



**Memo to Long Term Care Facilities on Disenrollment Issues
(05/26/15)**

ISSUE:

Only a Medicare beneficiary, the beneficiary’s legal representative or the party authorized to act on behalf of the beneficiary under state law (collectively “the representative”) can request enrollment or voluntary disenrollment from a Medicare plan. This applies equally for beneficiaries receiving care in a nursing facility or skilled nursing facility (Long Term Care, or LTC facilities). The CMS continues to see an unacceptable practice of LTC facilities disenrolling beneficiaries from Medicare advantage prescription drug plans (MAPDs) and enrolling them into stand-alone drug plans (PDPs) **without the beneficiary’s or the representative’s knowledge and/or complete understanding.** This action automatically returns the beneficiary to Original Medicare coverage for those services covered by Parts A and B. This practice is noncompliant with regulatory requirements.

Similarly unacceptable practices have been seen among LTC facilities serving Medicare-Medicaid (dually eligible) enrollees eligible to join a Medicare-Medicaid plan (MMP) as part of a demonstration under the Financial Alignment Initiative.¹ The same general regulatory requirements also apply in these circumstances (see discussion of demonstrations on the next page).

BACKGROUND:

CMS has received complaints from beneficiaries and their representatives, usually after the beneficiary has been discharged from the LTC facility, alleging they have been disenrolled from their MAPD plan without their consent. The discharged beneficiary finds out his or her Medicare Advantage (MA) coverage was terminated when he or she tries to access services and/or starts receiving bills for services that he or she believed the MAPD plan should cover. It is at this point that either the provider or the MA/MAPD plan informs the beneficiary that his/her enrollment was terminated.

In addition, CMS and the states have received mass requests, all initiated and completed by LTC facility staff, to opt out or disenroll LTC facility residents from MMP coverage under the Financial Alignment Initiative.

FACILITY’S RESPONSIBILITY:

Any change in a beneficiary’s health care coverage must be initiated by the beneficiary or his/her representative. If a beneficiary or their legal representative requests assistance from the LTC facility in changing the beneficiary’s health care coverage, the LTC facility should take the following steps to help ensure changes to a beneficiary’s health coverage comply with regulations regarding enrollment/disenrollment and resident rights:

¹ These demonstrations include Cal MediConnect in California, Medicare-Medicaid Alignment Initiative in Illinois, One Care in Massachusetts, MI Health Link in Michigan, Fully Integrated Duals Advantage (FIDA) in New York, MyCare in Ohio, Healthy Connections Prime in South Carolina, Dual Eligibles Integrated Care Demonstration in Texas, and Commonwealth Coordinate Care in Virginia



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#1) Explain **orally** and in **writing** the impact to the beneficiaries if they change to a stand-alone drug plan and Original Medicare. Information at a minimum should include:

- A clear explanation that the beneficiary would no longer be a member of the MAPD or MMP.
- An explanation that medical services will be billed to original Medicare and/or Medicaid and what this means regarding deductibles and copays and loss or lack of supplemental coverage for the beneficiary.
- The name of the drug plan that will cover the beneficiary's medications, including the deductible and co-pays/coinsurances especially related to their current drug therapy.
- Specific information regarding the beneficiary's opportunities to change Medicare plans and Medicare prescription drug coverage while in the facility (i.e. every month) and when discharged (i.e. for 2 months following the month of discharge) or by virtue of being eligible for Medicare and Medicaid (i.e. every month).
- An explanation that enrollment in the PDP will be effective the first day of the month following the month of enrollment/disenrollment.
- An explanation that in some cases the beneficiary may not be able to reenroll into the MA or MAPD plan the beneficiary previously had (or for that matter into any MA or MAPD plan) even if the beneficiary has a valid election period. (E.g. beneficiaries with ESRD that disenroll from an MA plan and return to original Medicare can never re-enroll in an MA plan; such beneficiaries must stay with original Medicare until the beneficiary no longer meets the definition of having ESRD. Employer sponsored MAPDs may not and do not have to accept a beneficiary back into the plan).

#2) Develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage that at a minimum include:

- Under what circumstances the facility can assist a beneficiary with a plan change.
- The need to obtain a document signed by the beneficiary or representative that acknowledges the specific information regarding the impact of a change in coverage was provided to them orally and in writing and that they understand the information.
- The need to obtain an attestation signed by the facility staff member that assisted with the change in enrollment attesting that the beneficiary or representative requested the change and that the beneficiary or representative (as applicable) received and understood the minimum required information listed above.

CONSEQUENCES OF BENEFICIARY DISENROLLMENT BY A LTC FACILITY

If documentation of a beneficiary's request to change enrollment cannot be provided by a LTC facility, CMS will consider the enrollment not to be legally valid, cancel the enrollment action and, if necessary and appropriate, reinstate the beneficiary's MA, MAPD or MMP coverage as if never disenrolled (Medicare Managed Care Manual, Chapter 2, Sec. 40.6). CMS will be reporting these incidents to the Medicare Drug Integrity Contractor (MEDIC) that investigates fraud and abuse incidents.



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Demonstration under the Financial Alignment Initiative:

Nine states (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia) currently participate in demonstrations in which MMPs enter into three-way contracts with CMS and the state to provide all services covered by Medicare Parts A, B, and D and Medicaid services, including SNF and nursing facility care. MMPs are required to coordinate delivery of Medicare and Medicaid services in order to improve the quality of care and the beneficiary's experience.

Medicare-Medicaid enrollees can enroll in an MMP by submitting a valid request for enrollment or through the passive enrollment process in which the state assigns Medicare-Medicaid enrollees to an MMP. Assignment may take into account the enrollee's current enrollment in a Medicaid managed care plan (if any) and the enrollee's current providers, including the nursing facility in which the enrollee may reside. Medicare-Medicaid enrollees receive prior notice of passive enrollment and can opt out prior to the date of enrollment or disenroll at any time after enrollment. Individuals who opt out or disenroll can choose Original Medicare and a stand-alone prescription drug plan or a Medicare Advantage with drug coverage (MAPD). **Only a beneficiary or his/her representative can execute a valid request to opt out or disenroll from an MMP or enroll in a PDP or MAPD.**

Continuity of Care under the Financial Alignment Initiative:

MMPs are required to continue to cover ongoing courses of treatment under existing providers, including through single case agreements, both for individuals who actively enroll in the MMP and for individuals who are passively enrolled. Continuity of care requirements include Medicaid coverage of nursing facility services and Medicare skilled nursing facility services. More Information for providers on continuity of care requirements is available from your state Medicaid agency.

ENROLLMENT PERIODS:

An institutionalized beneficiary has a continuous open enrollment period (OEPI) for purposes of changing enrollment in Medicare Advantage plans; this period does not end until two months after the month the beneficiary moves out of the institution.

Medicare-Medicaid beneficiaries have a continuous special enrollment period that permits them to enroll in a MA, MAPD, PDP, or MMP (in applicable states and subject to state-specific eligibility rules) during any month. As previously noted this enrollment is only valid when executed by the beneficiary/legal representative or as State law allows. The Medicare Managed Care Manual Chapter 2 has a full description of the relevant special enrollment periods.

DIVISION OF MEDICARE HEALTH PLANS OPERATION (DMHPO) RESPONSIBILITIES:

The following action will be taken when CMS becomes aware that a beneficiary's MAPD enrollment has been terminated and the beneficiary alleges that they did not request/know/understand that this was done. CMS will look to the facility to provide the above



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noted documentation to support that it appropriately assisted the beneficiary with their choice to change coverage. If the facility has the beneficiary sign documentation regarding their understanding of the change, we will expect to find that the beneficiary's assessed cognitive level also supports an ability to understand this type of information.

SURVEY AND CERTIFICATION RESPONSIBILITIES:

State Survey Agencies will continue to monitor LTC facilities for compliance with regulations at 42 CFR Part 483 and the accompanying surveyor guidance in Appendix PP of the State Operations Manual (SOM). To the extent a survey or complaint investigation finds a facility has changed a resident's Medicare plan enrollment or disenrolled a resident from their Medicare plan, surveyors should consider the facility's compliance with the following Federal regulations, as applicable.

- 42 CFR 483.10 (a)(3) and (4) *In the case of a resident adjudged incompetent ..., the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf and In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.* The facility should verify that a surrogate or representative has the necessary authority to make both financial and health care decisions. The facility must respect the resident's wishes to delegate decision-making authority. The surveyor may consider F152 if someone other than the appointed or designated representative is making decisions for the resident, Appendix PP, Chapter 7 of the SOM.
- 42 CFR 483.10(d)(2) *The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.* A change in health insurance coverage may affect a resident's medical care and treatment. A LTC facility may not play a role in changes to a resident's health insurance coverage without the resident's or designated representative full knowledge and consent. F154 in Appendix PP of Chapter 7 of the SOM provides guidance on the resident's right to be informed of health status, care and treatment.
- 42 CFR 483.12(d)(1)(i) *The facility must not require residents or potential residents to waive their rights to Medicare or Medicaid.* Surveyor guidance at F208 in Appendix PP of Chapter 7 of the SOM clarifies that facilities must not seek a direct or indirect waiver of rights to Medicare or Medicaid benefits. Under no circumstances, should a LTC facility require, request, coach, or steer any resident to select or change a plan for any reason.

See also the letter from the Center for Medicaid and State Operations/Survey and Certification Group (<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter06-16.pdf>) for information regarding surveyors' responsibilities related to LTC facility and Medicare Part D.



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RESOURCES - applicable regulations/requirements and manual directives:

- **Medicare Managed Care Manual**, Chapter 2; Section 30.3 Open Enrollment Period for Institutionalized Individuals (OEPI); Section 30.4.4.5 Special Enrollment Period for Dual Eligible Individuals (Medicare-Medicaid Enrollees)
- **Medicare Managed Care Manual**, Chapter 2; Section 40.2.1 Who May complete an Enrollment or Disenrollment Request)
- **42 C.F.R. § 422.60(c)** ... (c) *Election forms and other election mechanisms.* (1) The election must comply with CMS instructions regarding content and format and be approved by CMS as described in §422.2262. The election must be completed by the MA eligible individual (or the individual who will soon become eligible to elect an MA plan) and include authorization for disclosure and exchange of necessary information between the U.S. Department of Health and Human Services and its designees and the MA organization. Persons who assist beneficiaries in completing forms must sign the form, or through other approved mechanisms, indicate their relationship to the beneficiary.
- **42 C.F.R. § 423.32 Enrollment process. . . (b) (i)** The enrollment must be completed by the individual... Individuals who assist beneficiaries in completing the enrollment, including authorized representatives, must indicate they have provided assistance and their relationship to the beneficiary.
- **State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities**, This appendix includes the Federal requirements an institution must meet to qualify for participate in the Medicare and Medicaid Programs as a Long Term Care Facility and provides guidance to aid surveyors in interpretation of these requirements, http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.
- **State-specific information on the Financial Alignment Initiative**, including information for providers, is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>