DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR BENEFICIARY CHOICES

To: Medicare Advantage Organizations and 1876 Cost Plans

From: Anthony J. Culotta, Acting Director
Medicare Enrollment and Appeals Group

Subject: Updated Guidance On Facilitated Enrollments

Date: May 12, 2006

The purpose of this memo is to provide information and guidance about the following:

- Conducting facilitated enrollments on a monthly basis
- Modifications to effective dates for facilitated enrollments
- Modifications to Exhibit 28, MA Model Notice to Inform Member of Facilitated Enrollment and Exhibit 29, Acknowledgement of Request to Decline Part D

Facilitated Enrollment Conducted Monthly

Effective with this month, MA organizations and 1876 Cost Plans must begin facilitating enrollment of their non-full benefit dual eligible members who are eligible for the low-income subsidy (LIS) into MA-PD plans or cost plans that offer prescription drug benefits on a monthly basis. This includes new enrollees to MA-only plans (other than employer-sponsored plans, including "800" series plans, or beneficiaries for whom Retiree Drug Subsidy is being claimed), as well as existing enrollees of MA-only plans who become newly LIS-eligible. For 1876 Cost Plans' that offer a Part D optional supplemental benefit, this includes new enrollees to plan benefit packages (PBPs) that do not offer Part D, as well as existing enrollees of those PBPs who become newly LIS-eligible. Please see guidance issued March 17, 2006 (including correction issued April 10, 2006) on how to identify these beneficiaries.

Effective Date

The effective date of facilitated enrollment for all non-full dual, LIS-eligible members is the first day of the second month after the person is identified as qualifying for facilitated enrollment. For example, if the plan is notified in August 2006 that an existing member of an MA-only plan has become LIS eligible, the effective date is October 1, 2006. This replaces the previous effective date guidance in section 40.1.7 of Chapter 2 of the Medicare Managed Care Manual.

New Special Enrollment Period (SEP) for Certain LIS Beneficiaries

CMS has established an SEP to facilitate on-going enrollment of LIS beneficiaries who have not chosen a plan. The SEP applies to beneficiaries who newly qualify for the LIS because they

receive Supplemental Security Income (SSI) benefits, or apply and qualify. This SEP will allow newly LIS-eligible individuals to enroll in a Part D plan on their own. It permits those who are not currently members of an MA organization or 1876 Cost Plan that offers a Part D optional supplemental benefit to enroll in an organization's Part D plan. It also permits existing members of an MA-only plan or 1876 cost plan PBP without Part D to switch to a plan in the organization with Part D benefits.

The SEP will begin upon notification to the individual of his/her LIS status or the effective date of facilitated enrollment (whichever occurs first), and ends either when the individual enrolls in a Part D plan, or upon MA/cost plan's facilitated enrollment into their Part D product. For those who are not currently members of the organization who request enrollment via this SEP, proof of eligibility for this SEP may include the subsidy award letter from SSA or the state, or a notice from CMS informing the beneficiary that he/she has been deemed eligible for the subsidy. For existing members of the MA-only plan or 1876 cost plan's PBP without Part D, the notification from MARx that the person is newly LIS eligible is sufficient proof. If the beneficiary does not use the SEP to enroll in a plan, the organization should facilitate the person's enrollment; the beneficiary will then have an SEP to change back to the original plan.

Note that full and partial dual eligibles already have a continuous SEP per section 30.4.4.5 of Chapter 2.

Facilitated Enrollment and Opt-Out Notices

When notifying beneficiaries of facilitated enrollment, please use the attached updated Exhibit 28. As modified, the notice indicates that the deadline for opting out of facilitated enrollment is the last day of the month before the effective date of the facilitated enrollment. We are also using this opportunity to update Exhibit 29, the model notice for confirming a beneficiary's request to opt-out of either auto- or facilitated enrollment. Both revised notices are attached.

Summary of Differences Between Auto- and Facilitated Enrollment

Attached is a summary of the updates provided via guidance since Chapter 2 was issued in August 2006. These will be incorporated into the next update of Chapter 2.

Further Information

We appreciate MA organizations and 1876 Cost Plans' continued cooperation in ensuring full-benefit dual eligibles and other LIS-eligible individuals are enrolled in a timely manner to avoid coverage gaps. If you have any questions, please contact Sharon Donovan at (410) 786-2561 or sharon.donovan@cms.hhs.gov.

Attachments (3):

MA/Cost Plans Auto- and Facilitated Enrollment of LIS Beneficiaries
Exhibit 28 – Updated MA Model Notice to Inform Member of Facilitated Enrollment
Exhibit 29 – Updated Acknowledgement of Request to Decline Part D

Attachment 1: Enrollment of Full Benefit Duals and Other LIS-Eligible Beneficiaries Into Medicare Advantage Plans and Cost Plans for 2006

This document provides a high-level summary of guidance updating Sections 40.1.6 and 40.1.7 of Chapter 2 of the Medicare Managed Care Manual since its most recent issuance in August 2005. For details, please see guidance issued October 5, 2005; February 8, 2006; March 17, 2006; and April 10, 2006.

	Full Duals	**Non-Full Dual LIS Eligibles**
Frequency	Monthly	Monthly
Steps	• Identify full dual eligibles in MA-only plan who need to be enrolled into MA-PD • Send notice to beneficiary • If no answer within 10 business days, submit 71 transaction to move to MA-PD plan • If person opts-out, do not submit transaction (if opt-out after 10 days, submit 71 transaction to move them back to MA-only, but with prospective effective date)	• Identify non-full dual LIS beneficiaries in MA-only plan who need to be enrolled into MA-PD • Send notice to beneficiary • If no answer by last day before effective date of facilitated enrollment, submit 71 transaction to move to MA-PD plan • If person opts-out, do not submit transaction (if opt-out after deadline, submit 71 transaction to move them back to MA-only, but with prospective effective date)
Who needs to be moved	• Full dual who newly enrolls in MA-only plan • Beneficiary in MA-only plan who recently became Medicaid eligible and is thus newly full dual	• Non-full dual with LIS who newly enrolls in MA-only plan • Beneficiary in MA-only plan who recently became LIS-eligible
Who does not need to be moved	• Those who have already opted out	• Those who have already opted out • Those with RDS • Those in 800 series employer sponsored plan • Those in employer sponsored plans (other than 800 series)

Data to identify those in MA-only plan who need to be moved to MA-PD plan	Monthly MA full dual file	LIS data (either TRR, or bi-weekly LIS file): • Premium subsidy = 25, 50, 75 • Premium subsidy = 100 AND o LIS copay = 4 (15%) Or • LIS copay = 1 ($2/5) AND person is not on MA full dual file
Plan Into Which Beneficiary Should be Enrolled	MA-PD plan with lowest combined Part C and D premium or lowest Part D premium	MA-PD plan with lowest combined Part C and D premium or lowest Part D premium
Notice to send	Exhibit 27	Exhibit 28
Application date on transaction	10/15/05	First day of month prior to effective date of the enrollment
Enrollment type	S = Special Enrollment Period	S = Special Enrollment Period
Effective date	• First day of month person appeared on MA full dual file (will be retroactive) • Cannot be prior to start of enrollment in the MA-only plan.	• First day of second month after person identified as needing enrollment • Cannot be prior to start of enrollment in the MA-only plan.
Opting out	• Document and do not enroll again in future.	• Document and do not enroll again in future.

Attachment 2

Exhibit 28: MA Model Notice to Inform Member of Facilitated Enrollment

(Rev. 70, Issued: 09-30-05, Revised Effective Date: 06-01-06)

Referenced in section: 40.1.7

[Member # - if member # is SSN, only use last 4 digits]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you qualify to get extra help with your prescription drug costs from Medicare. Medicare is helping you enroll in our <name of MA-PD plan> that offers Medicare prescription drug coverage, beginning <effective date>. This way, you will pay the lowest possible premium for Medicare prescription drug coverage.

[This letter is proof of insurance that you should show during your doctor's appointments**.]**

[Plans: Include cost of premium less amount of premium assistance the member is eligible for, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.]

[*MA PPO and PFFS plans do not use the following paragraph*] Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services,** if you get health care from a non-<new Plan> doctor without prior authorization, you will have to pay for the health care yourself.

In addition, you also get prescription drug coverage through our plan.
With the addition of this Medicare prescription drug coverage, you will pay:

- [insert either $0 or $50] for your yearly prescription drug plan deductible,
- [insert copay amount: up to $2 and $5; or 15%] copayments when you fill a prescription.

Please remember that you must use network pharmacies to fill your prescription. You can only use an out-of-network pharmacy in special circumstances and should call us before filling your prescription. If you don't, you will have to pay the full cost of your drugs.

You are not required to be in our Medicare prescription drug plan and have the option to stay in <insert name of MA-only plan>. If you decide not to be enrolled and don't have other drug coverage at least as good as Medicare prescription drug coverage, you may have to pay more for this coverage at a later time. If you don't want Medicare prescription drug coverage, call our Member Services Department at <phone number>. TTY users should call <TTY number> by <insert last day before effective date>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

<Plan Representative>

<Material ID number> [<CMS approval Date>]

Attachment 3

Exhibit 29: Acknowledgement of Request to Decline Part D

(Rev. 70, Issued: 09-30-05, Revised Effective Date: 06-01-06)

Referenced in section(s): 40.1.6 and 40.1.7

Dear <name of member>:

As requested, we have processed your request to decline Medicare prescription drug coverage. You will continue to be a member of <MA Plan> that does not offer Medicare prescription drug coverage.

[Plans: *If beneficiary declines after the effective date of the auto- or facilitated enrollment, insert the following language:*. The effective date of your request will be (insert first day of month after request received).]

If you had Medicaid drug coverage, it will no longer pay for your prescription drugs. Our records show you can get extra help with your prescription drug costs from Medicare, but you must have Medicare prescription drug coverage to get this help.

Remember, even if you don't use a lot of prescription drugs now, you still should consider signing up for a Medicare prescription drug plan. For most people, joining now means you will pay your lowest possible monthly premium. If you didn't join a plan by May 15, 2006, and you don't currently have prescription drug coverage that covers at least as much as Medicare prescription drug coverage, your premium cost will go up by up to 1% per month for every month that you wait to enroll.

If you change you mind now or at anytime in the future, you can call <MA Plan> customer service at <number>, Monday through Friday between the hours of <hours>. TTY users should call <insert TTY number>.

Sincerely,

<Plan Representative>

<Material ID> [<CMS Approval Date>]