

Date: 10/5/2005

To: All Medicare Advantage (MA) Plans

From: Anthony Culotta /s/
Director, Medicare Enrollment and Appeals Group

Subject: Clarifications to Chapter 2 of the Medicare Managed Care Manual

The purpose of this letter is to provide clarification to Chapter 2 (Medicare Advantage Enrollment and Disenrollment) of the Medicare Managed Care Manual that was published in August 2005. This information will be included in the next update of Chapter 2. The following clarifications and additions are included in this letter:

- Clarifications to premium withhold option - **IMMEDIATE ACTION REQUIRED**
- Optional Telephonic Enrollment for current and potential members
- Combined acknowledgement/confirmation notice option
- Required language for Part D payment demonstrations
- Updated URL for CMS internet architecture requirements
- Clarification of section 40.2 – K; Premiums Owed to the MA organization
- Clarification of disenrollment process for nonpayment of plan premium
- Employer group enrollments and disenrollments
- Exhibit 12b: Model notice for CMS Rejection of Disenrollment
- Auto-enrollment for Full-Benefit Dual Eligible MA Members & Clarification of transition of full benefit duals to MA-PD with lowest premium
- Clarification of the use of Exhibit 27 versus the Annual Notice of Change (ANOC)

1. Premium withhold option – There are two important clarifications to the premium withhold option:

- At this time, neither the Railroad Retirement Board (RRB) nor the Office of Personnel Management (OPM) are able to process plan premium withhold requests. We will inform MA organizations when this option becomes available in the future. Until the RRB and OPM process becomes operational, beneficiaries will only be able to have plan premiums withheld from their Social Security (SSA) benefit check.
- Plans with monthly premiums that are not in ten cent increments (that is, a premium of \$32.65, rather than \$32.60 or \$32.70), must insert the following language in their beneficiary enrollment acknowledgement notices and any other notice provided to a beneficiary in response to a premium withhold request:

"Note: Although our monthly premium is [Insert plan premium], we will only collect [insert amount rounded down to ten cent amount] per month via your Social Security benefit, due to a minor computer processing issue. This small difference [insert: total yearly difference = difference x 12] requires no action on your part, absent further notice. If you have any questions about this process, please call [the plan's customer contact number]."

If you have already submitted the acknowledgement notice to the regional office for marketing approval, you may insert the language verbatim without additional review.

2. Telephonic Enrollment Option - Beginning November 15, 2005, MA organizations may accept requests for enrollment into their MA plans via an incoming (in-bound) telephone call. The following guidelines must be followed, in addition to all other program requirements:

- Enrollment requests may be accepted only during an incoming (or in-bound) telephone call from a beneficiary.
- Individuals must be advised that they are completing an enrollment.
- Each telephonic enrollment request must be recorded and include statement of the individual's agreement to be recorded, all required elements necessary to complete the enrollment (as described in Appendix 2), and a verbal attestation of the intent to enroll. All telephonic enrollment recordings must be maintained as provided in section 60.8 of Chapter 2.
- Collection of financial information (e.g. a credit card or bank account number) is prohibited at any time during the call.
- A notice of acknowledgement and other required information must be provided to the individual as described in Chapter 2 of this guidance.

The MA organization must ensure that all MA eligibility and enrollment requirements provided in Chapter 2 are met. Scripts for completing an enrollment request in this manner must be developed by the MA plan. The scripts must contain the required elements for completing an enrollment request as described in Appendix 2 of Chapter 2, and must obtain CMS approval in accordance with CMS Marketing Guidelines before use.

3. Combined Acknowledgement and Confirmation Notice - MA organizations may choose to provide required notices in response to CMS Transaction Reply Reports (TRR) in 1 of 2 ways:

1. The MA organization may use the Monthly TRR and follow the guidance in Chapter 2 as it appears today (i.e. providing both the acknowledgement and confirmation notice), or;
2. The MA organization may provide a single notice in response to the new weekly, or "mini" TRR. If the organization chooses this option, this notice must include language required in the acknowledgement notice (exhibits 4 and 4a) per §40.4.1 and the language from the confirmation notice (exhibits 6, 6a

and 8 respectively) per §40.4.2. This single notice must be provided within 5 business days of the receipt of the weekly (mini) TRR.

The organization must choose to send notices based upon **either** the monthly OR weekly reply – it may not utilize both options.

4. Part D Payment Demonstrations - Employer or union groups are prohibited from making payments of any kind on behalf of an individual enrolling in a Part D payment demonstration plan. Except for current MA enrollees who are becoming enrollees of an MA-PD Part D payment demonstration plan through the plan renewal process, each new individual enrolling in such a plan will be required to provide an attestation regarding employer or union group payment. MA organizations must include the following attestation statement along with the other required “statements of understanding” in all enrollment requests vehicles (e.g. the enrollment form) for individuals joining a Part D Payment Demonstration MA-PD plan:

“By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare drug plan.”

5. Updated URL for CMS internet architecture requirements - please refer to <http://www.cms.hhs.gov/it/enterprisearchitecture/default.asp> for use in developing both enrollment (section 40.1.3) and disenrollment (section 50.1.1) internet options.

6. Premiums Owed to the MA Organization - Section 40.2 is clarified as follows:

K. Premiums Owed to the MA Organization – For individuals enrolling in an MA-only (non MA-PD) plan, an MA organization may choose to wait for an enrolling individual’s payment of the MA-only plan premium before considering the enrollment election complete. An MA organization cannot consider an enrollment election incomplete if the individual enrolling has indicated that he or she wants the plan premium withheld from an SSA, or in the future RRB or OPM, benefit check.

For enrollment into either an MA-only or MA-PD plan, an MA organization may consider an enrollment election incomplete if there are premium amounts due to the organization from a prior enrollment, whether or not premium withhold from an SSA, RRB or OPM benefit check is selected.

The option chosen by the MA plan to consider the application complete or incomplete must be applied consistently to all members of the plan.

7. Disenrollment for Nonpayment of Premium - This information clarifies the guidance provided in section 50.3.1 of Chapter 2.

In the case of an enrollee who requests premium withhold from an SSA benefit check (and in the future, from an RRB or OPM check), the MA organization must wait until it receives a reply from CMS rejecting this request (e.g., if the individual does not have a benefit large enough to pay the entire premium through withholding) before considering the premium “unpaid.” The MA organization must then notify the enrollee when a premium withhold request is rejected and provide him or her with an opportunity to pay the premium. The grace period must be extended to accommodate this process.

If the individual does not provide payment by the due date, the plan would initiate the non-payment of premium process. The MA organization must send a notice of non-payment of premiums **within** 7 business days after the premium due date (MA Exhibit 19).

Calculating the Grace Period:

An MA plan must provide plan enrollees with a grace period of not less than 1 calendar month; however it may provide a grace period that is longer than 1 month, at its discretion.

The **grace period** must be a minimum of 1 calendar month that begins on the 1st day of the month on or after the due date for the unpaid premium amount. However, the grace period cannot begin until the individual has been notified of/billed for the actual premium amount due, with such notice/bill specifying the due date for that amount and providing an opportunity to pay. For new enrollees, an MA organization must wait until notified by CMS of the actual premium which the beneficiary is responsible for paying directly before the individual can be notified of/billed for the amount due. Thus, for these individuals, the due date cannot be until after the MA organization receives notification from CMS as to the beneficiary’s premium and it notifies the individual of the amount due. The grace period can then begin no earlier than the first day of the month on or after the due date.

8. Group Enrollment for Employer/Union Sponsors - CMS is providing a process for group enrollment into an employer group or union sponsored MA plan.

CMS will allow an employer group or union to enroll its retirees using a group enrollment process that provides CMS with any information the employer group or union has on other insurance coverage for the purposes of coordination of benefits.

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

- All beneficiaries must be notified that the group intends to enroll them in a MA plan that the group is offering; and

- The beneficiary may affirmatively opt out of such enrollment; the process to opt-out; and any consequences to group benefits opting out would bring; and
- This notice must be provided not less than 30 calendar days prior to the effective date of the beneficiary’s enrollment in the group sponsored MA plan.

Additionally, the information provided must include a summary of benefits offered under the group sponsored MA plan, an explanation of how to get more information about the MA plan, and an explanation on how to contact Medicare for information on other Medicare Health Plan options that might be available to the beneficiary. Each individual must also receive the information contained in Exhibit 2 of the Chapter 2 guidance, under the heading “Please Read & Sign Below.”

The employer group or union must provide all the information required for the MA organization to submit a complete enrollment request transaction to CMS as described in Chapter 2 of the Medicare Managed Care Manual (please refer to Appendix 2 of Chapter 2 for a complete list of the required data elements and any other relevant CMS systems guidance). Records must be maintained as outlined in section 60.8 of this chapter.

9. Group Disenrollment for Employer/Union Sponsors - CMS is providing a process for group disenrollment from an employer group or union sponsored MA plan.

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

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

- All beneficiaries must be notified that the group intends to disenroll them from the MA plan that the group is offering; and
- This notice must be provided not less than 30 calendar days prior to the effective date of the beneficiary’s disenrollment from the group sponsored MA plan.

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

The employer group or union must have and provide all the information required for the MA plan to submit a complete disenrollment request transaction to CMS as described in this and other CMS MA systems guidance. Records must be maintained as outlined in section 60.8 of this chapter.

11. Exhibit 12b – Model Notice for CMS Rejection of Disenrollment - Please correct the first sentence of this model by changing the word “enrollment” to “disenrollment.”

12. Auto-enrollment for Full-Benefit Dual Eligible MA Members & clarification of transition of Full Benefit Duals to the MA-PD with lowest premium

Auto-enrollment of full-benefit dual eligible individuals into Part D plans starts this month. MA organizations, MA-PFFS plans that will offer Part D, or Cost plans that will offer a Part D optional supplemental benefit will enroll their existing full-benefit dual eligible members on behalf of CMS. Please note this does not apply to MA organizations for which all of their plans (PBPs) will be MA-PD plans in 2006. It also does not apply to MA-PFFS plans that do not offer a Part D benefit, to cost plans that do not offer a Part D optional supplemental benefit, or to the U.S. territories, including Puerto Rico.

MA organizations should enroll only those full-benefit dual eligible members who are not otherwise transitioned into an MA-PD plan or cost plan Part D optional supplemental benefit. In 2005, plans will need to identify which of their full-benefit dual eligible members would be in an MA-only plan, or in a cost plan that does not offer a Part D optional supplemental benefit. To aid in this, CMS is sending each MA organization or cost plan a file of all their full-benefit dual eligibles from September 2005 through March 2006.

In transitioning their full benefit dual eligible individuals, MA organizations should enroll these members into the MA-PD with the lowest combined (Part C and Part D) premium. This is a clarification to the requirements provided under Section 40.1.6 in Chapter 2 of the Medicare Managed Care Manual, which currently stipulate that organizations must enroll their full benefit dual eligible members in the MA-PD plan with the lowest Part D premium. For 2006 only, however, in view of the previous guidance, an MA organization may alternatively follow the previous instruction of enrolling its full benefit dual eligible members into the MA-PD with the lowest Part D premium. Regardless of which option it chooses, the MA organization must apply the requirement consistently to all full-benefit dual eligible members of the plan.

Finally, submit an enrollment transaction and inform the beneficiary. Please see section 40.1.6 of Chapter 2 of the Medicare Managed Care Manual, on our website at: http://www.cms.hhs.gov/manuals/116_mmc/mc86c02.pdf

It is critical that all full-benefit dual eligible enrollees in the 50 states and the District of Columbia be enrolled into a Part D product effective January 1, 2006, since their Medicaid prescription drug coverage ends December 31, 2005. We appreciate your commitment to making this happen. If you have any questions about the auto-enrollment policy or procedures, please contact Sharon Donovan at Sharon.Donovan@cms.hhs.gov, or 410-786-2561.

13. Clarification of the use of Exhibit 27 versus the Annual Notice of Change (ANOC) - MA organizations must use the ANOC for informing members of auto-enrollments for a January 1, 2006 effective date. Otherwise, MA organizations must

use Exhibit 27 to inform its members of the auto-enrollment process on an ongoing basis for enrollments effective after 1/1/06.

Contact Information

If you have questions regarding the information contained in this letter, please contact your CMS Regional Office Plan Manager.