

Medicare-Medicaid Plan Enrollment and Disenrollment Guidance

Revised: TBD (effective 01/01/2019)

The Centers for Medicare & Medicaid Services (CMS) Medicare-Medicaid Financial Alignment Initiative serves people who are enrolled in both Medicare and Medicaid, also known as dual eligible beneficiaries. The goal of the Initiative is to ensure dual eligible beneficiaries have full access to seamless, high quality integrated health care. Through demonstrations under the capitated financial alignment model, integrated Medicare-Medicaid Plans (MMPs) enter into three-way contracts with CMS and states. The demonstrations also strive to simplify the processes for dual eligible individuals to access the care and services they are entitled to under Medicare and Medicaid programs. This includes providing beneficiaries with a seamless enrollment and disenrollment process as well as clear communication about that process. States play a critical role in this process by working with both CMS and MMPs to ensure that beneficiaries receive information about the demonstrations in clear and timely manner and are appropriately enrolled or disenrolled.

The National MMP Enrollment Guidance has been updated in several key areas since last issued in 2016. The changes provide additional clarity, reduce burden for states and beneficiaries, and incorporates changes in Medicare regulations:

- Reduction in the number of notices required in writing
- Clarifications on online enrollment, online disenrollment, and cancellations
- Clarifications on opt-out flags when cancelling vs. disenrolling
- Clarifications on loss of Medicaid eligibility and cancellation before enrollment
- Clarification on passive enrollment when only one MMP is available
- New information related to the Social Security Number Removal Initiative
- New/Updated Special Enrollment Periods (SEP) – dual-eligible individuals and other LIS-eligible individuals, and passive enrollment
- CARA Lock-In provisions

This revised guidance is effective January 1, 2019 (i.e., starting contract year 2019). This guidance update provides states and MMPs with additional flexibilities and further clarification around the handling of existing enrollment operations processes and enrollment policy. Additionally, this guidance provides updates to align with 2019 Medicare C/D regulation to comply with changes to the dual-eligible individuals and other LIS-eligible individuals SEP and the CARA Lock-In provisions.

All states and MMPs should effectuate the enrollment process in conformance with this guidance, including enrollments, disenrollments, and cancellations, opting out of passive enrollment, and all other relevant changes or updates. Enrollment brokers with whom the state contracts must also adhere to the same guidance. In limited instances, and with advance notice to CMS states may delegate some of these activities to the MMPs, who must then comply with this guidance. However, states cannot delegate to MMPs the following:

- Approval of requests for optional involuntary disenrollment (§ 40.3), and
- Passive enrollments (§ 30.2.5), although the submission of the passive enrollment transactions may be delegated.

States may append certain items in their Appendix 5, such as state-specific variations, Medicaid-specific requirements, and functions to MMPs. Appendix 5 should also include any state-specific terms used to refer to Medicaid. Functions clearly identified in the state's Appendix 5 can be delegated to the MMPs. However, MMPs are not allowed to delegate the identified functions to anyone else, including their contracted sales agents or other entities.

States will issue their own guidance when an individual opts out of the demonstration, but remains enrolled in the managed care organization solely for Medicaid benefits, e.g., when a state mandates enrollment for Medicaid. At the states' discretion, this guidance may be in a separate document, or may be included in the state's Appendix 5. Any additional state-specific requirements or modifications to the policies outlined in this national guidance, including those derived from the MOU or the three-way contract, must be specified in the state's Appendix 5.

To effectuate the enrollment process, states will have to update beneficiaries' enrollment status in both their state enrollment systems and CMS' MARx enrollment system. CMS has developed the Enrollment Reconciliation Toolkit, available at www.medicare-solution.com, to provide tools to support ongoing enrollment reconciliation. Please also see §50.6 for details on enrollment reconciliation. States must use the CMS Enrollment Vendor to submit enrollment-related transactions to CMS, and to receive CMS response files, including the Daily Transaction Reply Report (DTRR). For additional details on the CMS Enrollment Vendor, which is available to assist states with submitting enrollment-related files to CMS, please visit: www.medicare-solution.com. Please note, you must have an account and log-in in order to view the toolkit.

For MMP enrollment records requiring corrections or retroactive adjustments outside of "Current Calendar Month" (§50.6.1), states must send their request to the CMS Retroactive Processing Contractor (RPC). For general information about the RPC, please see: <http://www.reedassociates.org/>. For the demonstration-specific retroactive submission spreadsheet (located in the RPC Toolkit page): <http://www.reedassociates.org/rpc-submission-toolkit/>

While states will have primary responsibility for initiating enrollments, disenrollment, cancellations, and opt-out requests, MMPs will still be responsible for other required data exchanges required by Medicare, including updates to Medicare Part D Low Income Subsidy (LIS) status. Please refer to the CMS Plan Communications User Guide (PCUG) for related information on files that must be exchanged, including:

- File formats and valid values for data elements
- Transaction Codes (TC) – See page I-1 of the Appendices of PCUG
- Daily Transaction Reply Report (DTRR) Detailed Record Layout - See page F-49 of the Appendices of PCUG
- Transactions Reply Codes (TRC) - See page I-2 (Table I-2) of the Appendices of PCUG
- Disenrollment Reason Codes – See page I-1109 (Table I-7) of the Appendices of PCUG. The PCUG may be found on the CMS website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelppdesk/Plan_Communications_User_Guide.html

New Medicare Cards

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards. A new Medicare Beneficiary Identifier (MBI) is replacing the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions, like billing, eligibility status, and claim status.

Beginning in April 2018, CMS started sending the new Medicare cards with the MBI to all Medicare beneficiaries. As of April 1, 2018, CMS is only sending the MBI on enrollment related reports and files. States and MMPs will need to be prepared to process enrollment related transactions using the MBI as of April 2018.

Further information regarding this initiative can be found on the new Medicare cards website at <https://www.cms.gov/Medicare/New-Medicare-Card/index.html>.

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10 - Eligibility for Enrollment in Medicare-Medicaid Plans

In general, an individual is eligible to elect a Medicare-Medicaid Plan (MMP) when each of the following requirements is met:

1. The individual is entitled to or enrolled in Medicare Part A, enrolled in Part B, provided that he or she will be entitled to receive services under Medicare Part A and Part B and eligible to enroll in a Part D plan as of the effective date of coverage under the MMP;
2. The individual permanently resides (as defined by the state in Appendix 5) in the service area of the MMP;
3. The individual or his/her legal representative (as defined in Appendix 3), or the state or CMS on behalf of the individual, completes an enrollment request and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS (refer to Appendix 1 for a list of items required to complete the enrollment request and §30.3.1 for who may sign enrollment forms);
4. The individual is a U.S. citizen or lawfully present in the U.S. (refer to §10.2.1 and §30.1 for details on persons unlawfully present at the time of the enrollment request); and
5. The individual is eligible for Medical Assistance under a state plan under title XIX of the Social Security Act or under a waiver of such plan, and meets other criteria established by the state in the Memorandum of Understanding, the three-way contract, or as further detailed in Appendix 5.

Note: Separately from this demonstration, some states are seeking section 1915(b) waiver authority to mandatorily enroll dual eligible individuals in a Medicaid-only managed care program. This waiver authority does not extend to Medicare, so the individual's Medicare benefits are not affected. For example, an individual may be enrolled in a Medicaid-only Managed Long Term Services and Supports (MLTSS) plan that has the same parent organization as the MMP. The Medicaid-only program is different and it is not to be confused with the three-way MMP contract as states have separate contracts with plans for the Medicaid-only managed care product.

An MMP may not impose any additional eligibility requirements as a condition of enrollment other than those described in the Memorandum of Understanding (MOU), by the three-way contract among the MMP, state, and CMS; or as established by the state and CMS in this guidance, including Appendix 5.

A state must not deny a request for opt-in enrollment to otherwise eligible individuals covered under an employee benefit plan, but the state must follow the requirements in §30.3.5, and §30.3.6 to ensure the beneficiary understands the potential consequences of doing so. If the individual enrolls in a MMP and continues to be enrolled in his/her employer/union or spouse's group health benefits plan, then coordination of benefits rules apply.

An individual may not be enrolled in more than one MMP at any given time. Procedures for handling multiple transactions, cancellations, and reinstatements are described in §50.1, §50.2 and §50.3.

Individuals enrolled in an MMP may not concurrently enroll in a Medicare prescription drug plan (PDP), a Medicare Advantage plan, a Medicare cost plan, a PACE organization or another MMP or other coordinated care delivery systems.

10.1 - Entitlement to Medicare Parts A and B and Eligibility for Part D

To be eligible to elect an MMP, an individual must be entitled to or enrolled in Medicare Part A, enrolled in Part B, and eligible to enroll in a Part D plan as of the effective date of coverage under the MMP. Individuals who are eligible but not enrolled in Part A and/or Part B should, as appropriate, be screened by the state for Medicare Savings Programs, and/or be referred to the Social Security Administration (SSA) to learn when and how they can enroll in Part A and/or Part B in order to become eligible for enrollment into the MMP.

Eligibility for Part D does not exist:

- When the beneficiary is incarcerated.
- When the beneficiary lives abroad.
- For any month prior to the month of notification of the entitlement determination when the entitlement determination for Medicare Part A and B is made retroactively.

Beneficiaries who are not eligible for Part D may not enroll in an MMP.

10.2 - Place of Permanent Residence

An individual is eligible to elect an MMP if he or she permanently resides in the service area of the MMP. A temporary move into the MMP's service area does not enable the individual to elect the MMP; the state must deny such an enrollment request. Incarcerated individuals are to be considered as residing out of the plan service area, even if the correctional facility is located within the plan service area. Individuals who are confined in Institutions for Mental Disease (IMDs) such as state hospitals, psychiatric hospitals or the psychiatric unit of a hospital, are not considered to be "incarcerated" as CMS defines the term, and are therefore not excluded on that basis from the service area of the plan unless denoted as ineligible under the Memorandum of Understanding, the three-way contract, or in Appendix 5.

A permanent residence is normally the primary residence of an individual. Proof of permanent residence is normally established by the address of an individual's residence, but a state may use additional criteria. Note that there is no minimum residency period required for enrollment into an MMP.

In the case of homeless individuals, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) may be considered the place of permanent residence.

10.2.1 - Incarceration & Lawful Presence

See Appendix 3 for definitions of Incarcerations and Lawful Presence.

An individual must reside within the MMP's service area, which does not include confinement in a correctional facility such as a jail or prison, and be a U.S. citizen or be lawfully present in the U.S. in order to be eligible for MMP enrollment. These eligibility criteria apply even if the individual would otherwise qualify for the Part D low income subsidy (LIS).

CMS determines eligibility for enrollment for purposes of Medicare, and will notify states of an individual's ineligibility on these basis at the time of enrollment. Eligibility for enrollment is based on the incarceration or lawful presence status of the individual as of the effective date of enrollment. For example, if a period of unlawful presence status ends prior to the effective date of enrollment, the state must not deny the enrollment request on this basis, even if the individual is unlawfully present at the time the enrollment request is received by the state.

In addition, states may not consider any evidence of lawful presence provided by the individual when determining eligibility for enrollment. States are not permitted to request documentation of U.S. citizenship or lawful presence status; states may independently verify an individual's lawful presence status through the Federal Data Services Hub or the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) Program, a web-based application that provides lawful presence status. Individuals who dispute their lawful presence status should be referred to SSA. Likewise, plans are not permitted to accept incarceration release papers to supersede the incarceration data within CMS systems. Individuals who contest their incarceration status, as indicated in CMS systems, should be referred to SSA to request that their record be updated.

10.3 - Completion of Enrollment Request

Enrollment in an MMP is predicated on a beneficiary completing an enrollment request. The enrollment request may be made by the eligible individual or the individual's legal representative (as described in §30.3.1). In passive enrollments, the state or CMS notifies the MMP eligible individual that he or she will be considered to have made a request to enroll in an MMP by taking no additional action, following advance notification that includes plan selection. A beneficiary would be considered to have elected the plan selected by the state or CMS unless they choose a different plan or decline the passive enrollment.

An enrollment request must be made even if that individual is voluntarily electing an MMP offered by the organization offering the Medicare Advantage plan or Medicaid Managed Care Organization in which the person is currently enrolled.

Unless otherwise specified by the state and CMS, an eligible individual can voluntarily elect an MMP only if he or she completes an enrollment request. The individual must complete an enrollment request by phone, paper form, on-line, by mail, or by facsimile. The individual must provide required information to the state within required time frames, and submit the proper completed enrollment request to the state. Model enrollment forms are included as Exhibits 1 and 2.

An individual who is a member of an MMP and who wishes to elect another MMP offered by the same parent organization must complete a new enrollment request; however, that individual may use a short enrollment form in place of the comprehensive individual enrollment form. See Exhibit 2.

A state must deny enrollment to any individual who does not properly complete the opt-in enrollment request within required time frames. Procedures for completing the enrollment request are provided in §30.3. Refer to Appendix 3 for a definition of “completed election.”

10.4 - Agreeing to Abide by Medicare-Medicaid Plan Rules

An individual is eligible to elect an MMP if he or she is fully informed of and agrees to abide by the rules of the MMP that were provided during the enrollment process (refer to §30.5, §30.4.1 and §30.4.2 regarding what information must be provided to the individual during the enrollment process). “Fully informed” means that the individual must be provided the applicable rules of the MMP, as described in §30.5 of this guidance and in the state-specific Demonstration Marketing Guidelines. The state must deny enrollment to any individual who does not agree to abide by the rules of the MMP. Agreement to abide by the rules of the MMP in this context is made through the completion of the enrollment request. In the case of passive enrollment, agreement to abide by the rules is made by not declining passive enrollment.

10.5 - Medicaid Eligibility and Additional State-Specific Eligibility Requirements for Enrollment in Medicare-Medicaid Plans

States must limit enrollment to individuals who meet state-specific eligibility requirements as outlined in Appendix 5.

Before processing an enrollment into an MMP, the state must confirm MMP eligibility, including both Medicare eligibility and Medicaid eligibility.

20 - Elections and Effective Dates

Elections include both enrollment and disenrollment requests. It is generally the responsibility of the state to determine whether the individual is eligible for enrolling in an MMP. All enrollment requests are processed by the state. This includes passive enrollments.

In the Medicare Advantage program, most beneficiaries have specific periods (called “election periods”) during which they can request to enroll into a plan, or disenroll from an MA, PDP, or MMP. The election periods are applicable to enrollment in MMPs (as it is considered a type of Medicare Advantage Prescription Drug plan).

Election periods for MMPs follow those outlined for MA plans in § 30 of Chapter 2 of the Medicare Managed Care Manual. Some key election periods include:

- Initial Coordinated Election Period – an election period for those newly obtaining both Part A and Part B coverage. Under the ICEP, individuals can elect a plan up to three months in advance of when their Medicare Part A and B coverage begins (enrollment into MA plan or MMP only).
- Annual Election Period – an election period for all people with Medicare to join, switch or drop plan coverage between October 15 – December 7.
- MA Open Enrollment Period – an election period for those enrolled in MA coverage as of January 1 (or the first 3 months after first becoming Medicare eligible) to leave that plan and switch to another MA plan or go to Original Medicare.
- Open Enrollment Period for Institutionalized Individuals – an election period for those institutionalized to join, switch or drop plan coverage.
- Special Enrollment Periods – various election periods established to address certain situations impacting an individual’s enrollment, such as a plan non-renewal, change in residence, or a gain, loss or change in Medicaid or LIS status, etc. Availability and timing vary by SEP.

The table below summarizes the election periods discussed above and the suggested hierarchy of election periods (highest to lowest). This is not a comprehensive list of all election periods and does not negate a state’s responsibility to contact a beneficiary if they believe that multiple election periods may be available.

Election Period	Available	Considered “Used”
Part D IEP	Based on when first eligible for Part D	Upon effective date
MA OEP (must meet OEP requirements)	Annually	Upon application date
SEP - 5-Star plans	Ongoing	Available as long as election is in 5-Star plan
SEP - PACE	Ongoing for enrollment into PACE; two month window after disenrollment from PACE	Available as long as election is in PACE plan; upon application date for election subsequent to PACE disenrollment
SEP - Institutionalized	Ongoing if moving into/residing in facility; two month window after moving out of facility	Available while in facility; upon application date for election subsequent to moving out of facility
SEP – CMS/State Assignment	Within 3 months of assignment or notification of assignment, whichever is later	Upon application date

SEP – Change in Dual/LIS Status	Within 3 months of status change or notification of change, whichever is later	Upon application date
Dual SEP	Ongoing – One use per calendar quarter during the first nine months of the year	Upon application date
AEP	Annually	Multiple elections can be submitted during AEP, last rec'd will be considered the choice

20.1 - Special Election Periods (SEPs)

Most individuals can only make changes to their plan enrollment during the AEP or MA OEP. Special Election Periods (SEPs) permit changes at additional times during the year. SEPs are limited to certain situations that impact an individual's enrollment or opportunity for choice. As outlined in § 30.4 of Chapter 2 of the Medicare Managed Care Manual, there are various SEPs, including SEPs specifically for dual eligible beneficiaries.

20.1.1 – SEPs Specifically for Dual Eligible Beneficiaries

Beginning January 1, 2019, dual eligible beneficiaries will no longer have a continuous Medicare SEP to change plans throughout the year. As modified, the new SEP for dual-eligible individuals and other LIS-eligible individuals (further outlined at § 30.4.4 #5 in Chapter 2 of the Medicare Managed Care Manual) provides that dual eligible beneficiaries may request enrollment in a different plan **one** time during each of the first three quarters in a calendar year:

- January to March;
- April to June; and
- July to September.

Individuals may not use this SEP during the last calendar quarter (October to December).

The effective date of the individual's enrollment in their new plan would be the first of the month following receipt of an enrollment request. The SEP is considered "used" based on the month in which the election is made. That is, if an election is made in March and effective in April, the 1st quarter use of the SEP would be considered "used," not the 2nd quarter. Once a beneficiary uses the SEP in a given quarter, the beneficiary will have to either wait for the next quarter or qualify for another SEP in that same quarter in order to disenroll or switch to a different plan.

This SEP cannot be used to switch plans between October and December. However, beneficiaries will be able to make changes from October 15 to December 7 during the Annual Enrollment Period (AEP) for the following benefit year.

States that obtain demonstration authority to waive the dual-eligible individual and other LIS-eligible individual SEP should update Appendix 5 to indicate they will have a continuous SEP.

Limitation for "At-Risk" and "Potentially At-Risk" Beneficiaries:

Once an individual is identified by the MA-PD organization as a "potential at-risk" or "at-risk" beneficiary and the plan sponsor has sent written notice to the individual, he or she cannot use

the SEP for dual-eligible individuals and other LIS-eligible individuals to change plans while this designation is in place. The notice to the individual explains that this SEP is no longer available. Additional information on drug management programs is available at

<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html>.

See Chapter 2, Section §30 of the Medicare Managed Care Manual for more information for more information on the SEP limitation.

NOTE: The enrollment limitation for a potential at-risk or an at-risk individual will not apply to all other enrollment periods, including the MA OEP, AEP and all other SEPs.

There are two other SEPs specific to dual eligible beneficiaries. The enrollment limitation for a potential at-risk or an at-risk individual will not apply to these SEPs:

- **SEP for Individuals who Gain, Lose, or Have a Change in the Dual or LIS-Eligible Status** – Dual eligible beneficiaries who are no longer eligible for Title XIX benefits have an **one** time opportunity to make an election within three months of the change, or notification of such a change, whichever is later. SEP begins the month they receive notice of the loss of eligibility, even if the loss of eligibility is determined retroactively by the state. This means the individual can join, switch or drop MMP coverage during this SEP. The effective date of an enrollment request using this SEP would be the first of the month following receipt of an enrollment request. See §40.2.3 regarding involuntary disenrollment from the MMP based on loss of Medicaid eligibility.
- **SEP for CMS and State-Initiated Enrollments** – Individuals who are passively enrolled into a plan (including an MMP) have a **one**-time opportunity to disenroll from their current plan and switch to another plan or go to Original Medicare. The individual has three months from the effective date of the CMS or state-initiated enrollment, or notification of it, whichever is later, to use this SEP. It allows the individual to make an election before the passive 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. The effective date of an enrollment request using this SEP would be the first of the month following receipt of an enrollment request. Individuals passively enrolled due to a plan's non-renewal or termination may also be eligible for an SEP as outlined in § 30 of Chapter 2 of the Medicare Managed Care Manual

20.2 - Effective Date of Coverage for Opt-in Enrollments

Generally, beneficiaries may not request their enrollment effective date when voluntarily requesting enrollment. Furthermore, the effective date is generally not prior to the receipt of an enrollment request by the state. An enrollment cannot be effective prior to the date the beneficiary or his or her legal representative sign the enrollment form and submit the enrollment request. Section 30.3 includes procedures for handling situations when a beneficiary chooses an enrollment effective date that is not allowable based on the requirements outlined in this section.

States may establish a cutoff date for accepting opt-in enrollment requests. The effective date for individuals who submit an opt-in enrollment request after the cutoff date will be the first day of the second month after receipt of the request.

The effective date may not be earlier than the first day of the individual's entitlement to Medicare Part A and Part B and Medicaid, as well as eligibility for Part D and other demonstration eligibility criteria. States may obtain the Medicare eligibility information from CMS through –

- Territory Beneficiary Query (“TBQ”) (<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/TBQData.pdf>),
- Beneficiary Eligibility Query (“BEQ”) (See Section 3 “Accessing the CMS Systems for Eligibility Verification” of the [MAPD Plan Communications User Guide \(PCUG\) Main Guide](#), and pages F-64 to F-79 of the [PCUG Appendices](#) for the detailed BEQ file layout),
- Medicare Advantage Prescription Drug User Interface (MARx UI) (Information and user registration is available at <https://portal.cms.gov>), or
- the Enrollment Vendor (www.medicare-solution.com).

Generally, the effective date for opt-in enrollment requests is the first day of the month following the state's receipt of the enrollment request. Exceptions include:

- Individuals whose Medicaid and/or Medicare effective date is in the future; in those instances, the effective date for enrollment into the MMP is the first day of the month the individual meets MMP eligibility criteria, e.g., is eligible for both Medicaid and Medicare.
 - For Medicare, this includes the Initial Coordinated Enrollment Period, in which an individual may request enrollment up to three months before the start of their Medicare eligibility.
 - In addition, if a state establishes a cutoff date for receiving opt-in enrollments per §20, then the effective date for enrollment requests received after the effective date is the first day of the second month after the month of receipt.

The effective dates for passive enrollment are described in §30.2.5 of this guidance.

20.3 - Effective Date of Voluntary Disenrollment

Generally, beneficiaries may not select their effective date of disenrollment.

When a member voluntarily disenrolls from an MMP, he or she will remain in the MMP until the last day of the month in which the disenrollment request was received and approved, and will return to Original Medicare the first day of the following month. CMS will auto-enroll the member into a Medicare Prescription Drug Plan if he or she is eligible for the Medicare Part D Low Income Subsidy and did not elect a Medicare health or drug plan. The member will need to qualify for an SEP in order to elect a Medicare health or drug plan outside of a CMS Enrollment Period (see Section §20.1). If a member elects a Medicare health or drug plan while still a member of an MMP, he or she will automatically be disenrolled from the MMP upon successful submission of the enrollment in the new Medicare plan to CMS.

Individuals have until the last calendar day of the month to request disenrollment (please note this differs from the earlier cutoff permitted under §20.2 for enrollment requests). The effective

date for all voluntary disenrollments is the first day of the month following the state's receipt of the disenrollment request. This may not be modified in Appendix 5.

30 - Enrollment Procedures

States will be responsible for accepting enrollment and opt-out requests related to MMPs. States may accept enrollments via a range of mechanisms. Choices include accepting enrollments during a face-to-face interview in which a paper form is completed by the applicant, by phone, on-line, by mail, or by facsimile. A state may encourage the use of mechanisms other than a paper form, but must accept paper enrollment requests. Regardless of mechanism, the state must collect certain information necessary for CMS to process related transactions, and to notify beneficiaries of certain rights.

For opt-in enrollment requests, an individual (or his/her legal representative) must complete an enrollment form or other CMS-approved enrollment request mechanism to enroll in an MMP and must submit the enrollment request to the state. Please note that in this guidance, opt-in enrollment is used to mean beneficiary-initiated elections; this is distinguished from passive enrollments, which are considered opt-in in that the beneficiary's silence is considered agreement with the election. If an individual currently enrolled in a Medicare health or prescription drug plan wishes to elect an MMP offered by the same parent organization, he or she must complete a new enrollment request to enroll in the MMP.

Enrollment may also be made via the passive enrollment process as described in §30.2.5 of this guidance.

An MMP must accept enrollment and opt-out requests it receives through the state. MMPs may not accept enrollment and opt-out requests directly from individuals and process such requests themselves, but instead, must forward the request to the state within 2 business days, unless the state has delegated enrollment activities to the MMP. MMPs will receive enrollment-related notifications from both the state, as well as from CMS or its contractor (the latter via the Daily Transaction Reply Report (DTRR)). Please note that the DTRR will also include other notifications from CMS, e.g., changes in Low Income Subsidy copayment level. Please see the CMS Plan Communication User Guide (PCUG) for additional details.

Upon receiving an enrollment request, the state must determine eligibility for enrollment into the MMP and provide one of the following notices within the specified timeframes indicated below:

- Enrollment acknowledgement notice within 10 calendar days - Exhibit 3 (as described in §30.5.1). This may include the Request for additional information – Exhibit 6 (as described in §30.3.2);
- A single, combined enrollment acknowledgement/confirmation notice within 7 calendar days - Exhibit 4 (as described in §30.5.1); or
- Notice of denial within 10 calendar days - Exhibit 9 (as described in §30.3.3).

As described in §30.5.1, the state may use a single, combined acknowledgment/confirmation notice instead of separate acknowledgement (i.e., that request is received) and confirmation (i.e., that request is successfully processed) notices (see Exhibit 4). If a single, combined notice is used, it must be provided within 7 calendar days of receiving the confirmation of enrollment via the CMS Daily Transaction Reply Report (DTRR). If the enrollment transaction is rejected by CMS, the state must send the notice of rejection within 10 calendar days of receiving the DTRR (see Exhibit 10).

States will notify CMS via the Enrollment Vendor of enrollment and opt-out requests it has processed, using standard MARx transaction formats. Enrollments will be submitted on TC 61 transactions, and opt-out requests on TC 83 transactions. CMS will process these transactions and the Enrollment Vendor will send the DTRR to the MMP and the state. The Enrollment Vendor will ensure all applicable reports are provided to the MMP and/or the state. Should the state or the MMP identify discrepancies between state and CMS notification, the state may submit corrections to MARx, or may work with the CMS' Retroactive Processing Contractor (RPC) to process any needed corrections to CMS' systems. Unless otherwise directed in this guidance, required notices must be provided in response to information received from CMS on the DTRR that contains the earliest notification.

Please refer to §30.3.5 and §30.3.6 for additional instructions on processing enrollments in which an individual has other qualified prescription drug coverage through an employer or union group.

30.1 - Enrollment Process for Incarceration and Unlawful Presence

States will obtain an individual's incarceration and lawful presence status from the Batch Eligibility Query (BEQ) process or MARx eligibility query (M232 screen), since eligibility must be verified via one of these sources for all enrollment requests. The systems (BEQ or MARx eligibility query) will indicate an incarceration status or unlawful presence status of a non-U.S. citizen, including the start date (and possibly an end date) of an incarceration or unlawful presence status or period, in order for states to determine eligibility for enrollment. Individuals who are not incarcerated, or who are citizens or are lawfully present in the U.S., will not have any data reflected in the systems. The absence of such data indicates that CMS does not have any information indicating ineligibility on this basis at that time.

For those who are incarcerated or unlawfully present, as indicated in CMS systems, the state will determine the individual to be ineligible for enrollment based on the start date of the incarceration or unlawful presence status shown in our systems. If an individual is ineligible for MMP enrollment, the state must deny the enrollment request, notify the individual of the denial, and not submit an enrollment transaction to CMS. In most cases, if an enrollment transaction is submitted to CMS for an incarcerated or unlawfully present individual, CMS will reject the enrollment and notify the state with a Transaction Reply Code 345 (Enrollment Rejected – Confirmed Incarceration) or Transaction Reply Code 348 (Enrollment Rejected – Not Lawfully Present Period) on the Daily Transaction Reply Report (DTRR). However, under no circumstances should a state submit to CMS an enrollment transaction for an individual reflected in CMS systems as ineligible due to incarceration or unlawful presence. Upon receipt of an enrollment rejection, the state must issue a denial notice to the individual, if such notice has not previously been issued.

30.2 - Format of Enrollment Requests

At a minimum, the state must have a paper enrollment form process (as described in this guidance and approved by CMS) available for potential enrollees to request enrollment in an MMP. However, as noted in §30, states can use paper form, phone, internet, mail or facsimile as formats for potential enrollees to request enrollment in an MMP.

States must also process passive enrollments as described in §30.2.5 of this section.

30.2.1 - Enrollment Request Mechanism

The state must use an enrollment mechanism that is approved by CMS. A model enrollment form has been developed for enrollment into MMPs (see Exhibit 1).

States may utilize the model to ensure all required elements are included. States may develop their own materials using these models, subject to CMS approval. All enrollment mechanisms must include the required elements outlined in Appendix 1 and the applicant's acknowledgement of the following:

- Understanding of the requirement to continue to keep Medicare Parts A and B;
- Agreement to abide by the MMP's membership rules, as outlined in member materials;
- Consent to the disclosure and exchange of information necessary for the operation of the Medicare and Medicaid programs;
- Understanding that he or she can be enrolled in only one Medicare health plan and that enrollment in the MMP automatically disenrolls him/her from any other Medicare health plan and Medicare prescription drug plan;
- Understanding of the right to appeal service and payment denials made by the MMP; and
- Other state-specific requirements.

Please note that for passive enrollments, when the beneficiary does not decline passive enrollment, this is determined to be agreement with the items above.

Please refer to Appendix 1 for a complete listing of required elements that must be included on enrollment mechanisms and Exhibit 1 for complete information on the required statements.

States must include elements on the enrollment mechanism that correspond to the unique eligibility criteria (e.g., required Medicaid status) of the demonstration in their state.

No enrollment mechanism may include a question regarding binding arbitration, whether the individual receives hospice coverage or any other health screening information, with the exception of questions regarding ESRD status and nursing home status for the purpose of determining eligibility for enrollment in the MMP. However, the states may ask health related questions during completion of the enrollment request for the purpose of successful transition of care. These questions must be asked subsequent to the required enrollment request elements and clearly indicate that the information is only being collected to help in the successful transition of the individual's care in the MMP and is not to be used to determine if an individual can enroll in the MMP. Individuals cannot be excluded based on health conditions, except as otherwise specified in Appendix 5. The individual is not required to answer the health related questions in order for the enrollment request to be processed or submitted to the state. If the state receives an enrollment request without the health related information, they may follow up with the individual to obtain coordination information, however, the individual is not required to answer and the state may not delay in processing the request due to not having such information. The collected health information is to be securely and electronically forwarded to MMPs to start the care management and transition of care activities.

Refer to §50.8 for requirements regarding retention of enrollment request mechanisms.

30.2.2 - Enrollment Related Requests via Electronic Mechanisms

States may develop and offer the option for individuals to submit enrollment-related requests (i.e., opt-out, enrollment, disenrollment, and cancellation) to an MMP via the state's secure internet web site. The following guidelines must be applied, in addition to all other program requirements:

- Submit all materials and web pages and images (e.g., screen shots) related to the electronic enrollment process for CMS approval following the established process for the review and approval of marketing materials and other enrollment request mechanisms.
- Provide beneficiaries with all the information required by state-specific Demonstration Marketing Guidance.
- At a minimum, comply with CMS' data security policies (found at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/index.html?redirect=/informationSecurity/>). The state may also include additional security provisions. The CMS policies indicate that with regard to receiving such enrollments via the internet, an acceptable method of encryption must be utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to ensure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information.
- Provide the CMS Office of Information Technology with a pro forma notice of intent to use the internet for these purposes. The notice is essentially an attestation that the state is complying with the required encryption, authentication, and identification requirements.
Note: CMS reserves the right to audit the state to ascertain whether it is in compliance with the security policy.
- Advise each individual at the beginning of the electronic enrollment process that he or she is sending an actual enrollment request to the state.
- Capture the same data as required on the model enrollment form (see Exhibit 1 and Appendix 1).
- As part of the electronic enrollment process include a separate screen or page that includes an "Enroll Now," or "I Agree," type of button, that the individual must click on to indicate his/her intent to enroll and agreement to the release and authorization language, as provided on the model enrollment form (see Exhibit 1), and attest to the truthfulness of the data provided. The process must also remind the individual of the penalty for providing false information.
- The mechanism must capture an accurate time and date stamp at the time the applicant activates the step in the previous bullet (i.e., "Enroll Now" or "I agree" button or tool). The state will use this data to establish the application date for the enrollment request. This time stamp also marks the start of the seven day timeframe for processing the enrollment request, as it is at this time that the enrollment request is considered by CMS to be received by the state.
- If a legal representative is completing this enrollment request mechanism, he or she must attest that he or she has such authority to make the enrollment request and that proof of this authority is available upon request by CMS or the state.
- Inform the individual of the potential outcome(s) of completing the internet enrollment, including that he or she will be enrolled (if approved by CMS), and that he or she will receive notice (of acceptance or denial) following submission of the enrollment to CMS and state.

- Include a tracking mechanism to provide the individual with evidence that the internet enrollment request was received (e.g., a confirmation number).
- Maintain electronic records that are securely stored and readily reproducible for the period required in §50.8 of this guidance. The state's record of the enrollment request must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, the state, and/or CMS. A data extract file alone is not acceptable.
- The option of electronic enrollment is limited to requests submitted via the state's or state's enrollment broker website. Electronic enrollment via other means, such as a plan broker or plan website, is not permitted except in the instances when the state has delegated a given part of the enrollment process to the MMP.

Note: enrollments into MMPs will not be accepted by the Medicare Online Enrollment Center.

30.2.3 - Enrollment via Telephone

States may accept requests for enrollment into an MMP via an inbound telephone call. A state may accept an enrollment request via an outbound call when, during the course of a call made to a beneficiary for the purpose of outreach and education regarding the demonstration, the beneficiary expresses a desire to request enrollment in one of the available MMPs.

Please note that MMPs, including those MMPs that have delegated authority to enroll beneficiaries, cannot enroll beneficiaries via outbound calls. Please see § 70 and §80 of the Medicare Communications and Marketing Guidelines (<https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>) and the state-specific Demonstration Marketing Guidelines <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.html> for MMP instructions on conducting outreach and handling telephonic activities.

The requirements outlined in this section are applicable to telephonic enrollment requests based on both inbound and outbound calls for states and enrollment brokers only:

- Enrollment requests may be accepted during an incoming (or in-bound) telephone call from a beneficiary. This includes inbound calls to an incorrect department or extension transferred internally.
- Enrollment requests received from a beneficiary during an outbound telephone call must adhere to all requirements applicable to telephonic enrollment requests received via an inbound call.
- The state must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his or her authorized representative
- Individuals must be advised that they are completing an enrollment request.
- Each telephonic enrollment request must be recorded (audio) and include a statement of the individual's agreement to be recorded, all required elements necessary to complete the enrollment (as described in Appendix 1), and a verbal attestation of the intent to enroll. Here is a sample script the interviewer may use to get verbal consent from the individual:

“For this interview, we will ask you questions to process your (/or name of person’s) application for [Medicare-Medicaid Plan]. Your response will be recorded. At the end of the interview, we will ask you to confirm the accuracy and truthfulness of your answers.”

- If the request is made by someone other than the beneficiary, the recording must include the attestation regarding the individual’s authority under state or other applicable law to complete the request, in addition to the required contact information, e.g., Phone Number, Name and Address. All telephonic enrollment recordings must be reproducible and maintained as provided in §50.8.
- Include a tracking mechanism to provide the individual with evidence that the telephonic enrollment request was received (e.g. a confirmation number).

An acknowledgement notice and other required information must be provided to the individual as described in §30.5.1.

The state must ensure that all MMP eligibility and enrollment requirements provided in this guidance are met. Scripts for completing an enrollment request in this manner must be developed by the state, must contain the required elements for completing an enrollment request as described in Appendix 1.

The state should provide either the option for individuals to leave voicemails outside of operating hours when the state does not have a live call center representative available to answer calls, i.e., after hours, weekends, or for individuals to leave a phone number and receive a call back during regular business hours. CMS encourages states to respond to individuals within 2 business days.

30.2.4 - Outreach and Education for Individuals Eligible for but Not Enrolled in MMPs

States may conduct outreach and education on the benefits of enrolling in an MMP to those not already enrolled. This includes individuals in a service area or eligibility category where there is only opt-in enrollment, as well as individuals who have previously opted-out of passive enrollment into an MMP. States should ensure that outbound calls are made only occasionally and are not excessive or coercive in nature. This includes spacing out the timeframes between calls made to the individual and the number of calls made within a short period of time.

In addition, as provided under §70.6 of the Medicare Communications and Marketing Guidelines (<https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>), parent organizations of MMPs may contact current Medicare Advantage, Prescription Drug Plan, and Medicaid managed care members to promote other Medicare products they offer, including their MMP. MMPs are encouraged to use reasonable efforts to contact current members who are eligible for MMP enrollment to provide information about the benefits of their MMP product. MMPs should follow applicable Medicare Marketing Guidelines for conducting outreach calls (<https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>) and the state-specific Demonstration Marketing Guidelines (<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.html>).

30.2.5 - Passive Enrollment

CMS and a state may offer eligible individuals passive enrollment into MMPs. Passive enrollment is a process by which a beneficiary is informed that he or she will be considered to have made a request to enroll in an MMP by taking no action.

Passive enrollment into MMPs will be coordinated with CMS activities, such as LIS auto-enrollment and reassignment, to ensure that enrollment changes not initiated by eligible individuals are generally limited to once per benefit year. States may not passively enroll individuals into an MMP more than once per benefit year (see section H below), except with CMS' prior approval in the following limited situations:

- MMP mid-year terminations;
- MMP non-renewal; and
- If CMS and the state jointly determine that remaining in the MMP poses potential harm to members.

The state may not passively enroll an individual more than once per benefit year for any other reasons, including when the person voluntarily disenrolls (even if they have not explicitly requested to opt out of future passive enrollments) or if they are involuntarily disenrolled for the reasons outlined in §40.2 with the exception of short-term loss of Medicaid. Individuals who have short term loss of Medicaid may be rapidly re-enrolled back into their MMP (§40.2.3.3). Individuals who opt out of passive enrollment are not eligible for future passive enrollments (see section E below) for the life of the demonstration. Please note, that individuals who opt out of passive enrollment should not be rapidly re-enrolled.

The Comprehensive Addiction and Recovery Act of 2016 (CARA) allows for the establishment of a drug management program in Medicare Part D. As of January 1, 2019, if a beneficiary is in a drug management program and is in a potentially at-risk or at-risk status, the beneficiary may not be able to change plans using the Dual-eligible Individual or Other LIS-eligible Individual SEP. States should not passively enroll beneficiaries in a potential at-risk or at-risk status into MMPs unless their current plan is terminating. CMS will provide technical assistance on how to identify and exclude these individuals from passive enrollment into an MMP. For more information on CARA limitations, please see 42 CFR §423.153(f)

A new SEP is available to all individuals passively enrolled. This SEP allows the individual to make an election before the passive enrollment is effective in the receiving plan or after the coverage in the receiving plan starts. See § 20.1.1 and § 30.4.7 of Chapter 2 of the Medicare Managed Care Manual for more details about this SEP.

A. Individuals Eligible for Passive Enrollment

Individuals eligible for passive enrollment must:

- Be entitled to both Medicare Part A and Part B (See positions 1152-1331 in MMA response file or TBQ response);
- Be eligible to enroll in a Part D plan;

- Be entitled to Medicaid;
- Permanently reside in the service area of the MMP; and
- Meet additional criteria applicable to his/her state.

States may not passively enroll individuals who:

- Are enrolled with a PACE organization;
- Have employer or union sponsored health or drug coverage;
- Are being claimed by an employer for the Medicare Part D Retiree Drug Subsidy;
- Are incarcerated;
- Are not lawfully present;
- Have opted out of passive enrollment into an MMP;
- Have opted out of auto-enrollment into a Part D plan (since MMPs qualify as a Part D plan);
- If applicable, meet additional state-specific requirements in Appendix 5; or
- Permanently reside outside the service area of the MMP.

B. Passive Enrollment Process

The procedure for passive enrollment is as follows:

- a) The state must identify individuals meeting all applicable passive enrollment criteria in §30.2.5.A.
- b) The state must identify the MMP into which each individual will be passively enrolled.
 - i. States can utilize the most recent 12 months of Medicare Part A (inpatient), Part B (outpatient), Part D (prescription drug) and Medicaid claims history data to help identify the individual's most frequently utilized providers and medical facilities, e.g., physicians, medical groups, clinics, long-term care facility, etc. to assist with assigning beneficiaries to an MMP that best meets the current circumstances of the individual's needs. Note that claims data for individuals previously enrolled in Medicare health plans may not be available.
 - A. For individuals already enrolled in a Medicare Advantage plan or a Medicaid Managed Care Organization that also offers an MMP in the individual's service area, the state may fulfill this requirement by passively enrolling these individuals into the MMP offered by that organization.
 - B. States are encouraged to consult with beneficiary advocates and other stakeholders to develop and periodically update algorithms for passive enrollment.
 - ii. States may not passively enroll individuals into an MMP that, at the time of effectuation of the three-way contract, is offered by a legal entity that is either an outlier in CMS' past performance analysis and/or has any contracts with a "consistently low performing" icon (LPI) on the Medicare Plan Finder website as detailed in the past performance guidance for MMPs at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid->

[Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/2016MMPAnnualRequirements.pdf](#). After effectuation of the three-way contract, states may not passively enroll individuals into an MMP that is offered by a legal entity that is an outlier in CMS' past performance analysis.

- A. The only exception is when the individual to be passively enrolled is currently enrolled in a Medicaid Managed Care Organization or a Medicare Advantage plan sponsored by the same organization. Under this exception, the state may passively enroll the individual into the MMP sponsored by that same organization.
- B. When the legal entity is no longer considered by CMS to be a past performance outlier and/or no longer has any contracts with an LPI on the Medicare Plan Finder, the MMP may qualify to receive other passive enrollments.
- C. When an MMP contract whose past performance outlier or LPI status is attributable to a sibling legal entity's Medicare performance, the MMP may be eligible for passive enrollment if the MMP's legal entity has demonstrated both sufficient MMP contracting experience and satisfactory operational performance. "Sufficient MMP contracting experience" is considered to be a period of no less than 90 calendar days following the effective date of the first wave of passive enrollment that would have been applicable to the MMP contract in a particular state had the contract not been prohibited from receiving passive enrollment. In addition, the MMP in question would need to not otherwise be a past performance outlier (based on the most current analysis of the new legal entity's performance), and would need to have demonstrated satisfactory operational performance and capacity since effectuation of the three-way contract. Satisfactory operational performance could be determined through, but would not be limited to, the following:
 - 1. Satisfactory updated staffing estimates based on the projected new volume of enrollees. This information is initially collected as part of each MMP's readiness review process but would be re-reviewed based on the new enrollment assumptions.
 - 2. Analysis of any MMP monthly reported data.
 - 3. Review of any potential compliance actions either already issued, or in process of issuance; issues identified by Contract Management Team; and complaints data in the complaints tracking module in HPMS.
- D. If an MMP does not demonstrate satisfactory operational performance and capacity, MMCO and the state would delay receipt of passive enrollment for one or more additional cycles.

If, however, an organization is under sanction and that sanction is not removed at the time CMS and the state seek to effectuate the three-way contract, the organization will not be permitted to offer an MMP for the duration of the demonstration. An organization that is sanctioned after the effectuation of a contract will be unable to enroll any new members – either through passive or opt-in enrollment – until the sanction is lifted.

- c) States must notify individuals in writing about passive enrollment. States must provide CMS an opportunity to review and approve the 30-day (Exhibit 5) and 60-day notices (Exhibit 31) prior to their use. Draft notices should be submitted to CMS at least 30 days before implementing, to provide both CMS and the state appropriate time to review and make any necessary edits.
 - i. States may send general outreach notices prior to the notification of plan assignment; however states must send notices with plan assignments, as outlined below.
 - ii. No less than 60 calendar days and no more than 90 days prior to the enrollment effective date, the state:
 - A. Sends a passive enrollment notice to the individual informing him/her of his/her assigned plan and providing instructions to opt out of (i.e., decline) the passive enrollment.
 - B. Submits an enrollment transaction (TC 61) to CMS' MARx enrollment system to passively enroll the individual into the MMP. Please note:
 - 1. States may omit "4Rx data" (four data elements issued by plans that permit on-line, real time billing by pharmacists) from enrollment transactions (TC 61), and instead direct MMPs to submit them to CMS directly after receiving a Daily Transaction Reply Report (DTRR) that confirms enrollment.
 - 2. States should use the enrollment source code "J," indicating passive enrollment by the state.
 - iii. The state sends an address file to MMPs of those passively enrolled with them (see Appendix 5 for details). Please note, MMPs may also obtain address of enrollees from the CMS Batch Eligibility Query.
- d) The state sends a second reminder notice at least 30 days prior to the effective date.
- e) For individuals who request to cancel enrollment at any point prior to the passive enrollment effective date, the state must send:
 - i. an enrollment cancellation transaction (TC 82) to cancel the passive enrollment within 7 calendar days of receipt of the cancellation request; and
 - ii. an MMP Opt-Out Flag data element set to "Y" (opted out of passive enrollment into MMP Plan) in position 202 to register on CMS systems the request to opt out

of future passive enrollments into an MMP. The state must also store this in their state system to exclude them from future passive enrollments.

- f) The MMP may reach out to conduct an early health risk assessment (HRA) and screening no sooner than 20 days before the effective date of the passive enrollment. Please refer to §30.3.E. for more details about HRA.

C. Ongoing Passive Enrollment of Newly Demonstration Eligible Individuals

States may passively enroll existing dually eligible individuals who become newly demonstration eligible on a frequency to be determined by the state (e.g., daily, weekly, monthly, or annually). This includes individuals who:

- Move into a demonstration service area, and were not passively enrolled or re-assigned by Medicare effective the current calendar year; or
- Are no longer in an excluded category for passive enrollment (examples vary by state, but can include a change in the Medicaid eligibility category, such as no longer in Medicaid spend-down status).

The standard instructions for submitting transactions to CMS' MARx system and passive enrollment notifications to beneficiaries apply. States may request a file from CMS' demonstration enrollment vendor to support identification of newly dually eligible individuals. This MMP Prospective Dual File provides a bi-monthly lists of new dual eligibility in a given state, specifically those who originally had Medicaid only and then subsequently became Medicare eligible. The file will be expanded at a later date to include those who originally had Medicare only and then became Medicaid eligible. The file is intended to be a starting point; the state would then further screen the file to determine if an individual qualifies for demonstration passive enrollment.

D. Annual Passive Enrollment

In demonstrations with passive enrollment, CMS strongly encourages the use of monthly passive processing as described above. However, as an alternative to monthly passive enrollment, states may conduct an annual passive enrollment of some or all of the categories of individuals discussed in section C above on ongoing passive enrollment opportunities and §30.2.5 sections L and M below for newly dually eligible individuals who had Medicaid first, and newly dually eligible individuals who had Medicare first. This annual passive enrollment would occur in the fall of a given year for an effective date of January 1 of the following year. The annual passive enrollment process can include the following groups of individuals who become re-eligible for passive enrollment in the new calendar year:

- Those who involuntarily disenrolled from an MMP during the previous calendar year, e.g., due to short term loss of Medicaid;
- Those who were reassigned by CMS to a PDP effective January of the current calendar year and have not otherwise opted-out of passive enrollment in prior years;
- Dually eligible individual auto-enrolled by CMS to a PDP effective any month in current calendar year (referenced in section L. below as needing to be carved out of any monthly passive enrollment for those newly dually eligible who had Medicare first);

- New dually eligible individual who had Medicaid first (see section L below); and
- New dually eligible individuals who had Medicare first (see section M below).

E. Effective Date of Passive Enrollments

The effective date of passive enrollment is determined by the state, subject to the following conditions:

1. The effective date shall always be prospective, no less than 60 calendar days from the date the passive enrollment notice is sent to the individual and the passive enrollment transaction is submitted to CMS' systems.
2. The effective date shall always be the first day of a month.

F. Required Notices

The state must notify the beneficiary in writing that he or she will be passively enrolled in the MMP on the specified effective date if he or she does not opt out of the enrollment prior to the enrollment effective date. The notice must be sent no less than 60 calendar days prior to the enrollment effective date and must inform the beneficiary that he or she may opt out of passive enrollment into the MMP (see Exhibit 31). If the beneficiary does not respond or does not opt out prior to the enrollment effective date, the person's silence will be deemed to be an election of the MMP. Individuals passively enrolled are eligible for a Medicare Special Election Period (SEP) that allows them to request enrollment in a Medicare health plan (Medicare Advantage plan, MMP, Medicare cost plan or PACE Program) or into Original Medicare and a Medicare Part D plan, up to 3 months after the passive enrollment takes effect. This information is also available in the 60 day passive notice (Exhibit 31).

States should strive to mail the passive enrollment notice before submission of passive transaction to CMS. This is because the passive enrollment transaction will prompt an auto disenrollment notification to the beneficiary's current Medicare health or drug plan, which then prompts them to send a disenrollment notice. Efforts to have the passive notice arrive before that disenrollment notice will minimize beneficiary confusion. States that have implemented procedures to send passive notices after CMS accepts a transaction (i.e., to minimize enrollment discrepancies between state and CMS systems) should send the passive notice as soon as possible after receiving confirmation on the CMS DTRR.

Beneficiaries who have been passively enrolled will receive a second notice no later than 30 days prior to the effective date of their coverage, reminding individuals of the passive enrollment effective date, their choices (including opt out) and where to seek assistance (see Exhibit 5).

G. Opt Out of Passive Enrollment

Individuals may opt out of (i.e., affirmatively decline) passive enrollment into the MMP. An individual who opts out does not permanently surrender his or her eligibility for, or right to enroll in, an MMP; rather, this step ensures that CMS and the State do not include the person in future MMP passive enrollment processes for the life of the demonstration. Such individuals may opt in to an MMP.

Individuals who choose to opt out of passive enrollment into an MMP must do so by contacting the state or 1-800-MEDICARE. If the individual calls the MMP, the MMP will refer them to the state within 2 business days. Individuals who elect to call 1-800-MEDICARE to opt out may have their requests accepted and processed by CMS first, and then states and MMPs will receive a TC 42 via the Daily Transaction Reply Report (DTRR). Beneficiaries may opt out verbally or in writing. Once a beneficiary has opted out, the State must document this and exclude him or her from future passive enrollment processing.

The state should counsel the individual to ensure he or she understands the implications of the request to opt out of passive enrollment, and must acknowledge the individual's request in writing (see Exhibit 28) within 10 calendar days of receipt of the individual's request to opt out or receipt of the DTRR.

If the individual opts out after the enrollment transaction (TC 61) has been submitted, but prior to the passive enrollment effective date, the state must both cancel the passive enrollment with an enrollment cancellation transaction (TC 82) and include an MMP Opt-Out Flag data element "Y" (opted out of passive enrollment into MMP Plan) in position 202. CMS systems will attempt to restore the individual to his/her previous coverage; if that is not possible, CMS' systems will revert the individual to Original Medicare and will auto-enroll him/her into a Medicare Prescription Drug Plan. The individual will have access to the LI NET prescription drug plan during any coverage gap. Refer to Appendix 3 for LI NET definition.

If the individual requests to opt out and disenroll from the MMP after the effective date of a passive enrollment, the state must disenroll the individual prospectively by submitting a disenrollment transaction (TC 51) and include an MMP Opt Out Flag data element "Y" (opted out of passive enrollment into MMP Plan) in position 202. CMS' systems will revert the individual to Original Medicare and will auto-enroll him/her into a Medicare Prescription Drug Plan. The individual will have access to the LI NET prescription drug plan during any coverage gap.

The Part D Opt Out Flag indicates that the beneficiary has opted out of the Part D auto-enrollment and reassignment process. If this flag is on, it will prevent CMS from auto-enrolling or reassigning a beneficiary into a Part D plan. The MMP Opt-Out Flag only indicates that the beneficiary does not wish to be passively enrolled into an MMP. It will not prevent CMS auto-enrollment of the beneficiary into non-MMP Part D plans. Beneficiaries who have the Part D Opt-Out Flag should be excluded from all passive enrollments into MMP plans.

- Opting Out of Part D Auto-enrollment: Since MMPs offer the Medicare Part D benefit, individuals opting-out of future passive enrollments into the MMP may also want to opt out of future auto-enrollments by CMS into Medicare Part D plans (e.g., if they have employer coverage and the employer will terminate benefits if the individual has drug coverage elsewhere). The state should inform the beneficiary of the difference between an opt out from the MMP passive enrollment and opting out of the Part D auto-enrollment process; if the beneficiary has specific questions about the Part D auto-enrollment process, or wants to opt out of Part D, refer the beneficiary to 1-800-MEDICARE.

H. Excluding Individuals with Employer or Union Coverage from Passive Enrollment

Individuals with employer or union-sponsored coverage shall be excluded from passive enrollment. This includes Medicare “800 series” plans (i.e., Medicare Advantage or Part D plan benefit package ID numbers that start with “8”), employer-Sponsored plans (i.e., contract numbers that start with “E”), as well as individuals for whom an employer or union claims the Medicare Retiree Drug Subsidy (RDS).

When selecting individuals for passive enrollment in the MMP, the state must actively check all available systems (e.g., state systems, CMS’ Territory Beneficiary Query (TBQ,) Batch Eligibility Query (BEQ), or demonstration Enrollment Vendor) to ensure that individuals with employer or union sponsored coverage are excluded. There are three indicators in the MMA response file or the TBQ to verify if the individuals are enrolled in an employer or union sponsored plan **or** has the Medicare RDS:

1. Beneficiary’s Group Health Organization (GHO) Contract Number (position 1479-1483; contract numbers starting with “E” - employer sponsored contracts, “H” – Medicare Advantage products sponsored by employer, and “S” – Part D prescription drug coverage sponsored by an employer)
2. RDS Start/End Dates (positions 2903-2910 and 2911-2918)
3. Plan Benefit Package (PBP) Number (positions 1681-1688 and 1689-1696; PBP numbers starting with “8” are employer sponsored)

State may also use BEQ file exchange process to identify individuals with employer or union sponsored coverage as well as obtaining Medicare Part A and B entitlement information and current Medicare Advantage or Part D enrollment status. There are four data elements in the BEQ response file to verify if the individuals are enrolled in an employer or union sponsored plan/RDS:

1. Part C/D Contract Number (position 717-721)
2. Plan Benefit Package (PBP) Number (position 746-748)
3. Plan Type Code (position 749-750)
 - a. 21 – Employer-Only Demo
 - b. 30 – Employer/Union Only Direct Contract PDP
 - c. 40 – Employer/Union Only Direct Contract PFFS
 - d. 47 – Employer/Union Only Direct Contract local PPO
4. Employer Group Health Plan Indicator (position 751)
5. Part D/RDS Indicator (position 314-323)

For individuals for whom an employer or union is claiming the Medicare Part D RDS, it is possible the state will not be aware an individual has RDS until it submits an enrollment transaction (TC 61) and receives notification of RDS status on the DTRR. CMS’ MARx system will enforce a two-step process, initially rejecting the transaction, which will be indicated on the DTRR with a Transaction Reply Code of 127 – Part D Enrollment Rejected; Employer Subsidy Status (see §30.3.5 and §30.3.6 for additional detail). If the enrollment was passive, the state must let the rejection stand and not override it.

There are individuals (e.g., former school teachers, local government employees, etc.) who are enrolled in an employer or union sponsored plan, of which the state may be aware but CMS does

not have a record, either because they are not being claimed by the employer or union for the Part D RDS or because they are enrolled in a Medicare Part C or D plan that is not indicated in CMS systems as being an employer or union sponsored plan. Inclusion of these individuals in passive enrollment activities may result in the unintended loss of the individuals' employer or union sponsored coverage, including for their dependents. States must attempt to identify and exclude these individuals from passive enrollment in the MMP, including checking applicable data sources within the state's systems before doing passive enrollment, and preparing enrollment staff/brokers to appropriately advise those who are included in passive enrollment if they call with questions.

I. Information to Provide to Passively Enrolled Beneficiaries

The state must send the pre- and post-enrollment materials required to be provided to new enrollees. Please see §30.5.1.

J. Coordinating enrollment into Medicare-Medicaid Plan (MMP) with Medicare Prescription Drug Plan (PDP) Reassignment

On an annual basis, Medicare reassigns certain individuals who qualify for Extra Help (also known as Part D low income subsidy, for which Medicare-Medicaid enrollees automatically qualify) into PDP plans with premiums at or below the regional low income premium subsidy benchmark amount to make sure these individuals continue to pay "zero" premium for their prescription drug coverage. Individuals who qualify for Extra Help and are enrolled in terminating Medicare Advantage plans or PDPs are also reassigned. Reassignments generally occur twice each year in October and no later than mid-December, with enrollment into a new PDP effective the first of the following January. Passive enrollment into MMPs must be coordinated with CMS' annual reassignment process to avoid assigning an individual to a new PDP plan and then moving him or her to an MMP in the same year.

To ensure beneficiaries are not reassigned or passively enrolled more than once per benefit year, CMS provides data relating to the beneficiaries selected for reassignment to the state (based on the address of record) in September each year (i.e., the month before reassignment is actually processed in CMS' systems). A Medicare individual who is dually eligible and to be reassigned by Medicare effective January of a given year may **NOT** be passively enrolled into an MMP any earlier than January of the following year.

If a Medicare beneficiary who is identified by the state as being dually eligible is on CMS' list to be reassigned, the state may do one of the following:

1. Passively enroll the beneficiary effective January 1 following receipt of the record from CMS that indicates that the beneficiary is to be reassigned. For example, the state receives the record from CMS indicating that the beneficiary is to be reassigned effective January 1, 2017. The state may passively enroll, per CMS guidance below, the beneficiary effective January 1, 2017, effectively cancelling the reassignment.

States phasing in passive enrollment may adjust the passive enrollment effective date of individuals who would otherwise be reassigned January 1 of that year, to take precedence over reassignment. For example, if a Medicare-Medicaid beneficiary is subject to reassignment effective January, 2017, and is also scheduled to be included in MMP

passive enrollment effective March, 2017, the state may move up the passive enrollment effective date of this individual from March 1, 2017 to January 1, 2017.

OR

2. Passively enroll the beneficiary one year or more following the date of reassignment. Following the example above, this would be January 1, 2018 or later. Once the beneficiary has been reassigned, the state may not passively enroll that beneficiary until the following year (effective January).

To effectuate the first option above of ensuring passive enrollments take precedence, CMS and the state should use the steps below:

- a) CMS provides data relating to the individuals selected for reassignment to the state (based on the SSA mailing address of record) in September each year. The data elements that states will receive will be the following:
 - i. Medicare Number;
 - ii. Beneficiary Social Security Number;
 - iii. Beneficiary first name, last name, middle initial;
 - iv. Date of Birth; and
 - v. Gender code;
- b) Using the data provided in item (a), the state identifies those who are dually eligible whom they intend to passively enroll effective January 1;
- c) State submits passive enrollment transactions to CMS during a specific time period in October that CMS will announce annually. If a state misses the time period for submitting passive enrollments, the state must wait until the following year to passively enroll affected beneficiaries into an MMP (as outlined in option 2 above); and
- d) Once the state has submitted its passive enrollments per CMS' guidance, CMS will conduct its annual reassignment for all states. Beneficiaries that have been enrolled into an MMP with an effective date of January 1 of the coming year, prior to CMS performing its annual reassignment, will not be reassigned into a Medicare Part D plan because they will have equivalent prescription drug coverage under the MMP.

States must ensure that all passive enrollment transactions are accurately populated with the required data elements for passive enrollment. In particular, the application date on each of the passive enrollment transactions to take effect January 1 must be the date of the transaction submission, and the enrollment source code value must be set to "J." Applying these data elements will allow subsequent beneficiary elections to be respected. CMS may reject or cancel passive enrollment transactions that fail to adhere to all of the required data elements.

Mid to late October, CMS will send all states the list of individuals who are confirmed as having been reassigned effective January 1 (see Appendix 4) to a PDP plan. The state must not schedule passive enrollment for anyone on this list until an effective date of January 1 the following calendar year.

K. For States That Conduct Passive Enrollment For Effective Dates After January 1 (Non-January Effective Dates)

As noted above, states must exclude beneficiaries from current passive enrollment who have been reassigned to a Medicare PDP effective January 1 of the current year. The annual reassignment is considered the one passive enrollment for the individual in a calendar year, following parameters outlined in §30.2.5. Each year, CMS completes the annual reassignment process around mid-October for the upcoming calendar year. States receive a list of all beneficiaries who received the blue reassignment notice in their state to facilitate any inquiries the state might receive from beneficiaries (see Appendix 4 for the file layout). States must exclude beneficiaries on this list who have been reassigned to a Medicare PDP effective the upcoming January 1 from future passive enrollment for the upcoming calendar year.

L. Newly Dually Eligible Individuals Who Had Medicaid First

When a Medicaid eligible individual becomes Medicare eligible, the state may passively enroll the beneficiary into a MMP. The passive enrollment transactions from the state must be submitted to CMS between 63 and 90 days in advance of the MMP enrollment effective date, but no later than the 63rd day before the MMP enrollment effective date. The beneficiary must receive a passive enrollment notice at least 60 days in advance. The application date for monthly passive enrollments is the same as for other passive enrollments, i.e., the date the transaction is submitted to CMS' MARx enrollment system.

Please note that the MMP Prospective Dual File (for those who have Medicaid first) can be obtained from the enrollment vendor's website: <https://www.medicare-solution.com/>.

M. Newly Dually Eligible Individuals Who Had Medicare First

States may also passively enroll those who are newly dually eligible and who had Medicare prior to gaining Medicaid eligibility, i.e., who had Medicare first. There are two important considerations:

1. First, individuals in the Medicare-first population are eligible for passive enrollment on a monthly basis only if they currently have Part D coverage (i.e. those individuals who enrolled in a stand-alone Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug Plan (MA-PD) while having Medicare only). For those individuals in the this population who do *not* have a Part D plan, there is not enough advance notice for the state to passively enroll them into an MMP prior to Medicare's auto-enrollment of these individuals into a PDP (see next section for opportunity to include them in an annual passive enrollment).
2. Second, keeping with the principle that CMS and states will coordinate to make an election on behalf of a beneficiary only once per year, states will need to carve out those who have been auto-enrolled during the current calendar year, but may include them in passive enrollment for effective date of January 1 of the following year (i.e., submit transactions in October or November). The instructions on timing of beneficiary notices (i.e., 60 days and 30 days before effective date) and timing of enrollment transactions to CMS (i.e., 60 days prior to the effective date [with application date equal to transaction submission date]) are the same as for other passive enrollments outlined in §30.2.5. states should look closely at Beneficiary Enrollment Type Code (position 2425 in the

MMA response file) to find out how individual's current Part D enrollment was originated, focusing on the following:

- If Beneficiary Enrollment Type Code (aka Enrollment Source Code) is “A”, it means that the individual was auto-enrolled into a Part D prescription drug plan by CMS.
- If code value is “H”, it means that the individual was reassigned into a Part D plan

In both cases, states should check if the first effective date was in the previous calendar year, in which case the individual may be passively enrolled in the current calendar year.

Please note that the MMP Prospective Dual File for individuals who have Medicare first can be obtained from the enrollment vendor's website (<https://www.medicare-solution.com/>) after December 1, 2016.

N. Application Date for Passive Enrollment

States must enter the application date as equal to the date of submission of TC61 enrollment transaction to MARx for passive enrollments. (See Appendix 2 for more information about the application date).

O. 4Rx Data

“4Rx data” are four data elements issued by Medicare Part D plans indicating billing codes that facilitate real time billing by pharmacists. CMS requires prompt submission of 4Rx data to ensure steady flow of pharmacy billing information to the True Out-of-Pocket (TrOOP) Facilitator so that beneficiary can access their prescriptions without delay and billing/claims are processed timely. Please note that the MMP is the source of the 4Rx data – states that want to submit these data to CMS will first need to obtain them from the MMP.

The four Rx data elements are:

- Rx BIN – Benefit Identification Number
- Rx PCN – Processor Control Number
- Rx ID – Identification Number
- Rx GRP – Group Number

States may opt to submit 4Rx data on the enrollment transaction (TC 61), or may leave those fields blank. Note that states are strongly encouraged to use the same 4Rx submission process across all enrollments and MMPs within the state. If an MMP receives a CMS Daily Transaction Reply Report (DTRR) with confirmation of a successfully processed enrollment transaction that is missing 4Rx data (whether left blank intentionally or unintentionally by the State), the MMP is required to submit a 4Rx transaction (TC 72) to CMS' Enrollment Vendor within 72 hours of that DTRR.

P. Passive Enrollment in Service Area with Only One Available MMP

CMS may allow passive enrollment in a service area with one MMP. We note that an individual in a service areas with one MMP always has a choice of at least one other Medicare delivery

system (Original Medicare and Part D prescription drug coverage, and in nearly all counties, Medicare Advantage plans are available as well).

All requirements under section §30.2.5 apply. Medicaid managed care rules apply based on the applicable managed care authority (e.g., 1915(b), 1115(a), etc.).

30.3 - Processing the Opt-in Enrollment Request

When states receive a request from a beneficiary to opt-in (voluntarily enroll) into a MMP, the state needs to attempt to collect certain information and follow the procedures in this section. States should obtain and verify individuals' demographic information, including the spelling of the name, and to confirm the correct recording of gender, Medicare Number, and dates of entitlement to Medicare Part A and enrollment in Part B. The state must always check available systems (e.g., state systems; CMS' demonstration Enrollment Vendor query; TBQ; BEQ; or MARx online query) for information to complete an enrollment before requesting the beneficiary to provide the missing information as outlined in §30.3.2. When verifying this information with the individual, the state should contact the individual via telephone or other means, or request, but not require, that the individual include a copy of his or her Medicare card when mailing in the enrollment form. Regardless of whether or not the state has reviewed the Medicare card, the state must still validate and verify Medicare entitlement as described in item "B" below in this section.

Appendix 1 lists all the elements that must be provided by the applicant in order to consider an enrollment request "complete." If the state receives an enrollment request that contains all these elements, it must consider the enrollment complete even if all other data elements on the enrollment request are not provided. If a state receives CMS approval for an enrollment request that contains data elements in addition to those included in Appendix 1, the enrollment request is considered complete even if those additional elements are not provided.

If a state receives an enrollment request that does not have all necessary elements required in order to consider it complete, it must not immediately deny the enrollment. For example, if a beneficiary failed to fill out the "gender" field on the enrollment and the state has access to this information via available systems, it must use that source to complete the application before requesting the information from the beneficiary. If the required but missing information is not available via state or CMS systems, the enrollment request is considered incomplete and the state must follow the procedures outlined in §30.3.2 in order to complete the enrollment request.

The following must also be considered when processing an enrollment:

- A. Permanent Residence Information** - The state must determine whether or not the individual resides within the MMP service area. If an individual provides a Post Office Box as his or her place of residence on the enrollment request, the state must consider the enrollment request incomplete and must consult other sources, including state address data or contact with the individual to determine place of permanent residence. If the applicant claims permanent residency in two or more states or if there is a dispute over where the individual permanently resides, the state should consult the laws of the state in which the MMP is offered and determine whether the enrollee is considered a resident of the state.

Refer to Appendix 3 for a definition of “evidence of permanent residence,” and §10.2 for more information on determining residence for homeless individuals.

B. Entitlement Information - Following the procedures outlined in the Plan Communications User Guide (PCUG), states must verify Medicare entitlement using the Batch Eligibility Query (BEQ) process, MARx online query (M232 screen), MAPDIUI (Medicare Advantage Prescription Drug Interactive User Interface), Territory Beneficiary Query (TBQ) or CMS Enrollment Vendor’s Medicare Eligibility Query Service for all enrollment requests.

Individuals are not required to provide evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment request. If the CMS systems indicate that the individual is entitled to Medicare Part A and is enrolled in Part B, no further documentation of Medicare entitlement is needed from the individual.

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.

The Medicare Number will be assigned at the time CMS first receives entitlement information for a new beneficiary. In the event that the enrollment request doesn’t include the Medicare Number and the state is unable to locate the individual in the BEQ or MARx online query, the state should consider the enrollment request incomplete and follow § 30.3.2.

The individual may provide the Medicare Number to the state verbally or in writing. Examples of documents the beneficiary may send to the state which display 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 state. 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

C. Effective Date of Coverage - As described in §20.1, the state must determine the effective date of coverage for all opt-in enrollment requests. If the individual fills out an enrollment form in a face-to-face interview, the representative may advise the individual of the proposed effective date, but also stress to the individual that it is only a proposed effective date and that the individual will hear directly from the state to confirm the actual effective date. The state must notify the enrollee of the effective date of coverage prior to the effective date (refer to §30.5 for more information and a description of exceptions to this rule). States may establish early cutoff dates to receive opt-in

enrollment requests prior to the enrollment effective date. Early cutoff dates should be specified in the state Appendix 5. Opt-in enrollment requests received by the cut-off date would be effective the first day of the month following the month in which the enrollment request is initially received. Opt-in enrollment requests received after the cut-off date would be effective the first of the next following month.

States/MMPs must ensure enrollees have access to plan benefits as of the enrollment effective date and may not delay providing plan benefits while processing the enrollment request for submission to CMS systems or while awaiting confirmation of the enrollment from CMS systems via DTRR (further information is below in sections D and E; see §30.5 for a description of an exception to this rule). State should also send an address file to MMPs for all opt-in enrollment requests.

D. Health Related Information - Prior to submitting the enrollment to CMS, states may ask very limited health status questions, such as whether the individual has ESRD (if this is an eligibility criterion). Queries for this information are included on the model individual enrollment form in Exhibit 1. These queries are not considered to be health screening questions. With the exception of information obtained on ESRD status, where applicable, the responses to these questions must not have an effect on eligibility to enroll in an MMP.

Apart from collecting necessary health related information to determine eligibility for enrollment in the MMP, the state and their enrollment brokers may ask health related questions during completion of the enrollment request for the purpose of successful care management and transition of care activities prior to the effective date for opt-in (i.e., beneficiary initiated) enrollments once the transaction is processed by MARx. These questions should be asked after the required enrollment request has been completed. Further, the state or enrollment broker must clearly indicate to the individual that the information is only being collected to help in the successful transition of the individual's care in the MMP and will not be used to determine if an individual can enroll in the MMP. The individual is not required to answer the health related questions in order for the enrollment request to be processed or submitted to the MMP. The collected health information is to be securely and electronically forwarded to MMPs to start the care management and transition of care activities. The personally identifiable information (PII) and protected health information (PHI) must be safeguarded and any electronic data sharing or transmission of PII or PHI must abide by Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules.

The optional collection of health-related information by the state or enrollment broker does not eliminate the MMP's requirement to conduct health assessments for their members. It also does not preclude MMPs from conducting health assessments for individuals prior to the effective date of enrollment, as long as the transaction has been processed by CMS, as evidenced by receipt of an enrollment record on the CMS' Daily Transaction Reply Report (DTRR), and the provisions of subsection E below are met.

MMPs may request past 12 months of Medicare Part A (inpatient), Part B (outpatient) and Part D (prescription drug) claims history data from CMS to help identify the current circumstances of new enrollees' needs and the most frequently utilized providers and medical facilities, e.g., physicians, medical groups, clinics, long-term care facility, etc.

Please note that the data will not include any substance abuse diagnosis information. The MMP must make a formal request to CMS for this historical Medicare claims data of the beneficiaries that will be enrolled in the MMPs. The extract data files will be transmitted directly to MMPs on a monthly basis. Also, note that claims data for individuals previously enrolled in Medicare health plans may not be available.

E. Early Health Risk Assessment (HRA) - MMPs may conduct HRAs prior to the effective date for opt-in and passively enrolled beneficiaries, subject to the following beneficiary protections:

1. The MMP must provide advance notice to the Contract Management Team (CMT) that it intends to conduct early HRAs. This notification must be provided at least 60 days prior to implementing this policy.
2. The MMP must be ready for marketing, including its website, with all required materials.
3. For passive enrollees, the MMP welcome notice that is sent 30 days prior to passive enrollment effective date must be modified to indicate the plan may reach out before effective date to do a HRA, and that completion of the HRA is optional.
4. The MMP may reach out no sooner than 20 days before the effective date of the passive enrollment.
5. The MMP must emphasize the HRA is optional, and ask if the beneficiary wants to participate in the HRA at that time or later, after the enrollment is effective.
6. The MMP is required to educate the beneficiary about continuity of care requirements, and identify any transitional care needs, during the same encounter in which the early HRA is conducted.
7. In the event the MMP identifies an immediate health care need when conducting an HRA prior to the beneficiary's effective date of enrollment, the MMP is responsible for communicating this information to the beneficiary's current health coverage and ensuring a seamless transition to MMP-provided coverage upon the effective date of coverage.
8. The CMT will prohibit use of this policy for an MMP if concerns relating to its use are identified, including encouraging sicker members to disenroll.
9. MMPs would be required to notify the CMT if they choose to change the timing of how they conduct HRAs. For example, if the MMP implements this policy but later decides to conduct HRAs only on or after the coverage effective date, the MMP must notify the CMT before implementing that change. This notification shall occur no later than 60 days prior to implementing the change.

Additionally, the following guidance on reporting shall be followed for HRAs conducted prior to the effective date of enrollment:¹

1. If a beneficiary's HRA is completed prior to the beneficiary's effective date of coverage, the MMP shall report the completion (under Core Measures 2.1 and 2.2), as if it were conducted on the first effective date of coverage; and

¹ This reporting guidance applies to core measures. Guidance for reporting any applicable state-specific measures is provided in the state-specific reporting requirements.

2. If a beneficiary's HRA is completed prior to the beneficiary's effective date of coverage, the MMP shall complete the beneficiary's care plan by no later than the contractually required timeframe. In the event that a care plan is also finalized prior to the first effective enrollment date, the MMP should report completion of the care plan (under Core Measure 3.2) as if it were completed on the first effective enrollment date.

Note: To reduce beneficiary confusion regarding the purpose and use of the early HRA, we encourage MMPs to begin the assessment process with basic education about the demonstration, continuity of care protections, and opportunities to cancel, disenroll, or change plans.

F. Statements of Understanding - As outlined in §10.4, a beneficiary must understand and agree to abide by the rules of the MMP in order to be eligible to enroll. If the applicant fails to indicate his or her understanding of all plan rules listed on the enrollment form, the state may contact the applicant to clarify the MMP rules in order to complete the enrollment form. The state must document the contact and annotate the outcome of the contact. If the state is unable to contact the applicant to ensure his or her understanding, the enrollment form would be considered incomplete. For enrollments made by phone, the state shall provide the information verbally and annotate the beneficiary's understanding.

G. Applicant Signature and Date – For paper enrollment requests, the individual must sign the enrollment form. If the individual is unable to do so, a legal representative must sign the enrollment form (refer to §30.2 for more detail). If a legal representative enrolls an individual, the legal representative must attest to having the authority under state or other applicable 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 effect an enrollment request on behalf of the applicant is available and can be presented upon request by CMS.

The individual and/or legal representative must indicate his or her relationship to the individual and date he or she signed the enrollment form or completed the enrollment request; however, if he or she inadvertently fails to include the date on the enrollment request, then the date the state 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 state may verify the individual's intent to enroll with a phone call and document the contact, rather than return the paper enrollment form as incomplete. States are expected to have steps in place to authenticate the beneficiary's identity without compromising personally identifiable information (PII). The documentation of this contact will complete the enrollment request (assuming all other required elements are complete).

For passive enrollments and opt out of passive enrollments, as described in §30.2.2, an enrollee signature is not required.

H. Other Signatures - If the state representative helps the individual fill out the enrollment form, the representative must clearly indicate his/her name on the enrollment form. This includes pre-filling out any information on the enrollment form, such as the individual's phone number.

There are limited exceptions to this rule:

- If an individual requests that an enrollment form be mailed to him/her, the state representative may pre-fill only the individual's name and mailing address onto the form,
- The state representative's only additions to the enrollment form are to complete the "office use only" block, and/or
- The state representative needs to correct information on the enrollment due to an error found while verifying information (see "final verification of information" below).

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

J. Determining the Application Date - The state must date all enrollment requests as soon as they are initially received. The date the enrollment request is initially received is equivalent to the "application date" (refer to Appendix 3 for definitions of "receipt of enrollment request," "completed enrollment request" and "application date"). If the enrollment request is not complete at the time it is received, the additional documentation required for the enrollment request to be complete must be dated as soon as it is received. Appendix 2 describes the appropriate application date to include in the enrollment transaction submitted to CMS under various conditions.

K. Final Verification of Information - States that verify information before enrollment information has been transmitted to CMS may find that they must make corrections to an individual's enrollment request, including paper enrollment form, or election made by phone or internet. The state should make those corrections, and the individual making those corrections must place his or her initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, may be used by the state (in place of the initialing procedure described in the prior sentence), and must become a part of the enrollment file. These types of corrections will not result in the state having to co-sign the enrollment form.

L. Completed Enrollment Requests - Once the enrollment request is complete, the state must transmit the enrollment to CMS within the time frames prescribed in §30.4, and must send the individual the information described in §30.5 within the prescribed time frames. There are instances when a complete enrollment can turn out to be legally invalid. These instances are outlined in §30.5.

M. Additional Information for MMP Enrollment Requests – Individuals enrolling in an MMP must disclose any other existing coverage for prescription drugs.

N. 4Rx Data - States may opt to submit 4Rx data (four data elements issued by Part D plans indicating billing codes that facilitate real time billing by pharmacists) on the enrollment transaction (TC 61), or may leave those fields blank and instead instruct MMPs to submit

a 4Rx transaction (TC 72) directly to CMS' MARx system within 72 hour of receiving confirmation of enrollment is received on the CMS Daily Transaction Reply Report.

MMPs may need address data in order to submit and meet the 4Rx data submissions timeline of 72 hours. If the address data is not received from the state in time to submit within the 72 hour deadline, MMPS should check the BEQ.

30.3.1 - Who May Complete an Enrollment or Disenrollment Request

A Medicare-Medicaid beneficiary is generally the only individual who may execute a valid request for enrollment in or disenrollment from an MMP. However, another individual could be the legal representative or appropriate party to execute an enrollment or disenrollment request as the law of the state in which the beneficiary resides may allow. State is the governing authority and will apply applicable state laws that authorize persons to make such requests for Medicare beneficiaries. For example, persons authorized under state law may be 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 authority to act on behalf of the beneficiary in this capacity.

If a Medicare-Medicaid beneficiary is unable to sign an enrollment form or disenrollment request due to reasons such as physical limitations or illiteracy, state law would govern whether another individual may execute the enrollment request on behalf of the beneficiary. Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, states should check their laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

Where states are aware that an individual has a representative payee designated by the Social Security Administration (SSA) to handle the individual's finances, states should contact the representative payee to determine his or her legal relationship to the individual, and to ascertain whether he or she is the appropriate person, under state law, to execute the enrollment or disenrollment request. Representative payee status alone is not sufficient to enroll a Medicare-Medicaid beneficiary into an MMP.

When someone other than the Medicare-Medicaid beneficiary completes an enrollment or disenrollment request, he or she must:

- 1) Attest to having the authority under state or other applicable law to do so;
- 2) Confirm that proof of authorization, if any, required by state or other applicable law that empowers the individual to make an enrollment or disenrollment request on behalf of the individual is available and can be provided upon request by CMS. States cannot require such documentation as a condition of enrollment or disenrollment; and
- 3) Provide contact information.

The state must retain the record of this attestation as part of the record of the enrollment or disenrollment request for 10 years per the federal records retention guidance. A sample attestation is included in the model enrollment form (Exhibit 1).

If anyone has reason to believe that an individual making an election on behalf of a beneficiary may not be authorized under state or other applicable law to do so, the state should notify the Contract Management Team (CMT) with all applicable documentation regarding state or other applicable law and the case in question. The CMT may request supporting documentation from the individual making the election.

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

30.3.2 - When the Enrollment Request Is Incomplete

The state must make the determination whether the enrollment request is complete, and, within 10 calendar days of receipt of the enrollment request, notify the individual that additional information is needed, unless the required but missing information can be obtained via CMS or state systems. When the enrollment request is incomplete, the state must document all efforts to obtain additional documentation to complete the enrollment request and have an audit trail to document why the enrollment request needed additional documentation before it could be considered complete.

If the request is missing the Medicare Number, see §30.3.B for more information.

For incomplete enrollment requests received prior to the month of entitlement to Medicare Part A and enrollment in Part B, additional documentation to make the request complete must be received by the end of the month immediately preceding the individual's Medicare Part A and Part B effective date, or within 21 calendar days of the request for additional information (whichever is later). For incomplete enrollment requests received during the month of entitlement to Medicare Part A and enrollment in Part B or later, additional documentation to make the request complete must be received 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).

When the state receives an incomplete enrollment request near the end of either a month or an enrollment period, the use of the full 21 calendar day period to complete the request may extend beyond CMS systems plan submission "cut-off" date (these dates are provided in the PCUG). States may utilize an enrollment transaction (TC 61) during the 21 calendar day period or up to one month past the enrollment effective date to directly submit the request to CMS, as provided in the PCUG. An example, if the state receives on February 19th an incomplete enrollment request missing the plan choices, and is unable to connect with the beneficiary until March 5th to know what plan he or she wants to join, the state can submit a TC 61 enrollment transaction on March 5th for March 1st effective date.

If additional documentation needed to make the enrollment request "complete" is not received within allowable time frames, the state must deny the enrollment using the procedures outlined in §30.3.3.

Requesting Information from the Beneficiary - To obtain information to complete the enrollment request, the state must contact the individual to request the information within 10

calendar days of receipt of the enrollment request. The state may contact the beneficiary either in writing (see Exhibit 6 for a model notice) or orally. If the contact is made orally, the state must document the contact and retain the documentation in its records. The state must explain to the individual that he or she has 21 calendar days in which to submit the additional information or the enrollment will be denied in writing. Since an incomplete enrollment request is an invalid enrollment (as explained in §30.5), if the additional documentation is not received within allowable time frames, the state must send a denial of enrollment notice (see Exhibit 9).

If all documentation is received within allowable time frames and the enrollment request is complete, the state must transmit the enrollment to CMS within the time frames prescribed in §30.4, and must send the individual the information described in §30.5.

30.3.3 - Denial of Enrollment

Enrollment denials that occur before the State has transmitted the enrollment to CMS - A state must deny an enrollment within 10 calendar days of receiving the enrollment request based on its own determination of the ineligibility of the individual to elect the MMP. For an incomplete enrollment request that requires information from the applicant and for which the applicant fails to provide the information within the required time frame, a state must deny the enrollment within 10 calendar days of the expiration of the time frames described in §30.3.2.

Notice Requirement - The state must send notice of the denial to the individual that includes an explanation of the reason for denial (see Exhibit 9). 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.

30.3.4 - ESRD and Enrollment (applicable to States for which an individual's ESRD status is an enrollment eligibility criterion)

While Medicare Advantage normally prohibits individuals with ESRD from enrolling in an MA plan, states may opt to permit individuals with ESRD to enroll in an MMP, and may include individuals with ESRD in passive enrollment into an MMP. States that opt to do so should indicate this in Appendix 5.

If the state excludes individuals with ESRD from enrolling in MMPs and the state receives an enrollment request from an individual that shows active ESRD status from CMS or state systems, the state must check if the ESRD information is current since the individual may no longer require regular dialysis treatment or has received a kidney transplant (e.g., the individual informs the plan that this has occurred), thus making the individual eligible to enroll in an MMP. In these instances, the state should request that the individual submit medical documentation (e.g., a notice from the physician that documents that the individual has received a kidney transplant or no longer requires a regular course of dialysis to maintain life), using the procedures outlined in §30.3.2, as the enrollment request is considered incomplete. Upon receipt of this documentation, the state must enroll the beneficiary using the override procedures described in the PCUG.

If an individual indicates on the enrollment request that he or she does not have ESRD, but the state receives a CMS systems reply containing a “Code 45” or “Code 15” rejection (an

explanation of transaction reply codes is contained in the PCUG), the state must investigate further to determine whether the individual is eligible to enroll. This could be because the state permits enrollment of ESRD individuals into MMPs (as indicated in Appendix 5), or because they meet any one of the exceptions outlined in §20.2.2 of Chapter 2 of the Medicare Managed Care Manual. To determine eligibility, the state may contact the individual to request medical documentation using the procedures outlined in §30.3.2. Contact can be made orally, in which case the state must document the contact and retain the documentation in its records.

If the state learns that the individual is eligible to enroll for any of the exceptions provided in §20.2.2 of Chapter 2 of the Medicare Managed Care Manual, the individual must be permitted to enroll in the MMP if other applicable eligibility requirements are met. The state must submit the enrollment transaction with the ESRD Override field completed as instructed in the PCUG if the effective date of enrollment is within the current operating month for direct submission of the transaction. If the effective date of enrollment is “retroactive” (for CMS systems submission purposes) the request must be submitted to the CMS’ Retroactive Processing Contractor (RPC) with the following documentation:

1. Copy or record of the completed enrollment request, and
2. A description of the individual’s circumstances related to at least one of the exceptions in §20.2.2 of Chapter 2 of the Medicare Managed Care Manual by which the individual has been determined eligible to enroll by the state. 30.3.5 - Enrollment of Individuals Being Claimed for the Retiree Drug Subsidy (RDS)

Individuals enrolled in employer or union-sponsored plans for whom their employer or union is claiming the Medicare Retiree Drug Subsidy (RDS), will have special procedures to be followed to assure the individual is fully aware of the impact their enrollment into the MMP will have to their employer/union benefits.

CMS systems will compare state enrollment transactions to information CMS has regarding the whether the beneficiary is currently enrolled or being claimed for the Retiree Drug Subsidy (RDS). If there is a match indicating that the individual is being claimed for RDS, the enrollment will be conditionally rejected by CMS systems, and the state will receive a Code 127 on the DTRR.

Within 10 calendar days of receipt of the Code 127 conditional rejection, the state must contact the individual to confirm that the individual wants to be enrolled in the MMP, including the risk that the person may lose other employer benefits, including health benefits for her or him and/or spouse/dependents, and other employer benefits, including pension. Individuals will have 30 calendar days from the date they are contacted to respond.

The MMP must ensure that plan benefits are available to the individual as of the effective date of the initial enrollment request and must not delay providing plan benefits while awaiting reply of the applicant’s confirmation of intent to enroll. The state may contact the individual in writing (see Exhibit 6) or by phone and must document this contact and retain it with the record of the individual’s enrollment request.

If the individual confirms he or she wants to enroll in the MMP, the state must resubmit the enrollment transaction (TC 61) with the employer subsidy enrollment override flag (field position 88) set to “Y”. The effective date of enrollment will be based upon the individual’s

initial enrollment request. This effective date may be retroactive in the event that the confirmation step occurs after the effective date.

States are strongly encouraged to closely monitor their outreach efforts and to follow up with applicants prior to expiration of the 30 day timeframe. 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 Exhibit 9).

30.3.6 - Individuals with Employer/Union Coverage – Other Sources

There are individuals (e.g., former school teachers, local government employees) who are enrolled in an employer or union sponsored plans that are also a Medicare Advantage (contract numbers that start with “H”) or Part D (contract numbers that start with “S”) plan, whose plan benefit package ID numbers start with “8”, as well as, employer-sponsored plans (i.e., contract numbers that start with “E”), however; they are not being claimed by the employer or union for the Part D Retiree Drug Subsidy (RDS). Unlike individuals being claimed for the RDS, CMS systems will **not** initially reject enrollment transactions for individuals who have non-RDS employer or union sponsored coverage. If the beneficiary requests opt-in enrollment in the MMP, states should check state and CMS’ systems for employer or union coverage and, if no data are available, ask detailed questions to determine whether such coverage exists. Once the individual has been identified as having employer or union sponsored coverage, the state must inform him or her of the potential risks (i.e. loss of employer or union benefits) and confirm his/her intent to enroll in the MMP. An individual’s request for an opt-in enrollment should be effectuated only after he or she acknowledges an understanding of the consequence to his employer or union coverage and expresses intent to enroll into an MMP.

If the individual indicates he or she does not want to be enrolled, the state should submit an MMP enrollment cancellation transaction (TC 82), and include an MMP Opt-Out Flag data element as “Y” in field position 202 to opt the individual out of future passive enrollment into the MMPs. The state should inform the beneficiary of the difference between an opt out from MMP passive enrollment and opting out of the Part D auto-enrollment process: if the beneficiary has specific questions about the Part D auto-enrollment process, or wants to opt out of it, refer the beneficiary to 1-800-MEDICARE.

30.4 - Transmission of Enrollments to CMS

For all enrollment requests the state is not denying per the requirements in §30.3.3, the state must submit the information necessary for CMS to add the beneficiary to its records as an enrollee of the MMP within 7 calendar days of receipt of the **completed** enrollment request. CMS systems “down” days are included in the calculation of the 7 calendar days (refer to Appendix C of the Plan Communications User Guide (PCUG)). For the purpose of assessing compliance with this requirement, CMS will count the enrollment request receipt date as “day zero” and the following day as “day one.” All enrollment elections must be processed in chronological order by date of receipt of completed enrollment elections.

States are encouraged to submit transactions by the earliest possible date, but must submit the transactions within the required 7 calendar day time frame.

Please note that MMPs will receive both a Daily Transaction Reply Report (DTRR) from CMS, and files from the state, with notifications of enrollment-related transactions. PCUG outlines all the transaction reply codes which provide next steps and actions for state and MMPs to take based on each transaction reply code received in the DTRR.

Note: The requirement to submit the transaction within 7 calendar days does not affect the effective date of the individual's coverage under the MMP; the effective date must be established according to the procedures outlined in §20.

30.5 - Information Provided to Member

To reduce beneficiary confusion created when receiving multiple written notices, a number required notifications can also be combined so that the member does not receive multiple notices that are similar (see Summary of Notice Requirements in Appendices). Beneficiaries will also be given verbal notification in instances when a written notification is not required. Much of the enrollment information that a state must provide to the member must be sent prior to the effective date of coverage. However, some information will be sent after the effective date of coverage, as outlined below. A member's coverage begins on the effective date regardless of when the member receives all the information the plan sends.

Since states administer the enrollment process, the state will initiate most enrollment-related systems notifications and be aware of the need to notify the beneficiary. However, as discussed previously in §30, CMS' DTRR will "push" notifications on the DTRR which affect MMP enrollment status and necessitate enrollee notifications.

Notices should be written at the reading level specified in the three-way contract and translated consistent with the requirements outlined in the state-specific Demonstration Marketing Guidelines. Notices must be compliant with 45 C.F.R. Part 92, which implements the provisions of Section 1557 of the Affordable Care Act prohibiting discrimination on the basis of race, color, national origin, gender age, or disability in certain health programs and activities. Notices must provide information about individuals' rights and covered entities' obligations under Section 1557. Please see https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities?utm_campaign=subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov#h-139 for more information about the requirements under Section 1557.

While Exhibits 5a, 5b and 5c are typically the notices that states delegate to their MMPs, please note that states can delegate any notice to the MMP except Exhibit 31 (State 60-day Notice for Passively Enrolled Individuals) and Exhibit 5 (State 30-day Reminder Notice for Passively Enrolled Individuals). Any notices the state decides to delegate to the MMP must include the federal-state contracting disclaimer and any additional disclaimers required in the state-specific Marketing Guidance, as well as a Marketing Material ID. Please see the state-specific Marketing Guidance at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html>.

For a list of beneficiary notices, please see the Summary of Notice Requirements.

30.5.1 - Prior to the Effective Date of Coverage

Prior to the effective date of coverage, the state must provide the member with all the necessary information about being a member of the MMP, the plan rules, and the member's rights and responsibilities (an exception to this requirement is described in §30.5.2).

A. Acknowledgement/Confirmation Notice

The state shall send a notice acknowledging as well as confirming the request to enroll in the MMP.

Opt-in Enrollments:

For opt-in enrollments, the state may meet this requirement one of two ways:

1. Issue one notice that combines both the acknowledgement of receiving the request and the confirmation of enrollment (see Exhibit 4 [as described in §30]):
 - This notice is used most often, as determination of eligibility and submission of the enrollment transaction to CMS occurs within 7 days of receipt of the enrollment request.
 - This one notice meets the requirements of notification for acknowledging the request, confirming the enrollment, and providing the effective date of coverage. (Exhibits 3 and 7 are not necessary when issuing Exhibit 4.)
 - This notice must be provided no later than 10 calendar days after receipt of the request. (This is approximately 7 calendar days after the availability of the DTRR.)
 - If the state is unable to ensure that the beneficiary will receive this combination notice prior to the enrollment effective date (or within timeframes for incomplete enrollment requests or enrollments received at the end of the month), the state still must ensure that the beneficiary has the information required in §30.5.1 within the timeframes described there.
2. Issue two separate notices – one to acknowledge receipt of the request and a second to confirm the enrollment (see Exhibits 3 and 7):
 - This option is used less frequently, it may be used when an enrollment request is missing information and the state is unable to submit the enrollment transaction to CMS within the 7 day timeframe.
 - The first notice (Exhibit 3) acknowledges the receipt of the enrollment requests and conveys the effective date of coverage if the person is accepted into the MMP. This notice may include requests for missing information. This acknowledgment notice must be provided no later than 10 calendar days after receipt of the request.
 - The second notice (Exhibit 7) confirms the enrollment, and is sent when CMS' MARx system confirms that the enrollment processed. This confirmation notice must be provided no later than 10 calendar days after receiving the enrollment confirmation on the DTRR.

For all opt-in enrollments, the state must also provide evidence of the enrollment request to the individual, as follows:

- For paper enrollment requests, the state is not required to provide evidence of receipt outside of the acknowledgement or combination notice. States may choose to provide a confirmation number or other tracking mechanism indicating receipt of the paper enrollment request. However, states are expected to keep a copy of the individual's completed paper enrollment form, if the individual requests a copy of their completed enrollment request.
- For enrollment requests submitted via the internet, evidence that the online enrollment request was received (e.g., a confirmation number).
- For enrollment requests submitted via telephonic enrollment, evidence that the telephonic enrollment request was received (e.g., a confirmation number).

Passive Enrollments:

For passive enrollments, the state must send two notices:

- a notice 60 days prior to the effective date (see Exhibit 31); and
- a notice 30 days prior to the effective date (see Exhibit 5).

The MMP must also send a welcome notice (see Exhibit 5a) to the enrollee 30 days prior to the effective date. Please note that MMPs will receive confirmation from the CMS Daily Transaction Reply Report (DTRR) of passive enrollment approximately 60 days prior to their effective date.

B. Information About the MMP

1. For passive enrollments, the MMP **must** send the following for enrollee receipt 30 days prior to the effective date of coverage:
 - A welcome letter, which must contain 4Rx information. See Exhibit 5a.
 - An MMP-specific Summary of Benefits. (These individuals need to make a decision whether to retain their current coverage, allow the passive enrollment to take effect or change to another plan that better meets their needs). **This document is not required at the time of enrollment for opt-in enrollments.** Providing the Summary of Benefits, which is considered marketing material normally provided prior to the beneficiary making an enrollment request, ensures that those who are offered passive enrollment have a similar scope of information as those who opt-in (voluntarily enroll).
 - A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the MMP, or a distinct and separate notice alerting enrollees how to access or receive the formulary, consistent with the requirements of the Medicare Marketing Guidelines and the state-specific Marketing Guidance.
 - A combined Provider and Pharmacy Directory that includes all providers of Medicare, Medicaid, and additional benefits, or a distinct and separate notice alerting enrollees how to access or receive the directory, consistent with the requirements of the Medicare Marketing Guidelines and the state-specific Marketing Guidance.

- Proof of health insurance coverage so that he or she may begin using plan services as of the effective date. This proof must include the 4Rx prescription drug data necessary to access benefits.

Note: This proof of coverage is not the same as the Member Handbook (Evidence of Coverage) document described in the state-specific Demonstration Marketing Guidelines. The proof of coverage may be in the form of a Member ID Card, the enrollment form, and/or a notice to the member. As of the effective date of enrollment, plan systems should indicate active membership.

2. For passive enrollments, the MMP **must** send the following for enrollee receipt no later than the last calendar day of the month prior to the effective date of coverage:
 - A single Member ID Card for accessing all covered services under the MMP.
 - A Member Handbook (Evidence of Coverage).
3. For individuals who request to opt-in to the demonstration, the MMP **must** send the following materials for enrollee receipt no later than 10 calendar days after receiving a Daily Transaction Reply Report (DTRR) that confirms enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later:
 - A welcome letter, which must contain 4Rx information. See Exhibit 5b.
 - A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the MMP, or a distinct and separate notice alerting enrollees how to access or receive the formulary, consistent with the requirements of the Medicare Marketing Guidelines and the state-specific Marketing Guidance.
 - A combined Provider and Pharmacy Directory that includes all providers of Medicare, Medicaid, and additional benefits, or a distinct and separate notice alerting enrollees how to access or receive the directory, consistent with the requirements of the Medicare Marketing Guidelines and the state-specific Marketing Guidance.
 - A single Member ID card.
 - A Member Handbook (Evidence of Coverage).

Note: For opt-in enrollment requests received late in the month, see §30.5.2 (After the Effective Date of Coverage) for more information.

4. For all enrollments, regardless of how the enrollment request is made, the MMP **must** explain:
 - The charges for which the prospective member will be liable (e.g., coinsurance for Medicaid benefits in the MMP, if applicable; LIS copayments for Part D covered drugs, if applicable).
 - The prospective member's authorization for the disclosure and exchange of necessary information between the MMP, state, and CMS.
 - The requirements for use of MMP network providers. The state, or MMP as appropriate, must also obtain an acknowledgment by the individual that he or she understands that care will be received through designated providers except for

emergency services and urgently needed care. For passive enrollments, if the beneficiary does not decline passive enrollment, that is considered to be the required acknowledgement.

- The potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B and enrolled in Medicaid at the time coverage begins and he or she has used plan services after the effective date.
- The effective date of coverage and how to obtain services prior to the receipt of a Member ID card (if the MMP has not yet provided the ID card).

30.5.2 - After the Effective Date of Coverage

CMS recognizes that in some instances the state (or MMP, if the state delegates any notifications to the MMP) will be unable to provide the materials and required notifications to new enrollees prior to the effective date of coverage, as required in §30.5.1. These cases will generally occur when an opt-in enrollment request is received late in a month with an effective date of the first of the next month. In these cases, the state still must provide the member all materials described in §30.5.1 no later than 10 calendar days after receipt of the completed enrollment request.

Additionally, the state is also strongly encouraged to call these new members as soon as possible (within 1-3 calendar days) to provide the effective date, the information necessary to access benefits and to explain the MMP rules. The member's coverage will be active on the effective date regardless of whether or not the member has received all the information by the effective date.

It is expected that all of the items outlined in §30.5.1 will be sent prior to the effective date for passive enrollments.

Exceptions to the timeliness requirement of the Enrollment Confirmation Notice for Transaction Rejections

There are certain situations where sending an enrollment confirmation notice to a beneficiary cannot be done timely due to certain types of transaction rejections. These exceptions exist in order to prevent the individual from being penalized for a systems issue or delay, such as a state transmission or keying error. In addition, the rejection or enrollment denial notice requirement does not apply during the following:

- When the state receives a transaction rejection due to ESRD (if the State excludes individuals with ESRD from enrolling in an MMP); or
- When the state receives a transaction rejection indicating the individual does not have Medicare Part A and/or Medicare Part B, and the state has evidence to the contrary.

In these cases, the state should not send a rejection notice. The state should submit an enrollment request to RPC so that the enrollment can be manually processed. If a state rejects an enrollment and later receives additional information from the individual substantiating his or her eligibility, the state must obtain a new enrollment request from the individual in order to enroll the individual, and must process the enrollment with a current (i.e., not retroactive) effective date. Refer to §50.4 for more information regarding retroactive enrollments.

30.6 - Enrollments Not Legally Valid

When an enrollment is not legally valid, a retroactive cancellation of enrollment action may be necessary (refer to §50.5 for more information on retroactive disenrollments). In addition, a reinstatement to the Medicare or Medicaid plan in which the individual was originally enrolled may be necessary if the invalid enrollment resulted in an individual's disenrollment from his or her original plan of choice.

An enrollment that is not complete, as defined in Appendix 3, is not legally valid. In addition, an enrollment is not legally valid if it is later determined that the individual did not meet eligibility requirements at the time of enrollment. For example, an enrollment is not legally valid if a state determines at a later date that the individual provided an incorrect permanent address at the time of enrollment and the actual address is outside the MMP's service area. A second example could be an instance where an individual not authorized by state or other applicable law to make an enrollment request on another's behalf attempts to complete an enrollment request.

There are also instances in which an enrollment that appears to be complete can turn out to be legally invalid. In particular, an enrollment is considered incomplete if the member or his or her legal representative did not intend to enroll in the MMP. If there is evidence that the individual did not intend to enroll in the plan, the state should submit a retroactive disenrollment request to CMS. Evidence of lack of intent to enroll by the individual may include:

- An enrollment request signed by the individual when a legal representative should have signed for the individual;
- Request by the individual for cancellation of enrollment before the effective date (refer to §50.2 for procedures for processing cancellations);
- Enrolling in a supplemental insurance program immediately after enrolling in the MMP; or
- Receiving non-emergency or non-urgent services out-of-plan immediately after the effective date of coverage under the plan.

40 - Disenrollment Procedures

Disenrollments are elections made after the effective date of enrollment into an MMP. (Note – disenrollments are different than cancellations, which occur before the effective date of enrollment.) A disenrollment may be accompanied by a request to opt out of future passive enrollments into an MMP, and potentially a request to opt out of future auto-enrollments into a Medicare Prescription Drug Plan (also known as Part D) (see §30.2.5.G and §40.1).

Except as provided for in this section, a state or MMP may not, either orally or in writing, or by any action or inaction, request or encourage any member to disenroll. While a state or MMP may contact members to determine the reason for disenrollment or to explain how Medicaid and Medicare coverage will be provided moving forward, the state or MMP must not discourage members from disenrolling after they indicate their desire to do so. The state must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

An MMP must accept disenrollment requests it receives through the state. MMPs may not accept disenrollment requests directly from individuals and process such requests themselves, but instead, must forward the request to the state, unless the state has delegated enrollment activities to the MMP. Disenrollments from an MMP without an accompanying request to enroll in a Medicare health or drug plan will return the individual to Original Medicare; the individual will be auto-enrolled by CMS into a Medicare Prescription Drug Plan, and can access the LI NET transitional PDP during any coverage gap.

40.1 - Voluntary Disenrollment by Member

Unless otherwise waived, beginning January 1, 2019, a member may request disenrollment from an MMP only during one of the valid election periods outlined in §20 of this guidance.

The member may disenroll by:

1. Enrolling in another Medicare health or Part D plan, including a PACE organization;
2. Enrolling in another MMP;
3. Giving or faxing a signed written disenrollment notice to the state;
3. Calling 1-800-MEDICARE;
4. Calling the state's enrollment broker;
5. Submitting a request online via the state's secure internet website (if the state offers such option); or
6. If applicable, additional state-specific resources as identified in Appendix 5.

If a member verbally requests disenrollment from the MMP, the MMP must instruct the member to make the request in one of the ways described above. The MMP may alert the state who may send a disenrollment form to the member upon request (see Exhibits 12, 13, and 15).

States are not permitted to conduct disenrollment counseling to discourage members from disenrolling. States may only convey to individuals that they are leaving the demonstration and the difference in benefits upon the disenrollment effective date. Disenrollment requests made by telephone to the state/enrollment broker must be recorded.

If an individual who opted in to an MMP and submits a disenrollment request in order to disenroll from the MMP (i.e., does not disenroll from the MMP by enrolling in another plan), the state must submit a disenrollment transaction (TC 51) to CMS' MARx system. The disenrollment request must be dated when it is initially received by the MMP or state. If the individual indicates they also want to opt out of future passive enrollments into MMPs, states should include an MMP Opt-Out Flag data element "Y" (opted out of passive enrollment) in position 202 on the disenrollment transaction (TC 51). If the MMP receives the disenrollment request, it must forward the request to the state within two business days for processing.

If an individual calls 1-800-MEDICARE Call Center to disenroll from the MMP, the state can expect to receive the following disenrollment transactions from CMS' MARx system:

- TC 51 disenrollment transaction with a transaction reply code of 014 (Disenrollment Due to Enrollment in Another Plan), and
- TC 54 disenrollment transaction with a transaction reply code of 013 (Disenrollment Accepted as Submitted).

The state has the option to allow members to submit disenrollment requests via the Internet; however, certain conditions must be met. The state must, at a minimum, comply with the CMS security policies - found at <http://www.cms.hhs.gov/informationsecurity/>. However, the state may also include additional security provisions. The CMS policies indicate that with regard to receiving such disenrollments via the Internet, an acceptable method of encryption must be utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information.

In addition, CMS policies require states to provide the CMS Office of Information Technology with a pro forma notice of intent to use the Internet for these purposes. The notice is essentially an attestation that the state is complying with the required encryption, authentication, and identification requirements. The CMS reserves the right to audit the state to ascertain whether it is in compliance with the security policy. The effective date of the request is determined by the election period in which the valid request was received by the state. The election period is determined by the date the request is received at the site designated by the state.

The option of online disenrollment is limited to requests submitted via the state's website. Online disenrollment via other means, such as disenrollment requests submitted via email, are not permitted.

Per §30.3.1, when someone other than the Medicare beneficiary completes a disenrollment request, he or she must:

1. Attest that he or she has the authority under state law to make the disenrollment request on behalf of the individual;
2. Attest that proof of this authorization (if any), as required by state law, that empowers the individual to effectuate a disenrollment request on behalf of the applicant is available upon request by CMS; and
3. Provide contact information.

If a passively enrolled member voluntarily disenrolls from the MMP, the state should ask if he or she wants to opt out of future passive enrollments into MMPs. If the individual indicates he or

she wants to opt out of future passive enrollments, the state should submit the disenrollment transaction (TC 51), and include an MMP Opt-Out Flag data element “Y” (opted out of passive enrollment) in position 202. This individual may enroll in a MMP in the future by submitting an opt-in enrollment request.

40.1.1 - Request Signature and Date

When providing a written, voluntary request to disenroll, the individual must sign the disenrollment request. If the individual is unable to sign, a legal representative must sign the request (refer to §30.3.1 for more detail on who may complete enrollment and disenrollment requests). If a legal representative signs the request for the individual, then he or she 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 a disenrollment request on behalf of the applicant is available and can be presented upon request to CMS.

The individual and/or legal representative should write the date he or she signed the disenrollment request; however, if he or she inadvertently fails to include the date, then the date of receipt that the state places on the request form will serve as the signature date.

If a written disenrollment request is received and the signature is not included, the state may verify the individual’s intent to disenroll with a phone call and document the contact, rather than return the written request as incomplete.

40.1.2 - Effective Date of Voluntary Disenrollment

The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

40.1.3 - Notice Requirements

The state must provide the member with a disenrollment notice within 10 calendar days of receipt of the request to disenroll, whether the request was verbal, in writing, or electronic ; and whether directly to the state or forwarded by the 1-800-MEDICARE (via the DTRR), or other mechanism.

The disenrollment notice must include an explanation of the effective date of the disenrollment (see Exhibit 14). The state may also advise the disenrolling member to ask their providers to hold Original Medicare and Medicaid claims for up to one month so that Medicare and Medicaid computer records can be updated to show that the person is no longer enrolled in the plan. This is recommended so that the Original Medicare and Medicaid claims are processed for payment and not denied.

If the state receives a disenrollment request that it must deny, the state must notify the enrollee within 10 calendar days of the receipt of the request, and must include the reason for the denial (see Exhibit 17).

A state may deny a voluntary request for disenrollment only when:

1. The request was made by someone other than the enrollee and that individual is not the enrollee's legal representative (as described in §30.3.1).
2. The request was incomplete and the required information is not provided within the required time frame (as described in §40.4.2).
3. The request was made outside of an allowable election period as described in section §20, of this guidance.

40.2 - Required Involuntary Disenrollment

The state **must** disenroll a member in the following cases.

1. A change in residence (includes incarceration (§40.2.7) – see below) makes the individual ineligible to remain enrolled in the MMP (§40.2.1);
2. The member loses Medicaid eligibility or additional state-specific eligibility requirements (§40.2.3);
3. After period of deemed continued eligibility ends without the individual regaining Medicaid eligibility (§40.2.3.2);
4. The member dies (§40.2.4);
5. The MMP's contract with CMS is terminated, or the MMP reduces its service area to exclude the member (§40.2.5);
6. The individual materially misrepresents information to the MMP regarding reimbursement for third-party coverage (§40.2.6); or
7. The member is not lawfully present or loses lawful presence status (§40.2.8).

Incarceration - A member who is incarcerated (exception outlined in §10.2) is considered to be residing outside the MMP's service area, even if the correctional facility is located within the MMP's service area. However, states must disregard past periods of incarceration that have been served to completion if those periods have not already been addressed by the state or by CMS. Individuals who are ineligible due to confirmed incarceration may not remain enrolled in a MMP. See §40.2.7 for more information.

Unlawful Presence - A member is considered unlawfully present if they lose lawful presence status in the United States (8 CFR §245.1). Individuals who are ineligible due to unlawful presence may not enroll in an MMP or remain enrolled in a MMP. See §40.2.8 for more information.

Notice Requirements - In situations where the state disenrolls the member involuntarily on any basis except death, loss of Medicare entitlement, incarceration, or unlawful presence, notices of the upcoming disenrollment must be sent and must meet the following requirements. All disenrollment notices must:

1. Advise the member that the state is planning to disenroll the member and explain why such action is occurring;
2. Be mailed to the member before submission of the disenrollment transaction to CMS;
3. Include an explanation of the member's right to a hearing under the state's grievance procedures, if applicable. This explanation is not required if the disenrollment is a result of contract or plan termination or service area reduction, since a hearing would not be appropriate for that type of disenrollment; and

4. Notice should be sent to the member within 10 calendar days of receipt of the CMS DTRR. For more information please also see the Summary of Notice Requirements.

40.2.1 - Members Who Change Residence

States must disenroll members who move out of the service area or have been temporarily absent from the service area for more than six consecutive months. State may advise the member to contact the state to select a new MMP if one is available in the new service area to which he or she is moving.

Individuals who are disenrolled due to a change in residence are eligible for a Medicare SEP due to both the residence change and their dual eligible status, so they are able to request enrollment in a Medicare health plan or Part D plan (either a PDP or MA-PD) for which he or she is eligible in his or her new place of residence. An individual who fails to make an enrollment request will be defaulted by CMS into Original Medicare, and will be auto-enrolled by CMS into a Medicare Prescription Drug Plan. The individual will have access to the LI NET prescription drug plan during any coverage gap.

Throughout §40.2.1, it is expected that the state is determining eligibility and taking steps to research and notify members regarding changes in residence. However, states may defer these activities to the MMP. In this case, it is expected that the state and MMP are coordinated such that any communications received by either party are acted upon appropriately following the guidance below.

40.2.1.1 - General Rule

The state must disenroll a member if:

1. He or she permanently moves out of the service area;
2. The member's temporary absence from the service area exceeds 6 consecutive months; or
3. The member is incarcerated and, therefore, resides out of area.

40.2.1.2 - Effective Date of Disenrollment

Generally, disenrollments for out of the service area are effective the first day of the calendar month after the date the member begins residing outside of the MMP service area AND after the member or his or her legal representative notifies the state that he or she has moved and no longer resides in the service area. In the case of an individual who provides advance notice of the move, the disenrollment will be the first of the month following the date the member begins residing outside of the MMP service area. **EXAMPLE:** In the case of an individual who contacts the state in February to provide advance notice of their move in May, the disenrollment would be effective June 1, NOT March 1 (1st day of the month after beneficiary contacted the state). The individual must be able to fully access MMP services until the last calendar day of the month he or she moves to out of state or out of MMP service area.

If the member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the 1st of the month after the move), the state must submit this request to CMT (or its designee) for consideration of retroactive action.

NOTE: An SEP, as defined in Chapter 2, Section §30.4 of the Medicare Managed Care Manual, applies to individuals who are disenrolled due to a change in residence.

Disenrollment for a temporary absence from the MMP's service area that exceeds 6 months (§ 40.2.1.1) is effective the first day of the calendar month after 6 months have passed.

Disenrollment for incarceration (§ 40.2.1.1) is effective the first day of the calendar month following the first date of incarceration. Please see §40.2.7 regarding involuntary disenrollment from the MMP based on confirmed incarceration status.

NOTE: An SEP, as defined in Chapter 2, Section §30.4 of the Medicare Managed Care Manual, applies to individuals who are disenrolled due to incarceration when they are released.

Unless the member elects a Medicare health or drug plan, any disenrollment processed under these provisions for permanent move or temporary absence exceeding 6 months will result in a change to enrollment in Original Medicare and CMS will auto-enroll him or her into a Medicare Prescription Drug Plan except for disenrollment due to incarceration (see §40.2 above). The individual will have access to the LI NET prescription drug plan during any coverage gap.

40.2.1.3 - Researching and Acting on a Change of Address

This section applies to individuals already enrolled in an MMP, and after enrollment, the state becomes aware of a potential change of address. Within 10 calendar days of receiving a notice of a change of address or an indication of possible out-of-area residency from the member, the member's legal representative, a CMS DTRR, or another source, the state must make an attempt to contact the member to confirm whether the move is permanent (may use Exhibit 30 if the state chooses to contact the member in writing). The state must also document its efforts.

The requirement to attempt to contact the member does not apply to a new, prospective enrollment for which the state receives either TRC 011 (Enrollment Accepted) or TRC100 (PBP Change Accepted as Submitted) accompanied by TRC 016 (Enrollment Accepted – Out of Area) on the same DTRR, as these represent new enrollments for which the state recently confirmed the individual's permanent residence in the plan service area.

In the case of incarcerated individuals, the state is not required to contact the individual but must confirm the individual's out-of-area (i.e., incarcerated) status. Confirmation may include contacting the individual or other sources (e.g., penal facility, state Medicaid agency or other state or federal agency) to determine confirmation of incarceration and incarceration start and end dates. When a state is notified of a current member's past period of incarceration and has confirmed that this member's period of incarceration has ended (i.e., individual is no longer incarcerated), the state must continue the individual's enrollment, unless otherwise directed by CMS.

If the state confirms an individual's current incarceration status but does not obtain the start date of the current incarceration, the state must disenroll the individual prospectively for the first of the month following the date on which the current incarceration was confirmed. If the state confirms an individual's current incarceration status as well as the start date of the current incarceration, the state must disenroll the individual for the first of the month following the start

date of the incarceration, even if retroactive. If that disenrollment effective date is outside the range of effective dates allowed by MARx (based on the current calendar month), the state must submit the retroactive disenrollment request to the RPC (see §50.5).

The state must retain documentation from the member or member's legal representative of the notice of the change in address, including the determination of whether the member's out-of-area status is temporary or permanent.

1. If the state receives notice of a **permanent change** in address **from the member or the member's legal representative**, and the new address is outside the MMP's service area, the state must disenroll the member and provide proper notification (Exhibit 20).
2. If the state receives notice (or indication) of a potential change in address **from a source other than the member or the member's legal representative**, and the new address is outside the MMP's service area, the state may not assume the move is permanent until it has received confirmation from the member, the member's legal representative, or, for incarcerated individuals, public sources (such as a state/federal government entity or other public records).

The state must initiate disenrollment when it verifies a move is permanent or when the member has been absent from the service area for 6 months from the date the state learned of the change in address. The state must notify the member in writing of the disenrollment. If the member responded and confirmed the permanent move out of the service area, the state must send the notice (Exhibit 20) within 10 calendar days of the member's confirmation that the move is permanent. If the member failed to respond to the request for address confirmation, the state must send the notice (Exhibit 19) in the first 10 days of the sixth month from the date the state learned of the change in address.

States may consider the 6 months to have begun on the date given by the member as the date that he or she will be leaving the service area. If the member did not inform the state of when he or she left the service area, the state can consider the 6 months to have begun on the date it received information regarding the member's potential change in address (e.g., DTRR, out-of-area claims).

If the member does not respond to the request for verification within the time frame given by the state, the state cannot assume the move is permanent and may not disenroll the member until 6 months have passed. The state may continue its attempts to verify address information with the member.

3. **Temporary absences** - If the state determines the change in address is temporary, the state may not initiate disenrollment until 6 months have passed from the date the state received information regarding the member's absence from the service area (or from the date the member states that his/her address changed, if that date is earlier).

40.2.1.4 - Procedures for Developing Addresses for Members Whose Mail is Returned as Undeliverable

If an address is not current, the U.S. Postal Service (USPS) will return any member materials mailed first-class by the state or MMP as undeliverable.

In the event that any member materials are returned as undeliverable, the following steps apply:

1. If the USPS returns mail with a new forwarding address, the state should forward materials to the member and advise him or her to change his or her address with the SSA.
2. If the state receives documented proof of a member residence change that is outside of the MMP service area or mail is returned without a forwarding address, follow the procedures described in §40.2.1.3.
3. If the MMP receives claims for services from providers located outside the plan service area, the MMP may choose to follow up with the provider to obtain the member's address, and then notify the state.
4. If the state is successful in locating the member, advise him or her to update his or her records, if necessary, with the SSA by:
 - a. Calling the SSA toll-free number, 1-800-772-1213. TTY users should call 1-800-325-0778 weekdays from 7:00 a.m. to 7:00 p.m. EST;
 - b. Logging onto their **MySocialSecurity.gov** account at: <http://www.socialsecurity.gov/myaccount/>; or
 - c. Notifying the local SSA field office. An individual can get addresses and directions to SSA field offices from the Social Security Office Locator which is available on the internet at: <http://www.ssa.gov>.

States and MMPs are expected to continue to mail member materials to the undeliverable address, as a forwarding address may become available at a later date, and are encouraged to continue their efforts, as discussed above, to attempt to locate the member using any available resources, including state and CMS systems, and reaching out by phone or email (if these types of contact information are available) to identify new address information for the member. If a forwarding address becomes available, a state and MMP can send materials to that address as in item #1 above.

Also, when a member's residence address differs from CMS/SSA address information, states may report the residence address to CMS by submitting TC 76 - Residence Address Record Update. The purpose of the TC 76 is to update the state and County Code information for use in MMP service area determination and MMP's payment calculation. The residence address information is a second address; it does not update the permanent address information in CMS system, which is updated by notification from SSA or Railroad Retirement Board (RRB). Therefore, states should refer the beneficiary to SSA (or RRB if the individual is an RRB beneficiary) for a permanent address change. The detailed instructions and record layout of TC 76 are outlined in the CMS Plan Communication User Guide (PCUG) Appendices:

https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelppdesk/Plan_Communications_User_Guide.html

40.2.1.5 - Notice Requirements

1. **State or MMP notified of out-of-area permanent move** - When the state or MMP receives notice of a permanent change in address from the member or the member's legal representative, the state must provide notification of disenrollment to the member. This notice to the member, as well as the disenrollment transaction with disenrollment reason code 92 (these codes are provided in the CMS Plan Communication User Guide (PCUG)) to CMS, must be sent within 10 calendar days of the state learning of the permanent move.
2. **Out of area for 6 months** - When the member has been absent from the service area for 6 months after the date the state learned of the change in address from a source other than the member or the member's legal representative (or the date the member stated that his address changed, if that date is earlier), the state must provide notification of the upcoming disenrollment to the member. States are encouraged to follow up with members and to issue interim notices prior to the expiration of the 6 month period.

The notice of disenrollment must be provided within the first 10 calendar days of the sixth month. The transaction to CMS must be sent within 3 business days following the disenrollment effective date. CMS strongly encourages that states send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MMP services.

EXAMPLE: State learns of any indication of possible out-of-area residency from a source other than the member or the member's legal representative on January 20. The 6-month period ends on July 20. The state checks their systems and is not able to confirm member's new address. The state then conducts a verbal or written outreach to the member within 10 calendar days of receipt of the DTRR to determine if a residence change has occurred. (If the state does not receive any response from the member indicating this information is incorrect, the state may choose to use Exhibit 30 to contact the member in writing.) Therefore, the state must proceed with the disenrollment, effective August 1. The state sends a notice of disenrollment (Exhibit 19) to the member during the first 10 calendar days of July notifying the member that he or she will be disenrolled effective August 1. The transaction to CMS must be sent no later than 3 business days following July 31, the last day of the month in which the 6-month period ends.

40.2.2 - Loss of Medicare Part A or Part B

An individual cannot remain a member in an MMP if he or she is no longer entitled to both Medicare Part A and Part B benefits. The state will be notified by CMS via the DTRR that entitlement to either Medicare Part A and/or Part B has ended, and CMS will make the disenrollment effective the first day of the month following the last month of entitlement to either Medicare Part A or Part B benefits (whichever occurred first). The state will need to update its own enrollment system to reflect this CMS-initiated disenrollment.

Notice Requirements –Notification may be provided when the disenrollment is due to the loss of entitlement to either Medicare Part A or Part B so that any erroneous disenrollments can be corrected as soon as possible. CMS strongly encourages states, at a minimum, provide a verbal notice to the individual. The state may use Exhibit 24 if it chooses to contact the member in

writing. The state should make contact with the member (either verbally or through written notice) within 10 calendar days of the individual's contact with the MMP or state to report the erroneous disenrollment. In cases of erroneous disenrollment and notification, see §50.3.1.

40.2.3 - Loss of Medicaid Eligibility or Additional State-Specific Eligibility

An individual cannot remain a member in an MMP if he or she is no longer eligible for Medicaid benefits or no longer meets other criteria outlined in the Memorandum of Understanding, the three-way contract, or Appendix 5. Generally, an individual who loses Medicaid eligibility or loses eligibility based on state-specific requirements is disenrolled from the MMP on the first of the month following the state's notification to the MMP of the individual's loss of eligibility. This applies even in cases of retroactive Medicaid termination. However, for the loss of Medicaid eligibility only, MMPs may voluntarily elect to offer a period of deemed continued eligibility to their members, as outlined in §40.2.3.2.

Individuals who experienced a short-term loss of Medicaid retain the option to enroll in an MMP at any time during that benefit year once Medicaid has been regained. The state may passively enroll the individuals the following year as outlined in §30.2.5 or rapidly re-enroll the individual as outlined in §40.2.3.3. Please note that all rapid re-enrollment transactions submitted by the state (§40.2.3.3) to the MMP must be accepted.

If an individual experiences a loss of Medicaid and is disenrolled, but regains eligibility before the disenrollment takes effect (e.g., before the first of the upcoming month), the individual should remain in coverage as though the individual was never disenrolled. The state should restore the enrollment in its records and cancel the disenrollment action from CMS's records as outlined in §50.3.3. The individual does not qualify for rapid-reenrollment in this instance as he or she has regained eligibility prior to the disenrollment taking effect (§40.2.3.3).

40.2.3.1 - General Disenrollment Procedures due to Loss of Medicaid Eligibility or Additional State-Specific Eligibility

An MMP must continue to offer the full continuum of MMP benefits through the end of the calendar month in which the state notifies the MMP of the loss of Medicaid eligibility or loss of state-specific requirements. The beneficiary must also be notified of the involuntary disenrollment following the notice requirements below.

States are limited to only one passive enrollment of the individual in a calendar year, following parameters outlined in §30.2.5. However, an individual who was passively enrolled into the MMP and subsequently loses eligibility and is disenrolled may be rapidly re-enrolled within in the same calendar year into a MMP upon regaining Medicaid or state-specific eligibility no more than 2 months from the loss of their Medicaid eligibility (see §40.2.3.3 for more details on rapid re-enrollment).

Notice and Transaction Requirements – States are to follow normal protocols regarding notifying individuals of the loss of Medicaid eligibility. With regard to involuntary disenrollment from the MMP, the state must provide each member a written notice (see Exhibit 21) regarding the disenrollment due loss of Medicaid or state-specific eligibility at least 10 calendar days prior to the disenrollment effective date. The notice must include information

regarding the disenrollment effective date and the Medicare SEP for “dual eligible” individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program and who recently lost dual eligible status. Please see section §20.1.1 for more information on the SEP for individuals who gain, lose, or have a change in their dual or LIS status.

If a determination regarding the loss of Medicaid or state-specific eligibility occurs within the last 10 days of the month, the state must provide the affected member a written notice of disenrollment regarding the loss of eligibility within 3 business days of its determination. In this situation, the state is also strongly encouraged to call these affected member as soon as possible (within 1-3 calendar days) to provide the disenrollment effective date, to explain that the MMP will no longer cover services as of that date and to convey that the individual will have Original Medicare. For individuals who retain LIS status, CMS will auto-enroll him/her into a Medicare Prescription Drug Plan. The individual will have access to the LI NET prescription drug plan during any coverage gap.

States must submit a disenrollment transaction to CMS no later than 3 business days following the date Medicaid or other state-specific eligibility requirement ended. States can attempt to cancel the disenrollment by submitting TC 81- Cancellation Disenrollment transaction if the beneficiary’s Medicaid status has been restored before the disenrollment effective date. If unsuccessful in cancelling the disenrollment, the state must submit the case to the CMS Retroactive Processing Contractor (RPC).

40.2.3.2 - Optional Period of Deemed Continued Eligibility Due to Loss of Medicaid Eligibility

An MMP may choose to provide a deemed continued eligibility period for individuals who lose Medicaid eligibility, as long as the individual can reasonably be expected to regain Medicaid eligibility within specified period outlined in each state’s Appendix 5. If the MMP decides to offer this “grace period,” it must apply the criteria consistently to all members of the plan and fully inform the state and its members of this policy. The optional period of deemed continued eligibility starts on the first of the month following the month in which the MMP is notified of the loss of Medicaid eligibility by the state, even in cases of retroactive Medicaid termination.

Only members who are reasonably expected to regain eligibility in the state-specified timeframe are eligible for the grace period. If the MMP enrollee does not re-qualify within the plan’s period of deemed continued eligibility, he or she must be involuntarily disenrolled from the plan, with proper notice as outlined below, at the end of this period. Individuals who retain LIS status will transition to Original Medicare and be auto-enrolled into a Medicare Prescription Drug Plan by CMS. The individual will have access to the LI NET prescription drug plan during any coverage gap.

Any plan that elects to provide this grace period must continue to offer the full continuum of MMP benefits as outlined in its Plan Benefit Package (PBP), even if the state is not providing the Medicaid capitation payment to the MMP.

Notice Requirements - For individuals enrolled in MMPs that offer the period of deemed continued eligibility, the state must provide each affected individual a written notice regarding

the loss of eligibility. In addition, the state or MMP must provide the member a written notice about deemed continued enrollment within 10 calendar days of learning of the loss of Medicaid eligibility. This notice must provide the member an opportunity to prove that he or she is still eligible to be in the plan. In addition, the notice must include information regarding the period of deemed continued eligibility, including its duration, a complete description of the Medicare SEP for “dual eligible” individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program and who recently lost dual eligible status, the consequences of not regaining Medicaid eligibility within the period of deemed continued eligibility and the effective disenrollment date (see Exhibit 22). MMPs are encouraged to work with the individual and the state to assist the individual with regaining Medicaid eligibility during the period of deemed continued eligibility.

Should the individual not regain eligibility to Medicaid within the period of deemed continued eligibility, the state must provide each member a written notice regarding the involuntary disenrollment from the MMP due to loss of eligibility. The disenrollment notice to the individual and the transaction to CMS must be sent within 3 business days following the last day of the period of deemed continued eligibility. The notice must include information regarding the disenrollment effective date and the Medicare SEP for “dual eligible” individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program and who recently lost dual eligible status (see Exhibit 21).

Dual eligible beneficiaries who are no longer eligible for Title XIX benefits have a **one** time opportunity to make an election within three months of the change, or notification of such a change, whichever is later. SEP begins the month they receive notice of the loss of eligibility, even if the loss of eligibility is determined retroactively by the state. This means the individual can join, switch or drop MMP coverage during this SEP. The effective date of an enrollment request using this SEP would be the first of the month following receipt of an enrollment request.

Please see section §20.1.1 for more information on the SEP for individuals who gain, lose, or have a change in their dual or LIS status.

40.2.3.3 – Rapid Re-enrollment

If an individual is involuntarily disenrolled due to a loss in Medicaid, states may rapidly re-enroll the individual back into his/her original MMP. Rapid re-enrollment can only occur if the individual regains their Medicaid no more than 2 months from the effective date of disenrollment. Rapid re-enrollment is effective the first day of the month after the individual regains Medicaid eligibility. Please note that it is the expectation that states work with MMPs to ensure that individuals who are rapidly re-enrolled are placed back into the same enrollee-care coordinator relationship that they had prior to their disenrollment. Please note that individuals have the right to decline rapid re-enrollment at any time (see Exhibits 21 and 5c).

States must use the following specific data elements when submitting rapid re-enrollment transactions to CMS MARx system:

- Transaction Code = 61
- Application Date = Date of the File Submission to CMS
- Effective Date = 1st day of the month following the month individual regains Medicaid
- Election Type Code = “U” – Dual LIS SEP

- Enrollment Source Code – “J” – State-submitted Passive Enrollment

Please note that rapid re-enrollment policy will not automatically supplant the use of deemed continued eligibility (see section 40.2.3 and 40.2.3.2) in states with MMPs that adopt deemed continued eligibility. Instead, this policy is another option for states seeking to promote continuity of care and enrollment in MMPs. Please note that rapid re-enrollment can also be utilized in addition to deemed continued eligibility. For example, a beneficiary is enrolled in a MMP that offers 2 months of deemed continued eligibility. The beneficiary loses Medicaid eligibility on April 1, 2017 which means their 2 months deemed continued eligibility period would end on May 31, 2017. The beneficiary does not regain Medicaid eligibility by May 31, 2017 and is disenrolled from the MMP as of June 1, 2017 (Exhibit 21 is sent to the beneficiary). The beneficiary does not have Medicaid eligibility in June 2017 and July 2017. The beneficiary finally regains Medicaid eligibility effective August 1, 2017, therefore their rapid re-enrollment effective date would be September 1, 2017. Please note that rapid re-enrollment is always prospective, even if Medicaid is restored retroactively.

See §40.2.3 for when an individual experiences a loss of Medicaid and is disenrolled, but regains eligibility before the disenrollment takes effect.

Note: Rapid re-enrollment is not just limited to beneficiaries that have been passively enrolled but is also available to those individuals that opt-in to an MMP.

Notice Requirements – An Involuntary Disenrollment Notice Due to Loss of Medicaid (Exhibit 21), Welcome-back Notice (Exhibit 5c) and Enrollment Confirmation Notice (Exhibit 7) should be sent. Please note that there is no requirement to send the standard 60-day passive enrollment and 30-day passive enrollment reminder notices when an individual is rapidly re-enrolled.

40.2.4 - Death

CMS will disenroll a member from an MMP upon his or her death and CMS will notify the state via the DTRR. This disenrollment is effective the first day of the calendar month following the month of death.

Before receiving a death notification from CMS via the DTRR, states may, at their discretion, use the reported death in internal state system to end the member’s Medicaid eligibility and submit a disenrollment transaction to CMS with a disenrollment reason code of 64 - LOSS OF DEMONSTRATION ELIGIBILITY. States may report death information to Social Security so that the Death Master Record is updated. This action will also update CMS systems and generate the DTRR.

Notice Requirements –Notification to the member’s estate, or an emergency contact listed on the member’s record, may be provided when the disenrollment is due to death. Where states choose to make such notice, CMS encourages states to do so (either verbally or through written notice) within 10 calendar days of receiving information about the death so that any erroneous disenrollments can be corrected as soon as possible. The state may use Exhibit 23 if it chooses to send notification in writing. If the disenrollment occurred due to erroneous death indicator that resulted a loss of Medicaid eligibility or system error, see §50.3 and §50.3.3 for restoring MMP enrollment. In cases of erroneous disenrollment and notification, see §50.3.1.

40.2.5 - Terminations/Non Renewals

The state must disenroll a member from an MMP if the MMP's three-way contract with the state and CMS is terminated or if the MMP is discontinued or reduces its service area to exclude the member. The state and CMS will provide guidance on the transition process guidance and close-out instructions for MMPs during the termination/nonrenewal process.

A member who is disenrolled under these provisions is eligible for a Medicare SEP due to both the termination/non-renewal and their dual eligible status, so he or she is able to request enrollment in a Medicare health or Part D plan (PDP or MA-PD) for which he or she is eligible. A member who fails to make an enrollment request is deemed to have elected Original Medicare, and will be auto-enrolled by CMS into a PDP, and can access the LI NET transitional PDP during any coverage gap.

Notice Requirements - The state must give each MMP member a written notice of the effective date of the termination or service area reduction, and include a description of alternatives for obtaining benefits under the Medicare program. The state may also include the ability for affected individuals to enroll in another MMP, if available. The state can delegate the written notice to be sent by the terminating/non-renewing MMP. The notice must be sent 60 days prior to termination date. The state will need to customize the notice when this situation arises and must obtain approval from CMS on the notice before sending.

When a demonstration is ending, the last date for new enrollments must occur no later than six months before the demonstration's end date. For example, if a demonstration ends on December 31, new enrollments can occur through June 30 for an effective date of July 1.

40.2.6 - Material Misrepresentation Regarding Third-Party Reimbursement

If an MMP enrollee intentionally withholds or falsifies information about third-party reimbursement coverage, the individual must be disenrolled from the MMP. Involuntary disenrollment for this reason requires CMT approval. The state must submit any information it has regarding the claim of material misrepresentation to its CMT for review. Disenrollment for material misrepresentation of this information is effective the first of the month following the month in which the member is notified of the disenrollment or as the CMT specifies.

40.2.7 – Incarceration

In the case of incarcerated individuals, CMS will involuntarily disenroll individuals who are confirmed incarcerated based on data CMS receives from SSA. The disenrollment effective date for confirmed incarceration will be the first of the month following the member's incarceration start date. Incarcerated individuals will be defaulted to Medicare enrollment and coverage (subject to limits on the payment of claims) through Original Medicare. Currently, states receive notification of the individual's incarceration via the DTRR using specific TRC 155 (Incarceration Notification Received) to indicate that research is needed to determine if a member is incarcerated and resides out of the MMP's service area. At a future date CMS will automatically disenroll the individual and notify the state via the DTRR using specific TRC 346 (Prisoner Suspension Period Cancel/Disenroll) indicating beneficiary's benefits have been suspended. Under the new regulations and procedures as of the February 2016 CMS Software

release, CMS will effectuate disenrollments upon receipt of confirmed incarceration data from SSA instead of relying solely on states to investigate a member's potential out-of-area status due to incarceration.

If the state learns of a possible incarceration from a source other than CMS, the state must investigate and, following current process (outlined in §30.2 & 10.2.1), determine if the member resides in the MMP's service area and, if appropriate, involuntarily disenroll the member. If the incarceration information is received from other source with direct access to confirmed incarceration data, such as a penal facility or state/local law enrollment authorities, additional investigation is not necessary. Disenrollment is effective the first of the month following the state's confirmation of a current incarceration. State is required to send notification of the disenrollment to the individual.

In some circumstances, CMS may receive confirmed incarceration data with both the start and end dates (TRC 346 - Prisoner Suspension Period Cancel/Disenroll and TRC 347 - Reenrollment due to Closed Incarceration Period via two separate DTRR receipts on the same day), indicating a closed period occurring in the past. While CMS expects this to be infrequent, CMS will disenroll the individual from the MMP from the first of the month after the start date of the incarceration. CMS' MARx system automatically re-enrolls the individual into the MMP of which he or she was a member at the time eligibility is reestablished. States should reassess whether the individual still meets eligibility for the MMP and if not cancel the re-enrollment. Upon receipt of a CMS DTRR, states must update their records to accurately reflect each individual's enrollment status. States are also required to provide certain notices and information to beneficiaries when enrollment status is confirmed or changes.

SSA confirms and provides due process for individuals with an incarceration status prior to sending the data to CMS and before the individual's Medicare benefits are adversely affected. In the event an individual contests the CMS-effectuated involuntary disenrollment, states should first check the BEQ or MARx online query to confirm that CMS systems reflect an incarcerated status for the individual. If CMS systems reflect such a status, states should refer individuals to SSA to review and, if necessary, update their records. MMPs are not required to continue to provide coverage to such individuals while the issue is reviewed by SSA.

If, upon initial receipt of the individual's challenge, CMS systems indicate current Medicare eligibility and any past period of incarceration does not overlap with any portion of the individual's previous period of enrollment, the state should submit a reinstatement request to the Retroactive Processing Contractor (RPC) instead of referring the individual to SSA. In this case, the MMP may continue to provide coverage to the individual while the request is with the RPC. Once the reinstatement is processed, the state 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 had never been disenrolled.

Notice Requirements – States are required to send an involuntary disenrollment notice due to confirmed incarceration (see Exhibit 32) upon receipt of a TRC 346 (Prisoner Suspension Period Cancel/Disenroll) via Daily Transaction Reply Report (DTRR) **or** are required to send for loss of Medicaid status or state-specific eligibility status (see Exhibit 21) within ten (10) calendar days of learning of confirmed incarceration from a source other than CMS. This is to ensure that the member is aware of the loss of MMP coverage in the plan and any erroneous disenrollments can be corrected as soon as possible. State may include special messaging alerting the individual that

neither MMP nor Medicare pays for hospital or medical services while the individual is incarcerated. Should the disenrollment or notification later be found to be erroneous, please see §50.3.1 for how to handle such cases.

40.2.8 – Unlawful Presence Status

An individual may not remain enrolled in an MMP if not lawfully present in the United States. CMS will notify the state and the MMP with specific TRC 349 (Disenrollment Due to Not Lawfully Present Period) on the DTRR that the individual is not lawfully present, and CMS will make the disenrollment effective the first day of the month following the notification by CMS. State should make a similar update to their system, i.e., by disenrolling the individual as well receipt of the TRC 349 on the DTRR.

If states learn of the individual's unlawful presence status before receiving a notification from CMS via the DTRR, states may independently verify individual's lawful presence status through the Federal Data Services Hub or the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) Program, a web-based application that provides lawful presence status. At state's discretion, individual's Medicaid eligibility may be terminated and state must submit a disenrollment transaction to CMS with a disenrollment reason code of 64 - LOSS OF DEMONSTRATION ELIGIBILITY.

MMP may not request from a member any documentation of U.S. citizenship or alien status, as CMS or state provides the official status to the MMP.

SSA confirms and provides due process for unlawfully present individuals prior to sending the data to CMS and before the individual's Medicare benefits are adversely affected. In the event an individual contests the CMS-effectuated involuntary disenrollment, states should first check the BEQ or MARx online query to confirm that CMS systems reflect an unlawful presence status for the individual. If CMS systems reflect such a status, states should refer individuals to SSA to review and, if necessary, update their records. MMPs are not required to continue to provide coverage to such individuals while the issue is reviewed by SSA.

If, upon initial receipt of the individual's challenge, CMS systems indicate current Medicare eligibility and any past period of unlawful presence does not overlap with any portion of the individual's previous period of enrollment, state or the delegated MMP should submit a reinstatement request to the Retroactive Processing Contractor (RPC) instead of referring the individual to SSA. In this case, the MMP may continue to provide coverage to the individual while the request is with the RPC. Once the reinstatement is processed, the state 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 had never been disenrolled.

Notice Requirements – Following the loss of Medicaid eligibility based on a confirmation of unlawful presence status from the Federal Data Services Hub, the SAVE Program or receipt of a TRC 349 via DTRR, states should notify the beneficiary, using either Exhibit 21 (standard involuntary disenrollment notice for loss of eligibility) or Exhibit 33 (notice tailored for involuntary disenrollment due to unlawful presence status). Notice should be provided to the member within ten (10) calendar days so that the member is aware of the loss of MMP coverage

and any erroneous disenrollment can be corrected as soon as possible. Should the disenrollment or notification later be found to be erroneous, please see §50.3.1 for how to handle such cases.

Please note that states are required to send an involuntary notice for loss of Medicaid status or state-specific eligibility status (see Exhibit 21) within ten (10) calendar days of learning of the unlawful presence.

40.3 - Optional Involuntary Disenrollments

A state may request CMT approval to disenroll a member from a MMP if:

- The member engages in disruptive behavior; or
- The member provides fraudulent information on an enrollment request; or
- If the member permits abuse of an enrollment card in the MMP.

Notice Requirements - In situations where the state disenrolls the member involuntarily for any of the reasons addressed above, the state must send notice of the upcoming disenrollment that meets the following requirements:

- Advises the member that the state is planning to disenroll the member and why such action is occurring;
- Provides the effective date of termination; and
- Includes an explanation of the member's right to a hearing under the state's grievance procedures.

Unless otherwise indicated, all notices must be mailed to the member before submission of the disenrollment transaction to CMS.

40.3.1 - Disruptive Behavior

In conformance with Medicaid requirements in 42 CFR Part 438 and demonstration requirements in this guidance, the MMP **may** request approval from CMS and the state (via the CMT) to disenroll a member if his or her behavior is disruptive to the extent that his/her continued enrollment in the MMP substantially impairs the MMP's ability to arrange for or provide services to either that particular member or other members of the plan. However, the CMT may approve an MMP request to disenroll a member for disruptive behavior only after the MMP has met the requirements of this section. The CMT may not approve an MMP request to disenroll a member because he or she exercises the option to make treatment decisions with which the MMP disagrees, including the option of declining treatment and/or diagnostic testing. A request to disenroll a member because he/she chooses not to comply with any treatment regimen developed by the MMP or any health care professionals associated with the MMP will not be approved.

Before requesting the state's involvement and CMT's approval of disenrollment for disruptive behavior, the MMP, and the state, as appropriate, must make a serious effort to resolve the problems presented by the member's behavior. Such efforts to find resolution must include providing reasonable accommodations, as determined by the state or CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. The MMP and/or the state as appropriate, must also inform the individual of his or her right to use the MMP's, and the state's, as appropriate, grievance procedures.

As a first step, the MMP must submit documentation of the specific case to the state for review. If the state agrees with the request for involuntary disenrollment, the state must submit this documentation to the CMT with a recommendation for approval. This includes documentation:

- Of the disruptive behavior, including dates, locations, and actions that meet the criteria outlined in this section;
- Of the MMP's, and state's if applicable, serious efforts to resolve the problem with the individual;
- Of the MMP's, and state's if applicable, efforts to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act;
- Establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Describing any extenuating circumstances;
- That the state or MMP provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Summary of Notice Requirements);
- That the state or MMP then provided written notice of its intent to request involuntary disenrollment (see Summary of Notice Requirements);
- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the MMP's ability to arrange for or provide services to the individual or other members of the MMP;
- Member information, including age, diagnosis, mental status, functional status, a description of his or her social support systems and any other relevant information;
- Statements from providers describing their experiences with the member; and
- Any information provided by the member (e.g., complaints, statements).

Once the state reviews the request, it may either disapprove it, or forward the request and all related documentation to the CMT with a recommendation for approval. For purposes of considering these types of requests, the CMT shall include a representative from the CMS Center for Medicare. The CMT will review this documentation and consult with staff with appropriate clinical or medical expertise and decide whether the state may involuntarily disenroll the member from the MMP. Such review will include any documentation or information provided either by the MMP, the state, and the member (information provided by the member must be forwarded by the state to CMT). The CMT will make the decision within 20 business days after receipt of all the information required to complete its review.

Should the request be approved, the disenrollment is effective the first day of the calendar month after the month in which the MMP gives the member a written notice of the disenrollment, or as provided by the CMT. Any disenrollment processed under these provisions will always result in a change of enrollment to Original Medicare, and auto-enrollment by CMS into a Medicare Prescription Drug Plan, including access to the LI NET transitional PDP during any coverage gap.

If the request for involuntary disenrollment for disruptive behavior is approved:

- CMS and the state may require the MMP to provide reasonable accommodations to the individual in such exceptional circumstances that the state and CMS deems necessary.

- The MMP may request that the state consider prohibiting re-enrollment in the MMP. If this is not requested, and the individual is disenrolled due to disruptive behavior, the individual may re-enroll into the MMP in the future.

Notice Requirements - The disenrollment for disruptive behavior process requires 3 written notices:

- **Advance notice** to inform the member that the consequences of continued disruptive behavior may be disenrollment;
- **Notice of intent** to request the state and CMT's permission to disenroll the member; and
- **A planned action notice** advising that CMT and the state have approved the MMP's request.

Advance Notice – Prior to forwarding an involuntary disenrollment request to the state, the MMP must provide the member with written notice describing the behavior it has identified as disruptive and how it has impacted the MMP's ability to arrange for or provide services to the member or to other members of the plan. The notice must do the following:

1. Make clear that the member's current MMP coverage is still in effect.
2. Explain that his or her continued behavior may result in involuntary disenrollment and that cessation of the undesirable behavior may prevent this action.
3. Provide information about who the member may contact for more information or to ask questions about the notice.
4. Advise the member of his/her right to use the MMP's, and the state's if appropriate, grievance procedures and to submit any information or explanation.

Please note the following:

1. The Advance Notice should **not** include a projected effective date of disenrollment.
2. The MMP must include a copy of this notice and the date it was provided to the member in any information forwarded to the CMT and the state.
3. If the disruptive behavior ceases after the member receives notice and then later resumes, the MMP must begin the process again. This includes sending another advance notice.

Note: There are no national models for the above notices; the MMP will need to customize each notice following the requirements outlined in this section.

Notice of Intent – If the member's disruptive behavior continues despite the MMP's efforts, the MMP must notify him or her of its intent to request the state and CMT's permission to dis-enroll him/her for disruptive behavior. This notice must do the following:

1. Make clear that the member's current MMP coverage is still in effect.
2. Notify him/her of the MMP's intent to request the state and CMT's permission to dis-enroll him/her for disruptive behavior.
3. Provide information about who the member may contact for more information or to ask questions about the notice.
4. Advise the member of his/her right to use the MMP's, and the state's if appropriate, grievance procedures and to submit any information or explanation.

Please note the following:

1. The Notice of Intent should **not** include a projected effective date of disenrollment.
2. The MMP must include a copy of this notice and the date it was provided to the member in any information forwarded to CMT and the state.
3. The MMP must include a copy of this notice and the date it was provided to the member in any information forwarded to CMT and the state.

Planned Action Notice – If the state recommends and the CMT approves the request to disenroll a member for disruptive behavior, the state must provide the member with a written notice that contains (in addition to the notice requirements outlined in §40.3) the following:

1. A statement that this action was approved by the state and CMS and meets the requirements for disenrollment due to disruptive behavior described above. **Note:** The state may only provide the member with this required notice after the CMT notifies the state of its approval of the request.
2. Information about who the member may contact for more information or to ask questions about the notice.
3. Advise the member of his or her right to use the MMP's, and the state's if appropriate, grievance procedures and to submit any information or explanation.

The state can submit the disenrollment transaction to CMS only after providing the notice of disenrollment (Planned Action Notice) to the individual. The disenrollment is effective the first day of the calendar month after the month in which the state gives the member a written notice of the disenrollment, or as provided by CMT and the state.

If the CMT does not approve the request to disenroll, the MMP must provide the member with written notice, notifying them of that decision. If the MMP wishes to pursue another involuntary disenrollment request for the same member, the MMP must begin the process again. This includes sending another advance notice.

40.3.2 - Fraud and Abuse

A state **may** request CMT approval to cancel the enrollment of a member who knowingly provides on the enrollment form or other enrollment mechanism fraudulent information that materially affects the determination of an individual's eligibility to enroll in the plan. The MMP may also request to disenroll a member who intentionally permits others to use his/her enrollment card to obtain services or supplies from the plan or any authorized plan provider.

With such a disenrollment request, the MMP must immediately notify the state and CMT so the HHS Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse. If approved by the state and CMT, the disenrollment is effective the first day of the calendar month after the month in which the MMP gives the member the written notice. Any disenrollment processed under these provisions will always result in a change of enrollment to Original Medicare and auto-enrollment by CMS into a Medicare Prescription Drug Plan, as well as access the LI NET transitional PDP during any coverage gap.

Notice Requirements — The state must give the member a written notice of the disenrollment that contains the information required at §40.3. There are no national models for the above notices; the MMP will need to customize each notice following the requirements outlined in this section.

40.4 - Processing Disenrollments

An individual may request a disenrollment by contacting the state or 1-800-MEDICARE.

40.4.1 - Voluntary Disenrollments

After receipt of a completed disenrollment request from a member, the state is responsible for confirming the disenrollment is allowed (i.e., the member has a valid Medicare election period; note that states that have demonstration authority for a continuous SEP need not do this check). The state is then responsible for submitting the disenrollment transaction (TC 51) to CMS in a timely, accurate fashion. Such transmissions must occur within 7 calendar days of receipt of the completed disenrollment request, in order to ensure the correct effective date.

The state must maintain a system for receiving, controlling, and processing voluntary disenrollments from the MMP. This system should include:

- Recording the date on which each disenrollment request is received (regardless of whether the request is complete at the time it is received by the state);
- Recording the date on which supporting documents, if needed, for disenrollment requests are received;
- Processing disenrollment requests in chronological order by date of receipt of completed disenrollment requests;
- Transmitting disenrollment transaction to CMS within 7 calendar days of the receipt of the completed disenrollment request; and
- Notifying the member in writing to confirm the effective date of disenrollment within 10 calendar days of the availability of the DTRR for cases in which the voluntary disenrollment is effectuated by member's disenrollment request, an enrollment into another Medicare plan or MMP, or by 1-800-MEDICARE (see Exhibit 16).

Note that the state may not require that the beneficiary make the request in writing.

If the individual requests to opt-out from future passive enrollments into an MMP, and/or auto-enrollment into a Medicare Prescription Drug Plan, the state must take the following steps when it submits the disenrollment transaction (TC 51) to CMS' MARx system:

- An MMP Opt-Out Flag data element set to "Y" (opted-out of passive enrollment into MMP Plan) in position 202 to register on CMS systems the request to opt out of future passive enrollments into an MMP.
- For opting out of future Medicare auto-enrollments into a PDP, refer the individual to 1-800-MEDICARE.

40.4.2 - When the Disenrollment Request is Incomplete

When the disenrollment request is incomplete (e.g., missing wet signature on the written disenrollment request,), the state must document all efforts to obtain additional documentation to complete the disenrollment request and have an audit trail to document why additional documentation was needed before the request could be considered complete. The state must make this determination, and within 10 calendar days of receipt of the disenrollment request, must notify the individual that additional information is needed.

If a written disenrollment request is submitted and the signature is not included, the state may verify with the individual with a phone call and document the contact, rather than return the written request as incomplete.

Additional documentation to make the request complete must be received 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).

40.4.3 – Mandatory Involuntary Disenrollments

The state is responsible for submitting involuntary disenrollment transactions to CMS in a timely, accurate fashion.

The state must maintain a system for controlling and processing involuntary disenrollments. This includes:

- Maintaining documentation leading to the decision to involuntarily disenroll the member; and
- Notifying the member in writing of the upcoming involuntary disenrollment, including providing information on grievances rights, for all involuntary disenrollments, except disenrollments due to death and loss of Medicare Parts A and/or B.

In addition, CMS requires states to send confirmation of involuntary disenrollment to ensure the member is notified that the MMP services will discontinue after the disenrollment date.

40.5 – Disenrollments Not Legally Valid

When a disenrollment is not legally valid, a reinstatement action may be necessary (refer to §50.3). In addition, the reinstatement may result in a retroactive disenrollment from another plan. Since optional involuntary disenrollments (e.g., member engages in disruptive behavior; or member provides fraudulent information on an enrollment request, or member permits abuse of an enrollment card in the MMP, as stated in §40.3) are considered legal and valid disenrollments, individuals would not qualify for reinstatements in these cases.

A voluntary disenrollment that is not complete, as defined in 40.4.2, is not legally valid. In addition, there are instances in which a disenrollment that appears to be complete can turn out to be legally invalid. For example, automatic disenrollments due to an erroneous death indicator or an erroneous loss of Medicare Part A or Part B indicator are not legally valid.

A voluntary disenrollment is not complete if the member or his or her legal representative did not intend to disenroll from the MMP. If there is evidence that the member did not intend to disenroll from the MMP, the state should submit a reinstatement request to CMS (or its designee). Evidence that a member did not intend to disenroll may include:

- A disenrollment request signed by the member when a legal representative should be signing for the member; or
- Request by the member for cancellation of disenrollment before the effective date (refer to §50.2 for procedures for processing cancellations).

A member's deliberate attempt to dis-enroll from a plan (e.g., sending a written request for disenrollment to the MMP, 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.

50 – Post Enrollment Activities

Post-enrollment activities begin after the state receives the enrollment request from the individual (e.g., cancellations, opt-out, 4Rx, or other update transactions) or an individual has been notified of passive enrollment, and lasts until a decision is made with respect to an individual's enrollment request. Due to the nature of post-enrollment activities, flexibility is available for states and MMPs to perform certain tasks, such as sending notices. It is imperative that states and MMPs work together to determine which entity is performing which function prior to permitting any beneficiary to enroll in a given MMP.

50.1 - Multiple Transactions

Multiple transactions occur when CMS receives more than one enrollment request for the same individual with the same effective date in the same reporting period. An individual may not be enrolled in more than one MA, cost plan, PDP or MMP 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 made during an enrollment period will be accepted as the plan into which the individual intends to enroll. CMS systems determine this using the application date on the enrollment transaction. When there are two or more enrollment transactions with the same application date and effective date values, the first transaction successfully processed by CMS will take effect.

Given the use of the application date to identify the beneficiary's plan enrollment choice, retroactive enrollments will not be processed for multiple transactions that reject because the enrollment requests have the same application date (See Example 1 below).

EXAMPLES

1. An individual requests to two enrollment elections in the same day of the month – First into MMP and Second into Medicare Advantage Organization (MAO). State received and completed an enrollment request made on March 5th. An individual also completed an enrollment request for MAO by telephone on the same day, March 5th. Both enrollment requests have the same application date, since they were received on the same date. Both enrollments were submitted to CMS prior to the enrollment cut-off date for April 1 effective date. State transmitted the MMP enrollment to CMS on March 5th, the day it received the enrollment request; however, MAO waited until March 8th to transmit the enrollment to CMS. The enrollment for the MMP will be the transaction that is effective on April 1, as it was the first transaction successfully processed by CMS.
2. State receives two MMP enrollment requests in the same month. State processes MMP #1 enrollment with an application date of March 4th and MMP #2 enrollment with an application date of March 10th. The enrollment in MMP #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. State will receive a TC 51/TRC 015 (Enrollment Cancelled) for MMP #1 on the DTRR and TC 61/TRC 011 (Enrollment Accepted as Submitted) for MMP #2 on the DTRR. Both plans will receive respective copies of the appropriate TC/TRC on the DTRR.

In the event a rejection for multiple opt-in transactions (or an opt-in and passive enrollment) is reported to the state, the state may contact the individual. If the individual wishes to enroll in the MMP that received the multiple transactions rejections, the state must verify and document the individual's choice and submit a request with appropriate evidence to CMS' Retroactive Processing Contractor for review.

50.2 - Cancellations

Cancellations may be necessary in cases of mistaken enrollment made by an individual, mistaken disenrollment made by a member and/or an individual opts-out of passive enrollment into the MMP. Unless otherwise directed by CMS, an individual may cancel his/her enrollment (or disenrollment) request by contacting the state **prior** to the effective date of the enrollment (or disenrollment).

If a cancellation occurs after CMS records have changed, retroactive correction actions may be necessary. Refer to §50.3 and §50.5.

For cancellation of an opt-in enrollment and disenrollment from the MMP, the state must accept and document any verbal requests. The state has the right to request that a cancellation be in writing for their records, however they must accept and process the verbal request without delay. The state may not delay processing a cancellation made verbally, or online, if applicable (see §30.2.2).

For passively enrolled individuals as described in §30.2.5 of this guidance, an individual may cancel the passive enrollment, as well as request to opt out of future passive enrollment into the MMP, by telephone. The state may not require that the beneficiary make the request in writing. For processing opt-out requests, see §30.2.E.

All valid cancellation and opt-out requests must be honored. Refer to §30.3.1 for further detail on who can make such requests.

50.2.1 - Cancellation of Opt-in Enrollment

An individual's opt-in enrollment request can be cancelled only if the cancellation request is received by the state **prior** to the effective date of the enrollment via phone, in writing or in person, unless otherwise directed by CMT. If a cancellation request is received by the MMP, the MMP should notify the individual that they have to contact the state in order to cancel their enrollment.

If the enrollment transaction has not been submitted, the state should not transmit the opt-in enrollment to CMS. If, however, the state had already transmitted the opt-in enrollment by the time it receives the valid request for cancellation, it must submit a cancellation transaction (TC 82) to CMS, with an effective date equal to the effective date of the enrollment being cancelled. In the event the cancellation transaction fails or the state has other difficulty, the state must submit the request to cancel the action to CMS' Retroactive Processing Contractor (RPC) in order to cancel the enrollment. The state may submit a transaction to cancel only those enrollment transactions it submitted; in the event it was submitted by another entity, the state should work with that entity to ensure the cancellation is submitted.

When cancelling an enrollment transaction, the state must send a notice to the individual that states that the cancellation is being processed (see Exhibit 11). This notice should be sent within 10 calendar days of receipt of the cancellation request. This notice must inform the member that the cancellation should result in the individual remaining enrolled in the Medicare health and/or drug plan in which he or she was originally enrolled, so long as the individual remains eligible to be enrolled in that health plan.

If the member's request for cancellation occurs **after** the effective date of the enrollment, the cancellation cannot be processed. This request is a voluntary disenrollment request. (See § 40.4.1 for more information on voluntary disenrollments.) Any changes to leave the MMP after coverage begins requires a valid enrollment period.

- If he or she wants to return to his or her former Medicare plan or enroll in another Medicare plan, he or she will have to submit an enrollment request to that plan for a prospective enrollment effective date. This includes MMP changes within the same state or plan changes within the same MMP.
- If the member wants to return to Original Medicare instead of returning to his or her previous Medicare plan, the member can contact the state or 1-800-MEDICARE to disenroll from the MMP and the Original Medicare is effective the first day of the following month, i.e., after the month when MMP disenrollment request was received.

The state must inform the beneficiary that he or she is a member of the MMP as of the given effective date (as prescribed in §20.1), and must be instructed to continue to use plan services until the disenrollment goes into effect. Furthermore, the individual must be informed that he or she should enroll into a Part D plan to receive Part D drug coverage; otherwise he or she will be automatically enrolled into a Medicare Prescription Drug Plan and have access to the LI NET transitional PDP during any coverage gap (unless the beneficiary has opted-out of Part D).

When an MMP or state receives notification of an individual's reinstatement into an MMP, because the cancellation from enrollment into another plan is processed, the state has 10 calendar days to send the individual a notice informing him/her of the reinstatement (Exhibit 27).

For cancellation procedures for passive enrollments, please see §30.2.5.E.

50.2.2 - Cancellation of Voluntary Disenrollment

An individual's voluntary disenrollment request can be cancelled only if the request is made **prior** to the effective date of the disenrollment, unless otherwise directed by the CMT. If a cancellation request is received by the MMP, the MMP should notify the individual that they have to contact the state in order to cancel their disenrollment.

If the state delegates the submission of the voluntary disenrollment transaction to the MMP, the state must also delegate the submission of the cancellation of voluntary disenrollment to the MMP. Likewise, if the state submits the enrollment transaction for a given beneficiary, the state must also submit the cancellation. This is because CMS' MARx system will only accept a cancellation from the entity that submitted the transaction being cancelled.

If the disenrollment transaction has not been submitted, the state should not transmit the disenrollment to CMS. If, however, the state has already transmitted the disenrollment by the time it receives the valid request for cancellation, it must submit a cancellation of disenrollment transaction (TC 81) to CMS. To cancel the now-void disenrollment transaction, the state must submit the cancellation transaction with the effective date equal to the effective date of the disenrollment being cancelled. In the event the state has submitted the disenrollment and is unable to submit a cancellation of disenrollment transaction (TC 81), or has other difficulty, the state should submit the request to cancel the action to the RPC in order to cancel the disenrollment.

The state must send a notice to the member that states that the cancellation of the disenrollment request is being processed and instructs the member to continue using MMP services (see Exhibit 18). This notice should be sent within 10 calendar days of receipt of the cancellation request. If the request to cancel the transaction is received and processed by 1-800-MEDICARE, the state should send this notice within 10 calendar days of receipt of a TRC 288 on a MARx Daily Transaction Reply Report.

Within 10 calendar days of receipt of confirmation of the individual's reinstatement (i.e., the cancellation processed and the individual remains a member of the MMP), the state must send the member written notification of the reinstatement (Exhibit 27).

If the member's request for cancellation occurs **after** the effective date of the disenrollment, the cancellation cannot be processed. In some cases, reinstatement due to a mistaken disenrollment will be allowed, as outlined in §50.3.2. If a reinstatement is not allowed, the state should tell the member that he or she will remain enrolled in Original Medicare and that he or she will be automatically enrolled into a Medicare Prescription Drug Plan and have access to the LI NET transitional PDP during any coverage gap (unless the beneficiary has opted-out of Part D). If the individual wants to enroll in a MMP, he or she will have to have a valid election period and submit an enrollment request to the state for a prospective enrollment effective date.

50.2.3 - When A Cancellation Transaction is Rejected by CMS Systems (Transaction Reply Code (TRC) 284)

When a state receives a TRC 284 (Cancellation Rejected), while the cancellation remains valid, it could not be processed automatically in CMS' systems. The state must investigate the circumstances behind the rejection. If the rejection was due to incorrect data on the transaction, the state must correct the data and resubmit it to CMS. If the rejection was not due to such an error, and the request to cancel is valid, the state must promptly submit the request to the CMS' Retroactive Processing Contractor (RPC) for resolution.

50.2.4 - Cancellation Due to Notification from CMS (TRC 015)

When an MMP and state receive a TRC 015 (Enrollment Cancelled) in the Daily Transaction Reply Report (DTRR), it indicates that an enrollment must be cancelled. A cancellation may be the result of an action on the part of the beneficiary, CMS or another plan. Within 10 days of receiving the TRC 015, the plan must send the individual an acknowledgment notice of the cancellation (Exhibit 11).

50.3 - Reinstatements for Invalid Disenrollments

Reinstatements may be necessary if a disenrollment is not legally valid (refer to §40.5 to determine whether a disenrollment is not legally valid). The most common reasons warranting reinstatements are expected to be:

1. Disenrollment due to erroneous death indicator;
2. Disenrollment due to erroneous loss of Medicare Part A or Part B indicator;
3. Disenrollment due to erroneous loss of Medicaid eligibility or a state-specific eligibility requirement;
4. Reinstatements based on beneficiary cancellation of new enrollment in another plan;
5. MMP, CMS, or state error;
6. Erroneous lawful presence status; and
7. Erroneous incarceration information.

When a disenrolled individual contacts the MMP or state to indicate that he or she was disenrolled due to items 1, 2, 5, 6 or 7 listed above, and states that he or she wants to remain a member of the MMP, the state must instruct the member in writing to continue to use MMP services (refer to Exhibits 23, 24, 25, 32, and 33).

When a disenrolled individual contacts the state about item 3 (reinstatement based on erroneous loss of Medicaid or state-specific eligibility requirement), the state must verify that the individual is eligible to remain enrolled in the MMP. If there is any possibility that the state's records are erroneous and the individual could still be eligible, the state must instruct the member in writing to continue to use MMP services. If the MMP receives the request, they must forward it to the state within 2 business days. The state must send the notice (Exhibit 21) within 10 calendar days of the individual's contact with the MMP or state to report the erroneous disenrollment. Accordingly, MMP systems should indicate active membership as of the date state instructs the individual to continue to use plan services.

When a disenrolled individual contacts the state about item 4 (reinstatement based on enrollment cancellation), the state should follow the guidance in §50.3.2 below pertaining to those unique situations.

Within 10 calendar days of receipt of DTRR confirmation of the individual's reinstatement (TRC 713 or 287), the state must send the member notification of the reinstatement (Exhibit 27).

50.3.1 - Reinstatements for Disenrollment Due to Erroneous Death Indicator or Due to Erroneous Loss of Medicare Part A or Part B, Erroneous Incarceration Information, or Erroneous Unlawful Presence Information

A member must be reinstated if he or she was disenrolled in error, since he or she continues to be eligible. This may occur in the following situations:

- Erroneous death indicator;
- Erroneous loss of Medicare Part A or Part B;
- Erroneous lawful presence status; or
- Erroneous incarceration information.

CMS encourages states to send these notices, to ensure any erroneous disenrollments are corrected as soon as possible, or states may, instead, notify beneficiaries verbally. (Note: Exhibit 32 is required). Refer to Exhibits 23, 24, 32, and 33. Although states may request that individuals provide evidence of Medicare entitlement by a particular date, erroneous disenrollments must be corrected and the corresponding reinstatements processed, regardless of the date on which the individual disputes the erroneous disenrollment or provides evidence of Medicare entitlement.

To request consideration for reinstatement following disenrollment due to erroneous loss of Medicare Part A or Part B, the state must submit to RPC a copy of the notice to the member informing him/her to continue to use MMP services until the issue is resolved. The state must indicate the date the notice was sent informing the member of the disenrollment. Within 10 calendar days of receipt of DTRR confirmation of the individual's reinstatement (TRC 713 or 287), the state must send the member notification of the reinstatement (Exhibit 27).

CMS will attempt to automatically reinstate individuals to the MMP from which they were auto-disenrolled by an erroneous report of date of death, if there is a subsequent date of death correction that impacts the MMP enrollment. If this action fails, the state may submit to RPC a request for manual correction using the demonstration-specific retroactive submission spreadsheet. This spreadsheet includes an attestation that information submitted is accurate and complete, and it also include a justification why individual needs to be reinstated to the MMP under "REINSTMT" tab of the demonstration-specific retroactive submission spreadsheet. State may provide additional explanation under "Note" column on this "REINSTMT" tab of the demonstration-specific retroactive submission spreadsheet, including a copy of the notice to the member informing him/her to continue to use MMP services until the issue is resolved. Within 10 calendar days of receipt of DTRR confirmation of the individual's reinstatement (TRC 287), the State must send the member notification of the reinstatement (Exhibit 27).

50.3.2 - Reinstatements Based on Beneficiary Cancellation of New Enrollment

As stated in §40.5, deliberate, member-initiated disenrollments imply intent to disenroll. Therefore, reinstatements into an MMP generally will not be allowed if the member deliberately initiated a disenrollment. An exception is made for those members who were automatically disenrolled from the MMP because they enrolled in another plan but subsequently cancelled the enrollment in the new plan before the effective date.

In this situation, the individual cancels the enrollment into the new plan, as described in §50.2.1. Upon successful cancellation of enrollment in the new plan, CMS systems will attempt to automatically reinstate enrollment in the previous plan. Because this process is automatic, it is generally not necessary to request reinstatement via the RPC. Within 10 calendar days of receipt of DTRR confirmation of the individual's reinstatement (TRC 713 or 287), the state must send the member notification of the reinstatement (Exhibit 27).

In cases where the valid request to cancel enrollment into a new MMP or Medicare plan is not processed timely, or CMS systems cannot complete the request to cancel the enrollment and automatically re-instate the person to her/his original MMP, a request must be sent to the RPC to cancel the enrollment. The only entity that can submit the request to the RPC is the MMP or Medicare plan that submitted the enrollment to CMS, or the state in the case of an enrollment cancellation from another MMP. The state that is submitting the request to the RPC must use the

demonstration-specific retroactive submission spreadsheet. This spreadsheet includes an attestation that information submitted is accurate and complete, and it also includes a justification that the beneficiary requested cancellation of enrollment in the new plan is within required timeframes. State may provide additional explanation under “Note” column on this “Ret Cancel (TC 82)” tab of the demonstration-specific retroactive submission spreadsheet.

If the previous Medicare plan becomes aware of an unsuccessful reinstatement into its plan, it may contact its CMS Account Manager (AM) to investigate the issue with the state. Likewise, if a state becomes aware of an unsuccessful reinstatement into a MMP due to a cancellation from a Medicare plan, it may contact its Contract Management Team to investigate the issue with the Medicare plan. If the state becomes aware of an unsuccessful reinstatement into a MMP due to a cancellation from another MMP within the state (i.e., the cancellation was successful but the individual is not reinstated into the previous MMP), it may contact the RPC for assistance.

If the disenrolled individual contacts the state or the previous MMP requesting to remain a member of that MMP and wishes to cancel the enrollment in the “new” MMP, then state should cancel enrollment in the “new” MMP in order to successfully reinstate the individual to the previous MMP. If the individual has elected to enroll in another Medicare plan but wishes to remain enrolled in the previous MMP, while the individual may contact the Medicare plan directly to request an enrollment cancellation, state may bring the case to CMT for help working with the CMS Account Manager of that Medicare plan to ensure successful reinstatement to the previous MMP.

50.3.3 - Reinstatements Due to Mistaken Disenrollment Due to State or MMP Error

A disenrollment that is not the result of either a valid opt-in request or a valid circumstance that requires involuntary disenrollment is erroneous. When an erroneous disenrollment is the result of state error, the state must reinstate the individuals who were disenrolled.

In the case of an erroneous disenrollment that is a result of an error on the part of the MMP (e.g., if the MMP inadvertently submitted a transaction) or state, the MMP or state must restore the enrollment in its records. Additionally, the MMP or state must cancel the disenrollment action from CMS’s records, if the MMP or state had previously submitted such a transaction to CMS. MMPs or states must use the disenrollment cancellation function to complete this action for effective dates within the parameters that CMS systems allow for such corrections. For effective dates outside these parameters, the state or MMP may contact the RPC for assistance and submit the reinstatement request using the demonstration-specific retroactive submission spreadsheet.

Within 10 days of receipt of DTRR confirmation of the individual’s reinstatement (TRC 713 or 287), the state must send the member notification of the reinstatement (Exhibit 27).

50.4 - Retroactive Enrollments

If an individual has fulfilled all enrollment requirements, but the state is unable to process the enrollment in CMS systems for the required effective date (as outlined in §30.5), the state may contact the RPC for assistance to process for a manual retroactive enrollment.

When a valid request for enrollment has not been communicated to CMS successfully within the required timeframes in this guidance and the Current Calendar Month transaction submission timeframe, the state is required to submit the demonstration-specific retroactive submission spreadsheet to the RPC for manual review and potential action. The request for a retroactive enrollment entry should be made within the timeframes provided in the Standard Operating Procedures for the RPC (<http://www.reedassociates.org/retroactive-processing-sops/>). For these cases, the following must be included in the demonstration-specific retroactive submission spreadsheet and submitted to the RPC:

For Retroactive Enrollments:

- A **completed**, demonstration-specific retroactive submission spreadsheet. This spreadsheet includes an attestation that information submitted is accurate and complete.
- A justification next to each record that provides the reason for retroactive enrollment.

If retroactive enrollment is necessary due to MMP, CMS, or state error, the state may provide additional explanation under “Note” column on the “Ret Enrl (TC 61)” tab of the demonstration-specific retroactive submission spreadsheet, including why the retroactive action is necessary to correct the error, as well as the information described above as it applies to either opt-in or passive enrollment requests. Each text field under “Note” column has a 200-character limit, therefore the explanation must be brief and have relevant information supporting the requested correction.

Special Note Regarding Regional Office Casework Actions

When a state is directed by CMS, such as via an RO caseworker, to submit a retroactive enrollment or disenrollment request to resolve a complaint, the state must submit the request to RPC immediately. At the time, if a beneficiary is experiencing difficulties such as appointment cancellations with the provider, unsuccessful prescription re-fills, the State or MMP must provide as much as details about the case to CMT and at RO caseworker’s discretion, manual retroactive enrollment or disenrollment actions can be taken directly in the MARx UI. CMT should coordinate with the impacted MMP to ensure immediate resolution to the case, e.g., immediately delivery of Medicare and Medicaid services, including prescription drug coverage for the beneficiary.

50.5 - Retroactive Disenrollments

If a valid request for disenrollment was properly made, but not processed or acted upon by the state or MMP, the CMS’ Retroactive Processing Contractor (RPC) may grant a retroactive disenrollment. This includes:

- system error
- MMP or state error (see Appendix 3 for a definition of “system error” and “State or MMP error”)
- if the reason for the disenrollment is related to
 - a permanent move out of the plan service area (as outlined in §40.2.1.2),
 - a contract violation (as outlined in 42 CFR §422.62(b)(3)), or
 - other limited exceptional conditions established by CMT (e.g., fraudulent enrollment or misleading marketing practices).

When a valid request for disenrollment has not been communicated to CMS successfully within the required timeframes in this guidance and the Current Calendar Month transaction submission timeframe, the state is required to submit the demonstration-specific retroactive submission spreadsheet to RPC for manual review and corrective action. States must submit retroactive disenrollment requests to the RPC within the timeframes provided in the RPC Standard Operating Procedures (<http://www.reedassociates.org/retroactive-processing-sops/>). Once processed, CMS will recoup any capitation payment for the retroactive period.

A retroactive disenrollment request must be submitted by the state to RPC in cases in which the state has not properly processed a required involuntary disenrollment or acted upon the member's request for disenrollment as required in §40.4.1. A disenrollment request would be considered not properly acted upon or processed if the effective date is a date other than as required in §20.2. For example, if the request for retroactive disenrollment action is due to the state's confirmation of an incarcerated status with a retroactive start date (see §40.2.1.3), the state must submit retroactive disenrollment requests to the RPC with the effective date that is the first day of the month following the state's confirmation of an incarcerated status.

If an individual calls 1-800-MEDICARE regarding a retroactive disenrollment, 1-800-MEDICARE will refer the person to the state or its enrollment broker.

If the request for retroactive action is due to MMP or state error, the state must submit a demonstration-specific retroactive submission spreadsheet with attestation and justification that provides the reason for retroactive disenrollment to the RPC. States may provide additional explanation under "Note" column on the "Ret Disenrl (TC 51)" tab of the demonstration-specific retroactive submission spreadsheet, including why the retroactive action is necessary to correct the error. Each text field under "Note" column has a 200-character limit, therefore the explanation must be brief and have relevant information supporting the requested correction.

Note: In situations where a beneficiary may have been given false information by the state or the MMP, CMT will evaluate and research those scenarios on a case by case basis to determine if retroactive disenrollment would be appropriate.

50.6 - Reconciliation of Enrollment Transactions

States receive a Daily Transaction Reply Report (DTRR) from CMS that includes Transaction Reply Codes (TRCs) indicating if a record was processed successfully or rejected. If the TRC is accepted, the state and MMP should update their records, as appropriate. If rejected, the TRC indicates why the enrollment could not be processed and whether any action is needed by the state or MMP. Therefore, it is important that states and delegated MMPs understand the CMS submission timeframes for enrollment and disenrollment activity and carefully review the reports CMS provides in response to each enrollment file submission. Compliance with CMS submission timeframes for enrollment and disenrollment transaction, as well as thorough review of the reports CMS Enrollment Vendor provides in response to each submission, should allow for the correction and direct resubmission of transactions that failed within the CCM "Current Calendar Month." Adherence to these steps should accommodate most corrections necessary. Please note, whenever possible, the state should submit a corrective transaction request before the enrollment becomes effective.

States should coordinate closely with CMS and the impacted MMP to develop a plan that will ensure that members do not experience a disruption in care while any enrollment ~~the~~ discrepancy is being resolved.

CMS anticipates that all states and delegated MMPs will have ongoing data and report reconciliation processes to support timely administration of enrollment processes that identify and correct discrepancies between enrollment status on state and CMS' systems on a monthly basis. MMPs should work with their states to identify and submit enrollment discrepancies at least monthly to their CMT for research and resolution. In addition to the existing CMS Plan Communications User Guide (PCUG), the following list of tools has been developed to help identify enrollment discrepancies:

- **MARx Transaction Code/Transaction Reply Code (TC/TRC) Mapping Chart** - The mapping chart demonstrates how the MARx TC and TRCs are paired and communicated through the CMS daily transaction reply report (DTRR) to states and MMPs. It includes a 'State Action' column to further explain what each code means in the context of the demonstration and what next steps state should take upon receipt of the DTRR, which can be used in conjunction with the PCUG.
- **MMP Enrollment-Related Transactions** – This table is a high level summary of the MARx Transaction Code/Transaction Reply Code (TC/TRC) Mapping Chart and primarily focuses on the most frequently utilized transaction code and transaction reply code (TC/TRC) combinations, descriptions, and required action, if any, for each transaction.
- **MMP Enrollment Reconciliation File** - an ad hoc “recon file” that contains a point-in-time snapshot of Plan enrollment for each month retroactive to the start of a state’s demonstration.
- **CMS Enrollment Vendor’s Web Portal** – The web portal allows state users (including enrollment broker staff) to access all current and historical transactions communicated between states and CMS. The portal also provides useful tools such as
 1. “Enroll Recon” tool to help research and identify discrepancies between enrollment data in state and CMS systems,
 2. An ‘Online Processing’ tool which allows users to manually correct and submit transaction directly to CMS as needed.
- **Enrollment/Disenrollment Discrepancy Scenarios** - The scenarios document provides examples of various scenarios that can lead to enrollment/disenrollment discrepancies between CMS MARx enrollment data and state system data. The scenarios contain solutions to resolve the discrepancy when it occurs and recommended preventative measures going forward.

These tools are available on the CMS Enrollment Vendor’s website: <https://www.medicare-solution.com/mss/home/Index.jsp>.

50.6.1 - Window for Submitting Directly to MARx

The CMS MARx system accepts enrollment, disenrollment and cancellation transactions with effective dates based on the Current Calendar Month or CCM period, i.e., CCM – 1 month through CCM + 3 months, which requires the effective date to be within a 5-month parameter based on the current calendar month. For example, on any day when the current calendar month is April 2017 a state may submit an enrollment or disenrollment transaction to the Enrollment Vendor with an effective date of:

- March 1, 2017
- April 1, 2017
- May 1, 2017
- June 1, 2017
- July 1, 2017

(For more information about the CCM period and MARx, see http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelppdesk/Downloads/MARx_RM_HANDBOOK_Final_2010_12_16.pdf)

50.6.2 - When to Use CMS' Retroactive Processing Contractor (RPC)

States and delegated MMPs are required to resubmit failed transactions and rejected transactions within the CCM whenever possible. However, a state or delegated MMP may encounter situations where enrollment/disenrollment actions require CMS assistance.

Note: The demonstration-specific retroactive submission spreadsheet (referred to in §50.3, 50.3.1, 50.3.2, 50.3.3, 50.4, and 50.5) is used by the states and their enrollment brokers. Delegated MMPs must follow the existing RPC Standard Operating Procedures (<http://www.reedassociates.org/retroactive-processing-sops/>) and submit the following to the RPC:

- a cover letter from the organization,
- the standard RPC submission spreadsheet, and
- documentation for each beneficiary supporting the retroactive request.

The instructions below clarify the role of the CMS Retroactive Processing Contractor (RPC – Reed & Associates) for processing certain retroactive enrollment and disenrollment requests for states and delegated Medicare-Medicaid Plans (MMPs). When corrections are necessary, CMS has three distinct processes by which the state or delegated MMP will submit retroactive enrollment and disenrollment activity (including PBP and Segment changes). Each of these processes corresponds to one of the 3 categories of retroactivity as defined in the February 24, 2009 HPMS Memo, Instructions for Submitting Retroactive Enrollment and Disenrollment Activity:

- **Category 1** transactions represent normal business processes that states and MMPs may address through the MAPD Help Desk. If states encounter a situation where the CMS MARx system continuously rejects the enrollment or disenrollment transaction despite corrections and resubmissions to CMS Enrollment Vendor during the normal CCM period, or there are system outages, glitches, or submitter ID issues, the state must

contact the MAPD Helpdesk (Phone: 1-800-927-8069; Email: MAPDHelp@cms.hhs.gov) and seek guidance on how to reconcile the affected record.

- **Category 2** transactions represent normal business processes that states and delegated MMPs may address through the RPC. These are retroactive enrollment and disenrollment actions, including enrollment changes among different Plan Benefit Packages (PBP) changes, with effective dates **within 3 months**, or those resulting from automatic actions taken by CMS systems that are identified and reported.
- **Category 3** transactions represent normal business processes that states and delegated MMPs may address through the RPC which require review and concurrence by the CMS members of the CMT. These transactions are retroactive enrollment and disenrollment actions, including PBP changes, that have an effective date of the current calendar month minus 3 full calendar months or older. For example, if today is any day in May, effective dates of February 1 or earlier are **4 months or older** and, therefore, are Category 3 transactions.

50.6.3 - Critical Situations that Necessitate Immediate Submission

Enrollment or disenrollment transactions should be reconciled and resubmitted to the CMS Enrollment Vendor or the RPC through usual processes. However, if a state or delegated MMP has a critical complaint that requires immediate MARx action (e.g., beneficiary needs a prescription drug refill or has no access to medical care), the state or delegated MMP may contact the CMS members of the CMT directly to request MARx manual actions.

50.7 - User Interface (UI) Transactions Reply Codes (TRC) – Communications with Beneficiaries

TRCs may be generated when enrollment actions are submitted through the CMS User Interface (UI) rather than through the state, e.g., when a CMS Caseworker submits an enrollment-related transaction. Upon receipt of a CMS transaction reply, MMPs and states must update their records to accurately reflect each individual's enrollment status. States are also required to provide certain notices and information to beneficiaries when enrollment status is confirmed or changes. In the case of UI-TRC replies, the standard operating procedures for providing these notices and/or information may not fit some of the unique situations.

The table below provides guidelines for communicating with individuals when enrollment changes are reported to states using the 700 series TRCs that result from UI enrollment changes. In all cases, states will need to review the situations carefully to determine the necessity and appropriateness of sending notices. Some UI enrollment change processes will result in multiple 700-series TRCs being reported. States must determine the final disposition of the individual to ensure the correct message is provided in any notice sent. In complex situations, CMS encourages states to communicate directly (such as by telephone) with the individual, in addition to any required notice or materials. When it is necessary to send a notice, states must issue the notice within ten calendar days of receipt of the DTRR.

Table: “700 Series” TRCs

TRC	Beneficiary Communication Action
701 – New UI Enrollment	States may use existing confirmation notices, Exhibit 4 or Exhibit 7, as provided in CMS enrollment guidance. If such notice has already been provided with the same information, it is not necessary to provide it a second time.
702 – New UI Fill-in Enrollment	States must use Exhibit 29, “Enrollment Status Update.” Include the date range covered by the new fill-in period.
703 – UI Enrollment Cancel	If a cancellation notice applicable to this time period has already been provided, it is not necessary to provide it a second time. If notice has not been provided, states may use the existing cancellation of enrollment notice (see Exhibit 29). If the specific situation warrants, states may use Exhibit 29 instead, providing information that clearly indicates that the enrollment period in question has been cancelled.
704 – UI Enrollment Cancel - PBP Change	If the UI action is a correction to a plan submission error, the state may have already provided the correct plan (PBP) information; if that is the case, it is not necessary to send it a second time. If the individual has not received information about the specific plan (PBP), the state must send the materials required in §30.5.1 that would be provided for any new enrollment. States must also send Exhibit 29 describing the plan change, including the effective date. The impact of the change on plan premiums, cost sharing, and provider networks must be communicated clearly. It is not necessary to issue written notice to confirm the associated “enrollment cancelled” TRC that will accompany the enrollment into the new plan (PBP).
705 – New UI Enrollment - PBP Change	Follow the guidance provided above for TRC 704.
706 – UI Enrollment Cancel - Segment change	Plan (PBP) segment changes apply only to MA plans. MMPs or states should contact CMT if this TRC is received.
707- UI New enrollment - Segment Change	Plan (PBP) segment changes apply only to MA plans. MMPs or states should contact CMT if this TRC is received.
708 – UI End Date Assigned	This UI action has the same effect as a state-submitted disenrollment transaction (TC 51). Generally, states should follow existing guidance in §50.5 for providing notice and confirmation of the disenrollment. However, since many UI initiated-changes are retroactive, states may have already provided notice (with correct effective dates) and if so, need not provide it a second time. Additional clarification may be appropriate depending on the specifics of the case.
709 – UI Earlier Start Date	An existing enrollment period in the MMP has changed to start earlier than previously recorded. If the state has already provided notice reflecting this

TRC	Beneficiary Communication Action
	new effective date of enrollment, it is not necessary to provide it a second time. When the individual has not already received notice reflecting this effective date, states may use existing confirmation of enrollment notices where there is confidence that such notice will not cause undue confusion. Alternatively, states may use Exhibit 29, including in it the new effective date. Plans must also ensure individuals are fully aware of how to access coverage of services for the new time period, including their right to appeal.
710 – UI Later Start Date	An existing enrollment period start date has been changed to start on a later date. States must use Exhibit 29. Plans must explain the change in the effective date of coverage. States must also explain the impact on any paid claims from the time period affected.
711 – UI Earlier End Date	An enrollment period end date has been changed to occur earlier. States must use Exhibit 29. States must explain the change in the effective date of the end coverage. Plans must also explain the impact on any paid claims from the time period affected.
712 – UI Later End Date	An enrollment period end date has been changed to occur later. States must use Exhibit 29. States must explain the change in the effective date of the end of coverage. States must also ensure individuals are fully aware of how to access coverage of services for the new time period.
713 – UI Removed End Date	An enrollment period that previously had an end date is now open (and ongoing). States must use Exhibit 27 to explain the change and that enrollment in the MMP is now continuous. States must ensure individuals are fully aware of how to access coverage of services for the new time period and going forward.

50.8 - Storage of Enrollment and Disenrollment Request Records

MMPs and states are required to retain records of enrollment and disenrollment requests (i.e., copies of enrollment forms, etc.) for the current contract period and the previous 10 years.

It is appropriate to allow for storage on technologies that would allow the reviewer to access signed forms and other enrollment elections, such as optically scanned forms stored on disk or secure data repositories. Records of enrollment elections into, and disenrollment elections from, made by any other election mechanism (as described in §20.1) must also be retained as above.

Appendices

Appendix 1: Summary of Data Elements Required for MMP Enrollment Mechanisms and Completed Enrollment Requests

All data elements with a “Yes” in the “Beneficiary response required on request” column are necessary in order for the enrollment request to be considered complete.

	Data Element	Requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
1	Plan name ¹	Yes,	Yes	1, 2
2	Beneficiary name	Yes	Yes	1, 2
3	Beneficiary Date of Birth	Yes	Yes	1
4	Beneficiary Gender	Yes	Yes	1
5	Beneficiary Telephone Number	Yes	No	1, 2
6	Permanent Residence Address (with the exception of “County” – see below)	Yes	Yes	1, 2
7	County	No	No	1, 2
8	Mailing Address	Yes	No	1, 2
9	Name of person to contact in emergency, including phone number and relationship to beneficiary	No	No	1, 2
10	E-mail Address	No	No	1, 2
11	Beneficiary Medicare number	Yes	Yes	1, 2
12	Additional Medicare information contained on sample Medicare card, or copy of card	No	No	1, 2
13	Response to ESRD Question	Yes	Yes	1
14	Response to long term care question	No	No	1
15	Response to other insurance COB information	Yes	No ²	1, 2
16	Option to request materials in language other than English (language preference) or in accessible formats	Yes	No	1, 2

¹ If enrollment mechanism will be used for multiple plans, all plan names must be listed in a way that permits the applicant to clearly indicate his/her plan choice.

² Refer to CMS Coordination Of Benefits guidance for additional information

	Data Element	Requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
17	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	No	No	N/A
18	Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents	No	No	N/A
19	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	No	No	N/A
20	Name of chosen Primary Care Provider, clinic or health center (Optional Field)	No	No	1, 2
21	Beneficiary signature and/or Authorized Representative Signature	Yes	Yes ¹	1, 2
22	Date of signature	Yes	No ²	1, 2
23	Authorized representative contact information	Yes	Yes	1, 2
24	Employer or Union Name and Group Number	Yes	Yes	1, 2
25	Question of which plan the beneficiary is currently a member of and to which MMP the beneficiary is changing	Yes	Yes	2

¹ For some CMS approved enrollment elections, a signature is not required. For paper enrollment forms submitted without a signature, State may verify with the applicant by telephone and document the contact instead of returning form.

² As explained in §40.2, the beneficiary and/or legal representative should write the date s/he signed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment form, the stamped date of receipt that the State places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is not a necessary element.

	Data Element	Requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
26	Information provided under “Please Read and Sign Below” All elements provided in model language must be included on enrollment request mechanisms. May be provided as narrative or listed as statements of understanding	Yes	Yes	1, 2
27	Release of Information All elements provided in model language must be included on enrollment request mechanisms.	Yes	Yes	1, 2
28	Option to request materials in language other than English or in other formats	Yes	No	1, 2
29	Medicaid Number	Yes	Yes	1, 2

Appendix 2: Setting the Application Date on CMS Enrollment Transactions

The application date submitted on enrollment transactions plays a key role in CMS system edits that ensure the individual's choice of plan is honored. The application date is always a date prior to the effective date of enrollment. For more information about application date, see the definition provided in Appendix 3.

Enrollment Request Mechanism	Application Date	Special Notes
Paper Enrollment Forms received by mail or in person §30.2.1	The date the paper request is initially received	Paper requests submitted to or collected by state-authorized brokers are received by the state on the date the broker receives the form. Postmark is not considered for paper enrollment forms received by mail. MMPs or State Health Insurance Assistance Program (SHIP) must submit paper request to state within 2 business days.
Paper enrollment forms received by Fax §30.2.1	The date the fax is received on the state/broker's fax machine	Fax requests submitted to or collected by State-authorized brokers are received by the state on the date the fax is received on the agent or broker's fax machine.
State website online enrollment page §30.2.2	The date the request is completed via the state's website process	
Telephonic Enrollment §30.2.3	The date of the call	Telephonic enrollments must be recorded.
Passive Enrollment §30.2.5	The application date is the date the passive enrollment transaction is submitted to CMS' MARx system.	This must not be earlier than 90 days and not later than 60 days before the effective date.

Appendix 3: Definitions

The following definitions relate to topics addressed in this guidance.

Application Date – For paper enrollment forms and other enrollment request mechanisms, the application date is the date the enrollment request is initially received by the state as defined below. States must use this date in the appropriate field when submitting enrollment transactions to CMS. A summary of application dates for CMS enrollment transactions is provided in Appendix 2 of this guidance.

- For requests sent by mail, the application date is the date the application is received by the state (postmark is irrelevant).
- For requests received by fax, the application date is the date the fax is received on the state's fax machine.
- For requests submitted to state-authorized brokers, including by fax, the application date is the date the broker receives (accepts) the enrollment request and not the date the state receives the enrollment request from the agent/broker. For purposes of enrollment, receipt by the agent or broker employed by or contracting with the state, is considered receipt by the state, thus all CMS required timeframes for enrollment processing begin on this date.
- For requests accepted by approved telephonic enrollment mechanisms, the application date is the date of the call. The call must have followed the approved script, included a clear statement that the individual understands he or she is requesting enrollment, and have been recorded.
- For internet enrollment requests made directly to the state's website, the application date is the date the request is completed through the state's website process. This is true regardless of when a state ultimately retrieves or downloads the request.
- For passive enrollment, as described in §30.2.5, the application date is the date the transaction is submitted to CMS (which must be no later than 60 days before the effective date). This will ensure that any subsequent beneficiary-generated enrollment request will supersede the passive enrollment in CMS systems.

At-risk Beneficiary – A Part D eligible individual who is determined to be at-risk for misuse or abuse of a frequently abused drug in accordance with the requirements for drug management programs at § 423.153(f). Additional guidance about Part D drug management programs is available at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html>

Authorized Representative/Legal Representative – An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the state in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., 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 beneficiary in this capacity (see §30.3.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process, and does not provide broad legal authority to make another individual's healthcare decisions. Please note that CMS does not have data on individuals' authorized

representative status; states/MMPs would need to verify that status when someone is making an enrollment-related request on behalf of a beneficiary.

Cancellation of Enrollment Request - An action initiated by the individual to void an enrollment request before coverage has begun. To be valid, the cancellation request must be received by the state before the enrollment effective date.

Completed Election - An enrollment request is considered complete when:

1. The form/request is signed by the individual or legal representative or the enrollment request mechanism is completed;
2. For enrollments, evidence of entitlement to Medicare Part A and enrollment in Medicare Part B is obtained by the state (see below for definition of “evidence of Medicare Part A and Part B coverage”);
3. All necessary elements on the form are completed (for enrollments, see Appendix 1 for a list of elements that must be completed) or when the enrollment request is completed as outlined in this guidance; and,
4. When applicable, certification of a legal representative’s authority to make the enrollment request is obtained by attestation (refer to §30.3.1).

Days – Unless otherwise noted, “days” mean calendar days.

Denial of Enrollment Request - Occurs when a state determines that an individual is not eligible to make an enrollment request (e.g., the individual is not entitled to Medicare Part A or enrolled in Part B, the individual does not have Medicaid, etc.). The state should not submit the enrollment request transaction to CMS.

Effective Date of Coverage/Enrollment – The date on which an individual’s coverage in an MMP begins. The state must determine the effective date of enrollment for all enrollment requests. Instructions for determining the correct effective date of coverage are provided in §20.

Election - Enrollment in, or voluntary disenrollment from, an MMP, an MA plan or the traditional Medicare fee-for-service program (“Original Medicare”) constitutes an election (disenrollment from Original Medicare would occur only when an individual enrolls in an MMP or MA plan). The term “election” is used to describe either an enrollment or voluntary disenrollment. If the term “enrollment” is used alone, however, it is being used to describe only an enrollment, not a disenrollment. The same applies when the term “disenrollment” is used alone (i.e., the term is being used to describe only a disenrollment, and not an enrollment).

Election Period - The time(s) during which an eligible individual may request to enroll in or disenroll from an MA or Medicare prescription drug plan or MMP. The election period determines the effective date of coverage, as well as the types of enrollment requests allowed. There are several types of election periods, all of which are defined in Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual. Note that there are SEPs specifically for dual eligible beneficiaries outlined in § 20.1.1

Enrollment Request Mechanism - A method used by individuals to request to enroll in a MMP or Medicare health or drug plan. An individual who is a member of a MMP who wishes to elect a different MMP, even if it is offered by the same organization, may complete a new election

during a valid election period. An individual may complete the election via an electronic enrollment mechanism, as described in §30.2.2 of this guidance, or by telephone, as described in §30.2.3 of this guidance, if the state offers these choices. Individuals or their legal representatives must complete an enrollment request mechanism (e.g. enrollment form) to enroll in an MMP. An individual who is a member of a Medicare health or drug plan who wishes to elect a MMP within the same organization, must complete the comprehensive individual enrollment form or may complete the election via other enrollment mechanisms offered by the state.

Beneficiaries are not required to use a specific form to disenroll from an MMP; however, a model disenrollment form is provided in Exhibit 13.

Electronic Retroactive Processing Transmission (eRPT) application – This is a web-based application designed to facilitate and manage the electronic submission, workflow processing, and storage of documentation associated with retroactive adjustments submitted to the CMS Retroactive Processing Contractor (RPC).

Evidence of Entitlement (Medicare Part A and Part B Coverage) - A requirement to determine eligibility for enrollment into a MMP. It includes the individual's coverage start dates for Part A and Part B. CMS systems are updated within two business days of SSA processing a new or changed Part A or Part B entitlement. MA organizations must verify Medicare entitlement for all enrollment requests using either the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen). Therefore, the applicant is not required to provide evidence with the enrollment request.

Evidence of Permanent Residence - A permanent residence is normally the enrollee's primary residence. A state may request additional information such as voter's registration records, driver's license records, tax records, and utility bills to verify the primary residence. Such records must establish the permanent residence address, and not the mailing address, of the individual.

Incarceration – This term refers to the status of an individual who is in the custody of a penal authority and confined to a correctional facility, such as a jail or prison, or a mental health institution as a result of a criminal offense. Such individuals reside outside of the service area for the purposes of MMP eligibility, even if the correctional facility is located within the plan service area. Individuals who are confined Institutions for Mental Disease (IMDs), such as state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, as a result of violations of the penal code, are incarcerated as CMS defines the term for the purpose of MMP eligibility. The place of residence for these confirmed individuals is therefore not excluded from the service area of an MMP on that basis.

Individuals who are confined to IMDs, such as state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, for other reasons (e.g., because of court orders unrelated to penal violations) are not incarcerated. Normal service area rules apply to these individuals.

Involuntary Disenrollment – Disenrollments made necessary due to the state or MMP's determination that the individual is no longer eligible to remain enrolled in a plan, or when an state or MMP otherwise initiates disenrollment (e.g. loss of Medicaid, plan termination).

Lawful Presence – A lawfully present individual is defined in 8 CFR §1.3. An individual who is not lawfully present in the United States is not eligible for any federal public benefit, including payment of Medicare benefits. (8 U.S.C. 1611)

LI NET - The LI NET Program ensures that individuals with Medicare's low-income subsidy (LIS), or "Extra Help," who are not yet enrolled in a Part D prescription drug plan are still able to obtain immediate prescription drug coverage. The LI NET Program provides retroactive coverage for new full dual eligible beneficiaries (those individuals who are eligible for both Medicare and Medicaid or Medicare and Supplemental Security Income (SSI) from the Social Security Administration (SSA). Medicare automatically enrolls these individuals into the LI NET Program for eligible periods with an effective date retroactive (up to 36 months) to the start of their full-benefit dual eligible status. Enrollment in the LI NET Program is temporary until Medicare enrolls these individuals in a standard Medicare Part D plan for the future, or the person elects another Part D plan, whichever has the earlier effective date.

PACE - The Program for All-inclusive Care for the Elderly (PACE) model promotes the well-being of seniors with chronic care needs and their families by serving them in the community whenever possible. PACE serves individuals who are age 55 and older, need a nursing home level of care, are able to live safely in the community at the time of enrollment, and live in a PACE service area.

Potential At-risk Beneficiary - A Part D eligible individual who is identified 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). Additional guidance about Part D drug management programs is available at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.htm>

Opt-in Enrollment - In this guidance, "opt-in" is used to mean beneficiary-initiated elections; this is distinguished from passive enrollments, which are legally considered opt-in in that a beneficiary's "silence" is considered agreement with the election.

Opt Out – When an individual chooses to decline passive enrollment in an MMP and/or be excluded from future passive enrollments into an MMP for the duration of the demonstration.

Passive Enrollment- Enrollment process through which an eligible individual is enrolled by the state (or its vendor) into an MMP, following a minimum 60 calendar day advance written notification that includes the plan selection and the opportunity to select a different plan, make another enrollment decision, or decline enrollment into an MMP, or opt out of the demonstration prior to the effective date.

Rapid Re-Enrollment – Rapid re-enrollment is an enrollment action taken by the state on behalf of a beneficiary to re-enroll the individual into his/her original MMP within two months from the effective date of disenrollment due to loss of Medicaid. Rapid re-enrollment is effective the first day of the following month the individual re-establishes Medicaid and regains full dual eligible status.

Receipt of Enrollment Request - States may receive enrollment requests through various means, as described in §30.2. The state (and MMP, if received directly by the MMP) must date as received all enrollment requests as soon as they are initially received. This date will be used

to determine the effective date of the request. Refer to the definition of “Application Date” in this section for specific information regarding the correct date to report as the application date on enrollment transactions submitted to CMS.

Reinstatement of Election - An action that may be taken by CMS, state, or RPC to correct an erroneous disenrollment from a MMP or a Medicare health or drug plan. The reinstatement corrects an individual’s records by cancelling a disenrollment to reflect no gap in enrollment in the plan. A reinstatement may result in retroactive disenrollment from another Medicare plan or a MMP.

Rejection of Enrollment Request - Occurs when CMS has rejected an enrollment request submitted by the state. The rejection could be due to the state incorrectly submitting the transaction, to system error, or to an individual’s ineligibility to elect the plan.

Retroactive Processing Contractor (RPC) - The CMS contractor responsible for processing retroactive beneficiary enrollment/disenrollment change requests submitted by states/MMPs.

State or MMP Error - An error or delay in enrollment request processing made under the full control of state or MMP personnel and one that the State or MMP could have avoided.

System Error - A “system error” is an unintended error or delay in enrollment request processing that is clearly attributable to a specific state system, Federal government system (e.g., Social Security Administration (SSA) system, Railroad Retirement Board (RRB) system), and is related to Medicare entitlement information or other information required to process an enrollment request.

Temporary Move – A move into the MMP’s service area that does not enable the individual to elect the MMP because it is not permanent in nature. A dual eligible individual must be a permanent resident in the MMP service area to make an election to enroll in an MMP.

Voluntary Enrollment – Enrollment initiated by the beneficiary or his/her authorized representative. Throughout this guidance, voluntary enrollments are called “opt-in” enrollments.

Voluntary Disenrollment - Disenrollment initiated by a member or his/her authorized representative.

Appendix 4: File Layout for the Annual Reassignment File to States, Sent Each October

Referenced in §30.2.5 J

(Where “x” can be “H” for header and “T” for trailer)

Table 1: Re-Assignment State Response Files - Header Record

Data Field	Length	Position	Format	Valid Values
Header Code	8	1 8	CHAR	‘SRA’ for re-assign State notification file.
Sending Entity	8	9 16	CHAR	‘CMS ’ (CMS + 5 spaces)
File Creation Date	8	17 24	CHAR	CCYYMMDD Date file was created.
File Control Number	9	25 33	CHAR	Spaces
Filler	767	34 800	CHAR	Spaces

Record Length = 800

Table 2: Re-Assignment State Response Files - Detail Record

Data Field	Length	Position	Format	Valid Values
Record Type	3	1 3	CHAR	‘DTL’
Beneficiary Medicare Number	12	4 15	CHAR	
Beneficiary’s SSN	9	16 24	CHAR	Filled with Spaces if the SSN is not present.
Representative Payee Name	44	25 68	CHAR	
Beneficiary’s First Name	12	69 80	CHAR	
Beneficiary’s Middle Name	1	81 81	CHAR	
Beneficiary’s Last Name	28	82 109	CHAR	Last name starts in position 83 if a middle initial is present. Last names that exceed the length will have the last characters dropped.
Beneficiary’s Address Line 1	40	110 149	CHAR	Filled with the Address
Beneficiary’s Address Line 2	40	150 189	CHAR	Filled with the Address, if available.
Beneficiary’s Address Line 3	40	190 229	CHAR	Filled with the Address, if available.
Beneficiary’s Address Line 4	40	230 269	CHAR	Filled with the Address, if available.
Beneficiary’s Address Line 5	40	270 309	CHAR	Filled with the Address, if available.
Beneficiary’s Address Line 6	40	310 349	CHAR	Filled with the Address, if available.
Beneficiary’s City	26	350 375	CHAR	Filled with the City
Filler	1	376 376	CHAR	Spaces

Data Field	Length	Position	Format	Valid Values
Beneficiary's State	2	377 378	CHAR	Filled with the State Code
Filler	1	379 379	CHAR	Spaces
Beneficiary's Zip Code	10	389 389	CHAR	Filled with the Zip Code
Beneficiary's Next Year's Organization Marketing Name	50	390 439	CHAR	
Beneficiary's Next Year's Plan name	50	440 489	CHAR	
Beneficiary's Next Year's Plan Member Services Toll-Free Number	18	490 507	CHAR	
Beneficiary's Next Year's Plan Web Address	50	508 557	CHAR	
Beneficiary's LIS Subsidy Co-Payment Category	1	558 558	CHAR	1 - high co-pay 2 - low co-pay 3 - no co-pay 4 - 15%
Beneficiary's Next Year's Assign Effective Date	8	559 566	NUMERIC	CCYYMMDD
Beneficiary's Part D Premium Subsidy Percentage	3	567 569	CHAR	'100', '075', '050', or '025'
Beneficiary's PDP Region ID Code	2	570 571	NUMERIC	
Beneficiary's Current Year's Organization Name	50	572 621	CHAR	
Beneficiary's Current Year's Plan name	50	622 671	CHAR	
Beneficiary's Current Year's Plan Member Services Toll-Free Number	18	672 689	CHAR	
Beneficiary's Current Year's Plan Premium Liability	6	690 695	DECIMAL	
Filler	8	696 703	NUMERIC	Zero
Beneficiary's Next Year's Contract Number	5	704 708	CHAR	
Beneficiary's Next Year's PBP Number	3	709 711	CHAR	
Beneficiary's Current Year's Contract Number	5	712 716	CHAR	
Beneficiary's Current Year's PBP Number	3	717 719	CHAR	

Data Field	Length	Position	Format	Valid Values
Beneficiary's Next Year's Plan Premium Liability	6	720 725	DECIMAL	Used when the premium is increasing, decreasing, or remaining the same amount that is above the benchmark for the following year. Contains next year's premium for the current plan.
Filler	75	726 800	CHAR	Spaces

Record Length = 800

Table 3: Re-Assignment State Response Files - Trailer Record

Data Field	Length	Position	Format	Valid Values
Trailer Code	8	1 8	CHAR	'TRL' for re-assign State notification file.
Sending Entity	8	9 16	CHAR	'CMS ' (CMS + 5 spaces)
File Creation Date	8	17 24	CHAR	CCYYMMDD Date file was created.
File Control Number	9	25 33	CHAR	Spaces
Record Count	9	34 42	NUMERIC	Right justified. Count = Number of detail records.
Filler	758	43 800	CHAR	Spaces

Record Length = 800

Model Medicare-Medicaid Plan Enrollment Forms & Notices

This section contains national model notices for the state and Medicare-Medicaid Plan (MMP) to send to beneficiaries regarding enrollment matters. Required notices must be utilized by states unless stated otherwise. CMS recommends states consider utilizing non-required notices. States may require additional notices specific to their state.

Model notices may be tailored to a given state. The state may decide which notices it will send, and which notices it will delegate to MMPs to send to beneficiaries. In addition, in each state, the state or Federal reading level and translation requirements that are more beneficiary-friendly will be used (see State-Specific Demonstration Marketing Guidelines for details <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html>).

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 will have an equal opportunity to participate in enrollment, and communicating with the plan, as members who do not request accessible/alternate formats.

Notices must also be available in other languages and audio.

States must obtain CMS approval for enrollment notices. States should plan to submit draft notices to CMS at least 30 days before implementing, to provide both CMS and the state appropriate time to review and make any necessary edits.

Through beneficiary testing and Plain Language Reviews conducted, the national model notices have been revamped to improve written communication to the beneficiary. This includes lessening the amount of notices required to be sent to the beneficiary (please see Summary of Notice Requirements to determine which notices are mandatory), reducing the length of notices and improving the language and layout of the notices.

Summary of Notice Requirements

Referenced in §10, §20, §30, §40, and §50 of the MMP National Guidance

The chart below is a summary of notice requirements. For specific details on requirements and timeframes, please refer to the appropriate sections within this guidance. While Exhibits 5a, 5b, and 5c are typically notices that states delegate to their MMPs, states can delegate other notices to MMPs as well. Please note that any notices that the state delegates to the MMP must include all applicable disclaimers in the state-specific Demonstration Marketing Guidelines, and must be submitted as marketing materials in the Health Plan Management System (HPMS). Beneficiary notification is always required; however only certain notices (the notices that indicate a “yes” in the Required Field below) need to be in writing. Notices that indicate a “no” in the Required Field below, still require (at minimum) a verbal notice, and states/enrollment brokers should document verbal notification. Please note that all verbal notices should convey all of the critical information that would be found in the written notices.

Enrollment

Forms and Notices	Section	Required? 1	Timeframe	TRC
Exhibit 1: Model Medicare-Medicaid Individual Enrollment Request Form	10.3, 30.2.1, 30.2.2, 30.3, 30.3.1	Yes ²	N/A	N/A
Exhibit 2: Model Short Enrollment Request Form	10.3	No	N/A	N/A
Exhibit 3: Model Notice to Acknowledge Receipt of Completed Enrollment Request	30, 30.5.1	No ³	10 calendar days after receipt of the completed enrollment request	N/A
Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment	30, 30.2.5, 30.5, 30.5.2	Yes ⁴	7 calendar days of availability of the CMS Daily Transaction Reply Report (DTRR)	011, 016, 017, 022, 023, 701, 709, 710
Exhibit 5: State 30-day Reminder Notice for Passively Enrolled Individuals	30.5.1	Yes ⁵	30 days prior to the effective date	N/A
Exhibit 5a: MMP Welcome Notice for Passively Enrolled Individuals	30.5.1	Yes	30 days prior to the effective date	N/A
Exhibit 5b: MMP Welcome Notice for Individuals Who Voluntarily Enroll	30.5.1	Yes	10 calendar days of receipt of the DTRR that contains the earliest notification of the acceptance	011, 016, 017, 022, 023,
Exhibit 5c: MMP Welcome-back Notice for Individuals Who Are Rapidly Re-enrolled	30.2.5, 40.2.3, 40.2.3.3	Yes	10 calendar days of receipt of the DTRR that contains the earliest notification of the acceptance	011, 016, 017 022, 023
Exhibit 6: Model Notice for Requesting Information	30, 30.3.2	No	10 calendar days of receipt of the enrollment request.	N/A
Exhibit 7: Model Notice to Confirm Enrollment ⁶	30.2.5, 30.5.2, 40.2.3, 40.2.3.3	Yes ⁷	10 calendar days of the DTRR that contains the earliest notification of the acceptance	011, 016, 017 022, 023, 701, 709, 710
Exhibit 8: Model Notice for Individuals Identified on CMS Records as Members of Employer or Union Group Receiving the Retiree Drug Subsidy (RDS)	30.2.5	No	10 calendar days of receipt of the DTRR that contains Transaction Reply Code 127 - conditional rejection	127, 128

¹ Note: for items that indicate “No” the state may still need to provide notifications/forms in alternative/accessible written formats upon request.

² Other CMS approved communication may be used in addition to an enrollment form; i.e. phone call.

³ Required if Exhibit 4 is NOT used and mailed to the beneficiary.

⁴ Required if combined acknowledgement/confirmation notice (Exhibit 4) is used in response to the DTRR, as described in §30.5

⁵ This notice is not required for those individuals rapidly re-enrolled.

⁶ This notice is also required to be sent for those individuals who are rapidly re-enrolled.

⁷ Not required if Exhibit 4 is NOT used and mailed to the beneficiary.

Enrollment (continued)

Forms and Notices	Section	Required?	Timeframe	TRC
Exhibit 9: Model Notice for Denial of Enrollment	30, 30.3.2, 30.3.3, 30.2.5	Yes	10 calendar days of receipt of enrollment request OR expiration of time frame for requested additional information	N/A
Exhibit 10: Model Notice for CMS Rejection of Enrollment	30.5.2	Yes ¹	10 calendar days of the DTRR containing the earliest notification of the rejection	019, 032, 033, 045, 345, 348
Exhibit 11: Acknowledgement of Request to Cancel Enrollment	50.2.1	Yes	10 calendar days of receipt of the cancellation request	015, 312, 703, 704

Disenrollments

Forms and Notices	Section	Required? ²	Timeframe	TRC
Exhibit 12: Model Notice to Send Out Disenrollment Form	40.1	No	N/A	N/A
Exhibit 13: Model Disenrollment Form	40.1, 40.1.3	No ³	If individual requests, send within 10 calendar days of receipt of the request to dis-enroll	N/A
Exhibit 14: Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member	40.1.3	No	10 calendar days of receipt of the request to dis-enroll.	N/A
Exhibit 15: Model Notice to Request Information (Disenrollment)	40.1	No ⁴	10 calendar days of receipt of disenrollment request	N/A
Exhibit 16: Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)	40.1.3	Yes	10 calendar days of the availability of the DTRR	013, 014, 018, 025, 026, 711
Exhibit 17: Model Notice for Denial of Disenrollment	40.1.3	Yes	10 calendar days of the receipt of the disenrollment request	N/A
Exhibit 18: Model Acknowledgement of Request to Cancel Disenrollment	50.2.2	No	10 calendar days of receipt of the cancellation request	288, 291
Exhibit 19: Model Notice for Disenrollment Due to Out-of-Area Status (No Response to Request for Address Verification)	40.2.1.3	Yes	Within first 10 calendar days of the sixth month from the date the state learned of the change in address or possible out-of-area residency	154

¹ Exhibit 10 can be combined with Exhibit 9, as long as the notice conveys proper reason for the enrollment not occurring.

² Note: for items that indicate “No” the state may still need to provide notifications/forms in alternative/accessibile written formats upon request.

³ Notice is not required but should be sent if requested by the member. The State may not deny or refuse written disenrollment requests.

⁴ Missing Information can be requested/collected via other means, i.e. telephone.

Disenrollments (continued)

Forms and Notices	Section	Required?	Timeframe	TRC
Exhibit 20: Model Notice for Disenrollment Due to Confirmation of Out-of-Area Status (Upon New Address Verification from Member)	40.2.1.3	Yes	10 calendar days of receiving confirmation of out-of-area status	154
Exhibit 21: Model Notice for Loss of Medicaid Status or State-Specific Eligibility Status - Notification of Involuntary Disenrollment	30.2.5, 40.2.3, 40.2.3.3	Yes ¹	For loss of State-Specific eligibility status or if the MMP does NOT offer a period of deemed continued eligibility for loss of Medicaid status, 10 calendar days prior to the MMP disenrollment effective date. If MMP offers period of deemed continued eligibility for loss of Medicaid status, 3 calendar days following the end of the grace period.	078
Exhibit 22: Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid	40.2.3.2	Yes ²	10 calendar days of learning of the loss of Medicaid eligibility	N/A

Reinstatement

Forms and Notices	Section	Required? 3	Timeframe	TRC
Exhibit 23: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status	40.2.4, 50.3	No	10 calendar days of initial contact with member	018, 036, 090
Exhibit 24: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination	40.2.2, 50.3, 50.3.1	No	10 calendar days of initial contact with member	079, 081
Exhibit 25: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to State or Plan Error	50.2.2, 50.3	No	10 calendar days of initial contact with member	287
Exhibit 26: Model Notice to Close Out Request for Reinstatement	50.3.2	No	10 calendar days after information was due to the state	N/A
Exhibit 27: Model Acknowledgment of Reinstatement	50.2.1, 50.3, 50.3.1, 50.7	Yes	10 calendar days of receipt of DTRR confirmation of the individual's reinstatement	287, 713

¹ This notice is also required to be sent for those individuals who are rapidly re-enrolled.

² This notice is only for States/MMPs that offer deeming.

³ Note: for items that indicate "No" the state may still need to provide notifications/forms in alternative/accessible written formats upon request.

Miscellaneous

Forms and Notices	Section	Required? 1	Timeframe	TRC
Exhibit 28: Acknowledgement of Request to Opt Out of Medicare-Medicaid Plan (not connected to request to disenroll or cancel enrollment in MMP)	30.2.5	Yes	10 calendar days of receipt of the individual's request to opt out or receipt of the DTRR.	311, 718
Exhibit 29: Model Notice for Enrollment Status Update	50.7	No	10 calendar days of the availability of the DTRR	701-722
Exhibit 30: Model Notice to Research Potential Out of Area Status – Address Verification form included	40.2.1.3	No	10 calendar days of receiving a notice of a change of address or an indication of possible out-of-area residency from the member, the member's legal representative, a CMS DTRR, or another source	154
Exhibit 31: State 60-day Notice for Passively Enrolled Individuals (a 30-day passive reminder notice, Exhibit 5, is also required)	30.5.1	Yes ²	60 days prior to the effective date	N/A
Exhibit 32: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Incarceration	40.2	Yes	10 calendar days of receipt of DTRR confirmation of the individual's incarceration	346
Exhibit 33: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence	40.2.7 50.2.1 50.2.7	No	10 calendar days of receipt of DTRR confirmation of the individual's loss of lawful presence	349

¹ Note: for items that indicate “No” the state may still need to provide notifications/forms in alternative/accessible written formats upon request.

² Notice is not required for those individuals rapidly re-enrolled.

Exhibit 1: Model Medicare-Medicaid Plan Enrollment Request Form

Referenced in §10.3, §30.2.1, §30.2.2, §30.2, and §30.3.1

KEEP THIS FORM FOR YOUR RECORDS

Medicare <name of State Medicaid program> (Medicaid) Plan Application Form

To join a Medicare-Medicaid Plan, you must have **Medicare Part A (Hospital Insurance)**, **Medicare Part B (Medical Insurance)**, and **<name of State Medicaid Program>**. *[State may insert: You can also fill out this form online at <web address> or call <toll-free number> to join the Medicare-Medicaid Plan. The call is free.]*

Choose a health plan:

☐ <Plan name 1>

☐ <Plan name 3>

☐ <Plan name 2>

☐ <Plan name 4>

Your information:

Name: (first, middle, last)			
Date of birth: (__/__/__) M M D D Y Y Y Y		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Phone number: (____) ____ - ____	Second phone number: (____) ____ - ____	Email address:	
Home address:			
City:	State:	ZIP code:	County (optional):
Mailing address (if different from home address):			
City:	State:	ZIP code:	County (optional):
Emergency contact name:		Emergency contact phone number: () ____ - ____	
Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ____ <include list of available languages> ____ <include list of accessible formats (like Braille, audio tape, or large print) > Please contact <plan name> at <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.			

Tell us where you usually get health services:

Name of your primary care provider, clinic or, health center:	Phone number: (____) ____ - _____
---	--

Tell us about your Medicare & <name of State Medicaid program> coverage:

Fill in your Medicare and <name of State Medicaid program> information below. You can find this information on your red, white, and blue Medicare card, or the Railroad Retirement Board. Also, please put your <name of State Medicaid program> ID number as it appears on the front of your <name of State Medicaid program> card.

Medicare Card: <u>Name (as it appears on your Medicare card):</u> _____ <u>Medicare Number:</u> _____ <u>Is Entitled to:</u> _____ <u>Effective Date:</u> _____ <u>Hospital (Part A)</u> _____ <u>Medical (Part B)</u> _____ You must have Medicare Part A and Part B to join an MMP plan.	<State Medicaid Logo> <Medicaid Beneficiary> Medicaid number _____
---	--

Other personal information:

Do you have End-Stage Renal Disease (ESRD)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" and you've had a successful kidney transplant and/or no longer need regular dialysis, please attach a note from your doctor.		
Do you live in a long-term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," fill in the information below:		
Name of the facility:		Phone number: (____) ____ - _____
<i>[States may insert question(s) regarding additional Medicaid and/or demonstration-specific eligibility criteria.]</i>		
Do you work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No

Information about your health & prescription drug coverage:

Some people have other health or drug coverage through private insurance, TRICARE, employers, unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs (SPAPs).

Do you have other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "yes," fill in the information below:
Name of your plan (and employer, if applicable):	Group number:	
	ID number:	
Name of your plan (and employer, if applicable):	Group number:	
	ID number:	
Name of your plan (and employer, if applicable):	Group number:	
	ID number:	
Name of your plan (and employer, if applicable):	Group number:	
	ID number:	
Name of your plan (and employer, if applicable):	Group number:	
	ID number:	
<p>If you have health coverage from an employer or union right now, you (or your dependents) could lose that coverage when you join <Plan name>. Your employer or union can give you more information about your coverage. If you have questions, talk with the person in your office who takes care of benefits.</p>		

Please read and sign below.

When you sign this form, it means that you understand:

<ul style="list-style-type: none"> • <Plan name> has a contract with the federal government and with <State>. • The health services you get with your new plan may be different than the services you had before. • I must keep Medicare Parts A-and B, and <Name of state Medicaid program>. • I can be in only one Medicare plan at a time. • By joining <Plan name>, I'll end my enrollment in another Medicare health or prescription drug plan. • I must tell Medicare and <Name of State Medicaid program> about any prescription drug coverage that I have or may get in the future. • If I move, I need to tell <State/enrollment broker>. • As a member of <Plan name>, I have the right to appeal if I don't agree with <Plan name>'s decisions about payment or services. • I understand that the <Plan name>'s [Member Handbook (Evidence of Coverage)] includes the rules I must follow. • <Plan name> doesn't usually cover people while they're out of the country, but there may be some limited coverage near the U.S. border. • On the date <Plan name> coverage begins, I must get my health care from <Plan name> providers, except for emergency or urgently needed care, out-of-area dialysis or if I get <Plan name> or <State> approval to see other providers in some circumstances. • <Plan name> will cover my health care with <Plan name> doctors and other providers as outlined in the [Member Handbook(Evidence of Coverage)] to see what services are covered. • If I need to see a provider or other provider who isn't in <Plan name>, I may need prior authorization or I may have to pay out-of-pocket for the services I get. 	<ul style="list-style-type: none"> • <If permitted by State> I understand that if a sales agent, broker, or other individual employed by or contracted with <Plan name> is helping me, <Plan name> may pay that person when they enroll me. • By joining <Plan name>, I know that <Plan name> may share my information with Medicare and <Name of State Medicaid program> and other plans as necessary for treatment, payment, and health care operations. • I understand that prescription drugs are covered, but not always the same ones I'm already taking. I understand that I'll have access to my current drugs for at least 30 days, until I can switch to a different drug, and that I'll have access to my current providers for [insert State's continuity of care requirement and length of transition period, e.g., 90 days or more] once I join <Plan name>. I further understand that <Plan name> has providers and pharmacies I must use to get health care services, except for non-routine, emergency situations. • I know that <Plan name> may share my information including my prescription drug coverage with Medicare and <Name of State Medicaid program>. They may release it for research and other purposes, as allowed by federal statutes and regulations. • The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from <Plan name>. • My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that he or she is authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or <Name of State Medicaid program>.
--	---

Your signature:	Date:
------------------------	--------------

Information about your authorized representative, if applicable:

If you're the authorized representative, you must provide the following information, sign, and date below:

Name: _____ Signature: _____
(Please print.)

Date: _____

Address: _____

Phone number: (_____) _____ - _____

Relationship to person with Medicare and Medicaid: _____

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 2: Model Short Enrollment Request Form (for use in switching to another Medicare-Medicaid Plan offered by the same organization)

Referenced in §10.3

KEEP THIS FORM FOR YOUR RECORDS

Enrollment Application: Switching to Another Medicare -<name of State Medicaid program> Plan

To join a Medicare-Medicaid Plan, you must have Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), and name of State Medicaid program. *[State may insert: You can also fill out this form online at <web address> or call <toll-free number>, <days and hours of operation> to join the Medicare-Medicaid Plan. The call is free.]*

Choose the Medicare-Medicaid Plan you wish to enroll in:

☐ <Plan name 1>

☐ <Plan name 3>

☐ <Plan name 2>

☐ <Plan name 4>

Your information:

Name: (first, middle, last)

Name of plan you're currently enrolled in

Phone number:

(____) ____ - ____

Second phone number:

(____) ____ - ____

Email address:

Home address:

City:

State:

ZIP code:

County:

Mailing address (if different from home address):

City:

State:

ZIP code:

County:

Emergency contact name:

Emergency contact phone number:

(____) ____ - ____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

____ <include list of available languages>

____ <include list of accessible formats (like Braille, audio tape, or large print) >

Please contact <plan name> at <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number.>

Tell us where you usually get health services:

Name of primary care provider, clinic, or health center

Primary care provider phone

(____) ____ - ____

Tell us about your Medicare & <name of State Medicaid program> coverage:

Fill in your Medicare and <name of State Medicaid program> information below. You can find this information on your red, white, and blue Medicare card, or the Railroad Retirement Board. Also, please put your <name of State Medicaid program> ID number as it appears on the front of your card.

Medicare Card:

Name (as it appears on your Medicare card): _____

Medicare Number: _____

Is Entitled to: _____ **Effective Date:** _____

Hospital (Part A) _____

Medical (Part B) _____

You must have Medicare Part A and Part B to join an MMP.

<State Medicaid Logo>

<Medicaid Beneficiary>

Medicaid number

Please read and sign below.

When you sign this form, it means that you understand:

<ul style="list-style-type: none"> • <Plan name> has a contract with the federal government and with <State>. • The health services you get with your new plan may be different than the services you had before. • I must keep Part A, Part B, and <name of State Medicaid program>. • I can be in only one Medicare plan at a time. • By joining <Plan name>, I'll end my enrollment in another Medicare health or prescription drug plan. • I must tell Medicare and <Name of State Medicaid program> about any prescription drug coverage that I have or may get in the future. • If I move, I need to tell <State/enrollment broker>. • As a member of <Plan name>, I have the right to appeal if I don't agree with <Plan name>'s decisions about payment or services. • I understand that <Plan name>'s [<i>Member Handbook (Evidence of Coverage)</i>] includes the rules I must follow. • The <Plan name> doesn't usually cover people while they're out of the country, but there may be some limited coverage near the U.S. border. • On the date <Plan name> coverage begins, I must get my health care from <Plan name> providers, except for emergency or urgently needed care, out-of-area dialysis or if I get <Plan name> or <State> approval to see other providers in some circumstances. • <Plan name> will cover my health care with <Plan name> providers and other providers as outlined in the [<i>Member Handbook (Evidence of Coverage)</i>] to see what services are covered. 	<ul style="list-style-type: none"> • If I need to see a provider or other provider who isn't in <Plan name>, I may need prior authorization or I may have to pay out-of-pocket for the services I get. • <If permitted by State> I understand that if a sales agent, broker, or other individual employed by or contracted with <Plan name> is helping me, <Plan name> may pay that person when they enroll me. • By joining <Plan name>, I know that <Plan name> may share my information with Medicare and <Name of State Medicaid program> and other plans as necessary for treatment, payment, and health care operations. • I understand that prescription drugs are covered, but not always the same ones I'm already taking. I understand I'll have access to my current drugs for at least 30 days, until I can switch to different drug. I understand I'll have access to providers for [<i>insert State's continuity of care requirement and length of transition period, e.g., 90 days or more</i>] once I join <Plan name>. I further understand that <Plan name> has providers and pharmacies I must use to get health care services, except for non-routine, emergency situations. • I know that <Plan name> may share my information, including my prescription drug event data, with Medicare and <Name of State Medicaid program>. They may release it for research and other purposes, as allowed by federal statutes and regulations. • The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from <Plan name>. • My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that he or she is authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or <Name of State Medicaid program>.
--	---

Your signature:	Date:
------------------------	--------------

Information about your authorized representative, if applicable:

If you're the authorized representative, you must provide the following information, sign, and, date below:

Name: _____ Signature: _____
(Please print.)

Date: _____

Address: _____

Phone number: (_____) _____ - _____

Relationship to person with Medicare and Medicaid: _____

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 3 - Model Notice to Acknowledge Receipt of Completed Enrollment Request

Referenced in §30 and §30.5.1

KEEP THIS NOTICE FOR YOUR RECORDS

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Member ID>

<Rx ID>

<Rx GRP>

<Rx BIN>

<Rx PCN>

IMPORTANT INFORMATION ABOUT YOUR NEW MEDICARE - <name of State Medicaid program> PLAN

<Name>:

Thank you for your request to enroll in the <Plan name > Medicare-Medicaid Plan.

If Medicare and Medicaid approve your request, your <Plan name> health coverage will begin on **<effective date>**. In this plan, you'll get:

- Your **Medicare** benefits, including prescription drugs
- Your **Medicaid** benefits, including long-term services and supports (including services for a long-term medical condition so you can stay in your home as long as possible)
- Your choice of providers within the plan's network who work together to give you the care you need
- Extra benefits and services, including a care coordinator [*Plans may insert: and other covered services such as dental, vision, etc.*]
- Durable medical equipment <example of durable medical equipment>

What happens now?

- Medicare and Medicaid will review your enrollment information. Once the review is complete, you'll get a confirmation notice within 10 days. [*States should modify the number of days as appropriate.*]
- Don't make any other changes to your health insurance until you get your enrollment confirmation notice.
- If your request to enroll is approved, you can begin using <Plan name> providers on **<effective date>**. You should get your Member ID Card in the mail within 10 days [*States should modify the number of days as appropriate*]. **If you do not get your Member ID Card within 10 days, you may use this notice as proof of your coverage until you get your ID card.**
- To help with the transition to <plan name>, you can continue seeing the providers you go to now for [*Plan must describe the State's continuity of care requirement and place the period here, e.g., 90 days.*] You will also have access to at least one [*must be at least 30*]-day supply of the Part D drugs you currently take during your first [*must be at least 90*] days in the plan if you are taking a drug that is not on our List of Covered Drugs, if health plan rules do not let you get the amount ordered by your doctor, or if the drug requires

prior approval by <plan name>. *[If applicable, insert other State-specific continuity of care requirements.]*

How will I get my health services in <Plan name>?

- If you request for enrollment is approved, starting <effective date>, you must see a <Plan name> provider for all of your health services. You'll also have to use a <Plan name> pharmacy to get your drugs. If you need to see a provider who is not in <Plan name>, you must have "prior authorization" if you want <Plan name> to cover your health services. Prior authorization simply means approval from <Plan name> is needed before you can get certain services or drugs.
- To help with the transition to <plan name>, you can continue seeing the providers you go to now for *[Plan must describe the State's continuity of care requirement and place the period here, e.g., 90 days.]* You will also have access to at least one *[must be at least 30]-* day supply of the Part D drugs you currently take during your first *[must be at least 90]* days in the plan if you are taking a drug that is not on our List of Covered Drugs, if health plan rules do not let you get the amount ordered by your doctor, or if the drug requires prior approval by <plan name>. *[If applicable, insert other State-specific continuity of care requirements.]*
- Until your request for enrollment is approved, you don't need prior authorization for services and may use providers who aren't in <Plan name> until <date>. Once your request is approved, you must see a <Plan name> provider for all of your health services.
- A <Plan name> provider must provide or arrange for **all** of your health services, except emergency care, urgent care, or out-of-area dialysis services *[States may need to add additional exceptions (e.g., women health providers).]*
- Emergency care, urgent care, and dialysis services are covered even if you're **not** seeing a <Plan name> doctor. Talk with your provider or call <Plan name> at Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number> for more information. *[States should add other services that a member can get without a referral.]*

How much will I have to pay for health care services?

You won't have to pay a plan premium, deductible, or copays when getting health services through a <Plan name> provider.

How much will I have to pay for prescription drugs?

[If plan has any Part D cost sharing, insert the following paragraph and include LIS cost sharing information specific to the enrollee's LIS level: When you pick up your prescription drugs at our network pharmacy, you'll pay no more than <\$____> each time you get a generic drug that's covered by <Plan name> and no more than <\$____> each time you get a brand name drug that is covered by <Plan name>. Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact <Plan name> for more details.]

[If plan has any Medicaid cost sharing, insert copay information here.]

[If plan has no cost sharing for all Part D and/or Medicaid drugs, insert: You pay \$0 for <all or the rest of> your prescription drugs covered by the plan.]

[If applicable, insert copays for Medicaid services.]

[If applicable, insert:

How can I choose a primary care provider?

Information instructing member in simple terms on how to select a primary care provider/site, how to obtain services, explain which services do not need primary care provider's approval (when applicable), etc.]

Can I leave <Plan name > or select a new plan?

- *[States that continue to implement a continuous Special Election Period for dual eligible beneficiaries (duals SEP) insert: **Yes.** You may leave <plan name> or choose a new Medicare-Medicaid Plan **at any time during the year** by calling <state/enrollment broker number>, <days and hours of operation>.]*
- *[States that implement the new duals SEP effective 2019, insert: You may leave <Plan name> during certain times of the year, known as election periods. In certain situations, you may also be eligible to leave <Plan name> at other times of the year. You can find out if you are eligible by calling <State/enrollment broker number>, <days and hours of operation>.]*
- If you leave <Plan name>, your coverage will end the last day of the month after you tell us you want to leave and don't want <State> to enroll you in another Medicare-Medicaid Plan.
- If you leave <Plan name> and don't join a Medicare health or prescription drug plan, you'll be covered under Original Medicare and Medicare will enroll you in a Medicare prescription drug plan.
- If you have concerns with <Plan name>, call <State> ombudsman at <ombudsman number>, <days and hours of operation>.
- If you would like to discuss other enrollment choices, you can speak with a <State Health Insurance Assistance Program (SHIP) counselor> at <SHIP phone number>, <days and hours of operation>.
- If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you have questions about **<name of State Medicaid program>**, call <Medicaid phone number>, < days and hours of operation>.

[If the State delegates sending of this notice to Medicare-Medicaid Plan , the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name >?

If you have questions, you can visit <web address> or call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can also call <enrollment broker> at <enrollment broker number>, <days and hours of operation>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can contact your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment

Referenced in §30, §30.2.5, §30.5, and §30.5.2

KEEP THIS NOTICE FOR YOUR RECORDS

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Member ID>

<Rx ID>

<Rx GRP>

<Rx BIN>

<Rx PCN>

IMPORTANT INFORMATION ABOUT YOUR NEW MEDICARE - <name of State Medicaid Program> PLAN

<Name>:

You have new health and drug coverage through <Plan name>

Starting <effective date>, you will have a health plan designed to give you high quality care at a low cost or zero cost to you. You have new health and prescription drug coverage through <Plan name>. Medicare and Medicaid approved your application to enroll in this plan. Your coverage begins on < effective date>. You'll get a Member ID Card in the mail by <date>. This notice is proof of coverage until you get your Member ID Card. You can show this notice to your providers or pharmacy until you get your card.

What do I need to know about my new plan?

- Starting <effective date>, you must see a <Plan name> provider for all of your health services. You'll also have to use a <Plan name> pharmacy to get your drugs. If you need to see a provider who is not in <Plan name>, you must have "prior authorization" if you want <Plan name> to cover your health services. Prior authorization simply means that approval from <Plan name> is needed before you can get certain services or drugs.
- Because you're new to <Plan name>, you don't need prior authorization for services until <effective date>, and you may use doctors who aren't in <Plan name> until <date>. *[State to modify this language.]*
- To help with the transition to <plan name>, you can continue seeing the providers you go to now for *[Plan must describe the State's continuity of care requirement and place the period here, e.g., 90 days.]* You will also have access to at least one *[must be at least 30]-* day supply of the Part D drugs you currently take during your first *[must be at least 90]* days in the plan if you are taking a drug that is not on our List of Covered Drugs, if health plan rules do not let you get the amount ordered by your doctor, or if the drug requires prior approval by <plan name>. *[If applicable, insert other State-specific continuity of care requirements.]*
- A <Plan name> provider must provide or arrange for **all** of your health services, except emergency care, urgent care, or out-of-area dialysis services *[States may need to add additional exceptions (e.g., women health providers).]*

- Emergency care, urgent care, and dialysis are covered even if you're **not** seeing a <Plan name> doctor. Talk with your provider or call <Plan name> at Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number> for more information. *[States should add other services that a member can get without a referral.]*

How much do I have to pay for health services?

You don't have to pay a plan premium, deductible, or copays when getting health services through <Plan name>.

How much do I have to pay for prescription drugs?

[If plan has any Part D cost sharing, insert the following paragraph and include LIS cost sharing information specific to the enrollee's LIS level: When you pick up your prescription drugs at our network pharmacy, you'll pay no more than <\$____> each time you get a generic drug that's covered by <Plan name> and no more than <\$____> each time you get a brand name drug that is covered by <Plan name>. Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact <Plan name> for more details.]

[If plan has any Medicaid cost sharing, insert copay information here.]

[If plan has no cost sharing for all Part D and/or Medicaid drugs, insert: You pay \$0 for <all or the rest of> your prescription drugs covered by the plan.]

[If applicable, insert copays for Medicaid services.]

[If applicable, insert:

How can I choose a primary care provider?

Information instructing member in simple terms on how to select a primary care provider/site, how to obtain services, explain which services do not need primary care provider's approval (when applicable), etc.]

Can I leave <Plan name> or select a new plan?

- *[States that continue to implement a continuous Special Election Period for dual eligible beneficiaries (duals SEP) insert: **Yes.** You may leave <plan name> or choose a new Medicare-Medicaid Plan **at any time during the year** by calling <state/enrollment broker number>, <days and hours of operation>.]*
- *[States that implement the new duals SEP effective 2019, insert: You may leave <Plan name> during certain times of the year, known as election periods. In certain situations, you may also be eligible to leave <Plan name> at other times of the year. You can find out if you are eligible by calling <State/enrollment broker number>, <days and hours of operation>.]*
- If you leave <Plan name>, your coverage will end the last day of the month after you tell us you want to leave and don't want <State> to enroll you in another Medicare-Medicaid Plan.
- If you leave <Plan name> and don't join a Medicare health or prescription drug plan, you'll be covered under Original Medicare and Medicare will enroll you in a Medicare prescription drug plan.
- If you have concerns with <Plan name>, call <State> ombudsman at <ombudsman number>, <days and hours of operation>.

- If you would like to discuss other enrollment choices, you can speak with a <State Health Insurance Assistance Program (SHIP) counselor> at <SHIP phone number>, <days and hours of operation>.
- If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
If you have questions about <name of State Medicaid program>, call <Medicaid phone number>, <days and hours of operation>.

What if I leave <Plan name> and I don't want to join a different Medicare-Medicaid Plan or a Medicare Prescription Drug Plan?

- If you don't want to join either a Medicare-Medicaid Plan or a Medicare Prescription Drug Plan, call <State/enrollment broker> at <State/enrollment broker number >, <days and hours of operation>. TTY users should call <toll-free number>.
- Unless you tell your <state/enrollment broker> you don't want to join a different Medicare-Medicaid Plan, <State> may enroll you in another Medicare-Medicaid Plan in the future.
- If you leave <Plan name> and don't join a Medicare health or prescription drug plan on your own, you'll be covered under Original Medicare and Medicare may enroll you in a Medicare Prescription Drug Plan.

[If the State delegates sending of this notice to Medicare-Medicaid Plan , the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name >?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. If you have complaints, difficulty accessing care, or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 5: State 30-day Reminder Notice for Passively Enrolled Individuals

Referenced in §30.2.5

KEEP THIS NOTICE FOR YOUR RECORDS

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

Important reminder: You're being enrolled in a new health & drug plan.

You recently got a notice from your State about important changes to your health and drug coverage. <State> **will soon enroll you in <Parent Organization Name>'s <Plan name>.** This new plan includes your <Medicaid or State-specific Medicaid name> (sometimes called "Medicaid"), Medicare, and prescription drug benefits. This plan is designed to help your Medicare and <Medicaid or State-specific Medicaid name> work better together and includes new benefits and services that aren't available to you now.

Your new coverage starts <effective date>.

You do not have to do anything. You'll be automatically enrolled in <Plan name>. If you don't make another choice by <date>, your new coverage will start on <effective date>. <Plan name> will send you a new Member ID Card to use. This new card will replace the cards you use now.

For more information about your new plan, to find out what benefits your new plan covers, or to see if you can still see your current providers in your new plan, call <State's Customer Service Line> at <State Customer Service number>, <days and hours of operation>. TTY users should call <toll-free number number>.

You have other choices.

If you **don't** want to be enrolled in <Plan name>, you have other choices, including:

1. **Keep your current Medicare coverage or a similar option.** Call <State's Customer Service Line> at <State Customer Service number>, <days and hours of operation> and tell them you don't want to be in <Plan name> (you want to "opt out"). They can help you find out how to keep your current coverage or talk to you about similar choices available to you.
2. **Join a different plan that will include your Medicare, <Medicaid or State-specific Medicaid name>, and prescription drug benefits.** Call <State's Customer Service Line> at <State Customer Service number>, <days and hours of operation>. TTY users should call <toll-free number>. Tell them you don't want to be in <Plan name> and you want to join a different plan.
3. Call by <date> to make sure you get your plan materials in time for the start of your coverage.

<p>Note: You'll have 3 months after your coverage starts in <plan name> to change to another Medicare health plan.</p>

What you should do now?

- Review all of your choices carefully before making any decisions about your health care coverage. To talk about your choices, call <State's Customer Service Line> at <State Customer Service number>, <days and hours of operation>. TTY users should call <toll-free number>.
- **Decide which option is best for you:**
 - **To enroll in <Plan name>**, you don't have to do anything.
 - **To choose another option** (see your list of choices under "You have other choices" on page 1), call <State's Customer Service Line> at <State Customer Service number>, <days and hours of operations>. TTY users should call <toll-free number> by <date>.
 - **If you don't call and choose another health option by <date>, you'll be automatically enrolled in <Plan name>.**

[Plans should include the following paragraph if they intend to conduct early assessments:

What will happen now?

Someone from <Plan name> may call you to talk about your health and service needs before your services start on <enrollment effective date>. You can choose to wait until your services start before answering these questions. If you decide to wait, they will set a time after your enrollment date to discuss your health and service needs.]

Get more information:

- If you have concerns with this plan, call <State> ombudsman at <ombudsman number>, <days and hours of operation>.
- If you would like to discuss other enrollment choices, you can speak with a <State Health Insurance Assistance Plan (SHIP) counselor> at <SHIP number>, <days and hours of operation>.
- If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Exhibit 5a: MMP Welcome Notice for Passively Enrolled Individuals

Referenced in §30.5.1

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

Member ID:<Member ID>

Rx ID: <Rx ID>

Rx GRP: <Rx GRP>

Rx BIN: <Rx BIN>

Rx PCN: <Rx PCN>

Important: You have been enrolled in a new plan for your Medicare and <name of state Medicaid program> services. Keep this letter as proof of your coverage.

<Name>:

Welcome to <plan name> (Medicare-Medicaid Plan)!

Starting <effective date>, you will have a health plan designed to give you seamless, high quality care at a low cost or zero cost to you. <Insert Federal-State contracting disclaimer from State-specific Marketing Guidance>.

Your new coverage will include:

- Your choice of doctors, pharmacies, and other providers within the plan's network who work together to give you the care you need
- Prescription drugs
- Long-term services and supports to help you with an ongoing medical condition (Long-term services and supports are often provided in your home or a community setting so you don't have to go to a nursing home or hospital)
- *[If applicable, insert: Extra benefits and services, including a care coordinator [Plan may insert: and other covered services such as dental, vision, etc.]*
- Durable Medical Equipment, like *[Plan must insert two or three examples of covered items, such as crutches, walkers, wheelchairs, oxygen equipment, hospital beds, speech generating devices, nebulizers, intravenous (IV) infusion pumps.]*

This letter is proof of your new coverage. *[Plan that does not include the Member ID Card in the welcome mailing should insert: Please bring this letter with you to the pharmacy or office visit until you get your Member ID Card from us.]* If you have questions, call <plan name> Member Services at <toll-free number>, <days and hours of operation>. Call <toll-free number> if you use TTY.

You may begin using <plan name> network primary care providers and pharmacies for all of your health care services and prescription drugs as of <effective date>. If you need emergency or urgently needed care, or out-of-area dialysis services, you can use providers outside of <plan name>'s network.

To help with the transition to <plan name>, you can continue seeing the providers you go to now for *[Plan must describe the state's continuity of care requirement and place the period here, e.g., 90 days.]* You will also have access to a *[insert supply limit (must be the number of days in plan's one-month supply)]*-day supply of the Part D drugs you currently take during your first *[must be at least 90]* days in the plan if you are taking a drug that is not on our *List of Covered Drugs*, if health plan rules do not let you get the amount ordered by your doctor, or if the drug requires prior approval by <plan name>. *[If applicable, insert other state-specific continuity of care requirements.]*

[Plan may insert the following if it elects not to include the new member kit with the welcome mailing: You will get new member kit information separately.]

The new member kit includes:

- Summary of Benefits
- *List of Covered Drugs (Formulary)* *[Plan may delete and replace with the following if it elects not to send List of Covered Drugs to enrollees: Instructions for getting more information about the drugs on our List of Covered Drugs]*
- *Provider and Pharmacy Directory* *[Plan may delete and replace with the following if it elects not to send the Provider and Pharmacy Directory to enrollees: Instructions for getting more information about the providers and pharmacies in our network]*
- *[Plan may insert the following if it elects to include the Member ID Card with the welcome mailing: Member ID Card]*
- *[Plan may insert the following if it elects to include the Member Handbook with the welcome mailing: Member Handbook (Evidence of Coverage)]*

[If plan elects to send the Member ID Card separately from the welcome mailing, the plan must insert the following: Before <enrollment effective date>, we will send you a Member ID Card.]
[Plan may insert the following if it sends the Member Handbook separately from the welcome mailing: Before <enrollment effective date>, we will send you a Member Handbook (Evidence of Coverage).]

[If plan elects not to send the Member Handbook to enrollees, insert: An up-to-date copy of the Member Handbook (Evidence of Coverage) is always available on our website at <web address>. You may also call Member Services at <toll-free number> to ask us to mail you a Member Handbook.]

How much will I pay for <Plan name>?

You will not have to pay a plan premium, deductible, or copays when getting health services through a <Plan name> provider.

How much will I have to pay for prescription drugs?

[If plan has any Part D cost sharing, insert the following paragraph and include LIS cost sharing information specific to the enrollee's LIS level: When you pick up your prescription drugs at our network pharmacy, you'll pay no more than <\$____> each time you get a generic drug that's covered by <Plan name> and no more than <\$____> each time you get a brand name drug that is covered by <Plan name>. Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact <Plan name> for more details.]

[If plan has any Medicaid cost sharing, insert copay information here.]

[If plan has no cost sharing for all Part D and/or Medicaid drugs, insert: You pay \$0 for <all or the rest of> your prescription drugs covered by the plan.]

[If applicable, insert copays for Medicaid services.]

[If applicable, insert:

How can I choose a primary care provider?

Information instructing member in simple terms on how to select a primary care provider/site, how to obtain services, explain which services do not need primary care provider's approval (when applicable), etc.]

What if I have questions about <plan name>'s coverage?

- Call <plan name> <Member Services> at <toll-free number> <days and hours of operation>.
- Call <toll-free number> if you use TTY.

Visit <web address>.

What if I have other health or drug coverage?

If you have other health or drug coverage, such as from an employer or union, you or your dependents could lose your other health or drug coverage completely and not get it back if you join <Plan name>. Other types of health and drug coverage include TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Contact your benefits administrator if you have questions about your coverage.

What if I don't want to join <Plan name>?

You will be enrolled in <Plan name> unless you cancel the enrollment before <enrollment effective date>. You can call <state/enrollment broker> at <toll-free number>, <days and hours of operation> to cancel your enrollment with <plan name>. Call <toll-free number> if you use TTY.

What if I want to join a different Medicare-Medicaid Plan?

Call <state/enrollment broker> at <toll-free number>, <days and hours of operation> to join another Medicare-Medicaid Plan.

Can I leave <Plan name > or join a different plan after <effective date>?

[Plans in states that continue to implement a continuous Special Enrollment Period for dual eligible beneficiaries (duals SEP) insert: **Yes.** You may leave <plan name> or choose a new Medicare-Medicaid Plan **at any time during the year** by calling <state/enrollment broker number>, <days and hours of operation>.]

[Plans in states that implement the new duals SEP effective 2019, insert: **Yes.** You may leave <plan name> or choose a new Medicare-Medicaid Plan before **<effective date of enrollment>**. You'll also have from **<effective date of enrollment>** through **<three months after effective date of enrollment>** to change to another Medicare health plan.

If you don't make a change during this time, you'll only be able to change plans during certain times of the year or in certain situations. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in <plan name> will end on December 31 and your membership in the new plan will start on January 1.
- The **Medicare Advantage Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan will start the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. If you want to make a change, call <state/enrollment broker number>, <days and hours of operation>.]

If you leave <plan name> and don't want to enroll in another Medicare-Medicaid Plan, your coverage will end the last day of the month after you tell us. If you leave <plan name> and don't join a Medicare health or prescription drug plan, you'll be covered under Original Medicare and Medicare will enroll you in a Medicare prescription drug plan.

How can I contact Medicare?

If you want to join a Medicare health or prescription drug plan, want to know more about Medicare plans in your area, or have questions about Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week.
- Call 1-877-486-2048 if you use TTY.
- Visit the Medicare home page at <http://www.medicare.gov>.

What if I have questions about <name of state Medicaid program>?

If you have questions about <name of state Medicaid program>, call <Medicaid phone number>, <days and hours of operation>.

[Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to <https://www.hhs.gov/civil-rights/for-individuals/section-1557>.]

You can also get this document for free in other languages and formats, like large print, braille, or audio. Call *[insert Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation]*. The call is free.

Exhibit 5b: MMP Welcome Notice for Individuals Who Opt-in

Referenced in §30.5.1

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

Member ID: <Member #>

Rx ID: <RxID>

Rx GRP: <RxGRP>

Rx BIN: <RxBIN>

Rx PCN: <RxPCN>

Important: You have enrolled in a new plan for your Medicare and <name of state Medicaid program> services. Keep this letter as proof of your coverage.

<Name>:

Welcome to <plan name> (Medicare-Medicaid Plan)!

Starting <effective date>, you will have a health plan designed to give you seamless, high quality care at a low cost or zero cost to you. <Insert Federal-State contracting disclaimer from the State-specific Marketing Guidance>.

Your new coverage includes:

- Your choice of doctors, pharmacies and other providers within the plan's network who work together to give you the care you need
- Prescription drugs
- Long-term services and supports to help you with an ongoing medical condition (Long-term services and supports are often provided in your home or a community setting so you don't have to go to a nursing home or hospital.)
- *[If applicable, insert: Extra benefits and services, including a care coordinator [Plan may insert: and other covered services such as dental, vision, etc.]]*
- Durable Medical Equipment, like *[Plan must insert two or three examples of covered items, such as crutches, walkers, wheelchairs, oxygen equipment, hospital beds, speech generating devices, nebulizers, intravenous (IV) infusion pumps.]*

This letter is proof of your new coverage. *[Plan that does not include the Member ID Card in the welcome mailing should insert: Please bring this letter with you to the pharmacy or office visit until you get your Member ID Card from us.]* If you have questions, call <plan name> Member Services at <toll-free number>, <days and hours of operation>. Call <toll-free number> if you use TTY.

Except as described below, you must begin using <plan name> network primary care providers and pharmacies for all of your health care services and prescription drugs as of <effective date>. If you need emergency or urgently needed care, or out-of-area dialysis services, you can use providers outside of <plan name>'s network.

To help with the transition to <plan name>, you can continue seeing the providers you go to now for *[Plan must describe the state's continuity of care requirement and place the period here, (e.g., 90 days).]* You will also have access to a *[insert supply limit (must be the number of days in plan's one-month supply)]*-day supply of the Part D drugs you currently take during your first *[must be at least 90]* days in the plan if you are taking a drug that is not on our *List of Covered Drugs*, if health plan rules do not let you get the amount ordered by your doctor, or if the drug requires prior approval by <plan name>. *[If applicable, insert other state-specific continuity of care requirements.]*

[Plan may insert the following if it elects not to include the new member kit with the welcome mailing: You will get new member kit information separately.]

The new member kit includes:

- *List of Covered Drugs (Formulary)* *[Plan may delete and replace with the following if it elects not to send List of Covered Drugs to enrollees: Instructions for getting more information about the drugs on our List of Covered Drugs]*
- *Provider and Pharmacy Directory* *[Plan may delete and replace with the following if it elects not to send the Provider and Pharmacy Directory to enrollees: Instructions for getting more information about the providers and pharmacies in our network]*
- *[Plan may insert the following if it elects to include the Member ID Card with the welcome mailing: Member ID Card]*
- *[Plan may insert the following if it elects to include the Member Handbook with the welcome mailing: Member Handbook (Evidence of Coverage)]*
- *[Plan may insert the following if it elects to include the Summary of Benefits with the welcome mailing: Summary of Benefits]*

[If plan elects to send the Member ID Card separately from the welcome mailing, the plan must insert the following: Before <enrollment effective date>, we will send you a Member ID Card.]

[Plan may insert the following if it sends the Member Handbook separately from the welcome mailing: Before <enrollment effective date>, we will send you a Member Handbook (Evidence of Coverage).]

[If plan elects not to send the Member Handbook to enrollees, insert: An up-to-date copy of the Member Handbook (Evidence of Coverage) is always available on our website at <web address>. You may also call Member Services at <toll-free number> to ask us to mail you a Member Handbook.]

How much will I have to pay for <plan name>?

You will not have to pay a plan premium, deductible, or copays when getting health services through a <plan name> provider.

How much will I have to pay for prescription drugs?

[If plan has any Part D cost sharing, insert the following paragraph and include LIS cost sharing information specific to the enrollee's LIS level: When you pick up your prescription drugs at our network pharmacy, you'll pay no more than <\$____> each time you get a generic drug that's covered by <plan name> and no more than <\$____> each time you get a brand name drug that is covered by <plan name>. Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact <plan name> for more details.]

[If plan has any Medicaid cost sharing, insert copay information here.]

[If plan has no cost sharing for all Part D and/or Medicaid drugs, insert: You pay \$0 for <all or the rest of> your prescription drugs covered by the plan.]

[If applicable, insert:

How can I choose a primary care provider?

Information instructing member in simple terms how to select a primary care provider/site, how to obtain services, which services do not need primary care provider's approval (when applicable), etc.]

What if I have questions about <plan name>'s coverage?

- Call <plan name> <Member Services> at <toll-free number> <days and hours of operation>.
- Call <toll-free number> if you use TTY.
- Visit <web address>.

What if I have other health or prescription drug coverage?

If you have other health or drug coverage, such as from an employer or union, you or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>. Other types of health and drug coverage include TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Contact your benefits administrator if you have questions about your coverage.

What if I want to join a different Medicare-Medicaid Plan?

Call <state/enrollment broker> at <toll-free number>, <days and hours of operation> to join another Medicare-Medicaid Plan.

Can I leave <plan name> or join a different plan after <effective date>?

[Plans in states that continue to implement a continuous Special Enrollment Period for dual eligible beneficiaries (duals SEP) insert: Yes. You may leave <plan name> or choose a new Medicare-Medicaid Plan at any time during the year by calling <state/enrollment broker number>, <days and hours of operation>.]

[Plans in states that implement the new duals SEP effective 2019, insert: Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in <plan name> will end on December 31 and your membership in the new plan will start on January 1.
- The **Medicare Advantage Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan will start the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. If you want to make a change, call <state/enrollment broker number>, <days and hours of operation>.]

If you leave <plan name> and don't want to enroll in another Medicare-Medicaid Plan, your coverage will end the last day of the month after you tell us. If you leave <plan name> and don't join a Medicare health or prescription drug plan, you'll be covered under Original Medicare and Medicare will enroll you in a Medicare prescription drug plan.

How can I contact Medicare?

If you want to join a Medicare health or prescription drug plan, want to know more about Medicare plans in your area, or have questions about Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week.
- Call 1-877-486-2048 if you use TTY.
- Visit the Medicare home page at <http://www.medicare.gov>.

What if I have questions about <name of state Medicaid program>?

If you have questions about <name of state Medicaid program>, call <Medicaid phone number>, <days and hours of operation>.

[Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to <https://www.hhs.gov/civil-rights/for-individuals/section-1557>.]

You can also get this document for free in other languages and formats, like large print, braille, or audio. Call *[insert Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation]*. The call is free.

Exhibit 5c: MMP Welcome-back Notice for Individuals Who Are Rapidly Re-enrolled

Referenced in §30.2.5, §40.2.3, §40.2.3.3.

KEEP THIS NOTICE FOR YOUR RECORDS

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Member ID>

<Rx ID>

<Rx GRP>

<Rx BIN>

<Rx PCN>

Read this notice carefully, and keep it for your records.

IMPORTANT: YOU’VE BEEN RE-ENROLLED BACK INTO <PLAN NAME>.

<Name>:

Welcome back to <Plan Name> (Medicare-Medicaid Plan)!

Starting <effective date>, you’ll go back to <Plan name> and continue to get the same high quality care at a low cost or zero cost to you. *[Insert Federal-State contracting disclaimer from section 50.1 of the State-specific MMP marketing guidance: <Plan name> is a health plan that contracts with both Medicare and <Name of State Medicaid program> to provide benefits of both programs to enrollees.]*

Your coverage includes:

- Your choice of providers, pharmacies and other providers within the plan’s network who work together to give you the care you need
- Prescription drugs
- Long-term services and supports to help you with an ongoing medical condition (Long-term services and supports are often provided in your home or a community setting so you don’t have to go to a nursing home or hospital.)
- Extra benefits and services, including a care coordinator *[Plan may insert: and other covered services such as dental, vision, etc.]*
- Durable Medical Equipment <example of durable medical equipment>

This notice is proof of your coverage. *[Plan that does not include the Member ID Card in the welcome-back mailing should insert: Please bring this notice with you to the pharmacy or office visits for your health care services until you get your Member ID Card from us.]* If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>.

What happens now?

- You must begin using <Plan name> network primary care providers and pharmacies for all of your health care services and prescription drugs as of **<effective date>**. Remember, since you were in <Plan name> before, you can use the same providers and pharmacies you were seeing.
- If you need emergency or urgently needed care, or out-of-area dialysis services, you can use providers outside of <Plan name>'s network.
- You'll also have access to at least one *[must be at least 30]*-day supply of the Part D drugs you currently take during your first *[must be at least 90]* days back in the plan if you're taking a drug that's not on our List of Covered Drugs, if health plan rules don't let you get the amount ordered by your doctor, or if the drug requires prior approval by <Plan name>. *[If applicable, insert other State-specific continuity of care requirements.]*

[Plan should send Member ID Card along with this letter; as well as insert the following language]:

Below are instructions on how to access the following items you already got when you were enrolled before:

- List of Covered Drugs (also called a "formulary") *[Plan should insert instructions for accessing soft copy of List of Covered Drugs.]*
- Provider and Pharmacy Directory *[Plan should insert instructions for accessing soft copy Provider and Pharmacy Directory.]*
- Member Handbook (Evidence of Coverage) *[Plan should insert instructions for accessing Member Handbook.]*
- Summary of Benefits with the welcome mailing: Summary of Benefits *[Plan should insert instructions for accessing soft copy of Summary of Benefits.]*

How much will I have to pay for <Plan name>?

You won't have to pay a plan premium, deductible, or copays when getting health services through a <Plan name> provider.

How much will I have to pay for prescription drugs?

[If plan has any Part D cost sharing, insert the following paragraph and include LIS cost sharing information specific to the enrollee's LIS level: When you pick up your prescription drugs at our network pharmacy, you'll pay no more than <\$____> each time you get a generic drug that's covered by <Plan name> and no more than <\$____> each time you get a brand name drug that's covered by <Plan name>. Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact <Plan name> for more details.]

[If plan has any Medicaid cost sharing, insert copay information here.]

[If plan has no cost sharing for all Part D and/or Medicaid drugs, insert: You pay \$0 for <all or the rest of> your prescription drugs covered by <Plan name>.]

What choices do I have?

If you **don't** want to be enrolled in <Plan name>, you'll have 3 months, after your coverage starts in <plan name> to change to another Medicare health plan. Your other choices, include:

- **Keep your current Medicare coverage or a similar option.** Call <State/enrollment broker number Service> at <State Customer Service number>, <days and hours of operation> and tell them you don't want to be in <Plan name> (you want to "opt out"). They can help you find out how to keep your current coverage or talk to you about similar choices available to you.
- Join a different plan that will include your Medicare, <Medicaid or State-specific Medicaid name>, and prescription drug benefits. Call <State's Customer Service Line> at <State Customer Service number>, <days and hours of operation>. TTY users should call <toll-free number>. Tell them you don't want to be in <Plan name> and you want to join a different plan.

[The next sentences must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 6: Model Notice for Requesting Information

Referenced in §30 and §30.3.2

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Thank you for submitting an application to enroll in <Plan name>. **We need additional information from you to process your application.**

Please provide this information:

☐ Information: _____

We need this information by <date>. You can provide this information in one of the following ways:

- Call us at <Medicaid phone number>, <days and hours of operation>.
- Fax this information to <State Medicaid fax number>.
- Mail this information to <State-specific Medicaid program name and address>.

If we don't get this information by <date>, your application to enroll in <Plan name> will be denied.

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

- ☐ <include list of available languages>
- ☐ <include list of accessible formats (like Braille, audio tape, or large print) >

[Optional field: If States deliver some documents electronically, insert language explaining the types of documents available to send and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]

[States should modify as appropriate:

If you have questions or if you need information in an accessible format or language other than what is listed above, call <enrollment broker> at <enrollment broker toll-free number> <hours of operations>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <hours of operation>.]

If you have questions about Medicare or <name of State Medicaid program>

- If you have questions about **Medicare**, visit www.Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day 7 days a week. TTY users should call 1-877-486-2048.
- If you have questions about **<name of State Medicaid program>**, call <Medicaid phone number>, <days and hours of operation>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 7: Model Notice to Confirm Enrollment

Referenced in §30.2.5, §30.5.2, §40.2.3, §40.2.3.3

<Member ID >
<Rx ID>
<Rx GRP>
<Rx BIN>
<Rx PCN>

KEEP THIS NOTICE FOR YOUR RECORDS

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You now have <Plan name > coverage.

Your <Plan name> health and prescription drug coverage will start on <effective date>. You'll get a Member ID Card in the mail. This notice is proof of coverage until you get your Member ID Card. *[For rapid re-enrollment State should remove the above paragraph and insert: **You now have <Plan name > coverage again.***

Because you have gotten your Medicaid back, you have been re-enrolled back into <Plan name > and now have coverage again. Your <Plan name> health and prescription drug coverage will start on <effective date>. You'll get another Member ID Card in the mail and will also receive a Welcome-back letter that will include instructions on how to get all of the important member information you received before. <Plan name> will also work with you to make sure you go back to the same care coordinator that you had before.]

How much do I have to pay for health care services?

You don't have to pay a plan premium, deductible, or copays when getting health services through a <Plan name> doctor. *[For rapid re-enrollment Plan should replace with: Just like before, you don't have to pay a plan premium, deductible, or copays when getting health services through a <Plan name> doctor.]*

How much do I have to pay for prescription drugs?

[If plan has any Part D cost sharing, insert the following paragraph and include LIS cost sharing information specific to the enrollee's LIS level: When you pick up your prescription drugs at our network pharmacy, you'll pay no more than <\$____> each time you get a generic drug that's covered by <Plan name> and no more than <\$____> each time you get a brand name drug that's covered by <Plan name>. Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact <Plan name> for more details.]

[If plan has any Medicaid cost sharing, insert copayment information here.]

[If plan has no cost sharing for all Part D and/or Medicaid drugs, insert: You pay \$0 for <all or the rest of> your prescription drugs covered by the plan.]

[If applicable, insert copays for Medicaid services.]

Can I leave <Plan name> or join a different plan after <effective date>?

- *[States that continue to implement a continuous Special Election Period for dual eligible beneficiaries (duals SEP) insert: Yes. You may leave <plan name> or choose a new Medicare-Medicaid Plan at any time during the year by calling <state/enrollment broker number>, <days and hours of operation>.]*
- *[States that implement the new duals SEP effective 2019, insert: You may leave <Plan name> during certain times of the year, known as election periods. In certain situations, you may also be eligible to leave <Plan name> at other times of the year. You can find out if you are eligible by calling <State/enrollment broker number>, <days and hours of operation>.]*
- If you leave <Plan name>, your coverage will end the last day of the month after you tell us you want to leave and don't want <State> to enroll you in another Medicare-Medicaid Plan.
- If you leave <Plan name> and don't join a Medicare health or prescription drug plan, you'll be covered under Original Medicare and Medicare will enroll you in a Medicare prescription drug plan.
- If you have concerns with <Plan name>, call <State> ombudsman at <ombudsman number>, <days and hours of operation>.
- If you would like to discuss other enrollment choices, you can speak with a <State Health Insurance Assistance Program (SHIP) counselor> at <SHIP phone number>, <days and hours of operation>.
- If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. This call is free.

[If the State delegates sending of this notice to the Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name>?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English

version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 8: Model Notice for Individuals Identified on CMS Records as Members of Employer or Union Group Receiving the Retiree Drug Subsidy (RDS)

Referenced in §30.2.5

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Important information about enrolling in <Plan name >

You currently have employer group or union health plan coverage with drug coverage as good as Medicare prescription drug coverage. It's important to know that if you enroll in <Plan name>, you and your dependents could lose your employer or union health coverage and other benefits offered by your employer.

What should I do now?

- **If you have other health or drug coverage, like through an employer or union, you or your dependents could lose your other health or drug coverage completely and not get it back if you join <Plan name>.**
- Read all the materials you get from your insurer or plan provider to learn how joining a <Plan name> may affect you or your family current coverage.
- Please contact your employer or union benefit administrator for more information on how joining <Plan name> will affect your coverage.
- You may not need to join a <Plan name> if you have other types of health and drug coverage from TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy.
- Contact your benefits administrator if you have questions about your coverage.

What do I have to do if I decide to join <Plan name>?

- You must confirm your choice by calling <State/enrollment broker number>, <days and hours of operations> within **30 days** of getting this notice to confirm you still want to join <Plan name>. Your effective date will be **<effective date>**.
- **You won't be enrolled unless you call.**
- If we don't hear from you within **30 days** from the date of this notice, you won't be enrolled in <Plan name>.

What if I decide not to join <Plan name >?

You do not have to do anything. You will keep your employer or union health coverage.

What if I have questions?

Call <State/enrollment broker> at <State/enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free.

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 9: Model Notice for Denial of Enrollment

Referenced in §30, §30.3.2, §30.3.3, and §30.2.5

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You're not enrolled in <Plan name>

You applied to get health and drug coverage through <Plan name>. You can't be enrolled in <Plan name> at this time because *[States should add reasons, as appropriate]*:

- *[You don't have Medicare Part A (Hospital Insurance). You must have Part A to join <Plan name >.]*
- *[You don't have Medicare Part B (Medical Insurance). You must have Part B to join <Plan name >.]*
- *[You don't have Medicaid. You must have Medicaid to join <Plan name >.]*
- *[You aren't lawfully present in the U.S.]*
- *[You don't meet your State's requirements to join <Plan name >.]*
- *[You have End-Stage Renal Disease (ESRD) (permanent kidney failure that requires a regular course of dialysis or a kidney transplant). If you ESRD, you can't join <Plan name >.]*
- *[You're incarcerated and currently reside outside of <Plan name>service area.]*
- *[You don't live in <Plan name's> service area.]*
- *[You didn't send the information we asked for by the requested date.]*
- *[Someone who isn't your authorized representative asked that you join <Plan name >. You or your authorized representative are the only people who can ask that you join <Plan name >.]*
- *[You have drug coverage through your job or union, and you told us you don't want to join <Plan name > because your coverage would change.]*
- *[You aren't eligible for all Medicaid benefits.]*
- *[You attempted to enroll outside of an enrollment period or don't qualify for an enrollment period at this time.]*
- *[Other (specify in detail)]*

[Insert when applicable: <Plan name> will send you a bill for any health services that <Plan name> paid for you.].] [Insert if the denial reason is unlawful presence or incarceration: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U.S. or if you're incarcerated.]

What if I disagree with the decision or have questions?

Call <State/enrollment broker> at <State/enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>.

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, < days and hours of operation>. For complaints, difficulty accessing care or other similar issues call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 10: Model Notice for CMS Rejection of Enrollment

Referenced in §30.5.2

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You're not enrolled in <Plan name>.

You applied to get health and drug coverage through <Plan name>. You can't be enrolled in <Plan name> at this time because *[States should add reasons, as appropriate]*:

- *[You don't have Medicare Part A (Hospital Insurance). You must have Part A to join <Plan name>.]*
- *[You don't have Medicare Part B (Medical Insurance). You must have Part B to join <Plan name>.]*
- *[You have End-Stage Renal Disease (ESRD) (permanent kidney failure that requires a regular course of dialysis or a kidney transplant). If you have ESRD, you can't join <Plan name>.]*
- *[You attempted to enroll outside of an enrollment period or you don't qualify for an enrollment period at this time.]*

<Plan name> will send you a bill for any health services that <Plan name> paid for you.

What if I disagree with the decision or have questions?

Call <State/enrollment broker> at <State/enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>.

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 11: Acknowledgement of Request to Cancel Enrollment

Referenced in §50.2.1

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

We got your request to cancel your enrollment into <Plan name >

We got your request for cancellation prior to <effective date>. Your request for enrollment has been cancelled, so you will not be enrolled in <Plan name>. **You will return to the Medicare health or drug plan in which you were originally enrolled.**

What should I do now?

- If you submitted your request to cancel your enrollment before <effective date>, you do not need to do anything.
- Since we got your request prior to <effective date>, be sure to tell your providers that **you will not be** enrolled in <Plan name>.
- Inform providers if they need to submit claims for your health services and prescription drugs, there may be a slight delay in updating your records.

What coverage do I have now?

If you were enrolled in another Medicare health or prescription drug plan before you enrolled in <Plan name>, you should automatically be enrolled back into that plan.

If you don't get an enrollment acknowledgement notice from your previous plan **within 2 weeks** of getting this notice, contact them to confirm your enrollment. They may request a copy of this notice for their records. See the next section for who you should call if you have questions.

Who should I call if I have questions?

If you have questions, call <State/enrollment broker> at <State/enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.

[If the State delegates sending of this notice to Medicare-Medicaid Plan , the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name>?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 12: Model Notice to Send Out Disenrollment Form

Referenced in §40.1

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

DISENROLLMENT FORM INCLUDED: USE THIS FORM TO LEAVE <Plan name> and ENROLL IN ORIGINAL MEDICARE

<Name>:

You asked us to send you a Disenrollment Form.

We included a Disenrollment Form with this notice. Before you fill out the form, please read this notice about your request to disenroll from <Plan name>.

When you leave <Plan name>, you will no longer have:

- One plan that combines all of your Medicare and <name of State Medicaid program> services
- A care coordinator to manage your providers and services and make sure you get the care you need
- *[insert if Plan offers additional services: Additional services that may be covered by this Plan]*
- One Member ID Card for your Medicare and <name of State Medicaid program> health care and prescription drug services

Use the Disenrollment Form only if you want to leave your current plan and enroll in Original Medicare.

- If you don't want <State> to enroll you in another Medicare - <name of State Medicaid program> plan in the future (opt-out), you should call <State/enrollment broker> at <State/enrollment number>, <days and hours of operation> and tell the representative you don't want to join a Medicare-Medicaid Plan.
- You should not fill out this form if you are switching to another Medicare health plan, including another Medicare - <name of State Medicaid program> plan. When you join another Medicare health plan, we will automatically disenroll you from <Plan name>.
- You should not fill out this form if you are joining a Medicare prescription drug plan. When you join a Medicare prescription drug plan, we will automatically disenroll you from <Plan name> into Original Medicare.

How do I submit my disenrollment form?

If you want Original Medicare and no prescription drug coverage, fill out the form, sign it, and:

- Mail the form to <State-specific Medicaid program name and address> in the return envelope, or
- Fax the form to us with a signature and date at <fax number>.

- Instead of filling out the form, you can visit <website address> or call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. You can also contact Medicare to disenroll from <Plan name>. To disenroll from <Plan name>, to get information about Medicare plans in your area, or to join a Medicare plan, visit www.Medicare.gov, or call toll free 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How will I get my Medicaid services?

If you leave <Plan name> [*State should include instructions on State-specific Medicaid disenrollment policies.*]

What if I have questions?

Please call <State/enrollment broker> at <State/enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free.

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 13: Model Disenrollment Form

Referenced in §40.1 and §40.1.3

<Plan name> Disenrollment Form>

Please keep this notice and a copy of the completed Disenrollment Form for your records. For more information on disenrollment, visit <website address> or call <state/enrollment broker> at <toll-free number number>, <days and hours of operation>. TTY users should call <toll-free number number>. If you would like to discuss other enrollment options, you can speak with a <SHIP counselor> at <SHIP phone number> <days and hours of operation>.

How can I disenroll from <Plan name >?

[Plans in states that continue to implement a continuous duals SEP for enrollment into an MMP insert: You can end your membership in <plan name> Medicare-Medicaid Plan at any time during the year.]

[Plans in states that implement the new duals SEP effective 2019, insert: You may end your membership in our plan during certain times of the year, known as enrollment periods. In certain situations, you may also be eligible to leave the plan at other times of the year.]

- Complete this form and send back to us by mail or fax (see directions at end of form); **or**
- Call <State/enrollment broker> at <State/enrollment number>, <days and hours of operation>. TTY users should call <toll-free number>; **or**
- Call toll free 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

What do I need to know if I disenroll from <Plan name >?

- You'll continue to get your health services from <Plan name> until the date your coverage ends. To find out when your coverage ends:
 - Call <State/enrollment broker toll-free number>. Be sure to find out before getting health and prescription services outside the <Plan name> network.
 - You'll get a notice telling you the date you'll no longer be a member of <Plan name> after we get this form from you or when you switch to another Medicare plan.
- If you don't enroll in another Medicare plan before the date your coverage ends in <Plan name>:
 - You'll have Original Medicare, and Medicare may enroll you in a Medicare prescription drug plan; **or**
 - <State> may enroll you in another Medicare-Medicaid Plan, unless you tell <State/enrollment broker> you don't want them to by opting-out.

You do **not** need to use this form or call <State/enrollment broker> if you're planning to enroll or have enrolled in a Medicare health or Medicare prescription drug plan, including another Medicare-Medicaid Plan. Enrolling in another Medicare plan will automatically disenroll you from <Plan name>.

To get information about Medicare plans available in your area, visit www.Medicare.gov, or call toll free 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

<Plan name> Disenrollment Form

1. Personal information:

Name (first, middle, last)		
Date of birth (month, day, year) (/ /) M M D D Y Y Y Y		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Phone number	Medicare number (located on your red, white and blue Medicare card)	Medicaid number (located on your State-specific Medicaid card)

<p>Medicare Card: <u>Name (as it appears on your Medicare card):</u> _____ <u>Medicare Number:</u> _____ <u>Is Entitled to:</u> _____ <u>Effective Date:</u> _____ <u>Hospital (Part A)</u> _____ <u>Medical (Part B)</u> _____</p> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	<p style="text-align: center;"><State Medicaid Logo></p> <p style="text-align: center;"><Medicaid Beneficiary></p> <p>Medicaid number _____</p>
--	---

2. OPTIONAL: Why are you disenrolling from <Plan name >?

--

3. If you **don't want to join a Medicare prescription drug plan or a Medicare-Medicaid Plan, place an ☒ in the one or both of the boxes below.**

- ☐ I **don't** want Medicare to automatically enroll me in a Medicare prescription drug plan.
- ☐ I **don't** want <State> to enroll me in another Medicare-Medicaid Plan.

4. Read & sign below:

You or your authorized representative (a person who acts on your behalf) must sign and date the form below. Signing this form confirms that:

You are authorized under State law to complete this disenrollment.

Medicare can ask for documentation that authorizes this individual to act on your behalf.

Your signature	Date
----------------	------

Representative's signature	Date
----------------------------	------

Authorized representatives must also complete the following information:

Representative's name		
Representative's address		
City	State	ZIP code
Representative's phone number () _____ - _____	Representative's relationship to enrollee	

Send us the form in one of two ways:

1. Mail your completed form to <State-specific Medicaid program name and address>.
2. Fax your completed form to <fax number>.

If you choose to mail or fax this form, please keep a copy of this form for your record.

[The preceding sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 14: Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member

Referenced in §40.1.3

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

We got your request to disenroll from <Plan name>.

You'll be disenrolled from <Plan name> on <date>. <Plan name> will not pay for your *[Medicare or Medicare and <name of State Medicaid program>]* health services and prescription drugs after <date>.

You'll be covered by Original Medicare starting <date>.

You'll get your Medicare health services through Original Medicare starting <date> if you don't enroll in a Medicare health plan. When you see a provider through Original Medicare, you should use your red, white, and blue Medicare card to get health care services.

If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

IMPORTANT: You need to choose a Medicare Prescription Drug Plan.

When <Plan name> services end on <date>, <Plan name> prescription drug coverage ends too. You can enroll in a Medicare Advantage plan that includes prescription drug coverage or a Medicare Prescription Drug Plan.

- If you don't select a new prescription drug plan, Medicare will enroll you in one.
- If you don't want to join a Medicare prescription drug plan, you must call 1-800-MEDICARE.
- If you need help comparing prescription drug plans or would like to discuss other enrollment choices, you can speak with a <State Health Insurance Assistance Program (SHIP) counselor> at <SHIP phone number>, <days and hours of operation>.
- If you don't want <State> to enroll you in another Medicare-Medicaid Plan in the future, you must call <State/enrollment broker> at <State/enrollment broker >, <days and hours of operation> to opt-out. If you have questions or would like to join a Medicare Advantage or Medicare prescription drug plans, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

[If beneficiaries must enroll in a Medicaid health plan to get their Medicaid benefits insert the following paragraph:

You must choose a <name of State Medicaid program> health plan to get your <name of state Medicaid program> benefits.

[States will need to modify this language] If you don't choose another <name of State Medicaid program> health plan, you'll be assigned to <plan should insert either a <name of State Medicaid program> health plan or the <name of State Medicaid program> plan offered by <plan sponsor>.]

[If beneficiaries get Medicaid services through FFS, please include the following language. States will modify this language:

You'll still get <name of State Medicaid program> services.

Starting <date>, you'll get Medicaid services and can see any provider that accepts Medicaid. If you have general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. If you have complaints, difficulty accessing care, or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

Your health coverage change will become effective soon.

It may take up to 45 days for your records to be updated. If your providers need to send claims, tell them that you just left <Plan name> and there may be a short delay in updating your records.

[If the State delegates sending of this notice to Medicare-Medicaid Plan , the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name >?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

If you have questions about Medicare or <name of State Medicaid program>

- If you have questions about **Medicare**, visit www.Medicare.gov, or call toll free 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- If you have questions about <name of State Medicaid program>, call <Medicaid phone number>, <days and hours of operation>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 15: Model Notice to Request Information (Disenrollment)

Referenced in §40.1

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

We need more information from you.

We got your request to disenroll from <Plan name>, but we are missing some information. We need the information below to process your request to disenroll from <Plan name>.

[States should add reasons, as appropriate. States that add Other as a reason should include a simple description or example.]

- **[Your signature.** please sign your form.]
- [During certain times of the year, Medicare doesn't let you disenroll unless you meet certain special exceptions, such as you've moved out of the plan's service area. Please call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number> to determine if you're able to disenroll at this time. The call is free]
- **[You or an authorized representative** need to tell us you would like to leave <Plan name>. Someone who is not your authorized representative asked that you leave <Plan name>. You or your authorized representative is the only ones who can request that you leave <Plan name>.]

Please send us this information right away so we can process your request.

- Call us at <toll-free number> to give us the information over the phone, **or**
- Fax the information to us at <fax number>, **or**
- Mail the information to us at:
 <State>
 <Mailing address>
 <City>, <State> <ZIP>

If you don't give us this information by <date>, you will stay in <Plan name> .

Other ways to disenroll from <Plan name> :

You can also call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours days, 7 days a week to ask to leave <Plan name>. TTY users should call 1-877-486-2048.

[If the State delegates sending of this notice to Medicare-Medicaid Plan , the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name>?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 16: Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)

Referenced in §40.1.3

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You're <Plan name> coverage is ending.

You'll no longer be in <Plan name> as of <date>.

If you think there was a mistake:

If you didn't ask to leave <Plan name> and want to stay in <plan>, call <State/enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name>?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

If you have questions about Medicare or <name of State Medicaid program>:

- If you have questions about **Medicare**, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- If you have questions about <name of State Medicaid program>, call <Medicaid phone number>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 17: Model Notice for Denial of Disenrollment

Referenced in §40.1.3

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You've asked to be disenrolled from <Plan name >. We can't process your request to disenroll from <Plan name > because:

[Insert the following as appropriate:

You didn't send us the information we needed by <date>.

Or

You have attempted to make a change outside of an enrollment period.

Or

The request was made by someone other than you and that person isn't your authorized representative.]

If you think we made a mistake or you have questions:

- If you have any questions about the information in this notice, call <State/enrollment broker> at <State/enrollment broker number>, <days and hours of operation>. The call is free. TTY users should call <toll-free number>.
- For questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>.
- For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation> for more questions about the enrollment.
- For information on your Medicare coverage, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 18: Model Acknowledgement of Request to Cancel Disenrollment

Referenced in §50.2.2

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You're enrolled in <Plan name >.

We've got your request to cancel your disenrollment from <Plan name>. You'll continue to get your health and prescription drug services through <Plan name>. Keep using <Plan name> primary care *[insert the term the plan uses (e.g., Provider or Physician. State may also insert "physicians", "doctors", or "providers", if that is more appropriate)]* for your health care services and a network pharmacy for your drugs.

IMPORTANT: You need to cancel other Medicare or prescription drug plan coverage before it starts.

If you've recently applied to join a Medicare health or prescription drug plan, but you want to remain in <Plan name>, you must call the other plan and tell them to stop processing your application.

[If the State delegates sending of this notice to Medicare-Medicaid Plan , the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name >?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP> number>, <days and hours of operation>. For complaints, difficulty accessing care or similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

For information on your Medicare coverage, visit www.Medicare.gov , or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English

version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 19: Model Notice for Disenrollment Due to Out of Area Status (No Response to Request for Address Verification)

Referenced in §40.2.1.3

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

IMPORTANT: Your health care & prescription drug coverage will change on <effective date>.

On <date of notice requesting address verification>, you were sent a notice asking if you moved out of the <Plan name> service area. Because you didn't reply, **you've been disenrolled from <Plan name> on <disenrollment effective date>**. This means that beginning <effective date>, <Plan name> will no longer cover any health care services or prescription drugs you get.

To be a member of <Plan name>, you must live in the <Plan name> service area and can only temporarily leave the service area for up to 6 months in a row. This is because <Plan name> is providing coverage to you as part of <State Demonstration name>. The <State Demonstration name> is not offered nationwide. This program is only offered through <Plan name> in certain services areas within your State

You'll be covered by Original Medicare starting <effective date>.

- You'll get your Medicare health care services through Original Medicare starting <effective date> if you don't enroll in a Medicare health plan. When you see a provider through Original Medicare, you should use your red, white, and blue Medicare card to get health care services.
- You have the option to enroll in another Medicare health plan. If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You may need to choose a new Medicaid plan.

[States will need to modify this language] You may need to choose a Medicaid health plan to get Medicaid benefits. If you moved to a different State, you'll need to apply for Medicaid in that State.

Your prescription drug coverage has also changed.

Your drug coverage through <Plan name> ended on <effective date>. If you want prescription drug coverage, you need to join a Medicare Prescription Drug Plan or a Medicare Advantage plan with prescription drug coverage. If you don't choose a Medicare drug plan, Medicare will choose one for you.

You can join a new Medicare plan.

If you don't want health coverage through Original Medicare, you can join a new plan that serves the area where you now live. You may have up to two months to join a new Medicare Advantage Plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about plans that may serve your area. TTY users should call 1-877-486-2048.

What to do if you disagree with your disenrollment from <Plan name>.

If you don't agree with your disenrollment in <Plan name>, you can file a grievance asking us to reconsider our decision. Please call <State/enrollment broker> at <State/enrollment broker number>. TTY users should call <toll-free number> for information about how to file a grievance.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name>?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <State/enrollment broker> at <State/enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 20: Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)

Referenced in §40.2.1.3

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

IMPORTANT: Your health care & prescription drug coverage has changed.

Thank you for telling us your new address. Your permanent address is outside the <Plan name> service area. To stay a member of <Plan name>, you must live in the <Plan name> service area, but you can temporarily leave the service area for up to 6 months in a row. This is because <Plan name> is providing coverage to you as part of <State Demonstration name>. The <State Demonstration name> is not offered nationwide. This program is only offered through <Plan name> in certain services areas within your State. You will no longer be a member of <Plan name> as of disenrollment effective date. Because you've been disenrolled, <Plan name> won't cover any health care services or prescription drugs you get after effective date.

You'll be covered by Original Medicare starting <effective date>.

- You'll get your Medicare health care services through Original Medicare starting effective date if you don't enroll in a Medicare health plan. When you see a provider through Original Medicare, you should use your red, white, and blue Medicare card to get health care services.

You may need to choose a new Medicaid plan.

[States will need to modify this language] You may need to choose a Medicaid health plan to get Medicaid benefits. If you moved to a different State, you'll need to apply for Medicaid in that State.

Your prescription drug coverage has also changed.

You won't have any prescription drug coverage through <Plan name> starting effective date. If you want prescription drug coverage, you need to join a new Medicare Prescription Drug Plan or a Medicare Advantage plan with prescription drug. If you don't choose a Medicare drug plan by disenrollment effective date, Medicare will choose one for you.

You can join a new Medicare plan.

If you don't want health coverage through Original Medicare, you may join a new plan that serves the area where you now live. Visit www.Medicare.gov call toll-free number 1-800-MEDICARE (1-800-633-4227) for information about plans that serve your area. TTY users should call 1-877-486-2048.

- You have up to two months to enroll in another Medicare health plan. If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- If you don't enroll in a Medicare health plan during this special two-month period, you may have to wait until <insert beginning of next quarter> to enroll in a new plan. You may not enroll in a new Plan during other times of the year unless you meet certain special exceptions.

What to do if you disagree with your disenrollment from <Plan name >.

If you don't agree with your disenrollment in <Plan name>, you can file a grievance asking us to reconsider our decision. Look in your <EOC document name> for information about how to file a grievance.

If you've moved, you must also tell Social Security & Medicaid [or State-specific Medicaid program] your new address.

If you've moved, call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) and tell them your new address. TTY users should call 1-800-325-0778. The call is free. You can also change your address and phone number by going to my Social Security account at: <https://www.ssa.gov/myaccount/>. You can also call <State/enrollment broker> at <State/enrollment broker number>. TTY users should call <toll-free number>.

Call Medicaid at [\[plan should submit appropriate information\]](#) to tell them your new address and to find out your choices for getting Medicaid benefits. If you've already called Social Security and Medicaid and told them your new address, you don't need to call again.

[If the State delegates sending of this notice to Medicare-Medicaid Plan , the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name >?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 21: Model Notice for Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status - Notification of Involuntary Disenrollment

Referenced in §30.2.5, §40.2.3, §40.2.3.3

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Your health & prescription drug coverage is changing.

[Insert if individual lost Medicaid status: Your <Plan name> health and prescription drug coverage will end on <date> because you no longer qualify for <name of State Medicaid program>. <Plan name> can cover your health and prescription drug benefits only if you're eligible for both Medicare and <name of State Medicaid program>.]

[Insert if individual lost State-specific status: Your <Plan name> health and prescription drug coverage will end on <date> because you no longer qualify to be enrolled in <Plan name> <Plan name> can cover your health and prescription drug benefits only if you're eligible for both Medicare and <name of State Medicaid program> and <any State-specific eligibility requirements>.]

You'll be in Original Medicare and have a Medicare Prescription Drug Plan.

- When your <Plan name> services end on <date>, <Plan name> prescription drug coverage ends too. Medicare will enroll you in Original Medicare and in a Medicare Prescription Drug Plan.
- If you need help comparing prescription drug plans or would like to discuss other enrollment choices, you can speak with a <State Health Insurance Assistance Program (SHIP) counselor> at <SHIP phone number>, <days and hours of operation>.
- If you have questions or don't want Medicare to enroll you in a drug plan, you must call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **If you need to fill any covered prescriptions before your new Medicare Prescription Drug Plan coverage starts**, call Medicare's Limited Income NET program (also called LI NET) at 1-800-783-1307, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can also visit www.humana.com/pharmacists.

What to do if you want stay in <Plan name>.

<Plan name> can only cover your health services until <date>. If you think you might still qualify for <name of State Medicaid program>, please call <State/enrollment broker> at <State/enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>. This call is free. *[Insert other pertinent information about where person can re-apply for Medicaid].*

[States that are participating in rapid re-enrollment should insert the following:]

What happens if I get my Medicaid Back?

If you get your Medicaid back within 60 days from the date of this letter, you will be enrolled back into <Plan name> starting the month after you get Medicaid again. You'll have all of the same services you had before, have the same care coordinator, and be able to see all of the same providers.

If you **don't** want to be enrolled in <Plan name>, you have other choices, including:

- **Keep your current Medicare coverage or a similar option.** Call <State/enrollment broker number Service> at <State Customer Service number>, <days and hours of operation> and tell them you don't want to be in <Plan name> (you want to "opt out"). They can help you find out how to keep your current coverage or talk to you about similar choices available to you.
- Join a different plan that will include your Medicare, <Medicaid or State-specific Medicaid name>, and prescription drug benefits. Call <State's Customer Service Line> at <State Customer Service number>, <days and hours of operation>. TTY users should call <toll-free number>. Tell them you don't want to be in <Plan name> and you want to join a different plan.

You can join another Medicare plan if you don't get your Medicaid back.

- Because you no longer qualify for <name of State Medicaid program> and you're no longer eligible for <Plan name> after **<date plan ends>** due to you losing your Medicaid, you have up to **3 months** after **<date plan ends>** to join a Medicare health plan or Medicare prescription drug plan.
- Your new Medicare coverage will begin the 1st of the following month after you enrolled in a new Medicare health plan or Prescription Drug plan. If you don't take any action, <Plan name> will continue to cover your Medicare benefits until **<date plan ends>**.
- You can only make changes to your Medicare Prescription Drug Plan or Medicare health plan coverage during Annual Open Enrollment. Annual Open Enrollment happens every year from **October 15 through December 7**.
- There are exceptions to when you can make changes. You can leave a plan at other times during the year if:
 - You move out of the plan's service area,
 - You want to join a plan in your area with a 5-star rating, **or**
 - If your Extra Help ends, you can still make a change for three months after you find out that you are not getting Extra Help.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name>?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>, <days and hours of operation>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and

hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

If you have questions about Medicare or <name of State Medicaid program>:

- If you have questions about Medicare, visit www.Medicare.gov, or call toll-free number 1-800-633-4227 (1-800-MEDICARE) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- If you have questions about <name of State Medicaid program>, please call <Medicaid phone number>, <days and hours of operation>.

[The next sentences must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 22: Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid

Referenced in §40.2.3.2

KEEP THIS FOR YOUR RECORDS

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name >:

You no longer qualify for <name of State Medicaid program>.

Your health and prescription drug benefits will no longer be covered by <Plan name> because you're no longer eligible for both Medicare and <name of State Medicaid program>. Even though you're no longer eligible for Medicaid, you can continue to get your benefits from <Plan name> for up to **2 months**. To stay a member of <Plan name>, you must qualify for <name of State Medicaid program> by *<insert end date for period of deemed continued eligibility>*.

How long will I have coverage?

<Plan name> will continue to cover your benefits until *<insert end date for period of deemed continued eligibility>*. You have **2 months** to re-qualify for Medicaid.

When will my coverage end?

If you don't qualify for <name of State Medicaid program> within **2 months**, you'll be disenrolled from <Plan name>, and you'll get coverage through Original Medicare and a Medicare Prescription Drug Plan starting *<insert first of the month following the end date for period of deemed continued eligibility>*.

What can I do if I want to stay in <Plan name >?

<Plan name> can only cover your health and drug services until **<date period of deemed continued eligibility ends>**. If you think you may still qualify for <name of State Medicaid program>, call <State> at <State customer service number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. *[Insert other pertinent information about where person can re-apply for Medicaid]*.

What do I do if my coverage ends?

If you're disenrolled from <Plan name>, Medicare will enroll you in Original Medicare and a Medicare drug plan. You don't need to do anything for this to happen. If you don't want Medicare to enroll you in a drug plan or you have questions, call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You can join another Medicare plan.

Because you no longer qualify for <name of State Medicaid program> and you're no longer eligible for <Plan name> after **<date plan ends>**, you have up to **3 additional months** following

the end of your 2-month grace period to join a Medicare health or prescription drug plan. This means that you have two months from <date plan ends> to join a Medicare Advantage or Medicare prescription drug plan if you wish. If you choose this option, your new Medicare health or drug coverage will begin the **1st day** of the following month after you enrolled in the new health or drug plan.

You can make changes to your Medicare benefits only during certain times of the year.

- You can only make changes to your Medicare Prescription Drug Plan or Medicare health plan coverage during Annual Open Enrollment. Annual Open Enrollment happens every year from **October 15 through December 7**.
- There are exceptions to when you can make changes:
 - You can leave a plan at other times during the year if:
 - You move out of the plan's service area,
 - You want to join a plan in your area with a 5-star rating, or
 - If your *extra help* ends, you can still make a change for 3 months after you find out that you are not getting extra help.

Who should I contact if I have questions?

- **If you have questions about <Plan name>:**
 - Visit <web address>
 - Call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free.
 - Call <State/enrollment broker> at <State/enrollment broker number>.
- **If you have questions about Medicare:**
 - Visit www.Medicare.gov
 - Call toll-free number 1-800-633-4227 (1-800-MEDICARE) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **If you have questions about <name of State Medicaid program>:** call <Medicaid phone number>, <days and hours of operation>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 23: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status

Referenced in §40.2.4 and §50.3

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

To the Estate of <Name>:

Our records show <name> has passed away. Please accept our condolences.

Because of this report of death, <name>'s coverage in <Plan name> *[Insert: ended or will end]* as of <disenrollment effective date>.

If this information is wrong and you've already contacted Social Security, disregard this notice. If this information is wrong and you have not contact Social Security, here's how to fix this information:

- Call Social Security at toll- free 1-800-772-1213 (Monday to Friday 7am – 7pm) to have the record corrected. TTY users should call 1-800-325-0778. **Ask Social Security to give you a notice that says they've fixed your records.**
- Send a copy of Social Security's notice to<State> in the enclosed postage-paid envelope. You can also fax this information to <fax number for the State>. When we get this notice, we'll share this information with Medicare and Medicaid.

Note: Please keep using <Plan name> primary care *[insert the term the plan uses (e.g., Provider or Physician. Plans may also insert “physicians”, “doctors”, or “providers”, if that is more appropriate]* for your health services and network pharmacies while your records are being corrected by Social Security.

If you have questions

If you have any questions about this notice, call <State> at <State customer service number >, <days and hours of operation>. TTY users should call <toll-free number>.

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English

disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 24: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination

Referenced in §40.2.2, §50.3, and §50.3.1

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

[IMPORTANT: Your Medicare coverage has been corrected.]

Or

[IMPORTANT: Your Medicare coverage may end. Act now.]

We learned that your Medicare coverage has ended as of <date>. You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan name>.

*[States that **are** able to verify current Medicare entitlement insert:
Social Security and Medicare will correct your record.]*

Or

*[States that **are not** able to verify current Medicare entitlement insert:*

To stay in <Plan name>, do these 2 things no later than <insert the date that is 60 days from date of disenrollment notice>:

- Call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) to have them fix your records. TTY users should call 1-800-325-0778. **Ask Social Security to give you a notice that says they’ve fixed your records.**
- Send a copy of Social Security’s notice to <State> in the enclosed postage-paid envelope. You may also fax this information to <fax number of the State>.
- When we get this notice, we’ll share this information with Medicare and Medicaid.]

Please keep using your <Plan name> primary care *[insert the term the State uses (e.g., Provider or Physician. States may also insert “physicians”, “doctors”, or “providers”, if that is more appropriate]* for your health care services and your network pharmacy while your record is being corrected by Social Security and Medicare.

If you don’t have Medicare Part *[insert “A” and/or “B” as appropriate]*, or if you don’t send proof that you have Medicare by *[insert date: 60 days from date of disenrollment notice]*, you’ll have to pay for any health care service and prescription drug coverage you got after <disenrollment date>.

If you have any questions about this notice, call <State> at <State customer service number >, <days and hours of operation>. TTY users should call <toll-free number>. The call is free.

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 25: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to State or Plan Error

Referenced in §50.2.2 and §50.3

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

You’ve been re-enrolled in <Plan name> as of <effective date>.

Thank you for letting us know you still want to be a member of <Plan name>. By mistake, we *[select one based on the circumstance: disenrolled you from or cancelled your enrollment in]* our plan. *[Insert brief summary of the State/plan error that caused the disenrollment.]* We’ve corrected our records to show that you’re still a member of <Plan name>.

Please keep using your <Plan name> primary care *[insert the term the plan uses (e.g., Provider or Physician. States may also insert “physicians”, “doctors”, or “providers”, if that is more appropriate)]* for your health services and network pharmacy for your prescriptions.

[Insert one of the following sentences depending on plan policy:

You’ll get a new Member ID Card and other information for <Plan name>.

Or

Keep using the <Plan name>

Below are instructions on how to access the following items you already got when you were enrolled before:

- List of Covered Drugs (also called a “formulary”) *[Insert instructions for accessing soft copy of List of Covered Drugs.]*
- Provider and Pharmacy Directory *[Insert instructions for accessing soft copy Provider and Pharmacy Directory.]*
- Member Handbook (Evidence of Coverage) *[Insert s instructions for accessing a soft copy of the Member Handbook.]*
- Summary of Benefits with the welcome mailing: Summary of Benefits *[Insert instructions for accessing a soft copy of the Summary of Benefits.]*

[If the State delegates sending of this notice to Medicare-Medicaid Plan , the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name >?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

Thank you for your continued membership in <Plan name>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 26: Model Notice to Closeout Request for Reinstatement

Referenced in §50.3.2

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Your <Plan name> health services and prescription drug coverage have ended.

Your <Plan name> health services and prescription drug coverage ended on <effective date>.

You were sent a notice on <date of notice> asking you to send us information. This information was due to us by <date>. Because you didn't send this information by <date>, your health services and prescription drug coverage are no longer covered by <Plan name>.

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name>?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

For information on your Medicare choices, visit www.Medicare.gov, or call toll free 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 27: Model Acknowledgement of Reinstatement

Referenced in §50.2.1, §50.3, §50.3.1, and §50.7

KEEP THIS NOTICE FOR YOUR RECORDS

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

<State Name>has enrolled you back in <Plan name > as of <effective date>.

There will be no break in your health services and prescription drug coverage. You should keep using <Plan name> primary care *[insert the term the plan uses (e.g., Provider or Physician. Plans may also insert “physicians”, “doctors”, or “providers”, if that is more appropriate]* for your health care services and network pharmacy for your prescription drugs.

[Insert one of the following sentences depending on plan policy:

You’ll get a new Member ID Card and other information for <Plan name>.

Or

Keep using the <Plan name Member ID Card that you currently have.

Or

Call us at call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number> < if you can’t find your Member ID Card and need a new one.]

Or

Call us at call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number> < if you can’t find your Member ID Card and need a new one.]

Below are instructions on how to access the following items you already got when you were enrolled before:

- List of Covered Drugs (also called a “formulary”) *[Insert instructions for accessing soft copy of List of Covered Drugs.]*
- Provider and Pharmacy Directory *[Insert instructions for accessing soft copy Provider and Pharmacy Directory.]*

- Member Handbook (Evidence of Coverage) *[Insert instructions for accessing a soft copy of the Member Handbook.]*
- Summary of Benefits with the welcome mailing: Summary of Benefits *[Insert instructions for accessing soft copy of Summary of Benefits.]*

[If the State delegates sending of this notice to Medicare-Medicaid Plan , the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name >?

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 28: Acknowledgement of Request to Opt Out of Passive Enrollment into Medicare-Medicaid Plan (not connected to request to disenroll or cancel enrollment in MMP)

Referenced in §30.2.5

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

We got your request not to be enrolled in <Plan name >.

You told us you don't want <name of State Medicaid program> to enroll you in a Medicare-Medicaid Plan. We have notified <name of State Medicaid program> and <Medicare> and they will not enroll you again.

Important: If you were enrolled in another Medicare Advantage plan or Medicare prescription drug plan before enrolling with <Plan name>, you should be automatically enrolled back into that plan.

If you don't get an enrollment acknowledgement notice from your previous plan within **two (2) weeks** of receiving this notice, please contact them to confirm your enrollment. They may request a copy of this notice for their records.

You can change your mind about your coverage.

- If you change your mind and decide you would like to join <Medicare-Medicaid Plan >, call <enrollment broker> at <enrollment broker number>, <days and hours of operation>. TTY users should call <TTY number>. The call is free.
- To learn more about <Medicare-Medicaid Plan >, visit <web address>, or call Member Services at <toll-free number>,>, <days and hours of operation>. TTY users should call <TTY number>, <days> from <time> to <time>.The call is free.
- During certain times of the year, Medicare doesn't let you change plans unless you meet certain special exceptions, such as you've moved out of the plan's service area. If you have questions about when you can change plans, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman's number>, <days and hours of operation>.]

If you have questions about Medicare or <name of State Medicaid program>:

- If you have questions about **Medicare**, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- If you have questions about **<name of State Medicaid program>**, call <Medicaid phone number>, <days and hours of operation>.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 29: Model Notice for Enrollment Status Update

Referenced in §50.7

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Your enrollment in <Plan name > has changed.

[Insert one or more of the following, including sufficient detail to describe the specific enrollment change:]

You'll now get your health care services and prescription drug coverage through <Plan name >.

Your <Plan name> coverage starts <start date> and ends <end date>. *[Plan should insert information about how to access coverage, etc.]*

Or

You'll now get your health care services and prescription drug coverage through <new Plan name >.

Your enrollment in <name of old plan> has been changed to <name of new plan>. Your coverage with <new Plan name > starts <date>. *[Plans should insert information on cost sharing information, and other details the individual will need to ensure past and future coverage is clear.]*

Or

Your <Plan name > health care services and prescription drug coverage will start on <date>.

Your coverage in <Plan name> will start on <date>. This date is earlier than you were originally told. *[Plans should include information about coverage, and how to get refunded for prescriptions purchased in the period of retroactive coverage.]*

Or

Your <Plan name > health care services and prescription drug coverage will start on <date>.

Your coverage in <Plan name> will start on <date>. This date is later than you were originally told. *[Plans should insert information about impact to paid claims.]*

Or

Your <Plan name > health care services and prescription drug coverage [ended or will end] on <date>.

Your coverage in <Plan name> [ended **or** will end] on <date>. This means you [don't **or** won't] have coverage through <Plan name> after this date. *[Plans should insert appropriate descriptive information, such as impact on paid claims or how to submit claims, as applicable.]*

Or

Your enrollment in <Plan name> will end soon.

Your <Plan name> health services will end on <date>. This means you won't have coverage through <Plan name> after this date. *[Insert information about impact to any paid claims.]*

[Insert other pertinent and appropriate information regarding the enrollment status update and the resulting impact to the beneficiary as necessary.]

[If the State delegates sending of this notice to Medicare-Medicaid Plan, the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name>?

If you have questions, you can visit <web address or call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can also call <enrollment broker> at <enrollment broker number>. The call is free]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman at <Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 30: Model Notice to Research Potential Out of Area Status – Address Verification Form included

Referenced in §40.2.1.3

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

IMPORTANT: We need your address.

If you don't contact us to verify your address, you will be disenrolled from <Plan name > effective <disenrollment effective date>. This means that you will no longer be able to get health services or prescription drug coverage through <Plan name> as of <disenrollment effective date>.

If you've moved, you may no longer live in <Plan name >'s service area. Please provide your new address by <day prior to the disenrollment effective date>.

- **How to provide your address**

Call <phone> <days> from <hours>. TTY users should call <TTY number>. The call is free.

- Fill out the "Address Verification Form" and return it in the enclosed envelope or by fax.

Your permanent address must be inside <Plan name >'s service area.

You can be away from <Plan name>'s service area for up to 6 months in a row and still stay a member of <Plan name>. If you move and your new address is outside the service area, or if you leave the area for more than 6 months in a row, you'll be disenrolled from <Plan name>'s health services and prescription drug coverage. If you're disenrolled, you may be able to join a plan that serves the area where you now live.

You must also tell Social Security about your address change.

If you've moved and haven't told Social Security your new address, call toll-free number 1-800-772-1213 (Monday to Friday 7am – 7pm). TTY users should call 1-800-325-0778. The call is free. You can also change your address and phone number by going to my Social Security account at: <https://www.ssa.gov/myaccount/>

[If the State delegates sending of this notice to Medicare-Medicaid Plan , the Medicare-Medicaid Plan should insert:

Who should I call if I have questions about <Plan name >?

If you have questions, you can visit <web address> or call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. You can also call <enrollment broker> at <enrollment broker number>, <days and hours of operation>.]

[States should modify as appropriate:

If you have questions, call <enrollment broker> at <enrollment broker number>, <days and hours of operation>. TTY users should call <toll-free number>. For general questions about other enrollment choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operations>. For complaints, difficulty accessing care or other similar issues you can call your <State> Ombudsman < Ombudsman number>, <days and hours of operation>.]

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Address Verification Form

What is your permanent address?

Provide the permanent address where you live. This can't be a P.O. box.

Address		
City	State	ZIP code
County	Phone	

What is your temporary address?

(You may skip this section if you're living at your permanent address.)

Address		
City	State	ZIP code
County	Phone	
When did you begin living at this address?	When do you think you'll go back to your permanent address?	

Where you would like to get your mail?

Address		
City	State	ZIP code

Send us the form in one of two ways:

1. Mail your completed form to <address>.
2. Fax your completed form to <fax number>.

For more information, visit <web address>. **If you have questions**, call <Plan name> at <toll-free number>, <days and hours of operation>. The call is free.

Exhibit 31: State 60-day Notice for Passively Enrolled Individuals (a 30-day passive reminder notice, Exhibit 5, is also required)

Referenced in §30.5.1

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Important: You're being enrolled in a new health & drug plan.

There are new health plans available for <year> designed to help your Medicare and <Medicaid or State-specific Medicaid name> (sometimes called "Medicaid") benefits work better together and better for you. You won't lose any of your current benefits. Your new plan will include:

- Your full Medicare benefits, including prescription drug coverage
- Your full <Medicaid or State-specific Medicaid name> benefits, including <benefit>, <benefit>, and <benefit>
- New benefits and services that aren't available to you now, including <the convenience of only having to carry one insurance card>, <detail>, and <detail>

Can I join one of these plans?

- **Yes. You don't have to do anything to join a new plan. If you don't make another choice, you'll be automatically enrolled in <Plan name> starting <date>.**
- <Plan name> will send you a new health and drug card to use. This new card will replace the cards you use now. For more information on your new plan and the benefits and services that will soon be available to you, call <number>, <days and hours of operation>.
- Enrollment in <Plan name> means that you can only see providers that are in the <Plan name> network.

Expect to get a notice from your Medicare Part D Prescription Drug Plan or Medicare Advantage organization saying that your coverage will be ending. You will continue to get your prescription drug benefits from your current plan until your new prescription coverage from the <Plan name> plan starts. You will not lose your prescription drug coverage at any time.

Do I have other choices?

- **Yes.** You'll have 3 months, as of the effective date of your enrollment into <plan name> to change to another Medicare health plan. Your other choices include:
Keep your current Medicare coverage or a similar option. Call <State/Enrollment Broker> at <State/Enrollment Broker number>, <days and hours of operation> TTY users should call <toll-free number> and tell them you don't want to be in <Plan name> (you want to "opt out"). They can help you find out how to keep your current coverage or talk to you about similar choices available to you.
- **Join a different plan that will include your Medicare, <Medicaid or State-specific Medicaid name>, and prescription drug benefits.** These plans are similar to <Plan name>, but may include different benefits and services or have a different network of

providers, pharmacies, and other health care providers. There are several of these plans available in your area, including:

<Demonstration Plan 1>

<Demonstration Plan 2>

<Demonstration Plan 3>

- If you choose to join one of these plans, call <State's Customer Service Line> at <State Customer Service number>, <days and hours of operation> and tell them you don't want to be in <Plan name> and you want to join one of the plans above. Call by <date> to make sure you get your plan materials in time for the start of your coverage.

What should I do now?

Before making any decisions about your health care coverage, review all of your choices carefully. To talk about your choices, call <State's Customer Service Line> at <State Customer Service number>. When you decide which option is best for you:

- **To enroll in <Plan name>**, you don't have to do anything.
- **To choose another option** (listed under "Do I have other choices?" on page 1), call <State's Customer Service Line> at <State Customer Service number> by <date>.

Important: If you don't call and choose another health care option by <date>, you'll be automatically enrolled in <Plan name>.

[Plans should include the following paragraph they intend to conduct early assessments:]

What happens next?

Someone from our health plan will call you to talk about your health and service needs before your services start on <enrollment effective date>. You can choose to wait until your services start before answering these questions. If you choose to wait, we will set a time after your enrollment date to discuss your health and service needs.]

Where can I get more information?

- If you need help understanding information you get from plans or for free, personalized health insurance counseling, or need help comparing your health care choices, you can also call your State Health Insurance Assistance Program (SHIP) at <SHIP number>, <days and hours of operation>. For complaints or other similar issues
- You can contact your <State> Ombudsman at <Ombudsman number>, <days and hours of operations>. If you have questions about Medicare or need help with your Medicare choices, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE.
- If you're not sure who to call to get help, ask a family member or friend to help explain this notice to you.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English]

version.] **For more information**, visit <web address>. **If you have questions**, call <State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 32: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Incarceration

Referenced in §40.2

KEEP THIS FOR YOUR RECORDS

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

The Social Security Administration (SSA) reported information to Medicare that shows you are incarcerated. As a result, you will no longer have coverage through <Plan name> as of **<effective date>**. Your Medicare prescription drug coverage will also end on **<effective date>**. You will now have Original Medicare but will not be able to access services due to your current incarceration status.

What if I think there's been a mistake?

If you are not incarcerated or think that there has been a mistake, please call us at <phone number>, <days and hours of operation>. TTY users should call <TTY number>.

What happens to my Medicare, Medicare prescription drug coverage, and Medicaid?

While you are incarcerated, you are not eligible for coverage in <name of State demonstration program>. You will have Original Medicare but will not be able to access services due to your current incarceration status.

What happens when I am released and no longer incarcerated?

When you are released, you need to report your release to SSA, and contact your local Medicaid office to reapply for Medicaid and join a <name of State demonstration program> plan.

You will have a special opportunity to join a Medicare health or Part D plan. *This opportunity begins the month you are released and lasts for two additional months.* If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

Your new Medicare coverage will begin the 1st of the following month after you enrolled in a new Medicare health plan or Prescription Drug plan.

Who can I call to get more information?

[If the State delegates sending of this notice to Medicare-Medicaid Plan s, the Medicare-Medicaid Plan should insert:

If you have questions, you can visit <web address> or call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number TTY number>. You can also call <enrollment broker> at <enrollment broker number>, <days and hours of operation>. The call is free]

[States should modify as appropriate:

If you have any questions about this notice or about your Medicaid, you can call <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.] You can call Social Security at 1-800-772-1213, Monday through Friday, 7 am - 7 pm, if you have questions about your incarcerated status. TTY users should call 1-800-325-0778.

If you have questions about your Medicare coverage, you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also call <Plan name> at <toll-free number> if you have questions. TTY users should call <toll-free number TTY number>. The call is free.

Thank you.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Exhibit 33: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence

Referenced in §40.2.7, §50.2.1, §50.2.7

KEEP THIS FOR YOUR RECORDS

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

The Social Security Administration (SSA) reported information to Medicare that shows you are not lawfully present in the United States. As a result you will no longer have coverage through <Plan name> as of <effective date>. Your Medicare prescription drug coverage will also end on <effective date>. You will now have Original Medicare but will not be able to access services due to your current unlawful presence status.

What if I think there's been a mistake?

If you are lawfully present in the U.S. or think that there's been a mistake, please call us at <phone number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free.

What happens to my Medicare, Medicare prescription drug coverage, and Medicaid?

While you're unlawfully present in the United States, you're not eligible for coverage in the <name of state demonstration> program. You will have Original Medicare but won't be able to access services due to your current unlawful presence status.

What happens if I become lawfully present in the United States?

If you become lawfully present in the U.S. in the future and report it to SSA, contact your local Medicaid office and reapply for Medicaid to join a <name of State demonstration program> plan.

You can join a Medicare health or Medicare prescription drug plan. Your new Medicare coverage will begin the 1st of the following month after you enroll in a new Medicare health plan or Prescription Drug plan.

If you become lawfully present in the U.S. in the future and report it to SSA, you will have a special opportunity to join a Medicare health or Part D plan. This opportunity begins the month you regain lawful presence status and lasts for two additional months. If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

Who can I call to get more information?

[If the State delegates sending this notice to Medicare-Medicaid Plans, the Medicare-Medicaid Plan should insert:

If you have questions, call <Plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number TTY number>. You can visit <web address>. You can also call <enrollment broker> at <enrollment broker number>.]

[States should modify as appropriate:

If you have any questions about this notice or about your Medicaid, you can call <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.]

You can call Social Security at 1-800-772-1213, Monday through Friday, 7 am - 7 pm, if you have questions about your lawful presence status. TTY users should call 1-800-325-0778.

If you have questions about your Medicare coverage, you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also call <Plan name> at <toll-free number> if you have questions. TTY users should call <toll-free number TTY number>. We are open <days and hours of operation>.

Thank you.

[The next sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.] **For more information**, visit <web address>. **If you have questions**, call

<State/enrollment broker> at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.