Medicare Advantage and Part D
Enrollment and Disenrollment Guidance
Updated: August 8, 2024 and August 1, 2025

This guidance update is effective beginning with contract year 2026. All enrollments with an effective date on or after January 1, 2026, must be processed in accordance with the revised requirements. Plans are expected to use the updated model enrollment form for enrollment requests received on or after January 1, 2026. Organizations may, at their option, implement any new requirement consistent with this guidance prior to the required implementation date.

This guidance covers the enrollment and eligibility provisions set forth at 42 CFR § 422, Subpart B and 42 CFR § 423, Subpart B. It addresses eligibility requirements for enrollment and disenrollment, the election process, election periods, and effective dates of coverage for both Medicare Advantage (MA) organizations and Part D plan sponsors.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Organizations are required to provide information to individuals in accessible/alternate formats (for example, Large Print, Braille), upon request and thereafter, as outlined in Section 504 of the Rehabilitation Act of 1973 (and subsequent revisions). Such individuals must have an equal opportunity to participate in enrollment, paying premium bills, and communicating with the plan, as enrollees who do not request accessible/alternate formats.

The MA and Part D appendices and model exhibits for plan issued notices referenced in this guidance are posted at the following links:

MA: https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment
Part D: https://www.cms.gov/medicare/enrollment-renewal/part-d-plans

Table of Contents

10 – Definitions and Acronyms

10.1 – Definitions

The following definitions relate to topics addressed in this guidance.

Applicable Integrated Plan (AIP) – A type of integrated D-SNP defined in 42 CFR § 422.561 and Chapter 16-B.

Application Date – The date the completed enrollment request is initially received by the plan. Plans must use this date in the appropriate field when submitting enrollment transactions to CMS.

At-risk Beneficiary – A Part D eligible individual who is identified using clinical guidelines, not an exempted beneficiary, and determined to be at-risk for misuse or abuse of a frequently abused drug in accordance with the requirements for drug management programs at 42 CFR § 423.153(f), or an individual with respect to whom a plan received notice upon enrollment that the beneficiary was identified as an at-risk beneficiary under the plan in which the beneficiary was most recently enrolled and such identification had not been terminated upon disenrollment.

Authorized Representative – An individual who is legally able to act on behalf of the beneficiary, as allowed by applicable state laws, in order to execute an enrollment or disenrollment request. A representative may be appointed by the individual (consistent with the standards under applicable law) or may be authorized under law without a specific or explicit appointment.

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 plan before the enrollment effective date.

Chronic condition special needs plan (C-SNPs) – A type of SNP that restricts enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR § 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in 42 CFR § 422.4(a)(1)(iv).

Continuation Area – An additional area outside a Medicare Advantage local plan's service area within which the MAO furnishes or arranges for furnishing of services to the MA plan's enrollees.

Conversions – The action of converting individuals who are enrolled in a health plan offered by the MAO the month immediately before entitlement to Medicare Parts A and B into an MA plan offered by the same organization.

Denial of Enrollment Request – An action taken by the plan when it determines that an individual is not eligible to make an enrollment request, or the individual did not provide the information required to complete the enrollment request in a timely fashion, and does not submit

the enrollment request transaction to CMS. For example, the individual is not entitled to Medicare Part A or enrolled in Part B, the individual is not making the enrollment request during an election period, etc.

Dual Eligible Special Needs Plan (D-SNP) – A type of SNP that exclusively serves Medicare beneficiaries who are also entitled to Medicaid.

D-SNPs enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility. Individuals in the following Medicaid eligibility categories may be eligible to enroll in D-SNPs, to the extent permitted in the state Medicaid agency contract (see § 20.2.2 of Chapter 16-B):

- Full Medicaid (only);
- Qualified Medicare Beneficiary without other Medicaid (QMB Only);
- QMB Plus;
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB Only);
- SLMB Plus;
- Qualifying Individual (QI); and
- Qualified Disabled and Working Individual (QDWI).

States may vary in determining their eligibility categories; therefore, there may be state specific differences in the eligibility levels in comparison to those listed here.

Requirements for D-SNPs are described and defined further in 42 CFR § 422.2 and Chapter 16-B.

Effective Date (enrollment and disenrollment) – The date that an individual's coverage in a plan begins or ends.

Election (enrollment and disenrollment) – The act of an individual making an enrollment or disenrollment request. The term "election" is used to describe either an enrollment or voluntary disenrollment. If the term "enrollment" is used alone, it describes only an enrollment, not a disenrollment. If the term "disenrollment" is used alone, it describes only a disenrollment, and not an enrollment.

Election Period – The time frame that an eligible individual may request to enroll in or disenroll from a plan. Election periods vary and are outlined in § 30.

Enrollment Request Mechanism – A method used by individuals to request enrollment in a plan.

Exempted Beneficiary – Means with respect to a drug management program, an enrollee who:

- Has elected to receive hospice care or is receiving palliative or end-of-life care;
- Is a resident of a long-term care facility, of a facility described in Section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy;

- Is being treated for active cancer-related pain or
- Has sickle cell disease.

Facility-based Institutional special needs plan (FI-SNP) – A type of I-SNP that—
- Restricts enrollment to MA eligible individuals who meet the definition of institutionalized;
- Must own or contract with at least one institution, specified in the definition of institutionalized in this section, for each county in the plan's service area; and
- Must own or have a contractual arrangement with each institutionalized facility serving enrollees in the plan.

Full-Benefit Dual Eligible Individual – An individual who, for any month:
- Has coverage under a Part D or MA-PD plan, and
- Is determined eligible by the State for medical assistance for full benefits under title XIX of the Social Security Act (the Act) for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under Section 1115 of the Act (this does not include individuals under Pharmacy Plus program demonstrations or under a Section 1115 demonstration that provides pharmacy-only benefits to these individuals) or is determined by the state to be eligible for medical assistance under Section 1902(a)(10)(C) of the Act (medically needy) or Section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) – A type of integrated D-SNP defined in 42 CFR § 422.2 and Chapter 16-B.

Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) – A type of integrated D-SNP defined in 42 CFR § 422.2 and Chapter 16-B.

Hybrid Institutional special needs plan (HI-SNP) – A type of I-SNP that—
- Restricts enrollment to both MA eligible individuals who meet the definition of institutionalized and MA eligible individuals who meet the definition of institutionalized-equivalent in this section; and
- Meet the standards specified in the definitions of FI-SNP and IE-SNP.

Incarceration/Incarcerated – The status of an individual who is in the custody of a penal authority and confined to a correctional facility (e.g., a jail or prison, or a mental health institution) as a result of a criminal offense. This includes individuals who are confined to an Institution for Mental Disease (IMD) (e.g., state hospital, psychiatric hospital, or the psychiatric unit of a hospital), as a result of violations of the penal code. Such individuals reside outside of the service area for the purposes of plan eligibility, even if the correctional facility is located within the plan service area.

Individuals who are confined to IMDs as a result of court orders not related to penal violations, are not incarcerated as CMS defines that term, and are therefore not excluded on that basis from the plan service area.

Institutional-equivalent special needs plan (IE-SNP) – A type of I-SNP that restricts enrollment to MA eligible individuals who meet the definition of institutionalized-equivalent in 42 CFR § 422.2.

Institutional special needs plan (I-SNP) – A SNP that restricts enrollment to MA eligible individuals who meet the definition of institutionalized and institutionalized-equivalent in 42 CFR § 422.2. I-SNPs include the following subtypes:

- IE-SNP,
- HI-SNP, and
- FI-SNP.

Institutionalized – Please refer to 42 CFR § 422.2 "Institutionalized."

Institutionalized-equivalent – Please refer to 42 CFR § 422.2 "Institutionalized-equivalent."

Involuntary Disenrollment – Disenrollments initiated by CMS or the plan. Such disenrollments may be the result of the individual no longer being eligible to remain enrolled in a plan (e.g., resides out of the plan service area) or other circumstances (e.g., failure to pay premiums, plan termination).

Lawfully Present Individual – Refer to 8 CFR § 1.3 (Lawfully present aliens for purposes of applying for Social Security benefits) for a definition of an alien who is considered lawfully present in the United States. An individual who is not lawfully present in the Unites States is not eligible for any federal public benefit, including payment of Medicare benefits, under 8 U.S.C. § 1611.

MA-only Plan – A Medicare Advantage plan that does not include Medicare Part D qualified prescription drug coverage.

Medicaid MCO – A health plan that provides Medicaid services within a State as defined in § 438.2, and may be aligned with a FIDE, HIDE or AIP D-SNP.

Medicare Advantage Prescription Drug Plan (MA-PD) – A Medicare Advantage plan that includes Medicare Part D qualified prescription drug coverage.

Medicare Advantage Organization (MA organization) (MAO) – A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Medicare Advantage Plan – Health benefits coverage offered under a policy or contract by an MAO that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan (or in individual segments of a service area, under 42 CFR § 422.304(b)(2)).

Medicare Cost Plan – A plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursement contract under Section 1876(h) of the Act.

Out-of-Area Members – Members of an MA plan who live outside the service area and who elected the MA plan while residing outside the service area.

Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) – A premium amount separate from the Part D plan's monthly premium for individuals who have incomes over a certain amount. The Social Security Administration (SSA) assesses the amount annually based on the enrollee's available tax information.

Part D Late Enrollment Penalty (LEP) – An amount added to the Part D plan premium of an individual, except as described in 42 CFR § 423.780(e), who has a break in creditable prescription drug coverage of at least 63 consecutive days after the end of the individual's initial enrollment period, during which the individual was eligible to enroll in a Part D plan, was not covered under any creditable prescription drug coverage, and was not enrolled in a Part D plan. The Part D LEP is an additional amount added to the base beneficiary premium, along with other adjustments, to determine the monthly beneficiary premium.

Part D Plan – A prescription drug plan, an MA-PD plan, a PACE plan offering qualified prescription drug coverage, or a cost plan offering qualified prescription drug coverage.

Part D Plan Sponsor (Part D Sponsor) – A PDP sponsor, MA organization offering an MA-PD plan, a PACE organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage.

Partial-Benefit Dual Eligibles or Other Low-Income Subsidy (LIS) Eligible Individuals – For purposes of Medicare Part D benefits, individuals who are determined eligible for the Part D LIS who are not full-benefit dual eligible individuals as defined above. This includes individuals deemed eligible for LIS by virtue of having Qualified Medicare Beneficiary program (QMB)-only, Specified Low-Income Medicare Beneficiary program (SLMB)-only, Qualified Individual program (QI), Supplemental Security Income (SSI)-only; as well as those who apply and are determined eligible for LIS.

PDP Sponsor – A nongovernmental entity that is certified under this part as meeting the requirements and standards of this part that apply to entities that offer prescription drug plans. This includes fallback entities.

Permanent Residence – The enrollee's primary residence, not necessarily the individual's mailing address.

Potential At-risk Beneficiary – A Part D eligible individual who is identified using clinical guidelines, and not an exempted beneficiary, as being potentially at-risk for misuse or abuse of a frequently abused drug in accordance with the requirements for drug management programs at 42 CFR § 423.153(f).

Program of All-Inclusive Care for the Elderly (PACE) – A program of all-inclusive care for the elderly that is operated by an approved PACE organization and that provides comprehensive healthcare services to PACE enrollees in accordance with a PACE program agreement.

Receipt of Enrollment Request – Generally refers to the date in which the plan first gets the enrollment request. Plans may receive enrollment requests through various means, as described in § 40.1.

Reinstatement – An action that may be taken to correct a disenrollment that was made in error or when the enrollee has demonstrated good cause for a disenrollment based on failure to pay to be reversed. When a reinstatement occurs, the individual's enrollment record will only show the enrollment start date in the plan and coverage in that plan will be active and unbroken.

Rejection of Enrollment Request – A CMS action to not permit an enrollment transaction submitted by a plan. The rejection could be due to the plan incorrectly submitting the transactions, system error, or an individual's ineligibility to elect the MA/Part D plan.

Service Area – The CMS-approved geographic area where the plan provides coverage and the geographic area in which all plan enrollees generally must reside (exceptions may apply, for example in continuation areas). Facilities in which individuals are incarcerated are not included in the service area. For local MA plans, the service area is a county or multiple counties, and for MA regional plans is a region approved by CMS within which an MA-eligible individual may enroll in a particular MA plan offered by an MAO. To the extent practicable, PDP regions are the same as MA regions.

Special Needs Plan – A specific type of MA plan offered to certain groups of individuals:

- Institutionalized or institutionalized-equivalent individuals;
- Those entitled to Medical Assistance under a State Plan under Title XIX; and
- Individuals with severe or disabling chronic conditions, as defined at 42 CFR § 422.2 "Severe or disabling chronic condition."

State Pharmaceutical Assistance Program (SPAP) – A state program that provides financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of Part D eligible individuals and meets the requirements described under 42 CFR § 423.464(e)(1).

System Error – An unintended error or delay in enrollment request processing that is clearly attributable to a specific federal government system (e.g., 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 an enrollee or their authorized representative.

10.2 – Acronyms

AEP: Annual Election Period
AIP: Applicable Integrated Plan
BEQ: Batch Eligibility Query
CMS: Centers for Medicare & Medicaid Services
COB: Coordination of Benefits
D-SNP: Dual Eligible Special Needs Plan
DTRR: Daily Transaction Reply Report
EGHP: Employer/Union Group Health Plan
EGWP: Employer Group Waiver Plan
ESRD: End Stage Renal Disease
FIDE SNP: Fully Integrated Dual Eligible Special Needs Plan
HIDE SNP: Highly Integrated Dual Eligible Special Needs Plan
HMO/CMP: Health Maintenance Organization/Competitive Medical Plan
ICEP: Initial Coverage Election Period
IEP: Initial Enrollment Period
LEPD: Late Enrollment Penalty Data File
LIS: Low Income Subsidy (Extra Help)
MA: Medicare Advantage
MAO: Medicare Advantage Organization
MA-PD: Medicare Advantage Prescription Drug
MARx: Medicare Advantage Prescription Drug System
MCO: Managed Care Organization
MMCM: Medicare Managed Care Manual
MPWR: Monthly Premium Withholding Report Data File
MSA: Medical Savings Account
NUNCMO: Number of Uncovered Months
OEP: Open Enrollment Period
PACE: Program of All-Inclusive Care for the Elderly
PBP: Plan Benefit Package
PCUG: Plan Communication User Guide
PDP: Prescription Drug Plan
PFFS: Private Fee-For-Service
PPO: Premium Payment Option
RDS: Retiree Drug Subsidy
RRB: Railroad Retirement Board
SEP: Special Election Period
SPAP: State Pharmaceutical Assistance Program
SNP: Special Needs Plan
SSA: Social Security Administration
STRR: Special Transaction Reply Report

TRC: Transaction Reply Code
UI: User Interface

20 – Eligibility for Enrollment in MA and Part D Plans

42 CFR §§ 422.50, 423.30, and 423.32

To enroll in an MA or Part D plan the individual must:

MA plan	Part D plan
Be eligible to enroll in an MA plan by having Part A and Part B*	Be eligible to enroll in a Part D plan by having either Part A or Part B, or both
Permanently reside within the plan's service area*	
Be a United States citizen or be lawfully present in the U.S.	
Complete an enrollment request (as outlined in § 20.5)*	
Agree to abide by the rules of the plan	
Submit the enrollment request to the plan during a valid enrollment period*	
Meet additional requirements outlined in § 20.8 to elect hospice or enroll in Religious Fraternal Benefit (RFB), Medicare Medical Savings Account (MSA) plan or a Special Needs Plan (SNP)	N/A

*Limited exceptions apply.

Plans may not impose any additional eligibility requirements as a condition of enrollment other than those in the applicable regulations and outlined by CMS in this guidance.

Plans must also abide by the following:

- Plans may not deny enrollment to individuals based on other coverage under an employer/union-sponsored group health plan, provided they meet the eligibility requirements outlined.
- If the individual is enrolled in a qualified retiree drug plan that receives the retiree drug subsidy (RDS), the individual's status as a qualifying covered retiree will terminate.

20.1 – Simultaneous Enrollment in MA and Part D

Social Security Act §§ 1852 and 1857(i); 42 CFR §§ 422.50(b), 423.30(a)(2)(iii), (b), (d), and 423.104(f)(4)(i)

There are limits on the types of Part C and Part D plans that individuals may be enrolled in at the same time. Individuals may not be enrolled in more than one MA plan or more than one Part D plan at the same time. Additionally, with limited exceptions, an individual cannot be enrolled in both an MA plan and a stand-alone PDP.

Individual enrolled in:	Ability to have a separate stand-alone PDP:
MA coordinated care plan with Part D coverage (MA-PD plan)	No
MA coordinated care plan without Part D coverage (MA-only plan)	No
MA Private Fee-for-Service (PFFS) plan without Part D coverage	Yes (person can choose a stand-alone PDP, even if the organization offers another MA PFFS plan with Part D coverage)
MA PFFS plan with Part D coverage	No
Medicare MSA plan	Yes
Medicare cost plan	Yes
Original Medicare	Yes

Part C Policy:
Employer Group Waiver Plans (EGWP) with CMS approval may offer enrollment into an MA-only plan and a stand-alone PDP for its enrollees. See Chapter 9 of the Medicare Managed Care Manual for more information.

Part D Policy:
Individuals enrolled in Medicare cost plans may enroll in Part D coverage through a Medicare cost plan's optional supplemental Part D benefit or join a separate, stand-alone PDP.

20.2 – Entitlement to Medicare Parts A and B

42 CFR §§ 422.50 and 423.30

To be eligible to enroll in an MA or Part D plan, the individual must be entitled to/eligible for and enrolled in:

- Part A **and** B—for enrollment into MA plan (including MA-PD plan)
- Part A **or** Part B (or both)—for enrollment into a stand-alone Part D plan

The individual's Part A and/or Part B coverage must be in effect as of the date the plan's coverage starts.

Part C Policy:
There are limited exceptions to the requirement that individuals have both Part A and B coverage to enroll in an MA plan. See Chapter 9, Medicare Managed Care Manual, and § 20.2.1 below for more information on the enrollment of Part B-only individuals.

20.2.1 – Grandfathering of Members on January 1, 1999

42 CFR § 422.50

"Grandfathered" members are individuals who were automatically enrolled in an MA plan (then known as M+C plans) from a cost plan on January 1, 1999. These individuals may not have had Part A or did not reside in the plan's service area or continuation area, but the MAO cannot disenroll these individuals for those reasons. For more information about continuation areas, see § 20.3.1.

"Grandfathered" members may enroll in other MA plans within the same MAO and state. These individuals are not eligible to enroll in any MA plan outside of their current MAO unless they meet all MA eligibility requirements (including entitlement to and enrollment in Part A). If the individual loses Part B, the plan must disenroll the individual, as described in § 60.2.2.

The MAO must identify all Medicare Part B-only "grandfathered" individuals and inform them of their status annually. This notification may be included as part of the Evidence of Coverage. The notice must inform these individuals that if they disenroll from the MAO, they cannot elect another MA plan unless they also have Medicare Part A and remain enrolled in Medicare Part B.

MAOs may provide Part A-equivalent benefits to Medicare Part B-only grandfathered members. If an MAO offers Part A-equivalent coverage as a supplemental benefit in an MA plan, then the MAO may disenroll a Medicare Part B-only grandfathered member who fails to pay the organization's Part A-equivalent premiums. For more information on nonpayment of premiums, see § 60.3.1.

NOTE: Part B-only individuals currently enrolled in a cost plan are not "grandfathered" individuals and must get Part A to be eligible to enroll in an MA plan.

20.3 – Place of Permanent Residence

42 CFR §§ 422.2, 422.50, 422.54(b), 422.66(d), 422.74(b)(3)(ii), 422.74(d)(4)(iii), 423.4, 423.30, and 423.38(c)(7)

An individual is eligible to enroll in an MA or Part D plan if they permanently reside in the plan's service area. Permanent residence is not:

- A temporary move into the plan's service area;
- Living abroad; or
- Incarceration—incarcerated individuals reside out of the plan service area, even if the correctional facility, institution, or other place of confinement is located within the geographic boundaries of the plan service area.

Generally, the individual's primary residence establishes proof of permanent residence. There are instances where the individual has multiple residences or has a mailing address that is not the location of their permanent residence. A plan may request additional information that establishes the permanent residence address that is not the mailing address of the individual, such as:

- Voter registration records;
- Driver's license records (where such records accurately establish current residence);
- Tax records; or
- Utility bills.

Post Office Boxes: If an individual puts a post office box as their place of residence on the enrollment form, the enrollment request is considered incomplete, and the plan must take additional steps to determine if the individual physically resides in the plan's service area. If there is a dispute over where the individual permanently resides, the plan should refer to the law of the individual's state to determine if the individual is considered a resident of that state.

A post office box, shelter or clinic address, or an address for receiving mail may be considered evidence of a permanent residence in the service area for homeless individuals.

Separate Mailing Address: Some individuals may have a mailing address that differs from their permanent residence address and may not be within the geographic plan service area. If an individual requests that mail be sent to an alternate address, the plan should make every effort to accommodate these requests and should use this alternate address to provide required notices and other plan mailings, as appropriate. Plans must accommodate an individual's reasonable request to receive confidential communications, either at alternative locations or by alternative means, if the individual clearly states that not doing so could endanger them (See 45 CFR § 164.522(b)). Use of an alternate mailing address does not eliminate or change the requirement of residency for the purposes of plan eligibility, so the plan must still evaluate and make a determination as to residence.

For information regarding procedures for individuals that are auto-enrolled or facilitated-enrolled whose address is outside the plan's service area, see § 60.2.1.

Conversion of Enrollment into MA: Consistent with § 422.66(d), an MAO must accept individuals who request enrollment during their ICEP and who are enrolled in non-Medicare health coverage offered by the MAO the month immediately preceding the MA plan enrollment effective date.

Individuals converting to Medicare who wish to elect an MA plan offered by the same MAO must meet MA eligibility criteria and may reside in the MAO's continuation area, provided that an MAO chooses to offer this option and CMS determines that all applicable access requirements outlined in 42 CFR § 422.112 are met.

Enrollee Uses "Visitor/Traveler" Program in MA Plan: Consistent with § 422.74(d)(4)(iii), an enrollee may remain in the MA plan if the MAO offers "visitor" or "traveler" programs for enrollees who are consecutively out of the area for more than six months but less than 12 months, provided the MA plan includes the full range of services available to other enrollees. For more information on the "visitor/traveler" program, see § 60.2.1.

Part C Policy:
There are limited exceptions to the requirement for an individual to permanently reside in the plan's service area while continuing enrollment in the plan. These exceptions are optional for the MAO to offer:

- **Enrollee Affected by Service Area Reduction:** An enrollee may remain in the MA plan following a service area reduction (SAR) if: the individual permanently resided in the service area of the plan at the time the SAR goes into effect; and there is no other MA plan offered in the area at that time.
- **Enrollee Moves into Continuation Area:** Consistent with § 422.54, an enrollee may remain in the MA local plan when they permanently move into a geographic area designated by the MAO as a continuation area. For more information on continuation areas, see § 20.3.1.

20.3.1 – Continuation Areas

42 CFR §§ 422.50 and 422.54

With CMS approval, an MAO may establish continuation areas, separate and apart from an MA local plan's service area. See Chapter 11 of the Medicare Managed Care Manual regarding CMS approval of continuation areas.

If an MAO wants to offer a continuation of enrollment option under one or more of its MA local plans, it must obtain CMS' approval of the continuation area and make the option available to all enrollees of the MA local plan who make a permanent move to the continuation area. An MAO may require enrollees to give advance notice of their intent to use the continuation of enrollment option. If the MAO has this requirement, it must fully describe the required notification process in enrollee materials. In addition, the MAO must describe the continuation of enrollment option to all enrollees of the MA local plan, including those who reside in the continuation area.

Enrollees may choose to continue enrollment with the MA local plan only if they have permanently moved from the service area into the continuation area. An enrollee who permanently moves from the service area into the continuation area and does not choose the continuation of enrollment option must be disenrolled. Procedures for continuation of enrollment are in § 70.7.

20.4 – U.S. Citizenship or Lawful Presence

42 CFR §§ 422.50 and 423.30

An individual is eligible to enroll in a plan if they are a United States citizen or lawfully present in the United States, as determined pursuant to 8 CFR § 1.3. CMS will notify the plan if the individual is not eligible to enroll on this basis at the time of enrollment and the plan must deny an enrollment request if CMS has provided such a notice.

Exception: In the case where CMS systems show that an individual will have lawful presence status on or before the enrollment effective date, the plan must accept and process the enrollment

request, even if the individual is not lawfully present at the time the plan receives the enrollment request.

CMS uses its systems of records, which include data from SSA systems, as the primary resource for determining lawful presence status.

- If an individual provides evidence of their lawful presence status to the plan, it may not consider it when determining eligibility for enrollment.
- If an individual has evidence of their lawful presence status and there is a dispute over their status, the plan should refer the individual to SSA to have their status reviewed and adjusted by:
    - Calling SSA's toll-free number, 1-800-772-1213. TTY users should call 1-800-325-0778 weekdays from 8:00 a.m. to 7:00 p.m. local time.
    - Going to their local SSA field office. A beneficiary can get addresses and directions to SSA field offices from the Social Security Office Locator which is available at: http://www.ssa.gov/locator/.
- The plan may not request any documentation of U.S. citizenship or alien status.

20.5 – Completion of Enrollment Request

42 CFR §§ 422.50(a)(5) and 423.32

An individual (or their authorized representative, as described in § 50.1) must complete an enrollment request to enroll in a plan, **even if switching among plans offered by the same organization.** To make an election, the individual must:

- Complete an enrollment request;
- Provide required information to the organization within the required time frames;
- Submit the completed request to the organization during a valid enrollment period.

This is required for all enrollments, unless otherwise specified in regulation or in this guidance. CMS considers an enrollment request to have been completed by the individual if they accept the offer of an enrollment initiated by CMS, the state, the employer, or the MAO, as outlined in § 40.

Individuals may use any of the enrollment mechanisms offered by the organization to make their enrollment request. See § 40.1 for more information on the types of enrollment mechanisms allowed.

20.6 – Agreeing to Abide by Plan Rules

42 CFR § 422.50(a)(6)

To be eligible to enroll in a plan, it is our expectation that an individual would be fully informed of the plan's rules and agree to abide by them. This agreement would occur during the enrollment process and is made through the completion of the enrollment request. "Fully informed" means that the plan provides the individual with the applicable rules of the plan, as described in § 50.9 and any requirements outlined in 42 CFR §§ 422 and 423, Subpart V. It is our expectation that a plan would deny enrollment to any individual who does not agree to abide by the rules of the organization.

20.7 – Submitting the Enrollment Request During a Valid Enrollment Period

42 CFR §§ 422.60(a), (c), and 423.32

To be eligible to enroll in a plan, an individual must submit the request to the plan within a valid enrollment period. Plans may request that the individual attest to being eligible for an enrollment period during the enrollment process, but it may not request or require evidence. The plan must deny enrollment to any individual, not enrolling during the AEP, who is not eligible for a valid enrollment period or does not provide an attestation of eligibility for an enrollment period, when asked.

20.8 – Additional Policies for MA Plans

There are additional requirements for eligibility that apply only to enrollments into MA plans:

- The election of hospice benefits (§ 20.8.1);
- Religious Fraternal Benefit (RFB) plans (§ 20.8.2);
- Medicare Medical Savings Account (MSA) plans (§ 20.8.3);
- Special Needs Plans (SNP) (§ 20.8.4).

20.8.1 – Eligibility for and Election of Hospice Benefits

42 CFR §§ 422.50, 422.56, 422.110, and 422.320

An MAO must not deny enrollment to any eligible individual on the basis that they have elected the hospice benefit (except in the case of a Medicare MSA plan, as outlined in § 20.8.3). Until the MAO acknowledges that it has received the completed enrollment request and gives a coverage effective date to the individual, the MAO must not ask any questions related to the existence of a terminal illness or election of the hospice benefit. Such questions will be considered impermissible health screening.

The MAO may not disenroll any individual on the basis of the enrollee electing the hospice benefit either before or after becoming an enrollee of the MA plan.

NOTE: The election of hospice benefits entitles the individual to continue to receive through the MA plan any MA benefits other than those that are the responsibility of the Medicare hospice.

20.8.2 – Eligibility for MA Religious Fraternal Benefit (RFB) Plans

42 CFR §§ 422.2, 422.50, and 422.57

This MA plan is one that an RFB society may offer only to members of the church, or convention or group of churches with which the society is affiliated. The requirement for membership can be met by any documentation establishing membership issued by the church, or by using the church's records of membership. An individual must also meet all the other requirements to elect an MA plan.

20.8.3 – Eligibility for Medicare Medical Savings Account (MSA) Plans

42 CFR §§ 422.50, 422.56, and 422.104

An individual is not eligible to elect a Medicare MSA plan if any one of the following applies:

- The individual will reside in the United States for fewer than 183 calendar days during the year in which the enrollment request is effective;
- The individual is enrolled in the Federal Employees Health Benefits (FEHB) program, or is eligible for health care benefits through the Department of Veterans Affairs or the Department of Defense;
- The individual is dual eligible and is entitled to coverage of Medicare premium and/or cost-sharing under a Medicaid State plan;
- The individual is receiving hospice benefits under the Medicare benefit **prior to completing the enrollment request**; or
- The individual receives health benefits that cover all or part of the annual Medicare MSA deductible, such as through primary health care coverage other than Medicare, supplemental insurance policies not specifically permitted under 42 CFR § 422.104, or retirement health benefits.

20.8.4 – Eligibility for Enrollment in MA Special Needs Plans (SNP)

42 CFR §§ 422.2, 422.50, 422.52, and 422.514(h)

An MA Special Needs Plan (SNP) must limit enrollment to individuals who also meet the specified eligibility requirements per 42 CFR §§ 422.2, 422.52, and 422.514(h) (as applicable). Additional guidance is outlined in Chapter 16-B of the Medicare Managed Care Manual. For more information on an SEP following loss of SNP status, see § 30.6.13.

Dual-Eligible SNP:

A D-SNP may be required by the state Medicaid agency for the service area(s) covered by the D-SNP, through the contract required under 42 CFR § 422.107, to limit enrollment to specific eligibility groups for Medicaid. Before processing an enrollment into a D-SNP, the D-SNP must confirm both MA eligibility and Medicaid eligibility. For current enrollees, the D-SNP must verify continuing eligibility (e.g., full or partial dual status, as applicable) of enrollees at least as often as the state Medicaid agency conducts redeterminations of Medicaid eligibility.

Acceptable proof of Medicaid eligibility include:

- Current Medicaid card;
- Letter from the state agency that confirms entitlement to Medical Assistance; or
- Verification through a systems query to a state eligibility data system.

An individual's current eligibility for the Medicare Part D Low Income Subsidy (LIS) or any other Medicaid status flag in CMS systems are **not** acceptable for initial or ongoing Medicaid

eligibility verification for the purposes of determining D-SNP eligibility.

The Social Security number may only be requested in the enrollment mechanism if the state Medicaid agency requires it to verify Medicaid status.

FIDE SNP, HIDE SNP, and AIP:
Beginning in plan year 2027, where an MAO offers a D-SNP and its parent organization (or any entity that shares a parent organization with the MAO) also contracts with a state as a Medicaid MCO that enrolls full-benefit dual eligible individuals in the same service area, the D-SNP must limit new enrollment to individuals enrolled in (or in the process of enrolling in) the D-SNP's affiliated Medicaid MCO. This would apply when any part of the D-SNP service area(s) overlaps with any part of the Medicaid MCO service area, even if the two service areas do not perfectly align. Beginning in 2030, such D-SNPs must only enroll (or continue to cover) individuals enrolled in (or in the process of enrolling in) the affiliated Medicaid MCO, except that such D-SNPs may continue to implement deemed continued eligibility requirements as described in 42 CFR §422.52(d). More information about this exception can be found in Chapter 16-B.

Institutional SNP:
For enrollments into an institutional SNP (I-SNP), the organization must confirm that the individual meets the definition of "institutionalized" or the definition of "institutionalized-equivalent."

When an I-SNP opts to enroll individuals prior to a 90-day length-of-stay, the I-SNP may use a number of sources of information to show that the individual's condition makes it likely that the length-of-stay (or need for an institutional level-of-care) will be at least 90 days. Please refer to 42 CFR § 422.2 definitions of "Institutionalized" and "Institutionalized-equivalent," for additional information.

Chronic Condition SNP:
For enrollments into a chronic condition SNP (C-SNP), the organization must confirm that the individual has the qualifying condition. For more information on verification of eligibility for C-SNPs, see 42 CFR § 422.2 "Severe or disabling chronic condition."

30 – Election Periods and Effective Dates

Social Security Act §§ 1851(c)(1), 1851(g), and 1860D-1(b)(1)(B); 42 CFR §§ 422.60, 422.62, 422.68, 423.32, 423.36, and 423.38

An individual's enrollment or disenrollment request must be received during a valid election period.

It is the responsibility of the plan to determine the election period of each enrollment or disenrollment request. To make this determination, the plan may need to contact the individual directly. The plan may incorporate specific statements regarding eligibility of an election period with the enrollment or disenrollment request. However, if this information is not provided with the request, the plan must attempt to contact the individual by phone or other communication mechanism and determine within the seven-day requirement if they are eligible to make an election at that time (see MA Exhibits 5 and 11a; Part D Exhibits 3 and 11a).

Unless stated otherwise in this guidance, the organization **must** accept an individual's verbal or written confirmation regarding the conditions that make them eligible for the election period. Determination of eligibility for some election periods requires that the organization obtain the date on which the individual's circumstances changed (i.e., change in residence, loss of special needs status, etc.). Organizations that obtain this information on the enrollment or disenrollment request are not required to obtain an additional verbal or written confirmation of election period eligibility.

For enrollment requests obtained during a face-to-face interview or telephone request, the determination of election period eligibility can be made at that time. For enrollment requests made using paper, or via an electronic enrollment mechanism or the Medicare OEC (without accompanying CMS approval), the organization is not required to contact the applicant to confirm eligibility if the enrollment request includes the applicant's attestation of election period eligibility.

Generally, the enrollment effective date, i.e., when coverage begins under a plan, is the first of the month following a plan's receipt of an enrollment request. An individual can, in most situations, submit more than one enrollment request **prior to the effective date**. The last enrollment choice made, determined by plan receipt date, will be the choice that becomes effective. Once an election takes effect, eligibility for that election period ends. Please refer to § 70.1 for further information on "multiple transactions."

Unless a CMS-approved capacity limit or a CMS-issued enrollment sanction applies, all plans (with the exception of Medicare MSA and MA RFB plans) must accept requests to enroll during all election periods listed below. A plan that is closed due to a capacity limit must remain closed to all applicants (with the exception of MA plan reserved vacancies) until the limit is lifted. See § 50.10 for further information on capacity limits.

There are six types of election periods during which individuals may make elections:

Election Period	MA	MA-PD	PDP
Initial Enrollment Period for Part D (also referred to as the Part D IEP)		✔	✔
Initial Coverage Election Period (ICEP)	✔	✔	
Annual Coordinated Election Period (AEP) (also referred to as the "Fall Open Enrollment Period")	✔	✔	✔
Medicare Advantage Open Enrollment Period (MA OEP) (MA enrollees only)	✔	✔	
Open Enrollment Period for Institutionalized Individuals (OEPI)	✔	✔	
Special Election Periods (SEPs)	✔	✔	✔

30.1 – Part D IEP

Social Security Act § 1860D-1(b)(2); 42 CFR §§ 406.13(e), 422.62(b)(22), 423.40(a), 423.38(a)(3), and 423.40(a)

Occurs: The seven-month period that begins three months prior to the month the individual is first eligible for Medicare Part A and ends three months after the first month of eligibility (same as the IEP for Part B). The Part D IEP will generally correspond to the individual's 65th birthday, 25th month of disability, or active ESRD-status, see 42 CFR § 406.13 for more information about ESRD eligibility.

In general, an individual is eligible to enroll in a Part D plan when they are entitled to Part A and/or enrolled in Part B **and** live in the service area of a Part D plan.

An individual who is not eligible to enroll in Part D when first getting Medicare (e.g., resided in a foreign country, was incarcerated, unlawfully present, or did not enroll in Part A or Part B during their IEP), will have an IEP for Part D that starts three months before the month of eligibility for Part D and ends three months following the month of eligibility for Part D.

Individuals eligible for Medicare prior to turning 65 (such as for disability) will have another Part D IEP upon turning age 65. Where an individual is eligible for an additional Part D IEP upon turning 65, they are also eligible to make an MA election to coordinate with that additional Part D IEP. For more information on the coordinating MA SEP, see below.

If SSA makes a Medicare entitlement determination for a retroactive date, eligibility for Part D begins the month in which the individual receives notification of the retroactive entitlement decision and continues for three additional months.

Effective date: First of the month following the plan's receipt of the enrollment request, if (1) the enrollment request is made during or after the month that the individual's entitlement to Part A and/or enrollment in Part B is effective, and (2) the individual will be eligible to enroll in Part D no later than the first day of the next calendar months after making the Part D enrollment request.

If the Part D enrollment is made prior to the month of entitlement to Part A or enrollment in Part B, it is effective the first day of the month that the individual is entitled to or enrolled in Part A or enrolled in Part B.

If the individual is not eligible to enroll in Part D on the first day of the calendar month following the month in which the election to enroll in Part D is made, the enrollment in Part D is effective the first day of the month the individual is eligible for Part D.

Who can use: Individuals who have Part A **and/or** Part B and meet criteria for enrolling in a Part D plan.

Changes permitted: Enrollment into a PDP or MA-PD.

Examples:

- **Part D IEP corresponding to an individual's 65th birthday**
  Mrs. Smith's 65th birthday is April 20. She is entitled to Medicare Part A (as of April 1), and her Part B IEP began on January 1. Therefore, her Part D IEP began on January 1, and ends on July 31.

- **Part D IEP for working individual**
  Mr. Hackerman's 65th birthday was on March 23, 2020. He is currently working, and while he signed up for Medicare Part A benefits effective March 1, 2020, he declined enrollment in Part B, given his working status. He is eligible for Part D since he has Part A and lives in the Part D plan service area. Even though he did not enroll in Part B, his Part B IEP is still the three months before, the month of, and the three months following, his 65th birthday—that is, December 1, 2019, to June 30, 2020. His IEP for Part D is also December 1, 2019, to June 30, 2020.

- **Part D IEP for Medicare beneficiary living abroad**
  Mr. Duke lived in Italy at the time of his 65th birthday, which occurred on August 3, 2019. His Part B IEP began on May 1, 2019, and ended November 30, 2019. He plans to return to the U.S. to reside permanently in June 2021. Since he lived outside of the U.S. and, therefore, was not eligible to enroll in a Part D plan during his IEP for Part B, his IEP for Part D will occur when he meets all the eligibility requirements for Part D, that is, when he has Part A and/or B **and** lives in a Part D plan service area. His IEP for Part D is March 1, 2021, to September 30, 2021.

- **Part D IEP for Medicare beneficiary that was not enrolled in Medicare at the time of their 65th birthday**

Mrs. Benson was not eligible for premium-free Part A at the time of her 65th birthday, which occurred on May 15, 2022. Her Part B IEP began on February 1, 2022, and ended on August 31, 2022. Because she was still working, she did not enroll in premium-Part A or Part B; therefore, she was not eligible to enroll in a Part D plan during her IEP for Part B. Her IEP for Part D will occur when she meets all the eligibility requirements for Part D, that is, when she has Part A and/or B, and meets all other requirements for Part D enrollment. Mrs. Benson enrolled in premium-Part A and B in February 2024, during the GEP. Her IEP for Part D is December 1, 2023, to June 30, 2024.

- **Part D subsequent IEP for Medicare beneficiary that was enrolled in Medicare at the time of their 65th birthday**
  Mr. Ross turned 65 on May 9, 2021. His subsequent IEP began February 1, 2021 and ended August 31, 2021. He enrolls in a Part D plan on April 7, 2021. The effective date of coverage is May 1, 2021.

- **Part D IEP for retroactive Medicare determination**
  Mr. Schlosser received notification of his Medicare determination on June 15, 2020. He was informed in this notice that Medicare Part A was effective as of July 1, 2019. His Part D IEP began June 1, 2020, and ends September 30, 2020.

Coordinating MA SEP:

An individual eligible for an additional Part D IEP, such as an individual currently entitled to Medicare due to disability and who is attaining age 65, may make an MA election to coordinate with the additional Part D IEP. The SEP may be used regardless of whether the individual uses the Part D Initial Election Period to enroll in a PDP.

The SEP may be used to disenroll from an MA plan, with or without Part D benefits, to enroll in Original Medicare, or to enroll in an MA plan that does not include Part D benefits.

The SEP begins and ends concurrently with the additional Part D IEP.

30.2 – Initial Coverage Election Period (ICEP)

42 CFR §§ 406.13(e), 422.62(a)(1), and 422.68(a)

The ICEP is the period during which an individual newly eligible for MA may first enroll in an MA plan.

Occurs:

Always begins three months prior to the date an individual has **both Medicare Part A and Part B** for the first time. It ends either on:

1. The last day of the second month after the month in which they are first entitled to Part A and enrolled in Part B; or

2. The last day of their Part B IEP, whichever is later.

In most cases, the IEP for Part B begins three months before and ends three months after the month of the individual's 65th birthday. See 42 CFR § 407.14 regarding the Part B IEP.

The ICEP will generally correspond to when the individual turns 65, is in their 25th month of disability, or has an active ESRD-status, see 42 CFR § 406.13 for more information about ESRD eligibility.

Effective date: Generally, the first of the month following the plan's receipt of the enrollment request. However, if the enrollment request is made prior to an individual's first month of entitlement to both Part A and Part B, the request is effective as of the first day of the month in which the individual is entitled to both Part A and Part B.

Who can use: Individuals who newly have both Medicare Part A and B, as outlined above.

Changes permitted: Enrollment into MA/MA-PD plan.

NOTE: The ICEP and the IEP for Part D occur together as one period when a newly Medicare eligible individual has enrolled in **both** Part A and B at first eligibility. Should an individual delay enrollment into Part B to a later time, the ICEP and IEP for Part D become separate with the ICEP changing to then occur as the 3 months immediately preceding entitlement to **both** parts A and B (see § 30.1).

Examples:

- **ICEP corresponding to an individual's 65th birthday:**
  Mrs. Donovan's 65th birthday was on June 20. She is eligible for Medicare Part A and Part B beginning June 1 and has decided to enroll in Part B beginning on June 1. Her ICEP began on March 1 and ended on September 30.

- **ICEP corresponding to a working individual who delays enrolling in Part B:**
  Mrs. Smith's 65th birthday was on April 20, 2020. She was eligible for Medicare Part A and Part B beginning April 1, 2020. Because she is still working and has health insurance provided by her employer, she decided not to enroll in Part B during her initial enrollment period for Part B. Upon retiring in April 2025, she will have the opportunity to enroll in Part B (through a Part B SEP). She enrolls in Part B effective May 1, 2025. Her ICEP is February 1 through June 30, 2025.

- **ICEP corresponding to an individual enrolling in Part B for the first time during the General Enrollment Period**
  Mr. Jones, age 67, enrolls in Part B for the first time during the 2025 General Enrollment Period (GEP). His Part B coverage begins on April 1, 2025. His ICEP is January 1, 2025, to May 31, 2025.

See also § 30.6.3, Part D SEP for individuals who are not entitled to premium-free Part A and who enroll in Part B during the GEP.

30.3 – Annual Election Period (AEP)

42 CFR §§ 422.62(a)(2)(iii), 422.106(c), and 423.38(b)(3)

Occurs: October 15–December 7 every year

Effective date: January 1 of the following year

Who can use: All Medicare beneficiaries

Changes permitted:

- Enrollment into a plan
- Disenrollment from a plan

Part C Policy:
CMS has waived the requirement for MAOs to accept enrollment requests into employer/union-sponsored plans that are EGWPs during the AEP if the AEP and the employer/union-sponsored plan's open season do not occur simultaneously; however, MAOs must accept valid requests for disenrollment from an employer/union sponsored plan during the AEP.

Paper Enrollment Requests Received Prior to the AEP:
MAOs and Part D plan sponsors may not solicit submission of paper enrollment forms, (or accept telephone or electronic enrollment requests) prior to the start of the AEP.

Although marketing of prospective year plan offerings may begin on October 1 (42 CFR §§ 422.2263(a) and 423.2263(a)), enrollments may not occur until the beginning of the AEP. Therefore, Plans may not permit their brokers and agents to accept or solicit submission of paper enrollment forms prior to the start of the AEP. Plan elections and enrollments may occur during the AEP. Plans and their brokers and agents also should remind individuals that they cannot submit enrollment requests prior to the start of the AEP.

Despite these efforts, CMS recognizes that plans may receive unsolicited paper enrollment forms prior to the start of the AEP, given that marketing activities may begin prior to this date. To be considered unsolicited, the plan must have received the paper AEP enrollment request directly from the applicant and not through a sales agent or broker. Plans and their representatives may not accept unsolicited enrollment requests made through enrollment request mechanisms other than paper prior to the start of the AEP.

Because a plan may not permit its brokers or agents to accept or solicit submission of paper enrollment forms prior to the start of the AEP, the plan must investigate where there is an indication that its agents or brokers were involved in the submission of a paper AEP enrollment requests that was received prior to the start of the AEP (i.e., the name or contact information of a sales agent or broker).

If a plan receives unsolicited paper enrollment forms on or after October 1, but prior to the start of the AEP, it must retain and process them as follows:

- Within seven calendar days of the receipt of a complete paper enrollment request, the plan must provide the individual with a written notice that acknowledges receipt of the completed enrollment request and indicate that the enrollment will take effect on January 1 of the following year (refer to MA Exhibits 4, 4a, 4b, 4c, 4d, and 4e; Part D Exhibits 2, 2a, and 2b for model notices).

- Submit all transactions to CMS systems (MARx) on the first day of the AEP with an "application date" of October 15. Paper enrollment requests received from October 1 through October 14 must be submitted with an "application date" of October 15. Prior to the AEP, if an individual has submitted more than one AEP paper enrollment request, the individual will be enrolled in a plan based on the first application that is processed in MARx.

- Once the plan receives a MARx Daily Transaction Reply Report (DTRR) from CMS indicating whether the individual's enrollment has been accepted or rejected, it must meet the remainder of the requirements (e.g., sending a notice of the acceptance or rejection of the enrollment within 10 calendar days following receipt of the DTRR from CMS) provided in § 50.9.

NOTE: If plans receive an incomplete, unsolicited AEP paper enrollment request prior to the start of the AEP, they must follow existing guidance for working with individuals to complete the applications (refer to § 50.3).

30.4 – Medicare Advantage Open Enrollment Period (MA OEP)

42 CFR §§ 422.62(a)(3), 422.62(d)(1), 422.68(c), and 423.38(c)(26)

Occurs: January 1–March 31 every year **and** for a three-month period upon new entitlement to both Medicare Part A and B (which generally corresponds to an individual's ICEP—see examples below).

Effective Date: First of the month following the plan's receipt of the enrollment request.

Who Can Use: Individuals enrolled in either MA-PD or MA-only plans.

Changes Permitted:

- Disenrollment from an MA plan (MA-only, MA-PD) in order to switch to Original Medicare (with or without a stand-alone Part D plan)
- Enrollment into a different MA plan (MA-only, MA-PD)

Coordinating Part D SEP There is a coordinating Part D SEP available to enroll in a standalone Part D plan for the same effective date, when an individual changes from an MA-PD to Original Medicare.

Examples:

- **MA OEP corresponding to individual's 65th birthday:**
  Mrs. Jenkin's 65th birthday is June 20. She is entitled to Part A and enrolls in Part B effective June 1. She also enrolls in an MA plan effective July 1. In this scenario, Mrs. Jenkins' MA OEP begins the month of entitlement to both A and B and continues through the last day of the third month of entitlement (June 1–August 31).

- **MA OEP corresponding to delay of Part B enrollment:**
  Mr. Lake's 65th birthday was April 20, 2020. He is entitled to Part A beginning April 1, 2020. He is currently working, and has employer-sponsored coverage, and decides to enroll in Part B after he retires. He retires in April 2021 and enrolls in Part B effective May 1, 2021. He also enrolls in an MA plan effective June 1, 2021. In this scenario, Mr. Lake's MA OEP is May 1, 2021, through July 31, 2021.

NOTE: During the MA OEP, individuals may not:
- Switch from Original Medicare to join an MA plan.
- Make Part D plan changes if enrolled in Original Medicare,
- Make enrollment changes if enrolled in a Medicare Savings Account (MSA), cost plan, or PACE plan.

30.5 – Open Enrollment Period for Institutionalized Individuals (OEPI)

42 CFR §§ 422.60(a)(2), 422.62(a)(4), 422.68(c), and 423.38(c)(25)

Occurs: Continuous for an MA-eligible institutionalized individual who moves into, resides in, or moves out of an institution. The OEPI ends two months after the month the individual moves out of the institution (See 42 CFR § 422.2 for definition of "institutionalized").

Effective date: Generally, the first of the month following the plan's receipt of the enrollment request.

Who can use: An MA-eligible individual who meets the "institutionalized" requirements listed in 42 CFR § 422.2.

Changes permitted:
- Enrollment into MA plan (MA-only, MA-PD)
- Disenrollment from MA plan (MA-only, MA-PD)
- Enrollment into Original Medicare

The OEPI does not permit elections into or out of an MA MSA plan, as provided by 42 CFR § 422.62(a)(4) and 422.62(d).

An MAO that has chosen to be closed for OEPI enrollment requests must accept requests for disenrollment during the OEPI, as institutionalized individuals that are eligible to make elections under the OEPI may opt to enroll in Original Medicare or elect a different MA plan at any time.

NOTE: The definition of "institutionalized" for the purpose of the OEPI (as provided in 42 CFR § 422.2) differs from that used in determining when an institutionalized full-benefit dual eligible qualifies for the low-income subsidy copayment level of zero.

Coordinating Part D SEP:

An individual using the MA OEPI to disenroll from an MA plan that includes Part D benefits is eligible for a coordinating Part D SEP to enroll in a Part D plan.

This SEP begins the first day of the month in which the individual requests disenrollment from the MA plan and ends on the last day of the second month following the month the MA enrollment ended.

NOTE: The effective date of an election made during this SEP is the first day of the month following the month in which the enrollment/disenrollment request is received, but not prior to the month residency begins.

30.6 – Special Election Periods (SEPs)

42 CFR §§ 422.62(b), 422.68(d), 423.38(c), and 423.40(c)

Special election periods (SEPs) are election periods outside of the Part D IEP, ICEP, AEP, OEPI, or MA OEP, when an individual may elect a plan or change their current election. The effective date of an election made during an SEP is the first day of the month following the month in which the election is made, unless otherwise noted that the effective date may be retroactive or prospective past the following month. Coverage effective dates are always in whole calendar month increments; both retroactive and prospective effective dates are always the first of the calendar month. The SEPs discussed in this section include the following:

SEP for Individuals Who:	MA	MA-PD	PDP	Reference
Turn age 65 (SEP65)	✔	✔	✔	30.6.1
Are entitled to Medicare retroactively	✔	✔		30.6.2
Enroll in Part D during the Part B GEP		✔	✔	30.6.3
Terminated a Medigap policy when they enrolled for the first time in an MA plan and are still in a trial period	✔	✔	✔	30.6.4
Are institutionalized			✔	30.6.5
Use the OEPI to disenroll from an MA-PD plan			✔	30.6.6
Are eligible for Medicaid or the low-income subsidy (LIS)			✔	30.6.7
Gain, lose, or have a change in their dual-eligible or LIS status		✔	✔	30.6.8
Belong to a qualified SPAP or who lose SPAP eligibility		✔	✔	30.6.9
Have a plan or contract terminated or non-renewed, including: ▪ Have a plan or contract non-renewed ▪ Have a contract modified or terminated by mutual consent ▪ Have a contract terminated by CMS	✔	✔	✔	30.6.10 A B C
Are enrolled in a cost contract that is non-renewing for the area in which the enrollee resides	✔	✔	✔	30.6.11

SEP for Individuals Who:	MA	MA-PD	PDP	Reference
Are in PACE	✔	✔	✔	30.6.12
Lose special needs status	✔	✔	✔	30.6.13
Are eligible or are found ineligible to enroll in a C-SNP	✔	✔	✔	30.6.14
Disenroll from a cost plan with optional Part D supplemental benefits			✔	30.6.15
Election into or out of employer sponsored coverage	✔	✔	✔	30.6.16
Involuntarily lose creditable prescription drug coverage	✔	✔	✔	30.6.17
Were not adequately informed of a loss of creditable coverage*	✔	✔	✔	30.6.18
Disenroll from Part D to enroll in/maintain other creditable coverage	✔	✔	✔	30.6.19
Permanently change residence	✔	✔	✔	30.6.20
Are enrolled or not enrolled in Part D due to federal employee error*	✔	✔	✔	30.6.21
Want to enroll in a 5-star plan	✔	✔	✔	30.6.22
Use the 5-star SEP to enroll in a plan without Part D			✔	30.6.23
Requested materials in an accessible format	✔	✔	✔	30.6.24
Are affected by a government entity-declared disaster or emergency	✔	✔	✔	30.6.25
Are enrolled in a plan placed in receivership	✔	✔	✔	30.6.26
Are enrolled in a plan identified as a consistent poor performer	✔	✔	✔	30.6.27
Are enrolled in a plan that violates its contract*	✔	✔	✔	30.6.28
Disenroll in connection with a CMS sanction	✔	✔	✔	30.6.29
Receive notification of a CMS or state-initiated enrollment action	✔	✔	✔	30.6.30
Are involuntarily disenrolled from an MA-PD plan due to loss of Part B			✔	30.6.31
Are non-U.S. citizens who become lawfully present	✔	✔	✔	30.6.32
Are impacted by a CMS established significant change in provider network*	✔	✔	✔	30.6.33
Enroll in Medicare premium-Part A or Part B using an A/B Exceptional Condition SEP	✔	✔	✔	30.6.34
Are enrolling in a FIDE SNP, HIDE SNP, or AIP		✔		30.6.35
Have an exceptional circumstance*	✔	✔	✔	30.6.36

*Requires CMS approval.

Please refer to the PCUG, Table 3-8 (https://www.cms.gov/data-research/cms-information-technology/access-cms-data-application/mapd-plan-communication-user-guide) for more information on the election submission process using these SEPs, including: SEP reason code, plan type applicability (MA, MA-PD, PDP, Cost Drug, PACE, and MSA), and use for enrollment and/or disenrollment transactions.

Subject to the limits on the types of MA and Part D plans in which individuals may be enrolled simultaneously (see § 20.1), and unless otherwise specified below, an individual who uses an MA SEP to disenroll from an MA-PD plan may also use the SEP to enroll in a PDP. Unless

otherwise stated, an SEP is considered "used," and is no longer available, upon the effective date of enrollment in the new plan, or when the SEP time frame ends, **whichever comes first**. For example, if an SEP exists for an individual from May–July, then a plan must receive an enrollment request from that individual within that time frame (May 1–July 31). If an individual makes an enrollment request in May, for a June 1 effective date, the SEP cannot be used to change plans after June 1.

The term "coordinating SEP" refers to an SEP that is specific to MA or Part D which coordinates with another SEP such that making an election using one allows the simultaneous use of the "coordinating" other. For example, using an MA SEP may allow the use of the coordinating Part D SEP to make a Part D election at the same time as the MA election.

30.6.1 – SEP for individuals age 65 (SEP65)

Social Security Act §§ 1851(e)(4) and 1860D-1(b)(3)(E); 42 CFR §§ 422.62(c), 422.62(d)(2), and 423.38(c)(5)

MA eligible individuals who elect an MA plan (other than an MSA plan) during the initial enrollment period (IEP) for Part B surrounding their 65th birthday have an SEP. This "SEP65" allows the individual to disenroll from this MA plan and elect Original Medicare any time during the 12-month period that begins on the effective date of coverage in the MA plan.

The IEP for Part B is established by Medicare and begins three months before and ends three calendar months after the month of the individual's 65th birthday. Individuals entitled to Medicare prior to age 65 are not eligible for the SEP65.

Coordinating Part D SEP:

If the individual using the SEP65 is disenrolling from an MA-PD plan, they may (but are not required to) use this SEP to enroll in a stand-alone PDP. This coordinating SEP must be used at the same time the SEP65 is used.

30.6.2 – SEP for individuals whose Medicare entitlement determination was made retroactively

42 CFR § 422.62(b)(10)

An individual who becomes entitled retroactively to Medicare (e.g., if a determination is administratively delayed, not made timely by SSA, or not received timely by the individual) and has not been provided an opportunity to elect an MA plan (MA-only, MA-PD) during their MA ICEP, may elect an MA plan.

This SEP begins the month the individual receives the notice of the retroactive Medicare entitlement determination and ends two calendar months after the month the individual receives the notice. The effective date would be the first of the month following the month in which the election is made but would not be earlier than the first day of the month in which the notice of the Medicare entitlement determination is received by the individual.

30.6.3 – SEP for individuals who enroll in Part B during the Part B GEP

42 CFR § 423.38(c)(16)

An SEP will be provided to individuals who are **not** entitled to premium-free Part A and who enroll in Part B during the GEP for Part B (January–March). The SEP will begin when the individual submits their Part B application and ends after the first two months of Part B enrollment. An election will be effective the first of the month following the month the Part D sponsor receives the enrollment request. This SEP permits an enrollment choice in a PDP or MA-PD plan.

30.6.4 – SEP for individuals who terminated a Medigap policy upon enrolling for the first time in an MA plan and are still in a trial period

42 CFR §§ 422.62(b)(8) and 423.38(c)(24)

An individual who terminated a Medigap policy upon enrolling for the first time in an MA plan is eligible to make a one-time election to disenroll from their first MA plan to join Original Medicare, at any time of the year, if the individual is still in a "trial period" (12 months) and is eligible for "guaranteed issue" of a Medigap policy (as outlined in Section 1882(s)(3)(B)(v) of the Act). The MA SEP begins on the effective date of the individual's enrollment in the MA plan and ends after 12 months of enrollment.

Coordinating Part D SEP:

An individual using this SEP to disenroll from an MA-PD plan is eligible for a coordinating Part D SEP to make a one-time election to enroll in a PDP. This SEP begins the month they disenroll from the MA-PD plan and continues for two additional months.

30.6.5 – SEP for individuals who are institutionalized

42 CFR §§ 422.2 and 423.38(c)(15)

An individual who moves into, resides in, or moves out of an institution (see definition of "institutionalized" in 42 CFR § 422.2) is eligible to enroll in or disenroll from a Part D plan. The SEP begins when the individual moves into or out of an institution, continues while the individual resides in the institution, and ends two calendar months after the month the individual moves out of the institution.

NOTE: An election made during this SEP may never become effective prior to the first day of the month in which the individual's residency in an institution begins.

30.6.6 – SEP for individuals who use the OEPI to disenroll from an MA-PD plan

42 CFR § 423.38(c)(25)

An individual using the MA OEPI (see § 30.5) to disenroll from an MA plan that includes Part D benefits is eligible for a coordinating Part D SEP to enroll in a Part D plan.

This SEP begins the first day of the month in which the individual requests disenrollment from the MA plan and ends two calendar months after the month the MA enrollment ended.

NOTE: The effective date of an election made during this SEP is the first day of the month following the month in which the enrollment/disenrollment request is received, but not prior to the month residency begins.

30.6.7 – SEP for dual- or other LIS-eligible individuals

42 CFR §§ 423.38(c)(4) and 423.153(f)

The SEP for low-income subsidy eligible individuals is a Part D SEP that allows a "full-benefit dual eligible individual" or "partial-benefit dual eligible or other low-income subsidy (LIS) eligible individual" (see § 10) to enroll once per month into any standalone prescription drug plan but does not permit enrollment into MA-PD plans or changes between MA-PD plans.

The SEP may be used once per month with an effective date of the first of the following month.

NOTE: An individual is not eligible for this SEP if the individual has been identified as an "at-risk beneficiary" or "potential at-risk beneficiary" (see § 10). This SEP limitation starts when the individual receives the initial notice from the Part D plan that they are an at-risk beneficiary or a potential at-risk beneficiary and ends when one of the following situations occur:

Situation	SEP Limitation Ends
The plan determines the individual is not an at-risk beneficiary	60 days after the date on the initial notice or the date the beneficiary receives notice of the plan's determination, whichever occurs first
The plan determines the individual is an at-risk beneficiary	12 months from the date the individual is determined to be at-risk
The plan extends the individual's at-risk identification beyond the initial 12 months	24 months from the date the individual is determined to be "at-risk" **NOTE:** This is the maximum consecutive time the SEP limitation can be imposed for each "at-risk" limitation a sponsor implements
The individual's identification as an at-risk beneficiary or potential at-risk beneficiary is removed by the plan or by a favorable appeal	The date the identification is removed by the plan or upon effectuation of a favorable appeal

Additional information regarding this limitation for at-risk and potential at-risk beneficiaries is available on the CMS.gov website: https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/improving-drug-utilization-review-controls-part-d.

30.6.8 – SEP for individuals who gain, lose, or have a change in their dual- or LIS-eligible status

42 CFR § 423.38(c)(9)

The SEP for individuals who gain, lose, or have a change in their dual- or LIS-eligible status allows a "full-benefit dual eligible individual" or "other LIS-eligible individual" (see § 10) to enroll in or disenroll from a Part D plan one time if the individual gains, loses, or has a change in their Medicaid or subsidy-level status or LIS eligibility, including if the individual:

- Becomes eligible for any type of assistance from the Title XIX program and individuals who qualify for LIS (but who do not receive Medicaid benefits);
- Loses eligibility for any of the types of assistance described above; or
- Has a change in the level of assistance the individual receives, (e.g., stops receiving Medicaid benefits but still qualifies for LIS; has a change in cost-sharing; or becomes eligible for additional Medicaid benefits).
    - For example, this may occur when an individual newly qualifies as needing nursing home level of care and thus becomes eligible for certain Medicaid long term supports and services or becomes eligible for full Medicaid after having previously been eligible for Medicaid coverage of Medicare premiums or cost-sharing.

An individual may make an election using this SEP within three months of any of the changes noted above, or notification of such a change, whichever is later.

NOTE: Use of this SEP does not count towards the SEP for subsidy-eligible individuals described in § 30.6.7.

30.6.9 – SEP for individuals who belong to a qualified SPAP or who lose SPAP eligibility

42 CFR §§ 422.62(b)(12) and 423.38(c)(17)

An individual who belongs to a qualified "State Pharmaceutical Assistance Program" (SPAP) (§ 10), or the state acting as their authorized representative, can request to enroll in a PDP or MA-PD plan once per calendar year. An individual is also eligible for this SEP for a limited time after losing eligibility for SPAP benefits. See Chapter 14 of the Medicare Prescription Drug Benefit Manual for information regarding qualified SPAPs.

This SEP begins when the individual is enrolled in the SPAP and, upon loss of eligibility for SPAP benefits, for an additional two calendar months after either the month of the loss of eligibility or notification of the loss, whichever is later.

30.6.10 – SEPs for individuals whose plan or contract is terminated or non-renewed, including service area reductions

42 CFR §§ 422.62(b)(1), 422.74(e)(2)(ii), and 423.38(c)(6)

This is an SEP that can be used when CMS, an MAO, or a Part D sponsor has terminated an individual's MA or Part D plan contract, discontinued the plan in the area in which an individual resides (i.e., service area reduction), or notified an individual of an impending plan termination or an impending service area reduction. This SEP allows an eligible individual to enroll in an MA and/or Part D plan. See § 60.2.7 for further information on required involuntary disenrollments due to termination/non-renewal/service area reduction.

A. Non-Renewals
This SEP is for an individual whose plan or contract is non-renewed effective January 1 (i.e., termination or service area reduction, see 42 CFR §§ 422.506 and 423.507). It begins December 8 of the contract year and ends the last day of the following February. Enrollment requests received from December 8 through December 31 will have an effective date of January 1. Enrollment requests received in January will have an effective date of February 1. Enrollment requests received in February will have an effective date of March 1.

B. Termination or Modification by MAO, Part D Sponsor, or Mutual Consent
This SEP is for an individual whose plan or contract is terminated by an MAO or Part D sponsor or whose contract is terminated or modified by mutual consent (see 42 CFR §§ 422.508, 422.512, 423.508, and 423.510). It begins two months before the termination effective date and ends one month after the month of termination.

NOTE: An individual may request an effective date for the month after notice is given, or up to two months after the effective date of the termination, but the effective date may not be earlier than the date the new MAO receives the enrollment request.

> **Example:**
> If a Part D sponsor contract terminates for cause on April 30, an SEP lasts from March 1 through May 31. In this scenario, an individual could choose an effective date of April 1, May 1, or June 1 in a new PDP; however, the effective date may not be earlier than the date the new Part D sponsor receives the enrollment request.

Part C Policy:
If an individual does not elect a plan prior to the termination effective date, they will be defaulted to Original Medicare on the effective date of the termination. However, the SEP will still be in effect for one month after the effective date of the termination should the individual wish to subsequently elect an MA plan (for a prospective, not retroactive, effective date).

Part D Policy:
If an individual does not enroll in another PDP before the termination effective date, they will be disenrolled on the effective date of the termination. However, the SEP will still be in effect for one month after the effective date of the termination should the individual wish to subsequently elect an MA plan (for a prospective, not retroactive, effective date).

C. CMS Termination of Contract
This SEP is for an individual whose contract is terminated by CMS (see 42 CFR §§ 422.510 and 423.509). It begins one month before the termination effective date and ends two months after the termination effective date.

Part C Policy:
If an individual does not elect a plan prior to the termination effective date, they will be defaulted to Original Medicare on the effective date of the termination. However, the SEP will still be in

effect for two months after the effective date of the termination should the individual wish to subsequently elect an MA plan (for a prospective, not retroactive, effective date).

Part D Policy:
If an individual does not enroll in another PDP before the termination effective date, they will be disenrolled on the effective date of the termination. However, the SEP will still be in effect for two months after the effective date of the termination should the individual wish to subsequently elect an MA plan (for a prospective, not retroactive, effective date).

NOTE: A contract termination may occur midmonth if CMS terminates an MA plan or Part D plan contract immediately (see 42 CFR §§ 422.510(b)(2) and 423.509(b)(2)).

Individuals affected by MA or Part D plan consolidations are not eligible for this SEP because plan consolidations are not terminations nor non-renewals.

Individuals affected by CMS terminations of contract may select an effective date of up to three months after the month of termination.

> **Example:**
> CMS terminates a Part D sponsor contract effective June 30; the SEP lasts from June 1 through August 31. In this scenario, an individual could choose an effective date of July 1, August 1, or September 1; however, the effective date may not be earlier than the date the new Part D sponsor receives the enrollment request.

30.6.11 – SEP for individuals who are enrolled in a cost contract that is non-renewing for the area in which the enrollee resides

42 CFR §§ 422.62(b)(6) and 423.38(c)(13)

This SEP allows individuals to enroll in an MA or Part D plan if they are currently enrolled in a Medicare cost plan (see § 10) that is not renewing its contract for the area in which the enrollee resides.

This SEP begins December 8 of the current contract year and ends on the last day of February of the following year.

30.6.12 – SEP for individuals in the Program of All-inclusive Care for the Elderly (PACE)

42 CFR §§ 422.62(b)(7) and 423.38(c)(14)

This SEP allows individuals who are in the Program for All-inclusive Care for the Elderly (PACE) (see § 10) to disenroll from a PACE organization and enroll in an MA plan or Part D plan. This SEP also allows individuals who are enrolled in an MA plan and/or a Part D plan to disenroll from their plan(s) and enroll in a PACE organization.

The SEP for an individual who disenrolls from PACE to enroll in an MA or Part D plan begins on the effective date of the individual's PACE disenrollment. The SEP ends two calendar months after the effective date of the PACE disenrollment.

The SEP for an individual who disenrolls from an MA or Part D plan to enroll in a PACE organization begins on the effective date of the disenrollment from the MA or Part D plan. The SEP ends two calendar months after the effective date of the disenrollment from the MA or Part D plan.

30.6.13 – SEP for individuals who lose special needs status

42 CFR §§ 422.62(b)(11) and 423.38(c)(27)

This SEP allows individuals enrolled in a special needs plan (SNP) (see § 10) to enroll in an MA plan, when they no longer meet the applicable special needs status to remain enrolled in the SNP.

The SEP for an individual who loses special needs status begins the month the individual's special needs status changes and ends three calendar months after the effective date of the involuntary disenrollment from the SNP.

Coordinating Part D SEP:

In addition, CMS will provide an SEP to enroll in a Part D plan for those individuals who are no longer eligible for a SNP because they no longer meet special needs status.

30.6.14 – SEP for individuals who are eligible or are found ineligible to enroll in a C-SNP

42 CFR §§ 422.62(b)(13) and 423.38(c)(28)

This SEP allows individuals with severe or disabling chronic conditions to:

- Enroll in a Chronic Care special needs plan (C-SNP) (see § 10) designed to serve individuals with those conditions.
- Enroll in a different C-SNP that focuses on an individual's severe or disabling chronic condition, which is not a focus of their current C-SNP.

The SEP for either of the above scenarios is available while the individual has the qualifying condition(s) and ends upon enrollment in the C-SNP.

After enrollment into a C-SNP, an individual who is determined to not have the qualifying condition necessary to be eligible for the C-SNP may use this SEP to enroll in another MA-PD or MA-only plan (e.g., when the required post-enrollment verification with a provider did not confirm the information provided on the pre-enrollment assessment tool).

The SEP begins the month the MAO notifies the individual of the lack of eligibility for the C-SNP.

The SEP ends two calendar months following the month in which the MAO notifies the individual of the lack of eligibility.

Coordinating Part D SEP:

A coordinating Part D SEP permits a prospective enrollment into a PDP.

30.6.15 – SEP for individuals disenrolling from a cost plan with optional supplemental Part D benefits

42 CFR § 423.38(c)(19)

This Part D SEP allows an individual who is enrolled in a Medicare cost plan (see § 10) and an optional supplemental Part D benefit under that contract, to elect a Part D plan upon disenrolling from the cost contract.

The SEP begins the month the individual requests disenrollment from the cost contract. The SEP ends two calendar months after the month in which the individual requested disenrollment.

30.6.16 – SEP for individuals who elect into or out of employer sponsored coverage

42 CFR §§ 422.62(b)(4) and 423.38(c)(11)

This SEP allows eligible individuals to do the following:

- Enroll in an employer or union sponsored MA or Part D plan;
- Disenroll from an employer sponsored MA plan or Part D plan (i.e., Employer Group Health Plan (EGHP)) and enroll in a different MA or Part D plan;
- Disenroll from any employer-sponsored coverage (including Consolidated Omnibus Budget Reconciliation Act (COBRA)) to enroll in an MA or Part D plan.
- Disenroll from an MA plan or Part D plan to take employer sponsored coverage of any kind.

This SEP is available to individuals who have enrolled in or are enrolling in an employer or union sponsored MA or Part D plan. The SEP ends two months after the month the employer or union coverage of any type ends or when used to disenroll from an MA or Part D plan.

This SEP typically begins when the EGHP allows the individual to make changes to their coverage, such as during the employer's or union's "open season."

NOTE: An individual using this SEP may request an effective date of up to three months after the month in which the election is made; however, the effective date may not be earlier than the first day of the month following the month in which the election was made or the first day of the individual's entitlement to Medicare Parts A and B.

30.6.17 – SEP for individuals who involuntarily lose creditable prescription drug coverage

Social Security Act § 1860D-1(b)(3)(A); 42 CFR §§ 422.62(b)(19) and 423.38(c)(1)

This SEP allows individuals who experience an involuntary loss of creditable prescription drug coverage, including a reduction in the level of coverage such that it is no longer creditable

coverage (as defined at 42 CFR § 423.56(a)), to enroll in a PDP. The SEP begins when an individual is notified of the loss of (or reduction in) creditable coverage and ends two calendar months after either the loss (or reduction) occurs or the individual's receipt of the notice, whichever is later.

The effective date of coverage is the first of the month after the enrollment election request is made or, at the individual's request, may be later; however, the effective date may not be more than two months from the end of the SEP.

Coordinating MA SEP:

In addition, this SEP permits enrollment into an MA-PD plan and begins when an individual is notified of the loss of (or reduction in) creditable coverage and ends two calendar months after either the loss (or reduction) occurs or the individual's receipt of the notice, whichever is later.

The effective date of this SEP is the first of the month after the enrollment election is made or, at the individual's request, may be up to three months prospective.

NOTE: Loss of creditable prescription drug coverage due to failure to pay required premium is **not** considered involuntary loss of the coverage.

30.6.18 – SEP for individuals who were not adequately informed of a loss of creditable prescription drug coverage

42 CFR §§ 422.62(b)(20) and 423.38(c)(2)

A Medicare-eligible individual who was not adequately informed of the creditable status of drug coverage provided by an entity required to give such notice or was not adequately informed of a loss of creditable prescription drug coverage, (or that they never had creditable coverage) may be eligible to enroll in, or disenroll from, a PDP or an MA-PD plan. This SEP begins the month that CMS determines the individual is eligible for the SEP. The SEP ends two calendar months after the month CMS makes the determination of eligibility.

CMS determines eligibility for this SEP on a case-by-case basis, based on its determination that an entity offering prescription drug coverage to a Medicare-eligible individual, failed to provide accurate and timely disclosure of the loss of creditable prescription drug coverage or whether the prescription drug coverage offered was creditable.

30.6.19 – SEP for individuals who disenroll from Part D to enroll in or maintain other creditable coverage

42 CFR §§ 422.62(b)(14) and 423.38(c)(18)

This SEP allows an individual who is enrolled in a Part D plan to disenroll from that Part D plan to enroll in or maintain other creditable prescription drug coverage (e.g., TRICARE or VA coverage). An individual using this SEP to disenroll from an MA-PD plan may also use the SEP to elect Original Medicare or enroll in an MA-only plan. This SEP begins upon the individual's

disenrollment from the Part D plan and ends the first day of the month following the month in which a disenrollment request is received by the plan.

30.6.20 – SEP for individuals who change permanent residence

42 CFR §§ 422.62(b)(2) and 423.38(c)(7)

This SEP allows individuals to enroll in a new MA or Part D plan because they have changed their permanent residence. If an individual is enrolled in a plan at the time of the permanent change in residence, an SEP is not needed to effectuate an involuntary disenrollment from the plan, as they would no longer be eligible to be enrolled in the plan.

Common scenarios in which an individual is eligible for this SEP include when the individual:

- Changes their permanent residence to outside of the plan's service area (for MA plans, this includes a move out of an MA plan continuation area);
- Has been living outside of the U.S. and has now moved back to the U.S.;
- Was incarcerated and has now been released; or
- Has new MA or Part D plans available to them as a result of a permanent move.

The SEP begins:

- The date of the change in permanent residence;
- The month before the change in permanent residence, for an individual who notifies the MAO or Part D sponsor in advance of the change; or
- When the individual is being disenrolled because they have been out of the service area for over six months (Part C) or over 12 months (Part D) and the MAO or Part D plan has not been able to confirm the residency status of the individual. See below for more information.

The SEP ends:

- Two months following the month it begins; or
- Two months following the month of the move, whichever is later.

NOTE: An individual using this SEP may choose an effective date of up to three months after the month in which the plan receives the individual's enrollment request; however, the effective date may not be earlier than the date the individual moves to the new service area and the plan receives the enrollment request.

Part C Policy:
When the MAO learns from CMS or the U.S. Post Office (as described in § 60.2.1) that the individual has been out of the service area for over six months and the individual is disenrolled because the MAO has not been able to confirm the residency status of the individual, the SEP for that individual begins the first day of the sixth month and ends the last day of the eighth month of the individual's absence from the service area.

Part D Policy:
When the Part D sponsor learns from CMS or the U.S. Post Office (as described in § 60.2.1) that the individual has been out of the service area for over 12 months and the individual is disenrolled because the sponsor has not been able to confirm the residency status of the individual, the SEP for that individual begins the first day of the 12th month and ends the last day of the 14th month of the individual's absence from the service area.

Example 1:
In May, an individual notifies their MA plan in Florida that they intend to move to Arizona on June 18. An SEP exists for this individual from May 1 to August 31.

A. If the MAO receives the enrollment request from the individual in June (the month of the move), the individual can choose an effective date of July 1, August 1, or September 1.

B. If the MAO receives the enrollment request in July, the individual could choose an effective date of August 1, September 1, or October 1.

C. If an MAO in Arizona receives an enrollment request from the individual in August, the individual can choose an effective date of September 1, October 1, or November 1.

Example 2:
An individual resides in Florida and is currently enrolled in Original Medicare but is not enrolled in a PDP. The individual intends to move to Maryland on August 3 and wants to enroll in a PDP. An SEP exists for this individual from July 1 through October 31.

At the time the individual requests enrollment in an MA or Part D plan, the individual must provide the specific address where they will permanently reside upon moving into the service area, so that the sponsor can determine that the individual meets the residency requirements for enrollment in the plan.

30.6.21 – SEP for individuals who are enrolled or not enrolled in Part D due to an error by a federal employee

42 CFR §§ 422.62(b)(21) and 423.38(c)(3)

An individual whose enrollment or non-enrollment in a Part D plan, including an MA-PD plan, was erroneous due to an action, inaction, or error by a federal employee is eligible to enroll in or disenroll from the Part D plan, as determined by CMS on a case-by-case basis.

This SEP begins the month that CMS approves the SEP and ends two calendar months after the month of the approval.

30.6.22 – SEP for individuals who want to enroll in a 5-star plan

42 CFR §§ 422.62(b)(15), 423.38(c)(20), and 423.38(c)(29)

This SEP allows individuals to enroll in an MA plan or Part D plan with a Star Rating of 5 stars for an effective date during the year in which that plan has the 5-star overall rating, provided the

enrollee meets all the other requirements to enroll in that plan (e.g., living within the service area). Individuals may use the 5-star SEP to disenroll from an MA plan by enrolling in a 5-star MA or Part D plan that is open for enrollment.

As overall ratings are assigned for the plan contract year (January through December), possible enrollment effective dates are from January 1 to December 1 during the year for which the plan has been assigned an overall performance rating of five stars. An individual may not use this SEP for more than one enrollment in a contract year. The SEP begins December 8 prior to the contract year and ends November 30 of the contract year.

Examples:

- Plan X has an overall rating of 4.5 stars in 2020 and 5 stars for 2021. An individual could use this SEP to request enrollment in Plan X beginning December 8, 2020, for an effective date of January 1, 2021. An individual could not use the SEP to enroll in Plan X for an effective date on or before December 1, 2020, as the enrollment effective dates available during that period are prior to the contract year for which Plan X has been assigned a 5-star overall rating.
- Plan Y has an overall rating of 5 stars for 2020 but has lost that 5-star rating for 2021. An individual could use this SEP to request enrollment in Plan Y for the first of the following month until November 30, 2020, with the last possible effective date available being December 1, 2020. The individual could not use the SEP to submit an enrollment request in Plan Y on or after December 1, 2020, as the enrollment effective dates available during that period are after the contract year for which Plan Y is assigned a 5-star overall rating.

An individual using this SEP can enroll in an MA-only or an MA-PD plan, even if coming from Original Medicare (with or without concurrent enrollment in a PDP). Individuals enrolled in a plan with a 5-star overall rating may also switch to a different plan with a 5-star overall rating. An individual in an MA-only or MA-PD coordinated care plan who switches to a PDP with a 5-star overall rating will lose MA coverage and will revert to Original Medicare for basic medical coverage.

Regardless of whether the individual has Part D coverage prior to use of this SEP, any individual who enrolls in a 5-star MA Private Fee-for-Service plan without prescription drug coverage or a 5-star cost plan is eligible for a coordinating Part D SEP to enroll in a PDP.

Use of this SEP does not guarantee Part D coverage. If an individual in either an MA-PD plan or a PDP chooses to enroll in an MA-only coordinated care plan with a 5-star overall rating, that individual would lose Part D coverage and must wait for a subsequent enrollment period to obtain Part D coverage under the normal enrollment rules. Part D late enrollment penalties may also apply.

NOTE: An individual who disenrolls from an MA plan and enrolls only in a standalone PDP with a 5-star rating will automatically be enrolled in Original Medicare.

30.6.23 – SEP for individuals who use the 5-star SEP to enroll in a plan without Part D

42 CFR § 423.38(c)(29)

Individuals who use the 5-star SEP (described in § 30.6.22 above) to enroll in a 5-star MA-only Private Fee-for-Service plan without Part D benefits, or enrolls in a Section 1876 cost plan, is eligible to request enrollment in a PDP or the cost plan's optional supplemental Part D benefit, if offered. The PDP selected using this coordinating SEP does not have to be 5-star rated.

This SEP begins the month the individual uses the 5-star SEP and ends two calendar months after the month in which the 5-star SEP is used.

NOTE: Enrollment in an MA-only coordinated care plan prevents enrollment in a stand-alone PDP under 423.30(b). Individuals who use the 5-star SEP to enroll in an MA-only coordinated care plan are not eligible for this Part D SEP and must wait until their next valid election period in order to enroll in a plan with Part D coverage.

30.6.24 – SEP for individuals who requested materials in an accessible format

42 CFR §§ 422.62(b)(17) and 423.38(c)(22)

In order to comply with the prohibitions on discrimination in federal health care programs on the basis of disability outlined in Section 504 of the Rehabilitation Act of 1973 (Section 504), MAOs and Part D sponsors must provide materials in accessible formats to their enrollees. This generally includes formats such as Braille, data, and audio files, or other formats accepted by the enrollee in place of, or in addition to, the original print material.

This SEP is for individuals who requested but did not receive required notices or information in an accessible format within the same time frame as the MAO, Part D plan sponsor, or CMS provided the same information to individuals who did not request an accessible format. This SEP allows an individual equal time to make an enrollment decision and allows the individual to make the same election(s) that was permitted before the individual received the required notices in an accessible format.

This SEP begins at the end of the election period during which the individual was seeking to make an election and continues for at least as long as the time it takes for the information to be provided to the individual in an accessible format.

NOTE: MAOs and Part D plan sponsors may determine eligibility for this SEP when the criterion is met, ensuring adequate documentation of the situation (such as records indicating the amount of time taken to provide accessible versions of materials) is maintained. Individuals seeking assistance for this SEP may also contact 1-800-MEDICARE.

30.6.25 – SEP for individuals affected by a government-entity declared disaster or other emergency

42 CFR §§ 422.62(b)(18) and 423.38(c)(23)

An individual affected by an emergency or major disaster declared by a federal, state, or local government is eligible to enroll in or disenroll from an MA plan or a Part D plan.

An individual is eligible for this SEP if they:

- Reside, or resided at the start of the SEP eligibility period described below, in an area for which a federal, state, or local government entity has declared an emergency or major disaster, or they do not reside in an affected area but rely on help making healthcare decisions from one or more individuals who reside in an affected area.
- They were eligible for another election period at the time of SEP eligibility period; and
- Did not make an election during that other valid election period due to the disaster or other emergency.

The SEP starts as of the date the declaration is made, the incident start date or, if different, the start date identified in the declaration, whichever is earlier. The SEP ends two full calendar months following:

- the end date identified in the declaration or, if different,
- the date the end of the incident is announced, or, if no date is identified or announced,
- the date the incident automatically ends under applicable state or local law, or
- one year after the SEP start date, or renewal or extension.

The maximum length of this SEP, if the incident end date is not otherwise identified, is 14 full calendar months after the SEP start date, or, if applicable, the date of a renewal or extension of the emergency or disaster declaration.

30.6.26 – SEP for individuals enrolled in a plan placed in receivership

42 CFR §§ 422.62(b)(24) and 423.38(c)(31)

This SEP is for individuals enrolled in a plan offered by an MAO or Part D sponsor that has been placed into receivership by a state or territorial regulatory authority. The SEP begins the month the receivership is effective and continues until it is no longer in effect, or until the enrollee makes an election, whichever occurs first.

NOTE: When instructed by CMS, the MA plan or Part D plan that has been placed under receivership must notify its enrollees, in the form and manner directed by CMS, of the enrollees' eligibility for this SEP and how to use the SEP.

30.6.27 – SEP for individuals enrolled in a plan identified as a consistent poor performer

42 CFR §§ 422.62(b)(25) and 423.38(c)(32)

This SEP is for individuals enrolled in a plan that has been identified by CMS as a consistent poor performer with the low performing icon, in accordance with the applicable MA and Part D regulations (42 CFR §§ 422.166(h)(1)(ii) and 423.186(h)(1)(ii)). This SEP allows for a one-time election out of the plan with the low performing icon into another plan. This SEP exists while the individual is enrolled in the low performing plan. The SEP ends when the individual makes an election into a new plan.

30.6.28 – SEP for contract violations

42 CFR §§ 422.62(b)(3) and 423.38(c)(8)

This SEP is for individuals who demonstrate to CMS that their MAO or Part D plan sponsor substantially violated a material provision of the plan contract in relation to the individual or materially misrepresented the plan in communications with the individual. Such violations include, but are not limited to, an MAO or Part D sponsor:

- Materially misrepresenting the plan when marketing the plan.
- Failing to provide the individual, on a timely basis, medically necessary services, for which benefits are available under the plan.
- Failing to provide medical services in accordance with applicable quality standards.

The SEP will begin once CMS determines that a violation has occurred. Its length will depend on whether the individual immediately elects a new plan. Upon request, the individual may choose to be immediately disenrolled from the plan and be defaulted to Original Medicare or they may choose to immediately elect a new plan. If the individual does not immediately elect a new plan after the CMS determination, they have 90 calendar days to make an election.

An individual may elect another MA or Part D plan for an effective date of the first day of the month after the month the new sponsor receives the completed enrollment request. The individual may also choose an effective date of enrollment in the new plan beginning any of the three months after the month in which the sponsor receives the completed enrollment request. However, the effective date may not be earlier than the date the sponsor receives the completed enrollment request.

NOTE: On a case-by-case basis, CMS may process a retroactive disenrollment using this SEP.

30.6.29 – SEP for individuals who disenroll in connection with CMS sanction

42 CFR §§ 422.62(b)(5) and 423.38(c)(12)

This SEP allows individuals enrolled in an MA or Part D plan offered by an MAO or a Part D plan sponsor that has been sanctioned by CMS to disenroll from that plan in connection with the matter(s) that gave rise to the sanction. The SEP begins with the imposition of the sanction and ends when the sanction ends or when the individual makes an election, whichever occurs first.

Consistent with the disclosure requirements at 42 CFR §§ 422.111(g) and 423.128(f), CMS may require the MAO or Part D plan sponsor to notify current enrollees that, if the enrollees believe they are affected by the matter(s) that gave rise to the sanction, the enrollees may be eligible for an SEP. Enrollees in an MA plan offered by a sanctioned MAO may use this SEP to elect another MA plan or disenroll to original Medicare and enroll in a PDP. Enrollees in a PDP offered by a sanctioned Part D sponsor may use this SEP to elect another PDP.

30.6.30 – SEP for individuals who receive a notification of a CMS or State-initiated enrollment action

42 CFR §§ 422.60(g)(5) and 423.38(c)(10)

Individuals who are enrolled into a plan by CMS or a State (i.e., through passive enrollment, auto-enrollment, facilitated enrollment, and reassignment) have an SEP to disenroll from their CMS/State-initiated assigned plan and enroll into a different plan. The SEP permits a one-time election within three months of the effective date of the assignment, or notification of the assignment, whichever is later. It allows the individual to make an election before the enrollment is effective in the receiving plan or after the coverage in the receiving plan starts. This SEP must be used within three months of the start of coverage in the receiving plan, except that in the case where the notice is sent after the coverage in the receiving plan starts, the SEP ends three months after the date of the notice. This SEP is provided so that an individual may exercise any mandatory "opt-out" right provided to the enrollee as part of the CMS or State-initiated enrollment.

Individuals passively enrolled due to a plan's non-renewal or termination (outlined in § 40.1.6) may also be eligible for an SEP as outlined in § 30.6.10 of this Chapter.

30.6.31 – SEP for individuals involuntarily disenrolled from an MA-PD plan due to loss of Part B

42 CFR § 423.38(c)(33)

Individuals who are involuntarily disenrolled from an MA-PD plan due to loss of Part B but who continue to be entitled to Part A have an SEP to enroll in a PDP. Generally, MA enrollment requires the individual to have Medicare Part A and Part B, however, those individuals with Part A only can enroll in a PDP. The SEP begins when the individual is advised of the loss of Part B. The SEP ends two calendar months after the month in which the individual was advised of the loss of Part B.

30.6.32 – SEP for non-U.S. citizens who become lawfully present

42 CFR §§ 422.62(b)(16) and 423.38(c)(21)

CMS will provide an SEP for non-U.S. citizens who become lawfully present in the United States. The individual may use this SEP to request enrollment in any MA plan or Part D plan for which they are eligible, including an MA-PD. This SEP begins the month the individual attains lawful presence. The SEP ends two calendar months after the month lawful presence status begins.

30.6.33 – SEP for significant change in provider network

42 CFR §§ 422.62(b)(23) and 423.38(c)(30)

When CMS determines a change in a plan's provider network to be significant, affected enrollees are eligible for an SEP that permits enrollment in another MA plan or disenrollment from the MA plan that has changed its network to original Medicare. Enrollees are eligible for the SEP when the enrollee is assigned to, currently receiving care from, or has received care within the past three months from a provider or facility being terminated from the MA (or MA-PD) plan's provider network.

The SEP can be used only once upon a significant change in provider network. It begins the month enrollees are notified of eligibility for the SEP. The SEP ends two calendar months after the month in which enrollees are notified of their eligibility.

NOTE: When instructed by CMS, the MA plan that has significantly changed its network must notify its enrollees, in the form and manner directed by CMS, of the enrollees' eligibility for this SEP and how to use the SEP.

Coordinating Part D SEP:
MA enrollees using this SEP to disenroll from an MA plan may use this coordinating SEP to request enrollment in a PDP. This coordinating SEP begins the month the individual is notified of eligibility for the SEP and continues for two additional 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.

30.6.34 – SEP for individuals who enroll in Medicare premium-Part A or Part B using an exceptional condition SEP, as described in 42 CFR Parts 406.27 and 407.23

42 CFR §§ 422.62(b)(26) and 423.38(c)(34)

An SEP exists for individuals who enroll in Medicare premium-Part A or Part B using an exceptional condition SEP as described in 42 CFR §§ 406.27 and 407.23. The SEP begins when the individual submits their premium-Part A or Part B application and ends after the first two months of enrollment in premium Part A or Part B. The Part C or D plan enrollment is effective the first of the month following the month the plan receives the enrollment request.

30.6.35 – SEP for integrated care

42 CFR § 423.38(c)(35)

The integrated care SEP allows enrollment once per month into a FIDE SNP, HIDE SNP, or AIP D-SNP for dually eligible individuals who are enrolled in or in the process of enrolling in the D-SNPs affiliated Medicaid MCO. The integrated care SEP is available only to facilitate aligned enrollment, as defined in § 422.2, in the FIDE SNP, HIDE SNP, or AIP D-SNP and the affiliated Medicaid MCO.

The SEP may be used once per month with an effective date of the first of the following month.

30.6.36 – SEP for other exceptional circumstances

42 CFR §§ 422.62(b)(26) and 423.38(c)(36)

CMS will establish an SEP, on a case-by-case basis, for exceptional circumstances related to enrollment into or disenrollment from an MA or Part D plan that are not otherwise captured in regulation. Consistent with current practice, CMS will consider granting an enrollment or disenrollment opportunity in situations such as the following:

- Circumstances beyond the individual's control that prevented them from submitting a timely request to enroll in or disenroll from a plan during a valid election period. This is inclusive of, but not limited to, a serious medical emergency of the individual or their authorized representative during an entire election period, a change in hospice status, or mailed enrollment or disenrollment requests returned as undeliverable on or after the last day of an enrollment period.
- Situations in which an individual provides a verbal or written allegation that their enrollment in an MA or Part D plan was based upon misleading or incorrect information provided by a plan representative or State Health Insurance Assistance Program (SHIP) counselor, including situations where an individual states that they were enrolled into a plan without their knowledge or consent, and requests cancellation of the enrollment or disenrollment from the plan.
- An SEP may be warranted to ensure access to services, and when, without the approval of an enrollment exception, there could be adverse health consequences for the individual. This is inclusive of, but not limited to, maintaining continuity of care for a chronic condition and preventing an interruption in treatment.

CMS will review supporting details to determine eligibility for the SEP for exceptional circumstances. CMS's review can be in response to an individual's request for an exception to the current enrollment rules, as well as CMS' determination that an exception is warranted for a group of beneficiaries.

The SEP begins once CMS makes its determination and the enrollee has been notified. The effective date for an enrollment or disenrollment election using an approved enrollment exception is based on the individual's circumstances and will be effective the first of the month and may be either prospective or retroactive. The earliest prospective enrollment effective date is the first day of the calendar month following the month in which the election is made.

30.7 – Effective Dates of Coverage

42 CFR §§ 422.68 and 423.40

With the exception of some SEPs or, when election periods overlap, individuals may not request their enrollment effective date. Furthermore, except for the EGHP SEP, the effective date is generally not prior to the receipt of an enrollment request by the plan. An enrollment cannot be effective prior to the date the individual or their authorized representative completed the enrollment request. The effective date for an enrollment into an MA plan may not be earlier than the first day of the individual's entitlement to both Medicare Part A and Part B; for Part D plans, the effective date may not be earlier than the first day that the individuals is entitled to Medicare Part A and/or enrolled in Part B.

To determine the proper effective date, plans must determine which election period applies to each individual before the enrollment may be transmitted to CMS. The election period may be determined by reviewing information such as the individual's date of birth, Medicare card, a letter from SSA, or by the date the enrollment request is received by the plan.

Once the election period is identified, the plan must determine the effective date.

Examples:

A. Situation: On August 18, 2020, Mrs. Jones submits an enrollment request to a Part D plan. Her enrollment form shows she became entitled to Medicare Parts A and B March 1, 2012. She has indicated on her enrollment form that she lives in a long-term care facility.

   Analysis: Since the date the request was received was August 18, 2020, this is not an AEP request. The entitlement date for Medicare Parts A and B shows that she is not in her IEP for Part D. That leaves only an SEP. Mrs. Jones indicated that she resides in a long-term care facility, so this enrollment request can be processed under the SEP for Institutionalized Individuals (see § 30.6.5). The effective date for this enrollment is September 1, 2020.

B. Situation: Mr. Doe calls a PDP sponsor for plan information on October 2, 2020. The PDP representative discusses the PDP plans available and the enrollment requirements, including when an individual may enroll. Mr. Doe tells the representative that he is retiring and his employer coverage will end on October 31, 2020. He submits an enrollment request on October 6, 2020. His entitlement to Medicare Parts A and B was June 1, 2008. He indicates on the request that he does not reside in a long-term care facility.

   Analysis: Since the date the request was received was October 6, 2020, this is not an AEP request. The entitlement date for Medicare Parts A and B shows he is not in his IEP for Part D. No other details on the request itself point to any specific enrollment period, however we know that he has retired and his employer sponsored commercial coverage is ending. The enrollment can be processed using the SEP EGHP (see § 30.6.16). Mr. Doe can choose an effective date of up to three months after the month in which the request is made. The PDP sponsor contacts Mr. Doe, confirms his retirement, explains the SEP EGHP and asks him about the effective date. Since his employer coverage is ending on October 31, 2020, he requests a November 1, 2020, effective date.

An individual may make an enrollment request when they are eligible for more than one election period, resulting in more than one possible effective date. Therefore, if an MAO or Part D plan sponsor receives an enrollment request and determines the applicant is eligible for more than one election period, the plan must allow the individual to choose the enrollment effective date from those available under the applicable election periods (see exceptions in the next paragraph regarding the ICEP and Part D IEP). To accomplish this, the plan must attempt to contact the individual, and must document its attempt(s), to determine the individual's choice.

NOTE: This requirement does not apply to individual requests for enrollment into an employer or union sponsored plan using the group enrollment mechanism, as these may be submitted to CMS with the EGHP SEP election type code. Individuals who make an election via the employer or union election process will be assigned an effective date according to the SEP EGHP, unless the individual requests a different effective date that is allowed by one of the other elections periods for which they are eligible.

If one of the election periods for which the individual is eligible is the ICEP, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and Part B. If one of the election periods for which the individual is eligible is the Part D IEP, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and/or enrollment in Part B.

Examples:

- An individual is entitled to Medicare Part A and Part B in February. Their ICEP is the seven-month period from November through May. If the plan receives an enrollment request from that individual during the AEP (October 15–December 7), the individual may **not** choose a January 1 effective date. The individual must be given a February 1 effective date for the ICEP because January 1 is earlier than the month of entitlement to Medicare Part A and Part B.
- If an individual's IEP for Part D starts in November (i.e., they will be entitled to Medicare Part A and Part B in February) and a PDP sponsor receives an enrollment request from that individual during the AEP, then the individual may **not** choose a January 1 effective date (for the AEP) and must instead be given a February 1 effective date (for the IEP for Part D) because January 1 is earlier than the month of entitlement to Medicare Part A and/or enrollment in Part B.

If an individual is eligible for more than one election period and does not choose which election period to use, and the plan is unable to contact the individual, the plan must assign an election period using the following ranking of election periods. The election period with the highest rank generally determines the effective date of enrollment. If an individual is simultaneously eligible for more than one SEP and they do not make a choice, and the plan is unable to obtain the individual's desired enrollment effective date, the plan should assign the SEP that results in an effective date of the first of the month after the enrollment request is received by the plan.

Ranking of Election Periods: (1 = Highest, 5 = Lowest)

1. ICEP/Part D IEP
2. MA OEP
3. SEP
4. AEP
5. OEPI

30.8 – Effective Date of Coverage for Voluntary Disenrollments

42 CFR §§ 422.68 and 423.40

Similar to enrollments, with the exception of some SEPs or when election periods overlap, individuals may not select their effective date of disenrollment. Instead, plans are responsible for assigning the appropriate effective date based on the election period that is consistent with the controlling regulation(s).

It is possible for an individual to make a disenrollment request when more than one election period applies. If an MAO or Part D sponsor receives a disenrollment request when more than

one election period applies, the plan must allow the individual to choose which election period to use. If the individual does not make a choice, then the plan must assign the election period that results in the **earliest** disenrollment.

An MA or Part D plan enrollee may disenroll through the MAO or Part D sponsor or through 1-800-MEDICARE. If an enrollee elects a new MA or Part D plan while still an enrollee of a different plan, they will automatically be disenrolled from the old plan and enrolled in the new plan by CMS systems with no duplication or delay in coverage.

Part C Policy:
If an individual disenrolls through an MAO or 1-800-MEDICARE, the individual will return to Original Medicare unless they elect a new MA plan.

Part D Policy:
Individuals enrolled in any MA plan (except for an MA Private Fee-For-Service (PFFS) plan that does not offer a Part D benefit, or a Medicare Medical Savings Account (MSA) will be disenrolled from that MA plan upon successful enrollment in a PDP.

Effective dates for voluntary disenrollments are as follows:

Election Period	Effective Date of Disenrollment	Do plans have to accept disenrollment requests in this election period?
Medicare Advantage Open Enrollment Period (MA OEP) (MA enrollees only)	First day of the month after the month the MAO receives the disenrollment request.	Yes
Annual Election Period (AEP) (also referred to as the "Fall Open Enrollment Period")	January 1 of the following year.	Yes
Special Election Period (SEP)	Varies, as outlined in § 30.6	Yes
Open Enrollment Period for Institutionalized Individuals (OEPI)	First day of the month after the month the MAO receives the disenrollment request.	Yes

30.9 – Election Periods and Effective Dates for Medicare MSA Plans

42 CFR §§ 422.56 and 422.62(d)

Individuals may enroll in Medicare MSA plans only during the ICEP or the AEP; they may not enroll in Medicare MSA plans during an SEP (see exception below). The effective date of coverage is determined by the election period in which an enrollment request is made. Effective dates are provided in § 30.7 of this chapter.

Exception: To facilitate the offering of employer or union sponsored MSA plans, individuals may request enrollment into an employer or union sponsored MSA plan using the Employer Group Health Plan Special Election Period (EGHP SEP).

Individuals may disenroll from Medicare MSA plans only during the AEP or an SEP. The effective date of disenrollment during an SEP depends on the type of SEP. Additionally, MSA enrollees may not use the MA OEP to disenroll from the MSA. An individual who elects an MA MSA plan during the AEP and has never before elected an MA MSA plan may revoke that election, no later than December 15 of that same year.

40 – Enrollment Request Mechanisms

42 CFR §§ 422.60 and 423.32

A plan must accept enrollment requests it receives, whether in a face-to-face interview, by mail, by fax, or through other mechanisms defined by CMS, from individuals eligible to join a plan offered by the organization during a valid enrollment period.

Enrollment requests can be received by the following approved mechanisms:

Mechanism Type	MA	Part D	Initiated by:
Paper Enrollment Forms: Required mechanism for all plans	✔	✔	Individual
Electronic Enrollment	✔	✔	Individual
Medicare.gov Online Enrollment Center (OEC)	✔	✔	Individual
Telephonic Enrollment (Incoming telephone call to a plan representative or agent)	✔	✔	Individual
Default Enrollment process	✔		MAO
Passive Enrollment	✔	✔	CMS
Simplified (Opt-in) Enrollment Mechanism	✔		MAO
Auto- or Facilitated Enrollment processes	✔	✔	CMS/MAO
Reassignment of LIS Beneficiaries		✔	CMS
Employer or Union Group Health Plans (EGHPs)	✔	✔	Plan
SPAP Enrollment requests	✔	✔	SPAP

40.1 – Format of Enrollment Requests

42 CFR §§ 422.60(c) and 432.32

In addition to the paper enrollment form, plans may offer other approved mechanisms to request enrollment. Regardless of the mechanism used to make an election, the format by which the plan receives the enrollment request determines the format, content, and submission requirements that apply.

NOTE: For purposes of enrollment, receipt by the agent or broker employed by or contracting with the plan is considered receipt by the plan.

Plans must ensure all enrollment mechanisms comply with CMS' guidelines in format and content. See Appendix 2 for a complete list of required elements to be included in all enrollment mechanisms.

In addition to the information collected in the request, all enrollment mechanisms must include the applicant's acknowledgement of the following:

MA	Part D
Required to keep Part A **and** Part B	Required to keep Part A or Part B, or both
Consent to the disclosure and exchange of information between the U.S. Department of Health and Human Services (HHS), its designees and the MA or Part D plan; information may be used to track enrollment and other purposes, as allowed under federal law and regulations	
Can be enrolled in only one MA or Part D plan—and that enrollment automatically disenrolls the individual from any other MA or Part D plan (see § 20.1 for exceptions)	
The information provided in the enrollment request is correct; intentionally falsifying information will result in disenrollment	
Their signature indicates an understanding of the enrollment application, and that (if applicable) authorized representatives have legal authority to complete the enrollment request	
Benefits and services (excluding hospice and kidney acquisition costs for transplants) must be obtained from the plan in order to be covered as Medicare benefits	

The plan premium amount is not required to be displayed or disclosed on the enrollment mechanism unless it is part of the plan name. Plans may include the premium amount on the enrollment mechanism if they choose to do so, but they must do so consistently for all Plan Benefit Packages (PBPs) listed on the enrollment mechanism.

For enrollment between PBPs under the same parent organization, the plan may limit the data to be collected from the applicant to data it does not already have. However, the plan must obtain the following data to complete and process the enrollment:

- Minimal personal data sufficient for the plan to correctly identify the enrollee and their information within its systems;
- The applicant's Medicare number;
- The name of the plan selected for enrollment;
- A statement requesting preferred language or alternate format preference (applicant response not required; does not affect enrollment if not completed);
- The applicant's signature or attestation of intent to enroll, or, as applicable, from an authorized representative acting on the individual's behalf, and contact information; and,
- Any other data the plan does not already have in its records that is necessary to meet the requirements in Appendix 2.

If an MAO or Part D sponsor receives an enrollment request that does not have all necessary elements required in order to consider it complete, the plan must not immediately deny the enrollment. The MAO or Part D sponsor must always check available systems (i.e., BEQ, MARx online query) for information to complete an enrollment before requiring the individual to provide the missing information. If the required but missing information is not available via CMS systems, the enrollment request is considered incomplete, and the MAO or Part D sponsor must follow the procedures outlined in § 50.3 in order to complete the enrollment request.

For paper, telephone and electronic enrollment requests, all required elements as listed in Appendix 2 must be included. The "Beneficiary Signature and/or Authorized Representative Signature" element for a paper request is satisfied with a pen-and-ink signature, for a telephone request it is satisfied with a verbal attestation of intent to enroll, and for an electronic request it is satisfied with an electronic signature or a clear and distinct step that requires the applicant to activate an "Enroll Now," or "I Agree," type of button or tool. Follow the procedures outlined in § 50.3 to address incomplete enrollment requests.

Electronic signatures have the same legal effect and validity as pen-and-ink signatures. An MAO or Part D sponsor utilizing electronic signatures in electronic enrollment must, at a minimum, comply with the HIPAA data security and privacy policies. For more information on the requirements for legally binding electronic signatures, see the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. § 7001, and "Use of Electronic Signatures in Federal Organization Transactions" published by the Federal Chief Information Officers (CIO) Council.

As part of the enrollment mechanism, the plan may include the applicant's acknowledgment of the following:

- The plan has a contract with the federal government;
- Emergency coverage (both within and outside the plan's service area) and urgent care are always covered; and
- Sales agents/brokers may be compensated if they are helping the individual to enroll.

Enrollment mechanisms may not include:

- A question regarding binding arbitration;
- Whether the individual receives hospice care (except MSA plans); or
- Any other health screening information.

NOTE: Some exceptions apply for SNPs; please refer to § 20.8.4.

Enrollment mechanisms may not include any health screening information. However, MAOs may ask very limited health status questions related to a beneficiary's eligibility to join an MA plan, such as whether the individual is enrolled in Medicaid. An exception also exists for certain MA-SNPs since the plan will need to establish that the individual has such a condition to be determined eligible for enrollment in that specific SNP.

40.1.1 – Paper Enrollment Forms

Plans must have, at minimum, a paper enrollment form available for potential enrollees to request enrollment in a plan. Plans must accept paper enrollment requests received in paper format in a face-to-face interview, by mail, or by fax.

Example:
Mr. Chester meets with a broker to fill out a paper enrollment form during a face-to-face interview with a pen-and-ink signature. The broker receives (accepts) the completed paper enrollment request and conveys that information to the plan via an electronic mechanism. As outlined in this section, receipt by the agent or broker employed by or contracting with the plan, is considered receipt by the plan. Furthermore, the enrollment mechanism is determined based on how the plan receives the request. In this example, the plan received Mr. Chester's enrollment request in paper format.

Plans can utilize model enrollment forms included in MA Exhibits 1–3a or Part D Exhibits 1–1c or choose to develop their own materials subject to CMS marketing requirements. See 42 CFR §§ 422.2261(b), 422.2267, 423.2261(b), and 423.2267 for more information.

Plans can use the model short enrollment form ("short form") for enrollment requests into another plan offered by the same parent organization. For determining the appropriate use of the short form, CMS defines parent organization as the contract numbers (H#) and legal entities that are owned and operated by a single organization in a single State. Organizations must ensure that the short form contains all elements required for enrollment requests into a particular plan type. As a result, a short form may be used only for enrollment requests into another plan of the same type (i.e., HMO to HMO, PPO to PPO, or PFFS to PFFS).

40.1.2 – Electronic Enrollment

Plans may develop and offer electronic enrollment mechanisms made available via an electronic device or through a secure internet website. Plans also have the option of obtaining technical support, (e.g., licensed software) and related services from downstream entities, such as a broker or third-party website, as a means of facilitating and capturing the electronic enrollment request.

Plans may accept enrollment requests via electronic communications, including email, provided consent to use email to send enrollment information or other protected health information (PHI) has been obtained from the individual in advance. Additionally, plans must ensure reasonable safeguards are applied when transmitting PHI to ensure the confidentiality and integrity of data.

Example:
Ms. Riva contacts the plan to confirm receipt of her enrollment application. The plan is unable to locate the enrollment request and suggests Ms. Riva or the agent/broker email a copy of her scanned paper application instead of requesting she re-fax or mail the application. Ms. Riva emails a copy of the scanned paper application to the plan. The plan receives the enrollment application through a secure portal or email encryption method and processes the emailed application according to the requirements for electronic enrollment mechanisms.

Enrollment requests can take different forms from the point at which the individual makes the request to the point of receipt by the plan. The receipt of the request by the plan determines the applicable requirements for appropriate handling of beneficiary information.

Example:
Mr. Murphy contacts the agent or broker and expresses interest in enrolling in a plan. The agent emails Mr. Murphy, via a secured transmission, the enrollment application, and a scope of appointment for an electronic signature. Once the scope of appointment is secured, the agent contacts Mr. Murphy by telephone to discuss plan options available to him. The broker completes the enrollment on his computer (online) by entering Mr. Murphy's information in a fillable pdf. Once Mr. Murphy agrees to a plan option, the agent sends, via secured email, the completed enrollment application for an electronic signature. Mr. Murphy signs and emails the completed enrollment with electronic signature and the broker emails his application through a secure portal to the plan.

CMS holds plans responsible for ensuring the appropriate handling of any sensitive beneficiary information provided as part of the online enrollment.

In addition to the requirements outlined in § 40.1, electronic enrollment mechanisms must:

- Be submitted to and approved by CMS. This includes all materials, web pages, and images. See the Medicare Communications and Marketing Guidelines (MCMG) for more information.
- Comply with HIPAA data security and privacy requirements.
- Advise each individual at the beginning of the electronic enrollment process, that they are completing an enrollment request to the MAO or Part D sponsor, will be enrolled (if approved by CMS), and will receive notice (of acceptance or denial).
- Provide the individual with all the information required by CMS marketing rules and requirements, please see 42 CFR §§ 422 and 423, Subpart V.
- Obtain an electronic signature from the applicant or include a clear and distinct step that requires the applicant to activate an "Enroll Now," or "I Agree," type of button or tool indicating their intent to enroll. It must also be made clear to the applicant that, by taking this action, they agree to the release of information as provided on the model enrollment form (see Exhibit 1). See § 40.1 for information about legally binding electronic signatures.
- Capture an accurate time and date stamp at the time the applicant executes the electronic signature or activates the step in the previous bullet (i.e., "Enroll Now or I Agree" button or tool) for purposes of establishing the application date of the enrollment request. **This time stamp also marks the start of the seven-day time frame for processing the enrollment request,** as it is at this time that the enrollment request is considered by CMS to be received by the plan.
- Capture the date and time of the electronic communication or email for purposes of establishing the application date of the enrollment request. **This time stamp also marks the start of the seven-day time frame for processing the enrollment request, as it is at this time that the enrollment request is considered by CMS to be received by the plan.**

- Include a tracking mechanism (e.g., a confirmation number) indicating that the plan received the electronic enrollment request.
- Be retained, securely stored and readily reproducible for the period required in § 70.8. The plans record of the enrollment request must exist in a format that can be retrieved and accessible for later reference by each individual enrollee and/or CMS.

40.1.3 – Medicare Online Enrollment Center

Apart from the plan-sponsored electronic enrollment mechanism, CMS offers the online enrollment center (OEC) through 1) the Medicare.gov website, and 2) the 1-800-MEDICARE Call Center for enrollment into Medicare Advantage plans (except for MSA) and Medicare Prescription drug plans. The date and time "stamped" by the Medicare OEC will serve as the application date for purposes of determining the election period, enrollment effective date, and compliance with enrollment processing time frames. Plans should check for enrollment requests regularly.

The Medicare.gov OEC uses Coordinated Universal Time (UTC, formerly known as Greenwich Mean Time and is four hours ahead of Eastern Daylight Time and five hours ahead of Eastern Standard Time) as the system time to generate the timestamp of when an enrollment was received. For requests made via the OEC, the application date to be used for processing the enrollment request is the time and date that is 11 hours earlier than the time and date CMS "stamps" on the enrollment request at the time the individual completed the OEC process. This is true regardless of when the plan ultimately retrieves or downloads the request.

Example:
An individual completes an enrollment request and submits it via the OEC at 9:00 p.m. EST on December 7. The OEC will "stamp" this request as having been completed on December 8 at 2:00 a.m., which is the Universal Time Coordinated (UTC) equivalent time and date. The plan will use December 7, 3:00 p.m., as the application date for the purpose of addressing CMS enrollment policy requirements (e.g., application date, determination of election period, etc.).

40.1.4 – Enrollment via Telephone

Generally, plans may only accept requests for enrollment:

- Through an incoming (in-bound) telephone call to a plan representative or agent.
- During communications initiated by the organization when, during the course of outreach to provide information about their Medicare plan offerings to individuals with whom they have an existing business relationship, the individual expresses a desire to enroll in one of the organization's plans.

An existing business relationship includes an individual who leaves a message wishing for a call back, fills out a business reply card, or other way in which an individual might initiate the relationship with the organization. Other CMS marketing rules and requirements may apply, please see 42 CFR §§ 422 and 423, Subpart V.

The following standards apply, in addition to all other applicable program requirements:

<table>
<tr><th>MA plan</th><th>Part D plan</th></tr>
<tr><td colspan="2">For applicants without an existing business relationship with the organization, enrollment requests can only be accepted during an incoming call from the applicant</td></tr>
<tr><td colspan="2">All elements of the enrollment request must be provided solely by the applicant or their authorized representative, though they may receive assistance from a family member, friend, etc.</td></tr>
<tr><td colspan="2">Applicants must be advised that they are completing an enrollment request</td></tr>
<tr><td colspan="2">The applicant must agree to be recorded and verbally attest to their intent to enroll during the call</td></tr>
<tr><td colspan="2">A tracking mechanism is created as evidence the enrollment request was received (e.g., confirmation number)</td></tr>
<tr><td colspan="2">Individuals must receive notification/acknowledgment that the enrollment was received (see § 50.9.1)</td></tr>
<tr><td>Telephonic ICEP enrollment requests from individuals enrolled in a non-Medicare plan under the same organization (or parent organization) and transitioning to the MA plan without a break in coverage may be based on the simplified opt-in enrollment mechanism as described in § 40.1.7</td><td>N/A</td></tr>
</table>

Scripts for completing an enrollment request in this manner must be developed by the plan and submitted to CMS for review and approval. The scripts must contain the required elements for completing an enrollment request as described in Appendix 2 and must receive CMS approval.

40.1.5 – Default Enrollment Option for Medicaid Managed Care Plan Enrollees who are Newly Eligible for Medicare – Part C only

42 CFR §§ 422.66(c) and 422.68(a)

Default enrollment is an enrollment process that allows an MA Organization (MAO), following approval by the state and CMS, to enroll an enrollee of an affiliated Medicaid managed care plan into its Medicare Dual Eligible Specials Needs Plan (D-SNP) when that enrollee becomes newly eligible for Medicare (i.e., has both Medicare Part A and Part B for the first time) - unless the enrollee chooses otherwise.

Default enrollment is permitted only for individuals who:

- Are newly eligible for Medicare Advantage;
- Are currently enrolled in a Medicaid managed care plan offered by the MAO, or by an entity under the same parent organization as the MAO; and
- Will remain enrolled in the Medicaid managed care plan upon their conversion to Medicare.

Default enrollment is not available if an individual is enrolled in a more limited Medicaid prepaid inpatient health plan or prepaid ambulatory health plan, in a plan that only covers Medicare cost-sharing, or in a managed fee-for-service model such as primary care case management, health home, or accountable care organization. Some states apply additional conditions for default enrollment approval in their state Medicaid agency contract (SMAC).

CMS approval of default enrollment

To qualify for default enrollment, an MAO must have an affiliated Medicaid managed care plan. An affiliated Medicaid managed care plan is one that is offered by the MAO that also offers the D-SNP (or is offered by an entity under the same parent organization as the MAO).

MAOs may apply for default enrollment only where states have approved the use of the default enrollment process through its SMAC as defined in 42 CFR § 422.107.

MAOs must have a minimum overall quality rating from the most recently issued ratings of at least 3-stars (or be a low enrollment contract or new MA plan as defined in 42 CFR § 422.252) and must not have any prohibition on new enrollment imposed by CMS. MAOs must submit proposals to CMS via the HPMS default enrollment module and receive CMS approval before beginning any default enrollments under this authority.

MAOs must be able to demonstrate the state's agreement to provide prospective Medicare eligibility information for its Medicaid managed care plan enrollees. The information is necessary for CMS to add those individuals to its records as enrollees of the D-SNP within the timeframes to meet the noticing requirements specified under 42 CFR § 422.66(c)(2)(iv).

State role

- A state approves the use of default enrollment in its SMAC with the MAO; and
- Provide a description of its data sharing process and agreement to provision of prospective Medicare eligibility data to the MAO in a policy document from the state.

Examples of acceptable state policy documents include but are not limited to a SMAC, state letter, and/or a copy of the state's completed/signed *default enrollment plan application*, if applicable.

State data sharing processes and data provisioning agreements provide a description of the following:

- The CMS data source the state will use to identify Medicaid managed care plan enrollees who are in their Medicare initial coverage election period (ICEP) based on age or disability;
- Frequency at which the state will check the CMS data source;
- Method the state will use to transmit CMS eligibility data to the D-SNP (e.g., 834 enrollment file or other proprietary file;
- Data elements the state will share (necessary for the D-SNP to submit enrollment transactions to CMS) per § 422.66(d)(6) and § 422.60(e)(5);
- Frequency with which the state will transmit prospective Medicare eligibility data
- to the MAO to meet the noticing requirements. It is important to establish a process in which the state provides the Medicare eligibility data to the MAO in enough time for plans to send the required default enrollment notice to individuals no fewer than 60 days prior to the start of Medicare eligibility.

NOTE: Data provided by the state must include all information necessary to submit the enrollment transaction to CMS (Medicare Parts A and B entitlement date, Medicare number, date of birth, sex) for the default enrollment process to occur.

Medicaid eligibility redeterminations

Generally, default enrollment depends on Medicaid eligibility redeterminations being completed far enough in advance of the prospective enrollee's Medicare eligibility date for the D-SNP to meet the noticing requirement under 42 CFR § 422.66(c)(2)(iv). In certain circumstances, CMS can work with states when redeterminations cannot be completed at least 60-days in advance of the prospective enrollee's Medicare eligibility date per 42 CFR § 422.66(c)(2)(iii).

For example, if a Medicaid MCO enrollee has a Medicare eligibility effective date of October 1, the state Medicaid redetermination would need to be completed by July for the D-SNP to confirm MA eligibility, submit transactions to CMS, and send the individual notice no later than August 1.

Default enrollment renewal process

CMS only approves default enrollment for a period not to exceed five years, although CMS may suspend or rescind approval prior to the expiration of this period. To minimize the risk of disruption in default enrollment processing, MAOs should submit the required renewal documents to CMS well in advance of its 5-year approval end date. To continue conducting default enrollment without interruption, renewing D-SNP proposals must:

- Demonstrate state approval via the SMAC to continue conducting default enrollment;
- Not be prohibited by CMS from accepting new enrollments;
- Have a minimum overall rating from the most recently issued star ratings of at least 3 stars (or be a low enrollment contract or new MA plan as defined in 42 CFR 422.252);
- Provide a description of the state's data sharing process and agreement that the state will continue to provision prospective Medicare eligibility data to the MAO in a state policy document from the state. Examples of acceptable state policy documents include but are not limited to a SMAC, state letter, and/or a copy of the state's completed/signed *Default Enrollment Plan Application*, if applicable.
- Include a copy of their Advance Notice to Beneficiaries. Optional opt-out forms, telephone scripts and other supporting documentation that will be sent to prospective enrollees must be submitted to CMS for review.

Notice to individuals about default enrollment

To facilitate CMS approval under § 422.66(c)(2)(ii), MAOs seeking to implement (or renew) default enrollment must include a copy of the required written notice to individuals and copies of any written, telephonic, or electronic outreach materials for CMS prior approval, as well as a description of the organization's outreach activity for its default enrollment process. In additional to the materials required under § 422.111(b)(iii) for initial enrollments (e.g. comprehensive written statement describing cost-sharing protections an Medicare and Medicaid benefits (provided through Evidence of Coverage and Summary of Benefits)), MA organizations are required to send a written notice to identified eligible Medicaid managed care enrollees no fewer than 60 days prior to the effective date of Medicare eligibility and enrollment in the plan (MA Exhibit 39). The beneficiary notice for default enrollment must include information on:

- Whether the prospective enrollee's primary care physician is in the D-SNP network;
- The process an enrollee needs to take to access services offered under the plan;
- How an enrollee can opt out of (decline) the enrollment prior to the enrollment effective date to enroll in Original Medicare or choose another Medicare Advantage plan. This must include the opportunity to contact the MAO either in writing or by telephone to a toll-free number;
- The differences in premiums and cost-sharing amounts between the individual's current Medicaid MCO and the D-SNP;
- The differences in benefits between the individual's current Medicaid MCO and the D-SNP; and
- A general description of alternative Medicare health and drug coverage options available to an individual in his or her initial coverage election period.

Default enrollment process

The MAO will send the enrollment transaction to CMS at the same time that it sends the written notice to the affected individual (i.e., no fewer than 60 days prior to the enrollment effective date). Default enrollment transactions must be submitted with election code type 'J', enrollment source code 'B', and must always use the first day of an individual's ICEP as the application date. The enrollment effective date must always be the date of the individual's first entitlement to both Medicare Part A and Part B. The MAO should not discourage declination. The organization will submit opt-out requests to CMS as enrollment cancellations. Opt-out requests received after

coverage begins are to be processed as disenrollment requests; once enrolled in the MA plan, these individuals have access to an array of special election periods as described in §30.6.

Approval Period

CMS may approve an MAO to use the default enrollment process for a period of up to five years. Such approval will continue after contract consolidations where the surviving contract contains the approved Plan Benefit Package or other CMS-approved changes to the Plan Benefit Package if the D-SNP Plan Benefit Package continues to be offered by the same parent organization and continues to meet all qualifying criteria for default enrollment. A contract consolidation or Plan Benefit Package crosswalk to a new Plan Benefit Package will require submission of a new default enrollment proposal.

CMS may suspend or rescind approval prior to the expiration of this period if CMS determines the MAO is not in compliance with the regulatory requirements. MAOs that do not submit renewal applications prior to the expiration of their approval period may re-initiate default enrollment only after submitting a new initial proposal and receiving approval from CMS. Renewal applications are not permitted after an approval period has expired. MAOs may not continue to use default enrollment if they are pending a response from CMS at the time their approval period expires.

40.1.6 – Passive Enrollment by CMS

42 CFR §§ 422.60(g) and 423.32(g)

Passive enrollment is a process where CMS automatically enrolls an individual into another plan. The individual receives a notice of this change and has the opportunity to accept or decline the enrollment. If the individual takes no action, the individual has made a choice to accept the enrollment. CMS permits passive enrollments in specific, limited circumstances associated with:

- Immediate plan terminations,
- Situations in which remaining enrolled in the plan would pose potential harm to enrollees, and
- **Part C Policy:** Where CMS determines that passive enrollment is necessary to promote integrated care and continuity of care for full-benefit dual eligible individuals (see below).

Part C Policy: Passive enrollment is permitted in situations where CMS determines, after consulting with the relevant state Medicaid agency, passive enrollment is necessary to promote integrated care and continuity of care for full-benefit dual eligible individuals.

CMS will determine when passive enrollment is appropriate under 42 CFR § 422.60(g) and will initiate contact through the MAO's CMS account manager to discuss with the organization. CMS will consult with the State Medicaid agency and authorize passive enrollment for full-benefit dual eligibles enrolled in an integrated dual-eligible special needs plan (D-SNP) to continue access in integrated care when:

- The organization's Medicaid managed care plan non-renews or is terminated, or an integrated D-SNP non-renews at the end of the contract year.

CMS will provide specific instructions directly to the affected organizations (both the plan losing the enrollee and the plan receiving the enrollee) regarding processing the enrollments and specific information relevant to the situation for inclusion in notices.

Notices:

The receiving D-SNP will send notices to enrollees for all passive enrollments. The chart below outlines the requirements and timing:

Passive enrollment due to immediate plan termination or potential harm to enrollees	**Passive enrollment to continue access to integrated care (Part C policy)**
1 notice required	2 notices required
Notice language must: • Describe the costs and benefits of the plan; • Outline the process for accessing care in the plan; and • Explain how to decline the enrollment or choose another plan, including information on available SEPs, how to take that action and by when.	
CMS must approve notice language	
Notice must be sent: • Prior to the date coverage in the new plan begins; or • As soon as possible after coverage in the new plan begins if prior notice is not practicable	Notices must be sent: • First notice at least 60 calendar days prior to the date coverage in the new plan begins; and • Second notice at least 30 calendar days prior to the date coverage in the new plan begins

Evaluation of Plans Receiving Passive Enrollments:

For passive enrollment, CMS evaluates whether the receiving plan meets certain standards, including benefit structures and cost sharing similar to the plan losing enrollees due to passive enrollment, and ensures that individuals do not lose Part D coverage unintentionally (e.g., individuals in employer or union sponsored coverage not indicated in CMS' systems).

The charts below outline the parameters and requirements for this evaluation:

Passive enrollment due to immediate plan termination or potential harm to enrollees Key criteria CMS may use:	**Passive enrollment to continue access to integrated care (Part C policy)** Requirements (all must be met):
Similar or lower out-of-pocket maximum	Currently operate as a fully integrated dual eligible SNP (FIDE SNP) or, a highly integrated dual eligible SNP (HIDE SNP) (see Chapter 16-B)
Similar or lower hospital cost-sharing amount	Substantially similar provider and facility networks. Using National Provider Identifier (NPI) numbers, CMS will

Passive enrollment due to immediate plan termination or potential harm to enrollees Key criteria CMS may use:	**Passive enrollment to continue access to integrated care (Part C policy)** Requirements (all must be met):
	compare the MA network of the relinquishing D-SNP to that of the receiving D-SNP to assess overlap in provider and facility specialty types with the highest utilization by dually eligible individuals.
No additional network restrictions	Substantially similar Medicare and Medicaid covered benefits. Receiving D-SNPs will always meet the Medicare benefit comparability requirements provided they have an approved Plan Benefit Package (PBP) submission for the applicable Contract Year for which the passive enrollment takes place. CMS will not consider the receiving or relinquishing D-SNPs' supplemental benefits as part of the analysis of benefit comparability. CMS will consult with the applicable state Medicaid agency to ensure that affected enrollees' Medicaid benefits under the various available options are substantially similar to the benefits under their current Medicaid coverage.
Premium is not significantly higher	Have limits on premiums and cost-sharing that are appropriate for full-benefit dually eligible individuals (CMS interprets this standard as having no premium or cost-sharing ($0 for enrollees) (see Chapter 16-B)
Equivalent or higher value Part D benefit and formulary structure	Have overall MA star rating of at least three stars (Exception: plan is low enrollment contract or new plan without star ratings)
Similar Part B buy-down feature, if applicable	Not under sanction for new enrollments
Not under sanction for new enrollments	Have operational capacity (and agree) to accept the enrollments. CMS will scale the review of operational capacity based on the overall volume of passive enrollment and presence of other risk factors. CMS will assess several factors to determine operational capacity. These factors may include, but are not limited to: current

Passive enrollment due to immediate plan termination or potential harm to enrollees Key criteria CMS may use:	Passive enrollment to continue access to integrated care (Part C policy) Requirements (all must be met):
	enrollment in relation to the projected volume of passive enrollment; available Part C and Part D performance metrics; recent Medicare program audits; other compliance and enforcement activity; and other factors identified or requested by the state.

Special Election Period:
An SEP is available to all individuals who are passively enrolled in addition to the ability to opt-out of a passive enrollment. See § 30.6.30 for more details about this SEP. Individuals in non-renewing or terminating plans and dually eligible individuals also have the ability to use other existing SEPs outlined in § 30.

40.1.7 – Simplified (Opt-In) Enrollment Mechanism – Part C only

42 CFR § 422.66(d)(5)

This mechanism permits an MAO to use existing data it has from its non-Medicare lines of business (commercial, Marketplace, Medicaid, etc.) to obtain some of the information it would otherwise need to receive from the individual in the enrollment request. The MAO then obtains any other necessary data from the individual that it cannot get from its existing data source.

Use of this mechanism is not required. It is up to the MAO whether it has the capability and wants to share data between its Medicare and non-Medicare lines of business. CMS reminds MAOs of their obligations to the privacy and security of protected health information under the HIPAA Privacy and Security Rules, 45 CFR §§ 160 and 164, and that the MAO must evaluate whether and how use of data from other lines of business may be permissibly shared under those rules. This document is not HIPAA guidance.

MAOs may offer simplified enrollment only to individuals who:

- Are in their ICEP;
- Are enrolled in any type of non-Medicare plan under the same organization (or an entity under the same parent organization as the MAO); and
- Do not have a break in coverage between the non-Medicare plan and the MA plan.

The MAO identifies individuals who are enrolled in its non-Medicare coverage and in their ICEP. It may conduct outreach to these current enrollees and offer them the opportunity to enroll in their MA plan. Outreach efforts are considered marketing, and should clearly articulate the various plan offerings, plan structure, premium, costs, network, etc. Refer to the Medicare Communications and Marketing Guidelines (MCMG) for more information.

MAOs may offer simplified enrollment via paper, telephone or electronically, as outlined in § 40.1. For telephonic or electronic requests, the plan may limit the data to be collected from the applicant to those items it does not already have.

The MAO must ensure the data elements outlined in § 40.1 is collected for the simplified enrollment process.

Organizations are encouraged, but not required, to request premium payment option information in the simplified enrollment request. In the absence of a stated preference by the applicant, individuals are to be placed in direct billing status, as outlined in § 60.3.1. Additionally, the parameters outlined in §§ 40.1 must be met based on the method of the simplified enrollment request (telephonic, electronic, or paper).

Enrollments requested using this mechanism are the same as any other new ICEP enrollment the plan receives and should be processed similarly.

Example:
Mr. Smith is turning 65 in June and is enrolled in commercial coverage with an organization named Good Insurance. Good Insurance identifies in its records that Mr. Smith's Medicare Part A and B Initial Enrollment Period begins in March. Based on its data from Mr. Smith's commercial enrollment, Good Insurance knows that Mr. Smith lives in the service area of MA plans that Good Insurance offers.

A representative of Good Insurance calls Mr. Smith in May and identifies herself as his commercial health insurance plan. Using the plan's internal protocols, she confirms his identity on the call. In this call, she informs Mr. Smith that because he is soon to be eligible for Medicare, he can enroll in a plan that Good Insurance offers, just for people with Medicare. She provides information on Good Insurance MA plans available in Mr. Smith's area and asks if he is interested in enrolling in one of these plans or learning more. Mr. Smith expresses his interest in enrolling in Good Insurance's MA plan with prescription drugs. Good Insurance already has Mr. Smith's personal information via its internal systems and, while on the call, the representative obtains what is needed for the MA enrollment that Good Insurance does not already have. The representative uses this information to complete the telephonic enrollment request in Good Insurance's internal MA enrollment system. Good Insurance confirms the MA plan Mr. Smith wants to enroll in and asks for his Medicare number. Good Insurance explains the legal requirements for enrollment, release of information, and confirms Mr. Smith's understanding and acknowledgement/approval to process the request. Good Insurance also provides information to Mr. Smith to process his disenrollment from the commercial coverage to be effective as of May 31. Good Insurance processes the telephonic enrollment the same as other received requests and submits the enrollment transaction to CMS. Mr. Smith's MA plan coverage will begin on June 1, when his Medicare coverage begins.

40.1.8 – Auto- and Facilitated Enrollment

42 CFR § 423.34

Auto-enrollment and facilitated enrollment are enrollment mechanisms used by CMS to enroll eligible individuals (i.e., full-benefit dual-eligibles and other LIS eligible individuals) who have not elected a Part D plan into an MA-PD (from an MA-only plan) or PDP so that they have prescription drug coverage. The primary differences between the two are the populations and the enrollment effective date.

Auto-Enrollment:

Auto-Enrollment applies to only full-benefit dual eligibles. Full-benefit dual eligible individuals are:

- Eligible for comprehensive Title XIX Medicaid benefits, and
- Eligible for Medicare Part D.

This includes individuals who are eligible for comprehensive Medicaid benefits plus Medicaid payment of Medicare cost-sharing (sometimes known as QMB-plus or SLMB-plus).

This excludes full-benefit dual eligibles who:

- Live in any of the five U.S. territories;
- Live in another country;
- Are incarcerated, as defined in § 10;
- Are not lawfully present in the U.S.;
- Have opted out of auto-enrollment into the Part D benefit;
- Are not eligible to enroll in a PDP because they are enrolled in a Medicare Advantage plan, other than an MA PFFS plan that does not offer Part D or an MSA plan.
- Are enrolled in a § 1876 cost plan that offers a Part D optional supplemental benefit.
- Are enrolled in an MA-PFFS plan and are already enrolled in a stand-alone PDP;
- Are individuals for whom an employer or union is claiming the retiree drug subsidy; or are enrolled in an employer-sponsored MA-only plan, including MA-only "800 series" plans.

Part C Policy:

Under auto-enrollment, full-benefit dual eligible individuals in MA-only plans are enrolled by the MAO into an MA-PD plan unless they opt out. Full-benefit dual eligible individuals to be auto-enrolled include those who are:

- Full-benefit dual eligible upon initial enrollment into an MA-only plan; and,
- Existing Medicare enrollees of an MA-only plan who become newly eligible for Medicaid.

Part D Policy:

Full-benefit dual eligible individuals enrolled in Original Medicare, an MSA plan, or an MA PFFS plan that does not offer Part D who have not elected a Part D plan are auto-enrolled into a PDP by CMS.

Facilitated Enrollment:
Facilitated enrollment applies to partial-benefit dual eligibles and other LIS-eligible individuals.

Part C Policy:
Under facilitated enrollment, other LIS eligible individuals in MA-only plans are enrolled by the MAO into an MA-PD unless they opt out. Other LIS eligible individuals are defined as those deemed eligible for LIS because they are either:

- Determined eligible for the full LIS upon initial enrollment into an MA-only plan, or,
- An existing Medicare enrollee of an MA-only plan who becomes newly eligible for LIS.

Part D Policy:
Other LIS eligible individuals not enrolled in a Part D plan are facilitated enrolled into a PDP by CMS.

Other LIS eligible individuals excluded from this enrollment type are also excluded from auto-enrollment (see exclusion list above).

LI NET:
CMS implemented the Limited Income Newly Eligible Transition (LI NET) demonstration from January 1, 2010, to December 31, 2023, then as a permanent part of the Part D program starting January 1, 2024. LI NET provides immediate and retroactive Part D coverage for eligible low-income beneficiaries who do not yet have prescription drug coverage. Individuals who are LIS-eligible but do not yet have Part D coverage, and those individuals who have selected a Part D plan but whose enrollment has not taken effect, are enrolled by CMS into LI NET unless the individual has affirmatively declined enrollment in Part D. Individuals may be enrolled in LI NET through the auto- or facilitated enrollment processes, and may be automatically enrolled using the same processes into a Part D plan once LI NET coverage ends.

NOTE: Individuals may also enroll in LI NET through point of sale, application form, or direct reimbursement request.

LI NET enrollment begins on the first day of the month an individual is identified as LIS-eligible and ends after two months (or, for certain individuals with retroactive coverage, 36 months prior to the date such individual enrolls in (or opts out of) Part D coverage, whichever is later).

The LI NET sponsor solely qualifies to receive auto- or facilitated enrollments for limited periods of time, typically two months. CMS will auto- or facilitate enroll full-benefit dual eligible individuals and SSI benefit recipients into LI NET; partial-benefit dual eligible individuals and LIS applicants do not qualify for retroactive assignments.

An individual's enrollment in the LI NET program, which provides transitional coverage, ends when:

- The individual is auto-enrolled into a standalone Part D plan and that coverage has taken effect.
- The individual elects another Part D plan and that coverage has taken effect.
- The individual voluntarily disenrolls from the LI NET program.

- The individual is involuntarily disenrolled from Part D coverage.
- In the case of an individual in LI NET due to an immediate need, the individual's LIS eligibility cannot be confirmed within the period of LI NET coverage.

Summary of Differences between Auto- and Facilitated Enrollment Processes:

	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS Individuals
Steps	1. Identify full-benefit dual eligible individuals in an MA-only plan who need to be enrolled into an MA-PD plan 2. Notice sent to individual within 10 calendar days of identifying need for person to be auto-enrolled 3. If the individual does not opt out within 10 calendar days, submit transaction to move to an MA-PD plan	1. Identify partial-benefit dual eligibles and other LIS eligible individuals in an MA-only plan who need to be enrolled into an MA-PD plan 2. Notice sent to individual within 10 calendar days of identifying need for person to be facilitated enrolled 3. If the individual does not opt out by last day before effective date of facilitated enrollment, will be enrolled in an MA-PD plan
Who needs to be moved	• Full-benefit dual who newly enrolls in an MA-only plan • Individual in an MA-only plan who recently became eligible for full Medicaid benefits	• Partial-benefit dual or other LIS eligible individual who newly enrolls in an MA-only plan • Individual in an MA-only plan who recently became LIS-eligible
Plan into Which Beneficiary Should be Enrolled	MA-PD plan with the lowest combined Part C and D premium	
Notice Includes	• Name of receiving Part D plan and enrollment effective date • Costs associated with being an enrollee of the new plan (LIS copay amount) • Individual may choose another Part D plan (either another MA-PD plan or Original Medicare with a PDP) or • Can opt out of auto/facilitated enrollment into the Part D benefit by writing or calling the MA-PD/PDP into which the individual has been	• Name of receiving MA-PD plan and enrollment effective date • Costs associated with being an enrollee of the new plan (LIS deductible and copay amount) • Individual may choose another Part D plan (either another MA-PD plan or Original Medicare with a PDP) or • Can opt out of auto/facilitated enrollment into the Part D benefit by writing or calling the MA-PD/PDP into which the individual has been

	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS Individuals
	auto/facilitated enrolled or by calling 1-800-MEDICARE (for PDP opt out only) • Inform of a Special Election Period (SEP) that permits individual to change plans, even after the auto/facilitated enrollment takes effect	auto/facilitated enrolled or by calling 1-800-MEDICARE (for PDP opt out only) • Inform of a Special Election Period (SEP) that permits individual to change plans, even after the auto/facilitated enrollment takes effect
Effective date	• First day of month person qualified for LIS (will be retroactive) • Cannot be prior to start of enrollment in the MA-only plan	• First day of second month after person is identified for facilitated enrollment • Cannot be prior to start of enrollment in the MA-only plan
Opt out	• Document and do not auto-enroll again in future • Send a notice (see MA Exhibit 29; Part D Exhibit 26) confirming the opt out, with the implications of their request. This must be sent within 10 calendar days of the opt out request.	• Document and do not facilitate enrollment again in future • Send a notice (see MA Exhibit 29; Part D Exhibit 26) confirming the opt out, with the implications of their request. This must be sent within 10 calendar days of the opt out request.

Data on Transaction	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS
Application date	First day of month prior to enrollment effective date OR day after current application date on MA-only plan enrollment, whichever is later.	First day of month prior to effective date of the enrollment
Election Type Code	Z = MA auto-enrollment period*	U = Dual/LIS Special Election Period
Enrollment Source Code	E (MA-submitted auto-enrollment)*	F (MA-submitted facilitated enrollment

*Use of the enrollment period of "Z" and enrollment source code of "E" permits these TC 61 transactions for retroactive auto-enrollments to bypass normal MARx suspension of processing for retroactive effective dates and process immediately.

NOTE: If an individual opts-out after a TC 61 has been submitted, the effective date of returning to the MA-only plan is normally prospective, i.e., first day of the following month. However, through the 15th of the month after the month in which the notice was sent, at a full-benefit dual

eligible individual's request, the MAO may restore the person to the MA-only plan retroactive to the auto-enrollment effective date. This is accomplished by submitting a TC 61 with the same effective date and setting the opt-out flag. If a TC 61 has already been submitted to move the person to the MA-PD plan, the MAO sends another TC 61 (to move the person back to the MA-only plan), setting the Part D opt-out flag to Y (opt-out of auto-enrollment). If it has not, submit just the opt-out indicator on a TC 79.

40.1.9 – Reassignment of Certain LIS Beneficiaries

42 CFR § 423.34(c)(1)

CMS conducts reassignments in the fall of each year (Late October) for LIS beneficiaries in the following situations:

Part C Reassignment:
CMS will reassign all affected LIS eligible individuals in terminating MA plans. This includes non-renewing MA-only plans, as well as MA-PD plans and MA PFFS plans. In the case of an MA-only or MA-PD plan with a Service Area Reduction (SAR), reassignment will only be performed for counties that will no longer be served by the plan in the following year.

Beneficiaries who have LIS for the current calendar year and will continue to do so for the following calendar year will be included in this reassignment process.

Exception: LIS beneficiaries will not be reassigned if they have Part D coverage the following year. LIS beneficiaries will also not be reassigned if they (1) reside in the U.S. Territories, even if their MA-only or MA-PD plan is non-renewing, or (2) are enrolled in an employer-sponsored MA-only or MA-PD plan, unless the MA-only or MA-PD plan is non-renewing.

PDP Reassignment:
CMS will reassign affected LIS eligible individuals in the following circumstances:

Individuals enrolled in PDPs that will have a premium in the following year that will be above the benchmark amount (unless the amount above the benchmark is de minimis and plan volunteers to waive such amount) if they meet ALL the following criteria:

- Individuals that continue to be eligible for 100 percent premium subsidy LIS in the following year.
- Individuals were enrolled by CMS into their current PDP (i.e., through auto- and facilitated enrollment, reassignment).
- Individuals do not live in a U.S. territory.

In the case of PDPs that are non-renewing (terminating):

- All current LIS enrollees who continue to have LIS in the following year, regardless of premium subsidy amount, and regardless of whether the individual was assigned to or voluntarily enrolled in a plan.

CMS will only reassign individuals who meet the above criteria between October and the end of the year.

“Losing” PDPs

A PDP may lose LIS beneficiaries to reassignment in the following circumstances:

- The LIS beneficiary has a new premium liability in the following year for those eligible for 100 percent premium subsidy under LIS (i.e., premium goes above LIS benchmark), or
- The PDP is terminating the following year.

As part of determining whether a terminating PDP should be included in reassignment, CMS determines whether it is truly non-renewing (i.e., all individuals will be disenrolled with no automated enrollment into another PDP), or whether individuals are actually being cross-walked to a different PDP. If the latter, CMS will perform the following additional steps:

- Determine if the PDP had a premium below the LIS regional benchmark and a basic benefit in the current year.
  - If it does not, then the PDP will be carved out of reassignment (i.e., not considered “terminating” for purposes of reassignment), and all individuals will be cross-walked.
  - If it does, CMS will determine whether the PDP into which individuals are cross-walked qualify as a “Gaining” PDP per § 40.1.9.
    - If so, the individuals will not be included in reassignment, and all individuals will be cross-walked, since the plan into which they are being cross-walked will have no premium for those with 100 percent premium liability.
    - If not, individuals who meet the criteria for reassignment due to a premium increase will be reassigned (to ensure they have no new premium liability the following year); the remaining individuals will be cross-walked.

CMS account managers generally contact losing plans in September to confirm the plan is aware it will lose enrollees due to reassignment. Plans that are uncertain about whether they will lose to reassignment should contact their CMS account manager to confirm.

Volunteering for “De Minimis”
Per Section 1860D-14(a)(5) of the Social Security Act (the Act), a PDP or MA-PD plan may volunteer to waive the portion of the monthly adjusted basic beneficiary premium that is up to a de minimis amount above the LIS benchmark for an LIS eligible individual.

CMS will not reassign LIS individuals from Part D plans that volunteer to waive the de minimis amount. Though any Part D plan that qualifies may volunteer to waive the de minimis premium, generally, Part D plans likely to volunteer are those continuing PDPs that would otherwise lose enrollees to reassignment.

A Part D sponsor will volunteer to waive de minimis premium amount on a plan-by-plan basis. The Part D sponsor may opt to volunteer for one plan benefit package that qualifies and not another. For each plan benefit package that a sponsor volunteers, the sponsor agrees to waive the

de minimis premium amount for all LIS beneficiaries with 100 percent premium subsidy in that plan benefit package. This includes any enrollee for any month in the contract year for which the individual is 100 percent premium subsidy eligible. The Part D sponsor will be responsible for identifying these individuals based on existing data already transmitted by CMS, and ensuring no premium is charged to them.

Plans with de minimis premiums must inform CMS of their intent to participate in the voluntary de minimis program within five (5) business days after the de minimis amount is released. Plans will inform CMS of their intention to participate through HPMS.

Reassignment Process:

Part C:
CMS will reassign LIS beneficiaries from a non-renewing MA plan or MA plan with a service area reduction (SAR) to a stand-alone prescription drug plan (PDP). Individuals retain the option to elect another MA plan.

CMS will attempt to reassign individuals to a PDP offered by the same organization that offers the MA plan in which the LIS-eligible beneficiary is currently enrolled, wherever possible. If the organization has more than one such plan in that region, CMS will randomly reassign individuals among those plans.

If the MAO does **not** offer a qualifying PDP, CMS will randomly reassign affected individuals to PDP sponsors that have at least one qualifying PDP in that region.

NOTE: CMS may conduct a second reassignment for LIS beneficiaries in MA or Part D plans due to either premium increase or non-renewal. In the second reassignment, "gaining" PDPs will receive a second round of reassignees.

Part D:
CMS will attempt to reassign affected LIS PDP enrollees within the same sponsor, wherever possible, by the following:

- CMS will identify other qualified plans in the same region offered under the same contract number, or, if none are available;
- Under a different contract number sponsored by the same parent organization.

CMS will follow the two-step process used under auto/facilitated enrollment, i.e., random distribution first at the sponsor level, then randomly among qualifying plans within the sponsor.

NOTE: Individuals are not always assigned to a "gaining" PDP that serves the same region as the "losing" PDP. CMS will use the individual's state of residence to determine where the individual needs to be reassigned.

CMS Notification to Reassigned Individuals:
CMS notifies all individuals being reassigned. These notices are on blue paper and instruct individuals who are being reassigned due to a premium increase to contact their current plan if

they wish to remain with the plan for the following year. Per Section 1860D–14(d) of the Act, CMS will also provide reassigned individuals with information on formulary differences between the individual's former plan and new plan (with respect to the individual's drug regimen), and a description of the right to coverage determination, exception, reconsideration, appeal, or grievance.

Plan Communication to Affected Individuals:
PDPs receiving new enrollees ("gaining plans") after confirmation of reassignment, are responsible for providing enrollment confirmation and enrollment materials to beneficiaries within 10 calendar days of receiving confirmation of reassignment on a Special Transaction Reply Report (STRR).

PDPs "losing" enrollees to reassignment are responsible for sending an appropriate Annual Notice of Coverage (ANOC) and include the Evidence of Coverage (EOC) and LIS Rider. Additionally, "losing" plans will be required to send a notice confirming disenrollment from the plan due to reassignment within 10 calendar days from receiving disenrollment confirmation on a STRR.

PDPs "gaining" enrollees are responsible for providing enrollment confirmation and enrollment materials to individuals within 10 calendar days of receiving confirmation of reassignment on a STRR. "Gaining" PDPs do not need to send the 30-day Coordination of Benefits survey for new enrollees whether they are auto- or facilitated enrolled; they only need to conduct the annual survey.

Requests for "Re-enrollment" in the "Losing" Plan – Part D only
CMS' notices to affected individuals include instructions to contact their current plan if they wish to remain with the plan for the following year. If a reassigned individual contacts the plan and indicates that they wish to remain enrolled despite incurring premium liability, **the plan must take a new enrollment election** in accordance with §§ 40.1 and § 50. For the new enrollment, use the actual application date, which should be no earlier than October 15 of the current year; an election type of "S" (Special Election Period) and appropriate SEP reason code, and an effective date of January 1 of the following year.

As part of this enrollment, the plan must confirm and document the individual's understanding of the financial liability they will incur by remaining with the plan for the following year. **However, DO NOT transmit these enrollment elections to CMS until a STRR is received confirming the individual's disenrollment from the plan in late November.** If the "re-enrollment" transaction is sent in before disenrollment due to reassignment is confirmed, the transaction will be rejected as "beneficiary already enrolled."

40.1.10 – Additional Enrollment Request Mechanisms for Employer/Union Sponsored Coverage

42 CFR §§ 422.60(f) and 423.34(d)(3)

Plans may choose to accept voluntary enrollment requests directly from the employers or unions who sponsor MA or Part D coverage for employer/union group members using any of the

enrollment mechanisms described in this guidance applicable to individual-initiated requests. In addition, plans may also accept enrollment requests using either the group enrollment process or the optional enrollment request mechanism described below in this section.

It is the MAO or Part D sponsor's responsibility to ensure that all applicable MA or Part D enrollment requirements are met, regardless of the process utilized. In any case, the enrollment requests provided to the MAO or Part D sponsor by the employer or union will reflect the choice of retiree coverage individuals made using their employer's or union's process for selecting a health plan.

40.1.10.1 – Group Enrollment Mechanism

Outlined below are various requirements for plans using the group enrollment mechanism (e.g., time sensitive notification of individuals).

CMS will hold the MAO or Part D sponsor responsible if enrollments are not processed correctly and consistently with CMS policies and procedures. For coordination of benefits purposes, the plan must provide CMS with any information on other insurance coverage, as well as creditable coverage history for assessing the Part D late enrollment penalty.

It is the plan's responsibility to ensure the group enrollment process meets all applicable plan enrollment requirements.

The group enrollment process must include notification and materials to each individual as follows:

Step 1. Individuals receive advance notice of the employer/union's intent to enroll them in an MA or Part D plan sponsored by the employer/union.

Step 2. Plan or employer/union sends required notice at least 21 days prior to the group enrollment effective date. (If notice is not sent at least 21 days prior to the effective date, enrollments made using this group enrollment mechanism are invalid.)

Step 3. Notice must include:

- Clear instructions on how to opt out and the consequences of opting out;
- Enrollment effective date;
- Summary of Benefits offered under the MA/Part D plan;
- How to get further information on the employer or union sponsored plan;
- How to contact Medicare for other health plan options available; and
- Consent to release and disclosure of information (see § 40.1).

If notice requirements are met, the employer or union must provide the following in the group enrollment file(s) it sends to the plan:

- All the information (i.e., data elements) required for the plan to submit a complete enrollment request transaction to CMS (see Appendix 2); and
- The enrollment effective date as permitted in guidance.

For enrollments processed using the EGHP SEP, see § 30.6.16, the application date on the enrollment transaction submitted to CMS is the first day of the month prior to the effective date of the group enrollment. This will ensure that any subsequent individual-generated enrollment request will supersede the group enrollment in CMS systems. For the purposes of providing notices and meeting other time frame requirements as described in § 50.9, plans will use the date that they receive the enrollment request. The advance notice of group enrollment as described above is evaluated based on the effective date.

> **Example:**
> The plan receives a group enrollment mechanism file on January 24 for enrollments effective February 1. The receipt date for the required notices is January 24 and the application date submitted on the enrollment transactions is January 1. The advance notice must have been sent to the enrollees at least 21 days prior to February 1.

40.1.10.2 – Optional Mechanism for Group-sponsored Plan Enrollment

Employers or unions may opt to send group enrollment requests to plans electronically, instead of using a paper enrollment process to reflect each individual's election of coverage. This optional electronic enrollment mechanism can be used in place of paper enrollment request forms and does not require a signature since it is sent electronically. The plan should inform its Regional Office Account Manager of its intent to use this mechanism and identify the employer/union for which it will be accepting enrollments made in this manner. The employer record of each individual's election that is sent electronically to the plan must include all the data necessary for the organization or sponsor to determine each individual's eligibility for the plan, as described in § 20 of this chapter. The requirements for all other information provided to enrollees, both pre- and post- enrollment, as noted in § 50.9, are unchanged by this option.

See Appendix 2 for a complete list of required elements to be included in all enrollment mechanisms.

40.1.11 – Enrollment for Individuals in Qualified State Pharmaceutical Assistance Programs (SPAPs)

CMS will allow plans to accept enrollment requests in an agreed-upon electronic file format from qualified SPAPs, provided the SPAP has met the following requirements:

- Attests that it has the authority under State law to enroll on behalf of its members;
- Coordinates with the plan to provide the required data elements for the organization to process and submit an enrollment request to CMS (as outlined in § 40.1); and
- Provides a notice to its members in advance of submitting the request.

Notices provided to SPAP members must provide the following information:

- That the SPAP is enrolling on their behalf;
- How the MA/Part D enrollment will work with the SPAP; and
- How individuals can decline such enrollment.

Plans that agree to accept mass enrollment requests from SPAPs are required to process them like any other enrollment and in accordance with individual notification time frames.

It is important for the plan to work with the SPAP in the event that the plan encounters any problems processing the enrollment request in the format provided. Because the SPAP is the authorized representative of the individual, the plan is responsible for following up with the SPAP if:

- The enrollment is incomplete (to obtain missing information); or
- The enrollment is conditionally rejected due to the existence of employer or union sponsored drug coverage (to confirm that the individual understands the implications of enrolling in a Part D plan).

NOTE: For SPAP enrollment requests during the AEP, the application date used on the enrollment transaction submitted to CMS must be set to October 15. This will ensure that subsequent individual-generated enrollment requests made during the AEP will supersede the SPAP enrollment in CMS systems.

50 – Enrollment Processing

42 CFR §§ 422.50(a)(3), 422.60, 423.30, and 423.32

An MAO or Part D sponsor (except for MAOs that have reached a CMS-approved capacity limit) must accept without restriction, enrollment requests from individuals who are eligible to elect a plan offered by the organization during a valid election period. Accepting the enrollment request means that the organization must process it and determine eligibility for enrollment.

The initial step in processing an enrollment begins with the acceptance of an enrollment request from the individual or the individual's authorized representative and ends with the plan communicating, in writing, whether the individual's enrollment request has been accepted or denied by the plan or by CMS, in accordance with MA and Part D regulations, as explained in CMS guidance. As outlined below and further explained in §§ 50.1–50.5, processing the enrollment includes:

An MAO may specify a capacity limit for one or all of the MA plans it offers and reserve spaces for individual and employer or union group commercial members who are converting from a commercial product to an MA product at the time the member becomes eligible (i.e., conversion enrollments). When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all prospective enrollees (with the exception of reserved vacancies) until space becomes available. All requests from MAOs for a capacity limit should be submitted to the CMS Regional Office account manager.

Plans may not delay processing enrollment requests unless the individual's enrollment request is being placed on a waiting list (as described in § 50.10.1).

The following should also be considered when processing an enrollment:

- **Permanent Residence Information –** The plan must obtain the individual's permanent residence address to determine that they reside within the plan's service area. If an individual puts a Post Office Box as their place of residence, the plan must consider the enrollment election incomplete and must contact the individual to determine the place of permanent residence. If an individual wants to join a plan but has no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where they receive mail (e.g., social security checks) may be considered their permanent residence address. If the applicant claims permanent residency in two or more states, or if there is a dispute over where the individual permanently resides, the plan should consult the State law in which the plan operates and determine whether the applicant is considered a resident of the State, see § 20.3.

  Individuals for whom the Batch Eligibility Query (BEQ) or MARx online query (M232 screen) reflects an incarcerated status, that individual is considered to reside outside the service area and are, therefore, not eligible to enroll.

- **Entitlement Information and Medicare Number –** Following the procedures outlined in the CMS Plan Communications User Guide (PCUG), plans must verify Medicare

entitlement using the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen) for all enrollment requests, except enrollment requests from a current enrollee of a plan who is requesting enrollment into another plan offered by the same organization or sponsor with no break in coverage (i.e., "switching plans").

Individuals are not required to provide evidence of entitlement to Medicare Part A and/or enrollment in Part B with their enrollment request. If the systems (BEQ or MARx online query) indicate that the individual is entitled to Medicare Part A and/or enrolled in Part B, then no further documentation of Medicare entitlement from the individual is needed. CMS systems are updated within two business days of SSA processing new or changed Part A or Part B entitlement for a Medicare beneficiary. The CMS systems are the most up-to-date data regarding Medicare entitlement for the beneficiary.

At the time CMS first receives entitlement information for a new beneficiary, the Medicare Number will also be assigned for that individual. In the event that the enrollment request does not include the Medicare Number and the plan is unable to locate the individual in the BEQ or MARx online query, the plan should consider the enrollment request incomplete.

The individual may provide the Medicare Number to the plan verbally or in writing. Examples of possible documents the beneficiary may send to the plan which outline the Medicare Number (and entitlement information) include:

- Medicare card;
- Medicare Award notice from SSA (shows Medicare entitlement dates only);
- Benefit Verification notice from SSA (includes Medicare Number and entitlement start dates);
- Medicare card information from the individual's MyMedicare.gov account; and
- A notice from CMS regarding change in Medicare Number.

NOTE: If the beneficiary provides any of the notices listed above, the date on the letter should be no more than two months before the enrollment request was received by the plan. If there is a discrepancy between the entitlement information in a document and the information in CMS' systems, use the data in CMS systems to determine eligibility for enrollment.

- **Effective Date of Coverage –** The plan must determine the effective date of coverage for all enrollment requests. If the individual fills out an enrollment form in a face-to-face interview, then the plan representative may advise the individual of the proposed effective date; however, in order to provide individuals in this situation with accurate and complete information about their election, a plan representative should at the same time disclose that it is only a proposed effective date and that the individual will hear directly from the plan to confirm the actual effective date. The plan must notify the individual of the effective date of coverage prior to the effective date.

  With the exception of some SEPs and when election periods overlap, individuals may not choose their effective date. Instead, the plan is responsible for assigning the appropriate

effective date based on the election period. During face-to-face enrollments, plan staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed. See § 30.7 for more information about effective dates of coverage and multiple available effective dates.

If an individual submits an enrollment request with an unallowable effective date, or if the plan allowed the individual to select an unallowable effective date, the plan must notify the individual in a timely manner and explain that the enrollment must be processed with a different (allowable) effective date of enrollment. The plan should resolve the issue with the individual as to the correct effective date, and the notification must be documented. If the individual refuses to have the enrollment processed with the correct effective date, the individual can cancel the enrollment according to the procedures outlined in § 70.2.

Plans must ensure enrollees have access to plan benefits as of the effective date of enrollment the plan has determined and may not delay provision of plan benefits in anticipation of the submission to or reply from CMS systems.

For additional information about effective dates of coverage, refer to § 30.7.

For auto/facilitated enrollments, refer to § 40.1.8 of this guidance for more information.

- **Health Related Information –** Plans may not ask health screening questions during completion of the enrollment request.

  Exception for certain SNPs: An SNP offered to individuals with certain medical conditions (i.e., an SNP for chronic and disabling conditions), as permitted by CMS, will need to establish that the individual has such a condition to determine eligibility for enrollment in that specific SNP.

- **Signature and Date –** The individual must sign the enrollment form or complete the enrollment request mechanism. If the individual is unable to do so, an authorized representative must sign the enrollment form or complete the enrollment request mechanism. If an authorized representative enrolls an individual, the authorized representative 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 an enrollment request on behalf of the applicant is available and can be presented upon request by the plan or CMS.

  The authorized representative must indicate their relationship to the individual and date they signed the enrollment form or completed the enrollment request; however, if they inadvertently fail to include the date on the enrollment request, then the date the plan 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 plan may verify with the individual 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).

When an enrollment request mechanism other than paper is used, the individual or their authorized representative must complete the enrollment mechanism process, including the attestation of authorized representative status as described above. A pen-and-ink signature is not required. For a telephone request, the signature element is satisfied with a verbal attestation of intent to enroll; for an electronic request, it is satisfied with an electronic signature or a clear and distinct step that requires the applicant to activate an "Enroll Now," or "I Agree," type of button or tool. Electronic signatures have the same legal effect and validity as pen-and-ink signatures. A plan utilizing electronic signatures in electronic enrollment must, at a minimum, comply with the HIPAA privacy and security policies. For more information on the requirements for legally binding electronic signatures, see the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. § 7001, and "Use of Electronic Signatures in Federal Organization Transactions" published by the Federal Chief Information Officers (CIO) Council.

For auto- and facilitated enrollment as described in § 40.1.8, a signature is not required.

- **Other Signatures and Enrollee Assistance –** If the plan representative helps the individual fill out the enrollment form, then the plan representative must clearly indicate their name on the enrollment form. However, the plan representative does not have to include their name on the form when:
    - They prefill the individual's name, mailing address, phone number, or other demographic information, when the individual has requested that an enrollment form be mailed to them,
    - They fill in the "office use only" block, and/or
    - They correct information on the enrollment form after verifying information (see "verification and correction of information" below).

  Individuals (for example, State Health Insurance Assistance Program counselors, agents, and brokers) must indicate if they helped the applicant fill out the form and disclose their relationship to the applicant. Agents and brokers will also be expected to provide their assigned National Producer Number (NPN) if they assisted the applicant with completing the enrollment form.

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

- **Determining Application Date –** The plan must date all enrollment requests as soon as they are initially received. Except for enrollment requests submitted via the CMS Online Enrollment Center, requests made by the group enrollment mechanism, and auto- or facilitated enrollments, the date the enrollment request is initially received is equivalent to the "application date."

If the enrollment request is not complete at the time it is received, then the additional documentation required for the enrollment request to be complete must be dated as soon as it is received. Appendix 3 describes the appropriate application date to include in the enrollment transaction submitted to CMS under various conditions.

- **Verification and Correction of Information –** Some plans verify information before enrollment information has been transmitted to CMS. The plan may find that it must make corrections to an individual's enrollment request. For example, an individual may have made an error in writing their telephone number or may have transposed a digit in their date of birth. The plan should make this type of correction to the enrollment request (e.g., the enrollment form) when necessary, and the individual making those corrections should place their initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, or an electronic record of a similar nature, may be used (in place of the initialing procedure) and should become a part of the enrollment file. These types of corrections will not result in the plan having to cosign the enrollment form.

- **Premium Payment and Withhold Options –** Plans may include on all enrollment request mechanisms the option for individuals to: (1) pay plan premiums by being billed directly by the plan or (2) have the premiums withheld from their SSA/RRB benefit check. The plan may also choose to offer other payment methods, such as automatic deduction from the individual's bank or other financial institution or from a credit card.

  The enrollment mechanism can advise the individual that if they do not select a premium payment option, the default action will be direct bill.

  Railroad Retirement Board (RRB) enrollees may also submit requests to have their premiums withheld from their RRB retirement payments. Plans may choose to offer this option on all enrollment mechanisms as well.

  Part D Policy:
  On the enrollment mechanism, sponsors may also include in this section a statement that advises those individuals who qualify for extra help that if the extra help does not cover the entire plan premium, the individual is responsible for the amount that Medicare does not cover.

- **Premiums Owed to MAO (Part C Policy) –** For enrollment into either an MA-only or MA-PD plan, an MAO may consider an enrollment request incomplete if there are premium amounts due to the organization from a prior enrollment, whether or not premium withhold from an SSA benefit check is selected. The option chosen by the MA plan to consider the application complete or incomplete must be applied consistently to all potential enrollees of the plan.

Optional Exception for Dual-Eligible Individuals and Individuals who Qualify for the Low-Income Subsidy:

For enrollment requests submitted by dually eligible individuals and individuals who qualify for the low-income subsidy (LIS), an MAO may consider an enrollment request complete if there are premium amounts due to the organization from a prior enrollment, even if the MAO has a policy to consider such enrollment requests incomplete.

The MAO has the discretion to implement this exception to dually eligible individuals and individuals who qualify for LIS within each of its MA plans. If the MAO offers this exception in one of its plans, it must apply the policy to all such individuals who request enrollment in that MA plan.

- **U.S. Citizenship or Lawful Presence Information –** Plans must use the CMS Batch Eligibility Query (BEQ) (individual or batch submission) or, via online access, the MARx M232 screen to verify eligibility on the basis of incarceration status or unlawful presence status. An exception to this is an enrollment request from a current enrollee of a plan who is requesting enrollment into another plan offered by the same organization or sponsor with no break in coverage (i.e., "switching plans").

  Individuals are not required to provide evidence of U.S. citizenship or lawful presence status with the enrollment request, nor are plans permitted to request such information or documentation. The systems (BEQ or MARx online query) will indicate the lawful presence status of a non-U.S. citizen, including the start and, if applicable, the end date of the unlawful presence status of the individual.

  CMS eligibility queries will only reflect data for the existence of an unlawful presence status. When neither the BEQ nor the MARx online query shows any indication of unlawful presence in the U.S., the plan must treat the lack of information as confirmation of evidence of U.S. citizenship or lawful presence status.

  When either the BEQ or the MARx online query shows an indication of unlawful presence in the U.S. and the organization receives documentation of lawful presence from the applicant, the plan cannot use this documentation to establish eligibility. If the plan is provided evidence of lawful presence by the applicant in the form of a document from the Department of Homeland Security or SSA and neither the BEQ nor the MARx online query reflects this lawful presence status, the organization should refer the applicant to SSA to request that SSA update its records.

50.1 – Who May Complete an Enrollment or Disenrollment Request

42 CFR §§ 422.60, 423.30, 423.32, and 435.923

Generally, plans can accept enrollment requests from an eligible individual or the individual's authorized representative (as recognized by State laws) for enrollment in or disenrollment from an MA or Part D plan. CMS will recognize State laws that authorize persons to make such

requests for Medicare beneficiaries. For example, persons authorized under State law may include:

- 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 individual in this capacity.

When someone other than the eligible individual completes an enrollment or disenrollment request, they must:

1) Attest to having the authority under State law to do so;
2) Sign the completed form, or through other approved mechanisms, indicate their relationship to the individual; and
3) Provide contact information.

Plans must retain the record of this attestation as part of the record of the enrollment or disenrollment request.

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

If anyone has reason to believe that an individual making an election on behalf of an eligible individual may not be authorized under State law to do so, the organization should contact its CMS account manager with all applicable documentation regarding State law and the case in question. The account manager may request supporting documentation from the individual making the election.

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

50.2 – Determining Individual Eligibility to Process an Enrollment

42 CFR §§ 422.60, 423.30, and 423.32

Upon receiving an enrollment request, plans must verify the individual's eligibility to enroll in the MA or Part D plan.

To determine individual eligibility and consider the request complete, the plan must confirm:

- Medicare entitlement;
- Election period eligibility; and

- If the enrollment request contains all required information (noted in Appendix 2).

The plan verifies Medicare entitlement using CMS systems (i.e., the Batch Eligibility Query (BEQ) or the MARx online query), except for enrollment requests from a current enrollee switching to another plan offered by the same parent organization. Individuals are not required to provide evidence of entitlement to Medicare Part A and/or Part B with the enrollment request. If the enrollment request does not include the individual's Medicare Number and the plan is unable to locate the individual in the BEQ or MARx online query (or the plan's own files, in the case of a current enrollee switching to another plan offered by the same organization), the organization should consider the enrollment request incomplete and follow the steps outlined in § 50.3.

The plan is also responsible for determining the election period of each enrollment request. The plan can:

- Incorporate specific statements regarding eligibility for an election period with the enrollment or disenrollment request (see Exhibit 1a for optional use with enrollment mechanisms).

- Contact the individual (by phone or other communication mechanism) if the enrollment period cannot be determined from the information provided in the enrollment request.

The plan must not immediately deny an enrollment request that does not have all necessary elements required to consider it complete. If the enrollment request is incomplete, the plan must follow the procedures outlined in § 50.3 in order to complete the enrollment request.

If all plan eligibility and enrollment requirements are not met after being reviewed against CMS systems, the individual is determined ineligible, and the organization must deny the enrollment (see § 50.4 for notifying the individual).

50.3 – Incomplete Enrollment Requests

42 CFR §§ 422.50(a)(5), 423.30, and 423.32

When the enrollment request is incomplete, the plan must:

- Document its efforts to obtain information needed to complete the enrollment request.
- Check if the required but missing information can be obtained via CMS systems; and, if not,
- Notify the individual (in writing or orally) within 10 calendar days of receipt of the enrollment request that additional information is needed.

NOTE: To obtain information to complete the enrollment request, the plan may contact the individual in writing or by telephone. If the contact is made by telephone, the plan must document the contact and retain the documentation in its records. The plan must explain to the individual that they have 21 calendar days in which to submit the missing information, or the enrollment will be denied.

If additional documentation needed to make the enrollment request "complete" is not received within allowable time frames outlined below, the plan must deny the enrollment using the procedures outlined in § 50.4.

Enrollment period	Information to complete request must be received:
For incomplete ICEP/IEP enrollment requests received **prior** to the month of entitlement to Part A and/or enrollment in Part B	During the first three months of the ICEP/IEP, or within 21 calendar days of the request for additional information (whichever is later)—see Example 1 below.
For incomplete ICEP/IEP enrollment requests received **during** the month of entitlement to Part A and/or enrollment in Part B or later	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)—see Example 2 below.
For incomplete AEP enrollment requests:	By December 7, or within 21 calendar days of the request for additional information (whichever is later).
For all other enrollment periods:	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).

Example 1:
Ms. Stears' 65th birthday is April 20, 2023. She is eligible for Medicare Part A and Part B beginning April 1, 2023, and has decided to enroll in Part B beginning on April 1. Her ICEP begins on January 1, 2023, and ends on July 31. She submits an incomplete ICEP enrollment request on January 15, and the MAO requests the required, but missing, information on January 20. The enrollment request must be denied if the required information is not received by March 31.

Example 2:
Ms. Mohan's 65th birthday is June 10, 2023. She is eligible for Medicare Part A and Part B beginning June 1, 2023, and has decided to enroll in Part B beginning on June 1. Her ICEP begins on March 1, and ends on September 30. She submits an incomplete ICEP enrollment request on July 5, and the MAO requests the required but missing information on July 7. The enrollment request must be denied if the required information is not received by July 31.

50.4 – Denial of an Enrollment Request

Enrollment denials occur before the plan transmits the enrollment to CMS.

Generally, plans deny an enrollment when:

- An individual is determined ineligible to enroll in the plan (see § 20 on eligibility criteria) or,
- The individual fails to provide the information within the required time frames outlined in § 50.3.

The plan must send notice of the denial to the individual that includes an explanation of the reason for denial (see MA Exhibit 7 or Part D Exhibit 6). 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.

Example 1:
The plan receives an enrollment request from an individual on November 7 and determines on that same day that the individual is ineligible due to place of residence. The plan should send notice of denial within 10 calendar days from November 7.

Example 2:
The plan receives an enrollment form on November 7 from an individual, identifies the enrollment form as incomplete, and notifies the individual of the need for additional information on November 10. The individual does not submit the information by December 1 (as required under § 50.3), which means the organization must deny the enrollment. The organization should send notice of denial within 10 calendar days from December 1.

Example 3:
The plan receives an enrollment request from an individual on January 7 and is unable to determine, through direct contact with the individual or the individual's authorized representative, that the individual has a valid enrollment period available. The organization should send notice of denial within 10 calendar days from January 7.

50.5 – When the Enrollment Request is Complete

An enrollment request is considered complete when:

1. The enrollment request/mechanism is completed and signed by the individual or their authorized representative within required time frames (see Appendix 2);

2. Evidence of entitlement to Medicare Part A and/or enrollment in Medicare Part B is obtained by the plan;

3. If applicable, an attestation of an authorized representative's authority to make the enrollment request is obtained (refer to § 50.1).

4. For Special Needs Plans (SNP), SNP eligibility is verified, as outlined in § 20.8.4. Chronic condition SNPs (C-SNP) that utilize a pre-enrollment qualification assessment tool will consider the enrollment request to be complete upon receipt of the completed tool.

5. Dual-eligible individuals and individuals who qualify for the LIS have premium amounts due to the MA or Part D plan from a prior enrollment, and the plan offers this exception.

Once the enrollment request is complete, the plan must transmit the enrollment to CMS as outlined in § 50.8 and provide notification to the enrollee as outlined in § 50.9.

50.6 – Enrollment not Legally Valid

42 CFR §§ 422.66(b)(5)(i) and 423.36(c)(1)

There are instances when a completed enrollment can later be determined to be legally invalid. These instances may include, but are not limited to:

- An individual did not meet eligibility requirements at the time of enrollment, such as if a plan determines at a later date that the individual resides outside the plan's service area;
- An individual not authorized by State law makes an enrollment request on another's behalf; or
- The individual or their authorized representative did not intend to enroll in the plan. Evidence of lack of intent to enroll by the individual may include:
    - An enrollment request signed by the individual when an authorized representative should have signed for the individual;
    - Request by the individual for cancellation of enrollment before the effective date (refer to § 70.2 for procedures for processing cancellations);
    - **Part C Policy:** Enrolling in a supplemental insurance program immediately after enrolling in the MAO; or receiving non-emergency or non-urgent services out-of-plan immediately after the effective date of coverage under the plan.

When an enrollment is not legally valid, a cancellation of that enrollment may be necessary (refer to § 70.2 for more information). In addition, a reinstatement to the plan in which the individual was originally enrolled may occur if the invalid enrollment resulted in an individual's disenrollment from their original plan of choice.

50.7 – Other Qualified Prescription Drug Coverage Through an Employer or Union Retiree Drug Subsidy (RDS) Plan Sponsor

CMS systems will conditionally reject Part D enrollment transactions if the individual has other qualified prescription drug coverage through an employer or union Retiree Drug Subsidy (RDS) plan.

Within 10 calendar days of receipt of the conditional rejection (transaction reply code (TRC) 127), the plan must:

1) Contact the individual to confirm the individual's intent to enroll, and that the individual understands the implications of enrollment in a Part D plan on their employer or union coverage.

2) Inform the individual in writing or by telephone (contact must be documented and retained with the individual's enrollment request) that they have 30 calendar days to confirm their intent to enroll in the plan.

3) Ensure plan benefits are available to the individual as of the effective date of the initial enrollment request and that the provision of plan benefits is not delayed in anticipation of the applicant's confirmation of intent to enroll.

If the individual indicates that they are fully aware of any consequence to their employer or union coverage brought about by enrolling in the Part D Plan, and confirms the intent to enroll, the plan must update the transaction with the appropriate "flag" (detailed instructions for this activity are included with CMS systems guidance) and resubmit it for enrollment. The effective date of enrollment will be based upon the individual's initial enrollment request.

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 MA Exhibit 7 or Part D Exhibit 6).

50.8 – Transmission of Enrollment to CMS

42 CFR §§ 422.60(e)(5) and 423.32(c)

Plans are required to submit the information necessary for CMS to add the individual to its records as an enrollee of the MA or Part D organization within seven calendar days of receipt of the **completed** enrollment request. CMS system "down" days are included in the calculation of the seven calendar days (refer to https://www.cms.gov/research-statistics-data-and-systems/cms-information-technology/mapdhelpdesk/mapd-marx-calendars-and-schedules). To assess plan compliance, CMS will count the enrollment request receipt date as "day zero" and the following day as "day one."

When submitting enrollment transactions to CMS, the plan should use the application date that is appropriate for each enrollment request mechanism outlined in the chart below.

Enrollment Request Mechanism	Application Date	Special Notes
Paper Enrollment Forms § 40.1.1	The date the paper request is initially received	Paper requests submitted to or collected by sales agents or brokers are considered received by the MA or Part D organization on the date the agent or broker receives the request from the individual
Fax § 40.1.1	The date the fax is received on the plan's fax machine	

Medicare.gov Online Enrollment Center (OEC) § 40.1.3	11 hours prior to the UTC generated date and time	
Electronic enrollment process § 40.1.2	The date the enrollee completes the request via the plan's electronic enrollment process	
Approved Telephonic Enrollment § 40.1.4	The date of the call	
Default Enrollment Option for Newly MA Eligible Medicaid Managed Care Plan Enrollees § 40.1.5	First day of individual's Initial Coverage Election Period (ICEP)	Effective date must always be the date of the individual's first entitlement to **both** Medicare Part A and Part B
Other Special Processes for Application Dates	**Application Date**	**Special Notes**
All enrollment requests into employer or union sponsored plans using the SEP EGHP, regardless of mechanism used	First day of the month prior to the effective date of enrollment	This applies to all mechanisms including §§ 40.1.10 and 40.1.10.1
Auto- and Facilitated Enrollment § 40.1.8	The first of the month prior to the effective date of the auto/facilitated enrollment. For Part D plans, the application date is set by CMS.	For cost plans conducting auto- and facilitated enrollment per § 50.1.1 of Chapter 17-D, set the application date to the first of the month prior to the effective date of the auto/facilitated enrollment.
SPAP enrollment requests as permitted in § 40.1.11 made during the AEP	October 15	The effective date of enrollment is the following January 1

All enrollment requests must be processed in chronological order by date of receipt of the completed enrollment request. Plans are encouraged to submit transactions as early as possible to resolve data issues that arise from late submissions.

NOTE: The seven-day requirement to submit the transaction does not affect the effective date of the individual's enrollment in the plan, i.e., regardless of transaction submission date, the effective date must be established according to the procedures outlined in §§ 30.7 and 30.8.

Part C Policy:
Enrollment requests received after a plan exceeds a CMS-approved capacity limit must be submitted to CMS within seven calendar days after a vacancy becomes available.

50.9 – Information Provided to Enrollee

42 CFR §§ 422.60(e)(3) and 423.32(d)

The plan must provide required notices in response to information received from CMS on the DTRR that provides the earliest notification.

Within 10 calendar days of the availability of a DTRR from CMS, the plan must provide written notification to the individual acknowledging that their enrollment request has been accepted or denied by the plan or by CMS, in accordance with MA and Part D regulations, as explained in CMS guidance.

Once the enrollment has been accepted by CMS, plans may utilize a single ("combination") notice in place of the separate acknowledgement and confirmation notices described in §§ 50.9.1 and 50.9.2. The combination notice must be provided within seven calendar days of the availability of the DTRR. Although much of the enrollment information that the plan must provide to the enrollee must be sent prior to the effective date of coverage, some information will be sent after the effective date of coverage. An enrollee's coverage begins on the effective date regardless of when the enrollee receives all the information the plan sends.

If the enrollment request has been denied and the plan later receives additional information from the individual substantiating their eligibility, the plan must obtain a new enrollment request from the individual in order to enroll the individual and process the enrollment with a prospective effective date.

If an individual's enrollment request includes a request for SSA or RRB premium withhold and the enrollment transaction was processed by CMS after the monthly cut-off for payment, the plan must submit the request for premium withhold separate from the enrollment request. Plans should resubmit the request for premium withhold timely to ensure the individual can have premium withholding at the next possible effective date. Additionally, the MA or Part D plan must inform the individual that:

- If approved, their request for premium withholding will start in one to two months;
- The effective date for premium withholding will not be retroactive;
- They will be responsible for paying the organization directly for all premiums due from the enrollment effective date until the month in which premium withholding begins; and
- Failure to pay premiums for months in which premium withholding is not yet in effect can result in disenrollment from the plan (see § 60.3.1).

50.9.1 – Prior to the Effective Date of Coverage

42 CFR §§ 422.60(e) and 423.32(d)

Prior to the effective date of coverage, plans must provide enrollees with information about being an enrollee of the plan, the plan rules, and the member's rights and responsibilities. Plans must also provide the following to enrollees:

- For enrollment requests submitted via electronic enrollment or telephonic enrollment mechanisms, evidence that the enrollment request was received (e.g., a confirmation number);
- A notice acknowledging receipt of the completed enrollment request showing the effective date of coverage;
- Proof of health insurance coverage so the enrollee may begin using plan services as of the effective date. This proof must include the 4Rx data necessary to access benefits. See Chapter 14 of the PDBM for more information about 4Rx data.

NOTE: This proof of health insurance coverage is not the same as the Evidence of Coverage document described in the Medicare Communications and Marketing Guidelines. The proof of coverage may be in the form of member ID cards, the enrollment form, and/or a notice to the enrollee. As of the effective date of enrollment, plan systems should indicate active enrollment.

Regardless of whether an enrollment request is made in a face-to-face interview, by fax, by mail, or by other mechanisms defined by CMS, plans must explain:

- The charges for which the prospective enrollee will be liable, e.g., any premiums (this includes any Part D late enrollment penalty), coinsurance, fees, or other amounts (including general information about the low-income subsidy).
- The prospective enrollee's consent to the disclosure and exchange of necessary information between the plan and CMS;
- The potential for financial liability if it is found that the individual is not entitled to Medicare Part A and enrolled in Part B (for MA plans), or eligible for Part D, at the time coverage begins and the individual has used MA plan or Part D 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 plan has not yet provided the ID card).
- **Part C Policy:** The MAO must also obtain an acknowledgment by the individual that they understand that care will be received through designated providers except for emergency services, urgently needed care, out-of-area dialysis services, and cases in which the plan authorizes use of out-of-network providers.

50.9.2 – After the Effective Date of Coverage

42 CFR §§ 422.60(e) and 423.32(g)(2)

CMS recognizes that for some enrollment requests, the plan will be unable to provide the materials to the individual, including notification of the effective date, prior to the effective date, as generally required in § 50.9.1. These cases will usually occur only when an enrollment request is received by the plan in the last few days of a month, and the effective date is the first of the upcoming month.

In these cases, the plan still must provide the individual all materials described above no later than 10 calendar days after receipt of the enrollment request. Additionally, the plan is strongly encouraged to call these new enrollees as soon as possible (such as within one to three calendar days) to provide the effective date, information to access benefits, explain the plan's rules, and that coverage will be active on the effective date required by regulation regardless of whether or not the enrollee has received all the information by the effective date.

50.10 – Enrollment Processing During Closed Periods – Part C only

42 CFR §§ 422.60(a)(2) and 422.60(b)

An MAO may close an MA plan to OEP and OEPI enrollments, or when it reaches a CMS-approved capacity limit. A capacity limit allows an MA plan to close or limit enrollment for all election periods. As described in § 50.5, when an MAO is open for enrollment, it must process elections in order of date of receipt of the completed enrollment request.

50.10.1 – Procedures After Reaching Capacity Limit – Part C only

42 CFR §§ 422.60(a)(2) and 422.60(b)

If the number of individuals who elect to enroll in an MA plan exceeds a CMS-approved capacity limit, then the MAO may limit enrollment, only if it provides priority by, (1) the date the request was received and (2) then for other individuals in a manner that does not discriminate based on any factor related to health as described in 42 CFR § 422.110.

If an MAO receives completed enrollment requests between the time it reaches its limit and the time CMS approves the limit, or is closed to OEP or OEPI enrollments, it may follow one of two options **after it receives approval from CMS to limit enrollment:**

Option 1 – Deny the enrollment, or

Option 2 – Place the enrollment on a waiting list to be processed as vacancies occur, in the priority of acceptance, based on the date the completed request was accepted.

The MAO must take the same action for all enrollment requests received. In the case of enrollments received **after** the plan closes for enrollment, the date the MA plan reopens for enrollment, becomes the "receipt date" of enrollment forms received when the plan was closed.

> **Example:**
> If the plan was closed in April and reopens on May 1, then the receipt date of enrollment requests received in April is May 1. See below for procedures for following options 1 or 2.

If the MAO uses Option 1 – It must notify the individual in writing that it is denying the enrollment and should do so within 10 calendar days after it receives the enrollment request or after the MAO receives approval from CMS to limit enrollment.

If the MAO uses Option 2 – It must notify the individual in writing that they have been placed on a waiting list and should do so within 10 calendar days after the MAO receives the enrollment

request or after the MAO receives approval from CMS to limit enrollment. The notice must: (1) inform the individual that the enrollment request will not be processed until the plan reopens for enrollment, (2) include the date the plan will reopen, and (3) inform the individual that they may cancel the request for enrollment before the plan reopens or a vacancy occurs. All individuals who wish to wait for an opening must be placed on the waiting list.

If a vacancy becomes available, and the plan was closed for more than 30 calendar days since the receipt of the enrollment form, the MAO must first contact (by telephone or in writing) the individual to reaffirm the individual's intent to enroll before processing the enrollment.

There may be situations in which the MAO has closed enrollment in a service area yet receives an approval for a capacity limit for a portion of that same service area. Given that MA plans are either open or closed to OEP and OEPI enrollments for an ENTIRE plan service area, any vacancies which may open up may only be filled by individuals making AEP, ICEP or SEP enrollment elections by applying the rules for accepting enrollments when MA plans are closed. Further, it must take those individuals based upon enrollments received in chronological order.

The date the MA plan reopened becomes the "receipt date" of enrollment forms received when the plan was closed.

> **Example:**
> If the plan was closed in February and reopens on March 1, then the receipt date of enrollment requests received in February is March 1.

50.11 – Enrollment Procedures for Medicare MSA Plans – Part C only

42 CFR § 422.56

Individuals may enroll into a Medicare MSA plan only through the MAO offering that plan. MSA plans must have a paper enrollment form available for eligible individuals to request enrollment but may also offer an online enrollment mechanism as defined in § 40.1.2 through the organization's website. However, MSA plans are not available through the OEC on the Medicare.gov website.

Applications for Medicare MSAs must include the questions below. An individual must provide all required MSA specific information in order for the enrollment request for the MSA plan to be considered complete, including the answers to the following questions:

Question	Yes	No
1. To enroll in <MSA plan name>, you may not have other health coverage.		
a. Are you enrolled in a State Medicaid program?		
b. Are you receiving Medicare Hospice Benefits?		
c. Will you have other health coverage in addition to <MSA plan name>?		

Question	Yes	No
2. Will you reside in the United States for at least 183 days during each year you are enrolled in <MSA plan>?		
3. Do you or does your spouse work?		

Additionally, the organization must obtain the necessary banking and account information before the enrollment can be considered complete. The MAO should ensure its materials describing the MSA plan explain the details of having the MSA account and what options the individual will have regarding the account.

50.11.1 – Establishing the MSA Banking Account during the Enrollment Process

Social Security Act § 1853(e)(2)

Eligible individuals interested in enrolling in an MSA plan will need to establish an MSA bank account, with a bank the plan selects and that is separate from the individual's personal banking account, to accept MSA deposits in accordance with the MSA plan's procedures. Per Section 1853(e)(2) of the Act, payment of an MSA deposit cannot be made until the account has been established. MA plans have an obligation to disclose to enrollees and potential enrollees how the plan works and benefits coverage under § 422.111; for MSA plans, this includes how the account is required before MSA deposits can be made. The MSA account is a necessary component for effectuating coverage under the plan and to ensure successful enrollment.

Therefore, during the enrollment process, MSA organizations must:

- Inform individuals that the enrollment is not complete until the MSA account is set up.
- Have documentation that the account has been established prior to submitting the enrollment transaction to CMS.
- Inform individuals that once the enrollee's initial deposit has been received in the MSA account, the enrollee may then transfer the funds to their own banking institution.

NOTE: MARx will not reject an MSA enrollment transaction if CMS records show an open period of Medicaid or hospice coverage; however, MARx will provide information about these statuses. MSA plans should contact the individual to confirm or deny this information.

60 – Disenrollment

42 CFR §§ 422.66, 422.74, 423.36, and 423.44

Except as provided by law and described in this section, plans may not, either orally or in writing, or by any action or inaction, request or encourage any individual to disenroll from a plan. Plans may contact individuals to determine the reason for disenrollment; however, they must not discourage individuals from disenrolling. Consistent with prohibitions on discrimination for federal healthcare programs and in sections 1851(g), 1852(b), and 1860D-1(b)(1)(B)(v) of the Act, plans must apply disenrollment policies in a consistent manner for all enrollees.

60.1 – Voluntary Disenrollment

42 CFR §§ 422.66(b)(1), 422.74, and 423.36

Voluntary disenrollment can only be initiated by the enrollee or the enrollee's authorized representative as recognized by State laws (see § 50.1 for who may complete an enrollment or disenrollment request) during a valid election period (refer to § 30 on election periods). Individuals may voluntarily disenroll from a plan by:

- Enrolling in another plan (during a valid election period);
- Mailing or faxing a signed notice of disenrollment to the plan, or to the individual's employer/union group, where applicable;
- Submitting an electronic request via the plan's secure internet website (if the plan offers such an option); or
- Calling 1-800-MEDICARE.

If an enrollee verbally requests disenrollment from a plan, the plan must instruct the individual to make the request via one of the methods outlined above. The plan may send a disenrollment form to the individual upon request (see MA Exhibits 9, 9a, 10, and 10a;Part D Exhibits 8, 9, and 9a).

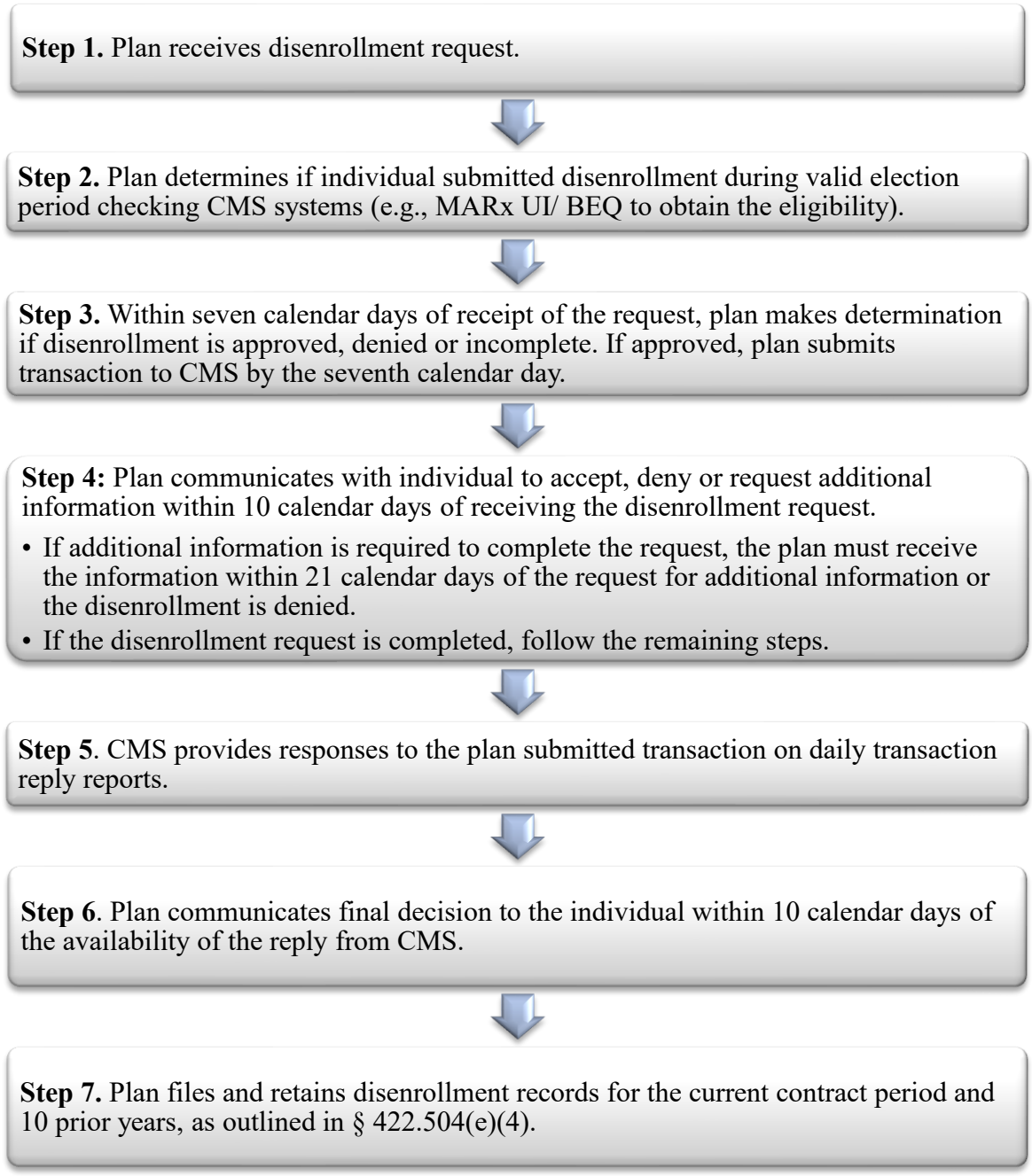
Plans accepting voluntary disenrollment requests via an electronic mechanism must, at a minimum, comply with the HIPAA data security and privacy policies.

Online disenrollment by other means, such as emailing the plan (including emailing an attachment of the signed notice of disenrollment) or via a broker website, are not permitted.

60.1.1 – Voluntary Disenrollment Processing

42 CFR §§ 422.66 (b)(3), 422.504(e)(4), 423.36, and 423.505(e)(4)

Processing a voluntary disenrollment request begins when a plan receives a disenrollment request from the individual or the individual's authorized representative and ends with the plan communicating, in writing, whether the individual's disenrollment request has been accepted or denied. In instances where the individual requests disenrollment directly from the plan, processing the disenrollment includes:



Plans may not delay processing and submitting disenrollment requests to CMS.

When the disenrollment request is received and processed as outlined above, the election period and date the plan received a valid request to disenroll will determine the effective date of the disenrollment (refer to § 30.8 for disenrollment effective dates).

Plans may choose, but are not required, to issue a disenrollment confirmation notice for an automatic disenrollment resulting from an individual's enrollment in a PBP within the same contract.

60.1.2 – Incomplete Disenrollment Requests

42 CFR §§ 422.60, 422.66, 423.32, and 423.36

When a disenrollment request is incomplete, the plan must:

- Document its efforts to obtain information to complete the disenrollment request; and,
- Notify the individual (in writing or verbally) within 10 calendar days of receipt of the disenrollment request that additional information is needed.

If a written disenrollment request is submitted and the signature is not included, the plan may contact the individual by phone to confirm the individual's intent to disenroll and document the phone call, rather than returning the written request to the individual for signature.

If any additional information needed to make the disenrollment request "complete" is not received within allowable time frames outlined below, the plan must deny the enrollment using the procedures outlined in § 60.1.3.

For incomplete disenrollment requests:	Information to complete request must be received:
During the AEP	By December 7, or within 21 calendar days of the request for additional information (whichever is later).
During all other enrollment periods	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).

60.1.3 – Denial of a Voluntary Disenrollment Request

42 CFR §§ 422.60(e), 422.66(b), 423.32(c), 423.32(d), and 423.36

Generally, plans deny a voluntary disenrollment request when the request was:

- Made outside of an allowable election period (see § 30 on election periods);
- Initiated by someone other than the individual or individual's authorized representative; or
- Incomplete, **and** the required information was not provided within the appropriate time frames outlined in § 60.1.2.

If any of the above listed reasons apply, the plan must send notice of the denial for disenrollment (MA Exhibit 12a; Part D Exhibit 11) to the individual that includes an explanation of the reason for denial, within 10 calendar days of receipt of the request or expiration of the request for additional information as described in § 60.1.2.

60.1.4 –Disenrollments not Legally Valid

42 CFR §§ 422.60(e) and 423.32(c)

There are instances when a completed disenrollment can later be determined to be legally invalid. These instances may include, but are not limited to:

- An automatic disenrollment occurred due to an erroneous death indicator, or an erroneous loss of Medicare Part A or B, or
- The individual or their authorized representative did not intend to disenroll from the plan.

Evidence of lack of intent to disenroll may include:

  - A disenrollment request signed by the individual when an authorized representative should have signed for the member;
  - Request by the individual for cancellation of disenrollment before the effective date (refer to § 70.2 for procedures for processing cancellations).

When a disenrollment is not legally valid, a reinstatement action may be necessary (refer to § 70.3 for more information on reinstatements). In addition, the reinstatement may result in a retroactive disenrollment from another plan (see § 70.5 for information on retroactive disenrollments).

In contrast, a member's deliberate attempt to disenroll from a plan (e.g., sending a written request for disenrollment to the MAO 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.

60.1.5 – Optional Mechanism for Employer/Union Disenrollments

42 CFR §§ 422.66(b)(3) and (f)

Plans may choose to accept voluntary disenrollment requests directly from the employer or unions who sponsor EGHP coverage for its enrollees without obtaining a written disenrollment request from each individual. This optional disenrollment request mechanism can be used in place of paper disenrollment forms and does not require a signature from the individual. The disenrollment transaction includes the data necessary for the organization or sponsor to determine each individual's eligibility to make a disenrollment request as described in § 60.1.1 . The requirements for all other information provided to enrollees post-disenrollment, are unchanged by this option and must be satisfied.

Plans that select this option need to:

- Inform the CMS account manager of its intent to use this mechanism.
- Ensure the accuracy of the disenrollment record made by each individual according to the processes the employer or union has in place.
- Record receipt (i.e., date) of request, which will be the date the employer's or union's disenrollment choice is received by the plan.
- Maintain appropriate safeguards to provide data security, exchange, and confidentiality of disenrollment information (i.e., the electronic file).
- File and retain disenrollment requests for current contract period and prior 10 years.

60.1.6 – Group Disenrollment for Employer/Union Sponsored MA and Part D plans

42 CFR §§ 422.74 and 423.36

CMS has provided, under our authority to waive or modify MA and Part D requirements that

hinder the design of, the offering of, or the enrollment in an employer or union sponsored MA and Part D retiree plans, a process for group disenrollment from employer or union sponsored MA and Part D plans.

CMS will allow employer or union plans to disenroll retirees from an MA or Part D plan at any time using a group disenrollment process.

In the group disenrollment process:

Step 1. Individuals receive advance notice of the employer or union's intent to disenroll them from a plan sponsored by the employer/union.

Step 2. Plan, employer, or union sends required notice at least 21 days prior to the effective date of the individual's disenrollment.

Step 3. After notice requirements are met, the employer or union must provide the following in the group disenrollment file(s) it sends to the plan:

- All the information (i.e., data elements) required for the plan to submit a complete disenrollment request transaction to CMS (see Appendix 2); and
- The disenrollment effective date as permitted in guidance.

Step 4. Individual notice must include information for enrollees to contact Medicare about other MA or Part D plan options.

Step 5. Plan files and retains disenrollment records for current contract period and prior 10 years as outlined in § 70.8.

60.1.7 – Disenrollment Process for Employer/Union Sponsored Coverage Terminations

When the contract between an employer or union group and an MAO or Part D sponsor is terminated, or the employer/union determines that an individual is no longer eligible to participate in the employer/union sponsored plan,[1] employer or union sponsored plans operating under waivers issued by CMS under sections 1857(i) and 1860D-22(b) of the Act, have two options for how to disenroll individuals from the current employer or union sponsored plan.

For both of the following options, the plan must ensure that the employer or union agrees to the following:

- The employer or union will provide the plan with timely notice of contract termination or the ineligibility of an individual to participate in the employer or union group sponsored plan. Such notice must be prospective, not retroactive.

[1] The employer/union establishes criteria for its retirees to participate in the employer/union sponsored plan. These criteria are exclusive of and in addition to the eligibility criteria for MA or Part D enrollment. Eligibility criteria to participate and receive employer/union sponsored benefits may include spouse/family status, payment to the employer/union of the individual's part of the premium, or other criteria determined by the employer/union.

- The employer or union must provide a prospective notice to its enrollees alerting them of the termination event and of other insurance options that may be available to them through their employer or union.

Option 1: Enroll the individual(s) in another MAO or Part D sponsor offered by the same MAO or Part D sponsor, unless the individual makes another choice. The individual must be eligible to enroll in this plan, including residing in the plan's service area. The individual plan selected for this option must be the same type of plan. For example, if the employer/union sponsored plan was an MA-PD coordinated care plan, the individual plan in this option must be an MA-PD coordinated care plan.

- MA enrollees may elect:
    - Another MA plan offered by the employer or union, join Original Medicare, or join another MA plan instead of electing an MA plan offered by the same MAO.
- Part D enrollees may elect:
    - Another PDP or MA-PD offered by the employer or union, disenroll from the PDP, or join another PDP or MA-PD plan, instead of electing a PDP offered by the same PDP sponsor.
- If the individual prefers not to be enrolled in the plan, they may contact the plan.
- If the individual would prefer enrolling in a different MA, PDP, or MA-PD plan, they must submit an enrollment request to their newly chosen MAO or Part D sponsor.
- If the individual takes no other action, they will be enrolled in a plan offered by the same MAO or Part D sponsor that offered the employer/union sponsored plan.
- **MA and Part D Notice requirements** – The plan (or the employer or union, acting on its behalf) must provide prospective notice to the enrollee that their plan is changing, including information about benefits, premiums, and/or copayments, at least 21 calendar days prior to the effective date of enrollment in the new plan.

Option 2: Disenroll individual(s) from the employer/union sponsored MA plan to Original Medicare following prospective notice; or disenroll individual from the Part D plan following prospective notice.

- **MA and Part D Notice requirements** – The MAO or Part D sponsor (or the employer or union, acting on its behalf) must provide prospective notice to the enrollee that their plan enrollment is ending at least 21 calendar days prior to the effective date of the disenrollment. The notice must include information about returning to Original Medicare and other plan options available to the enrollee and how to request enrollment.
- If the employer/union sponsored plan was an MA-PD plan or a PDP, the individual must be advised that the disenrollment action means the individual will not have Medicare drug coverage. Notice must include information about the potential for late enrollment penalties that may apply in the future.

The plan must outline in its written policies and procedures for the option it follows and must apply the same option for all enrollees of a particular employer/union sponsored plan. It is the plan's responsibility to ensure that the required elements of the disenrollment procedures

described above are understood by the employer or union and are part of the agreement with each employer or union, including contract termination notification requirements.

60.1.8 – Medigap Guaranteed Issue Notification Requirements for Disenrollments to Original Medicare during an SEP – Part C only

Social Security Act § 1882(s)(3)(D); 42 CFR 422.66(b)(3)(ii)

MA organizations are required to notify members of their Medigap guaranteed issue rights when members disenroll from the MA plan and into Original Medicare during a SEP. Model language discussing these Medigap rights has been provided in MA Exhibit 11 and MA Exhibit 12.

There may be cases when a Medigap issuer requires the beneficiary to provide additional documentation that they disenrolled as a result of an SEP and is eligible for such guaranteed issue rights. A beneficiary may contact the MA organization for assistance in providing such documentation. The MA organization may provide such a notice to the beneficiary upon request (see MA Exhibit 24).

60.2 – Required Involuntary Disenrollment

42 CFR §§ 422.74, 423.44(b)(2), and 423.44(e)

A CMS- or plan-initiated disenrollment, also referred to as involuntary disenrollment, is classified as either a required or optional involuntary disenrollment (§ 60.3).

An involuntary disenrollment is required, with certain exceptions, in the following circumstances:

- Enrollee no longer resides in the plan's service area (including incarceration) (§ 60.2.1);
- **Part C Policy:** Enrollee loses entitlement to either Medicare Part A or Part B (§ 60.2.2);
- **Part D Policy:** Enrollee loses eligibility for Part D (§ 60.2.2);
- **Part C Policy:** Enrollee loses special needs status and does not reestablish special needs plan (SNP) eligibility prior to the expiration of the period of deemed eligibility (see § 60.2.4 for more information on loss of special needs status);
- Enrollee fails to pay Part D-IRMAA and CMS notifies the plan to effectuate disenrollment (§ 60.2.5);
- Enrollee is not lawfully present in the United States (§ 60.2.6);
- Plan's contract is terminated, or has a service area reduction (§ 60.2.7); or
- **Part D Policy:** Enrollee materially misrepresents information to the Part D sponsor regarding reimbursement for third party coverage (§ 60.2.8).

Generally, notices must be sent for disenrollments effectuated by plans. There are some CMS-initiated disenrollments where notice is required to be sent by plans and other CMS-initiated disenrollments where notice is not required but encouraged (see the chart below).

Required Involuntary Disenrollment Reason	Effectuated		Plan Notice	
	Plan	CMS	Required	Encouraged
Enrollee no longer resides in the plan's service area (§ 60.2.1)	✔		✔	
Enrollee is incarcerated (§ 60.2.1.1)		✔	✔	
Part C Policy: Enrollee no longer has both Medicare Part A AND Part B (§ 60.2.2)		✔		✔
Enrollee loses Part D eligibility (§ 60.2.2)		✔		✔
Death of enrollee (§ 60.2.3)		✔		✔
Enrollee loses special needs status and does not reestablish SNP eligibility prior to the expiration of the period of deemed continued eligibility (§ 60.2.4)	✔		✔	
Enrollee fails to pay Part D-IRMAA and CMS notifies the plan to effectuate disenrollment (§ 60.2.5)		✔	✔	
Enrollee is not lawfully present in the United States (§ 60.2.6)		✔		✔
Plan's contract is terminated, or has a service area reduction, which excludes the enrollee (§ 60.2.7)	✔	✔	✔	
Enrollee materially misrepresents information to the Part D sponsor regarding		✔	✔	

Required Involuntary Disenrollment Reason	Effectuated		Plan Notice	
	Plan	CMS	Required	Encouraged
reimbursement for third party coverage (§ 60.2.8)				

Where required, the notice sent by the plan must advise the enrollee that they will be disenrolled and the reason for the disenrollment action.

In addition, where an involuntary disenrollment is required for the reasons listed below, the notice must be sent to the individual before the disenrollment transaction is submitted to CMS and must include an explanation of the individuals' right to file a grievance with the plan.

- Individual no longer resides in a plan's service area;
- Failure to pay premium;
- Loss of special needs status (Part C);
- Loss of MSA eligibility;
- Fraudulent information on election form or abuse of enrollment card ;
- Disruptive behavior.

For disenrollments effectuated by CMS due to incarceration or nonpayment of Part D-IRMAA, the disenrollment notice must advise the individual that the plan has disenrolled them and why such action is occurring. This notice should be mailed within 10 calendar days of receiving the disenrollment TRC on the DTRR from CMS.

Plans are strongly encouraged, but not required, to send notices for certain CMS-effectuated disenrollments, including:

- Death (MA and Part D Exhibit 13);
- Loss of entitlement (Exhibit 14); and
- Unlawful presence in the United States (MA Exhibit 38, Part D Exhibit 37).

60.2.1 – General Rule for Enrollees Who Change Permanent Address

42 CFR §§ 422.50 (a)(3)(ii), 422.74(d)(4), 422.74(e)(2), 423.44(b)(2)(i), 423.44(c), and 423.44(d)(5)

In general, an enrollee's permanent residence must be within the plan's service area for the individual to remain eligible to stay in the plan. The plan must disenroll an individual in any of the following circumstances:

- Enrollee permanently moves out of the service area and, for MA, new residence is not in a continuation area (see § 20.3.1 on CMS-approved continuation areas);
- **Part C Policy:** Enrollee is an out-of-area member (as defined in § 10) and permanently moves from the residence in which they resided at the time of enrollment in the MA plan to an area that is not in the service area or continuation area;

- **Part C Policy:** Enrollee permanently moves out of the continuation area of an MA local plan and their new residence is not in the service area or another continuation area of the MA local plan;
- **Part C Policy:** Enrollee permanently moves out of the service area (or continuation area, for continuation of enrollment enrollees in MA local plans) and into a continuation area, but chooses not to continue enrollment in the MA local plan (refer to § 70.7 for procedures for choosing the continuation of enrollment option); or
- Enrollee is incarcerated and, therefore, resides out of area for the duration of the incarceration.

With the exception of incarcerated individuals (see § 60.2.1.1), the disenrollment effective date for the above scenarios is the first day of the calendar month after the date the enrollee permanently leaves the plan's service area (or continuation area (Part C), as appropriate) AND after the individual or the individual's authorized representative notifies the plan that they have moved and no longer reside in the plan service area. If the enrollee provides advance notice of the move, the disenrollment occurs the first of the month following the month in which the individual indicates they will be moving.

If the enrollee establishes that a permanent move occurred in the past and requests retroactive disenrollment (not earlier than the first of the month after the move), the plan can submit this request to CMS (or its designee) for consideration of retroactive action.

Individuals who are disenrolled due to a change in residence may use the SEP described in 42 CFR § 422.62(b)(2) and 423.38(c)(7) (see also § 30.6.20) and select another MA or Part D plan in a service area that includes the individual's new residence. Any disenrollment from an MA plan processed under these provisions will result in a change to enrollment in Original Medicare unless the enrollee elects another MA plan during an applicable election period.

60.2.1.1 – Incarcerated Individuals

42 CFR §§ 422.74(d)(4)(v), 423.44(d)(5)(iii), and 423.44(d)(5)(iv)

In the case of incarcerated individuals, CMS will involuntarily disenroll incarcerated individuals based on data CMS receives from SSA. CMS will report the disenrollments to the plan via the DTRR providing TRC 346 Disenrollment due to Confirmed Incarceration.

When CMS notifies the plan of the disenrollment due to an enrollee's incarceration status, the disenrollment effective date is the first of the month after the incarceration start date, including for retroactive periods of incarceration.

When a plan receives an enrollee's incarceration status from a source other than CMS, an investigation is required to determine whether the individual is incarcerated. Confirmation may include contacting the individual or other sources to determine current incarceration status and incarceration start and end dates, if applicable.

If the plan confirms the enrollee is currently incarcerated but does not obtain the start date of the current incarceration, the plan must involuntarily disenroll the individual prospectively for the

first of the month following the date on which the current incarceration was confirmed. If the plan confirms an individual's current incarceration status as well as the start date of the current incarceration, the plan 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, the plan must submit the retroactive disenrollment request to the CMS Retroactive Processing Contractor (see § 70.5).

60.2.1.2 – Required Involuntary Disenrollments Based on Extended Absence

42 CFR §§ 422.74(d)(4)(ii) and 423.44(d)(5)(ii)

An MAO must disenroll an individual if:

- The enrollee's extended absence from the service area (or continuation area, for continuation of enrollment enrollees) exceeds six consecutive months (see § 60.2.1.2.1 for exception); or
- The enrollee is an out-of-area member (as defined in § 10), who leaves their residence for more than six months.

For MA plan enrollees, the disenrollment is effective the first day of the calendar month after six months have passed.

A Part D sponsor must disenroll an individual if the enrollee's extended absence from the service area exceeds 12 consecutive months. For Part D enrollees absent from the service area more than 12 consecutive months, the disenrollment is effective the first day of the 13th month.

60.2.1.2.1 – Exceptions for MA Enrollees Enrolled in Visitor or Traveler Programs

42 CFR § 422.74(d)(4)(iii)

There is an exception to the required involuntary disenrollment requirement for extended absences, as described in § 60.2.1.2 above, for individuals enrolled in MA plans that offer a visitor/traveler benefit, which allows a temporary absence from the plan service area, but within the United States, for up to 12 consecutive months. Such individuals are disenrolled if their absence from the service area exceeds 12 consecutive months (or the length of the visitor/traveler program if less than 12 months). Plans that offer such programs do not have to disenroll individuals in these extended programs who remain out of the service area for more than six months but less than 12 months. Plans may choose to limit this option to enrollees who travel to certain areas, as designated by the MAO, and who receive services from qualified providers.

Where an MA plan offers a visitor/traveler benefit, it must disenroll an individual if the enrollee is temporarily absent from the service area (or continuation area, as applicable) for more than 12 consecutive months (or the length of the visitor/traveler program if less than 12 months).

The disenrollment is effective the first day of the 13th month (or the first day of the month after the length of the visitor/traveler program if less than 12 months) after the individual left the service area (or continuation, as applicable).

60.2.1.3 – Researching and Acting on a Change of Address

42 CFR §§ 422.74(c), 422.74(d)(4), and 423.44(d)(5)

When researching changes of address, plans are encouraged to utilize CMS systems interfaces, internet search tools, address information from provider claims, and other available resources.

Plans may obtain either written or verbal verification of a change in address, as long as the policy applies to all enrollees.

Within 10 calendar days of receipt of a change of address or a possible out-of-area residency notification from the individual, the individual's authorized representative, CMS, or other reliable sources such as provider claims or the USPS, the plan must:

- Attempt to contact the enrollee to confirm the enrollee's permanent residence; and
- Document its efforts to determine an enrollee's residency status.

NOTE: Plans are not required to attempt to contact enrollees for prospective enrollments with the transaction reply codes: 011 (Enrollment Accepted) or 100 (PBP Change Accepted as Submitted), accompanied by 016 (Enrollment Accepted—Out of Area), that are on the same DTRR. These represent new enrollments for which the organization recently confirmed the individual's permanent residence in the plan service area.

An individual is considered to be temporarily absent from the plan service area when any one or more of the required materials and content referenced in §§ 422.2267(e) and 423.2267(e), if provided by mail, is returned to the plan sponsor by the U.S. Postal Service as undeliverable and a forwarding address is not provided.

If the plan confirms **the member's out-of-area status is temporary** (and does not exceed the applicable time limits described in § 60.2.1.2 above)**,** the plan must retain the individual as an enrollee.

If the individual (or their authorized representative) responded and confirmed the permanent move out of the service area, the plan must send the disenrollment notice (MA Exhibit 36, Part D Exhibit 37) within 10 calendar days of the individual's confirmation that the move is permanent.

Exception: MAOs will retain an enrollee who has permanently moved into a continuation area and chose the continuation of enrollment option (procedures for electing a continuation of enrollment option are outlined in § 70.7).

If the plan receives notice of a potential move out of the service area from a source other than the individual or the individual's authorized representative, the plan may not conclude a move is permanent until it has received confirmation of the move from the individual or the individual's authorized representative, or the period of permissible temporary absence has passed, whichever is earlier. The plan must initiate disenrollment if the individual (or their authorized representative) does not confirm the individual's permanent address prior to the expiration of the period of permissible temporary absence.

In the case of MA plan enrollees who fail to respond to the request for address confirmation and are disenrolled because they are absent from the service area for more than six months, the MAO must provide the disenrollment notice within the first 10 calendar days of the sixth month of such absence. Since individuals enrolled in MA plans that offer a visitor/traveler benefit are permitted an absence from the service area for up to 12 months, such individuals are disenrolled if their absence from the service area exceeds 12 months (or the length of the visitor/traveler program if less than 12 months). In this scenario, the MAO must provide notification of the upcoming disenrollment to the enrollee during the first 10 calendar days of the 12th month (or the last month of the allowable absence, per the visitor/traveler program).

For PDP enrollees who fail to respond to the request for address confirmation and are disenrolled because they are absent from the plan service area for more than 12 months the PDP must provide notification of the upcoming disenrollment to the enrollee within the first 10 calendar days of the 12th month of such absence.

MAOs and Part D plan sponsors must document the basis for involuntary disenrollment actions that are based on the residency requirements.

60.2.1.4 – Special Procedures for Auto- and Facilitated Enrollees Whose Address is Outside the PDP Region

CMS assigns most individuals based on data provided by State Medicaid Agencies to identify full-benefit dual eligible individuals, even if that state is different than that in the address in CMS' systems. When an individual whom CMS had auto/facilitated enrolled or reassigned (see § 40.1.8) has an address outside of the PDP's region (e.g., via a state and county code change on the DTRR), the PDP sponsor must try to determine the individual's permanent residence and retain documentation of such efforts.

Additionally, the plan should retain documentation from the enrollee or enrollee's authorized representative that includes:

- Notification of whether the member's out-of-area status is temporary or permanent.

The PDP sponsor may accept either written or verbal confirmation that an individual has moved out of the service area, as long as the plan applies the policy consistently among all enrollees.

If the plan confirms **the member's out-of-area status is temporary** (and does not exceed the applicable time limits described in § 60.2.1.2 above), the plan must retain the individual as an enrollee.

If the plan confirms **the member's out-of-area status is permanent** and has a PDP in the new region with a premium at or below the low-income premium subsidy amount for that region, the PDP sponsor may submit an enrollment transaction to enroll the individual in that PDP prospectively (See Part D Exhibit 27).

If the plan confirms **the member's out-of-area status is permanent** and does not have a PDP in the new region with a premium at or below the low-income premium subsidy amount for that

region, the plan must inform the individual that they must enroll in a PDP that serves the area where the individual now resides. The PDP must disenroll the individual, effective the first of the following month.

The plan must not disenroll the individual if the plan is unable to contact the auto/facilitated enrolled individual or receives no response. This also applies when the individual's address is listed as a P.O. Box.

60.2.1.5 – Procedures for Developing Addresses for Enrollees Whose Mail is Returned as Undeliverable

The United States Postal Service (USPS) will return any materials mailed first-class by the plan, as undeliverable if an address is not current. Mail returned as undeliverable may indicate:

- The individual no longer resides at the address specified and there is no change-of-address on the file;
- The forwarding order by USPS expired for the individual; or
- The address of record is incorrect.

For undeliverable or returned member materials, the plan should take the following steps:

1. Attempt to contact the enrollee to verify their current address.
2. If the USPS returns mail with a new forwarding address, forward plan materials to the individual.
3. If the plan receives documented proof of an individual's residence change that is outside of the plan service area or mail is returned without a forwarding address, follow the procedures described in § 60.2.1.3.
4. If the plan receives claims for services from a pharmacy or provider, the plan may contact the pharmacy or provider to obtain the individual's current address.
5. If the plan is successful in locating an individual whose mail was returned as undeliverable, the plan should update its internal records and, if appropriate, advise the individual to update their address and contact information with SSA through any of the below methods:
    - Sign into "my Social Security account" on https://www.ssa.gov/.
    - Call SSA at 1-800-772-1213. TTY users should call 1-800-325-0778 (weekdays from 8:00 a.m. to 7:00 p.m. local time).
    - Notify the local SSA field office.

Plans are expected to continue to mail materials to the member's address of record. If the postal service returns a piece of beneficiary communication to the plan, the plan should document the return and retain the returned material. It should continue to send future correspondence to that same address, as a forwarding address may become available at a later date. Additionally, CMS encourages the plan to continue its efforts, as discussed above, to attempt to locate the beneficiary using any available resources, including CMS systems, to identify new address information for the beneficiary. If a forwarding address becomes available, an organization can send materials to that address as in item #2 above.

As outlined in § 60.2.1.3, an individual is considered to be temporarily absent from the plan service area when any one or more of the required materials and content referenced in §§ 422.2267(e) and 423.2267(e), if provided by mail, is returned to the plan sponsor by the U.S. Postal Service as undeliverable and a forwarding address is not provided.

60.2.2 – Loss of Medicare Part A, Part B, or Eligibility for Part D

42 CFR §§ 422.50(a)(1), 422.74(b)(2)(ii), 422.74 (d)(5), 423.30(a)(i), 423.44(b)(2)(ii), 423.44(c), and 423.44(d)(3)

As described in § 20, an individual must be entitled to Medicare Part A **and** enrolled in Medicare Part B, among other criteria, in order to be eligible to elect an MA plan. To be eligible for Medicare Part D, an individual must be entitled to Medicare benefits under Part A **or** enrolled in Medicare Part B.

An individual is subject to disenrollment from an MA plan when they lose entitlement to Medicare Part A and/or B benefits. The disenrollment effective date is the first day of the calendar month following the last month of entitlement to either Part A or Part B benefits.

An individual is subject to disenrollment from a Part D plan when they lose Part D eligibility. The disenrollment effective date is the first day of the calendar month following the last month of Part D eligibility.

In the case of MA plans:

- CMS will notify the plan when the enrollee's Part A or B benefits ended (i.e., loss of entitlement)
- Plans may provide the enrollee with a notice of disenrollment (MA Exhibit 14) due to the loss of entitlement to either Medicare Part A and/or Part B to correct any erroneous disenrollment.

NOTE: An exception exists for Medicare Part B-only grandfathered members (as described in § 20.2.1) since these members initially enrolled in a § 1876 risk sharing plan, continue enrollment in an MA plan despite not being entitled to Medicare Part A or living in the plan's service area or continuation area.

In the case of Part D plans:

- CMS will notify the plan when the enrollee's Part D eligibility ended.
- Plans may provide the enrollee with a notice of disenrollment (Part D Exhibit 14) due to the loss of entitlement to either Medicare Part A and/or Part B to correct any erroneous disenrollment.

60.2.3 – Death of the Enrollee

42 CFR §§ 422.74(b)(2)(iii), 422.74(d)(6), 423.44(b)(2)(iii), and 423.44(d)(4)

CMS will notify the plan of the death of an enrollee and subsequently disenroll the individual. The disenrollment is effective the first day of the calendar month following the month of death.

Prior to receiving an official notification from CMS via the DTRR, plans may, at their discretion, make note of the reported death in internal plan systems in order to suppress premium bills and member notices. The plans are not allowed to disenroll a beneficiary for death unless CMS systems shows that the beneficiary is deceased.

MA plans have the option to send a disenrollment notice (MA Exhibit 13) to the estate of the enrollee, following receipt of a CMS notification, so that any erroneous disenrollment can be promptly corrected.

60.2.4 – Loss of Special Needs Status

42 CFR §§ 422.52(d) and 422.74(b)(2)(iv)

A SNP can continue to provide care for an enrollee who no longer meets the eligibility criteria for the plan (i.e., special needs status) if the individual can reasonably be expected to again meet the special needs criteria within a period of time not to exceed six months. The SNP may choose any length of time from one to six months for deeming continued eligibility, as long as it applies the criteria consistently to all enrollees of the plan and fully informs enrollees of its policy.

A plan should consider its ability to meet the needs of an enrollee that no longer meets the special needs status if and when applying the period of deemed continued eligibility. In the following instances, the SNP is expected to disenroll the individual:

- If an enrollee does not requalify within the plan's period of deemed continued eligibility, with proper notice (see below), at the end of this period.
- If the SNP is unable to provide continuity of care to an enrollee who loses eligibility (e.g., the enrollee leaves the institution or long-term care facility when enrolled in an institutional SNP).

The plan should provide the enrollee a notice of disenrollment a minimum of 30 days before the disenrollment regardless of the date of the loss of special needs status. The notice should be:

- Provided to the enrollee within 10 days of learning of the loss of special needs status affording the opportunity to prove that they are still eligible to remain in the plan.

The notice must include:

- Information regarding deemed continued eligibility;
- Duration of the period of deemed continued eligibility;
- Description of SEP eligibility (see § 30.6.13);
- Consequences of not regaining special needs status within the period of deemed continued eligibility; and
- Disenrollment effective date.

If the enrollee fails to regain special needs status during the period of deemed continued eligibility, the SNP is expected to provide the individual a written notice regarding involuntary disenrollment and submit the disenrollment transaction to CMS within three business days following the disenrollment effective date which is either (1) the last day of the period of deemed

continued eligibility, if applicable, or (2) a minimum of 30 days after providing the advance notice of disenrollment.

If the SNP fails to process the disenrollment timely:

- The SNP should send the disenrollment notice (MA Exhibit 32) to the enrollee regarding the potential for involuntary disenrollment with a proposed disenrollment date and the full length of the deemed continued eligibility period;
- The SNP should send the disenrollment notice (MA Exhibit 33) to the enrollee regarding the loss of special needs status with an explanation of the delay and the revised disenrollment date.

For information on premiums, benefits, and cost sharing during the period of deemed continued eligibility, see Chapter 16-B of the Medicare Managed Care Manual.

Individuals who lose special needs status are eligible for a Special Election Period to make a new election. See § 30.6.13 for more information.

60.2.5 – Failure to Pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)

42 CFR §§ 423.44(e), 423.286(d)(4), and 423.293(d)

Section 1860D-13(a)(7) of the Social Security Act requires that individuals be assessed a Part D income related monthly adjustment amount (Part D-IRMAA) in certain circumstances. The Part D-IRMAA is:

- A monthly amount that is added to the individual's Part D premium;
- Based on an individual's modified adjusted gross income (MAGI).

Individuals with Part D-IRMAA must pay this additional premium directly to the government, **not** to the plan. CMS has established a three-month initial grace period before individuals who fail to pay their Part D-IRMAA will be disenrolled from their MA-PD or Part D plan. After the three-month grace period, individuals who fail to pay their Part D IRMAA will be disenrolled from their MA-PD or Part D plan by CMS. CMS will notify the individual's plan of the disenrollment via the DTRR. The disenrollment effective date is the first day of the month after the initial grace period.

Example:
Ms. Jones owes a Part D-IRMAA and has a three-month grace period for premium payment. CMS bills Ms. Jones her monthly Part D-IRMAA amount, which is due March 1. Ms. Jones does not pay all the Part D-IRMAA amounts owed by the due date of the March bill. On March 7, the plan sends a nonpayment notice to Ms. Jones. She ignores the notice and subsequent monthly bills. Ms. Jones does not make the required payments during the three-month grace period (March, April, May). CMS disenrolls Ms. Jones effective June 1 and sends the plan a specific TRC via the DTRR.

The plan must send each affected individual a written notice of the disenrollment within 10 calendar days of receipt of the DTRR indicating disenrollment for nonpayment of the Part D-IRMAA.

When an enrollee fails to pay both Part D-IRMAA and the plan premium and the disenrollment effective dates are the same, the TRC for the disenrollment action will reflect the first disenrollment transaction that is processed by MARx. If the plan-generated disenrollment transaction, resulting from the failure to pay plan premiums, is processed by MARx before CMS initiates a disenrollment transaction for failure to pay Part D-IRMAA, the TRC will reflect the plan-generated disenrollment.

If the CMS generated disenrollment transaction for failure to pay Part D-IRMAA is processed first, plans will receive the TRC reflecting this action. In these cases, CMS will be unable to process the plan-generated disenrollment transaction because the individual is already disenrolled. When a plan determines that an enrollee was slated for disenrollment due to failure to pay the plan premium and the effective date of the disenrollment matches the Part-D IRMAA disenrollment effective date, plans have three options for notifying enrollees:

- Send the notice for failure to pay Part D-IRMAA (see Exhibit 21a);
- Send both the notice for failure to pay Part D-IRMAA and the plan notice for failure to pay premiums (see Exhibit 21a); or
- Send the plan notice for failure to pay premiums and include information regarding the Part D-IRMAA disenrollment (see Exhibit 21).

Enrollees involuntarily disenrolled from their plan for failure to pay Part D-IRMAA may ask for reinstatement into the plan from which they were disenrolled if the nonpayment of premiums was due to a circumstance that the individual could not reasonably foresee and could not control, such as an extended period of hospitalization. CMS (or an entity acting on behalf of CMS) may reinstate enrollment, without interruption of coverage, if the individual demonstrates good cause and pays the following amounts **in full** within three calendar months of the disenrollment effective date:

- The Part D-IRMAA amounts that caused the disenrollment for nonpayment of Part D-IRMAA; and
- Any past due plan premium amounts owed.

For more information on good cause, see § 70.3.5.

60.2.6 – Unlawful Presence Status

42 CFR §§ 422.74(b)(2)(v), 422.74(d)(8), 423.44(b)(2)(vi), and 423.44(d)(8)

SSA determines whether individuals are ineligible for enrollment on the basis of not being lawfully present in the United States. CMS will notify the plan (via DTRR) of an individual's ineligibility on this basis at the time of enrollment. Plans do not need to investigate to confirm the not lawfully present status of individuals disenrolled by CMS. In addition, plans are **not** required to continue to provide coverage to individuals contesting their lawfully present status while the issue is under review at SSA.

Following receipt of a CMS notification (via DTRR) of a disenrollment due to unlawful presence, CMS strongly suggests that the plan provide a notice (MA Exhibit 38; Part D Exhibit 37) to the individual within 10 calendar days of receipt of the DTRR regarding the loss of coverage. Involuntarily disenrolled individuals enrolled in an MA plan will be defaulted to Original Medicare.

The effective date for disenrollment based on not lawfully present status is the first of the month following notice by CMS that the individual is ineligible or the start date of ineligibility, whichever is later.

60.2.7 – Terminations/Non-renewals/Service Area Reduction

42 CFR §§ 422.62(b)(1), 422.74(b)(3), 422.74(d)(7), 422.506(a)(2), 422.508, 423.38(c)(6), 423.44(d)(6), 423.507(a)(2), and 423.508(c)

Plans are required to disenroll an individual if the plan's contract is terminated, discontinued, or if the service area is reduced and the individual's address is no longer within the plan's approved service area or continuation area. Plans must give each affected enrollee the effective date of the plan termination, non-renewal, or service area reduction, and include a description of alternatives for obtaining benefits under the Medicare program. Required time frames for these notices are outlined in §§ 422.506–422.513 and §§ 423.507–423.509.

Individuals who are disenrolled under these provisions have an SEP, as described in § 30.6.10, to elect a different MA or Part D plan or Original Medicare.

Exception: When an MAO discontinues offering an MA plan in a portion of its service area, the MAO can also elect to offer an option to continue enrollment in an MA local plan in the same organization to enrollees affected by the MA plan service area reduction, provided that no other MA plans are available in the affected area at that time (refer to § 20.3.1 for additional information on continuation areas). The organization may require an enrollee who chooses to continue enrollment to agree to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively through facilities designated by the organization within the plan service area.

60.2.8 – Material Misrepresentation Regarding Third-Party Reimbursement – Part D only

42 CFR §§ 423.44(b)(2)(v) and 423.44(c)(7)

If CMS determines an individual materially misrepresents information about third-party reimbursement coverage to the sponsor of a Part D plan, CMS requires that the individual be disenrolled from the plan. Involuntary disenrollment for this reason requires CMS approval. The Part D sponsor must submit any information it has regarding the claim of material misrepresentation to its CMS account manager for review. Disenrollment for material misrepresentation is effective the first day of the calendar month after the month in which the plan gives the individual written notice of the disenrollment.

60.3 – Optional Involuntary Disenrollments

42 CFR §§ 422.74(b)(1), 422.74(c), 422.74(d)(1)–(3), 423.44(b)(1), 423.44(c), and 423.44(d)(1)–(2)

If a plan adopts an involuntary disenrollment policy, it must be applied consistently to all enrollees.

Plans may disenroll an individual if:

- Premiums are not paid on a timely basis (§ 60.3.1);
- The enrollee engages in disruptive behavior (§ 60.3.2); or
- The enrollee provides fraudulent information on an enrollment request, or permits abuse of an enrollment card (§ 60.3.3)

In situations where the plan disenrolls the individual involuntarily for any of the reasons listed above, the plan sends a notice of the upcoming disenrollment (must be provided to the individual before the disenrollment is submitted to CMS) with the following:

- The reason the organization is planning to disenroll the individual;
- The effective date of the individual's disenrollment; and
- The individual's right to a hearing under the plan's grievance procedures.

60.3.1 – Failure to Pay Premiums

Section 504 of the Rehabilitation Act of 1973; 42 CFR §§ 422.74(b)(1)(i), 422.74(c), 422.74(d)(1), 422.74(d)(2)(c), 423.44(b)(1)(i), 423.44(c), 423.44(d)(1), 423.286(d)(3)

When an enrollee fails to pay the monthly basic and/or supplementary plan premiums, including any Part D late enrollment penalty, on a timely basis, the plan can opt to choose the following:

MA plan	Part D plan
• Do nothing (i.e., allow the member to remain enrolled in the same premium plan). • Disenroll the member after a grace period and proper notice. • Reduce the member's coverage if the member fails to pay the premium for optional supplemental benefits, but the member pays the premium for basic and mandatory supplemental benefits ("downgrade" coverage).	• Do nothing (i.e., allow the member to remain enrolled in the same PDP). • Disenroll the member after a grace period and proper notice.

MA-PD and PDP sponsors have the option to retain dually eligible enrollees and individuals who qualify for the low-income subsidy (LIS) who fail to pay premiums even if the plan has a policy to disenroll individuals for nonpayment of premiums, see § 60.3.1.3 for more information.

Disenrollment for failure to pay plan premiums is optional for each plan; however, plans must apply disenrollment policies consistently across all enrollees, including applying a consistent grace period of no less than two whole calendar months. During the calendar year plans may choose to increase the length of the initial grace period or establish a policy of not disenrolling individuals for failure to pay the plan premium as long as the new policy is applied consistently to all enrollees from that date forward.

> **Example:**
> A natural disaster affects three counties within a plan that services 10 counties. The plan increases their two-month grace period to six months to ease the burden for individuals affected by the natural disaster. The plan must provide this extended grace period to all enrollees in the PBP and not only those in the area affected by the natural disaster. The organization must report any changes to its policy for disenrollment for failure to pay premiums to its CMS account manager before implementing such changes.

Plans may not disenroll individuals who are considered to be in premium withhold status by CMS. Individuals who have requested premium withhold are considered to remain in premium withhold status until either:

- CMS notifies the organization that the premium-withhold request was rejected, failed, or been unsuccessful, or
- The enrollee requests to be billed directly.

Once the enrollee is considered to be in "direct bill" status, the plan must notify the enrollee of the premium owed and provide the appropriate grace period, as described below prior to disenrolling the individual.

However, even if an enrollee's premium payment status has been changed to "direct bill," if the enrollee can demonstrate that SSA or the Railroad Retirement Board (RRB) has withheld Part C and/or Part D premiums during the coverage month(s) in question, the enrollee will be considered to remain in premium withhold status. The individual **cannot** be disenrolled for failure to pay premium(s), whether or not the organization actually receives these premiums on a timely basis since by selecting the premium withhold option, the enrollee is deemed to have made a payment to the plan.

> **Example – Incorrect Continuation of Premium Withhold:**
> An individual was enrolled in Plan A and selected premium withhold. The individual subsequently enrolls in Plan B and does not select premium withhold. Upon receiving a direct bill from Plan B, the individual provides Plan B with proof that a premium deduction continues from their SSA benefit check. Since the enrollee provided Plan B with evidence that a premium amount is currently being deducted from his check, Plan B

cannot initiate the process to disenroll the individual for failure to pay premiums. Plan B must work with CMS to obtain appropriate premium reimbursement.

Further, an enrollee will continue to be considered in premium withhold status if a plan is notified by CMS that the enrollee's request for premium withholding is not successful as a result of systems or fund transfer issues between CMS and SSA or RRB, or between CMS and the plan. CMS recognizes that in some instances plans have not received premium amounts in their monthly CMS plan payment for enrollees who have elected SSA or RRB withholding. However, plans may not hold enrollees responsible for such issues, nor penalize them by attempting to disenroll them from their plan.

Example – Incorrect Data Due to Systems Miscommunication:
An enrollee requests premium withhold and Plan A correctly submits the request to CMS. The transaction request is submitted successfully by CMS to SSA or RRB and the appropriate premium amount is deducted from the enrollee's SSA or RRB benefit check. However, due to a systems issue between CMS and SSA or RRB, the premium withhold data is not correctly reflected in CMS systems. CMS does not pay the correct premium amount to Plan A. Plan A must work with CMS to obtain appropriate premium reimbursement and may **not** initiate the disenrollment process for the individual for failure to pay premiums while the premium continues to be withheld.

In addition, plans **may not** disenroll an individual or initiate the disenrollment process if the plan has been notified that an SPAP, or other payer is paying the Part D portion of the premium, and the plan has not yet coordinated receipt of the premium payments with the SPAP or other payer. (Refer to § 50.6 of Chapter 14 of the Medicare Prescription Drug Benefit Manual for additional information regarding coordination of premium payments).

Part C Policy:
Unless the individual elects another MA plan during an applicable election period, any disenrollment processed under these provisions will return the individual to Original Medicare.

60.3.1.1 – Partial Payments

42 CFR § 422.262

While plans may accept partial payments (i.e., less than one month's premium), it has the right to ask for full payment within the grace period. If the individual does not pay the required amount within the grace period, the effective date of disenrollment or reduction in coverage is the first day of the month after the grace period ends. **The plan has the right to take action to collect the unpaid premiums from the individual at any point during or after this process.**

60.3.1.2 – Calculating the Grace Period

42 CFR §§ 422.74(d)(1)(i)(B) and 423.44(d)(1)(iii)

Plans must provide enrollees with a grace period that:

- Is at least two whole calendar months;
- Is a whole number of calendar months and cannot include fractions of months; and

- Begins on the first day of the month for which the premium is unpaid, or the first day of the month following the date on which the plan bills the enrollee for the actual premium amount due, whichever is later.

NOTE: For individuals who have requested communications in an accessible format, the notification of unpaid premiums (e.g., the bill) are not considered delivered, and thus the grace period cannot begin until the organization fulfills its legal obligation, under Section 504 of the Rehabilitation Act of 1973, to provide the notification in an accessible format.

Option 1 – Plans may establish a grace period, not less than two whole calendar months, to start on the first day of the month for which the premium is unpaid, or the first day of the month following the date on which premium payment is requested, whichever is later.

If the overdue premium and all other premiums that become due during the grace period (in accordance with the terms of the enrollee's agreement with the plan) are not paid in full by the end of the grace period, the plan may terminate or reduce (if applicable) the enrollee's coverage. The enrollee must be notified of, or billed for, the actual premium amount due before the premium can be considered unpaid.

> **Example:**
> Plan QR has a three-month grace period for premium payment. The plan billed Mrs. Stone in June. Mrs. Stone's premium was due on July 1. She did not pay this premium and on July 6, the plan sent an appropriate notice of her delinquency. The enrollee ignores this notice and all subsequent premium bills. The grace period is the months of July, August, and September (three months). If she does not pay her July, August, and September premiums by the last day of September, she will be disenrolled from the plan, effective October 1.

Option 2 – Plans may use a "rollover" approach in applying the grace period

Under the "rollover" approach, the grace period would begin on the first day of the month for which the premium is unpaid, or the first day of the month following the date on which the plan bills. If the overdue premium for that month is not paid by the end of the grace period, the plan may terminate or reduce (if applicable) the enrollee's coverage. With this option, disenrollment occurs only if the unpaid premium on which the grace period began is not paid in full by the end of that period; subsequent premiums that become due during the grace period are not a factor in the plan's decision to disenroll at the end of that period. If the enrollee pays the premium for the first month of the grace period in full by the end of that period, the individual is not disenrolled. Failure to pay the premium for a subsequent month establishes a new grace period and a new disenrollment date. This process continues until the enrollee resolves the delinquency prior to expiration of the grace period and is not delinquent for any subsequent months.

Plans are not required to issue new notices each time the enrollee submits a partial premium payment (i.e., less than one month's premium), since this would not result in a change in the proposed disenrollment date. However, since payment of at least one month's past due premium causes the disenrollment date to "roll over" (i.e., move forward) commensurate with the number of month's premium received, plans must issue a notice warning of the potential for involuntary

disenrollment (see Exhibit 19) whenever payment of at least one month of premiums is received during the grace period. The notice includes the new disenrollment date and should be sent within 15 calendar days of the date the premium was due.

> **Example:**
> Plan XY has decided to offer a two-month grace period for nonpayment of plan premiums and has chosen the "rollover" approach to calculate the grace period. The plan bills Mr. Smith in December for the January premium. Mr. Smith fails to pay his January premium due January 1. The plan sends a notice to him on January 7 stating that his coverage will be terminated if the outstanding premium is not paid within the grace period. The notice advises him that his termination date would be March 1 (end of the two-month grace period). Mr. Smith then pays the January premium prior to the end of the two-month grace period (February 28), but does not pay the February premium, which the enrollee was billed for in January. A new two-month grace period is established which begins on the first of the next month for which the premium is unpaid (February 1). On February 9, the plan sends a notice to Mr. Smith reflecting the new grace period and the new anticipated termination date of April 1. The enrollee pays the premium for February before the grace period expires (April 1); therefore, the enrollee's coverage in the plan remains intact.

60.3.1.3 – Optional Exception for Dual-Eligible Individuals and Individuals who Qualify for the Low-Income Subsidy

MA-PD and PDP sponsors have the **option** to retain dually eligible enrollees and individuals who qualify for the low-income subsidy (LIS) who fail to pay premiums, even if the plan has a policy to disenroll individuals for nonpayment of premiums. For MA-only plans, organizations may retain individuals who are dually eligible for both Medicare and Medicaid.

If the MAO or Part D sponsor offers this option in one of its plans, it must apply the policy to all such individuals in that plan.

CMS requires plans to provide enrollees advance notice of this policy, and any yearly changes to the policy. Plans have the discretion as to how it will notify its enrollees (e.g., in an upcoming newsletter or other member mailing, such as the Annual Notice of Change). CMS recommends a general statement in such notifications to avoid confusing other enrollees for whom this policy does not apply.

> **Example:**
> "If you have Medicaid or extra help in paying for your Medicare prescription drugs and are having difficulty paying your plan premiums or cost sharing, please contact us."

A plan must report any changes to its policy for disenrollment for failure to pay premiums to its CMS account manager before implementing such changes.

Part C Policy:
The policy to retain individuals is based upon nonpayment of premiums for the standard benefit package of the MA plan. If the organization chooses this option, dually and other LIS-eligible individuals who fail to pay premiums for any optional supplemental benefit offered would be downgraded to the standard benefit package within that MA plan.

60.3.1.4 – Disenrollment Processing for Failure to Pay Premiums

42 CFR §§ 422.74(d)(1), 423.44(d)(1)

Plans must always provide enrollees the opportunity to pay premiums owed before initiating any disenrollment action.

If the plan chooses to disenroll an individual for failure to pay monthly premiums, the steps include:

Step 1. Plan demonstrates to CMS that it made a resonable effort to collect the unpaid premium amount.

Step 2. Plan alerts the enrollee that the premiums are delinquent.

Step 3. Plan provides the member with a grace period, that is, an opportunity to pay past due premiums in full. The length of the grace period must:

- Be at least two whole calendar months; and
- Begin on the first day of the month for which the premium is unpaid or the first day of the month following the date which premium payment is requested, whichever is later.

Step 4: Plan explains whether full payment within the grace period is required to avoid termination of enrollment.

Step 5. Plan provides the individual a notice of the disenrollment within three business days following the last day of the grace period:

- Explains why the individual is being disenrolled and effective date of disenrollment
- Informs of individual's rights under the plan's grievance procedures

Step 6. Plan submits the disenrollment transaction to CMS within three business days following the last day of the grace period; however, in no case may the disenrollment notice to the individual be sent after the transaction is submitted to CMS.

Once an individual is disenrolled for failure to pay premiums:

- Plan can decline re-enrollment in the plan until payment of any outstanding past due premiums is received.
- Re-enrollment or enrollment in another plan must be requested during a valid election period.

Payment of past due premiums after the disenrollment date does not create an opportunity for reinstatement into the plan from which the individual was disenrolled for failure to pay premiums, except that CMS (or an entity acting on behalf of CMS) may reinstate enrollment, without interruption of coverage, if the individual demonstrates good cause and pays all of the overdue premiums within three calendar months of the disenrollment date. For more information on good cause, see § 70.3.5. Likewise, disenrollment for failure to pay premiums does not, in itself, provide the individual an SEP to enroll in a different plan.

60.3.2 – Disruptive Behavior

42 CFR §§ 422.74(d)(2), 422.74(e)(1), 423.44(b)(1)(ii), and 423.44(d)(2)

A plan may request to disenroll an individual whose behavior is disruptive. Per §§ 422.74(d)(2) and 423.44(d)(2), an enrollee is disruptive if the enrollee's behavior substantially impairs the plan's ability to arrange or provide for services to the individual or other plan enrollees. Circumstances that may constitute or provide evidence of disruptive behavior include:

- Contracted providers of the plan in which the individual is enrolled refuse to see or treat the individual due to their behavior or actions;
- Incidents of physical violence or threats of harm that significantly impair the plan's ability to provide services to the individual or other enrollees;
- Abusive, inappropriate, or obscene language that is accompanied by an act of violence, by a threat of harm or perceived as a threat of harm by a provider, other patient, or plan employee; and
- Inappropriate conduct.

Circumstances that do not constitute disruptive behavior that may substantially impair the plan's ability to provide care include, but are not limited to:

- An individual exercising their right to pursue alternate treatment, to ignore medical advice, or to refuse a treatment regimen or diagnostic testing, even if the plan or provider disagrees with the individual's choice;
- An individual's behavior that can be attributed to a medical or mental health condition for which they are receiving services;
- Frequent calls to the plan.

The plan may disenroll an individual for disruptive behavior only after it has met the requirements of 42 CFR §§ 422.74(d)(2) and 423.44(d)(2) and has CMS' approval. Before requesting CMS' approval of disenrollment for disruptive behavior, the plan must make a serious effort to resolve the problems presented by the individual.

CMS recognizes that in many instances, plans request disenrollment after a pattern of disruptive behavior emerges. Under federal law, a serious effort to resolve the individual's issues means that the plan is expected to:

- Work with the individual to address concerns, seek solutions to meet the individual's needs, and continue to provide services to the individual;
- Provide a reasonable amount of time for the individual to demonstrate the ability to act appropriately, with efforts taken prior to submitting any requests for involuntary disenrollment to CMS;
- Inform the individual of their inappropriate behavior and consequences of this behavior in writing at the time such behavior occurs, including the member's right to file a grievance so that the individual is provided fair notice of the behavior to correct; and
- Determine on a case-by-case basis if a reasonable amount of time has passed for the individual to show improvement prior to submitting a request for involuntary disenrollment. Generally, this should be based on the frequency of receipt of services, the frequency of the continued inappropriate behavior, and the severity of the continued action.

CMS reviews and approves all involuntary disenrollment requests for disruptive behavior on a case-by-case basis considering all of the facts and circumstances. Plans must submit documentation of the specific case to CMS for review. The plan's request for involuntary disenrollment for disruptive behavior should include:

- Specifics of the disruptive behavior, including dates, locations, and actions;
- Explanation of how the individual's disruptive behavior has impacted the plan's ability to arrange for or provide services to the individual or other enrollees of the plan;
- Enrollee information, including diagnosis, mental status, functional status, and any other relevant information related to the individual's condition or ability to access services (e.g., unable to transport oneself to provider facilities, etc.);
- Statements and supporting documentation of the plan's serious efforts to resolve the problem with the individual; and
- Statements and supporting documentation that the plan provided the individual with appropriate notice of the inappropriate behavior, the consequences of the continued disruptive behavior, and the rights for the member to file a grievance.
- Statements of the plan's effort to provide reasonable accommodations for enrollees with disabilities in accordance with the Americans with Disabilities Act (if applicable);
- Any written statements (email or letter) from the plan or providers describing their experiences with the individual (and refusal to see or treat the individual) and a description of any extenuating circumstances cited under 42 CFR §§ 422.74(d)(2)(iii) and (iv) or 423.44(d)(2)(iii) and (iv);
- Any information provided by the individual related to the behavior that demonstrates their issues with the plan (e.g., complaints, statements).

Advance Notice

The Advance Notice notifies the individual of the adverse impact of their behavior and provides the individual an opportunity to cease the inappropriate behavior and remain enrolled in the plan.

If the disruptive behavior ceases after the individual receives the advance notice and then later resumes, the plan must begin the process again. The dated copy of the advance notice sent to the individual must be provided to CMS for documentation purposes and to establish that the plan complied with 42 CFR §§ 422.74(d)(2)(iii) and 423.44(d)(2)(iii).

CMS' Review of the Proposed Disenrollment
A plan submits disenrollment requests to its CMS Account Manager. Involuntary disenrollment requests should include all information that fulfills the requirements listed in this section, as the plan bears the burden of providing the information necessary to substantiate its request. CMS will review this documentation, consulting with the appropriate clinical staff and then decide whether the plan may involuntarily disenroll the individual. CMS will not review incomplete requests that do not include all of the information described in this section.

CMS will make the decision within 20 business days after it receives all required information and will notify the plan within five business days after making its decision.

The CMS account manager will obtain CMS Central Office concurrence before approving an involuntary disenrollment. The disenrollment is effective the first day of the calendar month after the month in which the plan gives the individual a written notice of the disenrollment, or as provided by CMS.

If the request for involuntary disenrollment for disruptive behavior is approved, CMS may require the plan to provide reasonable accommodations to the individual in such exceptional circumstances that CMS deems necessary. An example of a reasonable accommodation in this context is that CMS could require the plan to delay the effective date of involuntary disenrollment to coordinate with an MA or Part D enrollment period that would provide the individual an opportunity to obtain other coverage. If necessary, CMS will establish an SEP on a case-by-case basis.

Disenrollment Notice
After CMS notifies the plan of its approval of the disenrollment, the plan must provide the individual with a written notice that contains information stating the disenrollment was a result of the repeated behavior included in the Advance Notice. The written notice must include a statement that this disenrollment action was approved by CMS and meets the requirements for disenrollment due to disruptive behavior.

The plan can submit the disenrollment transaction to CMS after providing the disenrollment notice to the individual. The disenrollment is effective the first day of the calendar month after the month in which the plan gives the individual a written notice of the disenrollment, or as provided by CMS.

NOTE: For incidents of physical violence or threats of harm, the plan should engage local law enforcement to address the situation.

Any disenrollment processed for an MA enrollee under these provisions will always result in a change of enrollment to Original Medicare.

60.3.3 – Fraud and Abuse

42 CFR §§ 422.74(d)(3) and 423.44(b)(2)(v)

A plan may request to cancel the enrollment of an individual who knowingly provides, on the enrollment request form or by another enrollment request mechanism, fraudulent information that affects the determination of the individual's eligibility to enroll in the plan. The plan may also request to disenroll an individual who intentionally permits others to use their enrollment card to obtain services or supplies from the plan or any authorized plan provider.

Plans must provide the individual with a written notice of the disenrollment. This disenrollment is effective the first day of the calendar month after the plan provides the individual with the written notice. When such a cancellation or disenrollment occurs, the plan must immediately notify the CMS RO so the Office of the Inspector General may initiate an investigation of the alleged fraud and abuse.

NOTE: Any disenrollment processed for MA enrollees under these provisions will always result in a change of enrollment to Original Medicare.

60.4 – Disenrollment Procedures for Medicare MSA Plans

42 CFR §§ 422.62(d)(2), 422.74(b)(2)(vi), 422.74(d)(10), 422.74(e)(1)

Enrollees of Medicare MSA plans may only disenroll in writing through the MAO offering the Medicare MSA plan. Disenrollment through 1-800-MEDICARE is not accepted. MAOs offering Medicare MSA plans must otherwise follow the disenrollment policies and procedures outlined in this chapter.

Election periods and effective dates for disenrollment from Medicare MSA plans are outlined in § 30.9.

If an enrollee of a Medicare MSA plan no longer meets the MA MSA's eligibility criteria due to a mid-year change in eligibility, they must be disenrolled. The disenrollment is effective the first day of the calendar month following the MAO's notice to the individual that they are ineligible.

The plan must provide the individual with a written notice of the disenrollment with an explanation of why the MAO is planning to disenroll the individual. This notice must be provided to the individual before submission of the disenrollment to CMS. The notice must include an explanation of the individual's right to submit a grievance under the MAO's grievance procedures.

Any disenrollment processed for an MA enrollee due to loss of eligibility will always result in a change of enrollment to Original Medicare.

70 – Post-Enrollment Activities

42 CFR §§ 422.60, 422.66, 423.32, and 423.36

Post-enrollment activities occur after the plan receives the enrollment request from the individual (e.g., cancellations) and lasts until a decision is made with respect to an individual's enrollment request (e.g., retroactive transactions).

Post-enrollment activities include:

- Enrollment and disenrollment cancellations;
- Enrollment reinstatements; and
- Retroactive enrollments and disenrollments.

70.1 – Multiple Transactions

Multiple transactions occur when CMS receives more than one enrollment request for the same effective date. An individual may generally not be enrolled in more than one MA, Cost, or PDP plan 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 the individual makes during an enrollment period will be accepted as the plan into which the individual intends to enroll. If an individual elects more than one plan for the same effective date and with the same application date, the first transaction successfully processed by CMS will take effect. When simultaneous enrollment in certain MA plan types and a separate PDP is permitted, CMS systems will accept both enrollments.

Example:
Two MAOs receive enrollment forms from one individual for an April 1 effective date. MAO #1 receives a form on March 4 and MAO #2 receives a form on March 10 for an April 1 effective date. Both organizations submit enrollment transactions, including the applicable effective date and application date. The enrollment in MAO #2 will be the transaction that is accepted and will be effective on April 1 because the application date on the enrollment transaction is the later of the two submitted. Both plans receive the appropriate reply on the DTRR.

Example:
Two PDP sponsors receive enrollment requests from one individual for an April 1 effective date. PDP #1 receives a paper enrollment form with all required information on March 5. The individual completed an enrollment request for PDP #2 by telephone on the same day, March 5. Both enrollment requests have the same application date since they were received by the PDP on the same date. PDP #1 transmitted the enrollment to CMS on March 5, the day it received the enrollment request; however, PDP #2 waited until March 8 to transmit the enrollment to CMS. The enrollment for PDP #1 will be the transaction that is effective on April 1, as it was the first transaction successfully processed by CMS.

In the event a rejection for multiple transaction is reported to the plan, the MAO or Part D sponsor may contact the individual. If the individual wishes to enroll in a plan offered by the organization that received the multiple transaction reject, they must submit a new enrollment request during a valid enrollment period.

70.2 – Cancellations

A cancellation is an action taken by an individual to stop an enrollment or disenrollment request **prior to the effective date**. An individual may cancel their enrollment or disenrollment request by contacting the plan. Since a cancellation is not an election, an individual does not need an election period to request a cancellation. For enrollments into employer or union sponsored plans, cancellations received by the employer or union prior to the enrollment effective date are also acceptable.

> **Example:**
> Ms. Stears is an enrollee of Plan A. On November 12 (during the AEP), Ms. Stears contacts Plan B to request enrollment for a January 1 effective date. Plan B processes her request and receives confirmation from CMS that the enrollment will be effective for January 1. On December 21, Ms. Stears contacts Plan B again to say she has changed her mind and wants to stay with Plan A. Plan B must process an enrollment cancellation transaction.

A plan may accept a cancellation by phone, in writing, or in person. If a plan receives a verbal cancellation, it should document the verbal request. Plans have the right to request that a cancellation be in writing; however, the plan may not delay processing a cancellation once they have received the verbal cancellation. For facilitated enrollment as described in § 40.1.8 of this chapter, an individual may cancel (i.e., opt out of) the enrollment and affirmatively decline Part D benefits by telephone. The Part D sponsor may not require these cancellations in writing.

In some cases, CMS may be unable to automatically reinstate a prior enrollment after a successful cancellation. It may be necessary to take actions to restore the individual's prior coverage. Refer to §§ 70.3 and 70.4.

70.2.1 – Cancellation of Enrollment or Disenrollment

Cancellations received by the plan before submission of the enrollment or disenrollment transaction to CMS are processed internally by the plan. The enrollment or disenrollment transaction is not submitted to CMS. A cancellation transaction is not necessary.

> **Example:**
> Mr. Jones enrolls in Plan A with an effective date of January 1. On July 16, Mr. Jones is eligible for an election period and submits an enrollment request to enroll in Plan B for an effective date of August 1. On July 20, he changes his mind and decides he no longer wants to be enrolled in Plan B. Mr. Jones calls Plan B and requests that they cancel his enrollment request. Since Plan B has not yet submitted the enrollment transaction to CMS, Plan B does not need to submit a cancellation transaction to CMS. Plan B sends a cancellation notice to the individual.

Example:
Ms. Louis requests to disenroll from her current plan on April 11 for an effective date of May 1. Before the plan sends the disenrollment transaction to CMS, she changes her mind and requests to cancel the disenrollment on April 15. The plan does not submit the disenrollment transaction to CMS. A cancellation transaction is not necessary.

If the plan transmitted the enrollment/disenrollment transaction to CMS before it received the valid request for cancellation from the individual, it must submit a cancellation transaction to CMS to cancel the now-void enrollment/disenrollment transaction. In the event the cancellation transaction fails (i.e., rejects in MARx although the request to cancel is valid), plans must promptly submit the request to cancel the enrollment/disenrollment to the RPC.

Example:
Mr. Brown enrolls in Plan A (a PDP) with an effective date of January 1. On July 16, Mr. Brown is eligible for an election period and submits an enrollment request to enroll in Plan B (an MA-PD) for an effective date of August 1. On July 20, he realizes his drug coverage will change and wants to keep the drug coverage he currently has in Plan A. He calls Plan B and requests that they cancel the enrollment request. Since Plan B has already submitted the enrollment transaction to CMS, Plan B will need to submit an enrollment cancellation transaction to CMS.

Example:
Ms. Williams is enrolled in Plan A. On April 10, she requests to disenroll from Plan A. After Plan A submits the disenrollment transaction to CMS, she changes her mind on April 20. Plan A submits a disenrollment cancellation transaction and reinstates Ms. Williams into the plan.

A plan may cancel only those enrollment or disenrollment transactions it submitted to CMS. MARx accepts a cancellation only from the entity that submitted the enrollment/disenrollment transaction being cancelled. To cancel an enrollment, the plan must submit an enrollment cancellation transaction (TC 80) with an effective date equal to the effective date of the enrollment being cancelled. To cancel a disenrollment, the plan must submit a cancellation of disenrollment transaction (TC 81) with an effective date equal to the effective date of the disenrollment being cancelled.

CMS suggests plans processing the cancellation request notify individuals within 10 calendar days of receipt of the cancellation request. The notice includes:

- Instruction to the individual to continue using the MA and/or Part D services offered by the plan in which they are currently enrolled; and
- For enrollment cancellations, instruction for the individual to contact their previous plan to confirm enrollment if not automatically enrolled back into that plan.

If the individual's cancellation request is received by the plan after the effective date of the enrollment or disenrollment, the cancellation generally cannot be processed.[2] The plan must inform the individual that they are an enrollee of its plan. Any change to enroll in another plan after coverage begins requires a valid enrollment period and will have a prospective effective date.

An individual enrolled in an MA plan who cancels a request to enroll in a different plan remains enrolled in their current MA plan. The individual does not have the option of switching to Original Medicare instead of continuing enrollment in the same MA plan.

Cancellation of Medicare MSA Enrollment Request – Part C only:

An individual who elects a Medicare MSA plan during the AEP, and who has never before enrolled in a Medicare MSA plan, may cancel that enrollment request by December 15 of the year in which they requested enrollment in the Medicare MSA plan. This cancellation will ensure the enrollment request does not go into effect on January 1. An individual who cancels an MSA enrollment request after the end of the AEP on December 7 must be eligible for an election period other than the AEP if they wish to request enrollment in a plan for a January 1 effective date. See 42 CFR § 422.62(d)(2)(ii).

70.2.2 – Cancellation Transaction Rejection by CMS Systems (TRC 284)

When a plan receives a TRC 284 (Cancellation Rejected), the plan must investigate the circumstances behind the rejection in order to ensure proper processing of an enrollment transaction. If the rejection was due to incorrect data on the transaction, the plan must correct the data and resubmit it to CMS. If the rejection was due to an error the plan is unable to resolve, and the request to cancel is valid, the plan must promptly submit the request to CMS (or the RPC) for resolution and contact the MA-PD Help Desk (1-800-927-8069) to report not being able to submit the cancellation.

70.2.3 – Cancellation Due to Notification from CMS (TRC 015)

A plan receives a TRC 015 (Enrollment Removed) to indicate that an enrollment it received has been cancelled; CMS systems will reflect the enrollment as never having taken effect. A cancellation may be the result of an action on the part of the individual, CMS, or another plan.

Upon receipt of TRC 015, CMS encourages the plan to notify the individual of the enrollment cancellation.

[2] An exception to this is a cancellation request during the Outbound Education and Verification (OEV) process. A cancellation request received during the OEV can extend past the effective date of enrollment, only if the 15-day time frame to complete the OEV process extends the cancellation deadline past the effective date of enrollment. An enrollee has seven days from the date of the letter or call (i.e., successful OEV contact), or the last day of the month in which the enrollment was submitted, whichever is later to cancel their enrollment.

70.3 – Reinstatements

A reinstatement is a correction made by a plan, CMS (or the RPC) to "reverse" a disenrollment and restore the individual to their enrollment status as if the disenrollment had not occurred. A reinstatement does not require an election period, as it is not a new enrollment request. A reinstatement may be made back to a date when a plan was closed for enrollment. The most common reasons for reinstatements are:

1. Disenrollment due to erroneous death indicator;

2. Disenrollment due to erroneous loss of Medicare Part A or Part B indicator or Part D eligibility;

3. Disenrollment due to erroneous incarceration or unlawful presence information;

4. Individual cancellation of new enrollment;

5. Plan error; or,

6. Demonstration of good cause for failure to pay plan premiums or Part D-IRMAA timely.

CMS (or the RPC) will review requests for reinstatements on a case-by-case basis.

70.3.1 – Reinstatements for Disenrollment Due to Erroneous Death Indicator, Loss of Part A or Part B Entitlement or Loss of Part D Eligibility

When a disenrolled individual contacts the plan to state that they were disenrolled in error and states that they want to remain an enrollee of the plan, the plan should send the individual notification within 10 days, which acknowledges the erroneous disenrollment, and instructs the enrollee to continue to use plan services. Accordingly, plan systems should indicate active enrollment as of the date the plan instructs the individual to continue to use plan services.

Erroneous disenrollments must be corrected and the corresponding reinstatements processed, since the individual remains eligible, regardless of the date on which the individual disputes the erroneous disenrollment or provides evidence of MA or Part D eligibility.

NOTE: CMS will attempt to automatically reinstate individuals that were auto-disenrolled by a report of date of death if there is a subsequent date of death correction that impacts the plan enrollment.

70.3.2 – Reinstatements for Disenrollment Due to Erroneous Incarceration or Unlawful Presence Information

Individuals alleging disenrollment due to erroneous incarceration information or erroneous unlawful presence status must have their complaints reviewed by the plan and possibly referred

to SSA. Plans are not required to provide coverage to such individuals while the issue is reviewed by the plan or SSA.

In these instances, plans:

(1) Check CMS' systems to see if the incarceration or unlawful presence status has been removed (via MARx), and

(2) Ensure that the individual is otherwise eligible to remain enrolled as of the disenrollment effective date.

If CMS systems show that the erroneous incarceration or unlawful presence information has been corrected, the reinstatement request may be sent to the CMS RPC instead of referring the individual to SSA. However, if CMS systems continue to reflect an incarcerated or unlawful presence status, the plan should refer the individual to SSA so that they may review their records and make corrections, as appropriate. If SSA determines the information or status to be erroneous, CMS systems will be updated. The plan will receive notification of the individual's reinstatement from CMS via the DTRR. At that time, services should resume and coverage should be seamless, as though the individual was never disenrolled.

CMS suggests that the plan send the enrollee notification of the reinstatement (MA Exhibit 25a; Part D Exhibit 22a) within 10 days of receipt of DTRR confirmation of the individual's reinstatement.

70.3.3 – Reinstatements Based on Individual Cancellation of New Enrollment

42 CFR §§ 422.60 and 423.32

As stated in § 60.1.4 deliberate individual-initiated disenrollments imply intent to disenroll. Therefore, reinstatements generally will not be allowed if the individual intentionally initiated a disenrollment. An exception is made for those individuals who were automatically disenrolled because they enrolled in another plan but subsequently cancelled the enrollment in the new plan before the effective date.

If an individual changes their mind and does not want to change to a different plan, the individual must request to cancel the enrollment into the new plan prior to the effective date, as described in § 70.2.1.

When a cancellation of enrollment in a new plan is correctly submitted and processed:

1) The associated automatic disenrollment from the previous MA or Part D plan becomes invalid;

2) CMS systems will attempt to automatically reinstate enrollment in the previous plan; therefore, a request for reinstatement via the RO or RPC is not needed; and

3) Within 10 days of receipt of DTRR confirmation of the individual's reinstatement, the organization from which the individual was disenrolled must send the individual notification of the reinstatement.

The reinstatement notice should include:

- Confirmation of the individual's enrollment in the previous plan with no break in coverage;
- Plan specific information (i.e., membership card, benefits), as needed; and
- Plan contact information.

In cases where a valid cancellation request is not processed timely or CMS systems cannot complete the request, the new plan submits a request to the RPC to cancel the enrollment. This request will require complete documentation, including evidence that the individual requested cancellation of enrollment in the new plan within required time frames.

If the previous plan becomes aware of an unsuccessful reinstatement, the previous plan may contact a CMS Account Manager to investigate the issue with the new plan. In addition, the previous plan may refer the individual to the "new" plan to inquire about their options since the disenrolled individual contacted the previous plan requesting to remain an enrollee of that plan.

70.3.4 – Reinstatements Due to Plan Error

When an erroneous disenrollment is the result of plan error, the plan reinstates the individual that was disenrolled.

Additionally, if the plan previously submitted the disenrollment transaction to CMS, the plan must cancel the disenrollment action from CMS's records. Plans must use the disenrollment cancellation function to complete this action for effective dates within the parameters that CMS systems allow for such corrections. Plans should refer to the RPC's Standard Operating Procedures (SOP) for processing retroactive enrollment and disenrollment requests available at http://www.reedassociates.org/retroactive-processing-sops/).

70.3.5 – Reinstatements Based on a Determination of Good Cause for Failure to Pay Plan Premiums or Part D-IRMAA Timely

42 CFR §§ 422.74(d)(1)(v) and 423.44(d)(1)(vi)

If an individual has been involuntarily disenrolled for failure to pay either plan premiums (under § 60.3.1) **or** Part D-IRMAA (under § 60.2.5), they may request reinstatement for good cause, pursuant to 42 CFR §§ 422.74(d)(1)(v) and 423.44(d)(1)(vi), only when:

1. The request is received by the plan or CMS within 60 days of the individual's disenrollment effective date; and

2. The individual has not previously requested reinstatement for good cause during the same 60-day period following the involuntary disenrollment; and
3. The individual shows good cause for failure to pay within the initial grace period; and
4. The individual pays the plan premiums that were owed at the time of disenrollment, **in full,** within three months of the disenrollment; and
5. The individual establishes by a credible statement that failure to pay premiums within the initial grace period was due to circumstances for which the individual had no control, or which the individual could not reasonably have been expected to foresee; and
6. Where applicable, the individual pays the Part D-IRMAA, that was owed at the time of disenrollment, **in full,** within three months of the disenrollment.

Reinstatement of enrollment for good cause is provided only in rare circumstances in which the individual or their authorized representative was unable to make timely payment due to circumstances over which they had no control, or they could not reasonably have been expected to foresee. Requests for reinstatement must be accompanied by a credible statement (verbal or written) explaining the unforeseen and uncontrollable circumstances causing the failure to make timely payment. An individual may not make more than one reinstatement request for good cause during the same 60-day period.

Generally, these circumstances constitute good cause:

- A serious illness, institutionalization and/or hospitalization of the individual, or their authorized representative, which lasted for a significant portion of the grace period for the payment of the plan premium or Part D-IRMAA;
- Extended illness that is not chronic in nature, a serious (unexpected) complication to a chronic condition or rapid deterioration of the health of the enrollee, a spouse, another person living in the same household, person providing caregiver services to the individual, or the individual's authorized representative that occurs during the grace period for the payment of the plan premium or Part D-IRMAA;
- Recent death of a spouse, immediate family member, person living in the same household, person providing caregiver services to the individual, or the individual's authorized representative;
- Enrollee's home was severely damaged by a fire, natural disaster, or other unexpected event, such that the individual or the individual's authorized representative was prevented from making arrangement for payment of the plan premium or Part D-IRMAA during the grace period;
- An extreme weather-related, public safety, or other unforeseen event, declared as a federal or state level of emergency, prevented payment of the plan premium or Part D-IRMAA at any point during the grace period. For example, the enrollee's bank or U.S. Post Office was closed for a significant portion of the grace period; or,
- For disenrollments effectuated by CMS for failure to pay Part D-IRMAA, federal government error (i.e., CMS, SSA, or RRB) caused the Part D-IRMAA payment to be incorrect or late, and the enrollee was unaware of the error or unable to take action prior to the disenrollment effective date.

There may be situations in addition to those listed above that result in a favorable good cause determination. If an individual presents a circumstance which is not captured in the listed examples, it must meet standards at §§ 422.74(d)(1)(v)(C) and/or 423.44(d)(1)(vi) and (e) of being outside of the individual's control or unexpected such that the individual could not have reasonably foreseen its occurrence, and this circumstance must be the cause for the nonpayment of plan premiums or Part D-IRMAA. CMS expects circumstances constituting good cause to be rare.

Examples of circumstances that **do not** constitute good cause include:

- Allegation that bills or warning notices were not received due to unreported change of address or because the individual was out of town for personal non/emergency reasons, such as a vacation;
- Authorized representative did not pay timely on the individual's behalf;
- Lack of understanding of the ramifications of not paying plan premiums or Part D-IRMAA;
- Could not afford to pay premiums during the grace period; or
- Need for prescription medicines or other plan services.

For examples of cases for favorable and unfavorable good cause determinations, see Appendix 4.

For the purpose of determining good cause for enrollees with authorized representatives, the criteria for both favorable and unfavorable determinations apply as though the authorized representative is the enrollee.

In addition, good cause determinations are not organization determinations related to coverage and, therefore, are not appealable, see 42 CFR §§ 422 and 423, subpart M. However, an individual has the right to file a grievance against the plan related to the involuntary disenrollment.

NOTE: Requests for reinstatement for good cause related to nonpayment of plan premiums and/or Part D-IRMAA are not considered complaints against the plan; therefore, these types of Complaint Tracking Module (CTM) cases are excluded from tracking for the purposes of plan ratings.

70.3.5.1 – Process for Good Cause Determinations for Nonpayment of Plan Premiums

Pursuant to 42 CFR §§ 422.74(d)(1)(v) and/or 423.44(d)(1)(vi), plans process good cause determinations for failure to pay premiums.

When an individual initially contacts the plan following disenrollment for failure to pay plan premiums and indicates that they "have a good reason for not having paid the premiums", the plan must:

Step 1. Confirm that the request for reinstatement is being made within 60 calendar days of the disenrollment effective date.

Step 2. Inform the individual that reinstatement is a possibility only if it is determined that their failure to make timely payment was due to circumstances over which they had no control OR could not reasonably have been expected to foresee.

Step 3. Obtain a credible statement from the individual regarding the circumstance that prevented them from making timely payment.

Step 4. Obtain affirmation from the individual indicating their willingness and ability to pay all overdue plan premiums within three months of the disenrollment date in order for reinstatement to occur.

Step 5: Review the request and make a favorable or unfavorable good cause determination.

- If Steps 1-4 are met, CMS expects that plans will make such determinations within five business days of initial receipt of the request, so that the individual has a reasonable amount of time to make full payment for reinstatement.
- If the individual does not indicate that an unusual or unexpected circumstance caused the nonpayment of premiums, the plan should clearly communicate that the request will not be reviewed further and it does not meet the criteria for reinstatement. The individual remains disenrolled and they may not make another request for good cause during the same 60-day period following the involuntary disenrollment.

Reinstatement request received by:	Date/Time considered received by the plan
Mail	Request arrives in the organization's mailbox or mailroom
Fax	Request is received on the organization's fax machine
Telephone	Organization's representative receives the incoming call

Plans would need to collect any additional data that is needed to make a determination and make that determination within five business days of the date on which the individual first contacts the plan. In such cases where the plan does not have sufficient information to determine if the enrollee's circumstances meet the requirements, it should make a good faith effort to collect it within that time frame (e.g., making multiple attempts on different days or at different times). However, if attempts are unsuccessful, the plan must use the information provided with the initial request to make its determination.

Favorable Determinations

If the plan makes a favorable determination and there are past due premium amounts owed to the plan, the plan should notify the individual of this decision within three business days of making the determination. If the plan offers immediate payment options, such as payment by credit card via phone, it may provide the notification verbally; however, if the individual does not complete the payment at that time, the plan should issue a written notice to ensure that the individual has the information necessary to pay the owed amounts. This notice should include:

- Amount owed (i.e., the premiums owed at the time of disenrollment),
- Date by which payment must be received for reinstatement (i.e., last day of the third month following the disenrollment effective date),
- Where to send payment, and/or
- All payment options available, such as credit card or direct withdrawal from a bank account, if offered by the plan.

If, at the time the plan makes a favorable determination, there are no amounts owed to the plan for past due premiums, the plan should notify the individual of this decision either verbally or in writing within three business days of making the determination. If verbal notification is attempted but unsuccessful, a written notice should be provided. Verbal notification must be documented by the plan to meet CMS' RPC reinstatement submission requirements.

Reinstatements for good cause are considered complete when the plan receives a TRC 287 (Enrollment Reinstated) from CMS.

Plans have additional time beyond the deadline (i.e., three months from the disenrollment effective date) to verify payment by the bank and credit the payment to the individual's account with the plan. To provide adequate protections for individuals who make timely payment of their owed amounts, plans have five calendar days beyond the payment deadline to process the payment and submit the reinstatement request to the CMS RPC.

An individual **may not** be reinstated in cases where:

- The individual pays all plan premiums owed but does not receive a favorable good cause determination.
- The individual receives a favorable good cause determination but does not pay the plan premiums owed within three months of the disenrollment effective date.

In both of the circumstances above, the plan may re-enroll the individual for a prospective enrollment effective date at the individual's request only **if** the individual has a valid election period (i.e., AEP, SEP, etc.)—see §§ 30 and 50.

Example 1:
Mr. Smith is disenrolled for failure to pay plan premiums on April 1 (after the plan's required grace period expired). Mr. Smith contacts the plan and makes his request for reinstatement on April 15 and receives a favorable good cause determination on April 23. On April 21, the plan notifies Mr. Smith of the amount that he must pay by June 30 in order to be reinstated

into the plan. Mr. Smith pays the amount due on June 15. Mr. Smith is reinstated into the plan. (Note: If Mr. Smith did not pay his owed amount by June 30, he would not be reinstated.)

Example 2:
Mr. Smith is disenrolled by the plan for failure to pay plan premiums on July 1 (after the plan's required grace period expired). Mr. Smith mails in his past due premium payment amount to the plan on July 30. He contacts the plan and makes his request for reinstatement on August 10 and does **not** receive a favorable good cause determination. Mr. Smith may not be reinstated.

Example 3:
Mr. Smith is disenrolled by the plan for failure to pay plan premiums on November 1 (after the plan's required grace period expired). Mr. Smith mails in his past due premium payment amount to the plan on December 15 but does not contact the plan to request reinstatement. Because Mr. Smith does not have a favorable good cause determination, he may not be reinstated.

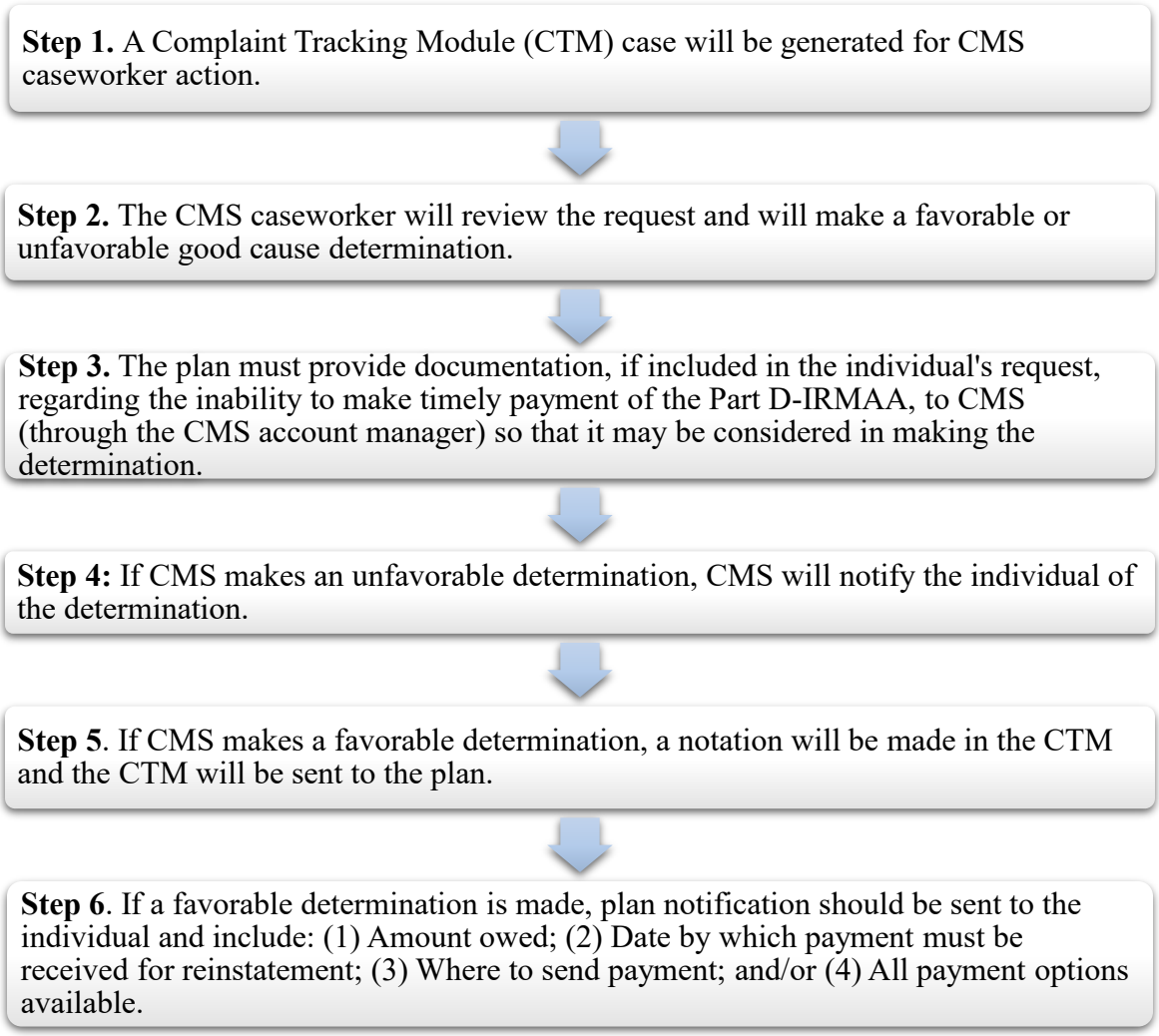
Unfavorable Determinations
If the plan makes an unfavorable determination, the plan should notify the individual of this decision, by phone or in writing, within three business days of making the determination.

NOTE: In cases where the involuntary disenrollment for failure to pay plan premiums is the result of plan error, plans should follow the reinstatement process outlined in § 70.3.4. Plans should not refer these individuals to 1-800-MEDICARE, nor should these cases be considered for reinstatement for good cause.

70.3.5.2 – Process for Good Cause Determinations for Nonpayment of Part D-IRMAA

When a disenrolled individual contacts the plan following disenrollment for failure to pay Part D-IRMAA and indicates that they "have a good reason for not paying the Part D-IRMAA," the plan must advise the individual to contact 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) within 60 calendar days of the disenrollment effective date to make the good cause reinstatement request.

Once a request is made with CMS via 1-800-MEDICARE:



Plans have additional time beyond the payment deadline (i.e., three months from the disenrollment effective date) 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 payment deadline to process the payment and notify CMS via CTM. Even if an individual has received a favorable good cause determination, the actual reinstatement will not occur until all required payments are made within three months of the disenrollment effective date.

An individual may not be reinstated in cases where:

- The individual pays all Part D-IRMAA amounts (and any plan premium amounts owed) but does not receive a favorable good cause determination.
- The individual receives a favorable good cause determination but does not pay the Part D-IRMAA amount (and/or any plan premiums owed) within three months of the disenrollment effective date.

In both of the circumstances above, the plan may re-enroll the individual for a prospective enrollment effective date at the individual's request, but only if the individual has a valid election period (i.e., AEP, SEP, etc.)—see §§ 30 and 50.

Example:
Mr. Smith is disenrolled by CMS for failure to pay Part D-IRMAA on August 1. He contacts 1-800-MEDICARE and makes his request for reinstatement on September 29 and receives a favorable good cause determination on October 5. CMS notifies Mr. Smith that he must pay the Part D-IRMAA amount by October 31. Mr. Smith pays his Part D-IRMAA owed amount on October 25. Mr. Smith is also delinquent on his plan premiums, and the plan notifies Mr. Smith that he must pay his plan premium by October 31. Mr. Smith pays his plan premium owed amount on November 5. Because the plan received Mr. Smith's payment for his plan premium amount after the due date, Mr. Smith may not be reinstated. (Note: If Mr. Smith had paid both his owed Part D-IRMAA and plan premiums by October 31, the plan would have had the additional five days to process the payment and he would have been reinstated.)

70.4 – Retroactive Enrollments

A retroactive enrollment is an enrollment with an effective date in the past. For example, a plan submits an enrollment transaction on March 5 with an effective date of March 1.

Occasionally, obtaining the information necessary to complete an enrollment request within the allowable time frames will extend beyond the effective date of enrollment. Plans must use the Code 61 enrollment transaction to submit the enrollment transaction directly to CMS within the Current Calendar Month (CCM) transaction processing time frame.

When a valid request for enrollment has not been communicated to CMS successfully within the required time frames in this guidance and the CCM transaction submission time frame, MA or Part D organizations are required to submit the appropriate documentation to CMS (or the RPC) for manual review and potential action. In addition, when the plan or CMS has been unable to process the enrollment in a timely manner, the following documentation must be submitted to the RPC:

- A copy of the signed completed enrollment form (the form must have been signed by the individual (or authorized representative) and received by the plan 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 plan prior to the requested effective date of coverage).

If the request for retroactive enrollment action is due to plan error, the plan must provide:

- A clear and detailed explanation supporting the requested correction;
    - The explanation should clearly state what the plan has communicated to the

individual throughout the period in question;

- Any relevant information or documentation supporting the requested correction such as a copy of the enrollment request (or evidence of the use of another enrollment mechanism).

CMS approves requests for retroactive enrollments on a case-by-case basis. The request for a retroactive enrollment should be made by the plan within the time frames provided in the SOP for the CMS RPC. The retroactive enrollment request may be denied if CMS determines that the plan did not notify the enrollee that they must use plan services instead of Original Medicare coverage during the period covered by the retroactive enrollment request.

NOTE: Unless an approved capacity limit applies, all MA plans are open for ICEP, IEP for Part D, AEP, and SEP enrollment requests; therefore, all MA plans are open for retroactive enrollments for these types of enrollment requests.

Special note regarding CMS Regional Office Casework actions

When an MA or Part D organization is directed by CMS to submit a retroactive enrollment or disenrollment request to resolve a complaint, the organization must provide the following two items as documentation to CMS (or the RPC):

- A screenshot of the Complaint Tracking Module (CTM) or other documentation showing the CMS authorization to submit the request to the CMS RPC, and,

- A copy of the enrollment or disenrollment request, if one is available—if it is not available, a brief explanation for the missing documentation.

70.5 – Retroactive Disenrollments

42 CFR §§ 422.66(b)(5), 423.36(c), and 423.36(f)

A retroactive disenrollment is a disenrollment with an effective date in the past, which is needed to make the enrollment record consistent with the individual's election decision or with the effective dates that are reflected in the regulation.

The RPC may grant a retroactive disenrollment if:

- A valid request for disenrollment was properly made by the individual, but not processed or acted upon for the required effective date, by the plan (or CMS);

- An enrollment was not legally valid (§ 50.6); or

- The reason for the disenrollment is related to:
    - A permanent move out of the plan service area (as outlined in § 60.2.1.2),
    - The plan's confirmation of an incarcerated status with a retroactive date (see § 60.2.1.1),
    - A contract violation (as outlined in 42 CFR §§ 422.62(b)(3) and 423.38(c)(8)), or

- Other limited exceptional conditions established by CMS (e.g., fraudulent enrollment or misleading marketing practices).

CMS approves retroactive disenrollments on a case-by-case basis. When a valid request for disenrollment has not been communicated to CMS successfully within the required time frames in this guidance and the CCM transaction submission time frame, MA or Part D organizations are required to submit the appropriate documentation to CMS (or the RPC) for manual review and potential action. This documentation would include:

- A clear and detailed explanation supporting the requested correction, including a description of what the plan has communicated to the individual throughout the period in question;
- Any relevant information or documentation supporting the requested correction such as a copy of the enrollment request (or evidence of the use of another enrollment mechanism).

Organizations must submit retroactive disenrollment requests to CMS (or the RPC) for review within the time frames provided in the SOP for the RPC and the CCM transaction submission time frame. If CMS approves a request for a retroactive disenrollment, the plan must return any premium paid by the individual for any month for which CMS processed a retroactive disenrollment. In addition, CMS will recoup any capitation payment for the retroactive period.

70.6 – Retroactive Transactions for Employer/Union Group Health Plan (EGHP) Enrollees

42 CFR §§ 422.60(f), 422.66(f), 423.32(i), and 423.36(e)

When an MA or Part D plan that has both a Medicare contract and a contract with an EGHP, the MAO or Part D sponsor may arrange for the employer or union to process enrollment requests for Medicare-entitled group members who wish to enroll in an MA or Part D plan. Retroactive transactions may be necessary and provided for under this section:

- If a delay exists between the time the individual completes the enrollment request through the EGHP and when the enrollment request is received by the plan; or

- Due to errors made by the EGHP, such as failing to forward a valid enrollment or disenrollment request within required time frames.

These transactions must be submitted to CMS (or the RPC) for review within the time frames provided in the SOP for the CMS RPC and the CCM transaction submission time frame.

NOTE: Repeated errors may indicate an ongoing problem and therefore will be forwarded to the plan's CMS Account Manager for compliance monitoring purposes. The organization's agreement with the EGHP should include the need to meet the requirements provided in this chapter that ensure the timely submission of enrollment and disenrollment requests to avoid such errors and reduce the need for retroactivity.

70.6.1 – EGHP Retroactive Enrollments

42 CFR §§ 422.66(f), 422.308(f)(2), 423.32(i), and 423.343(a)

Retroactive EGHP enrollment transactions are based on the need to make the enrollment record consistent with the individual's election decision or with the effective dates that are reflected in the regulation. These transactions may be submitted only for enrollment requests that were completed by an individual prior to the enrollment effective date but were delayed in being submitted by the employer or union to the MA or Part D plan. The effective date of EGHP enrollments may be retroactive up to, but may not exceed, 90 days (consistent with retroactive payment adjustments per §§ 422.308(f)(2) and 423.343(a)) from the date the organization received the request from the employer or union group.

> **Example:**
> For EGHPs, an effective date of March 1, February 1, or January 1 would reflect 30, 60 and 90 days of retroactivity, respectively. Therefore, if a completed EGHP enrollment request was received by the MA or Part D organization on March 5, the retroactive effective date could be January 1, February 1, or March 1, as long as the enrollment request was completed prior to the respective effective date.

Retroactive enrollments may not be processed unless the individual certifies that the MA or Part D organization (or EGHP/union) provided them with the explanation of enrollee rights disclosure statement as specified in 42 CFR § 422.111 at the time of enrollment. Refer to the Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) for more information.

70.6.2 – EGHP Retroactive Disenrollments

42 CFR §§ 422.66(f), 422.308(f)(2), 423.36(e), and 423.343(a)

The MA or Part D organization submits a retroactive disenrollment request to CMS (or the RPC) if an EGHP fails to provide the organization with timely notification of an individual's requested disenrollment and action is needed to make the enrollment record consistent with the individual's election decision or with the effective dates that are reflected in the regulation. The EGHP notification is considered untimely if it does not result in a disenrollment effective for the month following the month the request is received, or for the requested effective date (if later).

CMS may process disenrollments up to 90 days retroactively to conform to the adjustments in payment described under 42 CFR §§ 422.308(f)(2) and 423.343(a).

Similar to retroactive disenrollment for non-EGHPs, the plan must submit a disenrollment notice (i.e., documentation) to CMS (or the RPC) demonstrating that the individual acted to disenroll in a timely fashion (i.e., prospectively), but that the EGHP was late in providing the information to the MA or Part D organization (see § 70.5). Such documentation may include:

- An enrollment form for a different MA or Part D plan signed by the individual and given to the EGHP during an open enrollment season.

However, documentation may not include:

- A copy of a Medigap plan enrollment form unless the individual indicated on that form that they have canceled any other insurance.

70.7 – Election of Continuation of Enrollment Option for MA Local Plans – Part C only

42 CFR § 422.54

When an enrollee permanently moves from an MA local plan service area into the MAO's continuation area, the enrollee must decide if they want to continue enrollment in the MA local plan as described in § 20.3.1. The individual does not have to complete and sign a new enrollment form in order for the continuation to occur but must make this choice in a manner described in the MAO's policy and procedure documents.

The MAO must verify that the enrollee has established permanent residence in the continuation area. Proof of permanent residence is normally established using the procedures for establishing residence in the service area. See § 20.3.

The effective date of a continuation of enrollment change generally is the first day of the month after the individual moves into the continuation area.

70.8 – Storage of Enrollment and Disenrollment Records

42 CFR §§ 422.60(c)(2), 422.504(e)(1)(iv), 422.504(e)(4), 423.36(b)(3), 423.505(e)(1)(iii), and 423.505(e)(1)(iv)

Federal law requires plans to retain, and have available for inspection, enrollment, and disenrollment records for the current contract period and for 10 prior periods.

Plans may store records on various technologies (e.g., microfilm, disk, cloud) that allow the enrollment and disenrollment request, including the individual's signature and date, to be clearly viewed.

Records of enrollment and disenrollment requests made by any other enrollment request mechanism (as described in § 40.1) must also be retained as outlined above.