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# Enrollment Guidance Medicare Advantage and Part D Plans

## **Part 5**

**Version 6.0**  
**September 26, 2012**

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# Learning Objectives

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- After reviewing “Part 5: Enrollment Guidance - Medicare Advantage and Part D Plans” you will be able to explain:
  - Eligibility and enrollment rules;
  - Who can complete an enrollment form;
  - When beneficiaries can enroll or change plans;
  - Post enrollment requirements;
  - Enrollee protections; and
  - The disenrollment process.

# Who is Eligible to Enroll in MA or Part D Plans?

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- An individual is eligible to enroll in an MA plan if the individual is entitled to Medicare benefits under Part A and enrolled in Part B.
  - Generally, beneficiaries are not eligible if they have end-stage renal disease when first enrolling in the plan.
- An individual is eligible to enroll in a Part D plan if the individual is entitled to Medicare benefits under Part A and/or enrolled in Part B.
- For MA and Part D plans the individual must
  - Reside in the service area of the plan.
  - Submit a complete enrollment request (a legal representative may complete the enrollment request for the individual)
  - Be fully informed of and agree to abide by the plan rules provided during the enrollment request.

# Enrollment Rules

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- Medicare beneficiaries may be enrolled in only one MA plan and only one Part D plan at a time.
- If enrolled in a Medicare coordinated care plan (HMO/PPO) or a PFFS plan that includes Part D drug coverage, the beneficiary may not be enrolled in a stand-alone PDP.
  - Enrollment in a stand-alone PDP will result in automatic disenrollment from a Medicare coordinated care or PFFS plan that includes Part D coverage.
- Enrollees may be enrolled in a stand-alone PDP only if they are enrolled in:
  - Original fee-for-service Medicare;
  - Private Fee-for-Service (PFFS) plan without Part D drug coverage;
  - Medical Savings Account (MSA) plan; or
  - 1876 Cost plan.

## Enrollment Rules, cont'd.

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- The Medicare prescription drug benefit of a MA-PD is only available to members of the MA-PD plan.
- If a beneficiary is enrolled in a MA-PD plan, the enrollee must receive his/her Medicare prescription drug benefit through that plan.
  - Enrollees in certain Employer/Union retiree group plans may have different options.
- An MA or Part D plan may not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS.

## Formats of Enrollment Requests - Paper

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- Plan sponsors must accept enrollment requests, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, or through other mechanisms defined by CMS.
- Paper:
  - All plans must make available and accept a CMS-approved paper enrollment form appropriate to the plan type (MA, PDP, MA-PDP, MSA, or PFFS).
- Short forms:
  - A short enrollment form is available to allow for changes in plans offered by the same parent organization.

# Formats of Enrollment Requests - Internet

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- Enrollment via the internet:
  - CMS offers an on-line enrollment center through [www.medicare.gov](http://www.medicare.gov) and 1-800-MEDICARE.
  - MA and Part D plans may offer CMS-approved online enrollment on the plan sponsor's website.
  - The only online enrollment mechanism that third party entities (on behalf of the plan sponsor) may make available to potential enrollees is via the plan sponsor's website.
    - Online enrollment via an agent or broker website is NOT permitted.



# Formats of Enrollment Requests - Telephone

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- Enrollment via telephone:
  - Plans may accept incoming calls **only** from a beneficiary or authorized representative to complete an enrollment request.
  - A plan representative, agent or broker **must not** be present or on the phone.
  - Calls must be recorded.
  - Individuals must be advised that they are completing an enrollment request.
  - Collection of financial information is prohibited.

## Who May Complete the Enrollment Form?

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- If a paper enrollment form is used, the beneficiary must sign it.
- No other person can sign the enrollment form on behalf of the beneficiary without legal authority to do so.
  - For example, if both spouses cannot attend a sales presentation, the present spouse may make a decision to enroll and complete the enrollment form, but cannot enroll the absent spouse.
- If an individual executes the enrollment request on behalf of the beneficiary, he/she must sign the attestation on the enrollment form that states:
  - he/she has authority to make health care decisions for the beneficiary under State law and
  - can provide documentation of this authority to the plan sponsor or CMS upon request.

## Who May Complete the Enrollment Form?, cont'd.

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- As permitted under the law of the State where the beneficiary resides, CMS will allow a legal representative or other individual to execute an enrollment or disenrollment request on behalf of a beneficiary.
  - This may include court-appointed legal guardians, individuals with durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have authority to act for the beneficiary in this capacity.
    - The authority must pertain to health care decisions. Authority to make financial decisions or insurance purchases is not sufficient authority.
    - The authority may apply beginning on a specified date or may only apply when the beneficiary becomes incapacitated.

## Who May Complete the Enrollment Form?, cont'd.

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- If a marketing representative helps to complete the enrollment form, he/she must clearly indicate his/her name on the form.
  - Exceptions -- The marketing representative does not need to include his/her name on the form:
    - If a beneficiary requests an enrollment form be mailed to him/her and the name and mailing address are pre-filled;
    - If he/she fills in the “office use only” block; and/or
    - If he/she corrects information on the enrollment form after verifying an individual’s information and adding the representative’s initials and date next to the correction.
  - If the marketing representative pre-fills any other information, including the beneficiary’s phone number, he/she MUST include his/her name.
  - Marketing representatives must safeguard beneficiary information including enrollment forms.
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# What Information is Required to Complete the Enrollment Request?

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- CMS requires the following information for an enrollment request to be complete:
  - MA or Part D plan name
  - Beneficiary 's
    - Name;
    - Date of birth;
    - Sex;
    - Permanent residence address;
    - Medicare number;
    - Response to ESRD question; and
    - Signature and/or authorized representative signature
  - Authorized representative contact
  - Employer or union name and group number (if applicable)
  - Name of current MA plan (if applicable) and new plan
  - Verification of SNP eligibility (if applicable)
  - Acknowledgments (see next slide)
  - Release of information

If enrollment is completed during a face-to-face interview, the plan representative should use the individual's Medicare card to verify the spelling of the name, sex, Medicare number; and Part A and Part B effective dates.

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# Beneficiary Acknowledgements when Enrolling

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- The enrollment application form requires the beneficiary to acknowledge that he/she :
  - Must keep Medicare Part A and Part B if enrolling into an MA plan and must keep Part A or Part B if enrolling into a Part D plan;
  - Agrees to abide by the plan's membership rules as outlined in the member materials;
  - Consents to the disclosure and exchange of information necessary for the operation of the MA or Part D program;
  - Can be enrolled in only one MA and Part D or MA-PD plan and enrollment in the plan automatically disenrolls him/her from any other MA, Part D, or MA-PD plan; and
  - Understands his/her right to appeal service and payment denials the plan makes.

# Enrollment Discrimination Prohibitions

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- ❑ Marketing representatives may NOT
  - ❑ Deny or discourage beneficiary enrollment based on:
    - ❑ anticipated high need for health care services;
    - ❑ race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or sexual orientation; or
    - ❑ geographic location within the service area.
  - ❑ Target marketing to beneficiaries from higher income areas.
    - ❑ Note: Appointments must be scheduled without regard to the health or financial status of the beneficiary.
  - ❑ State or imply that only seniors may enroll, rather than all Medicare beneficiaries.

# Enrollment Discrimination Prohibition and Exceptions

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- ❑ Marketing representatives may NOT ask health questions unless they are necessary to determine eligibility to enroll (e.g., ESRD, chronic care SNPs, low income subsidy (LIS)).
- ❑ Certain plan products and services may only be available to enrollees with specific diagnoses (e.g., medication therapy management for those with chronic conditions).
- ❑ Only organizations offering SNPs may limit enrollment to individuals who:
  - ❑ are dual eligible;
  - ❑ are in an institution; or
  - ❑ have a severe or disabling chronic condition.
- ❑ Marketing representatives may target items and services to beneficiaries that correspond to these categories of SNP plans.



# Enrollment Periods

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- Beneficiaries may only enroll in or change plans at certain fixed times each year or under certain limited special circumstances.
  - If the application does not include information supporting a permissible election period, plans must contact the beneficiary to decide if enrollment is permissible.
- Enrollment periods are:
  - MA Initial Coverage Election Period (ICEP)
  - Part D Initial Enrollment Period (IEP)
  - MA and Part D Annual Election Period (AEP)
  - MA and Part D Special Enrollment Periods (SEP)
  - Open Enrollment Period for Institutionalized Individuals (OEPI)
  - MA 45-Day Disenrollment Period (MADP)
- **Cost Plan Enrollment**
  - Cost plans may but are not required to be open for enrollment during the MA Annual Election Period, but Cost plans that offer an optional supplemental Part D benefit must accept Part D enrollments during the AEP.
  - See slides 36 - 37 for more information on Cost plan enrollment periods



# Enrollment Periods

## Brief Summary

<b>Enrollment Period</b>	<b>MA Options</b>	<b>PDP Options</b>
<b>MA Initial Coverage Election Period (ICEP) / Part D Initial Enrollment Period (IEP)</b>	Enroll	Enroll
<b>Annual Election Period (AEP)</b>	Enroll, Disenroll, Change Plans	Enroll, Disenroll, Change Plans
<b>MA Disenrollment Period (MADP)</b>	Disenroll from an MA or MA-PD plan and return to Original Medicare	After disenrolling from an MA or MA-PD plan, may enroll in a PDP
<b>Special Election Period (SEP)</b>	Most permit enrollment, disenrollment and plan changes, however some are limited.	Most permit enrollment, disenrollment and plan changes, however some are limited.
<b>Open Enrollment Period for Institutionalized Individuals (OEPI)</b>	Enroll, Disenroll, Change Plans	(See Part D SEP for Institutional Individuals)

# Enrollment Periods

## MA Initial Coverage Election Period (ICEP)

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- The MA ICEP and the Part D IEP occur together as one period when a newly Medicare eligible individual has enrolled in BOTH Part A and Part B at first eligibility.
- Who is eligible for the MA ICEP?
  - The ICEP is available to individuals who are newly eligible for Medicare Advantage (MA).
- When does the MA ICEP take place?
  - The ICEP begins three months immediately before the individual's first entitlement to **both** Medicare Part A and Part B and ends on the later of the last day of the month preceding entitlement to both Part A and Part B, or the last day of the third month after the month in which an individual meets the eligibility requirements for Part B.
- What can individuals do during the MA ICEP?
  - During the ICEP, an eligible individual may enroll in an MA plan – or an MA-PD plan if the individual is eligible for Part A and enrolled in Part B.
  - The individual can make one enrollment choice under the ICEP. Once enrollment is effective, the ICEP is used.

# Enrollment Periods

## Part D Initial Enrollment Period (IEP)

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- The MA ICEP and the Part D IEP occur together as one period when a newly Medicare eligible individual has enrolled in BOTH Part A and B at first eligibility.
- Who is eligible for the Part D IEP?
  - The IEP is available to individuals who are newly eligible for Medicare Part D prescription drug coverage.
- When does the Part D IEP take place?
  - The IEP begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility.
  - Individuals eligible for Medicare prior to age 65 (such as for disability) will have another IEP when attaining age 65.
- What can individuals do during the Part D IEP?
  - Beneficiaries may make one Part D enrollment choice, including enrollment in an MA-PD plan.

# Enrollment Periods

## Annual Election Period

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- Who is eligible for the Annual Election Period?
  - The Annual Election Period is available to all MA and Part D eligible beneficiaries.
- When does the Annual Election Period take place?
  - 2011 and thereafter: October 15 – December 7
- What can beneficiaries do during the Annual Election Period?
  - No action is needed if the beneficiary chooses to keep his/her current plan. She/he should check for any benefit changes under the plan.
  - Beneficiaries may add or drop MA and/or drug coverage, or return to Original Medicare.
  - Beneficiaries may make more than one enrollment choice during the Annual Election Period, but the last one made prior to the end of the Annual Election Period, as determined by the date the plan or marketing representative receives the completed enrollment form, will be the election that takes effect.

## Enrollment Periods

### Annual Election Period, cont'd.,

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- ❑ Marketing representatives may not accept enrollment forms before October 15 for enrollments under the Annual Election Period.
- ❑ If a beneficiary sends an enrollment form to the plan before the Annual Election Period begins, the plan will process the application beginning on the first day of the election period (October 15).
- ❑ A beneficiary will receive an acknowledgment letter when the plan sponsor receives an early enrollment form.

# Enrollment Periods

## MA Disenrollment Period (MADP)

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- As noted, the Affordable Care Act, passed in 2010, created the MADP and eliminated the “Open Enrollment Period.” Exception: Institutionalized beneficiaries have a continuous open enrollment period.
- Who is eligible for the MADP?
  - All MA or MA-PD enrollees
- When does the MADP take place?
  - From January 1 – February 14 of each year.
- What can beneficiaries do during the MADP?
  - MA and MA-PD enrollees may request disenrollment from their plan and return to Original Medicare and subsequently may enroll in a PDP or may simply request enrollment in a PDP, resulting in automatic disenrollment from the MA plan. (Exception: MA-only PFFS must request disenrollment first.)

# Enrollment Periods

## Special Enrollment Periods (SEP)

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- Who is eligible for an SEP?
  - Part D eligible beneficiaries and those enrolled in an MA plan who experience certain qualifying events are allowed an SEP.



# Enrollment Periods

## Special Enrollment Periods (SEP), cont'd.

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- When does the SEP take place?
  - Timeframes for SEPs are variable, however, most begin on the first day of the month in which the qualifying event occurs and last for a total of three months. The SEP ends when the individual utilizes their SEP to make an allowed change, or the time period expires, whichever comes first. Where appropriate, SEPs allowing changes to MA coverage are coordinated with those allowing changes in Part D coverage.
  - Some (but not all) situations resulting in an SEP include:
    - Change in residence
    - Involuntary loss of creditable drug coverage
    - Exceptional conditions such as
      - Gaining or losing Medicaid eligibility
      - Gaining or losing the Part D low-income subsidy
      - Changing employer/union group health plan coverage
      - Enrollment based on incorrect or misleading information

# Enrollment Periods

## Special Enrollment Periods (SEP), cont'd.

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- What can beneficiaries do during an SEP?
  - Under Part D SEPs, qualifying beneficiaries generally have one opportunity to drop, add or change their Part D coverage.
  - Under MA SEPs, qualifying beneficiaries generally have one opportunity to change their MA coverage. (Except for MSA plan enrollees.)
    - But, if a beneficiary disenrolls from his/her MA plan and returns to Original Medicare, he/she may subsequently select a new MA plan, as long as he/she does so before the SEP expires.

# SEP – Contract Violations

## Marketing Misrepresentation

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- Who is eligible?
  - Beneficiaries who have enrolled in a Medicare Advantage plan based upon misleading information.
  - To take advantage of this SEP, beneficiaries must contact Medicare (e.g., call 1-800-MEDICARE).
- When does the SEP take place?
  - Begins when a determination is made by CMS that the beneficiary qualifies for the SEP.
  - Ends once a new enrollment decision is made.
- What can beneficiaries do during the SEP?
  - CMS will help all qualifying beneficiaries select a new Medicare plan option, which may include a different MA plan, a PDP, or Original Medicare.
  - Requests for retroactive enrollments will be handled by CMS Regional Office caseworkers who will discuss with beneficiaries the possible ramifications.

# Typical SEPs

## Change of Residence

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- Who is eligible?
  - MA and Part D enrollees who move out of their existing plan's service area, or who have new options available to them as a result of a permanent move.
  - Beneficiaries who have moved into a plan service area from a location where there was no Part D plan available (e.g. overseas) qualify for an SEP just for Part D election purposes.
- When does the SEP take place?
  - Begins either the month before the permanent move if the plan is notified in advance or the month the beneficiary provides notice of the move.
  - Continues for two months following the month it begins or the month of the move, whichever is later.
    - Example: A beneficiary resides in Florida and is currently in Original Medicare and not enrolled in an MA plan. The individual intends to move to Maryland on August 3. An SEP exists for this beneficiary from July 1 through October 31.
  - The individual may choose an effective date of up to 3 months after the month in which the enrollment form is received by the plan, but it may not be earlier than the date of the permanent move.
- What can beneficiaries do during the SEP?
  - Qualifying beneficiaries have one opportunity to enroll into a new MA or Part D plan.

# Typical SEPs - Involuntary Loss of Creditable Drug Coverage

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- Who is eligible?
  - Beneficiaries eligible for Part D who involuntarily lose creditable prescription drug coverage including a reduction in coverage so it is no longer creditable.
- When does the SEP take place?
  - Begins with the month in which the beneficiary is advised of loss of creditable coverage.
  - Ends 2 months after loss of creditable coverage or the date the individual received the notice, whichever is later.
- What can beneficiaries do during the SEP?
  - One opportunity to select a PDP or MA-PD plan.

# Typical SEPs - Exceptional Conditions Gaining or Losing Medicaid Eligibility

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- Who is eligible?
  - Beneficiaries who are entitled to Medicare Part A and/or Part B and receive any type of assistance from Medicaid (full benefits and partial benefits).
- When does the SEP take place?
  - Begins the month the beneficiary gains or loses dual eligibility.
  - If gaining eligibility: continues as long as the beneficiary receives Medicaid benefits. Note: dual eligible beneficiaries have a continuous special election period as long as they retain dual eligible status.
  - If losing eligibility: begins the month that Medicaid eligibility is lost and continues for two additional months.
- What can beneficiaries do during the SEP?
  - Beneficiaries entitled to Part A and Part B can enroll in or disenroll from an MA and/or Part D plan at any time. Those entitled only to Part B can only do so for PDPs.

# Typical SEPs - Exceptional Conditions Gaining Eligibility for Part D LIS

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- Who is eligible?
  - Non-dual beneficiaries who qualify for LIS but do not receive Medicaid benefits
- When does the SEP take place?
  - Begins on the month the individual becomes eligible for LIS.
  - Continues as long as s/he is eligible for LIS.
- What can beneficiaries do during the SEP?
  - Enroll in or disenroll from a PDP or MA-PD plan at any time.

# Typical SEPs - Exceptional Conditions

## Losing Eligibility for Part D LIS

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- Who is eligible?
  - (1) Beneficiaries who lose their LIS eligibility because they are no longer deemed eligible for the following calendar year.
  - (2) Beneficiaries who lose their LIS eligibility during the year outside of the annual redetermination process.
- When does the SEP take place?
  - Group 1: January 1 – March 31
  - Group 2: Begins the month beneficiaries are notified and continues for two months.
- What can be done during the SEP?
  - Enroll in or disenroll from a PDP or MA-PD plan.



# Typical SEPs - Exceptional Conditions Employer/Union Group Coverage

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- Who is eligible?
  - Beneficiaries who elect into or out of employer-sponsored MA plans.
  - Beneficiaries disenrolling from an MA plan to enroll in employer/union sponsored coverage that includes medical and/or drug coverage.
  - Beneficiaries disenrolling from employer sponsored coverage (including COBRA coverage) to elect an MA plan.
- When does the SEP take place?
  - Begins when the employer/union plan would otherwise allow the individual to make changes to his/her coverage.
  - Ends 2 months after the month the employer or union-sponsored coverage ends.
- What can be done during the SEP?
  - Qualifying beneficiaries have one opportunity to
    - Enroll in an employer group/union-sponsored MA or Part D plan;
    - Disenroll from an MA or Part D plan to take employer/union-sponsored coverage of any kind; or
    - Disenroll from employer/union-sponsored coverage to enroll in an MA or Part D plan.

# Typical SEPs - Exceptional Conditions

## 5-Star Plans

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- Who is eligible?
  - Beneficiaries who live in the service area of a 5-star plan and are enrolled in an MA or PDP plan, **or beginning in 2013, a Cost plan**
  - Beneficiaries who live in the service area of a 5-star plan, are enrolled in Original Medicare, and meet the eligibility requirements for Medicare Advantage or Part D plans
- When does the SEP take place?
  - The SEP is available each year beginning on December 8 and may be used once through November 30 of the following year. For example, the SEP for calendar year 2013 can be used from December 8, 2012 through November 30, 2012.
- What can be done during the SEP?
  - Disenroll from an MA plan, PDP or **Cost plan** or leave Original Medicare
  - Enroll in a 5-star MA plan, PDP or **Cost plan**
  - Eligible individuals may enroll in a 5-star plan through 1-800-MEDICARE, Medicare.gov, or directly through the 5-star plan.

# MA Open Enrollment Period for Institutionalized Individuals/Part D SEP for Institutionalized Individuals

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- Who is eligible?
  - Institutionalized individuals who move into, reside in, or move out of an institution including, for example, a skilled nursing facility, nursing facility, rehabilitation hospital, or hospital.
  - In addition, the OEPI is available for individuals who meet the definition of “institutionalized” to enroll in or disenroll from an MA SNP for institutionalized individuals.
- When does the OEPI take place?
  - The OEPI is continuous for *eligible individuals*. The OEPI ends two months after the month the individual moves out of the institution.
- What can be done during the SEP?
  - MA beneficiaries can make an unlimited number of MA enrollment requests and may disenroll from their MA plan.
  - Individuals may enroll in or disenroll from a Part D plan.
  - Beneficiaries in an MA plan may return to Original Medicare during the OEPI.

## Cost Plan Enrollment Periods

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- Cost plans must establish an annual open enrollment period of at least 30 days and may permit beneficiaries to enroll continuously throughout the year except in the following circumstance:
  - An organization with a Cost plan and an MA plan in the same service area may not enroll new individuals in the Cost plan.
  
- If a Cost plan is not continuously open for enrollment, it must publicize its enrollment period in appropriate media throughout its service area.
  
- Cost plans may close enrollment during the year and must notify CMS and the general public 30 days before doing so. Cost plans may also re-open enrollment but public notice is not required.

## Cost Plan Enrollment Periods, cont'd

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- For Cost plans that offer an optional supplemental Part D benefit, beneficiaries may select this benefit only during enrollment periods available under the Part D program, and Cost plans must accept Part D enrollments during these periods.
- A beneficiary who is enrolled in an MA plan must have a valid MA disenrollment period in order to switch to a Cost plan.

# Post-Enrollment: Outbound Verification Calls

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- ❑ For enrollments effectuated by an agent or broker, plan sponsors must call new applicants to confirm they wish to enroll and understand the features/rules of the plan. Marketing representatives must **not** make the call and must not be present with the applicant during the call.
  - ❑ Marketing representatives must:
    - Provide the beneficiary with a description of the enrollment verification process during the application process and
    - Obtain the best phone number from the beneficiary for the plan sponsor to use to make the enrollment verification call.
  - ❑ Exceptions: Plan sponsors are not required to conduct outbound verification calls for switches from one plan to another plan of the same type (e.g., PFFS to PFFS, or PDP to PDP) offered by the same MA or PDP organization or for enrollments into employer or union sponsored plans.
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# Post-Enrollment: Materials for the Beneficiary

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- After the plan receives the enrollment form and prior to the effective date of coverage all plans must provide the member with:
  - A notice acknowledging receipt of the complete enrollment request;
  - A copy of the completed paper enrollment form unless the individual already received a copy when completing the form;
  - The plan rules;
  - The member's rights and responsibilities;
  - Evidence of plan membership and the effective date of coverage so that he/she may begin using the plan services as of the effective date; and
  - Information for how to obtain services prior to the receipt of an ID card (if the sponsor has not yet provided the ID card).

# Post-Enrollment: Premium Payment

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- At a minimum, plans must offer beneficiaries the option to pay the monthly premium through
  - Direct billing by the plan;
  - Premium withholding from their Social Security check; and
  - Automatic withdrawal from a bank, credit card, or debit card.
- Plans also may offer other payment options such as a coupon book.



## Post-Enrollment: When does coverage begin?

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- ❑ If a beneficiary joins during the Annual Election Period, (October 15 – December 7, 2011), coverage begins January 1 of the following year.
- ❑ At other times, coverage generally begins on the first day of the month following the month in which the beneficiary joins a plan.
- ❑ Because a beneficiary may have more than one election period when completing the enrollment application, the marketing representative should know which election period the beneficiary is using.

# Enrollee Protections

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- Members of a plan have a right to:
  - Be treated with dignity and respect at all times;
  - Be protected from discrimination;
  - Select and/or change their personal primary care network provider without interference from the plan;
  - Learn about all of their treatment choices and participate in treatment decisions;
  - Have their questions about Medicare answered in a way they can understand; and
  - Have access to doctors, specialists and hospitals:
    - Enrollees in HMOs, PPOs, and SNPs must have access to provider networks that include enough doctors, specialists, and hospitals to provide all covered services necessary to meet enrollee needs. Enrollees throughout the plan's service area must have access to network providers within reasonable travel time.
    - Exception – In limited circumstances, PPOs that serve regions established by CMS (Regional PPOs) may offer specified services only through non-network providers with CMS approval.

# Enrollee Protections, cont'd.

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- Members of a plan have a right to:
  - Have access to covered Part D drugs through network pharmacies:
    - Have access to plan networks that include retail, specialty, and home infusion pharmacies to provide convenient access to covered drugs.
      - Exception: PFFS plans may provide access to covered drugs through a network or by covering the drugs at any pharmacy.
    - Have convenient access to network long term care pharmacies, if the enrollee resides in a long term care facility.
    - Have convenient access to Indian Health Service, Tribal, and urban Indian organization (I/T/U) pharmacies, if enrollees are American Indians or Alaska Natives (AI/AN)
  - Get emergency care when and where they need it;
  - Know how doctors are paid;
  - Have personal and health information kept private; and
  - Obtain a treatment plan from their Medicare Advantage organization.

# Enrollee Protections, cont'd.

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- Members of a plan have a right to:
  - File complaints (sometimes called grievances), including complaints about the quality of your care;
  - Get a decision about health care payment or services, or prescription drug coverage; and
  - Get a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage .

# Enrollee Protections: Complaints, Grievances, Coverage Decisions, Appeals

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- Medicare health plan and prescription drug plan members have two main processes to deal with problems they have with their plan.
  - The grievance process is used for complaints about the operations of a plan.
  - The appeals process is used to ask for a review of coverage decisions on plan benefits and coverage or payment.

## Enrollee Protections: Grievances

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- Members or their representatives may file a grievance if they experience problems with their health care services such as timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
  - Grievance issues also may include complaints that a covered health service, procedure, or item furnished during a course of treatment did not meet accepted standards for delivery of health care.
  - An enrollee or their representative may make the complaint orally, in writing, or via a CMS website at: <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Beginning in 2012 plans will provide a link to the CMS website on the plan's main web page.
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# Enrollee Protections: Coverage Decisions

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- Coverage decisions are determinations made by a Medicare health plan or prescription drug plan with respect to whether medical care or prescription drugs are covered, the way in which they are covered, and problems related to payment .
- Examples of times when a member may need a coverage decision include:
  - To obtain payment for certain services, such as the type or level of services the enrollee thinks should be furnished;
  - To obtain payment for services when the member is temporarily out of the area;
  - To continue a service that the enrollee believes is medically necessary; or
  - To obtain payment for a prescription drug.

# Enrollee Protections: Appeals of Coverage Decisions

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- ❑ If a member is not satisfied with the coverage decision, he/she or in some cases his/her physician can appeal the decision.
- ❑ An appeal is a formal way to ask the plan to review or change a coverage decision.
- ❑ An appeal can be filed if :
  - A member believes a Medicare health plan does not pay for or allow, or ends a service that should be covered; or
  - A member believes a Medicare prescription drug plan has not allowed or paid for a Part D prescription drug that should be covered.



# Enrollee Protections: Appeals of Coverage Decisions, cont'd

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- Medicare health plans and prescription drug plans must provide members with a written description of the appeal process.
- To file an appeal members should look at their plan materials, call their plan, or visit [www.medicare.gov](http://www.medicare.gov).
- As noted in Part 3, “Medicare Part D Prescription Drug Coverage,” Part D plans
  - Provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a coverage determination or appeal a decision; and
  - Require network pharmacies to provide enrollees with a printed notice with the plan’s toll-free number and website for requesting a coverage determination.
- Marketing representatives can learn about plan specific appeal processes in their product specific training.

# Disenrollment from MA, Part D or Cost Plans

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- There are two types of disenrollment:
    - Voluntary disenrollment:
      - A member chooses to leave a plan because he/she wants to leave.
      - Members can only voluntarily disenroll during a valid enrollment or disenrollment period.
      - When a member changes plan coverage, he/she will be disenrolled automatically from the previous plan.
    - Involuntary disenrollment:
      - In certain situations, the plan may be required or may have the option to end a member's membership.
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## Disenrollment from MA, Part D or Cost Plans, cont'd

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- ❑ Plans or their marketing representatives may **not** either orally or in writing or by any action or inaction request or encourage any plan member to disenroll from the plan except in specific situations authorized by CMS.
- ❑ Plans may contact members to determine the reason for a voluntary disenrollment, but must not discourage a member from disenrolling after he or she indicates a desire to do so.
- ❑ Plans or their marketing representatives must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

# Voluntary Disenrollment from MA or Part D Plans

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- During a valid enrollment/disenrollment period a member may request disenrollment from an MA or prescription drug plan by:
    - Enrolling in another plan;
    - Sending or faxing a signed written notice to the plan sponsor (or employer/union group, if applicable);
    - Submitting a request via the internet to the plan sponsor (if the plan offers this option); or
    - Calling 1-800-MEDICARE or for TTY users call 1-1-877-486-2048.
  - Members making verbal requests must be instructed to make the request via one of the above methods.
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# Voluntary Disenrollment from MA or Part D Plans, cont'd

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- Exceptions:
  - At the discretion of the plan sponsor, employer or union group sponsored plans may accept verbal disenrollment requests from members and need not require written requests.
  - Employer or union sponsored plans may also permit disenrollment through a group disenrollment process.
  - To disenroll from an MSA plan members must write to the plan. The enrollee cannot disenroll via 1-800-MEDICARE.
  - To disenroll from PFFS and not enroll in another plan, members should contact the plan or Medicare.
  - To ensure disenrollment from a PDP, members should submit a written request or call Medicare in the following situations:
    - Joining an MA PFFS plan without drug coverage;
    - Joining an MSA plan; and
    - When NOT joining any other health or prescription drug plan.

# Voluntary Disenrollment from Cost Plans

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- Medicare Cost plan members may end their membership at any time during the year and enroll in Original Medicare.
  - The member must submit a written request and cannot disenroll by calling Medicare.
  
- A beneficiary who disenrolls from a Cost plan may join an MA plan or a PDP during the Annual Election Period or other MA or Part D election period

# Involuntary Disenrollment from MA, Part D or Cost Plans

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- There are two types of involuntary disenrollments by plans.
    - Required involuntary disenrollments by plans: CMS requires a plan sponsor to disenroll the individual.
    - Optional involuntary disenrollments: CMS provides an option for plan sponsors to disenroll individuals under certain circumstances.
  
  - CMS will disenroll beneficiaries who fail to pay the additional Part D premium based on income, i.e., the “Part D income related monthly adjustment amount” (Part D-IRMAA).
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# Involuntary Disenrollment from MA or Part D Plans, cont'd

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- Plan sponsors must disenroll a member from the plan in the following situations:
  - A permanent change in residence (including incarceration) makes the member ineligible to be enrolled (see slide 52 for rules regarding temporary change in residence);
  - The member does not stay enrolled in Part A and Part B for MA and MA/PD plans or does not stay enrolled in Part A or Part B for PDP plans;
  - A SNP member loses special needs status;
  - The member dies; or
  - The plan sponsor's contract is terminated, withdrawn, or the service area is reduced and excludes the member.  
(Exceptions apply).



# Involuntary Disenrollment from MA or Part D Plans, cont'd

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- Requirements for members who change residence
  - MA Organizations:
    - May offer an extended visitor/traveler (V/T) benefit of up to 12 months.
    - Do not need to disenroll members in these programs who remain temporarily out of the area for up to 12 months.
    - Must disenroll members who are not in these (V/T) programs who have been out of the area more than 6 months
    - Individuals have an SEP to enroll in a MA, MA-PD, or PDP.
  - Part D Plan Sponsors:
    - Must disenroll a member 12 months after identifying that the individual has moved outside of the service area if the plan has been unable to confirm the move with the member.
    - Exceptions may apply for members who have low income subsidy.

# Involuntary Disenrollment from Cost and MSA Plans

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- Medicare cost plans must disenroll a member:
  - Who does not stay continuously enrolled in Part B
  - Moves out of the service area for more than 90 days (up to 12 months for some plans)
  
- MSA Plans must disenroll a member:
  - Who no longer meets MSA eligibility requirements
  - Beneficiaries with end stage renal disease (ESRD) or who are receiving hospice benefits can not join a MSA plan, however may stay in a MSA plan if they qualify for these benefits after enrolling.

## Involuntary Disenrollment from MA, Part D or Cost Plans – At Plan Option, cont'd

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- Plan sponsors may involuntarily disenroll a member from the plan if the member:
  - Does not pay premiums on a timely basis;
  - Engages in disruptive behavior;
  - Provides fraudulent information on an enrollment request;
  - Knowingly falsifies or withholds information about third party reimbursement for prescription drugs under Part D; or
  - Allows another individual to use his or her enrollment card.
- Plan sponsors must take action consistently among all members of each discrete plan.

# Involuntary Disenrollment from MA, Part D, or Cost Plans – At Plan Option, cont'd

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## □ Enrollee's Rights:

- For failure to pay plan premiums the plan sponsor must:
  - Notify the member in writing and
  - Provide members with a grace period of not less than 2 months.
  - Exceptions apply for payment of premiums for dual eligible individuals and those who qualify for the Part D low income subsidy.
  - CMS may extend the grace period for good cause and reinstate enrollment if the beneficiary pays the overdue premiums within 3 calendar months of disenrollment.
- Cost plans may disenroll a member for failure to pay plan premiums and/or cost-sharing and must:
  - Notify the member in writing before the member is required to leave the plan.

# Involuntary Disenrollment from MA, Part D, or Cost Plans – At Plan Option, cont'd

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## □ Enrollee's Rights, cont'd:

- A plan sponsor may not end a member's enrollment for any reason related to the member's health.
  - Exception for SNPs because a member must be involuntarily disenrolled if he/she loses special needs status, which may be health-related
  - If the member believes they are being encouraged to leave the plan because of his/her health, the member should contact Medicare.
    - 1-800-MEDICARE
    - TTY Users should call 1-877-486-2048
- Members have the right to make a complaint if the plan ends their membership.
  - If a plan ends an enrollee's membership, the plan must tell the member the reason in writing and explain how the member may file a complaint against the plan.
  - Under specified circumstances, a member may be reinstated in his/her former plan (e.g., error or demonstration of "good cause" for failure to pay premiums)

## Additional information

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- Guidance for Eligibility, Enrollment and Disenrollment procedures for Medicare Advantage (MA) plans, including MA-PD plans, is provided in Chapter 2 of the Medicare Managed Care Manual.
  - [https://www.cms.gov/MedicareMangCareEligEnrol/01\\_Overview.asp](https://www.cms.gov/MedicareMangCareEligEnrol/01_Overview.asp)
- Similar guidance for 1876 Cost plans is provided in Chapter 17, Subpart D of the same manual.
  - <http://www.cms.gov/MedicareMangCareEligEnrol/>
- CMS provides instructions for enrolling Medicare beneficiaries in Medicare Prescription Drug Plans (PDPs) in the Agency's PDP Guidance for Eligibility, Enrollment and Disenrollment.
  - <http://www.cms.gov/MedicarePresDrugEligEnrol/>