for employer or union coverage and, if no data are available, ask detailed questions to determine whether such coverage exists. Once the individual has been identified as having employer or union sponsored coverage, the State must inform him/her of the potential risks (i.e. loss of employer or union benefits) and confirm his/her intent to enroll in the MMP. An individual's request to voluntarily enroll should be effectuated only after he/she acknowledges an understanding of the consequence to his employer or union coverage and expresses intent to enroll into an MMP.

If the individual indicates she/he does not want to be enrolled, the State should submit an opt-out transaction (TC 83) for both passive enrollment into MMPs and opt-out transaction (TC 79) for autoenrollment in Medicare Prescription Drug Plans.

30.3 - Transmission of Enrollments to CMS

For all enrollment requests the State is not denying per the requirements in §30.2.3, the State must submit the information necessary for CMS to add the beneficiary to its records as an enrollee of the MMP within 7 calendar days of receipt of the **completed** enrollment request. CMS system "down" days are included in the calculation of the 7 calendar days (refer to Appendix C of the PCUG). For the purpose of assessing compliance with this requirement, CMS will count the enrollment request receipt date as "day zero" and the following day as "day one." All enrollment elections must be processed in chronological order by date of receipt of completed enrollment elections.

States are encouraged to submit transactions by the earliest possible date, but must submit the transactions within the required 7 calendar day time frame.

Please note that MMPs will receive both a Daily Transaction Reply Report from CMS, and files from the State, with notifications of enrollment-related transactions. MMPs should follow the procedures outlined in the PCUG. .

NOTE: The requirement to submit the transaction within 7 calendar days does not affect the effective date of the individual's coverage under the plan; the effective date must be established according to the procedures outlined in §20.

30.4 - Information Provided to Member

Much of the enrollment information that a State must provide to the member must be sent prior to the effective date of coverage. However, some information will be sent after the effective date of coverage, as outlined below. A member's coverage begins on the effective date regardless of when the member receives all the information the plan sends.

As discussed previously (§30), the State must provide required notices in response to information received from CMS on the DTRR that provides the earliest notification.

For voluntary enrollments, the State may provide the required notices described in §§ 30.4.1 and 30.4.2 or may utilize a single ("combination") notice (see Exhibit 4). The combination notice

takes the place of separate acknowledgement and confirmation notices and, as such, requires expedited issuance. To use the combination notice, the State must be able to provide this notice within 7 calendar days of the availability of the DTRR. Additionally, when following this option to use the combination notice, if the State is unable to ensure that the beneficiary will receive this combination notice prior to the enrollment effective date (or within timeframes for incomplete enrollment requests or enrollments received at the end of the month), the State still must ensure that the beneficiary has the information required in §30.4.1 within the timeframes described therein.

Notices should follow whichever reading level and translation requirements, i.e., the State's or Medicare's, are more beneficiary friendly. Please see the State-specific Demonstration Marketing Guidelines under **Marketing Guidance and Model Materials for Medicare-Medicaid Plans** at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

30.4.1 - Prior to the Effective Date of Coverage

Prior to the effective date of coverage, the State (or MMP, if State delegates certain notifications to the MMP), must provide the member with all the necessary information about being a member of the MMP, the plan rules, and the member's rights and responsibilities (an exception to this requirement is described in §30.4.2).

A. Acknowledgement Notice

The State shall send a notice acknowledging the request to enroll in the MMP.

1. For voluntary enrollments, the State may satisfy this requirement by issuing a separate acknowledgement notice or by including the required acknowledgement information in a single, combined enrollment acknowledgement and enrollment confirmation notice:
 - Two separate notices (see Exhibit 3 and 7):
 - A notice acknowledging receipt of the completed enrollment request (see Exhibit 3) and showing the effective date of coverage. This notice must be provided no later than 10 calendar days after receipt of the completed enrollment request.
 - When CMS' MARx system confirms enrollment is processed, a confirmation of enrollment notice (see Exhibit 7). This notice must be provided no later than 10 calendar days after receipt of confirmation on CMS' Daily Transaction Reply Report ;
 - A single, combined acknowledgment and confirmation notice (see Exhibit 4): The combination notice takes the place of separate acknowledgement and confirmation notices and so requires expedited issuance. To use the combination notice, the State must be able to provide this notice within 7 calendar days of the availability of the DTRR. Additionally, when following this option to use the combination notice, if the State is unable to ensure that the beneficiary will receive this combination notice prior to the enrollment effective date (or within timeframes for incomplete enrollment requests or enrollments received at the end

of the month), the State still must ensure that the beneficiary has the information required in §30.4.1 within the timeframes described there.

2. For voluntary enrollments, the State must also provide the evidence of the enrollment request to the individual, as follows:
 - For paper enrollment requests, a copy of the individual's completed paper enrollment form, if the individual does not already have a copy of their completed enrollment request.
 - For enrollment requests submitted via the internet, evidence that the online enrollment request was received (e.g., a confirmation number).
 - For enrollment requests submitted via telephonic enrollment, evidence that the telephonic enrollment request was received (e.g., a confirmation number).
3. For passive enrollments, the State (or MMP) must send a welcome letter for passive enrollees (see Exhibit 5a) 30 days prior to the effective date. Please note that MMPs will receive confirmation from the CMS Daily Transaction Reply Report of passive enrollment approximately 60 days prior to their effective date.

B. Information about the MMP.

1. For passive enrollments, the MMP must send the following 30 days prior to the effective date of coverage:
 - An MMP-specific Summary of Benefits for those offered passive enrollment. (These individuals need to make a decision whether to retain their current coverage, allow the passive enrollment to take effect or change to another plan that better meets their needs). This document is not required for voluntary enrollments. Providing the Summary of Benefits, which is considered marketing material normally provided prior to the beneficiary making an enrollment request, ensures that those who are offered passive enrollment have a similar scope of information as those who voluntarily enroll.
 - A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the MMP.
 - A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits.
 - Proof of health insurance coverage so that he/she may begin using plan services as of the effective date. This proof must include the 4Rx prescription drug data necessary to access benefits.

NOTE: This proof of coverage is not the same as the Evidence of Coverage document described in the State-specific Demonstration Marketing Guidelines. The proof of coverage may be in the form of a member ID card, the enrollment

form, and/or a notice to the member. As of the effective date of enrollment, plan systems should indicate active membership.

2. For passive enrollments, the MMP must send the following no later than the last calendar day of the month prior to the effective date of coverage:
 - A single ID card for accessing all covered services under the MMP.
 - A Member Handbook (Evidence of Coverage) to ensure that they have sufficient information about plan benefits to make an informed decision prior to the enrollment effective date.
3. For individuals who opt into the demonstration (voluntary enrollment), MMP must provide the following materials no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later:
 - A comprehensive integrated formulary
 - A combined provider and pharmacy directory
 - A single ID card
 - A Member Handbook (Evidence of Coverage)

NOTE: For voluntary enrollment requests received late in the month, see §30.4.2 (After the Effective Date of Coverage) for more information.

4. For all enrollments, regardless of how the enrollment request is made, the MMP must explain:
 - The charges for which the prospective member will be liable (e.g., coinsurance for Medicaid benefits in MMP, if applicable; LIS copayments for Part D covered drugs), if this information is available at the time the acknowledgement notice is issued (confirmation notices and combination acknowledgement/confirmation notices must contain this information).
 - The prospective member's authorization for the disclosure and exchange of necessary information between the MMP, State, and CMS.
 - The requirements for use of MMP network providers. The State, or MMP as appropriate, must also obtain an acknowledgment by the individual that he/she understands that care will be received through designated providers except for emergency services and urgently needed care. For passive enrollments, if the beneficiary does not decline passive enrollment, that is considered to be the required acknowledgement.

- The potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B and enrolled in Medicaid at the time coverage begins and he/she has used plan services after the effective date.
- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the MMP has not yet provided the ID card).

30.4.2 - After the Effective Date of Coverage

CMS recognizes that in some instances the State (or MMP, if the State delegates any notifications to the MMP) will be unable to provide the materials and required notifications to new enrollees prior to the effective date, as required in §30.4.1. These cases will generally occur when a voluntary enrollment request is received late in a month with an effective date of the first of the next month. In these cases, the State still must provide the member all materials described in §30.4.1 no later than 10 calendar days after receipt of the completed enrollment request. Additionally, the State is also strongly encouraged to call these new members as soon as possible (within 1-3 calendar days) to provide the effective date, the information necessary to access benefits and to explain the MMP rules. The member's coverage will be active on the effective date regardless of whether or not the member has received all the information by the effective date.

It is expected that all of the items outlined in §30.4.1 will be sent prior to the effective date for passive enrollments.

Acceptance/Rejection of Enrollment

Once the State receives a DTRR from CMS indicating whether the individual's enrollment has been accepted or rejected, the State must notify the individual in writing of CMS' acceptance or rejection of the enrollment within 10 calendar days of the DTRR that contains the earliest notification of the acceptance or rejection (see Exhibits 4, 7 and 10 for model letters). The enrollment confirmation notice must explain the charges for which the prospective member will be liable (e.g., any coinsurance for Medicaid services, as applicable, and LIS copayment levels for Part D covered drugs). The enrollment confirmation notice must specify the limits applicable to the level of low-income subsidy to which the person is entitled.

There are exceptions to this notice requirement for certain types of transaction rejections. These exceptions exist so as not to penalize the individual for a systems issue or delay, such as a plan transmission or keying error. In addition, this rejection notice requirement does not apply when the State receives a transaction rejection due to ESRD (if State excludes individuals with ESRD from enrolling in an MMP), no Medicare Part A and/or no Medicare Part B, and the State has evidence to the contrary. In this case, the State should not send a rejection notice and must request a retroactive enrollment from CMS (or its designee) within the timeframes provided in the RPC Standard Operating Procedures. If CMS (or its designee) is unable to process the retroactive enrollment due to its determination that the individual is not eligible, the State must notify the individual of the rejection in writing within 10 calendar days after CMS' (or its designee's) determination. Retroactive enrollments are covered in more detail in §50.4.

If a State rejects an enrollment and later receives additional information from the individual substantiating his/her eligibility, the State must obtain a new enrollment request from the

individual in order to enroll the individual, and must process the enrollment with a current (i.e., not retroactive) effective date. Refer to §50.4 for more information regarding retroactive enrollments.

As noted elsewhere, the MMP will receive the CMS DTRR simultaneously with the State.

30.5 - Enrollments Not Legally Valid

When an enrollment is not legally valid, a retroactive cancellation of enrollment action may be necessary (refer to §50.5 for more information on retroactive disenrollments). In addition, a reinstatement to the Medicare or Medicaid plan in which the individual was originally enrolled may be necessary if the invalid enrollment resulted in an individual's disenrollment from his/her original plan of choice.

An enrollment that is not complete, as defined in Appendix 3, is not legally valid. In addition, an enrollment is not legally valid if it is later determined that the individual did not meet eligibility requirements at the time of enrollment. For example, an enrollment is not legally valid if a State determines at a later date that the individual provided an incorrect permanent address at the time of enrollment and the actual address is outside the MMP's service area. A second example could be an instance where an individual not authorized by State or other applicable law to make an enrollment request on another's behalf attempts to complete an enrollment request.

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

- An enrollment request signed by the individual when a legal representative should have signed for the individual;
- Request by the individual for cancellation of enrollment before the effective date (refer to §50.2 for procedures for processing cancellations);
- Enrolling in a supplemental insurance program immediately after enrolling in the MMP;
or
- Receiving non-emergency or non-urgent services out-of-plan immediately after the effective date of coverage under the plan.

40 - Disenrollment Procedures

Disenrollments are elections made after the effective date of enrollment into an MMP. It may be accompanied by a request to opt out of future passive enrollments into an MMP, and potentially a request to opt out of future autoenrollments into a Medicare Prescription Drug Plan (see §§ 30.1.4.E and 40.1).

Except as provided for in this section, a State or MMP may not, either orally or in writing, or by any action or inaction, request or encourage any member to disenroll. While a State or MMP may contact members to determine the reason for disenrollment or to explain how Medicaid and Medicare coverage will be provided moving forward, the State or MMP must not discourage members from disenrolling after they indicate their desire to do so. The State must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

An MMP must accept disenrollment requests it receives through the State. MMPs may not accept disenrollment requests directly from individuals and process such requests themselves, but instead, must forward the request to the State, unless the State has deferred enrollment activities to the MMP. Disenrollments from an MMP without an accompanying request to enroll in a Medicare health or drug plan will return the individual to Original Medicare; the individual will be auto-enrolled by CMS into a Medicare Prescription Drug Plan, and can access the LI NET transitional PDP during any coverage gap.

40.1 - Voluntary Disenrollment by Member

A member may request disenrollment from an MMP in any month and for any reason. The member may disenroll by:

1. Enrolling in another Medicare health or Part D plan, including a PACE organization;
2. Enrolling in another MMP;
3. Giving or faxing a signed written disenrollment notice to the State/MMP;
3. Calling 1-800-MEDICARE;
4. Calling the State's enrollment broker; or
5. <if applicable>Additional state-specific resources as identified in Appendix 5.

If a member verbally requests disenrollment from the MMP, the MMP must instruct the member to make the request in one of the ways described above. The MMP may alert the State who may send a disenrollment form to the member upon request (see Exhibits 12, 13, and 15).

States are not permitted to conduct disenrollment counseling to discourage members from disenrolling. States may only convey to individuals that they are leaving the demonstration and the difference in benefits upon the disenrollment effective date. Disenrollment requests made by telephone to the State enrollment broker must be recorded.

If an individual submits a disenrollment request in order to disenroll from the MMP (i.e., does not disenroll from the MMP by enrolling in another plan), the State must submit a disenrollment transaction (TC 51) to CMS' MARx system. The disenrollment request must be dated when it is

initially received by the MMP or State. If the MMP receives the disenrollment request, it must forward the request to the State within 2 business days for processing.

Per §30.2.1, when someone other than the Medicare beneficiary completes a disenrollment request, he or she must:

1. Attest that he or she has the authority under State law to make the disenrollment request on behalf of the individual;
2. Attest that proof of this authorization (if any), as required by State law, that empowers the individual to effectuate a disenrollment request on behalf of the applicant is available upon request by CMS; and
3. Provide contact information.

If a passively enrolled member voluntarily disenrolls from the MMP, the State should ask if he/she wants to opt out of future passive enrollments into MMPs. If the individual indicates she/he wants to opt out of future passive enrollments, the State should submit the disenrollment transaction (TC 51), showing an MMP Opt -Out Flag data elements as “Y” = Opted out of passive enrollment in position 202. This individual may enroll in a MMP in the future by submitting a voluntary enrollment request.

40.1.1 - Request Signature and Date

When providing a written, voluntary request to disenroll, the individual must sign the disenrollment request. If the individual is unable to sign, a legal representative must sign the request (refer to §30.2.1 for more detail on who may complete enrollment and disenrollment requests). If a legal representative signs the request for the individual, then he or she must attest to having the authority under State law to do so, and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effectuate a disenrollment request on behalf of the applicant is available and can be presented upon request to CMS.

The individual and/or legal representative should write the date he/she signed the disenrollment request; however, if he/she inadvertently fails to include the date, then the date of receipt that the State places on the request form will serve as the signature date.

If a written disenrollment request is received and the signature is not included, the State may verify the individual’s intent to disenroll with a phone call and document the contact, rather than return the written request as incomplete.

40.1.2 - Effective Date of Disenrollment

The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

40.1.3 - Notice Requirements

After the member submits a request to disenroll (see Exhibit 13), the State must provide the member with a disenrollment notice within 10 calendar days of receipt of the request to disenroll.

The disenrollment notice must include an explanation of the effective date of the disenrollment (see Exhibit 14). The State may also advise the disenrolling member to ask their providers to hold Original Medicare and Medicaid claims for up to one month so that Medicare and Medicaid computer records can be updated to show that the person is no longer enrolled in the plan. This is recommended so that the Original Medicare and Medicaid claim are processed for payment and not denied.

If the State receives a disenrollment request that it must deny, the State must notify the enrollee within 10 calendar days of the receipt of the request, and must include the reason for the denial (see Exhibit 17).

A State may deny a voluntary request for disenrollment only when:

1. The request was made by someone other than the enrollee and that individual is not the enrollee's legal representative (as described in §30.2.1).
2. The request was incomplete and the required information is not provided within the required time frame (as described in §40.4.2).

Since Medicare beneficiaries have the option of disenrolling from the MMP by calling 1-800-MEDICARE or by enrolling in a Medicare health plan or Medicare prescription drug plan, the State will not always receive a request for disenrollment directly from the member and will instead learn of the disenrollment through the DTRR. If the State learns of the voluntary disenrollment from the DTRR (as opposed to a written request from the member), the State must send a written confirmation notice of the disenrollment to the member within 10 calendar days of the availability of the DTRR (see Exhibit 16).

40.2 - Required Involuntary Disenrollment

The State **must** disenroll a member in the following cases.

1. A change in residence (includes incarceration – see below) makes the individual ineligible to remain enrolled in the MMP (§40.2.1);
2. The member loses entitlement to either Medicare Part A or Part B (§40.2.2);
3. The member loses Medicaid eligibility or additional State-specific eligibility requirements (§40.2.3);
4. The member dies (§40.2.4);
5. The MMP's contract with CMS is terminated, or the MMP reduces its service area to exclude the member (§40.2.5); or
6. The individual materially misrepresents information to the MMP regarding reimbursement for third-party coverage (§40.2.6).

Incarceration – A member who is incarcerated (exception outlined in §10.2) is considered to be residing outside the MMP's service area, even if the correctional facility is located within the plan's service area. However, States must disregard past periods of incarceration that have been served to completion if those periods have not already been addressed by the State or by CMS.

Notice Requirements - In situations where the State disenrolls the member involuntarily on any basis except death or loss of Medicare entitlement, notices of the upcoming disenrollment must be sent and must meet the following requirements. All disenrollment notices must:

1. Advise the member that the State is planning to disenroll the member and explain why such action is occurring;
2. Be mailed to the member before submission of the disenrollment transaction to CMS; and
3. Include an explanation of the member's right to a hearing under the State's grievance procedures. This explanation is not required if the disenrollment is a result of contract or plan termination or service area reduction, since a hearing would not be appropriate for that type of disenrollment.

40.2.1 - Members Who Change Residence

States must disenroll members who move out of the service area or have been temporarily absent from the service area for more than 6 consecutive months. State may advise the member to contact the State for selecting a new MMP if it is available in the new service area he/she is moving to.

Individuals who are disenrolled due to a change in residence are eligible for a Medicare SEP due to both the residence change and their dual eligible status, so they are able to request enrollment in an Medicare health plan or Part D plan (either a PDP or MA-PD) for which he/she is eligible in his/her new place of residence. A member who fails to make an enrollment request is deemed to have elected Original Medicare, and will be auto-enrolled by CMS into a Medicare Prescription Drug Plan, and can access the LI NET transitional PDP during any coverage gap.

Throughout §40.2.1, it is expected that the State is determining eligibility and taking steps to research and notify members regarding changes in residence. However, States may defer these activities to the MMP. In this case, it is expected that the State and MMP are coordinated such that any communications received by either party are acted upon appropriately following the guidance below.

40.2.1.1 - General Rule

The State must disenroll a member if:

1. He/she permanently moves out of the service area;
2. The member's temporary absence from the service area exceeds 6 consecutive months;
3. The member is incarcerated and, therefore, out of area.

40.2.1.2 - Effective Date

Generally, disenrollments for **reasons 1 and 3** above are effective the first day of the calendar month after the date the member begins residing outside of the MMP service area AND after the member or his/her legal representative notifies the State that he/she has moved and no longer resides in the service area. In the case of an individual who provides advance notice of the move, the disenrollment will be the first of the month following the month in which the individual indicates he/she will be moving. In the case of incarcerated individuals, States may receive notification of the individual's out-of-area status via a DTRR; disenrollment is effective the first of the month following the State's confirmation of a current incarceration. If the member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the 1st of the month after the move), the State must submit this request to CMS (or its designee) for consideration of retroactive action.

Disenrollment for **reason 2** above is effective the first day of the calendar month after 6 months have passed.

Unless the member elects a Medicare health plan during an applicable election period, any disenrollment processed under these provisions will result in a change to enrollment in Original Medicare and CMS will auto-enroll him/her into a Medicare Prescription Drug Plan. The individual will have access to the LI NET prescription drug plan during any coverage gap.

40.2.1.3 - Researching and Acting on a Change of Address

Within 10 calendar days of receiving a notice of a change of address or an indication of possible out-of-area residency from the member, the member's legal representative, a CMS DTRR, or another source, the State must make an attempt to contact the member to confirm whether the move is permanent (may use Exhibit 30 if contacting the member in writing). The State must also document its efforts. The requirement to attempt to contact the member does not apply to a prospective enrollment for which the State receives either TRC 011 (Enrollment Accepted) or TRC100 (PBP Change Accepted as Submitted) accompanied by TRC 016 (Enrollment Accepted – Out of Area) on the same DTRR, as these represent new enrollments for which the State recently confirmed the individual's permanent residence in the plan service area. In the case of incarcerated individuals, the State is not required to contact the individual but must confirm the individual's out-of-area (e.g. incarcerated) status. States may obtain either written or verbal verification of changes in address, as long as the State applies the policy consistently among all members. When a State is notified of a current member's past period of incarceration and has confirmed that this member's period of incarceration has ended (i.e. individual is no longer incarcerated), the State must continue the individual's enrollment, unless otherwise directed by CMS.

If the State confirms an individual's current incarceration status but does not obtain the start date of the current incarceration, the State must disenroll the individual prospectively for the first of the month following the date on which the current incarceration was confirmed. If the State confirms an individual's current incarceration status as well as the start date of the current incarceration, the State must disenroll the individual for the first of the month following the start date of the incarceration. If that disenrollment effective date is outside the range of effective

dates allowed by MARx (based on the current calendar month), the State must submit the retroactive disenrollment request to the RPC (see §50.5).

The State must retain documentation from the member or member's legal representative of the notice of the change in address, including the determination of whether the member's out-of-area status is temporary or permanent.

1. If the State receives notice of a **permanent change** in address **from the member or the member's legal representative**, and the new address is outside the MMP's service area, the State must disenroll the member and provide proper notification (Exhibit 20).
2. If the State receives notice (or indication) of a potential change in address **from a source other than the member or the member's legal representative**, and the new address is outside the MMP's service area, the State may not assume the move is permanent until it has received confirmation from the member, the member's legal representative, or, for incarcerated individuals, public sources (such as a state/federal government entity or other public records).

The State must initiate disenrollment when it verifies a move is permanent or when the member has been absent from the service area for 6 months from the date the State learned of the change in address. The State must notify the member in writing of the disenrollment. If the member responded and confirmed the permanent move out of the service area, the State must send the notice (Exhibit 20) within 10 calendar days of the member's confirmation that the move is permanent. If the member failed to respond to the request for address confirmation the State must send the notice (Exhibit 19) in the first 10 days of the sixth month from the date the State learned of the change in address.

States may consider the 6 months to have begun on the date given by the member as the date that he/she will be leaving the service area. If the member did not inform the State of when he/she left the service area, the State can consider the 6 months to have begun on the date it received information regarding the member's potential change in address (e.g. DTRR, out-of-area claims).

If the member does not respond to the request for verification within the time frame given by the State, the State cannot assume the move is permanent and may not disenroll the member until 6 months have passed. The State may continue its attempts to verify address information with the member.

3. **Temporary absences** - If the State determines the change in address is temporary, the State may not initiate disenrollment until 6 months have passed from the date the State received information regarding the member's absence from the service area (or from the date the member states that his/her address changed, if that date is earlier).

40.2.1.4 - Procedures for Developing Addresses for Members Whose Mail is Returned as Undeliverable

If an address is not current, the United States Postal Service (USPS) will return any materials mailed first-class by the State or MMP as undeliverable.

In the event that any member materials are returned as undeliverable, the State must take the following steps:

1. If the USPS returns mail with a new forwarding address, forward materials to the member and advise him/her to change his/her address with the Social Security Administration.
2. If the State receives documented proof of a member residence change that is outside of the MMP service area or mail is returned without a forwarding address, follow the procedures described in §40.2.1.3.
3. If the MMP receives claims for services from providers located outside the plan service area, the MMP may choose to follow up with the provider to obtain the member's address.
4. If the State is successful in locating the member, advise him/her to update his/her records, if necessary, with the Social Security Administration by:
 - a. Calling the SSA toll-free number, 1-800-772-1213. TTY users should call 1-800-325-0778 weekdays from 7:00 a.m. to 7:00 p.m. EST;
 - b. Going to *my* Social Security at: <http://www.socialsecurity.gov/myaccount/>; or
 - c. Notifying the local SSA field office. An individual can get addresses and directions to SSA field offices from the Social Security Office Locator which is available on the Internet at: <http://www.socialsecurity.gov/locator/>.

States and MMPs are expected to continue to mail member materials to the undeliverable address, as a forwarding address may become available at a later date, and are encouraged to continue their efforts, as discussed above, to attempt to locate the member using any available resources, including State and CMS systems, and reaching out by phone or email (if these types of contact information are available) to identify new address information for the member. If a forwarding address becomes available, a State and MMP can send materials to that address as in item #1 above.

Also, when a member's residence addresses differs from CMS/SSA address information, States may report the residence address to CMS by submitting TC 76 - Residence Address Record Update via the CMS enrollment vendor. The purpose of the TC 76 is to update the State and County Code information for use in MMP service area determination and Plan's payment calculation. The residence address information is a second address; it does not update the permanent address information in CMS system, which is updated by notification from SSA or Railroad Retirement Board (RRB). Therefore, States should refer the beneficiary to SSA (or RRB if the individual is an RRB beneficiary) for a permanent address change. The detailed instructions and record layout of TC 76 are outlined in the MARx Redesign & Modernization Handbook at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/downloads/MARx_RM_HANDBOOK_Final_2010_12_16.pdf.

40.2.1.5 - Notice Requirements

1. **State or MMP notified of out-of-area permanent move** - When the State or MMP receives notice of a permanent change in address from the member or the member's legal

representative, the State must provide notification of disenrollment to the member. This notice to the member, as well as the disenrollment transaction with disenrollment reason code 92 (these codes are provided in the CMS Plan Communication User Guide (PCUG)) to CMS, must be sent within 10 calendar days of the State or MMP's learning of the permanent move.

2. **Out of area for 6 months** - When the member has been absent from the service area for 6 months after the date the State or MMP learned of the change in address from a source other than the member or the member's legal representative (or the date the member stated that his address changed, if that date is earlier), the State must provide notification of the upcoming disenrollment to the member. States are encouraged to follow up with members and to issue interim notices prior to the expiration of the 6 month period.

The notice of disenrollment must be provided within the first 10 calendar days of the sixth month. The transaction to CMS must be sent within 3 business days following the disenrollment effective date. CMS strongly encourages that States send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MMP services.

EXAMPLE

State receives a DTRR on January 20 indicating an "out of area" State and County Code. The 6-month period ends on July 20. The State sends a notice to the member to determine if a residence change has occurred (exhibit 30) within 10 calendar days of receipt of the DTRR and does not receive any response from the member indicating this information is incorrect. Therefore, the State must proceed with the disenrollment, effective August 1. The State sends a notice of disenrollment (exhibit 19) to the member during the first 10 calendar days of July notifying the member that he/she will be disenrolled effective August 1. The transaction to CMS must be sent no later than 3 business days following July 31.

40.2.2 - Loss of Medicare Part A or Part B

An individual cannot remain a member in an MMP if he/she is no longer entitled to both Medicare Part A and Part B benefits. The State will be notified by CMS via the DTRR that entitlement to either Medicare Part A and/or Part B has ended, and CMS will make the disenrollment effective the first day of the month following the last month of entitlement to either Medicare Part A or Part B benefits (whichever occurred first).

Notice Requirements – States must provide notice when the disenrollment is due to the loss of entitlement to either Medicare Part A or Part B (see Exhibit 24) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §50.3.1.

40.2.3 – Loss of Medicaid Eligibility or Additional State-Specific Eligibility

An individual cannot remain a member in an MMP if he/she is no longer eligible for Medicaid benefits or no longer meets other criteria outlined in the Memorandum of Understanding, the three-way contract or Appendix 5. Generally, an individual who loses Medicaid eligibility or

loses eligibility based on State-specific requirements is disenrolled from the MMP on the first of the month following the State's notification to the MMP of the individual's loss of eligibility. This applies even in cases of retroactive Medicaid termination. However, for the loss of Medicaid eligibility only, MMPs may voluntarily elect to offer a period of deemed continued eligibility to their members, as outlined in §40.2.3.2.

40.2.3.1 – General Disenrollment Procedures due to Loss of Medicaid Eligibility or Additional State-Specific Eligibility

An MMP must continue to offer the full continuum of MMP benefits through the end of the calendar month in which the State notifies the MMP of the loss of Medicaid eligibility or loss of State-specific requirements. The beneficiary must also be notified of the involuntary disenrollment following the notice requirements below.

An individual who was passively enrolled into the MMP and subsequently loses eligibility and is disenrolled may not again be passively enrolled into a MMP upon regaining Medicaid or State-specific eligibility in the same calendar year. States are limited to only one passive enrollment of the individual in a calendar year, following parameters outlined in §30.1.4.

Notice Requirements – States are to follow normal protocols regarding notifying individuals of the loss of Medicaid eligibility. With regard to involuntary disenrollment from the MMP, the State must provide each member a written notice regarding the loss of Medicaid or State-specific eligibility at least 10 calendar days prior to the disenrollment effective date. The notice must include information regarding the disenrollment effective date and the Medicare SEP for which such individuals are eligible (see Exhibit 21 and §30.4.4, item #5 of Chapter 2 of the Medicare Managed Care Manual). States must submit a disenrollment transaction to CMS no later than 3 business days following the date Medicaid or other State-specific eligibility requirement ended. States can attempt to cancel the disenrollment by submitting TC 81-Cancellation Disenrollment transaction if the beneficiary's Medicaid status has been restored before the disenrollment effective date. If unsuccessful in cancelling the disenrollment, the State must submit the case to the CMS Retroactive Processing Contractor (RPC).

If a determination regarding the loss of Medicaid or State-specific eligibility occurs within the last 10 days of the month, the State must provide the affected member a written notice of disenrollment regarding the loss of eligibility within 3 business days of its determination. In this situation, the State is also strongly encouraged to call these affected members as soon as possible (within 1-3 calendar days) to provide the disenrollment effective date, to explain that the MMP will no longer cover services as of that date and to convey that the individual will have Original Medicare. For individuals who retain LIS status, CMS will auto-enroll him/her into a Medicare Prescription Drug Plan. The individual will have access to the LI NET prescription drug plan during any coverage gap.

40.2.3.2 – Optional Period of Deemed Continued Eligibility Due to Loss of Medicaid Eligibility

An MMP may choose to provide a two-month period of deemed continued eligibility for individuals who lose Medicaid eligibility, as long as the individual can reasonably be expected to regain Medicaid eligibility within (2) months. If the MMP decides to offer this "grace period," it must apply the criteria consistently to all members of the plan and fully inform the State and its

members of this policy. The optional period of deemed continued eligibility starts on the first of the month following the month in which the MMP is notified of the loss of Medicaid eligibility by the State, even in cases of retroactive Medicaid termination.

Only members who are reasonably expected to regain eligibility in the 2-month timeframe are eligible for the grace period. If the MMP enrollee does not re-qualify within the plan's period of deemed continued eligibility, he/she must be involuntarily disenrolled from the plan, with proper notice as outlined below, at the end of this period. Individuals who retain LIS status will be put in Original Medicare and auto-enrolled into a Medicare Prescription Drug Plan by CMS.

Any plan that elects to provide this grace period must continue to offer the full continuum of MMP benefits as outlined in its Plan Benefit Package (PBP), even if the State is not providing the Medicaid capitation payment to the MMP.

Notice Requirements -

For individuals enrolled in MMPs which offer the period of deemed continued eligibility, the State must provide each affected individual a written notice regarding the loss of eligibility. In addition, the MMP must provide the member a written notice within 10 calendar days of learning of the loss of Medicaid eligibility. This notice must provide the member an opportunity to prove that he/she is still eligible to be in the plan. In addition, the notice must include information regarding the period of deemed continued eligibility, including its duration, a complete description of the Medicare SEP for which individuals are eligible (see §30.4.4, item #5 of Chapter 2 of the Medicare Managed Care Manual), the consequences of not regaining Medicaid eligibility within the period of deemed continued eligibility and the effective disenrollment date (see Exhibit 22). Organizations are encouraged to work with the individual and the State to assist the individual with regaining Medicaid eligibility during the period of deemed continued eligibility.

Should the individual not regain eligibility to Medicaid within the period of deemed continued eligibility, the State must provide each member a written notice regarding the involuntary disenrollment from the MMP/demonstration due to loss of eligibility. The disenrollment notice to the individual and the transaction to CMS must be sent within 3 business days following the last day of the period of deemed continued eligibility. The notice must include information regarding the disenrollment effective date and the Medicare SEP for which such individuals are eligible (see Exhibit 21).

40.2.4 - Death

CMS will disenroll a member from an MMP upon his/her death and CMS will notify the State and MMP that the member has died via the DTRR. This disenrollment is effective the first day of the calendar month following the month of death. Before receiving a death notification from CMS via the DTRR, States may, at their discretion, make note of the reported death in internal State or MMP systems in order to suppress member notices. States may report death information to Social Security so that the Death Master Record is updated. This action will also update CMS systems and generate the DTRR.

Notice Requirements – Following receipt of a decedent's death information, the State is required to send a notice to the member's estate (see Exhibit 23) so that any erroneous

disenrollments can be corrected as soon as possible. If the disenrollment occurred due to erroneous loss of Medicaid eligibility, see §50.3 and §50.3.3 for restoring MMP enrollment. In cases of erroneous disenrollment and notification, see §50.3.1.

40.2.5 - Terminations/Nonrenewals

The State must disenroll a member from an MMP if the MMP's contract with CMS is terminated or if the MMP is discontinued or reduces its service area to exclude the member.

A member who is disenrolled under these provisions is eligible for a Medicare SEP due to both the termination/non-renewal and their dual eligible status, so they are able to request enrollment in an Medicare health or Part D plan (PDP or MA-PD) for which he/she is eligible. A member who fails to make an enrollment request is deemed to have elected Original Medicare, and will be auto-enrolled by CMS into a Medicare Prescription Drug Plan, and can access the LI NET transitional PDP during any coverage gap.

Notice Requirements - The State must give each Medicare member a written notice of the effective date of the termination or service area reduction, and include a description of alternatives for obtaining benefits under the Medicare program. The State may also include the ability for affected individuals to enroll in another MMP, if available.

40.2.6 – Material Misrepresentation Regarding Third-Party Reimbursement

If an MMP enrollee intentionally withholds or falsifies information about third-party reimbursement coverage, CMS requires that the individual be disenrolled from the MMP. Involuntary disenrollment for this reason requires CMS approval. The State must submit any information it has regarding the claim of material misrepresentation to its Contract Review Team for review. Disenrollment for materials misrepresentation of this information is effective the first of the month following the month in which the member is notified of the disenrollment, or as CMS specifies.

40.3 - Optional Involuntary Disenrollments

A State may request CMS approval to disenroll a member from a MMP if:

- The member engages in disruptive behavior; or
- The member provides fraudulent information on an enrollment request, or if the member permits abuse of an enrollment card in the MMP.

Notice Requirements - In situations where the State disenrolls the member involuntarily for any of the reasons addressed above, the State must send notice of the upcoming disenrollment that meets the following requirements:

- Advises the member that the State is planning to disenroll the member and why such action is occurring;
- Provides the effective date of termination; and

- Includes an explanation of the member's right to a hearing under the State's grievance procedures.

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

40.3.1 - Disruptive Behavior

In conformance with Medicaid requirements in 42 CFR 438 and demonstration requirements in this guidance, the MMP **may** request approval from CMS and the State to disenroll a member if his/her behavior is disruptive to the extent that his/her continued enrollment in the MMP substantially impairs the MMP's ability to arrange for or provide services to either that particular member or other members of the plan. However, CMS and the State may approve an MMP request to disenroll a member for disruptive behavior only after the MMP has met the requirements of this section. The State may not approve an MMP request to disenroll a member because he/she exercises the option to make treatment decisions with which the MMP disagrees, including the option of declining treatment and/or diagnostic testing. A request to disenroll a member because he/she chooses not to comply with any treatment regimen developed by the MMP or any health care professionals associated with the MMP will not be approved.

Before requesting the State's involvement and CMS' approval of disenrollment for disruptive behavior, the MMP, and the State as appropriate, must make a serious effort to resolve the problems presented by the member. Such efforts to find resolution must include providing reasonable accommodations, as determined by the State or CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. The MMP and/or the State as appropriate, must also inform the individual of his or her right to use the MMP's, and the State's, as appropriate, grievance procedures.

The MMP must submit documentation of the specific case to the State for review. If the State agrees with the request for involuntary disenrollment, the State must submit this documentation to CMS with a recommendation for approval. This includes documentation:

- Of the disruptive behavior;
- Of the MMP's, and State's if applicable, serious efforts to resolve the problem with the individual;
- Of the MMP's, and State's if applicable, efforts to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act;
- Establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Describing any extenuating circumstances;

- That the State or MMP provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Notice Requirements); and
- That the State or MMP then provided written notice of its intent to request involuntary disenrollment (see Notice Requirements).
- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the MMP's ability to arrange for or provide services to the individual or other members of the MMP;
- Member information, including age, diagnosis, mental status, functional status, a description of his or her social support systems and any other relevant information;
- Statements from providers describing their experiences with the member; and
- Any information provided by the member.

Once the State reviews the request, it may either disapprove it, or forward the request and all related documentation to CMS with a recommendation for approval. CMS will review this documentation and consult with staff with appropriate clinical or medical expertise and decide whether the State may involuntarily disenroll the member from the MMP. Such review will include any documentation or information provided either by the MMP, the State, and the member (information provided by the member must be forwarded by the State to CMS). CMS will make the decision within 20 business days after receipt of all the information required to complete its review. CMS will notify the State within 5 (five) business days after making its decision.

The disenrollment is effective the first day of the calendar month after the month in which the State gives the member a written notice of the disenrollment, or as provided by CMS. Any disenrollment processed under these provisions will always result in a change of enrollment to Original Medicare, and auto-enrollment by CMS into a Medicare Prescription Drug Plan, including access to the LI NET transitional PDP during any coverage gap.

If the request for involuntary disenrollment for disruptive behavior is approved:

- CMS and the State may require the MMP to provide reasonable accommodations to the individual in such exceptional circumstances that the State and CMS deems necessary.
- The MMP may request that the State consider prohibiting re-enrollment in the MMP. If this is not requested, and the individual is disenrolled due to disruptive behavior, the individual may re-enroll into the MMP in the future.

Notice Requirements

The disenrollment for disruptive behavior process requires 3 written notices:

- **Advance notice** to inform the member that the consequences of continued disruptive behavior will be disenrollment;
- **Notice of intent** to request the State and CMS' permission to disenroll the member; and

- **A planned action notice** advising that CMS and the State have approved the MMP's request.

Advance Notice

Prior to forwarding an involuntary disenrollment request to the State, the MMP must provide the member with written notice describing the behavior it has identified as disruptive and how it has impacted the MMP's ability to arrange for or provide services to the member or to other members of the plan. The notice must explain that his/her continued behavior may result in involuntary disenrollment and that cessation of the undesirable behavior may prevent this action. The MMP must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS and the State.

NOTE: If the disruptive behavior ceases after the member receives notice and then later resumes, the MMP must begin the process again. This includes sending another advance notice.

Notice of Intent

If the member's disruptive behavior continues despite the MMP's efforts, the MMP must notify him/her of its intent to request the State and CMS' permission to disenroll him/her for disruptive behavior. This notice must also advise the member of his/her right to use the MMP's, and the State's if appropriate, grievance procedures and to submit any information or explanation. The MMP must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS and the State.

Planned Action Notice

If the State recommends and CMS approves the request to disenroll a member for disruptive behavior, the State must provide the member with a written notice that contains, in addition to the notice requirements outlined in §40.3, a statement that this action was approved by the State and CMS and meets the requirements for disenrollment due to disruptive behavior described above. The State may only provide the member with this required notice after CMS notifies the State of its approval of the request.

The State can submit the disenrollment transaction to CMS only after providing the notice of disenrollment (Planned Action Notice) to the individual. The disenrollment is effective the first day of the calendar month after the month in which the State gives the member a written notice of the disenrollment, or as provided by CMS and the State.

40.3.2 - Fraud and Abuse

A State **may** request CMS approval to cancel the enrollment of a member who knowingly provides on the enrollment form or other enrollment mechanism fraudulent information that materially affects the determination of an individual's eligibility to enroll in the plan. The MMP may also request to disenroll a member who intentionally permits others to use his/her enrollment card to obtain services or supplies from the plan or any authorized plan provider.

With such a disenrollment request, the MMP must immediately notify the State and CMS so the HHS Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse. If approved by CMS and the State, and if appropriate, the disenrollment is effective the

first day of the calendar month after the month in which the MMP gives the member the written notice. Any disenrollment processed under these provisions will always result in a change of enrollment to Original Medicare, and auto-enrollment by CMS into a Medicare Prescription Drug Plan, as well as access the LI NET transitional PDP during any coverage gap.

Notice Requirements - The State must give the member a written notice of the disenrollment that contains the information required at §40.3.

40.4 - Processing Disenrollments

40.4.1 - Voluntary Disenrollments

After receipt of a completed disenrollment request from a member, the State is responsible for submitting the disenrollment transaction (TC 51) to CMS in a timely, accurate fashion. Such transmissions must occur within 7 calendar days of receipt of the completed disenrollment request, in order to ensure the correct effective date.

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

- Recording the date on which each disenrollment request is received (regardless of whether the request is complete at the time it is received by the State or the MMP);
- Recording the date on which supporting documents for disenrollment requests are received;
- Processing disenrollment requests in chronological order by date of receipt of completed disenrollment requests;
- Transmitting disenrollment information to CMS within 7 calendar days of the receipt of the completed disenrollment request; and
- One of the two following items based on the receipt of the voluntary disenrollment request:
 - Notifying the member in writing within 10 calendar days after receiving the member's written disenrollment request, to acknowledge receipt of the completed disenrollment request, and to provide the effective date (see Exhibit 14). States are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the DTRR; or
 - Notifying the member in writing to confirm the effective date of disenrollment within 10 calendar days of the availability of the DTRR for cases in which the voluntary disenrollment is effectuated by enrollment into another Medicare plan or MMP or by 1-800-MEDICARE (see Exhibit 16).

If the individual request to opt out from future passive enrollments into an MMP, and/or autoenrollment into a Medicare Prescription Drug Plan, the State must take the following steps when it submits the disenrollment transaction (TC 51) to CMS' MARx system:

- For opting out of future passive enrollments, submit also the opt out transaction (TC 83).
- For opting out of future Medicare autoenrollments into a PDP, refer the individual to 1-800-MEDICARE..

40.4.2 – When the Disenrollment Request is Incomplete

When the disenrollment request is incomplete, the State must document all efforts to obtain additional documentation to complete the disenrollment request and have an audit trail to document why additional documentation was needed before the request could be considered complete. The State must make this determination, and within 10 calendar days of receipt of the disenrollment request, must notify the individual that additional information is needed.

If a written disenrollment request is submitted and the signature is not included, the State may verify with the individual with a phone call and document the contact, rather than return the written request as incomplete.

Additional documentation to make the request complete must be received by the end of the month in which the disenrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).

40.4.3 - Involuntary Disenrollments

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

The State must maintain a system for controlling and processing involuntary disenrollments. This includes:

- Maintaining documentation leading to the decision to involuntarily disenroll the member; and
- Notifying the member in writing of the upcoming involuntary disenrollment, including providing information on grievance rights, for all involuntary disenrollments, except disenrollments due to death and loss of Medicare Parts A and/or B.

In addition, CMS requires States to send confirmation of involuntary disenrollment to ensure the member discontinues use of MMP services after the disenrollment date.

40.5 - Disenrollments Not Legally Valid

When a disenrollment is not legally valid, a reinstatement action may be necessary (refer to §50.3). In addition, the reinstatement may result in a retroactive disenrollment from another plan. Since optional involuntary disenrollments (as stated in §40.3) are considered legal and valid disenrollments, individuals would not qualify for reinstatements in these cases.

A voluntary disenrollment that is not complete, as defined in Appendix 3, is not legally valid. In addition, there are instances in which a disenrollment that appears to be complete can turn out to

be legally invalid. For example, automatic disenrollments due to an erroneous death indicator or an erroneous loss of Medicare Part A or Part B indicator are not legally valid.

CMS and the State do not regard a voluntary disenrollment as complete if the member or his/her legal representative did not intend to disenroll from the MMP. If there is evidence that the member did not intend to disenroll from the MMP, the State should submit a reinstatement request to CMS (or its designee). Evidence that a member did not intend to disenroll may include:

- A disenrollment request signed by the member when a legal representative should be signing for the member; or
- Request by the member for cancellation of disenrollment before the effective date (refer to §50.2 for procedures for processing cancellations).

CMS and the State believe that a member's deliberate attempt to disenroll from a plan (e.g., sending a written request for disenrollment to the MMP, or calling 1-800-MEDICARE) implies intent to disenroll. Therefore, unless other factors indicate that this disenrollment is not valid, what appears to be a deliberate, member-initiated disenrollment should be considered valid.

50 - Post-Enrollment Activities

Post-enrollment activities begin after the State receives the enrollment request from the individual (e.g., cancellations, opt-out, 4Rx, or other update transactions) or an individual has been notified of passive enrollment and lasts until a decision is made with respect to an individual's enrollment request. Due to the nature of post-enrollment activities, flexibility is available for States and MMPs to perform certain tasks, such as sending notices. It is imperative that States and MMPs work together to determine which entity is performing which function prior to permitting any beneficiary to enroll in a given MMP.

50.1 - Multiple Transactions

Multiple transactions occur when CMS receives more than one enrollment request for the same individual with the same effective date in the same reporting period. An individual may not be enrolled in more than one MA, cost plan, PDP or MMP at any given time (however, an individual may be simultaneously enrolled in a cost plan and a separate PDP plan or in certain MA plan types and a separate PDP plan).

Generally, the last enrollment request made during an enrollment period will be accepted as the plan into which the individual intends to enroll. CMS systems, determines this using the application date on the enrollment transaction. When there are two or more enrollment transactions with the same application date and effective date values, the first transaction successfully processed by CMS will take effect.

Given the use of the application date to identify the beneficiary's plan enrollment choice, retroactive enrollments will not be processed for multiple transactions that reject because the enrollment requests have the same application date.

In the event a rejection for multiple voluntary transactions (or a voluntary and passive enrollment) is reported to the State, the State may contact the individual. If the individual wishes to enroll in the MMP that received the multiple transaction reject, the State must verify and document the individual's choice and submit a request with appropriate evidence to CMS' Retroactive Processing Contractor for review.

50.2 - Cancellations

Cancellations may be necessary in cases of mistaken enrollment made by an individual, mistaken disenrollment made by a member and/or an individual opts-out of passive enrollment into the MMP. Unless otherwise directed by CMS, an individual may cancel his/her enrollment (or disenrollment) request by contacting the State **prior** to the effective date of the enrollment (or disenrollment).

If a cancellation occurs after CMS records have changed, retroactive correction actions may be necessary. Refer to §§ 50.3 and 50.5.

The State must accept and document any verbal requests for cancellation of a voluntary enrollment and disenrollment as well as requests for opt out of passive enrollment into the MMP. The State has the right to request that a cancellation be in writing for their records, however they must accept and process the verbal request without delay. The State may not delay processing a cancellation made verbally.

For passively enrolled individuals as described in §30.1.4 of this guidance, an individual may opt out of the passive enrollment into the MMP by telephone. The State may not require that the beneficiary make the request in writing. For processing opt out requests, see §30.1.4 E.

Valid cancellation and opt out requests made in writing must be honored. Refer to §30.2.1 for further detail on who can make such requests.

50.2.1 - Cancellation of Voluntary Enrollment

An individual's voluntary enrollment request can be cancelled only if the cancellation request is received by the State **prior** to the effective date of the enrollment via phone, in writing or in person, unless otherwise directed by CMS. If a cancellation request is received by the MMP, the MMP should notify the individual that they have to contact the State in order to cancel their enrollment.

If the enrollment transaction has not been submitted, the State should not transmit the voluntary enrollment to CMS. If, however, the State had already transmitted the voluntary enrollment by the time it receives the valid request for cancellation, it must submit a cancellation transaction (TC 82) to CMS to cancel the now void enrollment transaction. In the event the cancellation transaction fails or the State has other difficulty, the State must submit the request to cancel the action to CMS' Retroactive Processing Contractor (RPC) in order to cancel the enrollment.

When canceling an enrollment transaction, the State must send a letter to the individual that states that the cancellation is being processed (see Exhibit 11). This notice should be sent within

10 calendar days of receipt of the cancellation request. This notice must inform the member that the cancellation should result in the individual remaining enrolled in the health and/or drug plan in which he/she was originally enrolled, so long as the individual remains eligible to be enrolled in that health plan.

The State may submit a transaction to cancel only those enrollment transactions it submitted. To cancel an enrollment, the State must submit an enrollment cancellation transaction (TC 82) with an effective date equal to the effective date of the enrollment being cancelled.

If the member's request for cancellation occurs **after** the effective date of the enrollment, the cancellation generally cannot be processed. The State must inform the beneficiary that he/she is a member of the MMP. If he/she wants to return to his/her former Medicare plan or enroll in another Medicare plan, he/she will have to submit an enrollment request to that plan for a prospective enrollment effective date. This includes MMP changes within the same State or plan changes within the same MMP.

If the member wants to return to Original Medicare instead of returning to his/her previous Medicare plan, the member can contact the State or 1-800-MEDICARE to disenroll from the MMP as described in §40.1 of this guidance. The member must be informed that he/she will be a member of the plan as of the given effective date (as prescribed in §20.1), and must be instructed to continue to use plan services until the disenrollment goes into effect. Furthermore, the individual must be informed that he/she should enroll into a Part D plan to receive Part D drug coverage; otherwise he/she will be automatically enrolled into a Medicare Prescription Drug Plan and have access to the LI NET transitional PDP during any coverage gap (unless the beneficiary has opted-out of Part D).

Regardless of the State personnel receiving the request, the State must document all contact with the beneficiary associated with the cancellation request.

When an MMP or State receives notification of an individual's reinstatement, because the cancellation from enrollment into another plan is processed, the State has 10 calendar days to send the individual a notice informing him/her of the reinstatement (Exhibit 27).

For cancellation procedures for passive enrollments, please see §30.1.4.E.

50.2.2 - Cancellation of Voluntary Disenrollment

An individual's voluntary disenrollment request can be cancelled only if the request to do so is made **prior** to the effective date of the disenrollment, unless otherwise directed jointly by the State and CMS. If a cancellation request is received by the MMP, the MMP should notify the individual that they have to contact the State in order to cancel their disenrollment.

If the State delegates the submission of the voluntary disenrollment transaction to the MMP, the State must also delegate the submission of the cancellation of voluntary disenrollment to the MMP. Likewise, if the State submits the enrollment transaction for a given beneficiary, the State must also submit the cancellation. This is because CMS' MARx system will only accept a cancellation from the entity that submitted the transaction being cancelled.

If the disenrollment transaction has not been submitted, the State should not transmit the disenrollment to CMS. If, however, the State has already transmitted the disenrollment by the time it receives the valid request for cancellation, it must submit a cancellation of disenrollment transaction (TC 81) to CMS. To cancel the now-void disenrollment transaction, the State must submit the cancellation transaction with the effective date equal to the effective date of the disenrollment being cancelled. In the event the State has submitted the disenrollment and is unable to submit a cancellation of disenrollment transaction (TC 81), or has other difficulty, the State should submit the request to cancel the action to the RPC in order to cancel the disenrollment.

The State must send a letter to the member that states that the cancellation of the disenrollment request is being processed and instructs the member to continue using MMP plan services (see Exhibit 18). This notice should be sent within 10 calendar days of receipt of the cancellation request. If the request to cancel the transaction is received and processed by 1-800-MEDICARE, the State should send this notice within 10 calendar days of receipt of a TRC 288.

Within 10 calendar days of receipt of confirmation of the individual's reinstatement (i.e., the cancellation processed and the individual remains a member of the MMP), the State must send the member written notification of the reinstatement (Exhibit 27).

If the member's request for cancellation occurs **after** the effective date of the disenrollment, the cancellation cannot be processed. In some cases, reinstatement due to a mistaken disenrollment will be allowed, as outlined in §50.3.2. If a reinstatement is not allowed, the State should tell the member that he/she will remain enrolled in Original Medicare and that he/she will be automatically enrolled into a Medicare Prescription Drug Plan and have access to the LI NET transitional PDP during any coverage gap (unless the beneficiary has opted-out of Part D). If the individual wants to enroll in a MMP, he/she will have to submit an enrollment request to the State for a prospective enrollment effective date.

50.2.3 – When A Cancellation Transaction is Rejected by CMS Systems (Transaction Reply Code (TRC) 284)

When a State receives a TRC 284 (Cancellation Rejected), while the cancellation remains valid, it could not be processed automatically in CMS' systems. The State must investigate the circumstances behind the rejection. If the rejection was due to incorrect data on the transaction, the State must correct the data and resubmit it to CMS. If the rejection was not due to such an error, and the request to cancel is valid, the State must promptly submit the request to the CMS' Retroactive Processing Contractor (RPC) for resolution.

50.3 - Reinstatements

Reinstatements may be necessary if a disenrollment is not legally valid (refer to §40.5 to determine whether a disenrollment is not legally valid). The most common reasons warranting reinstatements are expected to be:

1. Disenrollment due to erroneous death indicator;
2. Disenrollment due to erroneous loss of Medicare Part A or Part B indicator;

3. Disenrollment due to erroneous loss of Medicaid eligibility or a State-specific eligibility requirement;
4. Reinstatements based on beneficiary cancellation of new enrollment in another plan; and
5. MMP, CMS, or State error.

When a disenrolled individual contacts the MMP or State to indicate that he/she was disenrolled due to items 1, 2 or 5 listed above, and states that he/she wants to remain a member of the MMP, the State must instruct the member in writing to continue to use MMP services (refer to Exhibits 23, 24 and 25). When a disenrolled individual contacts the State about item 3 (reinstatement based on erroneous loss of Medicaid or State-specific eligibility requirement), the State must verify that the individual is eligible to remain enrolled in the MMP. If there is any possibility that the State's records are erroneous and the individual could still be eligible, the State must instruct the member in writing to continue to use MMP services. If the MMP receives the request, they must forward it to the State within 2 business days. The State must send the notice within 10 calendar days of the individual's contact with the MMP or State to report the erroneous disenrollment. Accordingly, plan systems should indicate active membership as of the date the MMP or State instructs the individual to continue to use plan services.

When a disenrolled individual contacts the State about item 4 (reinstatement based on enrollment cancellation), the State should follow the guidance in §50.3.2 below pertaining to those unique situations.

Within 10 calendar days of receipt of DTRR confirmation of the individual's reinstatement (TRC 713 or 287), the MMP must send the member notification of the reinstatement (Exhibit 27).

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

A member must be reinstated if he/she was disenrolled due to an erroneous death indicator or erroneous loss of Part A or Part B, since he/she continues to be eligible. States have the option of sending notification of disenrollment due to death or loss of Part A or B to the individual. CMS strongly suggests that States send these notices, to ensure any erroneous disenrollments are corrected as soon as possible (See Exhibit 24). Although States may request that individuals provide evidence of Medicare entitlement by a particular date, erroneous disenrollments must be corrected and the corresponding reinstatements processed, regardless of the date on which the individual disputes the erroneous disenrollment or provides evidence of Medicare entitlement.

To request consideration for reinstatement following disenrollment due to erroneous loss of Medicare Part A or Part B, the State must submit to CMS (or its designee) a copy of the letter to the member informing him/her to continue to use MMP services until the issue is resolved. The State must indicate the date the letter was sent (See Exhibit 24). Within 10 calendar days of receipt of DTRR confirmation of the individual's reinstatement (TRC 713 or 287), the State must send the member notification of the reinstatement (Exhibit 27).

CMS will attempt to automatically reinstate individuals to the MMP from which they were auto-disenrolled by an erroneous report of date of death, if there is a subsequent date of death correction that impacts the plan enrollment. If this action fails, the State may submit to CMS (or its designee) a request for manual correction, including a copy of the letter to the member informing him/her to continue to use MMP services until the issue is resolved. Within 10 calendar days of receipt of DTRR confirmation of the individual's reinstatement (TRC 287), the State must send the member notification of the reinstatement (Exhibit 27).

50.3.2 - Reinstatements Based on Beneficiary Cancellation of New Enrollment

As stated in §40.5, deliberate member-initiated disenrollments imply intent to disenroll. Therefore, reinstatements into an MMP generally will not be allowed if the member deliberately initiated a disenrollment. An exception is made for those members who were automatically disenrolled from the MMP because they enrolled in another plan but subsequently cancelled the enrollment in the new plan before the effective date.

In this situation, the individual cancels the enrollment into the new plan, as described in §50.2.1. Upon successful cancellation of enrollment in the new plan, CMS systems will attempt to automatically reinstate enrollment in the previous plan. Because this process is automatic, it is generally not necessary to request reinstatement via the RPC. Within 10 calendar days of receipt of DTRR confirmation of the individual's reinstatement (TRC 713 or 287), the State must send the member notification of the reinstatement (Exhibit 27).

In cases where the valid request to cancel enrollment into a new MMP or Medicare plan is not processed timely or CMS systems cannot complete the request, a request must be sent to the RPC to cancel the enrollment. The only entity that can submit the request to the RPC is the Medicare plan that submitted the enrollment to CMS, or the State in the case of an enrollment cancellation from another MMP. This request will require complete documentation, including evidence that the beneficiary requested cancellation of enrollment in the new plan within required timeframes.

If the previous Medicare plan becomes aware of an unsuccessful reinstatement into its plan, it may contact a CMS Account Manager to investigate the issue with the State. Likewise, if a State becomes aware of an unsuccessful reinstatement into a MMP due to a cancellation from a Medicare plan, it may contact its Contract Review Team to investigate the issue with the Medicare plan. If the State becomes aware of an unsuccessful reinstatement into a MMP due to a cancellation from another MMP within the State (i.e., the cancellation was successful but the individual is not reinstated into the previous MMP), it may contact the RPC for assistance.

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

50.3.3 - Reinstatements Due to Mistaken Disenrollment Due to State or MMP Error

A disenrollment that is not the result of either a valid voluntary request or a valid circumstance that requires involuntary disenrollment is erroneous. When an erroneous disenrollment is the result of MMP or State error, the MMP or State must reinstate the individuals who were disenrolled.

In the case of an erroneous disenrollment that is a result of an error on the part of the MMP (if State delegates to MMP, or MMP inadvertently submitted a transaction) or State, the MMP or State must restore the enrollment in its records. Additionally, the MMP or State must cancel the disenrollment action from CMS's records, if the MMP or State had previously submitted such a transaction to CMS. MMPs or States must use the disenrollment cancellation function to complete this action for effective dates within the parameters that CMS systems allow for such corrections. For effective dates outside these parameters, the State must submit the request to the MMP's Contract Review Team with full documentation and explanation for review. If approved, the State may manually complete appropriate corrections to CMS systems. The Contract Review Team will provide instructions as to how to complete that activity.

Within 10 days of receipt of DTRR confirmation of the individual's reinstatement (TRC 713 or 287), the State must send the member notification of the reinstatement (Exhibit 27).

50.4 - Retroactive Enrollments

If an individual has fulfilled all enrollment requirements, but the State or CMS is unable to process the enrollment in CMS systems for the required effective date (as outlined in §30.5), the CMS' Retroactive Processing Contractor (RPC) may process a retroactive enrollment.

When a valid request for enrollment has not been communicated to CMS successfully within the required timeframes in this guidance and the Current Calendar Month transaction submission timeframe, the State submitting the transaction is required to submit the appropriate documentation and explanation to the RPC for manual review and potential action. The request for a retroactive enrollment entry should be made within the timeframes provided in the Standard Operating Procedures for the RPC. For these cases, the following documentation must be submitted to the RPC:

For voluntary enrollments:

- A copy of signed, completed enrollment form (the form must have been signed by the individual (or authorized representative) and received by the State prior to the requested effective date of coverage, in order to effectuate the requested effective date of coverage); or
- A copy of the enrollment request record (the enrollment request record must show that the enrollment request was made and received by the State prior to the requested effective date of coverage).

The retroactive enrollment request may be denied if CMS determines that the State did not notify the member that he/she must use MMP plan services beginning on the effective date of enrollment and during the period of retroactivity.

If retroactive enrollment is necessary due to MMP, CMS, or State error, the State must provide a clear and detailed explanation of the error, including why the retroactive action is necessary to correct the error, as well as the information described above as it applies to either voluntary or passive enrollment requests. The explanation must include clear information regarding what the MMP or State has communicated to the affected individual throughout the period in question. The MMP or State must also include any relevant information or documentation supporting the requested correction. Such information could include a copy of the enrollment request form (or clear evidence of the use of another enrollment mechanism) and evidence of notices sent to the individual related to or caused by the error.

Special note regarding Regional Office Casework actions

When a State is directed by CMS, such as via an RO caseworker, to submit a retroactive enrollment or disenrollment request to resolve a complaint, the State must provide the following two (2) items as documentation to the RPC:

- A screen print from the Complaint Tracking Module (CTM) or other documentation showing the CMS RO decision and direction to submit the request to the RPC; and
- A copy of the enrollment or disenrollment request, if one is available. Occasionally, due to the nature of casework, this item may not be available. When that occurs, the State should submit a brief statement of explanation for the missing documentation. If the beneficiary was passively enrolled, the State should submit a brief statement explaining the basis of its request, and provide any available supporting documentation.

Note: State must obtain prior CMS approval before proceeding to retroactively enroll or disenroll the member.

50.5 - Retroactive Disenrollments

If a valid request for disenrollment was properly made, but not processed or acted upon (as outlined in the following paragraph) by the State or MMP, which includes not only system error, but MMP or State error (see Appendix 3 for a definition of “system error” and “State or MMP error”), the CMS’ Retroactive Processing Contractor (RPC) may grant a retroactive disenrollment. The RPC may also process a retroactive disenrollment if the reason for the disenrollment is related to a permanent move out of the plan service area (as outlined in §40.2.1.2), a contract violation (as outlined in 42 CFR 422.62(b)(3)) or other limited exceptional conditions established by CMS (e.g. fraudulent enrollment or misleading marketing practices).

When a valid request for disenrollment has not been communicated to CMS successfully within the required timeframes in this guidance and the Current Calendar Month transaction submission timeframe, the State is required to submit the appropriate documentation to CMS (or its designee) for manual review and potential action. Retroactive disenrollment requests can be submitted to CMS (or its designee) by the State. Requests from a State must include a copy or other record of the disenrollment request made by the individual, as well as an explanation as to why the disenrollment was not processed correctly. States must submit retroactive disenrollment requests to the RPC within the timeframes provided in the RPC Standard Operating Procedures. Once processed, CMS will retrieve any capitation payment for the retroactive period.

A retroactive disenrollment request must be submitted by the State to CMS (or its designee) in cases in which the State has not properly processed a required involuntary disenrollment or acted upon the member's request for disenrollment as required in §40.4.1 of these instructions. A disenrollment request would be considered not properly acted upon or processed if the effective date is a date other than as required in §20.1. If the request for retroactive disenrollment action is due to the State's or MMP's confirmation of an incarcerated status with a retroactive start date (see §40.2.1.3), the State or MMP must provide written confirmation of the incarcerated status, including the start date. Such confirmation could include documentation of telephonic communications.

If an individual calls 1-800-MEDICARE regarding a retroactive disenrollment, 1-800-MEDICARE will refer the person to the State or its enrollment broker.

If the request for retroactive action is due to MMP or State error, the State must provide a clear and detailed explanation of the error including why the retroactive action is necessary to correct the error. The explanation must include clear information regarding what the MMP or State has communicated to the affected individual throughout the period in question, including evidence that the individual was notified prospectively of the disenrollment. The State must also include any relevant information supporting the requested correction. Such information could include a copy of the disenrollment request and evidence of notices sent to the individual related to or caused by the error in question and which demonstrate that the retroactive disenrollment is appropriate under the circumstances.

50.6 – User Interface (UI) Transactions Reply Codes (TRC) – Communications with Beneficiaries

TRCs may be generated when enrollment actions are submitted through the CMS User Interface rather than through the State, e.g., when a CMS Caseworker submits an enrollment-related transaction. Upon receipt of a CMS transaction reply, MMPs and States must update their records to accurately reflect each individual's enrollment status. States are also required to provide certain notices and information to beneficiaries when enrollment status is confirmed or changes. In the case of UI-TRC replies, the standard operating procedures for providing these notices and/or information may not fit some of the unique situations that many UI enrollment changes address.

The table below provides guidelines for communicating with individuals when enrollment changes are reported to States using the "700 series" TRCs that result from UI enrollment changes. In all cases, States will need to review the situations carefully to determine the necessity and appropriateness of sending notices. Some UI enrollment change processes will result in multiple 700-series TRCs being reported. States must determine the final disposition of the individual to ensure the correct message is provided in any notice sent. In complex situations, CMS encourages States to communicate directly (such as by telephone) with the individual, in addition to any required notice or materials. When it is necessary to send a notice, States must issue the notice within ten calendar days of receipt of the DTRR.

TRC	Beneficiary Communication Action
701 – New UI Enrollment	States may use existing confirmation notices as provided in CMS enrollment guidance. If such notice has already been provided with the same information, it is not necessary to provide it a second time.
702 – New UI Fill-in Enrollment	States must use Exhibit 29, “Enrollment Status Update.” Include the date range covered by the new fill-in period.
703 – UI Enrollment Cancel	If a cancellation notice applicable to this time period has already been provided, it is not necessary to provide it a second time. If notice has not been provided, States may use the existing cancellation of enrollment notice as provided in CMS enrollment guidance. If the specific situation warrants, States may use Exhibit 28 instead, providing information that clearly indicates that the enrollment period in question has been cancelled.
704 – UI Enrollment Cancel - PBP Change	If the UI action is a correction to a plan submission error, the State may have already provided the correct plan (PBP) information; if that’s the case, it is not necessary to send it a second time. If the individual has not received information about the specific plan (PBP), the MMP or State must send the materials required in CMS enrollment guidance that would be provided for any new enrollment. MMPs or States must also send Exhibit 29 describing the plan change, including the effective date. The impact of the change on plan premiums, cost sharing, and provider networks must be communicated clearly. It is not necessary to issue written notice to confirm the associated “enrollment canceled” TRC that will accompany the enrollment into the new plan (PBP).
705 – New UI Enrollment - PBP Change	Follow the guidance provided above for TRC 704.
706 – UI Enrollment Cancel - Segment change	Plan (PBP) segment changes apply only to MA plans. MMPs or States should contact CMS if this TRC is received.
707- UI New enrollment - Segment Change	Plan (PBP) segment changes apply only to MA plans. MMPs or States should contact CMS if this TRC is received.
708 – UI End Date Assigned	This UI action has the same effect as an State- submitted disenrollment transaction (TC 51). Generally, MMPs or States should follow existing CMS enrollment guidance for providing notice and confirmation of the disenrollment. However, since many UI initiated-changes are retroactive, MMPs or States may have already provided notice (with correct effective dates) and if so, need not provide it a second time. Additional clarification may be appropriate depending on the specifics of the case.

709 – UI Earlier Start Date	An existing enrollment period in the MMP has changed to start earlier than previously recorded. If the MMP or State has already provided notice reflecting this new effective date of enrollment, it is not necessary to provide it a second time. When the individual has not already received notice reflecting this effective date, States may use existing confirmation of enrollment notices where there is confidence that such notice will not cause undue confusion. Alternatively, States may use Exhibit 29, including in it the new effective date. Plans must also ensure individuals are fully aware of how to access coverage of services for the new time period, including their right to appeal.
710 – UI Later Start Date	An existing enrollment period start date has been changed to start on a later date. or States must use Exhibit 29. Plans must explain the change in the effective date of coverage. States must also explain the impact on any paid claims from the time period affected.
711 – UI Earlier End Date	An enrollment period end date has been changed to occur earlier. States must use Exhibit 29. States must explain the change in the effective date of the end coverage. Plans must also explain the impact on any paid claims from the time period affected.
712 – UI Later End Date	An enrollment period end date has been changed to occur later. States must use Exhibit 29. States must explain the change in the effective date of the end of coverage. States must also ensure individuals are fully aware of how to access coverage of services for the new time period.
713 – UI Removed End Date	An enrollment period that previously had an end date is now open (and ongoing). States must use Exhibit 27 to explain the change and that enrollment in the MMP is now continuous. States must ensure individuals are fully aware of how to access coverage of services for the new time period and going forward.

50.7 - Storage of Enrollment and Disenrollment Request Records

MMPs and States are required to retain records of enrollment and disenrollment requests (i.e., copies of enrollment forms, etc.) for the current contract period and the previous 10 years.

It is appropriate to allow for storage on microfilm, as long as microfilm versions of enrollment forms and disenrollment requests showing the signature and the date are available to reviewers. Similarly, other technologies that would allow the reviewer to access signed forms and other enrollment elections may also be allowed, such as optically scanned forms stored on disk. Records of enrollment elections into, and disenrollment elections from, made by any other election mechanism (as described in §20.1) must also be retained as above.

Appendices

Summary of MMP Notice and Data Element Requirements

Appendix 1: Summary of Data Elements Required for MMP Enrollment Mechanisms and Completed Enrollment Requests

All data elements with a “Yes” in the “Beneficiary response required on request” column are necessary in order for the enrollment request to be considered complete.

	Data Element	CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
1	Plan name ¹	Yes	Yes	1, 2
2	Beneficiary name	Yes	Yes	1, 2
3	Beneficiary Date of Birth	Yes	Yes	1
4	Beneficiary Gender	Yes	Yes	1
5	Beneficiary Telephone Number	Yes	No	1, 2
6	Permanent Residence Address (with the exception of “County” – see below)	Yes	Yes	1, 2
7	County	No	No	1, 2
8	Mailing Address	Yes	No	1, 2
9	Name of person to contact in emergency, including phone number and relationship to beneficiary	No	No	1, 2
10	E-mail Address	No	No	1, 2
11	Beneficiary Medicare number	Yes	Yes	1, 2
12	Additional Medicare information contained on sample Medicare card, or copy of card	No	No	1, 2
13	Response to ESRD Question	Yes	Yes	1
14	Response to long term care question	No	No	1
15	Response to other insurance COB information	Yes	No ²	1, 2
16	Language preference and alternative formats	Yes	No	1, 2
17	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	No	No	N/A
18	Question of whether spouse or	No	No	N/A

¹ If enrollment mechanism will be used for multiple plans, all plan names must be listed in a way that permits the applicant to clearly indicate his/her plan choice.

² Refer to CMS Coordination Of Benefits guidance for additional information

	Data Element	CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
	dependents are covered under the plan and, if applicable, name of spouse or dependents			
19	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	No	No	N/A
20	Name of chosen Primary Care Provider, clinic or health center (Optional Field)	No	No	1, 2
21	Beneficiary signature and/or Authorized Representative Signature	Yes	Yes ³	1, 2
22	Date of signature	Yes	No ⁴	1, 2
23	Authorized representative contact information	Yes	Yes	1, 2
24	Employer or Union Name and Group Number	Yes	Yes	1, 2
25	Question of which plan the beneficiary is currently a member of and to which MMP the beneficiary is changing	Yes	Yes	2
26	Information provided under “Please Read and Sign Below” All elements provided in model language must be included on enrollment request mechanisms. May be provided as narrative or listed as statements of understanding	Yes	Yes	1, 2
27	Release of Information All elements provided in model language must be included on enrollment request mechanisms.	Yes	Yes	1, 2
28	Option to request materials in language other than English or in other formats	Yes	No	1, 2

³ For some CMS approved enrollment elections, a signature is not required. For paper enrollment forms submitted without a signature, organization may verify with the applicant by telephone and document the contact instead of returning form.

⁴ As explained in §40.2, the beneficiary and/or legal representative should write the date s/he signed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment form, the stamped date of receipt that the State places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is not a necessary element.

	Data Element	CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
29	Medicaid Number	Yes	Yes	1, 2

Appendix 2: Setting the Application Date on CMS Enrollment Transactions

The application date submitted on enrollment transactions plays a key role in CMS system edits that ensure the individual's choice of plan is honored. The application date is always a date prior to the effective date of enrollment. For more information about application date, see Appendix 3.

Enrollment Request Mechanism	Application Date	Special Notes
Paper Enrollment Forms received by mail or in person §30.1.1	The date the paper request is initially received	Paper requests submitted to or collected by State-authorized brokers are received by the State on the date the agent or broker receives the form. Postmark is not considered for paper enrollment forms received by mail.
Paper enrollment forms received by Fax §30.1.1	The date the fax is received on the State's fax machine	Fax requests submitted to or collected by State-authorized brokers are received by the State on the date the fax is received on the agent or broker's fax machine.
State website online enrollment page §30.1.2	The date the request is completed via the State's website process	
Telephonic Enrollment §30.1.3	The date of the call	Telephonic enrollments must be recorded.
Passive Enrollment §30.1.4	For January 1, effective date, the application date is October 14. For all other effective dates from February through December, the application date is the date the passive enrollment transaction is submitted to CMS' MARx system	This must not be earlier than 90 days and not later than 60 days before the effective date.

Appendix 3: Definitions

The following definitions relate to topics addressed in this guidance.

Application Date – For paper enrollment forms and other enrollment request mechanisms, the application date is the date the enrollment request is initially received by the State as defined below. States must use this date in the appropriate field when submitting enrollment transactions to CMS. A summary of application dates for CMS enrollment transactions is provided in Appendix 2 of this guidance.

- For requests sent by mail, the application date is the date the application is received by the State (postmark is irrelevant).
- For requests received by fax, the application date is the date the fax is received on the State's fax machine.
- For requests submitted to State-authorized brokers, including by fax, the application date is the date the agent/broker receives (accepts) the enrollment request and not the date the State receives the enrollment request from the agent/broker. For purposes of enrollment, receipt by the agent or broker employed by or contracting with the State, is considered receipt by the State, thus all CMS required timeframes for enrollment processing begin on this date.
- For requests accepted by approved telephonic enrollment mechanisms, the application date is the date of the call. The call must have followed the approved script, included a clear statement that the individual understands he or she is requesting enrollment, and have been recorded.
- For internet enrollment requests made directly to the State's website, the application date is the date the request is completed through the State's website process. This is true regardless of when a State ultimately retrieves or downloads the request.
- For passive enrollment, as described in §40.1.4, the application date is:
 - October 15 for passive enrollments effective January 1;
 - For all other passive enrollments effective February through December, the application date will be the date the transaction is submitted to CMS (which must be no later than 60 days before the effective date). This will ensure that any subsequent beneficiary-generated enrollment request will supersede the passive enrollment in CMS systems.

Authorized Representative/Legal Representative – An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §30.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process, and does not provide broad legal authority to make another individual's healthcare decisions. Please note that CMS does not have data on individuals' authorized representative status; States/MMPs would need to verify that status when someone is making an enrollment-related request on behalf of a beneficiary.

Cancellation of Enrollment Request - An action initiated by the individual to cancel an enrollment request. To be valid, the cancellation request must be received by the State before the enrollment effective date.

Completed Election - An enrollment request is considered complete when:

1. The form/request is signed by the individual or legal representative or the enrollment request mechanism is completed;
2. For enrollments, evidence of entitlement to Medicare Part A and enrollment in Medicare Part B is obtained by the State (see below for definition of “evidence of Medicare Part A and Part B coverage”);
3. All necessary elements on the form are completed (for enrollments, see Appendix 1 for a list of elements that must be completed) or when the enrollment request mechanism is completed as CMS directs; and,
4. When applicable, certification of a legal representative’s authority to make the enrollment request is obtained by attestation (refer to §30.2.1).

Days – Unless otherwise noted, “days” mean calendar days.

Denial of Enrollment Request - Occurs when a State determines that an individual is not eligible to make an enrollment request (e.g., the individual is not entitled to Medicare Part A or enrolled in Part B, the individual does not have Medicaid, etc.), and therefore determines it should not submit the enrollment request transaction to CMS.

Effective Date of Coverage/Enrollment – The date on which an individual’s coverage in an MMP begins. The State must determine the effective date of enrollment for all enrollment requests. Instructions for determining the correct effective date of coverage are provided in §30.6.

Election - Enrollment in, or voluntary disenrollment from, an MMP, an MA plan or the traditional Medicare fee-for-service program (“Original Medicare”) constitutes an election (disenrollment from Original Medicare would occur only when an individual enrolls in an MMP or MA plan). The term “election” is used to describe either an enrollment or voluntary disenrollment. If the term “enrollment” is used alone, however, it is being used to describe only an enrollment, not a disenrollment. The same applies when the term “disenrollment” is used alone (i.e., the term is being used to describe only a disenrollment, and not an enrollment).

Election Period - The time(s) during which an eligible individual may request to enroll in or disenroll from an MA or Medicare prescription drug plan or MMP. The election period determines the effective date of coverage, as well as the types of enrollment requests allowed. There are several types of election periods, all of which are defined in Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual.

Enrollment Request Mechanism - A method used by individuals to request to enroll in a MMP or Medicare health or drug plan. **An individual who is a member of a MMP who wishes to elect a different MMP, even if it is in the same organization, must complete a new election during a valid enrollment period to enroll in the new Medicare plan.** However, that

individual may use a short enrollment form or a “plan selection” form to make the election in place of the comprehensive individual enrollment form or may complete the election via the Internet, as described in §30.1.2 of this guidance, or by telephone, as described in §30.1.3 of this guidance, if the State offers these options. Individuals or their legal representatives must complete an enrollment request mechanism (e.g. enrollment form) to enroll in an MMP. An individual who is a member of a Medicare health or drug plan who wishes to elect a MMP within the same organization, must complete the comprehensive individual enrollment form or may complete the election via other enrollment mechanisms offered by the State.

Beneficiaries are not required to use a specific form to disenroll from an MMP; however, a model disenrollment form is provided in Exhibit 13.

Electronic Retroactive Processing Transmission (eRPT) application – This is a web-based application designed to facilitate and manage the electronic submission, workflow processing, and storage of documentation associated with retroactive adjustments submitted to CMS Retroactive Processing Contractor (RPC).

Evidence of Entitlement (Medicare Part A and Part B Coverage) - For the purposes of completing an enrollment request, the State must verify Medicare entitlement for all enrollment requests using either the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen). Therefore, the applicant is not required to provide evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment request.

If CMS systems do not show Medicare entitlement, the State must consider the individual’s Medicare ID card as evidence of Medicare entitlement. If CMS systems do not show Medicare entitlement and the individual’s Medicare ID card is not available, the State must consider an SSA award letter that shows the Medicare HICN and effective date of Part A/B as evidence of Medicare entitlement.

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

Incarceration – This term refers to the status of an individual who is confined to a correctional facility, such as a jail or prison. An individual who is incarcerated is considered to be residing outside of the service area for the purposes of MMP eligibility, even if the correctional facility is located within the plan service area. Individuals who are in Institutions for Mental Disease (IMDs), such as individuals who are confined to state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, are not considered to be incarcerated as CMS defines the term for the purpose of MMP eligibility. These individuals are therefore not excluded from the service area of an MMP on that basis.

Involuntary Disenrollment - Disenrollments made necessary due to the State or MMP’s determination that the individual is no longer eligible to remain enrolled in a plan, or when an State or MMP otherwise initiates disenrollment (e.g. loss of Medicaid, plan termination).

PACE – The Program for All-inclusive Care for the Elderly (PACE) model promotes the well-being of seniors with chronic care needs and their families by serving them in the community whenever possible. PACE serves individuals who are age 55 and older, are able to live safely in the community at the time of enrollment, and live in a PACE service area.

Receipt of Enrollment Request - States may receive enrollment requests through various means, as described in §30.1. The State (and MMP, if received directly by the MMP) must date as received all enrollment requests as soon as they are initially received. This date will be used to determine the effective date of the request. Refer to the definition of “Application Date” in this section for specific information regarding the correct date to report as the application date on enrollment transactions submitted to CMS.

Reinstatement of Election - An action that may be taken by CMS to correct an erroneous disenrollment from a MMP or a Medicare health or drug plan. The reinstatement corrects an individual’s records by canceling a disenrollment to reflect no gap in enrollment in the plan. A reinstatement may result in retroactive disenrollment from another Medicare plan or a MMP.

Rejection of Enrollment Request - Occurs when CMS has rejected an enrollment request submitted by the State. The rejection could be due to the State incorrectly submitting the transaction, to system error, or to an individual’s ineligibility to elect the plan.

Retroactive Processing Contractor (RPC) - The CMS contractor responsible for processing retroactive beneficiary enrollment/disenrollment change requests submitted by States/Plan Sponsors.

State or MMP Error - An error or delay in enrollment request processing made under the full control of State or MMP personnel and one that the State or MMP could have avoided.

System Error - A “system error” is an unintended error or delay in enrollment request processing that is clearly attributable to a specific Federal government system (e.g., Social Security Administration (SSA) system, Railroad Retirement Board (RRB) system), and is related to Medicare entitlement information or other information required to process an enrollment request.

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

Voluntary Enrollment - In this guidance, “voluntary” is used to mean beneficiary-initiated elections; this is distinguished from passive enrollments, which are legally considered voluntary in that a beneficiary’s “silence” is considered agreement with the election. Voluntary enrollments are sometime also called “opt-in” enrollments.

Appendix 4 -- Model Medicare-Medicaid Plan Enrollment Forms & Notices

This section contains national model notices for the State and Medicare-Medicaid plan (MMP) to send to beneficiaries regarding enrollment matters. States may require additional notices specific to their State.

Note: Model notices may be tailored to a given State and the State may decide which notices it will send, and which notices it will delegate to MMPs to send to beneficiaries. In addition, in each State, the State or federal reading level and translation requirements that are more beneficiary-friendly will be used.

Summary of Notice Requirements

Referenced in §§ 10, 20, 30, 40, and 50

This Exhibit is intended to be a summary of notice requirements. For exact detail on requirements and timeframes, refer to the appropriate sections within this guidance.

Forms and Notices	Section	Required?	Timeframe
Enrollment			
Exhibit 1: Model Medicare-Medicaid Individual Enrollment Request Form	10.3, 30.1.1, 30.1.2, 30.2, 30.2.1	Yes¹	N/A
Exhibit 2: Model Short Enrollment Request Form	10.3	No	N/A
Exhibit 3: Model Notice to Acknowledge Receipt of Completed Enrollment Request	30, 30.4.1	Yes²	10 calendar days after receipt of the completed enrollment request
Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment	30, 30.1.4, 30.4, 30.4.2	Yes³	7 calendar days of availability of the CMS Daily Transaction Reply Report (DTRR)
Exhibit 5: CMS or State Reminder Notice for Passively Enrolled Individuals	30.4.1	Yes	30 days prior to the effective date
Exhibit 5a: MMP Welcome Letter for Passively Enrolled Individuals	30.4.1	Yes⁴	30 days prior to the effective date
Exhibit 6: Model Notice for Requesting Information	30, 30.2.2	No	10 calendar days of receipt of the enrollment request.
Exhibit 7: Model Notice to Confirm Enrollment	30.4.2	Yes⁵	10 calendar days of the DTRR that contains the earliest notification of the acceptance or rejection
Exhibit 8: Model Notice for Individuals Identified on CMS Records as Members of Employer or Union Group Receiving the Retiree Drug Subsidy (RDS)	30.2.5	Yes	10 calendar days of receipt of the DTRR that contains Transaction Reply Code 127 - conditional rejection
Exhibit 9: Model Notice for Denial of Enrollment	30, 30.2.2, 30.2.3, 30.2.5	Yes	10 calendar days of receipt of enrollment request OR expiration of time frame for requested additional information
Exhibit 10: Model Notice for CMS Rejection of Enrollment	30.4.2	Yes	10 calendar days of the DTRR containing the earliest notification of the rejection
Exhibit 11: Acknowledgement of Request to Cancel Enrollment	50.2.1	Yes	10 calendar days of receipt of the cancellation request
Disenrollment			
Exhibit 12: Model Notice to Send Out Disenrollment Form	40.1	No	N/A

¹ Other CMS approved enrollment election mechanisms may take the place of an enrollment form

² Required unless combined acknowledgement/confirmation notice (Exhibit 4) is issued.

³ Required if combined acknowledgement/confirmation notice used in response to the DTRR, as described in §30.4

⁴ Welcome letter to the passive enrollee may be sent by MMP or State.

⁵ Required unless combined acknowledgement/confirmation notice (Exhibit 4) is issued.

Forms and Notices	Section	Required?	Timeframe
Disenrollment (continued)			
Exhibit 13: Model Disenrollment Form	40.1, 40.1.3	No	If individual requests, send within 10 calendar days of receipt of the request to disenroll
Exhibit 14: Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member	40.1.3	Yes	10 calendar days of receipt of the request to disenroll.
Exhibit 15: Model Notice to Request Information (Disenrollment)	40.1	Yes	10 calendar days of receipt of disenrollment request
Exhibit 16: Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)	40.1.3	Yes	10 calendar days of the availability of the DTRR
Exhibit 17: Model Notice for Denial of Disenrollment	40.1.3	Yes	10 calendar days of the receipt of the disenrollment request
Exhibit 18: Model Acknowledgement of Request to Cancel Disenrollment	50.2.2	Yes	10 calendar days of receipt of the cancellation request
Exhibit 19: Model Notice for Disenrollment Due to Out-of-Area Status (No Response to Request for Address Verification)	40.2.1.3	Yes	Within first 10 calendar days of the sixth month from the date the State learned of the change in address or possible out-of-area residency
Exhibit 20: Model Notice for Disenrollment Due to Confirmation of Out-of-Area Status (Upon New Address Verification from Member)	40.2.1.3	Yes	10 calendar days of receiving confirmation of out-of-area status
Exhibit 21: Model Notice for Loss of Medicaid Status or State-Specific Eligibility Status - Notification of Involuntary Disenrollment	40.2.3	Yes	For loss of State-specific eligibility status or if the MMP does NOT offer a period of deemed continued eligibility for loss of Medicaid status, 10 calendar days prior to the MMP disenrollment effective date. If MMP offers period of deemed continued eligibility for loss of Medicaid status, 3 calendar days following the end of the grace period.
Exhibit 22: Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid	40.2.3.2	Yes	10 calendar days of learning of the loss of Medicaid eligibility
Reinstatement			
Exhibit 23: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status	40.2.4, 50.3	Yes	10 calendar days of initial contact with member
Exhibit 24: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination	40.2.2, 50.3, 50.3.1	Yes	10 calendar days of initial contact with member
Exhibit 25: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to State or Plan Error	50.2.2, 50.3	Yes	10 calendar days of initial contact with member
Exhibit 26: Model Notice to Close Out Request for Reinstatement	50.3.2	Yes	10 calendar days after information was due to the State

Forms and Notices	Section	Required?	Timeframe
Reinstatement (continued)			
Exhibit 27: Model Acknowledgment of Reinstatement	50.2.1, 50.3, 50.3.1, 50.6	Yes	10 calendar days of receipt of DTRR confirmation of the individual's reinstatement
Miscellaneous			
Exhibit 28: Acknowledgement of Request to Opt Out of Medicare-Medicaid Plan (not connected to request to disenroll or cancel enrollment in MMP)	30.1.4	Yes	10 calendar days of receipt of the individual's request to opt out or receipt of the DTRR.
Exhibit 29: Model Notice for Enrollment Status Update	50.6	Yes	10 calendar days of the availability of the DTRR
Exhibit 30: Model Notice to Research Potential Out of Area Status – Address Verification form included	40.2.1.3	Yes	10 calendar days of receiving a notice of a change of address or an indication of possible out-of-area residency from the member, the member's legal representative, a CMS DTRR, or another source

Exhibit 1: Model Medicare-Medicaid Individual Enrollment Request Form

Referenced in §§ 10.3, 30.1.1, 30.1.2, 30.2, 30.2.1

Keep a copy of this form for your records

Medicare - <name of State Medicaid program> Plan Application Form

To join a Medicare-Medicaid plan, you must have **Medicare Part A**, **Medicare Part B**, and **<name of state Medicaid Program>**. *[State may insert: You can also fill out this form online at <web address> or call <toll-free number> to join the Medicare-Medicaid plan. The call is free.]*

Choose a health plan:

<input type="checkbox"/> <Plan name 1>	<input type="checkbox"/> <Plan name 3>
<input type="checkbox"/> <Plan name 2>	<input type="checkbox"/> <Plan name 4>

Tell us about yourself:

Name: (first, middle, last)			
Date of birth: (<u> </u> / <u> </u> / <u> </u>) M M D D Y Y Y Y		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Phone number: (<u> </u>) <u> </u> - <u> </u>	Another phone number: (<u> </u>) <u> </u> - <u> </u>	Email Address:	
Address where you live:			
City:	State:	ZIP code:	County (Optional):
Address where you get mail (if different from where you live):			
City:	State:	ZIP code:	County (Optional):
Emergency contact name:		Emergency contact phone: (<u> </u>) <u> </u> - <u> </u>	
If you are not a native English speaker, you can call <phone number> to get the form in a different language. TTY users should call <toll-free number>.			

Tell us where you usually get health services:

Name of your primary care provider, clinic or, health center:	Phone number: (____) ____ - _____
---	--

Tell us about your Medicare & <name of state Medicaid program> coverage:

Fill in your Medicare and <name of state Medicaid program> information below. You can find this information on your red, white, and blue Medicare card, or a letter from Social Security or the Railroad Retirement Board. Also, please put your <name of state Medicaid program> ID number as it appears on the front of your card.

 <p>SAMPLE ONLY</p> <p>Name: _____</p> <p>Medicare Claim Number Sex ____</p> <p>_____ - _____ - _____</p> <p>Is Entitled To Effective Date</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p>	<p><State Medicaid Logo></p> <p><Medicaid Beneficiary></p> <p>Medicaid number</p> <p>_____</p>
---	---

Other personal information:

Do you have End-Stage Renal Disease (ESRD)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" and you've had a successful kidney transplant and/or no longer need regular dialysis, please attach a note from your doctor.		
Do you live in a long-term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill in the information below:		
Name of the facility:		Phone number: (____) ____ - _____
[States may insert question(s) regarding additional Medicaid and/or demonstration-specific eligibility criteria]		
Do you work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No

Your health coverage including your prescription drug coverage:

Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs.

Do you have other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, fill in the information below:</i>	
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
If you have health coverage from an employer or union right now, you or your dependents could lose that coverage when you join <plan>. Your employer or union can give you more information about your coverage. If you have questions, talk with the person in your office who takes care of benefits.	

Please read and sign below.

When you sign this form, it means that you understand:

- | | |
|--|--|
| <ul style="list-style-type: none">• <Plan> has a contract with the federal government and with <state>.• The health services you get with your new plan may be different than the services you had before.• I must keep Medicare Part A, Part B and <name of state Medicaid program>.• I can be in only one Medicare plan at a time.• By joining <plan>, I will end my enrollment in another Medicare health or prescription drug plan.• I must tell Medicare and <name of state Medicaid program> about any prescription drug coverage that I have or may get in the future.• If I move, I need to tell <State/enrollment broker>.• As a member of <plan>, I have the right to appeal if I don't agree with <plan>'s decisions about payment or services.• I understand that the <plan>'s <i>[insert either Member Handbook or Evidence of Coverage document]</i> includes the rules I must follow.• The <plan> doesn't usually cover people while they're out of the country, but there may be some limited coverage near the U.S. border.• On the date <plan> coverage begins, I must get my health care from <plan> doctors, except for emergency or urgently needed care, out-of-area dialysis or if I get <plan> or <State> approval to see other providers in some circumstances.• <Plan> will cover my health care with <plan> doctors and other providers as outlined in the <i>[insert either Member Handbook or Evidence of Coverage document]</i> to see what services are covered.• If I need to see a doctor or other provider who is not in <plan>, I may need prior authorization or I may have to pay out-of-pocket for the services I get. | <ul style="list-style-type: none">• <if permitted by state> I understand that if a sales agent, broker, or other individual employed by or contracted with <plan> is helping me, <plan> may pay that person when they enroll me.• By joining <plan>, I know that <plan> may share my information with Medicare and <name of state Medicaid program> and other plans as necessary for treatment, payment, and health care operations.• I understand that prescription drugs are covered, but not always the same ones I'm already taking. I understand that I'll have access to my current drugs for at least 30 days, until I can switch to a different drug, and that I will have access to my current doctors for <i>[insert state's continuity of care requirement and length of transition period, e.g., 90 days or more]</i> once I join <plan>. I further understand that <plan> has providers and pharmacies I must use to get health care services, except for non-routine, emergency situations.• I know that <plan> may share my information including my prescription drug information with Medicare and <name of state Medicaid program>. They may release it for research and other purposes, as allowed by Federal statutes and regulations.• The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from the <plan>.• My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that he or she is authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or <name of state Medicaid program>. |
|--|--|

Your signature:	Date:
<p>If you are the authorized representative, you must provide the following information, sign, and date below:</p> <p>Name: _____ Signature: _____ (Please Print)</p> <p>Address: _____</p> <p>Phone Number: (_____) _____ - _____</p> <p>Relationship to Enrollee: _____</p> <p>Today's Date: _____</p>	

For more information, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free phone number> <days and hours of operation>. TTY users should call <toll-free number>. The call is free. This information is available for free in other languages and formats like Braille or audio CD. *[The preceding sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]*

[<Marketing Material ID>]

Exhibit 2: Model Short Enrollment Request Form (for use in switching to another Medicare-Medicaid Plan offered by the same organization)

Referenced in §10.3

Keep this form for your records

Enrollment Application: Switching to another Medicare - <name of State Medicaid program> Plan

To join a Medicare-Medicaid plan, you must have **Medicare Part A**, **Medicare Part B**, and **name of state Medicaid program**. *[State may insert: You can also fill out this form online at <web address> or call <toll-free number> to join the Medicare-Medicaid plan. The call is free.]*

Choose the Medicare-Medicaid plan you wish to enroll:

<input type="checkbox"/> <Plan name 1>	<input type="checkbox"/> <Plan name 3>
<input type="checkbox"/> <Plan name 2>	<input type="checkbox"/> <Plan name 4>

Tell us about yourself:

Name: (first, middle, last)			
Plan you are in now			
Phone number: (____) ____ - _____	Another phone number: (____) ____ - _____	Email address:	
Address where you live:			
City:	State:	ZIP code:	County:
Address where you get mail (if different from where you live):			
City:	State:	ZIP code:	County:
Emergency contact name:		Emergency contact phone: (____) ____ - _____	
If you are not a native English speaker, you can call <phone number> to get the form in a different language. TTY users should call <toll-free number>.			

Tell us where you usually get health services:

Name of primary care provider, clinic, or health center	Primary care provider phone (____) _____ - _____
---	---

Tell us about your Medicare & <name of state Medicaid program> coverage:

Fill in your Medicare and <name of state Medicaid program> information below. You can find this information on your red, white, and blue Medicare card, or a letter from Social Security or the Railroad Retirement Board. Also, please put your <name of state Medicaid program> ID number as it appears on the front of your card.

	
SAMPLE ONLY	
Name: _____	
Medicare Claim Number	Sex ____
_____ - _____ - _____	
Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

<State Medicaid Logo>
<Medicaid Beneficiary>
Medicaid number

Please read and sign below.

When you sign this form, it means that you understand:

- | | |
|--|---|
| <ul style="list-style-type: none">• <Plan> has a contract with the federal government and with <state>.• The health services you get with your new plan may be different than the services you had before.• I must keep Medicare Part A, Part B and <name of state Medicaid program>.• I can be in only one Medicare plan at a time.• By joining <plan>, I will end my enrollment in another Medicare health or prescription drug plan.• I must tell Medicare and <name of state Medicaid program> about any prescription drug coverage that I have or may get in the future.• If I move, I need to tell <State/enrollment broker>.• As a member of <plan>, I have the right to appeal if I don't agree with <plan>'s decisions about payment or services.• I understand that the <plan>'s <i>[insert either Member Handbook or Evidence of Coverage document]</i> includes the rules I must follow.• The <plan> doesn't usually cover people while they're out of the country, but there may be some limited coverage near the U.S. border.• On the date <plan> coverage begins, I must get my health care from <plan> doctors, except for emergency or urgently needed care, out-of-area dialysis or if I get <plan> or <State> approval to see other providers in some circumstances.• <Plan> will cover my health care with <plan> doctors and other providers as outlined in the <i>[insert either Member Handbook or Evidence of Coverage document]</i> to see what services are covered. | <ul style="list-style-type: none">• If I need to see a doctor or other provider who is not in <plan>, I may need prior authorization or I may have to pay out-of-pocket for the services I get.• <if permitted by state> I understand that if a sales agent, broker, or other individual employed by or contracted with <plan> is helping me, <plan> may pay that person when they enroll me.• By joining <plan>, I know that <plan> may share my information with Medicare and <name of state Medicaid program> and other plans as necessary for treatment, payment, and health care operations.• I understand that prescription drugs are covered, but not always the same ones I'm already taking. I understand I'll have access to my current drugs for at least 30 days, until I can switch to different drug. I understand I will have access to doctors for <i>[insert state's continuity of care requirement and length of transition period, e.g., 90 days or more]</i> once I join <plan>. I further understand that <plan> has providers and pharmacies I must use to get health care services, except for non-routine, emergency situations.• I know that <plan> may share my information, including my prescription drug event data, with Medicare and <name of state Medicaid program>. They may release it for research and other purposes, as allowed by Federal statutes and regulations.• The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from the <plan>.• My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that he or she is authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or <name of state Medicaid program>. |
|--|---|

Your signature:	Date:
<p>If you are the authorized representative, you must provide the following information, sign, and date below:</p> <p>Name: _____ Signature: _____ (Please Print)</p> <p>Address: _____</p> <p>Phone Number: (_____) _____ - _____</p> <p>Relationship to Enrollee: _____</p> <p>Today's Date: _____</p>	

For more information, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free phone number> <days and hours of operation>. TTY users should call <toll-free number>. The call is free. This information is available for free in other languages and formats like Braille or audio CD. *[The preceding sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]*

[<Marketing Material ID>]

Exhibit 3 - Model Notice to Acknowledge Receipt of Completed Enrollment Request

Referenced in §§ 30, 30.4.1

<Date>

Keep this notice for your records

<Name>

<Address>

<City>, <State> <ZIP>

<Member # >

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

IMPORTANT INFORMATION ABOUT YOUR NEW MEDICARE - <name of State Medicaid program> PLAN

<Name>:

Thank you for submitting a request to enroll in the <plan> Medicare-Medicaid Plan

If approved by Medicare and Medicaid, your <plan> health coverage will begin on <effective date>. In this plan, you'll get:

- Your Medicare benefits, including prescription drugs
- Your Medicaid benefits, including long-term services and supports. Long-term services and supports include services for a long-term medical condition so you can stay in your home as long as possible.
- Your choice of doctors and other providers within the plans network who work together to give you the care you need
- *[If applicable insert: Extra benefits and services, including a care coordinator [Plans may insert: and other covered services such as dental, vision, etc.]]*
- Durable Medical Equipment

What should I do now?

Medicare and Medicaid will do a final review of your enrollment. Once the review is complete, you'll get a letter to confirm your enrollment within 10 days *[States should modify the number of days as appropriate]*. Don't make any other changes to your health insurance, i.e., Medicare Supplemental Insurance (Medigap) plan, or other insurance, you may have until your enrollment is confirmed. You can begin using <plan> doctors on <effective date>. You'll get an ID card in the mail within 10 days *[States should modify the number of days as appropriate]*, **but you may use this letter as proof of your coverage now.**

What should I know about <plan>?

You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <plan>. *[Insert if the state does not accept ESRD beneficiaries: Also, if you have End-Stage Renal Disease, you will not be able to become a member of <plan name >. Call*

<enrollment broker> at <phone number> to learn about your other choices; you may pay a reduced copayment or \$0 copayment for your prescription drugs.]

How will I get my health services in <plan>?

Starting <effective date>, you must see a <plan> provider for all your health services. You will also have to use a <plan> pharmacy to get your medicines. This means:

- <Plan> will pay for your health services with <plan> doctors and <plan> providers.
- If you need to see a doctor who isn't in <plan>, you must have "prior authorization" if you want <plan name > to cover your health services. Prior authorization means <plan name > gives you advanced permission to see a doctor who isn't in <plan name >.
- Because you're new to <plan name >, you don't need prior authorization for services until <date>, and you may use doctors who aren't in <plan>.
- A <plan> doctor must provide or arrange for **all** of your health services, except emergency care, urgent care, or out-of-area dialysis services *[States may need to add additional exceptions (e.g., women health providers)].*
- Emergency care, urgent care, and dialysis services are covered even if you're **not** seeing a <plan> doctor. Talk with your doctor or call <plan> at <member services number> for more information. *[States should add other services that a member can get without a referral.]*

How much will I have to pay for health care services?

You will not have to pay a plan premium, deductible, or copayments when receiving health services through a <plan name> doctor.

How much will I have to pay for prescription drugs?

When you pick up your prescription drugs, you'll pay at the pharmacy. You'll pay no more than <\$ ___ > each time you receive a generic drug that's covered by <plan name>, and no more than <\$ ___ > each time you receive a brand name drug that is covered by <plan name>.

[If applicable, insert copayments for Medicaid services.]

Can I leave <plan> or select a new plan?

Yes. You may leave <plan> or choose a new Medicare-Medicaid plan **at any time** by calling <state/enrollment broker number>. If you choose to leave <plan>, your coverage will end the last day of the month after you tell us you want to leave and don't want <state> to enroll you in another Medicare-Medicaid plan. If you leave <plan> and don't join a Medicare health or prescription drug plan, you'll be covered under Original Medicare and Medicare will enroll you in a Medicare prescription drug plan. If you have concerns with <plan>, call <State ombudsman office> at <ombudsman phone number>. If you would like to discuss other enrollment options, you can speak with a <SHIP counselor> at <SHIP phone number>. If you have questions about Medicare plans in your area, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

[If applicable, insert:

How can I choose a primary care provider?

Information instructing member in simple terms on how to select a primary care provider/site, how to obtain services, explain which services do not need primary care provider's approval (when applicable), etc.]

[If the State delegates sending of this notice to Medicare-Medicaid plan, the Medicare-Medicaid plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

Who should I call if I have questions about Medicare or <name of state Medicaid program>?

If you have questions about **Medicare**, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.Medicare.gov. TTY users should call 1-877-486-2048. If you have questions about **<name of state Medicaid program>**, call <Medicaid phone number>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats, like Braille and audio CD.

[<Marketing Material ID>]

Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment

Referenced in §§ 30, 30.1.4, 30.4, 30.4.2

Keep this notice for your records

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Member # >

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

IMPORTANT INFORMATION ABOUT YOUR NEW MEDICARE - <name of State Medicaid Program> PLAN

<Name>:

You have new health coverage through <plan>

Congratulations! Medicare and Medicaid have approved your application to get health and prescription drug coverage through <plan>. Your new coverage begins on <date>. You'll get a member card in the mail by <date>. Show this letter to your doctors or pharmacy until you get your card.

What do I need to know about my new plan?

Starting <date>, you must see a <plan> provider for all your health services (except for emergency services, out-of-area urgent care, or out-of-area dialysis). You must also use a <plan> pharmacy to get your medicines. This means:

- <Plan> will pay for your health care with <plan> doctors and <plan> providers.
- If you need to see a doctor who isn't in <plan>, you must have "prior authorization" if you want <plan> to pay for your health services, or you may have to pay out-of-pocket for these services. "Prior authorization" means that <plan> gives you permission to see a doctor who isn't in <plan>.
- Because you're new to <plan>, you don't need prior authorization for services until <date>, and you may use doctors who aren't in <plan> until <date>. *[State to modify this language].*
- Emergency care, urgent care, and dialysis are covered even if you're **not** seeing a <plan> doctor. Talk with your doctor or call <plan> at <member services number> for more information. *[States should add other services that a member can get without a referral.]*

How much do I have to pay for health services?

You don't have to pay a plan premium, deductible or coinsurance amount when getting health services through <plan>. You will pay a reduced copayment or \$0 copayment when you have a prescription filled.

How much do I have to pay for prescription drugs?

When you pick up your prescription drugs, you'll pay a reduced copayment or \$0 copayment at the pharmacy. You'll pay no more than <\$ ___> each time you receive a generic drug that's covered by <plan name>, and no more than <\$ ___> each time you receive a brand name drug that is covered by <plan name>.

[If applicable, insert copayments for Medicaid services.]

Can I leave <plan> or select a new plan?

Yes. You may leave <plan> or choose a new Medicare-Medicaid plan **at any time** by calling <state/enrollment broker number>. If you choose to leave <plan>, your coverage will end the last day of the month after you tell us you want to leave and don't want <state> to enroll you in another Medicare-Medicaid plan. If you leave <plan> and don't join a Medicare health or prescription drug plan, you'll be covered under Original Medicare and Medicare will enroll you in a Medicare prescription drug plan. If you have concerns with this plan, call <State ombudsman office> at <ombudsman phone number>. If you would like to discuss other enrollment options, you can speak with a <SHIP counselor> at <SHIP phone number>. If you have questions about Medicare plans in your area, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

What if I leave <plan> and I don't want to join a different Medicare-Medicaid plan or a Medicare Prescription Drug Plan?

If you don't want to join either a Medicare-Medicaid plan or a Medicare Prescription Drug Plan, you should call <state/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>.

Unless you tell your <state/enrollment broker> you don't want to join a different Medicare-Medicaid plan, <state> may enroll you in another Medicare-Medicaid plan in the future. If you leave <plan> and don't join a Medicare health or prescription drug plan on your own, you'll be covered under Original Medicare and Medicare may enroll you in a Medicare Prescription Drug Plan.

[If applicable, insert:

How can I choose a primary care provider?

Information instructing member in simple terms on how to select a primary care provider/site, how to obtain services, explain which services do not need primary care provider's approval (when applicable), etc.]

[If the State delegates sending of this notice to Medicare-Medicaid plan, the Medicare-Medicaid plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

If you have questions about Medicare or <name of state Medicaid program>

If you have questions about **Medicare**, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048. If you have questions about <name of state Medicaid program>, call <Medicaid phone number>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats, like Braille and audio CD.

[<Marketing Material ID>]

Exhibit 5: State Reminder Notice for Passively Enrolled Individuals

Referenced in § 30.1.4

Keep this notice for your records

<Member's Name>

<Last 4 digits of HICN>

<Address>

<Date>

<City State Zip>

Read this notice carefully and keep it for your records.

Important reminder: You're being enrolled in a new health & drug plan

You recently got a notice from your state about important changes in your health and drug coverage. <State> **will soon enroll you in <Org Name>'s <Plan Name>**. This new plan includes your <Medicaid or state-specific Medicaid name> (sometimes called "Medicaid"), Medicare, and prescription drug benefits. This plan is designed to help your Medicare and <Medicaid or state-specific Medicaid name> work better together and includes new benefits and services that aren't available to you now.

Your new coverage starts <effective date>

You'll be automatically enrolled in <Plan Name>, so you don't have to do anything. If you don't make another choice by <date>, your new coverage will start on <effective date>. <Plan Name> will send you a new health and drug card to use. This new card will replace the cards you use now.

For more information about your new plan, to find out what benefits your new plan covers, or to see if you can still see your current doctors in your new plan, call <State's Customer Service Line> at <State Customer Service number and TTY> during <call center hours>.

You have other options

If you **don't** want to be enrolled in <Plan Name>, you have other options, including:

1. **Keep your current Medicare coverage or a similar option.** Call <State's Customer Service Line> at <State Customer Service number> and tell them you don't want to be in <Plan Name> (you want to "opt out"). They can help you find out how to keep your current coverage or talk to you about similar options available to you.
2. **Join a different plan that will include your Medicare, <Medicaid or state-specific Medicaid name>, and prescription drug benefits.** Call <State's Customer Service Line> at <State Customer Service number> and tell them you don't want to be in <Plan Name> and you want to join a different plan. Call by <date> to make sure you get your plan materials in time for the start of your coverage.

Note: Remember, you have the right to join Original Medicare and a Medicare drug plan at any time.

What you should do now

Step 1: Review all of your options carefully before making any decisions about your health care coverage. To talk about your options, call <State's Customer Service Line> at <State Customer Service number>.

Step 2: Decide which option is best for you:

- **To enroll in <Plan Name>**, you don't have to do anything.
- **To choose another option** (listed under "You have other options" on page 1), call <State's Customer Service Line> at <State Customer Service number> by <date>. If you don't call and choose another health option by <date>, you'll be automatically enrolled in <Plan Name>.

Get more information

- If you need help understanding information you get from plans or for free, personalized health insurance counseling, call your State Health Insurance Assistance Program (SHIP) at <SHIP number>.
- If you need help comparing your health care options, call <State>'s Ombudsman's Office at <State Ombudsman's number>, your local Office on Aging, or <appropriate state contact>.
- If you have questions about Medicare or need help with your Medicare options, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Exhibit 5a: MMP Welcome Letter for Enrolled Individuals

Referenced in §30.4.1

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Member # >

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

IMPORTANT: YOU HAVE BEEN ENROLLED INTO A NEW PLAN FOR YOUR MEDICARE AND <name of State Medicaid Program> SERVICES.

<Name>:

Welcome to <plan name>!

Starting <effective date>, you will have a health plan designed to give you seamless, high quality care at a low cost or zero cost to you. <Plan name> is a Medicare-Medicaid plan that contracts with both Medicare and <name of state Medicaid program> to provide all benefits of both programs to individuals with both Medicare and Medicaid. Your new coverage includes:

- Your choice of doctors, pharmacies and other providers within the plan's network who work together to give you the care you need
- Prescription drugs
- Long-term services and supports (Long-term services and supports include services for a long-term medical condition so you don't have to go to a nursing home or hospital.)
- *[If applicable, insert: Extra benefits and services, including a care coordinator [Plans may insert: and other covered services such as dental, vision, etc.]]*
- Durable Medical Equipment

You may begin using <plan name> network primary care providers and pharmacies for all of your health care services and prescription drugs as of <effective date>. If you need emergency or urgently needed care, or out-of-area dialysis services, you can use providers outside of <plan name>'s network. To help with the transition to <plan name>, you can continue seeing the doctors you go to now for *[Plan should discuss the state's continuity of care requirement and place the period here, e.g., 90 days.]* You will also have access to drugs you currently take during your first *[must be at least 90]* days in the plan if you are taking a drug that is not our List of Covered Drugs, if health plan rules do not let you get the amount ordered by your doctor, or if the drug requires prior approval by <plan name>.

This letter is proof of your new coverage. Please bring this letter with you to the pharmacy or office visit until you receive your member card from us. You will receive new member kit information separately.

The new member kit includes:

- Summary of Benefits (for passive enrollments only, not required for voluntary enrollments)
- List of Covered Drugs (Formulary)
- Provider and Pharmacy Directory
- Membership Identification Card
- Member Handbook (Evidence of Coverage)

How much will I have to pay for <plan name>?

You will not have to pay a plan premium, deductible, or copayments when receiving health services through a <plan name> doctor.

How much do I have to pay for prescription drugs?

When you pick up your prescription drugs at our network pharmacy, you'll pay a reduced copayment or \$0 copayment at the pharmacy. You'll pay no more than <\$ ___> each time you receive a generic drug that's covered by <plan name>, and no more than <\$ ___> each time you receive a brand name drug that is covered by <plan name>.

[If applicable, insert copayments for Medicaid services.]

[If applicable, insert:

How can I choose a primary care provider?

Information instructing member in simple terms on how to select a primary care provider/site, how to obtain services, explain which services do not need primary care provider's approval (when applicable), etc.]

What if I have other health or prescription drug coverage?

If you have other health or drug coverage, such as from an employer or union, you or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>. Other types of health and drug coverage include TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Contact your benefits administrator if you have questions about your coverage.

What if I don't want to join <plan name>?

You will be enrolled in <plan name> unless you cancel the enrollment before <enrollment effective date>. You can call <state/enrollment broker> at (toll-free number>, <days and hours of operation> to cancel your enrollment with <plan name>. TTY users should call <TTY number>. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048). Tell the representative that you do not want <State> to enroll you in a Medicare-Medicaid plan.

What if I want to join a different Medicare-Medicaid plan or a Medicare health or drug plan?

You should call <state/enrollment broker> at <toll-free number>, <days and hours of operation> to join another Medicare-Medicaid plan. To join a Medicare health plan or Medicare

prescription drug plan, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

Can I leave <plan name> or join a different plan after <effective date>?

Yes. You may leave <plan> or choose a new Medicare-Medicaid plan **at any time** by calling <state/enrollment broker number>. If you choose to leave <plan>, your coverage will end the last day of the month after you tell us you want to leave and don't want <state> to enroll you in another Medicare-Medicaid plan. If you leave <plan> and don't join a Medicare health or prescription drug plan, you'll be covered under Original Medicare and Medicare will enroll you in a Medicare prescription drug plan. If you have concerns with this plan, call <State ombudsman office> at <ombudsman phone number>. If you would like to discuss other enrollment options, you can speak with a <SHIP counselor> at <SHIP phone number>. If you have questions about Medicare plans in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit Medicare.gov. TTY users should call 1-877-486-2048.

Who should I call if I have questions about <plan name>'s coverage?

If you have questions, call <plan name> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>.

Who should I call if I have questions about Medicare or <name of state Medicaid program>?

If you have questions about **Medicare**, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048. If you have questions about <name of state Medicaid program >, call <Medicaid phone number>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats, like Braille and audio CD.

[<Marketing Material ID>]

Exhibit 6: Model Notice for requesting information

Referenced in §§30, 30.2.2

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Thank you for submitting an application to join <plan name>. We need additional information from you to process your application to enroll in <plan name>.

Please provide:

Information: _____

You can provide this information in one of 3 ways. Choose the way that works best for you.

1. You can call us by phone with this information at <Medicaid phone number>.
2. You can fax this information to <state Medicaid fax number>.

You can mail this information to <state-specific Medicaid program name and address>.

Provide this information by <date>.

If we don't get this information by <date>, your application to enroll in <plan> will be denied.

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

If you have questions about Medicare or <name of state Medicaid program>

If you have questions about **Medicare**, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048. If you have questions about **<name of state Medicaid program>**, please call <Medicaid phone number>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 7: Model Notice to Confirm Enrollment

Referenced in §30.4.2

Keep this notice for your records

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

<Member # >

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

You are now in <plan>

Medicare and <name of State Medicaid program> have confirmed your enrollment in <plan> beginning <effective date>. You will get a member card in the mail . Show this letter to your doctors or pharmacy until you get your card.

How much do you have to pay for health care services?

You don't have to pay a plan premium, deductible or copayments when getting health services through <plan> doctor.

How much do I have to pay for prescription drugs?

When you pick up your prescription drugs, you'll pay a reduced copayment or \$0 copayment at the pharmacy. You'll pay no more than <\$ ___ > each time you receive a generic drug that's covered by <plan name>, and no more than <\$ ___ > each time you receive a brand name drug that is covered by <plan name>.

[If applicable, insert copayments for Medicaid services.]

Can I leave <plan> or select a new plan?

Yes. You may leave <plan> or choose a new Medicare-Medicaid plan **at any time** by calling <state/enrollment broker number>. If you choose to leave <plan>, your coverage will end the last day of the month after you tell us you want to leave and don't want <state> to enroll you in another Medicare-Medicaid plan. If you leave <plan> and don't join a Medicare health or prescription drug plan, you'll be covered under Original Medicare and Medicare will enroll you in a Medicare prescription drug plan. If you have concerns with this plan, call <State ombudsman office> at <ombudsman phone number>. If you would like to discuss other enrollment options, you can speak with a <SHIP counselor> at <SHIP phone number>. If you have questions about Medicare plans in your area, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

[If the State delegates sending of this notice to Medicare-Medicaid plan, the Medicare-Medicaid plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 8: Model Notice for Individuals Identified on CMS Records As Members of Employer or Union Group Receiving the Retiree Drug Subsidy (RDS)

Referenced in §30.2.5

<Date>	<Member # >
<Name>	<RxID>
<Address>	<RxGroup>
<City>, <State> <ZIP>	<RxBin>
	<RxPCN>

<Name>:

You've asked to join <plan>

Medicare has informed us you belong to an employer group or union health plan whose drug coverage is as good as Medicare prescription drug plan coverage. To complete your enrollment, we need you to confirm that you want to be enrolled in <plan>. You should know that you and your dependents could lose your employer or union health coverage and other benefits offered by your employer if you join <plan>. If you haven't already done so, tell your employer's or union's benefits administrator that you are thinking about joining a Medicare health plan with prescription drug coverage. The administrator can tell you what will happen to your employer or union health coverage if you join <plan>.

If you decide to join <plan>

Please call <state/enrollment broker number> within **30 days** of receiving this letter to confirm you still want to join <plan>. We will not complete your enrollment until you call. Your effective date will be <effective date>. If we don't hear from you within 30 days from the date of this notice, we won't process your enrollment.

If you decide not to join <plan>

Your enrollment in your employer or union health coverage will continue. You will pay for any health care services you already received through your employer or union health coverage.

If you have questions

Please call <state/enrollment broker> at <toll-free number>, <days and hours of operation>. The call is free. TTY users should call <toll-free number>.

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 9: Model Notice for Denial of Enrollment

Referenced in §§ 30, 30.2.2, 30.2.3, 30.2.5

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Thank you for applying to join <plan>

We cannot accept your request to join <plan> because *[States should add reasons, as appropriate]*:

- *[You do not have Medicare Part A. You must have Medicare Part A to join <plan>.]*
- *[You do not have Medicare Part B. You must have Medicare Part B to join <plan>.]*
- *[You do not have Medicaid. You must have Medicaid to join <plan>.]*
- *[You do not meet State-specific requirements to join <plan>.]*
- *[You have End Stage Renal Disease (kidney disease). If you have kidney disease, you cannot join <plan>.]*
- *[You do not live in <plan name's> service area.]*
- *[You did not send the information we asked for by the requested date.]*
- *[Someone who is not your authorized representative asked that you join the <plan>. You or your authorized representative are the only one who can ask that you join <plan>.]*
- *[You have drug coverage through your job or your union. You told us you do not want to join <plan> because your coverage will change.]*
- *[You are not eligible for all Medicaid benefits.]*

If <plan> paid for any health services

<Plan> will send you a bill for any health services that <plan> paid for you.

If you think we made a mistake or you have questions

Please call <state/enrollment broker> at <toll-free number>, <days and hours of operation>. The call is free. TTY users should call <toll-free number>.

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 10: Model Notice for CMS Rejection of Enrollment

Referenced in §30.4.2

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Thank you for applying to join <plan>

Medicare has denied your request to join <plan> because *[States should add reasons, as appropriate]*:

- *[You do not have Medicare Part A. You must have Medicare Part A to join <plan>.]*
- *[You do not have Medicare Part B. You must have Medicare Part B to join <plan>.]*
- *[You have End Stage Renal Disease (kidney disease). If you have kidney disease, you cannot join <plan>.]*

If <plan> paid for any health services

<Plan> will send you a bill for any health services that <plan> paid for you.

If you think we made a mistake or you have questions

Please call <state/enrollment broker> at <toll-free number>, <days and hours of operation>. The call is free. TTY users should call <toll-free number>.

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 11: Acknowledgement of Request to Cancel Enrollment

Referenced in §50.2.1

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You won't be enrolled in <plan>

Your request to cancel your enrollment in <plan> was received and is being processed. It may take up to 45 days for your records to be updated. Tell your doctors that if they need to submit claims for your health services and prescription drugs, there may be a slight delay in updating your records.

[Insert if previously enrolled in another Medicare plan or PDP:

Your enrollment in <previous plan name> will continue

<Previous plan name> is the Medicare plan you were in before you requested to enroll in <plan>. If you don't get a letter from <previous plan name> by <date>, you should call them at <previous plan number> to confirm your enrollment.]

[Insert if previous enrollment status unknown:

If you were enrolled in another Medicare health or prescription drug plan before you enrolled in <plan>, you should be automatically enrolled back in that plan.

If you don't get an enrollment acknowledgement letter from your previous plan within 2 weeks of getting this letter, contact them to confirm your enrollment. They may request a copy of this letter for their records.]

What if I leave <plan> and I don't want to join a different Medicare-Medicaid plan or a Medicare Prescription Drug Plan?

If you don't want to join either a Medicare-Medicaid plan or a Medicare Prescription Drug Plan, you should call <state/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>.

Unless you tell your <state/enrollment broker> you don't want to join a different Medicare-Medicaid plan, <state> may enroll you in another Medicare-Medicaid plan in the future. If you leave <plan> and don't join a Medicare health or prescription drug plan on your own, you'll be covered under Original Medicare and Medicare may enroll you in a Medicare Prescription Drug Plan.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 12: Model Notice to Send Out Disenrollment Form

Referenced in §40.1

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

DIENROLLMENT FORM INCLUDED: USE THIS FORM TO LEAVE <plan> and ENROLL IN ORIGINAL MEDICARE

<Name>:

You asked us to send you a Disenrollment Form

We are including a Disenrollment Form with this letter. Before you fill out the form, please read this letter regarding your request to disenroll from <plan>.

When you leave <plan>, you will no longer have:

- One plan that combines all of your Medicare and <name of State Medicaid program> services
- *[insert if Plan offers care coordinators: A care coordinator to manage your providers and services and make sure you get the care you need]*
- *[insert if Plan offers additional services: Additional services that may be covered by this Plan]*
- One ID card for your Medicare and <name of State Medicaid program> health care and prescription drug services

Use the Disenrollment Form only if you want to change to Original Medicare with no Medicare prescription drug coverage

- If you don't want <state> to enroll you in another **Medicare - <name of State Medicaid program>** plan in the future, you should call <state/enrollment broker> at <toll-free number>, <days and hours of operation> and tell the representative you don't want to join a Medicare-Medicaid plan.
- You **should not** fill out this form if you are switching to another **Medicare health plan, including another Medicare - <name of State Medicaid program>** plan. When you join another Medicare health plan, we will automatically disenroll you from <plan>.
- You **should not** fill out this form if you are joining a **Medicare prescription drug plan**. When you join a Medicare prescription drug plan, we will automatically disenroll you from <plan> to Original Medicare.

Submitting the form

If you want Original Medicare and no prescription drug coverage, fill out the form, sign it, and:

- Mail the form to <state-specific Medicaid program name and address> in the return envelope, or
- Fax the form to us with a signature and date at <fax>.

Instead of filling out the form, you can call Medicare to disenroll from <plan name>. To disenroll from <plan>, to get information about Medicare plans in your area or to join a Medicare plan, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Getting your Medicaid Services

If you leave <plan> *[State should include instructions on state-specific Medicaid disenrollment policies]*

If you have questions

Please call <state/enrollment broker> at <toll-free number>, <days and hours of operation>. The call is free. TTY users should call <toll-free number>.

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 13: Model Disenrollment Form

Referenced in §§ 40.1, 40.1.3

<Plan> Disenrollment Form

Please keep this notice and a copy of the completed disenrollment form for your records. For more information on disenrollment, visit <website address> or call <state/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. If you would like to discuss other enrollment options, you can speak with a <SHIP counselor> at <SHIP phone number>.

Complete this form or call <state/enrollment broker> to leave <plan>

Complete this form **or** call <state/enrollment broker> at <toll-free number>, <days and hours of operation> to disenroll from <plan>. TTY users should call <toll-free number>. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Important information about disenrolling from <plan>

- You'll continue to get your health services from <plan> until the date your coverage ends. To find out when your coverage ends:
 - Call <state/enrollment broker toll-free number>. Be sure to find out before getting health and prescription services outside the <plan> network.
 - You'll get a letter telling you the date you'll no longer be a member of <plan> after we get this form from you or when you switch to another Medicare plan.
- If you do not enroll in another Medicare plan before the date your coverage ends in <plan>, you'll have Original Medicare, and Medicare may enroll you in a **Medicare prescription drug plan** or <state> may enroll you in **another Medicare-Medicaid plan**, unless you tell <state/enrollment broker> you don't want them to.
- You **do not** need to use this form or call <state/enrollment broker> if you're planning to enroll or have enrolled in a Medicare health or Medicare prescription drug plan, including another Medicare-Medicaid plan. Enrolling in another Medicare plan will automatically disenroll you from <plan>. To get information about Medicare plans available in your area, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov. TTY users should call 1-877-486-2048.

1. Please tell us about yourself:

Name (first, middle, last)		
Date of birth (month, day, year) (___ ___ / ___ ___ / ___ ___ ___ ___) M M D D Y Y Y Y		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
Phone number	Medicare number (located on your red, white and blue Medicare card)	Medicaid number (located on your state-specific Medicaid card)

2. OPTIONAL: Why are you disenrolling from <plan>?

--

3. If you **don't want to join a Medicare prescription drug plan or Medicare-Medicaid plan, place an in the box below.**

- I do not want Medicare to automatically enroll me in a Medicare prescription drug plan.
- I do not want <state> to enroll me in another Medicare-Medicaid plan.

4. Read & sign below:

You or your authorized representative (a person who acts on your behalf) must sign and date the form below. A person who signs the form, his/her signature shows that:

- He or she is authorized under State law to complete this disenrollment, and
- Medicare can ask for documentation that authorizes this individual to act on your behalf.

Your signature	Date
Representative's signature	Date

Authorized representatives must also complete the following information:

Representative's name		
Representative's address		
City	State	ZIP code
Representative's phone number () _____ - _____	Representative's relationship to enrollee	

Send us the form in one of two ways:

1. Mail your completed form to <state-specific Medicaid program name and address >.
2. Fax your completed form to <fax number>.

If you choose to mail or fax this form, please keep a copy of this form for your record.

For more information, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free phone number> <days and hours of operation>. TTY users should call <toll-free number>. The call is free. This information is available for free in other languages and formats like Braille or audio CD. *[The preceding sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]*

[<Marketing Material ID>]

Exhibit 14: Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member

Referenced in §40.1.3

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

We received your request to disenroll from <plan name>. You'll be disenrolled from <plan> on <date>. <Plan> will not pay for your *[Medicare or Medicare and <name of state Medicaid program>]* health services and prescription drugs after <date>.

You'll be covered by Original Medicare starting <date>

You'll get your Medicare health services through Original Medicare starting <date> if you don't enroll in a Medicare health plan. When you see a doctor through Original Medicare, you should use your red, white, and blue Medicare card to receive health care services.

If you have questions about Medicare plans in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

IMPORTANT: You need to choose a Medicare Prescription Drug Plan

When <plan> services end on <date>, <plan> prescription drug coverage ends too. You can enroll in a Medicare Advantage plan that includes prescription drug coverage or a Medicare Prescription Drug Plan. If you don't select a new prescription drug plan, Medicare will enroll you in one. If you don't want to join a Medicare prescription drug plan, you must call 1-800-MEDICARE. If you don't want <state> to enroll you in another Medicare-Medicaid plan in the future, you must call <state/enrollment broker> at <toll-free number>, <days and hours of operation>.

If you have questions or would like to join a Medicare Advantage or Medicare prescription drug plans, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

[If beneficiaries must enroll in a Medicaid health plan to receive their Medicaid benefits insert the following paragraph:

You must choose a <name of state Medicaid program> health plan to get your <name of state Medicaid program> benefits.

[States will need to modify this language] If you don't choose another <name of state Medicaid program> health plan, you'll be assigned to <plan should insert either a <name of state Medicaid

program> health plan or the <name of state Medicaid program> plan offered by <plan sponsor>.]

[If beneficiaries receive Medicaid services through FFS, please include the following language. States will modify this language:

You'll still get <name of state Medicaid program> services

Starting <date>, you'll get Medicaid services and can see any doctor that accepts Medicaid. If you have any questions, contact your State Health Insurance Assistance Program (SHIP) at <SHIP number>, or the < Medicaid> ombudsman (representing your concerns) at <ombudsman number>.]

Your health coverage change will happen soon

It may take up to 45 days for your records to be updated. If your doctors need to send claims, tell them that you just left <plan> and there may be a short delay in updating your records.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

If you have questions about Medicare or <name of state Medicaid program>

If you have questions about **Medicare**, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you have questions about **<name of state Medicaid program>**, call <Medicaid phone number>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 15: Model Notice to Request Information (Disenrollment)

Referenced in §40.1

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

We need more information from you

We received your request to disenroll from <plan>, but it is missing some information. We need the information below to process your request to leave <plan> (disenroll). *[States should add reasons, as appropriate.]*

- *[Your signature. please sign your form.]*
- *[You or an authorized representative need to tell us you would like to leave <plan>. Someone who is not your authorized representative asked that you leave <plan>. You or your authorized representative is the only ones who can request that you leave <plan>.]*
- *[Other reason]*

Please give us this information right away so we can process your request

- Call us at <toll-free number> to give us the information over the phone, **or**
 - Fax the information to us at <fax number>, **or**
 - Mail the information to us at:
 - <State>
 - <Mailing address>
 - <City,> <State> <ZIP>
- If you don't give us this information by <date>, you will stay in <plan>.

Other ways to disenroll from <plan>

You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a days, 7 days a week to ask to leave <plan> by telephone. TTY users should call 1-877-486-2048.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 16: Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)

Referenced in §40.1.3

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You're <plan> coverage is ending

You'll no longer be in <plan> as of <date>. You may want to tell your doctors that there may be a delay in updating your records.

If you think there was a mistake

If you didn't ask to leave <plan> and want to stay in <plan >, call <State/enrollment broker number> now. TTY users should call <TTY number>, <days> from <time> - <time>.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

If you have questions about Medicare or <name of state Medicaid program>

If you have questions about **Medicare**, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048. If you have questions about **<name of state Medicaid program>**, call <Medicaid phone number>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 17: Model Notice for Denial of Disenrollment

Referenced in §40.1.3

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You've asked to be disenrolled from <plan>. We can't process your request to disenroll from <plan> because:

[Insert the following as appropriate:

You didn't send us the information we needed by <date>.

Or

The request was made by someone other than you and that person isn't your authorized representative.]

If you think we made a mistake and you have questions

If you have any questions about the information in this letter, call <State/enrollment broker> at <enrollment broker number>, <days and hours of operation>. The call is free. TTY users should call <toll-free number>. You can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, or the <State> ombudsman at <ombudsman number> for more questions about the enrollment.

For information on your Medicare coverage, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 18: Model Acknowledgement of Request to Cancel Disenrollment

Referenced in §50.2.2

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You're enrolled in <plan>

We've received your request to cancel your disenrollment from <plan>. You'll continue to get your health and prescription drug services through <plan>. Keep using <plan> primary care *[insert the term the plan uses (e.g., Provider or Physician. Plans may also insert "physicians", "doctors", or "providers", if that is more appropriate)]* for your health care services and a network pharmacy for your drugs.

IMPORTANT: You need to cancel your other Medicare or prescription drug plan before it starts

If you've recently applied to join a Medicare health or prescription drug plan, but you want to remain in <plan>, you must call the other plan and tell them to stop processing your application.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

For information on your Medicare coverage, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 19: Model Notice for Disenrollment Due to Out of Area Status (No Response to Request for Address Verification)

Referenced in §40.2.1.3

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

IMPORTANT: Your health care & prescription drug coverage will change

On <date of notice requesting address verification>, you were sent a letter asking if you moved out of the <plan> service area. Because you didn't reply, **you've been disenrolled from <plan> on <disenrollment effective date>**. To be a member of <plan>, you must live in the <plan> service area, although you can temporarily leave the service area for up to 6 months in a row. Beginning, <effective date>, <Plan> will no longer cover any health care services or prescription drugs you get.

You'll be covered by Original Medicare starting <effective date>

You'll get your Medicare health care services through Original Medicare starting <effective date> if you don't enroll in a Medicare health plan. When you see a doctor through Original Medicare, you should use your red, white, and blue Medicare card to receive health care services.

You have the option to enroll in another Medicare health plan. If you have questions about Medicare plans in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

You may need to choose a new Medicaid plan

[States will need to modify this language] You may need to choose a Medicaid health plan to get Medicaid benefits. If you moved to a different state, you'll need to apply for Medicaid in that state.

Your prescription drug coverage has also changed

Your drug coverage ended on <effective date>. If you want prescription drug coverage, you need to join a Medicare Prescription Drug Plan or a Medicare Advantage plan with prescription drug coverage. If you don't choose a Medicare drug plan, Medicare will choose one for you.

You can join a new Medicare plan

If you don't want health coverage through Original Medicare, you can join a new plan that serves the area where you now live. Call 1-800-MEDICARE (1-800-633-4227) for information about plans that serve your area. TTY users should call 1-877-486-2048.

What to do if you disagree with your disenrollment in <plan>

If you don't agree with your disenrollment in <plan>, you can file a grievance asking us to reconsider our decision. Look in your <EOC document name> for information about how to file a grievance.

If you've moved, you must tell Social Security & Medicaid *[or state-specific Medicaid program]* your new address

If you've moved, call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) and tell them your new address. TTY users should call 1-800-325-0778. Also, call Medicaid at *[plan should submit appropriate information]* to tell them your new address and to find out your options for getting Medicaid benefits. If you've moved to a state that offers same coverage as <plan>, contact your local Medicaid office for more information about the enrollment.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 20: Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)

Referenced in §40.2.1.3

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

IMPORTANT: Your health care & prescription drug coverage has changed

Thank you for telling us your new address. Your permanent address is outside the <plan> service area. To stay a member of <plan>, you must live in the <plan> service area, although you can temporarily leave the service area for up to 6 months in a row. You will no longer be a member of <plan> as of <disenrollment effective date>. Because you've been disenrolled, <plan> won't cover any health care services or prescription drugs you get after <effective date>.

You'll be covered by Original Medicare starting <effective date>

You'll get your Medicare health care services through Original Medicare starting <effective date> if you don't enroll in a Medicare health plan. When you see a doctor through Original Medicare, you should use your red, white, and blue Medicare card to receive health care services.

You have the option to enroll in another Medicare health plan. If you have questions about Medicare plans in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

You may need to choose a new Medicaid plan

[States will need to modify this language] You may need to choose a Medicaid health plan to get Medicaid benefits. If you moved to a different state, you'll need to apply for Medicaid in that state.

Your prescription drug coverage has also changed

You won't have any prescription drug coverage through <plan> starting <effective date>. If you want prescription drug coverage, you need to join a new Medicare Prescription Drug Plan or a Medicare Advantage plan with prescription drug. If you don't choose a Medicare drug plan by <disenrollment effective date>, Medicare will choose one for you.

You can join a new Medicare plan

If you don't want health coverage through Original Medicare, you may join a new plan that serves the area where you now live. Call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov for information about plans that serve your area. TTY users should call 1-877-486-2048.

What to do if you disagree with your disenrollment in <plan>

If you don't agree with your disenrollment in <plan>, you can file a grievance asking us to reconsider our decision. Look in your <EOC document name> for information about how to file a grievance.

If you've moved, you must also tell Social Security & Medicaid *[or state-specific Medicaid program]* your new address

If you've moved, call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) and tell them your new address. TTY users should call 1-800-325-0778. Also, call Medicaid at *[plan should submit appropriate information]* to tell them your new address and to find out your options for getting Medicaid benefits. If you've already called Social Security and Medicaid and told them your new address, you don't need to call again.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 21: Model Notice for Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status - Notification of Involuntary Disenrollment

Referenced in §40.2.3

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Your health & prescription drug coverage is changing

[Insert if individual lost Medicaid status: Your <plan> health and prescription drug coverage will end on <date> because you no longer qualify for <name of state Medicaid program>.

<Plan> can cover your health and prescription drug benefits only if you're eligible for both Medicare and <name of state Medicaid program>.]

[Insert if individual lost State-specific status: Your <plan> health and prescription drug coverage will end on <date> because you no longer qualify to be enrolled in <Plan>. <Plan> can cover your health and prescription drug benefits only if you're eligible for both Medicare and <name of state Medicaid program> and <list State-specific eligibility requirement>.]

You'll be in Original Medicare and have a Medicare Prescription Drug Plan

When your <plan> services end on <date>, <plan> prescription drug coverage ends too. Medicare will enroll you in Original Medicare and in a Medicare Prescription Drug Plan. If you have questions or don't want Medicare to enroll you in a drug plan, you must call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

What to do if you want stay in <plan>

<Plan> can only cover your health services until <date>. If you think you might still qualify for <name of state Medicaid program>, please call <State> at <toll-free number>, <days and hours of operation>. The call is free. TTY users should call <toll-free number>. *[Insert other pertinent information about where person can re-apply for Medicaid].*

You can join another Medicare plan.

Because you no longer qualify for <name of state Medicaid program> and you are no longer eligible for <plan> after <date plan ends>, you have up to **two months** to join a Medicare health plan or Medicare prescription drug plan. Your new Medicare coverage will begin the 1st of the following month after you enrolled in a new Medicare health plan or Prescription Drug plan. If you don't take any action, your <plan> will continue to cover your Medicare benefits until <date plan ends>.

After two months have passed, you can make changes to your Medicare benefits only during certain times of the year.

Medicare limits when you can make changes to your coverage. From October 15 through December 7 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year.

There are exceptions to when you can make changes.

You can leave a plan at other times during the year if:

- you move out of the plan's service area,
- you want to join a plan in your area with a 5-star rating, or
- you qualify for *extra help* paying for prescription drug coverage. If you are getting *extra help* with your prescription drug costs, you may join or leave a plan at any time. If your *extra help* ends, you can still make a change for two months after you find out that you are not getting extra help.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

If you have questions about Medicare or <name of state Medicaid program>:

If you have questions about Medicare, please call 1-800-633-4227 (1-800-MEDICARE), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048. If you have questions about <name of state Medicaid program>, please call <Medicaid phone number>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 22: Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid

Referenced in §40.2.3.2

Keep this notice for your records

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name >:

You no longer qualify for <name of state Medicaid program>

Your health and prescription drug benefits will no longer be covered by <Plan> because you're no longer eligible for both Medicare and <name of state Medicaid program>. Even though you're no longer eligible for Medicaid, you can continue to get your benefits from <Plan> for up to 2 months. To stay a member of <Plan>, you must again qualify for <name of state Medicaid program> by *<insert end date for period of deemed continued eligibility>*.

How long will I have coverage?

<Plan> will continue to cover your benefits until *<insert end date for period of deemed continued eligibility>*. You have 2 months to again qualify for Medicaid.

When will my coverage end?

If you don't qualify for <name of state Medicaid program> within 2 months, you'll be disenrolled from <Plan>, and you'll get coverage through Original Medicare and a Medicare Prescription Drug Plan starting *<insert first of the month following the end date for period of deemed continued eligibility>*.

What can I do if I want to stay in <Plan>?

<Plan> can only cover your health and drug services until *<date period of deemed continued eligibility ends>*. **If you think you may still qualify for <name of state Medicaid program>, call <State> at <toll-free number>, <days and hours of operation>**. The call is free. TTY users should call <toll-free number>. *[Insert other pertinent information about where person can re-apply for Medicaid]*.

What do I do if my coverage ends?

If you're disenrolled from <Plan>, Medicare will enroll you in Original Medicare and a Medicare drug plan. You don't need to do anything for this to happen. If you don't want Medicare to enroll you in a drug plan or you have questions, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You can join another Medicare plan

Because you no longer qualify for <name of state Medicaid program> and you're no longer eligible for <Plan> after *<date plan ends>*, you have up to **2 months** following the end of the 2-month grace period to join a Medicare health or prescription drug plan. If you choose this option, your new Medicare health or drug coverage will begin the 1st day of the following month after you enrolled in the new health or drug plan.

After the 2 months are over, you can only make changes to your Medicare coverage during certain times of the year

If you don't change plans by <date>, you can only make changes to your Medicare coverage during certain times of the year. From October 15–December 7 each year, you can enroll in a new Medicare health or drug plan for coverage starting the following year.

There are exceptions to when you can make changes

You can leave a plan and join a new one at other times during the year if you meet certain special exceptions, including:

- You move out of the plan's service area
- You want to join a plan in your area with a 5-star rating
- You qualify for Extra Help paying for prescription drug coverage. If you're getting Extra Help with your drug costs, you may join or leave a plan at any time. If your Extra Help ends, you can still make a change for 2 months after you find out you're no longer getting Extra Help.

Who should I contact if I have questions?

- **If you have questions about <Plan>:**
 - Call <Plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>.
 - Visit <web address>.
 - Call <enrollment broker> at <enrollment broker number>.
- **If you have questions about Medicare:**
 - Visit www.medicare.gov.
 - Call 1-800-633-4227 (1-800-MEDICARE), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **If you have questions about <name of state Medicaid program>, call <Medicaid phone number>.**

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats, like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 23: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status

Referenced in §§40.2.4, 50.3

<date>

<Name>

<Address>

<City>, <State> <ZIP>

To the Estate of <Name>:

Our records show <name> has passed away. Please accept our condolences.

Because of this report of death, <name>'s coverage in <plan> *[Insert: ended or will end]* as of <disenrollment effective date>.

If this information is wrong and you've already contacted Social Security, disregard this letter. If this is wrong, here's how to fix this information:

1. Call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) to have your records corrected. TTY users should call 1-800-325-0778. **Ask Social Security to give you a letter that says they've fixed your records.**
2. Send a copy of Social Security's letter to<State> in the enclosed postage-paid envelope. You can also fax this information to <fax number of the State>. When we get this letter, we'll share this information with Medicare and Medicaid.

Note: Please keep using <plan> primary care *[insert the term the plan uses (e.g., Provider or Physician. Plans may also insert "physicians", "doctors", or "providers", if that is more appropriate)]* for your health services and network pharmacies while your records are being corrected by Social Security.

If you have questions

If you have any questions about this letter, call <State> toll-free at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>.

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 24: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination

Referenced in §§ 40.2.2, 50.3, 50.3.1

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

[IMPORTANT: Your Medicare coverage has been corrected.]

or

[IMPORTANT: Your Medicare coverage may end. Act now.]

We learned that your Medicare coverage has ended as of <date>. You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <plan>.

*[States that **are** able to verify current Medicare entitlement insert:
Social Security and Medicare will correct your record.]*

Or

*[States that **are not** able to verify current Medicare entitlement insert:
To stay in <plan>, do these 2 things no later than <insert the date that is 60 days from date of disenrollment notice>:*

1. Call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) to have them fix your records. TTY users should call 1-800-325-0778. **Ask Social Security to give you a letter that says they’ve fixed your records.**
2. Send a copy of Social Security’s letter to <State> in the enclosed postage-paid envelope. You may also fax this information to <fax number of the State>. When we get this letter, we’ll share this information with Medicare and Medicaid.]

Please keep using your <plan> primary care *[insert the term the State uses (e.g., Provider or Physician. States may also insert “physicians”, “doctors”, or “providers”, if that is more appropriate)]* for your health care services and your network pharmacy while your record is being corrected by Social Security and Medicare.

If you don’t have Medicare Part *[insert “A” and/or “B” as appropriate]*, or if you don’t send proof that you have Medicare by *[insert date: 60 days from date of disenrollment notice]*, you’ll have to pay for any health care service and prescription drug coverage you got after <disenrollment date>.

If you have any questions about this letter, call <State> at <toll-free number>, <days and hours of operation>. The call is free. TTY users should call <toll-free number>.

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 25: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to State or Plan Error

Referenced in §§ 50.2.2, 50.3

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You've been enrolled back in <plan> as of <effective date>

Thank you for letting us know you still want to be a member of <plan>. By mistake, we [*select one based on the circumstance*: disenrolled you from *or* cancelled your enrollment in] our plan. [*Insert brief summary of the State/plan error that caused the disenrollment.*] We've changed our records to show that you're still a member of <plan>.

Please keep using your <plan> primary care [*insert the term the plan uses (e.g., Provider or Physician. States may also insert "physicians", "doctors", or "providers", if that is more appropriate)*] for your health services and network pharmacy for your prescriptions.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

Thank you for your continued membership in <plan>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 26: Model Notice to Close Out Request for Reinstatement

Referenced in §50.3.2

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Your <plan> health services and prescription drug coverage have ended

Your <plan> health services and prescription drug coverage ended on <effective date>. You were sent a letter on <date of letter> asking you to send us information. This information was due to us by <date>. Because you didn't send this information by <date>, your health services and prescription drug coverage are no longer covered by <plan>.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

For information on your Medicare options, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 27: Model Acknowledgement of Reinstatement

Referenced in §§ 50.2.1, 50.3, 50.3.1, 50.6

Keep this notice for your records

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

The State has enrolled you back in <plan> as of <effective date>

There will be no break in your health services and prescription drug coverage. You should keep using <plan> primary care *[insert the term the plan uses (e.g., Provider or Physician. Plans may also insert “physicians”, “doctors”, or “providers”, if that is more appropriate)]* for your health care services and network pharmacy for your prescription drugs.

[Insert one of the following sentences depending on plan policy:

You’ll get a new ID card and other information for <plan>.

or

Keep using the <plan> ID card that you currently have.

or

Call us at <phone> if you can’t find your ID card and need a new one.]

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

Thank you for your continued membership in <plan>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English

version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 28: Acknowledgement of Request to Opt Out of Passive Enrollment into Medicare-Medicaid Plan (not connected to request to disenroll or cancel enrollment in MMP)

Referenced in §30.1.4

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

We got your request not to be enrolled in <plan>.

You told us you don't want <name of State Medicaid program> to enroll you in an Medicare-Medicaid Plan. We have notified <name of State Medicaid program> and <Medicare> and they will not enroll you again.

Important: If you were enrolled in another Medicare Advantage plan or Medicare prescription drug plan before enrolling with <plan name>, you should be automatically enrolled back into that plan.

If you don't receive an enrollment acknowledgement letter from your previous plan within two (2) weeks of receiving this letter, please contact them to confirm your enrollment. They may request a copy of this letter for their records.

You can change your mind about your coverage

If you change your mind and decide you would like to join <Medicare-Medicaid Plan>, call <enrollment broker> at <enrollment broker number>, <days> from <time>-<time>. TTY users should call <TTY number>.

To learn more about <Medicare-Medicaid Plan>, visit <web address>, or call Member Services at <plan toll-free number>< days and hours of operation>. TTY users should call <TTY number>, <days> from <time> to <time>.

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman's number>.]

If you have questions about Medicare or <name of state Medicaid program>

If you have questions about **Medicare**, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.medicare.gov. TTY users should call 1-877-486-2048. If you have questions about <name of state Medicaid program>, call <Medicaid phone number>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 29: Model Notice for Enrollment Status Update

Referenced in §50.6

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Your enrollment in <plan> has changed

[Insert one or more of the following, including sufficient detail to describe the specific enrollment change:

You'll now get your health care services and prescription drug coverage through <plan>

Your <plan> coverage starts <start date> and ends <end date>. *[Plan should insert information about how to access coverage, etc.]*

or

You'll now get your health care services and prescription drug coverage through <new plan name>

Your enrollment in <name of old plan> has been changed to <name of new plan>. Your coverage with <new plan name> starts <date>. *[Plans should insert information on cost sharing information, and other details the individual will need to ensure past and future coverage is clear.]*

or

Your <plan> health care services and prescription drug coverage will start on <date>

Your coverage in <plan> will start on <date>. This date is earlier than you were originally told. *[Plans should include information about coverage, and how to get refunded for prescriptions purchased in the period of retroactive coverage.]*

or

Your <plan> health care services and prescription drug coverage will start on <date>

Your coverage in <plan> will start on <date>. This date is later than you were originally told. *[Plans should insert information about impact to paid claims.]*

or

Your <plan> health care services and prescription drug coverage [ended **or will end] on <date>**

Your coverage in <plan> [ended **or** will end] on <date>. This means you [don't **or** won't] have coverage through <plan> after this date. *[Plans should insert appropriate descriptive information, such as impact on paid claims or how to submit claims, as applicable.]*

or

Your enrollment in <plan> will end soon

Your <plan> health services will end on <date>. This means you won't have coverage through <plan> after this date. *[Insert information about impact to any paid claims.]*

[Insert other pertinent and appropriate information regarding the enrollment status update and the resulting impact to the beneficiary as necessary.]

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

[<Marketing Material ID>]

Exhibit 30: Model Notice to Research Potential Out of Area Status – Address Verification Form included

Referenced in §40.2.1.3

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

IMPORTANT: We need to know where you live

If you don't contact us to verify your address, you will be disenrolled from <plan name> effective <disenrollment effective date>. This means that you will no longer be able to get health services or prescription drug coverage through <plan> as of this date.

If you've moved, you may no longer live in <plan>'s service area. Please provide your new address by <day prior to the disenrollment effective date>.

How to provide your address

You can do one of the following:

1. **Call** <phone>, <days> from <hours>. TTY users should call <TTY number>.
2. **Fill out the "Address Verification Form"** and return it in the enclosed envelope or by fax.

Your permanent address must be inside <plan>'s service area

You can be away from <plan>'s service area for up to 6 months in a row and still stay a member of <plan>. If you move and your new address is outside the service area, or if you leave the area for more than 6 months in a row, you'll be disenrolled from <plan>'s health services and prescription drug coverage. If you're disenrolled, you'll be able to join a plan that serves the area where you now live.

You must also tell Social Security about your address change

If you've moved and haven't told Social Security your new address, call 1-800-772-1213 (Monday to Friday 7am – 7pm). TTY users should call 1-800-325-0778.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY user should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States that will send this notice should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about enrollment, you can also call your State Health Insurance Assistance Program at <number>, or the <State> ombudsman at <ombudsman number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] This information is available for free in other languages and formats like Braille or audio CD.

Address Verification Form

What is your permanent address?

Provide the permanent address where you live. This can't be a P.O. box.

Address		
City	State	ZIP code
County	Phone	

Temporary address

(You may skip this section if you're living at your permanent address.)

If you don't live at your permanent address, what is your temporary address?

This can't be a P.O. box.

Address		
City	State	ZIP code
County	Phone	
When did you begin living at this address?	When do you think you'll go back to your permanent address?	

Where you would like to get your mail?

Address		
City	State	ZIP code

Send us the form in one of two ways:

1. Mail your completed form to <address>.
2. Fax your completed form to <fax number>.

For more information, visit <web address>. **If you have questions,** call <plan> at <toll-free number>, <days and hours of operation>. The call is free.

[<Marketing Material ID>]