Good Cause Process and Operational Changes
Frequently Asked Questions
December 11, 2015

A. Triage Process

A1: Will CMS share the 1-800-MEDICARE scripts?

CMS will outline the process used by Medicare Customer Service Representatives (CSRs), including the sequence of questions used to determine an individual's eligibility to request reinstatement for good cause. This information will be posted on the Medicare Advantage (MA)/cost and Prescription Drug Plan (PDP) enrollment webpages.

A2: When the plan's CSR explains to the individual about their disenrollment for nonpayment of plan premium, should the CSR ask the individual if they had an unforeseen or uncontrollable circumstance as to why they didn't pay timely to start the good cause triage process?

No. The individual needs to initiate the request for good cause.

A3: Should the CSR tell the individual the situations listed in guidance, ask leading questions or provide examples when determining eligibility to make the good cause request or when initially asking for the individual's situation that prevented timely payment of premiums?

No. Plans should not ask leading questions or provide examples of unexpected or unforeseeable circumstance when initially asking if the individual had a reason for nonpayment of plan premium as part of the triage process or when initially collecting the individual's circumstance information. Following the individual's initial description of the reason for nonpayment, plans will need to probe to obtain sufficient detail of the circumstance provided by the individual (e.g., dates, duration, etc.) to determine if the good cause request can be approved.

A4: May the plan accept a request for reinstatement for good cause beyond the 60-day period if an individual alleges having experienced an exceptional circumstance that prevented a timely request?

No. To be eligible to make a good cause reinstatement request, the former member (or his or her authorized representative) must contact the plan within 60 days of the disenrollment effective date. Plans should consider requests received after the 60-day period as not meeting the initial screening criteria.

A5: During triage, if the former member does not meet the eligibility criteria to make a good cause request, is that considered a determination and is a notice for an unfavorable determination required?

No. The screening questions determine whether an individual is able to request reinstatement for good cause. The fact that an individual does not meet the initial screening criteria does not constitute an unfavorable good cause determination and, therefore, the notice regarding an unfavorable determination would not be issued. However, the caller must be told/notified that they are not eligible to request good cause at the time they are determined not eligible.

B. Processing Good Cause Requests

B1: Is the date the good cause request is received "Day 1" or "Day zero" for the purpose of counting the 5 business day requirement?

For the purpose of assessing compliance with this requirement, CMS will count the reinstatement request receipt date as "Day zero" and the following day as "Day 1."

B2: Would a former member's allegation of non-receipt of the premium bill constitute good cause?

No. As stated in the 2016 MA, PDP and cost plan enrollment guidance, an allegation that a premium bill was not received does not constitute good cause.

B3: Can the plan issue an unfavorable determination because information obtained during intake didn't include enough detail?

Yes; however, plans are strongly encouraged to obtain all necessary information during the initial contact with the individual submitting the reinstatement request. During the initial intake process, the plan determines the former member's eligibility to request reinstatement for good cause by ascertaining whether the request is made within 60 calendar days, obtaining affirmation that the member can pay the owed amounts within 3 months, and that the member had an unusual or unexpected circumstance that prevented them from making timely payment. If all three criteria to make a good cause request are met, the plan should, during that initial intake process, obtain the credible statement of the unforeseen circumstance and details surrounding that circumstance (dates, duration, etc.). Since plans have only 5 business days to make a determination, plans should conduct any follow-up by phone (not in writing) to obtain any details necessary to inform the decision. CMS expects that plans will make an effort to obtain necessary information not provided during the initial intake during this 5 business day window. Plans must make either a favorable or unfavorable determination within the 5 business day period; the determination will be based on the information the plan was successful in obtaining during this period.

B4. If the plan makes an unfavorable determination because it was unable to obtain information necessary during the 5 business day window, would the plan include the language in the model notice about being unable to reach the beneficiary?

Yes. Should the plan be unsuccessful in its attempts to reach the former member to obtain additional information and the resulting determination is unfavorable, the plan may use the language in the model notice that indicates it was unable to reach the beneficiary.

B5: Is there a conflict between the "3 calendar day" requirement included in the guidance update memo and the "3 business day" requirement included in the enrollment guidance materials posted on the enrollment webpage?

Yes. CMS inadvertently put "3 calendar days" in the Health Plan Management System (HPMS) memorandum. The information in the 2016 MA, PDP and cost plan enrollment guidance currently posted on the CMS enrollment webpage is correct. If the plan makes a favorable determination and there are amounts owed to the plan for past due premiums, the plan should notify the individual of this decision in writing within three (3) business days of making the determination.

B6: The 2016 enrollment guidance materials state that "plans have five (5) calendar days beyond the payment deadline to process the payment and submit the reinstatement request to the CMS Retroactive Processing Contractor (RPC)." Is it 5 days for both processing the payment <u>and</u> getting the request to RPC?

Yes. Plans have up to 5 calendar days from the payment receipt date to submit the reinstatement to the RPC. This 5 day period includes any additional time plans may need to verify payment by the bank and credit the payment to the individual's account.

B7: If the plan issued a favorable determination and the premium amounts owed are satisfied, will the plan be required to send the decision in writing within 3 business days?

No. As stated in the 2016 MA, PDP and cost plan enrollment guidance, if the plan offers immediate payment options, such as payment by credit card via phone, and the individual completes the payment at that time, verbal communication/notification of the favorable determination is acceptable.

B8: Would Employer/Union Group Health Plan (EGHP) members disenrolled for nonpayment of plan premium be eligible for an SEP to make a new enrollment request back into the plan if the plan determines they do not meet the criteria for good cause reinstatement?

Yes. The option to request reinstatement for good cause does not affect an individual's eligibility for another SEP. If an EGHP member has a valid SEP, they can use the SEP to request a new enrollment in a plan for a prospective enrollment effective date. If the plan receives an enrollment request from an individual who owes a premium amount from a previous enrollment, the plan may consider the enrollment request to be incomplete until the delinquency is resolved.

B9: Can plans submit reinstatement requests through the daily submission file as opposed to the RPC if it's within applicable timeframes?

No. Since reinstatement for good cause will always take place after the disenrollment effective date, all reinstatements approved by plans will need to be sent to RPC.

B10: Which model notice should MA organizations issue upon receipt of Transaction Reply Code (TRC) 287? Is the same model notice applicable to receipt of TRC 713?

As stated in the 2016 MA enrollment guidance, reinstatements for good cause are considered complete by CMS when TRC 287 (Enrollment Reinstated) is sent by CMS to the plan. Within 10 calendar days of receipt of TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a). The same model notice is referenced in the guidance for TRC 713 (UI Removed End Date), where it is stated that organizations use Exhibit 25a to explain the reinstatement.

B11: How would the audit/monitoring protocol be implemented? Would it be done by the RPC?

The audit/monitoring protocol will be developed in 2016. At this time, CMS is still in the initial phases of determining the data elements to be included in this protocol.

B12: How will CMS handle duplicate Complaint Tracking Modules (CTMs) already resolved by the plan?

CMS expects plans to follow current processes outlined in the 2015 CTM Standard Operating Procedure (SOP). If the prior complaint had been resolved satisfactorily, the plan should close the complaint and note it was a repeat complaint in the resolution notes. The plan should verify the beneficiary has been informed of the resolution. However, if the first complaint is sufficiently distinct from the second complaint, the plan is to keep both complaints open until they are resolved.

B13: When will the Complaints Tracking Module (CTM) Standard Operating Procedures (SOP) be released?

The CTM SOP effective January 1, 2016, will be released in December 2015.