DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

MEDICARE ENROLLMENT & APPEALS GROUP

DATE: August 18, 2015

TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, Section 1876 Cost Organizations

FROM: Arrah Tabe-Bedward
Director, Medicare Enrollment & Appeals Group

SUBJECT: Revisions to Good Cause Processes for Contract Year 2016

The purpose of this memorandum is to inform Prescription Drug Plan (PDP) sponsors, Medicare Advantage (MA) organizations, and §1876 cost plans of revised guidance related to reinstatement of enrollment for good cause.

Background:
On February 12, 2015, the Centers for Medicare & Medicaid Services (CMS) published "CMS-4159-F2, Contract Year 2016 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" (80 FR 7912) which included a provision to allow CMS to designate another entity, such as an MA organization, Part D plan sponsor, or entity offering a cost plan, to act on its behalf to review good cause requests following involuntary disenrollment for non-payment of plan premiums and to effectuate reinstatements of enrollment when good cause criteria are met. As further described in the 2016 Call Letter, starting January 1, 2016, CMS will assign the good cause process to plans, with the expectation that they perform the work from start to finish (that is, intake, research, decision, notification, and effectuation). Our expectation is that plans will develop their own internal processes for reviews, based on our guidance, and carry out the majority of this workload without involving CMS. CMS will continue to process good cause reinstatement requests from individuals disenrolled by CMS for failure to pay the Part D income related monthly adjustment amount (Part D-IRMAA).

Guidance:
The policies outlined within this memorandum apply to §1876 cost plans, Part D plan sponsors, all MA plan types, and Program for All-Inclusive Care for the Elderly (PACE) organizations.

As of January 1, 2016, individuals disenrolled for non-payment of plan premiums who wish to request reinstatement for good cause will be directed to contact the plan from which they were disenrolled. For cost plans, this includes requests from individuals disenrolled for non-payment

of other charges, such as deductible or coinsurance amounts, in addition to non-payment of premiums.

Individuals who request good cause reinstatement must make their request within 60 calendar days of the disenrollment effective date. Reinstatement is permitted for good cause only in rare situations in which the member (or the individual responsible for paying the member's premiums) was unable to make or arrange for timely payment (i.e., within the plan's grace period) due to circumstances over which he or she had no control and could not reasonably be expected to foresee. As such, circumstances that result in a favorable good cause determination are generally limited to situations in which the individual was incapacitated for a significant portion of the plan's grace period or had a significant, life-changing event that prevented the ability to pay the owed amounts within the grace period. Examples include an extended period of hospitalization that was not planned in advance, death of a spouse, loss of home from fire or other natural disaster, or a situation or event resulting in the declaration of a federal or state emergency.

Upon receipt of a reinstatement request for good cause, plans will verify that the request is made within the 60-day timeframe and will obtain the individual's credible statement of the unforeseen circumstance(s) and his or her willingness and ability to pay all the owed amounts within three months of the disenrollment effective date. The plan will then review the statement to assess whether it meets the regulatory standards and issue a favorable or unfavorable determination. If the plan makes a favorable determination, it should send notification to the individual within three calendar days of making that determination to convey the amount owed and the deadline for making full payment in order to be reinstated.

If the individual receives a favorable good cause determination and makes full payment of the amounts owed within three months of the disenrollment effective date, the plan should reinstate the individual's coverage and, within five calendar days, submit the reinstatement request to CMS' retroactive processing contractor to update CMS systems.

The processing of reinstatement requests for individuals disenrolled by CMS for failure to pay Part D-IRMAA is not changing. CMS will continue to receive those requests, make the determinations and notify plans of any favorable determinations. Plans remain responsible for notifying the individual and collecting any owed plan premiums required for the individual's reinstatement into the Part D plan.

Also, in response to a question regarding the option of an individual to challenge a plan's unfavorable good cause determination, we reiterate that such determinations cannot be appealed as they are not organization or coverage determinations subject to the appeal requirements in parts 417 subpart Q (cost plans), part 422 subpart M (MA plans) and part 423 subpart M (Part D plans). Complaints received by CMS subsequent to a plan's determination will be reviewed by CMS and, if CMS determines the plan acted inappropriately, may be included in CTM metrics.

Model notices for plan determinations have been updated and will be available when the revised enrollment guidance materials are posted, as described below. The revised guidance will include

examples of circumstances and the corresponding favorable or unfavorable good cause determination that would be made for that case.

Timing of Policy Implementation:
CMS will transfer this responsibility to plans starting January 1, 2016, such that plans will be responsible for the intake and processing of good cause reinstatement requests for individuals disenrolled effective December 31, 2015, and later.

CMS is in the process of developing an oversight protocol under which we will review both favorable and unfavorable good cause decisions to ensure that the plans' processing of all such cases is in line with our guidance.

The revised guidance and model materials will be incorporated into the MA, PDP, and cost plan enrollment guidance materials posted at the links below within 10 business days of this memorandum:

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

It is expected that organizations are already in the process of developing the internal processes and procedures necessary to assume responsibility for the receipt, review and effectuation of the good cause process as of January 1, 2016. We urge plans to complete this preparation well in advance of this implementation date. Please direct questions regarding the submission and/or review of member materials to your CMS Account Manager. For enrollment policy questions, please submit your inquiry to PDPENROLLMENT@cms.hhs.gov and copy your CMS Account Manager.