Medicare-Medicaid Plan Enrollment and Disenrollment Guidance

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The CMS Medicare-Medicaid Financial Alignment Initiative serves people who are enrolled in both Medicare and Medicaid, also known as dual eligibles or Medicare-Medicaid enrollees. The goal of the Initiative is to ensure Medicare-Medicaid enrollees 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, reflecting policy/operational flexibilities that have been implemented from June 2013 to date:

- New and appropriate outreach and beneficiary notification practices to ensure that beneficiaries are kept informed along the way but not overwhelmed with unnecessary information. **Note:** National model notice templates have gone through beneficiary testing and Plain Language Review. The results of those reviews have been incorporated into the national templates to provide beneficiaries with more clear and succinct information.
- New operational tools developed to synchronize enrollment status in state, CMS, and MMP enrollment systems, and
- Policy changes made since 2013 to further improve enrollment processes while preserving beneficiary protections.

This revised guidance is effective starting contract year 2017. All MMP enrollments with an effective date on or after January 1, 2017, must be processed in accordance with the guidance requirements. This includes important beneficiary protections such as rules around accepting elections, timeframes for submitting them to CMS, and using model enrollment forms and notices.

This guidance has been updated under the assumption that States will continue to administer the enrollment process, including enrollments, disenrollment, 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 CMS prior approval, States may delegate some of these activities to the MMPs. 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.

States administering the enrollment process will have to update not only their system, but CMS' MARx enrollment system. CMS has developed the Enrollment Reconciliation Toolkit, available at www.medicare-solution.com, to provide tools to support on-going enrollment reconciliation. Please also see §50.6 for details on enrollment reconciliation. States (or delegated MMPs) 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 (available to assist States with submitting enrollment-related files to CMS), please visit: www.medicare-solution.com.

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

While States are assumed to have the lead on administering 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-81 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-108 (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/mapdhelpdesk/Plan_Communications_User_Guide.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/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 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/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 bases 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 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/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/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.

On an ongoing (i.e., month to month) basis, individuals who meet the criteria for enrollment in MMPs may:

- Switch from Original Medicare to an MMP;
- Switch from a Medicare health or drug plan to an MMP;
- Switch from an MMP to a Medicare health or drug plan;
- Switch from one MMP to another MMP;
- Switch from an MMP to Original Medicare;
- Switch from an MMP to a PACE organization; or
- If applicable, additional choices specific to Medicaid benefit, as specified in Appendix 5.

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, or disenroll from, a MMP. The election periods are applicable to enrollment in MMPs (as it is considered a type of Medicare Part D prescription drug plan). For the Initial Coordinated Election Period, individuals may elect a plan up to three months in advance of the month in which their entitlement to Medicare Part A and enrollment into Medicare Part B are effective.

There are "Special Enrollment Periods" that permit changes at additional times during the year. Medicare-Medicaid enrollees who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program have a continuous Medicare Special Enrollment Period (SEP) to request enrollment in or disenrollment from a Medicare health or drug plan. This SEP begins the month the individual becomes dually-eligible and exists as long as he/she is eligible for both Medicare and Medicaid. This SEP permits individuals to enroll into or disenroll from MMPs in any month, including switching MMPs. The effective date of an election made using this SEP is the first of the month following receipt of the enrollment or disenrollment request.

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.

Individuals who are no longer eligible for Title XIX benefits, have an SEP beginning the month they receive notice of the loss of eligibility plus two additional months to make an enrollment choice in an Medicare Advantage or Part D plan, even if the loss of eligibility is determined retroactively by the State. Please see §40.2.3 regarding involuntary disenrollment from the MMP based on loss of Medicaid eligibility.

20.1 - 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/her legal representative signed the enrollment form or submitted 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.

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 –

- "TBQ" query (http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/TBQData.pdf),
- "BEQ" process (See Section 3 of the PCUG Main Guide – Accessing the CMS Systems for Eligibility Verification and see pages F-47~F-59 of the Appendices of PCUG for the detailed BEQ file layout),
- MARx online query (M232 screen), 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.

20.2 - Effective Date of Voluntary Disenrollment

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

When a member voluntarily disenrolls from an MMP, he/she will remain in the MMP until the last day of the month in which the disenrollment request was received, 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/she is eligible for the Medicare Part D Low Income Subsidy and did not elect a Part D plan. If a member elects a Medicare health or drug plan while still a member of an MMP, he/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 §20.1 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/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 (or the MMP on its behalf) must determine eligibility for enrollment into the MMP and provide within 7calendar days of receiving the enrollment request, one of the following:

- Combined Enrollment Acknowledgement/Confirmation notice - Exhibit 4 (as described in §30.5.1); or
- Notice of denial - Exhibit 9 (as described in 30.3.3).

As described in §30.5, the State may use a 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 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 (or the MMP on its behalf) must send the notice of rejection within 7 calendar days of receiving the DTRR (see Exhibit 10).

States will notify CMS via the Enrollment Vender 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 online query (M232 screen), since eligibility must be verified via one of these sources for all enrollment requests. The systems (BEQ or MARx online 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 these bases at that time.

For those who are incarcerated or unlawfully present, as indicated in CMS systems, the State (or delegated MMP) 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 (or delegated MMP) 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 plan 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 (TRR). However, under no circumstances should a State (or delegated MMP) 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 (or delegated MMP) 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 specific model enrollment form has been developed for enrollment into MMPs (see Exhibit 1).

States should 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 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/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 plan.

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 via the Internet

States may develop and offer the option for individuals to submit enrollment requests into 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 related to the online enrollment process for CMS approval.
- Provide beneficiaries with all the information required by State-specific Demonstration Marketing Guidelines.
- At a minimum, comply with CMS' internet 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 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.
- Provide the CMS Office of Information Services with a pro forma notice of intent to use the Internet for these purposes. The notice is essentially an attestation that the MA organization is complying with the required encryption, authentication, and identification requirements. **Note:** CMS reserves the right to audit the MA organization to ascertain whether it is in compliance with the security policy.
- Advise each individual at the beginning of the online enrollment process that he/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 online 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.
- If a legal representative is completing this enrollment request mechanism, he/she must attest that he/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/she will be enrolled (if approved by CMS), and that he/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 online enrollment is limited to requests submitted via the State's or state's enrollment broker website. Online enrollment via other means, such as a plan broker or plan website, is not permitted except in the instances when the State has delegated enrollment to the MMP.

Note that 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. The requirements outlined in this section are applicable to telephonic enrollment requests based on both inbound and outbound calls:

- 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/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.

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. In addition, as provided under §70.6 of the Medicare 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.

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 one 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 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.

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); or
- If applicable, meet additional state-specific requirements in Appendix 5.

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 and Medicaid claim 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.

ii. States may not passively enroll individuals into an MMP offered by an organization that is either an outlier in CMS' past performance analysis and/or has 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

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 organization is no longer considered by CMS to be a past performance outlier and/or no longer has an LPI on the Medicare Plan Finder, the MMP may qualify to receive other passive enrollments.

1. 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. We will consider sufficient MMP contracting experience 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:

iii. 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.

iv. Analysis of any MMP monthly reported data.

v. 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.

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 at minimum 30-day (Exhibit 5) and 60-day notices (Exhibit 31) prior to their use.

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 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:

A. 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 opt out at any point prior to the passive enrollment effective date, the State must send an opt-out transaction (TC 83) within 7 calendar days 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) 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.

g) 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. On-Going 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, or monthly). 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. The Early 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

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 on-going passive enrollment opportunities and §30.2.5 sections L and M under 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;
- New dually eligible individual auto-enrolled by CMS to a PDP effective any month in current calendar year (reference in section above 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; and
- New dually eligible individuals who had Medicare first.

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 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/she will be passively enrolled in the MMP on the specified effective date if he/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 she/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. The 60 day passive enrollment notice will inform individuals of their eligibility for a Medicare Special Enrollment Period (SEP) that allows them to request prospective enrollment in a Medicare health plan (Medicare Advantage plan, cost plan or PACE Program) or into Original Medicare and a Medicare Part D plan, even after the passive enrollment takes effect.

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. 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 DTRR. Beneficiaries may opt out verbally or in writing. Once a beneficiary has opted out, the State must document this and exclude him/her from future passive enrollment processing.

The State should counsel the individual to ensure he/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 cancel the passive enrollment with an enrollment cancellation transaction (TC 82) showing an MMP Opt-Out Flag data element as "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 disenrollment after the effective date of a passive enrollment, the State must disenroll the individual prospectively by submitting a disenrollment transaction (TC 51) showing an MMP Opt-Out Flag data element as "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.

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 voluntarily enroll into a MMP.

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 opting-out of the MMP passive enrollment and the Part D auto-enrollment process, and 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.

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 Retirement Drug Subsidy (RDS).

When selecting individuals for passive enrollment in the MMP, the State (or the State enrollment broker) must actively check all available systems (e.g., State systems, CMS' Territory Beneficiary Query (TBQ,) Batch Eligibility Query (BEQ), or 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 accompanying with **or** without 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:

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)

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, which the State may be aware of 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

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. 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. Reassignment

occurs in October each year, with enrollment into a new PDP effective the first of the following January.

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). An individual included in Medicare reassignment effective January of a given year may NOT be passively enrolled into an MMP any earlier than January of the following year. If a beneficiary will 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 will be reassigned. For example, the State receives the record from CMS indicating that the beneficiary will be reassigned effective January 1, 2017. The State may passively enroll, per CMS guidance below, the beneficiary effective January 1, 2017, effectively canceling 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, 2017to January1, 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. Beneficiary Health Insurance Claim Numbers (HICNs);
   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 whom they will passively enroll effective January 1 of the following year;
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 re-assignment 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 reassigned effective the upcoming 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. States should calculate the application date for monthly passive enrollments using the same methodology as other passive enrollments, i.e., that it should be the same as the date the transaction is submitted to CMS' MARx enrollment system.

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 "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 Medicare-only). For those individuals in the Medicare-first 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.

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:

RxBIN – Benefit Identification Number
RxPCN – Processor Control Number
RxID – Identification Number
RxGRP – 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.

30.3 - Processing the Opt-in Enrollment Request

When States receive requests to voluntarily enroll into MMPs, they need 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 sex, Health Insurance Claim 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 requiring 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/her Medicare card when mailing in the enrollment form. Regardless of whether or not the State has reviewed the Medicare Identification 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 has received 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 "sex" 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/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) 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 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.

When none of the Medicare beneficiary eligibility queries show Medicare entitlement, the State must consider the individual's Medicare ID card to be evidence of Medicare entitlement. When neither the BEQ/MARx/MAPDIUI query nor the Medicare ID card is available, the State must consider an SSA Award Notice that shows Medicare entitlement (including start dates) as evidence of Medicare entitlement.

If the State is not able to verify entitlement as described above, refer to §40.2.2 for additional procedures.

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 must 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 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). As with passive enrollments, if the State or CMS systems show a discrepancy in the enrollment status then the 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 to 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 individual's 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 and approval from the CMT:

1. The MMP is ready for marketing, including their website with all required materials.
2. 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 HRA, and that completion of the HRA is opt-in.
3. The MMP may reach out no sooner than 20 days before the effective date of the passive enrollment.
4. The MMP must emphasize the HRA is opt-in, and ask if the beneficiary wants to participate in the HRA at that time or later after the enrollment is effective.
5. 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.
6. 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.

7. The CMT will disapprove use of this policy for an MMP if concerns relating to its use are identified, including encouraging sicker members to disenroll.
8. 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 chooses to obtain CMT approval to conduct HRAs prior to the coverage effective date then later changes to conducting HRAs on or after the coverage effective date, the MMP must notify the CMT before implementing this change.

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

1. If a beneficiary's HRA is completed prior to the beneficiary's effective date of coverage, the MMP shall report the completion (Core 2.1 and 2.2), as if it were conducted on the first effective date of coverage;
2. If a beneficiary's HRA is completed prior to the beneficiary's effective date of coverage, the MMP shall complete the beneficiary's Individualized Care Plan (ICP) within the contractually required 30 days of when the HRA was conducted. The MMP shall report the ICP completion (CA 1.1, 1.2, 1.3, 1.4 and 1.5) as if the HRA were conducted on the first effective date of coverage; and
3. The MMP shall notify to the CMT if the MMP intends to discontinue conducting HRAs prior to the enrollment effective date. This notification shall occur no later than 60 days prior to implementing the change.

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/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/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/her relationship to the individual and date he/she signed the enrollment form or completed the enrollment request; however, if he/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. 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/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 SSA to handle the individual's finances, States should contact the representative payee to determine his/her legal relationship to the individual, and to ascertain whether he/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

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. The State must make this determination and, within 10 calendar days of receipt of the enrollment request, must notify the individual that additional information is needed, unless the required but missing information can be obtained via CMS or State systems.

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/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/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/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/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/she wants to enroll the in the MMP, the State must resubmit the enrollment transaction (TC 61) with the employer subsidy enrollment override flag field 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 plan also include Medicare Advantage (contract numbers that start with "H") or Part D (contract numbers that start with "S" whose plan benefit package ID numbers start with "8", employer-Sponsored plans (i.e., contract numbers that start with "E" **but that 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 voluntarily requests 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/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 to voluntarily enroll should be effectuated only after he/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 she/he does not want to be enrolled, the State should submit a MMP enrollment cancellation transaction (TC 82) and an MMP Opt-Out Update transaction (TC 83) to opt them out of future passive enrollment into the MMPs. The State should inform the beneficiary of the difference between opting-out of the MMP passive enrollment and the Part D auto-enrollment process, and 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 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 follow whichever reading level and translation requirements outlined in the State-specific Demonstration Marketing Guidelines. 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. Any notices that the State decides to delegate to the MMP must include the federal-state contracting disclaimer and will be issued a Marketing Number by CMS. Please see the State-specific Demonstration Marketing Guidelines at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

National model notice templates have gone through beneficiary testing and Plain Language Review. The results of those reviews have been incorporated into the national templates to

provide beneficiaries with more clear and succinct information. 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 (or MMP, if State delegates certain notifications to the MMP), 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.

1. For opt-in enrollments, the State may satisfy this requirement by issuing a separate acknowledgement notice or by including the required acknowledgement information in a single, combined enrollment acknowledgement and enrollment confirmation notice:
   - Two separate notices (see Exhibit 3 and 7):
     - A notice acknowledging receipt of the completed enrollment request (see Exhibit 3) and showing the effective date of coverage. This notice must be provided no later than 10 calendar days after receipt of the completed enrollment request.
     - When CMS' MARx system confirms enrollment is processed, a confirmation of enrollment notice (see Exhibit 7). This notice must be provided no later than 10 calendar days after receipt of confirmation on CMS' Daily Transaction Reply Report ;
   - A single, combined enrollment acknowledgment and confirmation notice (see Exhibit 4):
     The combination notice takes the place of separate acknowledgement and confirmation notices and so requires expedited issuance. To use the combination notice, the State must be able to provide this notice within 7 calendar days of the availability of the DTRR. Additionally, when following this option to use the combination notice, 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. For opt-in enrollments, the State must also provide the evidence of the enrollment request to the individual, as follows:

   - For paper enrollment requests, a copy of the individual's completed paper enrollment form, if the individual does not already have 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).

3. For passive enrollments, the State must send a 60-day notice (see Exhibit 31) 60 days prior to the effective date and a 30-day notice (see Exhibit 5) 30 days prior to the effective date. The State, or MMP, must also send a welcome notice (see Exhibit 5b) for enrollee receipt 30 days prior to the effective date. Please note that MMPs will receive confirmation from the CMS Daily Transaction Reply Report 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). <u>This document is not required at the time of enrollment for opt-in enrollments</u>. 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 voluntarily enroll.

   - A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the MMP.

   - A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits, or a separate notice alerting enrollees how to access or receive the directory, consistent with the requirements of the Medicare Marketing Guidelines and the State-specific Demonstration Marketing Guidelines.

   - Proof of health insurance coverage so that he/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 opt-in to the demonstration (opt-in enrollment), the MMP **must** provide the following materials for enrollee receipt no later than ten (10) calendar days from receipt of CMS confirmation of 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.
        - A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits, or a separate notice alerting enrollees how to access or receive the directory, consistent with the requirements of the Medicare Marketing Guidelines and the State-specific Demonstration Marketing Guidelines.
    - A single 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/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/she has used plan services after the effective date.
    - The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the 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, 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/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/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 not as actually complete if the member or his/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. It 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 (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 LINET transitional PDP during any coverage gap.

40.1 - Voluntary Disenrollment by Member

A member may request disenrollment from an MMP in any month and for any reason. 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/MMP;
3. Calling 1-800-MEDICARE;
4. Calling the State's enrollment broker; or
5. 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 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 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).

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/she wants to opt out of future passive enrollments into MMPs. If the individual indicates she/he wants to opt out of future passive enrollments, the State should submit the disenrollment transaction (TC 51), showing an MMP Opt-Out Flag data elements as "Y" (opted out of passive enrollment) in position 202.This individual may enroll in a MMP in the future by submitting a voluntary enrollment request.

40.1.1 - Request Signature and Date

When providing a written, opt-in 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/she signed the disenrollment request; however, if he/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 on-line; and whether directly to the State or forwarded by the via 1-800-MEDICARE/DTRR, or other mechanism. Since Medicare beneficiaries have the option of disenrolling from the MMP by calling 1-800-MEDICARE or by enrolling in a Medicare health plan or Medicare prescription drug plan, the State will not always receive a request for disenrollment directly from the member and will instead learn of the disenrollment through the DTRR.

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 claim 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 opt-in 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).

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 entitlement to either Medicare Part A or Part B (§40.2.2);
3. The member loses Medicaid eligibility or additional State-specific eligibility requirements (§40.2.3);
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); or
6. The individual materially misrepresents information to the MMP regarding reimbursement for third-party coverage (§40.2.6);
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.

Unlawful Presence - A member who is not lawfully present or loses lawful presence in the United States. (8 CFR 241.5) Individuals who are ineligible due to unlawful presence may not request for an enrollment into an MMP or remain enrolled in a MMP.

Notice Requirements - In situations where the State disenrolls the member involuntarily on any basis except death, or loss of Medicare entitlement or 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; and
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.
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 for selecting a new MMP if it is available in the new service area he/she is moving to.

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 an Medicare health plan or Part D plan (either a PDP or MA-PD) for which he/she is eligible in his/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/she permanently moves out of the service area;
2. The member's temporary absence from the service area exceeds 6 consecutive months;
3. The member is incarcerated and, therefore, resides out of area; or
4. The member is not lawfully present.

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/her legal representative notifies the State that he/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 month in which the individual indicates he/she will be moving.

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.

Disenrollment for **reason 2 (**§ 40.2.1.1) above is effective the first day of the calendar month after 6 months have passed.

Disenrollment for **reason 3 (**§ 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.

Disenrollment for **reason 4 (**§ 40.2.1.1) is effective the first day of the calendar month following the first date of unlawful presence. Please see §40.2.8 regarding involuntary disenrollment from the MMP based on unlawful presence status.

Unless the member elects a Medicare health plan, any disenrollment processed under these provisions will result in a change to enrollment in Original Medicare and CMS will auto-enroll him/her into a Medicare Prescription Drug Plan except for disenrollment due to incarceration or unlawful presence (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 become 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 contacting the member in writing). States may obtain either written or verbal verification of changes in address, as long as the State applies the policy consistently among all members. 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 (e.g. 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/she will be leaving the service area. If the member did not inform the State of when he/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 materials mailed first-class by the State or MMP as undeliverable.

In the event that any member materials are returned as undeliverable, the State must take the following steps:

1. If the USPS returns mail with a new forwarding address, forward materials to the member and advise him/her to change his/her address with the Social Security Administration.
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/her to update his/her records, if necessary, with the Social Security Administration 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. Going to "*my* Social Security" 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.socialsecurity.gov/locator/.

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 addresses 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 Plan'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/mapdhelpdesk/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 or MMP's 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 or MMP 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 receives a DTRR on January 20 indicating an "out of area" State and County Code. The 6-month period ends on July 20. The State sends a notice to the member to determine if a residence change has occurred (Exhibit 30) within 10 calendar days of receipt of the DTRR and does not receive any response from the member indicating this information is incorrect. 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/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/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).

Notice Requirements – CMS strongly suggests that notices be provided when the disenrollment is due to the loss of entitlement to either Medicare Part A or Part B (see Exhibit 24) so that any erroneous disenrollments can be corrected as soon as possible. The State may send the 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/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. Please note that all rapid re-enrollment transactions submitted by the State (§40.2.3.3) to the MMP must be accepted.

Individuals who experienced a short-term loss of Medicaid retain the option to voluntarily 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.

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.

An individual who was passively enrolled into the MMP and subsequently loses eligibility and is disenrolled may not again be passively enrolled in the same calendar year into a MMP upon regaining Medicaid or State-specific eligibility. States are limited to only one passive enrollment of the individual in a calendar year, following parameters outlined in §30.2.5.

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 two-month 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 or individuals who recently lost dual-eligible 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 members 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/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 be put in Original Medicare and 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 within 10 calendar days of learning of the loss of Medicaid eligibility. This notice must provide the member an opportunity to prove that he/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 or 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 which such individuals are eligible (see Exhibit 21).

40.2.3.3 – Rapid Re-enrollment

If an individual is involuntarily disenrolled due to a loss in Medicaid States may opt to 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 60 days from the effective date of disenrollment. Rapid re-enrollment is effective the first day of the following month the individual re-establishes Medicaid and regains full dual eligible status. Please note that it is the expectation that States work with Plans to ensure that when possible, individuals who are rapidly re-enrolled are placed back into the same enrollee-care coordinator relationship that they had prior to their disenrollment.

States (or delegated MMPs) 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 deeming (see section 40.2.3 and 40.2.3.2) in States with MMPs that adopt deeming. 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 deeming. Individuals who opt-out of passive enrollment are not eligible for future passive enrollments (see §30.2.5 E) for the life of the demonstration.

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

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/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 – Following receipt of a decedent's death information, the State is strongly encouraged to send a notice to the member's estate (see Exhibit 23) so that any erroneous disenrollments can be corrected as soon as possible. If the disenrollment occurred due to erroneous death 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/Nonrenewals

The State must disenroll a member from an MMP if the MMP's contract with CMS is terminated or if the MMP is discontinued or reduces its service area to exclude the member.

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 they are able to request enrollment in an Medicare health or Part D plan (PDP or MA-PD) for which he/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 Medicare Prescription Drug Plan, and can access the LINET transitional PDP during any coverage gap.

Notice Requirements - The State must give each Medicare 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. There is no national model for this notice; customized versions are developed when this situation arises.

When a Demonstration is ending within a State, the last date for new enrollments must occur no later than six months before the Demonstrations end date. For example, if a demonstration ends on 12/31; new enrollments can come thru up to 6/30 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 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 Contract Management Team 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 CMTCMT 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 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. States should also expect to receive an involuntary disenrollment notification via the DTRR using specific TRC 346 (Prisoner Suspension Period Cancel/Disenroll) indicating beneficiary's benefits have been suspended due to a confirmed incarceration period. 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 processes, 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.

SSA confirms and provides due process for individuals with an incarceration status prior to sending the data to CMS and before the individuals 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 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, 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 – 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 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.

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 individuals 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 are strongly encouraged to send an involuntary disenrollment notice due to unlawful presence (see Exhibit 33) or 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. This is to ensure that the member is aware of the loss of MMP coverage and any erroneous disenrollments 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.

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 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/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/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' 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. 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;
- 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 Notice Requirements); and
- That the State or MMP then provided written notice of its intent to request involuntary disenrollment (see 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.

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. The CMT will notify the State within 5 (five) business days after making its decision.

Should the request be approved, 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. 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 will be disenrollment;
- **Notice of intent** to request the State and CMT' 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 explain that his/her continued behavior may result in involuntary disenrollment and that cessation of the undesirable behavior may prevent this action. The MMP must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS and the State.

Note: 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.

Notice of Intent – If the member's disruptive behavior continues despite the MMP's efforts, the MMP must notify him/her of its intent to request the State and CMS' permission to disenroll him/her for disruptive behavior. This notice must also 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. The MMP must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS 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, a statement that this action was approved by the State and CMS and meets the requirements for disenrollment due to disruptive behavior described above. The State may only provide the member with this required notice after the CMT notifies the State of its approval of the request.

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 CMS and the State.

If the CMT does not approve the request to diseroll, the State should provide the member with written notice, notifying them of that decision. If the disruptive behavior does not cease after the member receives notice that they will NOT be disenrolled, 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.

40.4 - Processing Disenrollments

Unless otherwise directed by CMS, 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 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 or the MMP);
- 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 or 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 discontinues use of MMP services 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 Appendix 3, 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/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 disenroll 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 MAO #1 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 a 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 a 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.

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 the 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 §30.2.5 E.

Valid cancellation and opt-out requests made in writing 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 CMS. 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 canceling 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/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 generally cannot be processed. The State must inform the beneficiary that he/she is a member of the MMP. If he/she wants to return to his/her former Medicare plan or enroll in another Medicare plan, he/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/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 member must be informed that

he/she will be a member of the plan 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/she should enroll into a Part D plan to receive Part D drug coverage; otherwise he/she will be automatically enrolled into a Medicare Prescription Drug Plan and have access to the LINET 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 to do so 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/she will remain enrolled in Original Medicare and that he/she will be automatically enrolled into a Medicare Prescription Drug Plan and have access to the LINET 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/she will have to 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 ten (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/she was disenrolled due to items 1, 2, 5, 6 or 7 listed above, and states that he/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, plan systems should indicate active membership as of the date the MMP or 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 Part A or Part B;
- Erroneous lawful presence status; or
- Erroneous incarceration information.

States are strongly encouraged to send these notices, to ensure any erroneous disenrollments are corrected as soon as possible. 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 CMS (or its 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 (See Exhibit 24).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 plan 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 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 a 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 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 MMP or State error, the MMP or 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 (if State delegates to MMP, or 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 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 26).

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/pages/retro.sops.asp). 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 voluntary 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/pages/retro.sops.asp). Once processed, CMS will retrieve any capitation payment for the retroactive period.

A retroactive disenrollment request must be submitted by the State to CMS (or 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 of these instructions. 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 or MMP's confirmation of an incarcerated status with a retroactive start date (see §40.2.1.3), the State or MMP 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.

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 (please see, Model Medicare-Medicaid Plan Enrollment Forms & Notices) 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.

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 identity 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. Whenever possible, the state should submit a corrective transaction request before the enrollment becomes effective.

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 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/mapdhelpdesk/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 is used by the States and their enrollment brokers referred in §50.3, 50.3.1, 50.3.2, 50.3.3, 50.4, and 50.5. Delegated MMPs must follow the existing RPC Standard Operating Procedures (http://www.reedassociates.org/pages/retro.sops.asp) 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 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 as provided in CMS enrollment guidance. 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's 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 MMP or State must send the materials required in CMS enrollment guidance that would be provided for any new enrollment. MMPs or 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 canceled" 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.

TRC	Beneficiary Communication Action
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, MMPs or States should follow existing CMS enrollment guidance for providing notice and confirmation of the disenrollment. However, since many UI initiated-changes are retroactive, MMPs or 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 MMP or State has already provided notice reflecting this 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, or 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 microfilm, as long as microfilm versions of enrollment forms and disenrollment requests showing the signature and the date are available to reviewers. Similarly, other technologies that would allow the reviewer to access signed forms and other enrollment elections may also be allowed, such as optically scanned forms stored on disk. 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	Language preference and alternative 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, organization 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 SHIP must submit paper request to State within 2 business days.

Enrollment Request Mechanism	Application Date	Special Notes
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 §302.5, 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.

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.), and therefore determines it 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 Special Election Period (SEP) begins the month the individual becomes dually eligible and exists as long as he or she receives Medicaid benefits. "Dual-Eligible" individuals may elect a plan or change his or her current plan election anytime throughout the calendar year.

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 anytime to enroll in the new Medicare plan throughout the year**. 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) - For the purposes of completing an enrollment request, the State must verify Medicare entitlement for all enrollment requests including, but not limited to, either the MMA/TBQ response, CMS Enrollment Vendor's Medicare Beneficiary Database query, Batch Eligibility Query (BEQ) process or MARx online query (M232 screen).Therefore, the applicant is not required to provide evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment request.

If CMS systems do not show Medicare entitlement, the State must consider the individual's Medicare ID card as evidence of Medicare entitlement. If CMS systems do not show Medicare entitlement and the individual's Medicare ID card is not available, the State must consider an SSA award notice that shows the Medicare HICN and effective date of Part A/B as evidence of Medicare entitlement.

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 Unites States is not eligible for any federal public benefit, including payment of Medicare benefits. (8 U.S.C. 1611)

LINET - The LINET 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 LINET Program provides retroactive coverage for new full dual eligibles (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 LINET 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.

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-in enrollments are sometime also called "voluntary" enrollments.

Opt Out – When an individual chooses to be excluded from future auto-enrollments or 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 60 days 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 canceling 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.

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's Health Insurance Claim	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).).

Notices must also be available in other languages and formats such as large print, braille, and audio.

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