DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE ENROLLMENT & APPEALS GROUP

DATE: August 14, 2014

TO: Prescription Drug Plan Sponsors, Medicare Advantage Organizations and Cost Plans

FROM: Arrah Tabe-Bedward
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SUBJECT: Revisions to Medicare Advantage (Chapter 2), Prescription Drug Plan (Chapter 3) and Medicare Cost Plan (Chapter 17D) Enrollment Guidance for Contract Year 2015

The Centers for Medicare & Medicaid Services (CMS) is issuing Medicare Advantage (MA), Prescription Drug Plan (PDP), and §1876 Cost Plan Enrollment and Disenrollment Guidance revisions for contract year 2015. This revision includes new requirements and minor clarifications, corrections, and updates to model notices.

The guidance revisions in this memorandum apply as described below to MA organizations, Part D plan sponsors, and/or §1876 cost plans. All enrollments with an effective date on or after January 1, 2015, must be processed in accordance with the revised guidance requirements, including new model notices. Organizations may, at their option, implement any aspect of this guidance prior to the required implementation date.

A summary of changes and clarifications is included in the attachment. The revised chapters, in their entirety, will be posted at the links below within 5 business days of this memorandum:

- MA and Cost Plan enrollment guidance: http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html
- PDP enrollment guidance: http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/index.html

Please direct questions regarding the submission and/or review of member materials to your CMS Account Manager. For enrollment policy questions, please submit your inquiry to PDPENROLLMENT@cms.hhs.gov and copy your CMS Account Manager.

ATTACHMENT

SUMMARY OF CHANGES TO CHAPTERS 2, 3, AND 17-D

The adjustments to the enrollment chapters are listed below. If more than one section of guidance was affected due to policy changes on a single topic, those sections appear next to each other in this attachment, and may not be in numeric order by guidance section. Some of the entries show updated text as it would appear in the revised chapter. When an adjustment is being made to Chapters 2, 3, and 17-D, and the language in the chapters is identical, it will be listed below only once and will reflect the language for Chapter 2. Minor revisions, such as replacing "MA organization" with "PDP sponsor" or "cost plan," will be reflected in the updated enrollment guidance posted to the enrollment webpages.

Chapter 3, §30.3.4

For consistency with language in the MA enrollment guidance regarding contract modifications by mutual consent, we modified the first paragraph in the second bullet to read as follows:

- **PDP Sponsor Termination of Contract and Terminations/Contract Modifications by Mutual Consent -** An SEP exists for members of a PDP who will be affected by a termination of contract by the PDP sponsor or a modification or termination of the contract by mutual consent (see 42 CFR §423.508 for contract requirements regarding terminations). The SEP begins two months before the proposed termination effective date and ends one month after the month in which the termination occurs.

Chapter 2, §30.4.6

As outlined in the 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, released on April 7, 2014, we added a new section establishing an SEP for significant change in provider network.

> **30.4.6 – SEP for Significant Change in Provider Network** – An SEP exists for situations in which CMS determines that changes to an MA plan's provider network that occur outside the course of routine contract initiation and renewal cycles are considered significant based on the affect or potential to affect, current plan enrollees.
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> CMS will establish an SEP, on a case by case basis, if it determines a network change to be significant. The SEP will be in effect once CMS makes its determination and enrollees have been notified. The SEP begins the month the individual is notified of the network change and continues for an additional two months. Enrollment in the new plan is effective the first day of the month after the plan receives the enrollment request.
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> The scope of the SEP will be determined by CMS, and it may include enrollees who have been affected, or who may be affected, by the network change. Individuals eligible for the SEP may disenroll from the MA plan and elect Original Medicare or another MA plan, including an MA-PD even if they did not have prescription drug coverage previously. CMS will provide specific instructions directly to the affected organization, including instructions on required beneficiary notifications and information to be provided to affected beneficiaries regarding other enrollment options, if applicable.

Chapter 3, §30.3.8 - SEPs for Exceptional Conditions

We also established a Part D SEP to coordinate with the new "SEP for Significant Change in Provider Network" in the MA program.

> **I. SEP to enroll in a PDP - MA enrollees using the "SEP for Significant Change in Provider Network" to disenroll from an MA Plan** – MA enrollees using the "SEP for Significant Change in Provider Network" to disenroll from an MA plan may request enrollment in a PDP. This coordinating SEP begins the month the individual is notified of the network change and continues for an additional two months. This SEP permits one enrollment and ends when the individual has enrolled in the PDP**.** An individual may use this SEP to request enrollment in a PDP subsequent to having submitted a disenrollment to the MA plan or may simply request enrollment in the PDP, resulting in automatic disenrollment from the MA plan. Enrollment in the PDP is effective the first day of the month after the plan sponsor receives the enrollment request.

Chapter 2, §30.9

In response to questions about the process for requesting capacity limits, we have added the following language to the end of the first paragraph of the section:

> All requests from MA organizations for a capacity limit should be submitted to the CMS Regional Office account manager.

Chapters 2 and 3, §50.4.1; Chapter 17-D, 50.1.1

As part of the Medicare-Medicaid Financial Alignment Initiative, participating States passively enroll certain dual eligible beneficiaries into Medicare-Medicaid Plans (MMP), resulting in disenrollment from their current MA, cost, or Part D plan. These individuals will receive a disenrollment notice from their current plan around the same time they receive a notice from the State regarding their passive enrollment into the MMP. Because the existing model disenrollment notice is intended for use by all plans, there is no mention of MMP passive enrollment as the cause of disenrollment from the current plan. CMS seeks to minimize any possible beneficiary confusion by having the "losing" plan send a disenrollment notice, specific to this scenario, that explains that disenrollment from the current plan was the result of passive enrollment by the state into the MMP.

As outlined in the July 15, 2014, HPMS memorandum entitled "Advance Announcement of the November 2014 Software Release," a new Transaction Reply Code (TRC) 340 (Disenroll-New MMP) will be generated to notify a plan when one of its members has been disenrolled due to MMP passive enrollment so the plan may send the appropriate disenrollment notice. The language in all three chapters has been revised to reflect that dual eligible beneficiaries consenting to passive enrollment into an MMP must receive a disenrollment notice within 10 calendar days of receipt of the DTRR noting the disenrollment action. It further indicates that notice is also required when such an individual consents to passive enrollment to a new PBP within the same organization. New model notices and the text changes will be annotated in the revised guidance.

Chapters 2 and 3, §50.2.6; Chapter 17-D, §50.2.5

We removed the requirement for payment of an additional three months of premiums for "good cause" reinstatement for failure to pay plan premiums or failure to pay the Part D Income Related Monthly Adjustment Amount (Part D-IRMAA). The last paragraph reads as follows:

> **Reinstatement for "Good Cause"** – Individuals involuntarily disenrolled from their MA-PD plan for failure to pay Part D-IRMAA have the opportunity to ask CMS for reinstatement into the plan from which they were disenrolled. CMS may reinstate enrollment, without interruption of coverage, if the individual demonstrates "good cause" and pays all Part D-IRMAA and plan premium amounts that caused the disenrollment within 3 calendar months after the disenrollment effective date (see §60.3.4).

Chapter 3, §50.2.6

We removed the two paragraphs under "Cost Plans Offering Supplemental Part D Benefit" as this information is now included in Chapter 17, Subchapter D.

Chapter 3, §60.2.4

We removed the paragraph regarding individuals who lose their cost plan optional supplemental Part D benefit as a result of failure to pay the premium associated with the optional supplemental Part D benefit or the assessed Part D-IRMAA amount to CMS, as this information is included in Chapter 17, Subchapter D.

Chapter 2, § 60.3.4; Chapter 3, § 60.2.4; Chapter 17-D, §60.6.3

These sections are revised to incorporate previously released guidance on January 5, 2012, (Reinstatement Based on "Good Cause" Determinations for Failure to Pay Plan Premiums or the Part D-IRMAA) providing plans additional time beyond the three month "good cause" reinstatement timeframe in order to verify payment by the bank and credit the payment to the individual's account. To provide adequate protections for individuals who make timely payment of their owed amounts, plans have five calendar days beyond the individual's "good cause" reinstatement payment deadline in which to process the payment and notify CMS via the Complaint Tracking Module (CTM).

In addition, these revisions address the scenario in which the disenrolled individual is required to pay plan premiums in order to be reinstated, after receiving a favorable determination by CMS. We clarify that if an individual is disenrolled for nonpayment of plan premiums, the individual is only required to pay the owed plan premium amounts, even if the individual is also assessed Part D-IRMAA, in order to be reinstated. In contrast, following requirements in 42 CFR 423.44(e)(3), if the individual is disenrolled for nonpayment of Part D-IRMAA, the individual must pay any owed premium amounts in addition to the owed Part D-IRMAA, in order to be reinstated. We further clarify that within five calendar days of receipt of the required plan premium amount, the plan will send the reinstatement request to either CMS or to the CMS Retroactive Processing Contractor (RPC), depending on which entity effectuated the involuntary disenrollment. If CMS disenrolled the individual for failure to pay Part D-IRMAA, the plan will notify CMS via CTM of the need to reinstate the individual. Alternatively, if the individual was disenrolled by the plan for failure to pay plan premiums, the plan will submit the reinstatement request to the CMS RPC.

We also removed the requirement for payment of an additional three months of premiums following the disenrollment effective date and clarified the examples of circumstances that may constitute "good cause." Lastly, we clarified that for purposes of the "good cause" policy, an authorized representative is defined as the individual responsible for the beneficiary's financial affairs. The text changes to these sections will be annotated in the guidance.

Chapter 2, §60.2.4; Chapter 3, §60.1.4; Chapter 17-D, §60.5.3

In response to questions from plan sponsors, we added a new section, as follows, as well as a new model notice:

> **60.2.4 – Cancellation Due to Notification from CMS (TRC 015)**
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> When an MA organization receives a TRC 015 (Enrollment Cancelled), it indicates that an enrollment must be cancelled. A cancellation may be the result of an action on the part of the beneficiary, CMS, or another plan.
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> Within seven calendar days of receiving the TRC 015, the plan must send the individual an acknowledgment notice of the cancellation (Exhibit 25b).