CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2012 Regional Technical Assistance

Wednesday, August 8, 2012

Enrollment

ARDX
A. Reddix & Associates

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2012 Regional Technical Assistance

Baltimore, MD
August 8, 2012

2012 Regional Technical Assistance

Enrollment

Introduction

Purpose

- The Enrollment session will provide information and resources that will simplify and clarify the terminology, processes, and changes in plan enrollment.
- By providing enrollment and disenrollment guidelines, we ultimately encourage accurate processing.

Technical Assistance Tools

- CD with Downloaded Materials
- PowerPoint Slides
- Resource and Participant Guides
- Job Aids
- Question Cards
- Evaluation Form

Questions

Options available for asking questions:

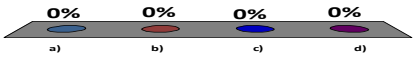
- Onsite Question Cards
- Email: enrollment@ardx.net
- Live during session or through WebEx

Practice Example

Please select your response to this question.

Today's training covers _____.

a) Encounter Data
➔ b) Enrollment
c) Prescription Drug Event
d) Payment



Demographic Polling

Please let us know your type of organization:

0%	a) Medicare Advantage (MA)
0%	b) Medicare Advantage-Prescription Drug (MAPD)
0%	c) Program for All Inclusive Care for the Elderly (PACE)
0%	d) Third Party Submitter
0%	e) Other

Demographic Polling

Please tell us your role within your organization:

0%	1. Data Analyst
0%	2. Compliance Officer
0%	3. Operations Staff
0%	4. IT Staff
0%	5. Other

Morning Agenda

- Introduction
- Data and Statistics Review
- Enrollment Data Validation and Quality Review
- Break
- Enrollment Reconciliation
- Out-of-Area Policy and Action
- Lunch Break

Afternoon Agenda

- Introduction to the e-RPT
- Break
- Breakout Sessions
  - Number of Uncovered Months
  - Break
  - Low Income Subsidy Data: TRR and Match Rate
- Q&A and Closing Remarks

Learning Objectives

- Review data and statistics in order to reveal improvement opportunities.
- Clarify the objectives and expectations of the required Enrollment Data Validation (EDV) Review process.
- Explain the process for reconciling beneficiary data from CMS generated reports against Plan records.
- Provide policy and procedures for identifying and acting on individuals who potentially reside Out of Area (OAA) and/or require a permanent address change.

Learning Objectives

- Introduce the new process for Retroactive Submission (eRPT).
- Provide better understanding of the policy for calculating and submitting the number of uncovered months for members.
- Examine Low Income Subsidy, Match Rate, and Best Available Evidence.

2012 Regional Technical Assistance

Enrollment

Data and Statistics Review

Purpose

- Review enrollment statistics
- Highlight progress in plan enrollment operations
- Discuss improvement opportunities
- Provide reminders

Medicare Enrollment

- **Total Medicare Beneficiaries = 48.9M**
  - Aged: 40.4 M*
  - Disabled: 8.5 M*

*Approximate, rounded numbers; 2011

Health and Part D Plans Enrollment

- **Health Plans:** 13,463,449
- **PDP:** 19,809,803
- **Total:** **33,273,252***

*As of May 2012

MARx Transactions - Total

Year	Total Submitted	Rejected	%
2008	27,150,564	3,387,835	**12.48%**
2009	23,856,588	2,019,941	**8.5%**
2010	27,325,471	1,300,927	**4.8%**
2011	39,281,590	1,709,539	**4.3%**

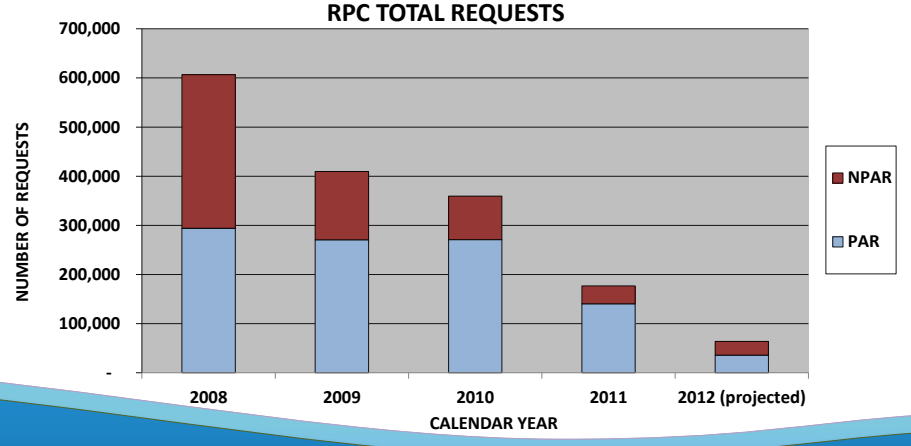
MARx Transactions: Enrollment/Disenrollment

Year	Total Enrollment/ Disenrollment	% Rejected (Net)
2010	11,588,182	5.5%
2011	11,907,225	2.97%

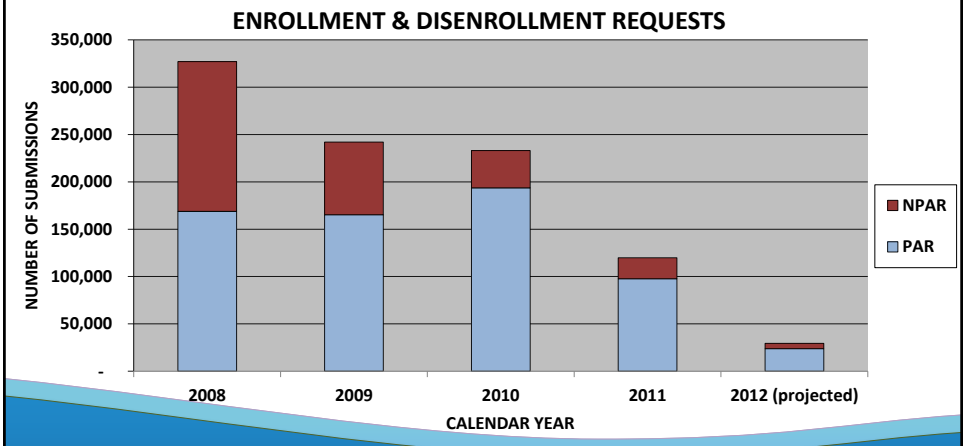
Manual Corrections

- RPC Manual Corrections:
  - 2008: **606,718**
  - 2009: **409,555**
  - 2010: **359,432**
  - 2011: **177,046**
  - 2012: **64,012*** (*projected)

RPC Trends

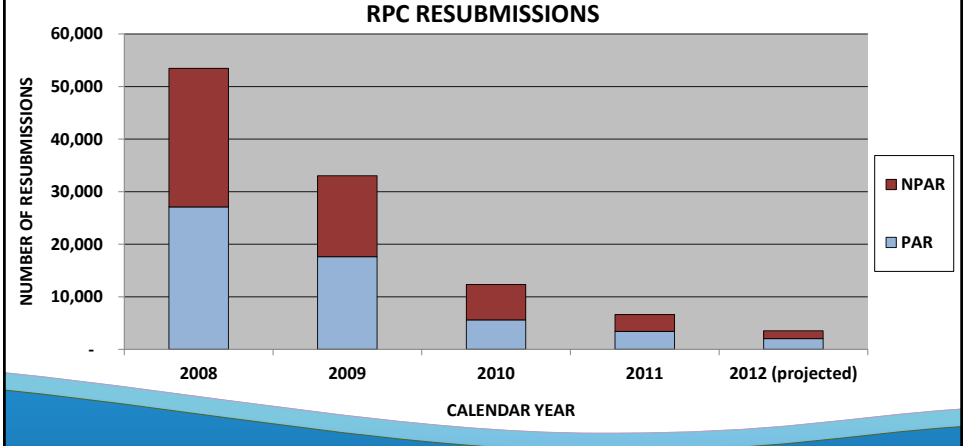


RPC - Enrollment and Disenrollment



Data and Statistics Review
2012 Regional Technical Assistance

RPC Resubmissions



Data and Statistics Review
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Progress

- Since 2008, MARx total rejections improved from 12.5% to under 4.5% in 2011.
- MARx Enrollment and Disenrollment rejections (net) improved to 2.97% for 2011.
- Manual RPC correction requests have been greatly reduced.

Continued Improvement

- Review your successes and apply those concepts broadly.
- Conduct staff training on election periods and important timeframes.
- Continue to employ internal controls.
- Reconcile.

Focus Areas

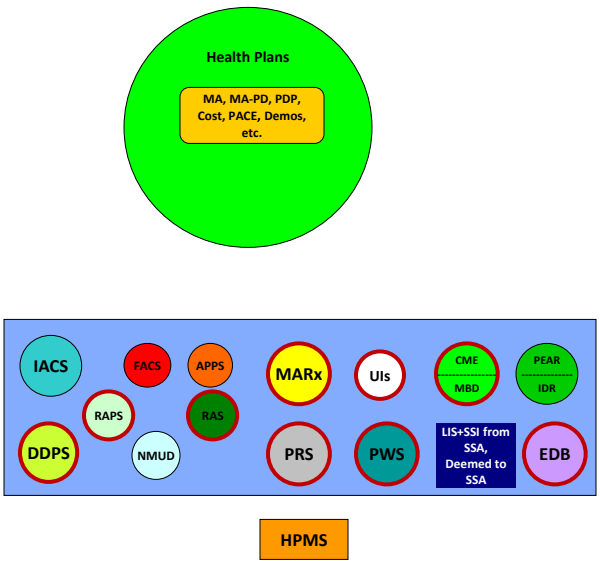
- RPC Submissions
  - Quality and internal controls
  - Submission enhancements coming soon
  - RPC Quality Reviews
- Plan to Plan Enrollment within a contract
- Modified Data to defeat rejections
  - Never submit changed data

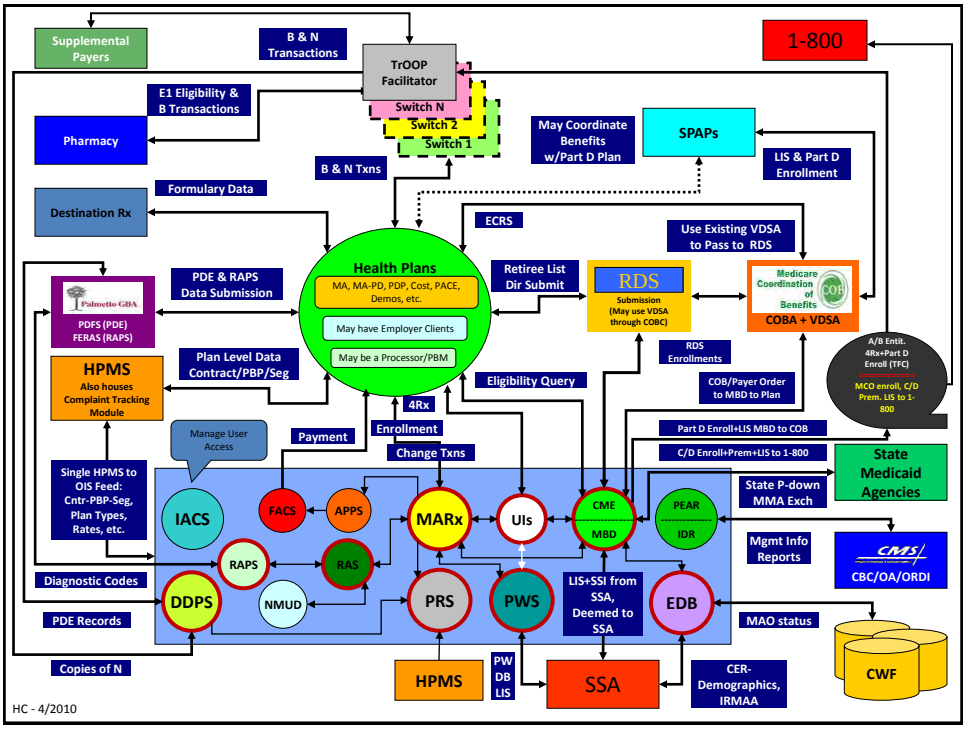
End of Year Reminder

- Not too early to be thinking about EOY
  - Accurate PBP crosswalk is the key
- Watch for the EOY Memo in the Fall
  - Review with all functional areas
- MA Organizations – "Plan Submitted" transactions

Context

- Your data as part of a much larger machine
- Dependent and down-stream processes
- Complexity of the picture underscoring the need for accurate and timely enrollment data

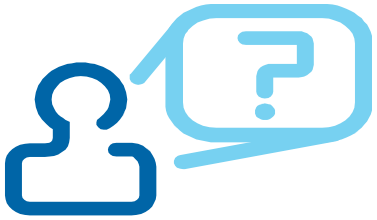




Summary

- Over 33 million beneficiaries enrolled
- Excellent progress in Enrollment Operations
- Stay with it - review focus areas
- Accurate data and the larger context
- Enjoy the rest of today's sessions!

Questions



2012 Regional Technical Assistance

Evaluation

Please take a moment to complete the evaluation form for the following module:

Data and Statistics Review

Your Feedback is Important!
Thank you!

2012 Regional Technical Assistance

Enrollment

Enrollment Data Validation (EDV) & Quality Review as Performed by the RPC

Purpose

- Review CMS' objectives and expectations of the required Enrollment Data Validation (EDV) Review process.
- Clarify guidelines on Plan-submitted MARx transactions.

EDV Learning Objectives

- In May 2011, CMS released significant enhancements to MARx.
- MARx is now a calendar-based processing system that aligns processing availability with CMS enrollment policies.
- As part of the MARx redesign, CMS requires a review process to validate transactions directly submitted by Plans – ***Enrollment Data Validation (EDV).***

EDV Overview

- A post-processing review of transactions submitted ensures the accuracy and validity of data.
- RPC generates a monthly listing of randomly selected transactions.
- Sampled transactions are sent to the Plan's designated EDV Point of Contact.

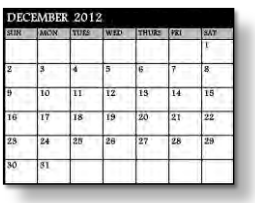
EDV Overview

- Plans have seven (7) business days to return documentation to RPC for review.
- RPC reviews documentation and validates transactions.
- EDV results are sent to CMS Central Office and Regional Offices (RO) for review and further action.

Note: More information on the EDV Review Process can be found on the RPC's website in the EDV Toolkit.

EDV Status

- CMS completed four (4) rounds of EDV.
- Since that time, CMS has evaluated the process.
- The EDV Review Process will resume Mid-December, 2012 – more information to come from the RPC.



EDV Expectations

- Plans should have no difficulty substantiating all transactions.
- Plans that are unable to provide adequate documentation will be referred to CMS RO Managers for review and appropriate action.

Common Data Validation Issues – Plan Responses

Some Plans had difficulty responding to EDV requests on time, including:

- Responding late – past deadline posted in EDV Request Email;
- No response; and
- Responding with incomplete information or missing documentation.

Data Validation Findings – Submitting Inaccurate Data to Force Transactions

Plans submitted inaccurate data to MARx to circumvent a MARx System edit or "correct" an issue.

Example: Inappropriate use of a "new" enrollment (TC 61 or online) to reinstate a member

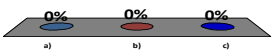
Question

When is it appropriate to submit inaccurate data to circumvent a MARx system edit or to "correct" an issue?

a) When a Plan wishes to reinstate a beneficiary

b) When a Plan wishes to ensure its enrollment is the last enrollment

→ c) Never



Data Validation Findings – Submitting Inaccurate Data to Force Transactions

- Plans may only use the Disenrollment Cancellation function (TC81) to process a Reinstatement directly.
  - TC81 is not available for CMS-generated disenrollment; submit to RPC as appropriate.
- Submitting a false enrollment with an invalid application date and/or election type is a serious issue.

Data Validation Findings – Submitting Noncompliant Transactions

- Plans must comply with CMS requirements.
- Examples of noncompliant scenarios seen include:
  - Grievances;
  - No documentation;
  - Unable to supply valid/complete documentation (i.e. missing written request from beneficiary for disenrollment); and
  - Agent requesting changes to enrollment on behalf of member.

Data Validation Findings - Residence Address

- Some Plans could not substantiate that they performed the necessary tasks to validate beneficiaries' addresses when they received notification that a beneficiary resided outside of the service area.
- Follow CMS guidance on beneficiaries residing outside of a service area.

Residence Address Correction

Plans should submit residence address information to MARx for every enrollee.

a) True

→ b) False

How to Address Issues

- Review and comply with applicable laws, guidance, and SOPs relating to submitting transactions to CMS and responding to an EDV request.
- All transactions submitted to MARx (batch or UI) must be compliant with all CMS requirements.

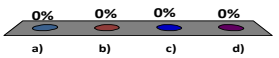
How to Address Issues

- There can be situations that require action, but cannot be substantiated fully, such as lost/destroyed documentation.
  - These transactions may not be submitted to MARx.
  - Refer such cases, with complete explanations, to RO or RPC as appropriate.

Question

What do you do in instances when a Plan must take an enrollment-related action, but the action may not be compliant with CMS policies?

a) Submit to MARx anyway
b) Contact RO or RPC as appropriate
c) Never submit action
d) None of the above



RPC Resources for EDV

Reed & Associates Website
http://www.reedassociates.org/edvSOPs.php
***RPC EDV Toolkit will be updated by end of August 2012**

Reed & Associates Client Services
13330 California Street, Suite 200
Omaha, NE 68154
402-315-3660 (phone)
402-315-3700 (fax)
clientservices@reedassociates.org

CMS Resources for Submitting Transactions

- Medicare Managed Care Manual - Chapter 2
- Medicare Prescription Drug Benefit Manual – Chapter 3
- CMS Plan Communications User Guide (PCUG)
- MARx User Interface (UI) Handbook
- MARx R&M Handbook

QUESTIONS?

Evaluation

Please take a moment to complete the evaluation form for the following module:

Enrollment Data Validation &
Quality Review as Performed by the RPC

Your Feedback is Important!

Thank you!

2012 Regional Technical Assistance

Enrollment

Enrollment Reconciliation

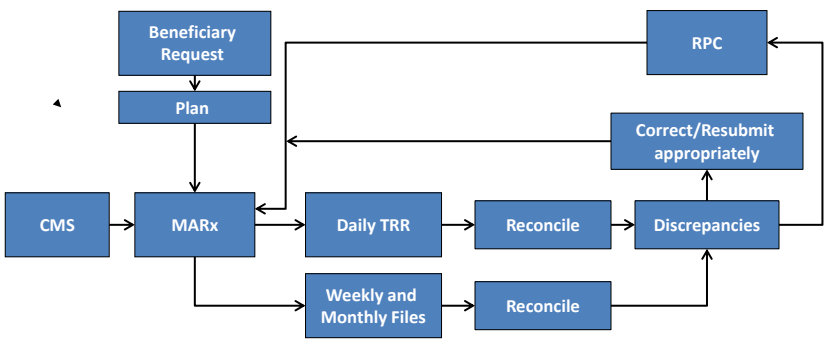
Purpose

- Review reconciliation concepts.
- Provide example based on enrollment transaction (TC 61) submission and response.
- Discuss reconciling beneficiary data between CMS-generated reports against Plan records.

Learning Objectives

- Reconcile transactions submitted by Plans with CMS reply.
- Reconcile CMS generated transactions.
- Review CMS data and Plan data.
- Understand the Current Payment Month process.

Data Submission and Reconciliation Cycle



Reconciling Transactions: Example 1

- Plan submits batch enrollment TC61 for Beneficiary A.
- TRR data shows TC 61 accepted with TRC 011, 121.
- Reconcile CMS response with Plan data.

Reconciling Transactions: Example 1 (continued)

- TC 011 - Reconcile to ensure data match:
  - Enrollment effective date
  - Contract/PBP
  - Premiums, Premium Withhold, Late Enrollment Penalty, etc.
  - Status: (Hospice, ESRD, etc.)

  – Material generation as appropriate

Reconciling Transactions: Example 1 (continued)

- Reconcile TRC 121.
  - Record LIS status for beneficiary in Plan records.
  - Apply correct LIS Copay amounts.
    - Is 4Rx still correct?
  - Adjust premium as appropriate.
- Verify data with monthly LIS/LEP Report.

Reconciling Transactions: Example 2

123456789A XXXXXXX YYYYY B219280901TS999937090000001161Y2012080101
123456789A XXXXXXX YYYYY B219280901TS999937090000011761Y2012080101

- CMS-generated enrollment transaction (TC61)
- TRC 011 (Enrollment Accepted as Submitted)
- TRC 117 (FBD Auto Enrollment Accepted)

Process CMS Auto Enrollment

- Reconcile TRC 011, update records to add Enrollee, and match CMS data.
- TRC 117 informs plan that this is a CMS auto/facilitated enrollment.
- Submit 4Rx data.
- Reconcile beneficiary address information when received.
- Send appropriate materials.

Current Payment Month Process

- Payments are based on Current Payment Month.
- Enrollments are based on Current Calendar Month.
- Enrollments process independently from payments.

Current Payment Month Process (continued)

- Current Calendar Month (CCM)
- Current Payment Month (CPM)

Current Calendar Month (CCM) Process

- Standard operational range for normal enrollment and disenrollment activity is CCM-1 thru CCM +3.
- Standard range for **EGHP** enrollment and disenrollment activity is CCM-3 thru CCM+3.
- All policy requirements apply; the operational range options do not change the requirements.

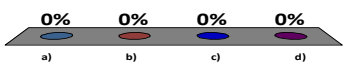
Current Calendar Month Process

- CCM Range for CCM = May 2012
  - **Normal Enrollments** effective dates that may be submitted: April 1, May 1, June 1, July 1, and August 1, 2012
  - **EGHP Enrollments** effective dates that may be submitted: February 1, March 1, April 1, May 1, June 1, July 1, and August 1, 2012

Question

If CCM is February 2012, what is the earliest effective date that a Plan can submit for a standard enrollment?

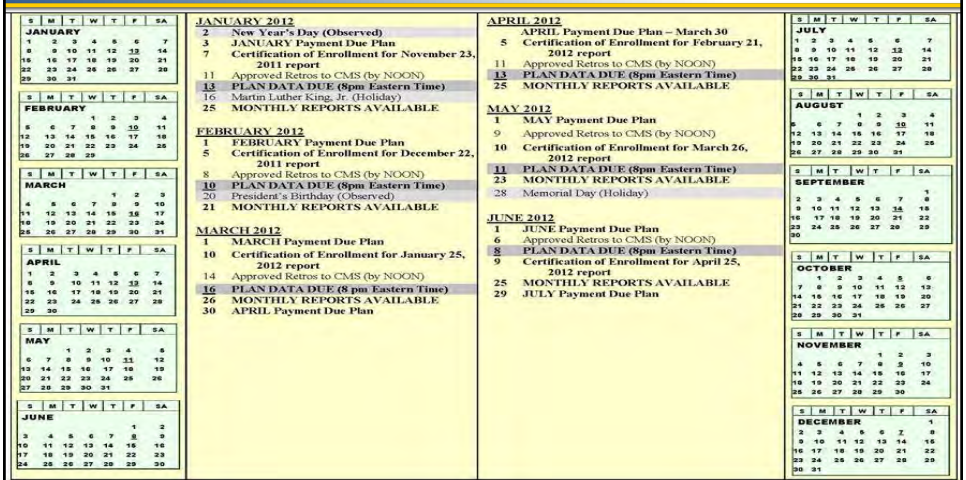
a) December 2011
→ b) January 2012
c) February 2012
d) March 2012



Current Payment Month Process

- CPM – Current Payment Month
  - CPM is the next prospective calendar month for which payment is calculated using the Plan enrollments, disenrollments, and adjustments recorded through the Plan Data Due Date that comes before the payment
  - CMS-designated Plan Data Due Dates in the PCUG
    - refer to section C of the PCUG

Year 2012 MARx Plan Monthly Schedule



JANUARY 2012
- 2 New Year's Day (Observed)
- 3 JANUARY Payment Due Plan
- 7 Certification of Enrollment for November 23, 2011 report
- 11 Approved Retros to CMS (by NOON)
- 13 PLAN DATA DUE (8pm Eastern Time)
- 16 Martin Luther King, Jr. (Holiday)
- 25 MONTHLY REPORTS AVAILABLE

FEBRUARY 2012
- 1 FEBRUARY Payment Due Plan
- 5 Certification of Enrollment for December 22, 2011 report
- 8 Approved Retros to CMS (by NOON)
- 10 PLAN DATA DUE (8pm Eastern Time)
- 20 President's Birthday (Observed)
- 21 MONTHLY REPORTS AVAILABLE

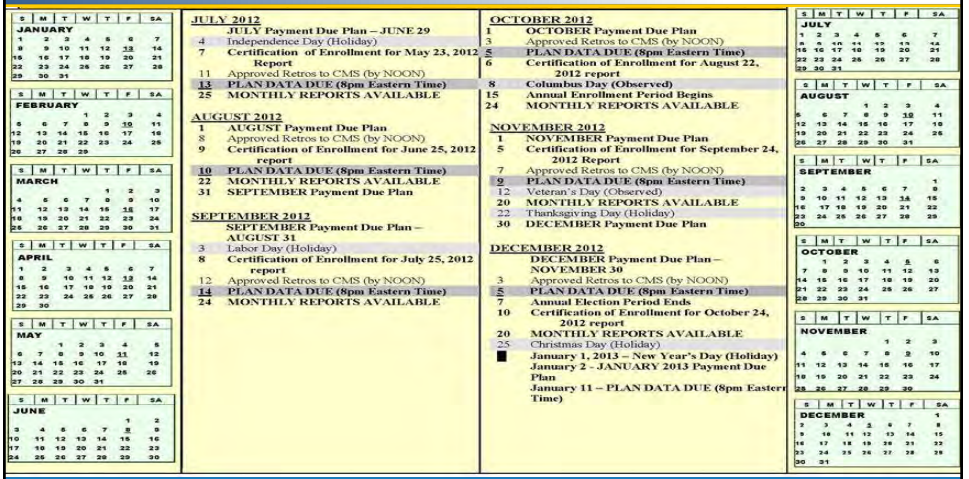
MARCH 2012
- 1 MARCH Payment Due Plan
- 10 Certification of Enrollment for January 25, 2012 report
- 14 Approved Retros to CMS (by NOON)
- 16 PLAN DATA DUE (8 pm Eastern Time)
- 26 MONTHLY REPORTS AVAILABLE
- 30 APRIL Payment Due Plan

APRIL 2012
- APRIL Payment Due Plan – March 30
- 5 Certification of Enrollment for February 21, 2012 report
- 11 Approved Retros to CMS (by NOON)
- 13 PLAN DATA DUE (8pm Eastern Time)
- 25 MONTHLY REPORTS AVAILABLE

MAY 2012
- 1 MAY Payment Due Plan
- 9 Approved Retros to CMS (by NOON)
- 10 Certification of Enrollment for March 26, 2012 report
- 11 PLAN DATA DUE (8pm Eastern Time)
- 23 MONTHLY REPORTS AVAILABLE
- 28 Memorial Day (Holiday)

JUNE 2012
- 1 JUNE Payment Due Plan
- 6 Approved Retros to CMS (by NOON)
- 8 PLAN DATA DUE (8pm Eastern Time)
- 9 Certification of Enrollment for April 25, 2012 report
- 25 MONTHLY REPORTS AVAILABLE
- 29 JULY Payment Due Plan

Year 2012 MARx Plan Monthly Schedule (continued)



JULY 2012
- JULY Payment Due Plan – JUNE 29
- 4 Independence Day (Holiday)
- 7 Certification of Enrollment for May 23, 2012 Report
- 11 Approved Retros to CMS (by NOON)
- 13 PLAN DATA DUE (8pm Eastern Time)
- 25 MONTHLY REPORTS AVAILABLE

AUGUST 2012
- 1 AUGUST Payment Due Plan
- 8 Approved Retros to CMS (by NOON)
- 9 Certification of Enrollment for June 25, 2012 report
- 10 PLAN DATA DUE (8pm Eastern Time)
- 22 MONTHLY REPORTS AVAILABLE
- 31 SEPTEMBER Payment Due Plan

SEPTEMBER 2012
- SEPTEMBER Payment Due Plan – AUGUST 31
- 3 Labor Day (Holiday)
- 8 Certification of Enrollment for July 25, 2012 report
- 12 Approved Retros to CMS (by NOON)
- 14 PLAN DATA DUE (8pm Eastern Time)
- 24 MONTHLY REPORTS AVAILABLE

OCTOBER 2012
- 1 OCTOBER Payment Due Plan
- 3 Approved Retros to CMS (by NOON)
- 5 PLAN DATA DUE (8pm Eastern Time)
- 6 Certification of Enrollment for August 22, 2012 report
- 8 Columbus Day (Observed)
- 15 Annual Enrollment Period Begins
- 24 MONTHLY REPORTS AVAILABLE

NOVEMBER 2012
- 1 NOVEMBER Payment Due Plan
- 5 Certification of Enrollment for September 24, 2012 Report
- 7 Approved Retros to CMS (by NOON)
- 9 PLAN DATA DUE (8pm Eastern Time)
- 12 Veteran's Day (Observed)
- 20 MONTHLY REPORTS AVAILABLE
- 22 Thanksgiving Day (Holiday)
- 30 DECEMBER Payment Due Plan

DECEMBER 2012
- DECEMBER Payment Due Plan – NOVEMBER 30
- 3 Approved Retros to CMS (by NOON)
- 5 PLAN DATA DUE (8pm Eastern Time)
- 7 Annual Election Period Ends
- 10 Certification of Enrollment for October 24, 2012 report
- 20 MONTHLY REPORTS AVAILABLE
- 25 Christmas Day (Holiday)
- January 1, 2013 – New Year's Day (Holiday)
- January 2 - JANUARY 2013 Payment Due Plan
- January 11 – PLAN DATA DUE (8pm Eastern Time)

CMS Reported Data and Plan Data

- CPM: Example # 1
  - Today's date: 07/09/2012
  - Plan data due date: 07/13/2012 (August CPM)
  - TC 61 enrollment submitted effective 08/01/2012

CMS Reported Data and Plan Data (continued)

- Plan receives daily TRR on 07/10/2012.
- Plan receives MMR on 07/23/2012.
- Beneficiary will appear on August MMR.

CMS Reported Data vs. Plan Data

- CPM: Example # 2
  - Today's date: 07/16/2012
  - Plan data due date was: 07/13/2012 (August CPM)
  - TC61 enrollment submitted effective 08/01/2012

CMS Reported Data and Plan Data

- Plan receives daily TRR on 07/17/2012.
- Review and update records.
- Plan receives MMR on 07/23/2012.
- Above Beneficiary **will not** appear on August MMR.
- Beneficiary information will appear on the following month's MMR.

Question

Using the Year 2012 MARx Plan Monthly Schedule, if an enrollment is submitted and accepted by CMS on April 7, 2012, will the beneficiary appear on the May MMR?

→ a) Yes
b) No

CMS Reported Data and Plan Data

- Check TRR data against Plan data.
  - Check Plan-submitted transactions and CMS-generated transactions/notifications.
  - Ensure data agrees.
  - Update beneficiary records accordingly.

CMS Reported Data and Plan Data

- Compare MMR to Plan data and expected payment.
  *Note Remember the effect of CPM!!
- Compare Full Enrollment File (FEF) to Plan data enrollment records.
- Check and validate cross-reference HICN data.

CMS Reported Data and Plan Data (continued)

- Check FEF against Plan enrollment records.
  - FEF displays current enrollment.
  - Verify Plan records and FEF agree.
  - MMR may not match FEF.
    - CPM means that the MMR includes for whom payment is received.
    - Retroactive payment adjustments may appear on MMR displaying beneficiaries not currently in Plan.

CMS Reported Data and Plan Data (continued)

- Check and validate cross-reference HICN data.
  - Maintain and track HICN history.
  - Make sure to apply the correct, current HICN.
  - Also, if beneficiaries in the same Plan have the same name, make sure to apply changes to correct HICN/Name.

Methods of Reconciliation

- Reconcile data continuously.
  - TRRs are daily, and therefore reconcile in days.
  - Beneficiary data can change daily.
  - Do not reconcile only in ranges such as quarterly or annually.

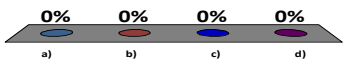
Methods of Reconciliation (continued)

- Analyze discrepancies in reports.
  - Follow each transaction to logical end.
  - Again, match Plan records/data with CMS reports.
  - Notify RPC and/or Account Manager as appropriate if discrepancies are identified that require assistance.
  - Contact the MAPD Help Desk for technical systems problems.

Question

How often should Plans reconcile CMS data with their own?

a) Monthly
b) In monthly ranges
→ c) Continuously
d) Only when the Plan believes there is an issue



Methods of Reconciliation

- Handling Special TRRs
  - Coordinate special TRR data with Plan records.
  - Determine if reported data/TRCs require Plan action.
  - Complete beneficiary notifications that may apply.

Summary

- Reconciling Transactions
- Current Calendar Month
- Current Payment Month Process
- CMS-Reported Data and Plan Data
- Methods of Reconciling

Questions?

Evaluation

Please take a moment to complete the evaluation form for the following module:

Enrollment Reconciliation

Your Feedback is Important!
Thank you!

2012 Regional Technical Assistance

Enrollment

Out of Area Policy and Action

Purpose

- This module provides policy and procedures for identifying and acting on individuals who reside Out of Area (OOA) and/or require a permanent address change.

Objectives

At the completion of this module, participants will be able to:

- Effectively identify individuals who reside out of the plan's service area;
- Correctly disenroll individuals due to OOA;
- Update an individual's permanent address in the CMS systems; and
- Submit valid, supporting documentation to the Retroactive Processing Contractor (RPC).

General Guidance

- An individual is eligible to elect enrollment into a plan if permanently residing in the plan's service area.
  - Exceptions:
    - MA Continuation Areas
    - Joining MA Plan upon conversion to Medicare
    - Plan terminations
- MA Plans may offer "Visitor" or "Traveler" programs.
  - May be out of service area up to 12 months
  - Only applies to beneficiaries already enrolled (beneficiaries cannot enroll while permanent residence is in a visitor/ traveler area)

Area of Residence

Chapter 2, §20.3; Chapter 3, §20.2

- Permanent residence address is used to verify eligibility for enrollment.
  - Mailing, temporary, or secondary addresses are not used to determine eligibility
- If P.O. Box is used on enrollment form, plan must verify residence in area.

Area of Residence (continued)

- Plans may request additional information to verify permanent address at time of enrollment. Examples include:
  - Voter registration cards;
  - Tax records; and
  - Utility bills.
- Plans may consider the following as permanent addresses for homeless individuals:
  - P.O. Box;
  - Shelter or clinic address; or
  - Address where individual receives mail.

Out of Area Notifications

- How do you find out if a beneficiary is possibly residing outside of your plan's service area?

  CMS Reports:

  – Monthly Membership Report or full enrollment file

  – Daily TRR

    - TRC 016: Enrollment Accepted; Out of Area
    - TRC 154: Out of Area Status
    - TRC 155: Incarceration Notification Received

Out of Area Notifications (continued)

- Other Sources:
  – User Interface (UI) update – MARx screen message
  – Beneficiary (or legal representative) contact
  – Third party contact, including:
    - State files for incarceration status
    - Employer group notification
  – Returned mail
- Clock for determining OOA begins with the date the plan receives notification.

Out of Area Notifications
Plan Action

- Plan must confirm the possible move is permanent with the beneficiary or legal representative.
  - *Chapter 2 and Chapter 3, §50.2.1.3*
  - Must make attempt to contact within 10 calendar days
  - Must document efforts
- Confirmation not necessary if the OOA notification is result of a new, prospective enrollment transaction.
  - *Chapter 2 and Chapter 3, §50.2.1.3*
  - Receive TRC 011 or TRC 100 and a TRC 016 on same daily TRR (D-TRR)

Plan Action
Member Confirms No Move

- Contact is made, and the beneficiary or legal representative states a permanent move did not occur.
- Plan must update address in CMS systems:
  - Submit Residence Address Change (RAC – TC 76 transaction) to MARx.
  - Submit State and County Code (SCC) change request to the RPC (MARx System Issues) only when the TC 76 is unsuccessful.

Acceptable Documentation for RACs & SCCs

- Member or legal representative contact documentation:
  - Phone log
  - Written correspondence
  - Address verification form
- Incarceration confirmation documentation
- Employer group notification

Note: Address and effective date for RAC transaction to MARx (or SCC Update via RPC when necessary) must be supported by documentation. (An explanation from the plan is not acceptable.)

Submitting Address Change Transactions

- Do not delay address change notifications or requests from beneficiary.
  - Implement timely research and action to minimize retroactive transactions.
- Plans should NOT submit address "updates" to MARx unless it is a change (update or delete).
  - Systematically "pushing" address information to CMS without current supporting documentation will result in compliance findings through the EDV review process.

Plan Action
Member Confirms Move

- Contact is made, and the beneficiary or legal representative confirms the permanent move.
- Plan must disenroll member if out of service area, including:
  - –New residence is OOA and is not in a MA continuation area.
  - –New residence is OOA and in a MA continuation area, but member chooses not to continue enrollment in MA local plan.
  - –Member is incarcerated, and therefore, OOA.
- Plan must send disenrollment notice to member.

Disenrollment Effective Date
Move Confirmed

- Disenrollment effective 1st day of the month after the member begins residing OOA and after notification of move by member.
- If move occurred in past, and member requests retroactive disenrollment, the effective date may be 1st of the month after the month of the move or later.
  - – May be necessary to send the request to the RPC for retroactive processing.

NOTE: Effective date cannot be earlier than the 1st of the month following the month the move occurred.

Submitting the Disenrollment Transaction

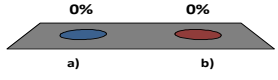
- Disenrollment Reason Code = 92
  - DRC 92: Move Outside of Plan Service Area
    - *Must use if beneficiary is out of the plan service area (according to the procedures in CMS disenrollment guidance) and the plan meets all requirements necessary to effectuate an involuntary disenrollment.*
- Election Period = X (for use with Involuntary Disenrollment)

Case Study #1

Mr. Smith contacts his plan (located in Rhode Island) on March 23, 2012. He states he moved to Texas on January 4, 2012, and requests a disenrollment effective date of January 1, 2012. Is this a valid effective date?

a) Yes

→ b) No



Plan Action
No Response by Member

- Plan must make multiple attempts to contact member.
- Plan must disenroll member if:
  - Member does not respond to address confirmation attempts within six (6) months (MA plan) or 12 months (PDP).
  - Member's temporary absence from the service area or continuation area exceeds six (6) (MA plan) or 12 (PDP) consecutive months.
    - Member is enrolled in MA plan that offers visitor/traveler program and temporary absence exceeds 12 months.
- Plan must send disenrollment notice to member.

Disenrollment Effective Date
No Response

- No response, or temporarily out of the service area for more than six (6) months (MA)/12 months (PDPs)
  - Disenrollment effective the 1st day of the calendar month after six (6) months (or 12 months for PDPs) have passed since date plan learned of possible OOA status
- MA plan offers visitor/traveler program and absence exceeds 12 months (or the length of the program)
  - Disenrollment effective the 1st day of the 13th month after the MA plan learned of the possible OOA status (or month following end of program)

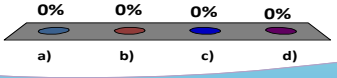
Case Study #2

Ms. Jones is enrolled in an MA plan. The plan receives returned mail sent to Ms. Jones' address on March 4, 2012. The plan mails a residence verification form to Ms. Jones on March 7, 2012. On April 17, Ms. Jones' son contacts the plan and confirms her permanent move OOA. The son indicates that he is not the legal representative for Ms. Jones.

Case Study #2 (continued)

After six months, the plan has not received confirmation of the move, and must disenroll the beneficiary. What is the correct effective date?

a) April 1, 2012
b) May 1, 2012
c) September 1, 2012
→ d) October 1, 2012



Other Related Disenrollment Policies

- Plans must apply all other disenrollment processes while determining if a member is OOA.
- If involuntary disenrollment applies, submit the transaction based on the action that caused the disenrollment.
  - Other reasons may include non-payment of premiums, loss of special needs eligibility, etc.
  - The earliest possible effective date must be used.

Case Study #3

On February 24, 2012, an MAPD plan receives a TRC 154 indicating Ms. Blue is OOA. The plan attempts to contact Ms. Blue via phone, and sends a verification letter. On March 1st, the plan starts the three-month grace period clock as Ms. Blue has not paid her premium. Today is June 1st, and neither payment nor address confirmation has been received.

Case Study #3 (continued)

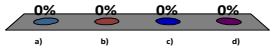
What is the plan's correct action?

a) Submit a retroactive disenrollment request to the RPC effective March 1, 2012 for OOA.

→ b) Process a disenrollment effective July 1, 2012 for non-payment.

c) Wait until August 24, 2012 to process a disenrollment effective September 1, 2012 for OOA.

d) Submit retroactive disenrollment request to RPC effective April 1, 2012 for non-payment.



Incarceration

- Incarcerated individuals are considered to be residing out of the plan service area, even if the facility is located within the area.
- Organizations may learn of a member's incarcerated status via:
  - TRR (TRC 155): Incarceration Notification Received;
  - Contact with the member or legal representative; or
  - Contact with another third party.

Incarceration

- If incarceration status is learned via TRR or third party, the organization must confirm the status is correct.
- Confirmation can be acquired by:
  - Contact with beneficiary or legal representative
  - State/Federal Entities
  - Public records
  - Inmate locator web sites
- If incarceration occurred in past (individual is released), plan must retain member.

Disenrollment Effective Date - Incarceration

- Incarceration start date is obtained, disenrollment is effective the 1st of the month following the start date of the incarceration.
  - Transaction may need to be submitted to the RPC for retroactive processing based on the valid effective date.

Disenrollment Effective Date – Incarceration (continued)

- Incarceration start date is not obtained, disenrollment is effective for the 1st of the month following the month the incarceration status is confirmed.
  - If status cannot be confirmed within six (6) months (MA)/12 months (PDP) of the initial notification, disenrollment is effective the 1st day of the month after the 6/12 months have passed.

Case Study #4

On May 5, 2012, a plan receives a TRC 155 indicating Jane Doe is incarcerated in a facility within the plan's service area. On May 21, 2012, the plan receives a state file confirming Ms. Doe's incarceration starting January 27, 2012.

Case Study #4 (continued)

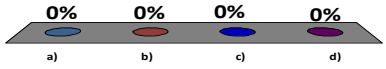
What is the plan's next step?

a) Process a disenrollment effective June 1, 2012.

b) Process a disenrollment effective February 1, 2012.

c) Submit a disenrollment request with documentation to the RPC effective February 1, 2012.

d) No action is required. The facility is within the plan's service area.



Summary

- Plans must check various sources regularly to find notification of possible out of area cases requiring action.
- Plans must repeatedly attempt to contact members using various methods until response or OOA clock ends.
- When multiple policies are in play, process the disenrollment using the policy that has the earliest date of disenrollment.
- Submit RAC TC 76 only for confirmed residence address changes/corrections.

Summary

- Submit to RPC an SCC change request only when the TC 76 is unsuccessful.
- Plans must provide valid documentation when making requests to RPC.
- The organization/sponsor must have evidence such as documentation of call to/from member or member's representative.
  - Online screen prints are not acceptable evidence.

2012 Regional Technical Assistance

Evaluation

Please take a moment to complete the evaluation form for the following module:

Out of Area Policy and Action

Your Feedback is Important!
Thank you!

MODULE 4 – OUT OF AREA POLICY AND ACTION

Purpose

This module provides current policy and procedures for identifying and acting on individuals who potentially reside out of area (OOA) and/or require a permanent address change.

Learning Objectives

At the completion of this module, participants will be able to:

- Effectively identify individuals who reside out of the plan's service area;
- Correctly disenroll individuals due to out of area;
- Update an individual's permanent address in the CMS systems; and
- Submit valid supporting documentation to the Retroactive Processing Contractor (RPC).

ICON KEY	
Definition	
Example	
Reminder	
Resource	

4.1 Definitions

4.1.1 Medicare Managed Care Manual (MA Guidance), Chapter 2 Definitions

Continuation Area/Continuation of Enrollment Option - A continuation area is an additional CMS-approved area outside the MA local plan's service area within which the MA organization furnishes or arranges for furnishing of services to the MA local plan's continuation of enrollment members. MA organizations have the option of establishing continuation areas for MA local plans.

Evidence of Permanent Residence - A permanent residence is normally the enrollee's primary residence. An MA organization 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 confined to a correctional facility, such as a jail or prison. An individual who is incarcerated is considered to be residing outside of the service area for the purposes of MA plan eligibility, even if the correctional facility is located within the plan service area. Beneficiaries who are in Institutions for Mental Disease (IMDs), such as individuals who are confined to state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, are not considered to be incarcerated as CMS defines the term for the purpose of MA eligibility. These individuals are therefore not excluded from the service area of an MA plan on that basis.

Out of Area Members - Members of an MA plan who live outside the service area and who elected the MA plan while residing outside the service area (as allowed in §§20.0, 20.3, 50.2.1, and 50.2.4).

4.1.2 Medicare Prescription Drug Benefit Manual (PDP Guidance), Chapter 3 Definitions

Incarceration - This term refers to the status of an individual who is confined to a correctional facility, such as a jail or prison. An individual who is incarcerated is considered to be residing outside of the service area for the purposes of Part D plan eligibility, even if the correctional facility is located within the plan's service area. Beneficiaries who are in Institutions for Mental Disease (IMDs), such as individuals who are confined to state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, are not considered to be incarcerated as CMS defines the term for the purpose of Part D plan eligibility. These individuals are therefore not excluded from the service area of a Part D plan on that basis.

4.2 General Guidance on Eligibility for Enrollment

Individuals must permanently reside in the plan's service area to be eligible to enroll. There are a few exceptions, such as continuation areas, enrollment conversions into a MA upon Medicare entitlement, and plan terminations. In addition, plans may offer visitor or traveler programs to their enrolled members for up to twelve (12) months.

Regulation on eligibility to enroll in a MA plan: 42 CFR 422.50

Regulation on eligibility to enroll in a PDP: 42 CFR 423.30

4.2.1 Excerpt from 2012 MA Guidance (Chapter 2), §20.3: Place of Permanent Residence

An individual is eligible to elect an MA plan if he/she permanently resides in the service area of the MA plan. 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. A temporary move into the MA plan's service area does not enable the individual to elect the MA plan; the MA organization must deny such an enrollment request.

EXCEPTIONS:

- An MA organization may offer a continuation of enrollment option to MA local plan enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the MA organization as a continuation area (refer to §20.8 for more detail on the requirements for the continuation of enrollment option).
- Conversions: Individuals who are enrolled in a health plan of the MA organization and are converting to Medicare Parts A and B can elect an MA local plan offered by the same MA organization during their ICEP even if they reside in the MA organization's continuation area. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2.)
- A member who was enrolled in an MA plan covering the area in which the member permanently resides at the time the plan was terminated in that area, may remain enrolled in the MA plan while living outside the plan's new reduced service area if:
  - There is no other MA plan serving the area at that time;
  - The MA organization offers this option; and
  - The member agrees to receive services through providers in the MA plan's service area.

- The MA organization has the option to also allow individuals who are converting to Medicare Parts A and B to elect the MA plan during their ICEP even if they reside outside the service and continuation area. This option may be offered provided that CMS determines that all applicable MA access requirements in 42 CFR 422.112 are met for that individual through the MA plan's established provider network providing services in the MA plan service area, and the organization furnishes the same benefits to the individual as to members who reside in the service area. The organization must apply the policy consistently for all individuals. These members will be known as "out of area" members. This option applies both to individual members and to employer or union sponsored group plan members of the MA organization.

Individuals who do not meet the above requirements may not elect the MA plan. The MA organization must deny enrollment to these individuals.

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 an MA organization may request additional information such as voter's registration records, driver's license records (where such records accurately establish current residence), tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual. If an individual puts a Post Office Box as his/her place of residence on the enrollment form, the MA organization must contact the individual to confirm that the individual resides in the service area. If there is a dispute over where the individual permanently resides, the MA organization should determine whether, according to the law of the MA organization's State, the person would be considered a resident of that State.

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.

MA organizations have the option to offer "visitor" or "traveler" programs for currently enrolled individuals who are consecutively out of the area for up to 12 months, provided the plan includes the full range of services available to other members (refer to §50.2.1 for more detail on the requirements for the "visitor/traveler" option). Residence in an area designated for a "visitor" or "traveler" program does not make an individual eligible to enroll in an MA plan, but rather applies to already enrolled individuals.

Excerpt: §20.3.1 - Mailing Address

As described in §20.3, an individual's eligibility to enroll in an MA plan is in part determined by the individual's permanent residence in the service area of that MA plan. Some individuals may have separate mailing addresses that may or may not be within the geographic plan service area. If an individual requests that mail be sent to an alternate address, such as that of a relative, MA organizations should make every effort to accommodate these requests, and should use this alternate address to provide required notices and other plan mailings, as appropriate. The model MA plan enrollment application forms provided in this [2012 MA] guidance include a mechanism to collect a mailing address. Use of an alternate address does not eliminate or change the requirement of residency for the purposes of MA plan eligibility.

4.2.2 Excerpt from 2012 PDP Guidance (Chapter 3), §20.2: Place of Permanent Residence

An individual is eligible for Part D and able to enroll in a PDP if he/she permanently resides in the service area (region) of the PDP. A temporary stay in the PDP's service area does not enable the individual to enroll. An individual who is living abroad or is incarcerated does not meet the requirement of permanently residing in the service area of a Part D plan (even if the correctional facility is located within the plan service area). Individuals who are confined in state hospitals, IMDs (Institutions for Mental Disease), psychiatric hospitals, or the psychiatric

unit of a hospital are not considered to be "incarcerated" as CMS defines that term, and are therefore not excluded on that basis from the service area of a Part D plan. Thus, they are eligible for Part D, provided that they meet the other Part D eligibility requirements.

A permanent residence is normally the primary residence of an individual. Generally, permanent residence is established by the address provided by the individual, but a PDP sponsor may request additional information, such as voter's registration records, driver's license records (where such records accurately establish current residence), tax records, or utility bills if there is a question. Such records must establish the permanent residence address, and not the mailing address, of the individual. If an individual puts a Post Office Box as his/her place of residence on the enrollment request, the PDP sponsor must contact the individual to confirm that the individual lives in the service area. If there is a dispute over where the individual permanently resides, the PDP sponsor should determine whether, according to the law of the State, the person would be considered a resident of that State. Additional instructions regarding disenrollment of members who may live out of the sponsor's service can be found in §50.2.1 of [the 2012 PDP] guidance.

Separately, individuals may have mailing addresses that may or may not be within the geographic plan service area. If an individual requests that mail be sent to an alternate address, such as that of a relative for example, PDP sponsors should make every effort to accommodate these requests, and should use this address to provide the required notices in this [2012 PDP] guidance and other plan mailings as appropriate. The model PDP enrollment forms provided in this [2012 PDP] guidance include a mechanism to collect an alternate mailing address. Use of an alternate mailing address does not eliminate or change the residency requirement for the purposes of PDP eligibility.

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.

Additional information regarding residence for individuals that are auto enrolled or facilitated enrolled is provided in §50.2.1 of [the 2012 PDP] guidance.

4.3 General Policy for Current Members Who Reside Out of the Service Area

4.3.1 Excerpt from 2012 MA Guidance (Chapter 2), §50.2.1: Members Who Change Residence

MA organizations may offer (or continue to offer) extended "visitor" or "traveler" programs to members of coordinated care plans who have been out of the service area for up to 12 months. The MA organizations that offer such programs do not have to disenroll members in these extended programs who remain out of the service area for more than six (6) months but less than 12 months. As mentioned at 42 CFR 422.74(d) (4) (iii), MA organizations offering a plan with a visitor/traveler program must make this option available to all enrollees who are absent for an extended period from the MA plan's service area. However, MA organizations may limit this option to enrollees who travel to certain areas, as defined by the MA organization, and who receive services from qualified providers. Organizations offering MA-PFFS plans may allow continued enrollment of individuals absent from the plan service area for up to 12 months, given that PFFS plans provide access to plan benefits and services from providers located outside the plan service area.

MA organizations offering plans without these programs must disenroll members who have been out of the service area for more than six (6) months.

An SEP, as defined in §30.4.1, applies to individuals who are disenrolled due to a change in residence. An individual may choose another MA or Part D plan (either a PDP or MA-PD) during this SEP.

Excerpt: §50.2.1.1 - General Rule

The MA organization must disenroll a member if:

1. He/she permanently moves out of the service area and his/her new residence is not in a continuation area;
2. The member's temporary absence from the service area (or continuation area, for continuation of enrollment members) exceeds six (6) consecutive months;
3. The member is enrolled in an MA plan that offers a visitor/traveler program and his/her temporary absence exceeds 12 consecutive months (or the length of the visitor/traveler program if less than 12 months);
4. The member is an out of area member (as defined in §10), and permanently moves to an area that is not in the service area or continuation area;
5. He/she permanently moves out of the continuation area of an MA local plan and his/her new residence is not in the service area or another continuation area of the MA local plan;
6. The member permanently moves out of the service area (or continuation area, for continuation of enrollment members in MA local plans) and into a continuation area, but chooses not to continue enrollment in the MA local plan (refer to §60.7 for procedures for choosing the continuation of enrollment option);
7. The member is an out of area member (as defined in §10), who leaves his/her residence for more than six (6) months;
8. The member is incarcerated and, therefore, out of area.

Excerpt: §5.3.1.2 - Effective Date

Generally disenrollments for **reasons 1, 4, 5, 6 and 8** above are effective the first day of the calendar month after the date the member begins residing outside of the MA plan's service area (or continuation area, as appropriate) AND after the member or his/her legal representative notifies the organization that s/he has moved and no longer resides in the plan 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. In the case of incarcerated individuals, MA organizations may receive notification of the individual's out of area status via a TRR; disenrollment is effective the first of the month following the organization's confirmation of a current incarceration. If the member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the first of the month after the move), the MA organization can submit this request to CMS (or its designee) for consideration of retroactive action.

Disenrollment for **reasons 2 and 7** above is effective the first day of the calendar month after six (6) months have passed. Disenrollment for **reason 3** is effective the first day of the 13th month (or the length of the visitor/traveler program if less than 12 months) after the individual left the service area.

Unless the member elects another Medicare managed care plan during an applicable election period, any disenrollment processed under these provisions will result in a change to enrollment in Original Medicare.

4.3.2 Excerpt from 2012 PDP Guidance (Chapter 3), §50.2.1: Sponsor Receives Notification of Possible Residence Change

The Part D sponsor must disenroll an individual when an individual (or legal representative) notifies the PDP that he or she has moved and no longer resides in the service area of a PDP. The sponsor must retain documentation of the permanent change of address and disenroll the individual. If the sponsor offers another PDP in the region into which the beneficiary has moved, the sponsor may use this opportunity to inform the beneficiary of its other PDP product(s).

If the PDP sponsor learns of a beneficiary address change that is outside the PDP service area from either CMS (i.e. a state and county code change on the TRR) or from the U.S. Postal Service (USPS), it must follow the "Researching and Acting on a Change of Address" procedures outlined below.

An SEP, as defined in §20.3.1, applies to individuals who are disenrolled due to a change in residence. An individual may choose another MA or Part D plan (either a PDP or MA-PD) during this SEP.

Excerpt: §50.2.1.1 – General Rule

The Part D sponsor 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 12 consecutive months;
3. The member is incarcerated and, therefore, out of area.

Excerpt: §50.2.1.2 – Effective Date

Disenrollment is effective on the first of the month following the month in which the individual (or his or her legal representative) notifies the PDP sponsor that s/he has moved and no longer resides in the plan 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. In the case of incarcerated individuals, sponsors may receive notification of the individual's out of area status via a TRR; disenrollment is effective the first of the month following the sponsor's confirmation of a current incarceration. If the member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the first of the month after the move), the sponsor can submit this request to CMS (or its designee) for consideration of retroactive action.

Disenrollment as a result of receiving information from either CMS or the U.S. Post Office that the individual has not confirmed will be effective the first day of the calendar month after 12 months have passed.

4.4 Receiving Notification of Possible Residence Change of Existing Member

Information of possible residence change is provided to plans in various ways. Such information may be received through the following sources:

- CMS Reports:
  - Monthly membership report or full enrollment file
  - Daily Transaction Reply Reports (TRRs), including:
    - TRC 016: Enrollment Accepted; Out of Area
    - TRC 154: Out of Area Status
    - TRC 155: Incarceration Notification Received

- Other Sources:
  - User Interface (UI) update – MARx screen message (Figure 4A)
  - Beneficiary (or legal representative) contact
  - Third party contact, including:
    - State files for incarceration status
    - Employer group notification
  - Returned mail

Figure 4A provides an excerpt of Table 10-34 of the Plan Communication User Guide (PCUG).

**FIGURE 4A – EXCERPT OF TABLE 10-34 OF THE PCUG MAIN GUIDE:
MCO REPRESENTATIVE (UI UPDATE) (M221) FIELD DESCRIPTIONS AND ACTIONS**

MESSAGE TYPE	MESSAGE TEXT	SUGGESTED ACTION
Success	Enrollment accepted as submitted, out of area	No action required.

4.4.1 Plan Response to Notification of Possible Residence Change

The clock to determine if a member is out of area begins with the date the plan receives notification of the possible residence change. MA plans must determine out of area within six (6) months. Part D plans must determine out of area within twelve (12) months.

If the notification was a result of a new, prospective enrollment transaction, confirmation of the move is not required. In this case, the plan will receive either:

1. A Transaction Reply Report with a TRC 011, or
2. A Transaction Reply Report with both TRC 100 and TRC 016.

If the plan receives notification for an existing member, the plan must confirm if the possible move is permanent with the beneficiary or the legal representative. This must occur within ten (10) calendar days of receiving such a notification, and the plan must document its efforts.

4.4.2 Excerpt from 2012 MA Guidance (Chapter 2), §50.2.1.3: Researching and Acting on a Change of Address

Within ten 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 TRR, or another source, the MA organization must make an attempt to contact the member to confirm whether the move is permanent (may use Exhibit 34 [of 2012 MA Guidance] if contacting the member in writing). The MA organization must also document its efforts. The requirement to attempt to contact the member does not apply to a prospective enrollment for which the organization receives either transaction reply code 011 (Enrollment Accepted) or 100 (PBP Change Accepted as Submitted) accompanied by 016 (Enrollment Accepted – Out of Area) on the same TRR, as these represent new enrollments for which the organization recently confirmed the individual's permanent residence in the plan service area. In the case of incarcerated individuals, the MA organization is not required to contact the individual but must confirm the individual's out of area (e.g. incarcerated) status. MA organizations may obtain either written or verbal verification of changes in address, as long as the MA organization applies the policy consistently among all members. When an organization 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 organization must continue the individual's enrollment, unless otherwise directed by CMS.

If the MA organization confirms an individual's current incarceration status but does not obtain the start date of the current incarceration, the organization must disenroll the individual prospectively for the first of the month following the date on which the current incarceration was confirmed. If the MA organization confirms an individual's current incarceration status as well as the start date of the current incarceration, the organization must disenroll the individual for the first of the month following the start date of the incarceration. If that disenrollment effective date is outside the range of effective dates allowed by MARx (based on the current calendar month), the MA organization must submit the retroactive disenrollment request to the CMS Retroactive Processing Contractor (see §60.5).

The MA organization 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 MA organization receives notice of a permanent change in address from the member or the member's legal representative, and the new address is outside the MA plan's service area (or continuation area, for continuation of enrollment members), the MA organization must disenroll the member and provide proper notification (Exhibit 36 [of 2012 MA Guidance]). The only exception is if the member has permanently moved into the continuation area and chosen the continuation of enrollment option (procedures for electing a continuation of enrollment option are outlined in §60.8).

2. If the MA organization 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 MA plan's service area (or continuation area, for continuation of enrollment members), the MA organization 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 MA organization must initiate disenrollment when it verifies a move is permanent or when the member has been out of the service area (or continuation area, for continuation of enrollment members) for six (6) months from the date the MA organization learned of the change in address. The MA organization must notify the member in writing of the disenrollment. If the member responded and confirmed the permanent move out of the service area, the MA organization must send the notice (Exhibit 36 [of 2012 MA Guidance]) 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 MA organization must send the notice (Exhibit 35 [of 2012 MA Guidance]) in the first ten days of the sixth month from the date the MA organization learned of the change in address.

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

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

3. Temporary absences - If the MA organization determines the change in address is temporary, the MA organization may not initiate disenrollment until six (6) months have passed from the date the MA organization 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).

   If the MA organization offers a visitor/traveler program, the MA organization must initiate disenrollment if it learns that the individual continues to remain out of the service area during the 12 months (or the length of its visitor/traveler program if less than 12 months).

4.4.3 Excerpt from 2012 MA Guidance (Chapter 2), §50.2.1.4: Procedures for Developing Addresses for Members Whose Mail is Returned as Undeliverable

If an address is not current, the USPS will return any materials mailed first-class by the organization as undeliverable.

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

1. If the USPS returns mail with a new forwarding address, forward plan materials to the beneficiary and advise the plan member to change his or her address with the Social Security Administration.
2. If the organization receives documented proof of a beneficiary change that is outside of the plan service area or mail is returned without a forwarding address, follow the procedures described in §50.2.1.3.
3. If the organization receives claims for services from providers located outside the plan service area, the organization may choose to follow up with the provider to obtain the member's address.
4. If the organization is successful in locating the beneficiary, advise the beneficiary to update records with the Social Security Administration by:
   a. Calling their 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 http://www.ssa.gov/changeaddress.html on the SSA website; or
   c. Notifying the local SSA field office. A beneficiary 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/.

An organization is expected to continue to mail beneficiary materials to the undeliverable address, as a forwarding address may become available at a later date, and is encouraged to continue its efforts, as discussed above, to attempt to locate the beneficiary using any available resources, including CMS systems, to identify new address information for the beneficiary. If a forwarding address becomes available, an organization can send materials to that address as in item #1 above.

4.4.4 Excerpt from 2012 PDP Guidance (Chapter 3), §50.2.1.3: Researching and Acting on a Change of Address

Within ten calendar days of receiving information from either CMS or the USPS that a beneficiary may no longer reside in the service area, a PDP sponsor must make an attempt to contact the member to determine the beneficiary's permanent residence, and must document its efforts in doing so (may use Exhibit 33 [of 2012 PDP Guidance] if contacting the member in writing). The requirement to attempt to contact the member does not

apply to a prospective enrollment for which the sponsor receives either transaction reply code 011 (Enrollment Accepted) or 100 (PBP Change Accepted as Submitted) accompanied by transaction reply code 016 (Enrollment Accepted – Out of Area) on the same TRR, as these represent new enrollments for which the organization recently confirmed the individual's permanent residence in the plan service area. In the case of incarcerated individuals, the PDP may also confirm the individual's out of area (i.e. incarcerated) status with public sources (such as a state/federal government entity or other public records) rather than direct contact with the individual. The PDP sponsor may accept either written or verbal confirmation that an individual has moved out of the service area, as long as the PDP sponsor applies the policy consistently among all members. PDP sponsors may disregard past periods of incarceration that have been served to completion and have not already been addressed by a plan or CMS.

If a sponsor confirms an individual's current incarceration status but does not obtain the start date of the current incarceration, the sponsor must disenroll the individual prospectively for the first of the month following the date on which the current incarceration was confirmed. If a sponsor confirms an individual's current incarceration status as well as the start date of the current incarceration, the sponsor must disenroll the individual for the first of the month following the start date of the incarceration. If that disenrollment effective date is outside the range of effective dates allowed by MARx (based on the current calendar month), the sponsor must submit the retroactive disenrollment request to the CMS Retroactive Processing Contractor (see §60.4).

If the PDP sponsor does not receive confirmation from the member (or his or her legal representative) within a 12 month period, the PDP sponsor must initiate disenrollment. The 12 month period will begin on the date the change of address is identified (e.g. through the TRR or forward address notification from the USPS).

When researching changes of address, CMS encourages sponsors to utilize resources available to them, including any CMS systems interfaces, internet search tools, address information from provider claims, etc.

4.4.5 Excerpt from 2012 PDP Guidance (Chapter 3), §50.2.1.4: Special Procedures for Auto and Facilitated Enrollees Whose Address is Outside the PDP Region

CMS assigns most beneficiaries based on the State Medicaid Agency that reports the individual as dual eligible, even if that state is different than that in the address on CMS' systems. In addition, beneficiaries may move after auto/facilitated enrollment occurs. If the PDP sponsor discovers that an individual whom CMS had auto/facilitated enrolled or reassigned has an address outside of the PDP sponsor's region (e.g. via a state and county code change on the TRR or the USPS), the PDP sponsor must make an attempt to determine the beneficiary's permanent residence and must document its efforts in doing so. The PDP sponsor may accept either written or verbal confirmation that an individual has moved out of the service area, as long as the PDP sponsor applies the policy consistently among all members.

If the sponsor confirms the move is temporary, the PDP sponsor must retain the individual as a member.

If the sponsor confirms the move is permanent and has a PDP in the new region that offers a basic benefit package (i.e. other than enhanced) with a premium at or below the low-income premium subsidy amount for that region, the PDP organization may submit an enrollment transaction to enroll the beneficiary in that PDP prospectively (see Exhibit 27 [of 2012 PDP Guidance]). Sponsors must use the first day of the month prior to the enrollment effective date as the application date and an enrollment source code data value of "B." In this event, no enrollment form or other election is necessary. However, an enrollment form is necessary if the beneficiary chooses to enroll into another type of plan (e.g. enhanced) in the new region.

If the sponsor confirms the move is permanent and does not have a PDP in the new region that offers a basic benefit package with a premium at or below the low-income premium subsidy amount for that region, the PDP sponsor must inform the beneficiary that he/she must enroll in a PDP that serves the area where he/she now resides. The sponsor must disenroll the beneficiary, effective the first of following month (see Exhibit 28 [of 2012 PDP Guidance]).

If the sponsor is unable to contact the auto/facilitated enrolled beneficiary, or receives no response, the PDP sponsor must not disenroll the beneficiary. This includes situations in which the beneficiary's address is listed as a P.O. Box.

4.5 Plan Action: Beneficiary Confirms NO Move

If the member or legal representative confirms that he/she still resides in the plan's service area, they may remain enrolled in the plan. In addition, the plan must update the member's address in CMS systems by submitting a Residence Address Change (RAC – TC 76 transaction) to MARx.

Submit State and County Code (SCC) change request to the RPC (MARx System Issues) only when the TC 76 is unsuccessful.

Both of these actions must be supported by documentation to the RPC. Documentation may include incarceration confirmation documentation, employer group notification or member contact documentation such as a phone log, written correspondence or address verification form. Online screen shots are not acceptable evidence.

It is important that plans do not delay submitting address changes in order to minimize retroactive transactions. Plans should not systematically "push" address information to CMS without current supporting documentation, as this will result in compliance findings through the EDV Review process.

4.6 Plan Action: Beneficiary Confirms Permanent Move

If the member or legal representative confirms that he/she moved out of the plan's service area, they must be disenrolled from the plan. Individuals that are confirmed to be incarcerated must also be disenrolled, as incarceration is considered out of area. For MA plans with continuation areas, individuals must be disenrolled if:

- New residence is OOA and is not in a MA continuation area; or
- New residence is OOA and in a MA continuation area, but member chooses not to continue enrollment in MA local plan.

For all involuntary disenrollments related to out of area, the plan must send a disenrollment notification to the member. Exhibit 36 [of 2012 MA Guidance] may be used for MA plans; Exhibit 35 [of 2012 PDP Guidance] may be used for PDPs.

4.6.1 Excerpt of MA Guidance (Chapter 2), §50.2.1.5: Notice Requirements

MA organization notified of out of area permanent move - When the organization receives notice of a permanent change in address from the member or the member's legal representative, it must provide notification of disenrollment to the member. This notice to the member, as well as the disenrollment transaction to CMS, must be sent within 10 calendar days of the MA organization's learning of the permanent move.

In the notice, the MA organization is encouraged to inform the member who moves out of the service area that he/she may have certain Medigap enrollment opportunities available to them. These opportunities end 63 days after coverage with the MA organization ends. The MA organization can direct the beneficiary to contact the State Health Insurance Assistance Program (SHIP) for additional information on Medigap insurance.

4.6.2 Excerpt of PDP Guidance (Chapter 3), §50.2.1.6: Notice Requirements

Part D sponsor notified of out of area permanent move - When the sponsor receives notice of a permanent change in address from the individual, it must provide notification of disenrollment to the member. This notice to the member, as well as the disenrollment transaction to CMS, must be sent within 10 calendar days of the PDP sponsor's learning of the permanent move.

4.6.3 Determining Effective Date for Involuntary Disenrollment

See section 4.3.1 and 4.3.2 of this participant guide for excerpts from guidance related to disenrollment effective date.

For individuals who confirm the permanent move out of the plan's service area, the effective date is generally the first of the month after the date the member starts to reside outside of the plan's service area AND after the member (or legal representative) notifies the organization of the move. If the individual provides advance notice of the move, the disenrollment effective date is the first of the month following the month in which the individual stated they were moving.

Example

Ms. Jones is enrolled in "Plan Healthy Choice" which has a service area of certain counties in New York**.** On April 10, Ms. Jones calls her plan to tell them she is moving to Florida**.** Her move will take place on July 1**.** Her disenrollment effective date is August 1.

If an individual notifies the plan of the permanent residence change after the move takes place and requests retroactive disenrollment, the effective date may be first of the month after the month of the move or later**.** The effective date may not be earlier than the first of the month after the move.

4.6.4 Processing the Involuntary Disenrollment

Disenrollments due to permanent residence change (out of area) are involuntary.

When submitting the transaction to CMS, select DRC 92 (Move Outside of Plan Service Area). For the identification of the election period to process the disenrollment, select "X" (the SEP for permanent moves).

4.6.5 Case Study #1

Mr. Smith contacts his plan (located in Rhode Island) on March 23, 2012. He states he moved to Texas on January 4, 2012, and requests a disenrollment effective date of January 1, 2012. Is this a valid effective date?

a) Yes
b) No

Answer: _____

Things to keep in mind:

- What is the starting point for this disenrollment request on the workflow chart?
- What would the effective date of disenrollment be if Mr. Smith hadn't requested a retroactive effective date for his disenrollment?
- What is the relationship of the requested retroactive disenrollment date to the date of the actual move?
- What should the plan's contact person tell Mr. Smith?

Notes: _____

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4.7 Plan Action: No Response from Member

The plan must disenroll a member if:

- Member does not respond to address confirmation attempts within six (6) months (MA plan) or twelve (12) months (PDP);
- Member's temporary absence from the service area or continuation area exceeds six (6) (MA plan) or twelve (12) consecutive months (PDP); including
  - Member is enrolled in MA plan that offers visitor/traveler program and temporary absence exceeds twelve (12) months.

For all involuntary disenrollments related to out of area, the plan must send a disenrollment notification to the member. Exhibit 35 [of 2012 MA Guidance] may be used for MA plans; Exhibit 34 [of 2012 PDP Guidance] may be used for PDPs.

4.7.1 Excerpt of MA Guidance (Chapter 2), §50.2.1.5: Notice Requirements

Out of Area for six (6) months - When the member has been out of the service area for six (6) months after the date the MA organization 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 MA organization must provide notification of the upcoming disenrollment to the member. Organizations are encouraged to follow up with members and to issue interim notices prior to the expiration of the six (6) month period.

The notice of disenrollment must be provided within the first ten calendar days of the sixth month. The transaction to CMS must be sent within three (3) business days following the disenrollment effective date.

This notice must also be provided to out of area members (as defined in §10) who leave their residence and that absence exceeds six (6) months.

The CMS strongly encourages that MA organizations send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MA organization services.

EXAMPLE: MA organization receives a TRR on January 20 indicating an "out of area" State and County Code. The six-month period ends on July 20. The MA organization sends a notice to the member within 10 calendar days of receipt of the TRR, and does not receive any response from the member indicating this information is incorrect.

Therefore, the MA organization will proceed with the disenrollment, effective August 1. The MA organization sends a notice to the member during the first 10 calendar days of July notifying him that he will be disenrolled effective August 1. The transaction to CMS must be sent no later than three (3) business days following July 31.

Visitor/Traveler Program Option - When the member has been out of the service area for 12 months (or the length of its visitor/traveler program if less than 12 months), the MA organization must provide notification of the upcoming disenrollment to the member.

The notice of disenrollment must be provided during the first ten calendar days of the 12th month (or the length of its visitor/traveler program). The transaction to CMS must be sent within three (3) business days following the disenrollment effective date.

The CMS strongly encourages that MA organizations send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MA organization services.

4.7.2 Excerpt of PDP Guidance (Chapter 3), §50.2.1.6: Notice Requirements

Out of Area for 12 months - When the individual has been out of the service area for 12 months after the date the sponsor learned of the change in address from either CMS or the USPS and the sponsor has not be able to obtain confirmation, the sponsor must provide notification of the upcoming disenrollment to the individual. Sponsors are encouraged to follow up with members and to issue interim notices prior to the expiration of the 12 month period.

The notice of disenrollment must be provided within the first ten calendar days of the 12th month. The notice should advise the member to notify the PDP sponsor as soon as possible if the information is incorrect. The transaction to CMS must be sent within three (3) business days following the disenrollment effective date.

CMS strongly encourages that sponsors send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use plan services.

4.7.3 Determining Effective Date for Involuntary Disenrollment

See 4.3.1 and 4.3.2 of this participant guide for excerpts from guidance related to disenrollment effective date.

For cases where there is no response, the disenrollment is effective the first day of the calendar month after six (6) months (MA) or twelve (12) months (PDP) have passed since date plan learned of possible OOA status. If the MA plan offers a visitor/traveler program and the temporary absence exceeds twelve (12) months (or the length of the program), the disenrollment is effective the first day of the 13th month after the plan learned of the possible out of area status (or month following end of program).

4.7.4 Processing the Involuntary Disenrollment

Disenrollments due to permanent residence change (out of area) are involuntary.

When submitting the transaction to CMS, select DRC 92 (Move Outside of Plan Service Area). For the identification of the election period to process the disenrollment, select “X” (the SEP for permanent moves).

4.7.5 Case Study #2

Ms. Jones is enrolled in an MA plan. The plan receives returned mail sent to Ms. Jones' address on March 4, 2012. The plan mails a residence verification form to Ms. Jones on March 7, 2012. On April 17, Ms. Jones' son contacts the plan and confirms her permanent move OOA. The son indicates that he is not the legal representative for Ms. Jones. After six (6) months, the plan has not received confirmation of the move, and must disenroll the beneficiary. What is the correct effective date?

a) April 1, 2012
b) May 1, 2012
c) September 1, 2012
d) October 1, 2012

Answer: _____

Things to keep in mind:

- What is the starting point for this disenrollment request?
- When does the "six-month clock" start? When does it end?
- How does end of the "six-month clock" determine the effective date of the disenrollment?
- What else should the plan's contact person tell the beneficiary's son?
- What should the plan do if the verification form comes back before six months have passed? What would be the effective date in that circumstance?

Notes: _____

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4.8 Plan Action: No Response from Member AND Other Related Disenrollment Policies

Plans must apply all other disenrollment processes while determining if a member is out of area. If an involuntary disenrollment applies, process the transaction based on the action that caused the disenrollment. Other reasons may include non-payment of premiums, loss of special needs eligibility, etc. The disenrollment effective date follows whichever disenrollment policy completes its process first, causing the disenrollment action. In other words, process whichever disenrollment policy scenario occurs first.

Example

Mr. Keller is enrolled in "Big Apple Part D Plan" (PDP) which serves all of Ohio. "Big Apple Part D Plan" also has a policy to disenroll for non-payment of premiums, and has a three (3) month grace period before involuntarily disenrolling members. On September 1, the plan received a TRC 154 on their TRR, and started the 12-month clock to research and determine if the member is permanently residing out of the plan's service area. "Big Apple Part D Plan" attempted contact and received no response. They sent a letter to the member to attempt to get a response. Each month, the plan attempts contact with Mr. Keller. Starting in January, the plan stopped receiving premium payments from Mr. Keller. "Big Apple Part D Plan" also attempts to contact Mr. Keller about his premium delinquency, following guidance in §50.3.1 of Chapter 3, including sending notices of possible disenrollment.

If the plan's grace period for non-payment ended before response/confirmation of a permanent move had been received, the plan would involuntarily disenroll Mr. Keller for non-payment of premiums. Conversely, if the plan

received response/confirmation of a permanent move prior to the ending of the non-payment of premiums grace period, and the disenrollment effective date for the move occurred earlier than the possible effective date for non-payment of premiums, the plan would involuntarily disenroll Mr. Keller for a move outside of the plan area.

The notice used to notify the member of the involuntary disenrollment matches the reason code for the disenrollment.

4.8.1 Case Study #3

On February 24, 2012, a MAPD plan receives a TRC 154 indicating Ms. Blue is out of area. The plan attempts to contact Ms. Blue via phone and sends a verification letter. On March 1st, the plan starts the three (3) month grace period clock as Ms. Blue has not paid her premium. Today is June 1st and neither payment nor address confirmation has been received. What is the plan's correct action?

a) Submit a retroactive disenrollment request to the RPC effective March 1, 2012 for OOA.
b) Process a disenrollment effective July 1, 2012 for non-payment.
c) Wait until August 24, 2012 to process a disenrollment effective September 1, 2012 for OOA.
d) Submit a retroactive disenrollment request to the RPC effective April 1, 2012 for non-payment.

Answer: _____

Things to keep in mind:

- What is the starting point for this disenrollment request?
- When does the "OOA clock" start? When does it end?
- What are the possible disenrollment dates in this situation?
- Which date is the one that will apply in this situation?
- For which reason is the beneficiary disenrolled?

Notes: _____

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4.9 Plan Action: Incarceration

If the incarceration status is learned via TRR or a third party, the organization must confirm the status is correct. Confirmation of incarceration cannot be verified via CMS systems. Plans can confirm incarceration status through the following:

- Contact with beneficiary or legal representative;
- State/Federal Entities;
- Public records; and/or
- Inmate locator web sites.

If incarceration occurred in past (i.e., the individual is released and no longer incarcerated), plan may not disenroll and must retain the member.

4.9.1 Determining Effective Date for Involuntary Disenrollment

See 4.3.1 and 4.3.2 of this participant guide for excerpts from guidance related to disenrollment effective date.

If an incarceration start date is obtained, the disenrollment is effective the first of the month following the start date of the incarceration. This transaction may need to be submitted to the RPC for retroactive processing based on the valid effective date.

If an incarceration start date is not obtained, the disenrollment is effective for the first of the month following the month the incarceration status is confirmed. And, if the status cannot be confirmed within six (6) months (MA) or within twelve (12) months (PDP) of the initial notification, the disenrollment is effective the first day of the month after the six (6) or twelve (12) months have passed.

4.9.2 Case Study #4

On May 5, 2012, a PDP receives a TRC 154 indicating Mr. Doe is incarcerated in a facility within the plan's service area. On May 21, 2012, the plan receives a state file confirming Ms. Doe's incarceration starting January 27, 2012. What is the plan's next step?

a) Process a disenrollment effective June 1, 2012.
b) Process a disenrollment effective February 1, 2012.
c) Submit a disenrollment request to the RPC effective February 1, 2012.
d) No action is required. The facility is within the plan's service area.

Answer: _____

Things to keep in mind:

- Does it matter that the facility is in the plan's service area?
- What should the plan do with the state file?
- What is the effective date of disenrollment?
- When does the "OOA clock" start? When does it end? Is it relevant?
- What should the plan have done if it didn't receive confirmation of the incarceration?
- What should the plan do if it finds out that Ms. Doe was released on April 14, 2012?

Notes: _____

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2012 Regional Technical Assistance

Enrollment

Electronic Retroactive Processing Transmission (eRPT)

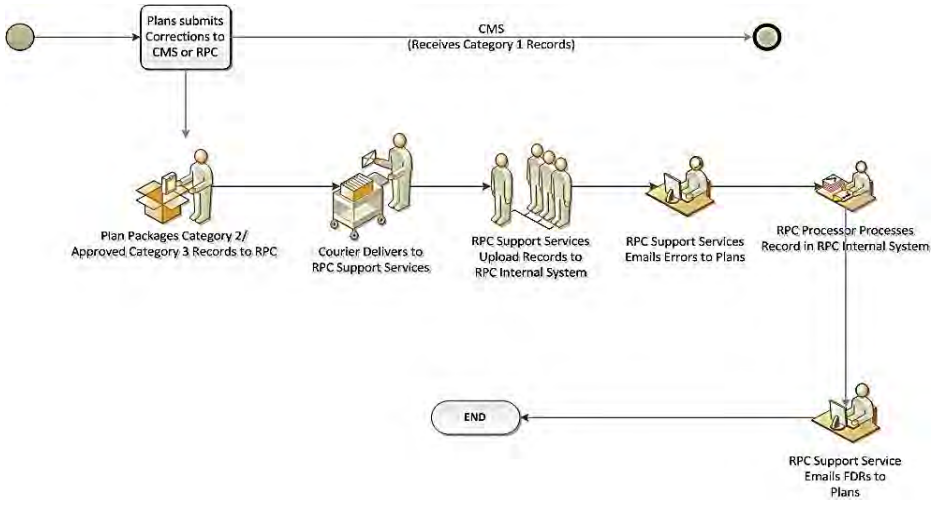
Agenda

- Introduction
- Current Process for Retroactive Submission
- Overview of eRPT Application
- Plan User Roles in eRPT
- How eRPT will Improve the Process for Plan Users
- Features of eRPT
- Benefits of eRPT
- Access to the eRPT Application
- Application Walkthrough
- eRPT Application Training
- eRPT Availability
- eRPT Support
- Questions

Introduction

- eRPT CMS Business Owner
  - Andrea Hamilton
- eRPT CMS Business Owner - Back Up
  - Tammie Wall
- eRPT Development Team
  - CAS Severn, Inc.

Current Process for Retroactive Submission



Overview of eRPT Application

- The Electronic Retroactive Processing Transmission (eRPT) is a web-based application.
- It is designed to facilitate and manage electronic submission, workflow processing, and storage of documentation associated with MAPD, MA only, COST, PACE, Private Fee-for-Service, and Prescription Drug Plan (PDP) retroactive change requests.

Overview of eRPT Application (continued)

- It also includes creating inquiry requests and Enrollment Data Validation review packages based on the user access level.
- eRPT also provides the capability for a Plan User to respond to an Enrollment Data Validation review package submitted by either CMS or RPC.
- The CMS Regional Office approval process occurs entirely within the system.

Plan User Roles in eRPT

- Create Retroactive Packages.
- Create Transaction Inquiry Requests.
- Review response documents provided by RPC. For example: FDR, Error Report, etc.
- Receive and act on Notifications.

How eRPT Will Improve the Process for Plan Users

- Plan Users will no longer need to burn information on to CDs to submit requests to RPC.
- Plan Users will no longer need to mail or email any information to the RPC.
- Plan submissions will reach RPC in a more timely fashion.
- Plan Users will also no longer need to contact Regional Office Account Managers via email for RO Approval Letters.

Features of eRPT

- Internet facing user interface
- User-friendly interface to create and view retroactive packages
- Tracks package status easily via the user interface
- Notifications within eRPT when there is any action taken by the RPC
  - For example: If there are any documents submitted by RPC for the Plans to review

Benefits of eRPT

- Eliminates costs associated with mailing any submission to the RPC.
- Requests to Regional Office Account Managers for approval letters can be handled within eRPT.
- Retroactive submissions can be tracked within eRPT.
- All packages and responses can be tracked within eRPT by any user who has access to the contract.

Access to the eRPT Application

- Plan Users with the following MARx job codes mapped to their IACS User ID will have access to the eRPT application:
  - mama-representative
  - mama-coreeuiupdate
- Additional Plan Users who require access to eRPT application will need to send an email to:
  - CMS_eRPTinquiries@cms.hhs.gov
- The URL to eRPT will be provided by the MAPD Help Desk once the application is live.

Application Walkthrough

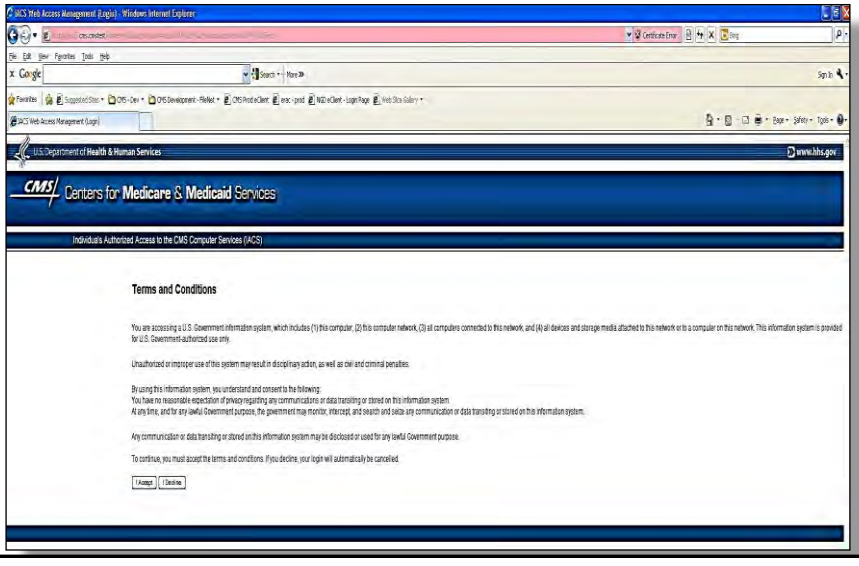
- Login
- Introduction to the eRPT application User Interface
- Create Package – Submission Package
- Update Package
- Delete Package
- Create Package – Transaction Inquiry
- Search Package
- View Package
- Add Response Documents to Review Package
- Track Package Status
- Notifications

Login

- The eRPT application can be accessed using the URL that will be provided by the MAPD Help Desk.
- Upon accessing the above mentioned URL, the login screen will display.

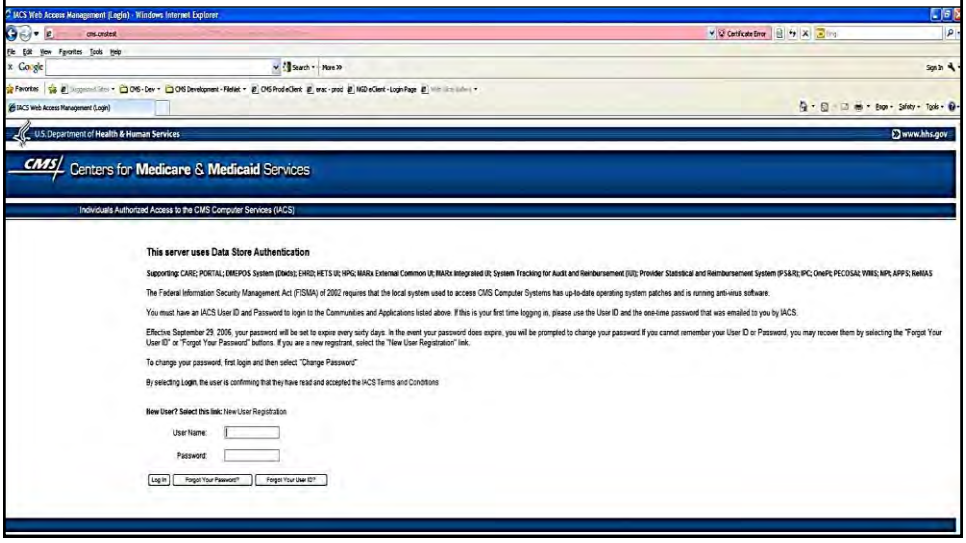
Login (continued)

Please read the Terms and Conditions. Click the ***"I Accept"*** button.



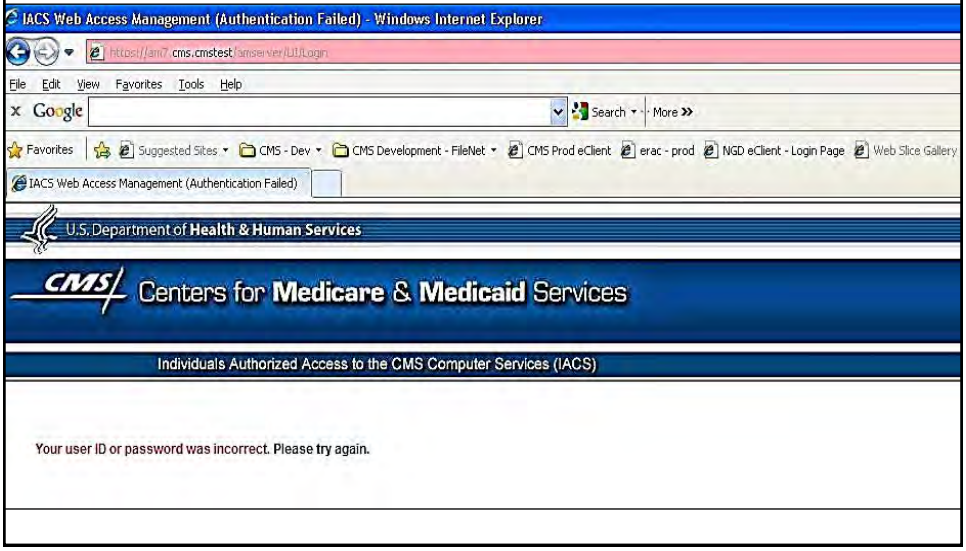
Login (continued)

Please enter your EUA ID/IACS ID and password to login to the eRPT application, and click the ***"Log In"*** button.



Login (continued)

If the wrong credentials are entered, the following screen will display.



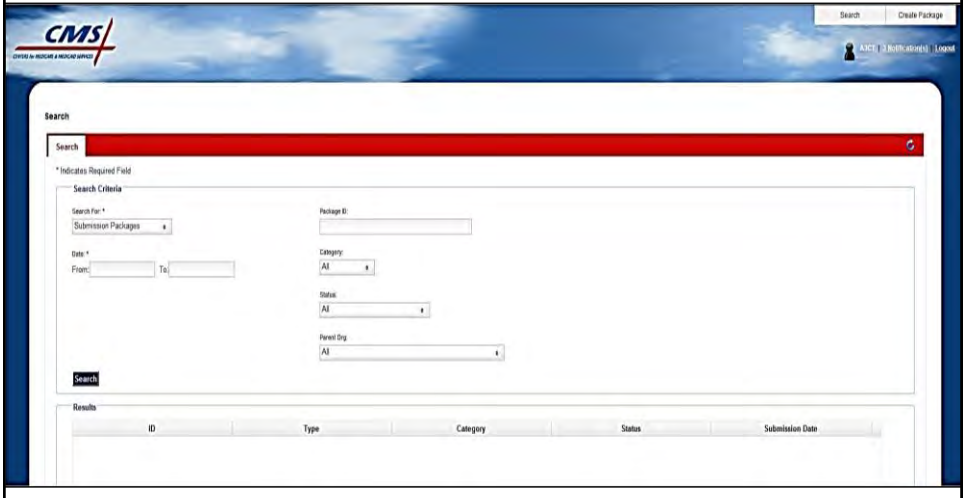
Login (continued)

Upon successful login, the user will see the eRPT application landing page.

Note: Based on the user access, the landing page may be different.

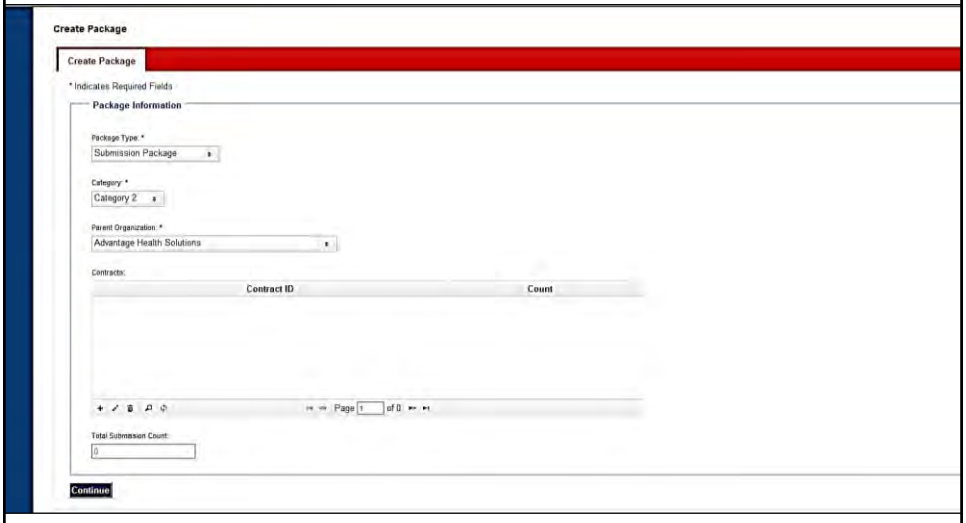
Introduction to the eRPT Application User Interface

Search Page



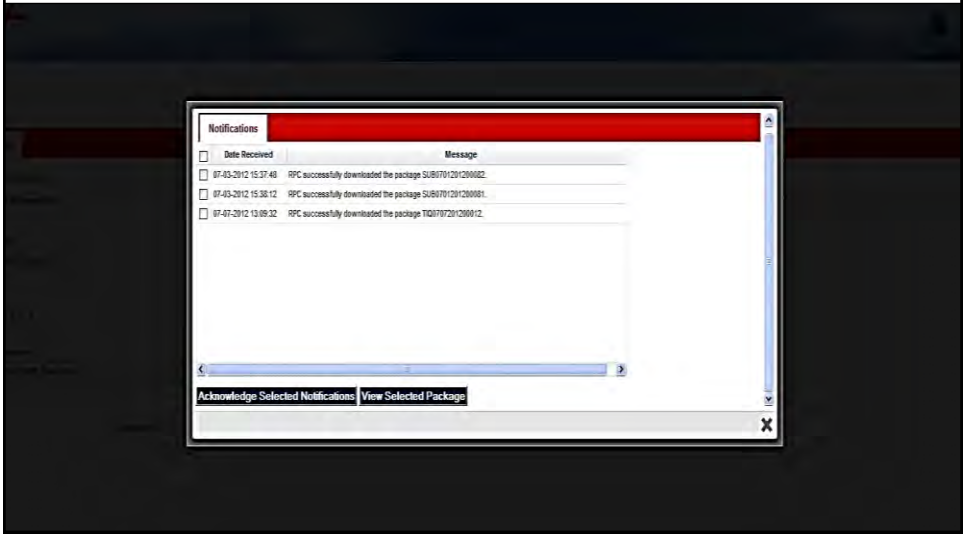
Introduction to the eRPT Application User Interface (continued)

Create Package



Introduction to the eRPT Application User Interface (continued)

Notifications



Exiting the eRPT Application

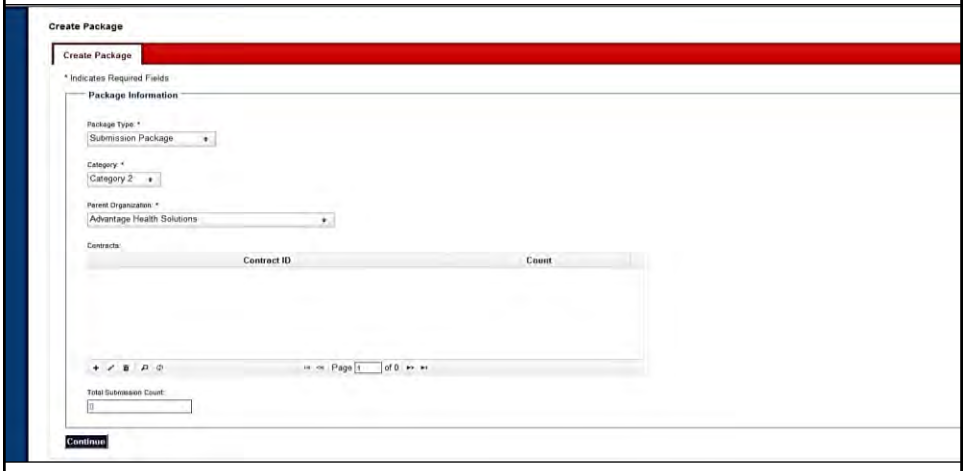
Click the ***"Logout"*** link on the top right of the screen.

Exiting the eRPT Application (continued)

Upon successfully logging out of the eRPT application, the users will see the screen as shown below.

Create Package – Submission Package

Login to the eRPT application, then select the ***"Create Package"*** menu option on the top right corner of the screen.

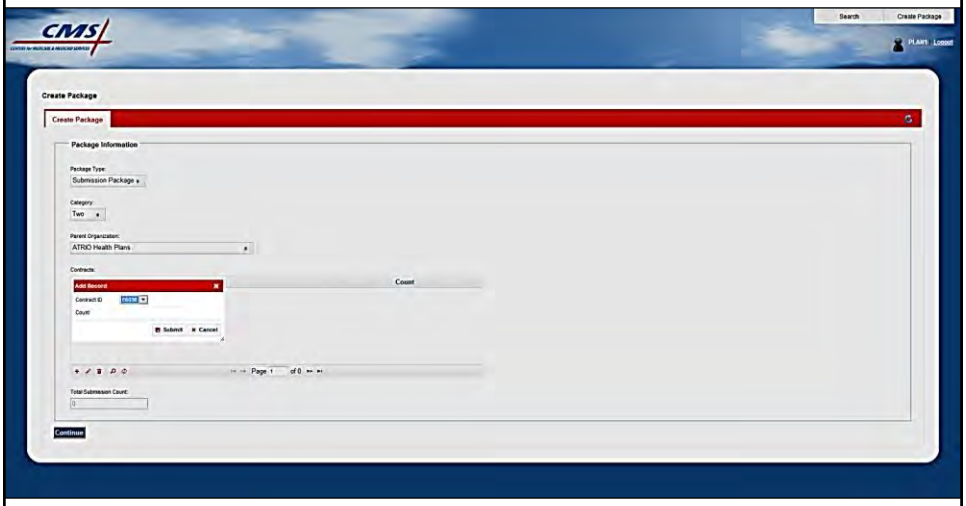


Create Package – Submission Package (continued)

- This screen allows the user to enter the details for Submission Package.
- The following fields need to be entered to create a Submission Package:
  - Package Type – Select "Submission Package" from the drop down.
  - Category – Select the category code appropriate to the package from the dynamically populated drop down.
  - Parent Organization – Select your Organization from the drop down.
  - Contracts:
    - Contract Id – Select the contract ID from the drop down.
    - Count – Enter the number of transactions submitted for the contract.

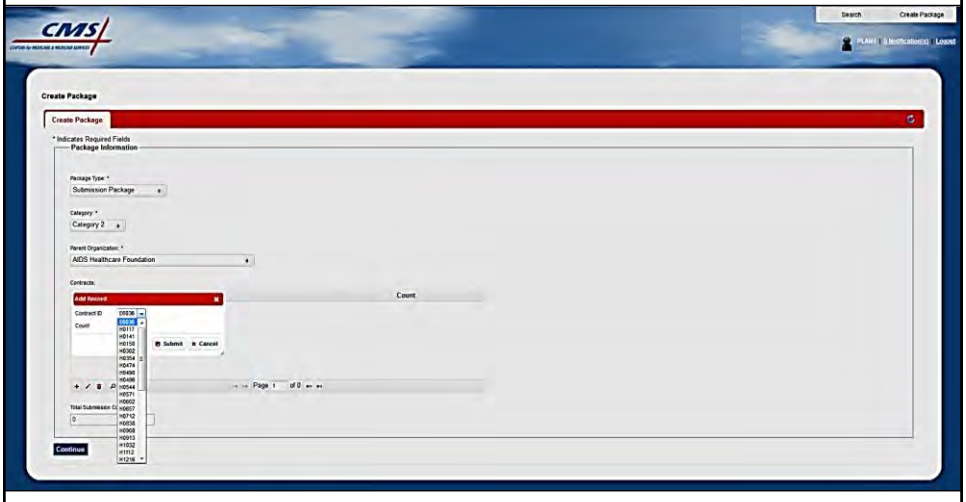
Create Package – Submission Package (continued)

To add contract information, select the "**+**" icon in the contracts grid, and a pop-up window will appear as shown below.



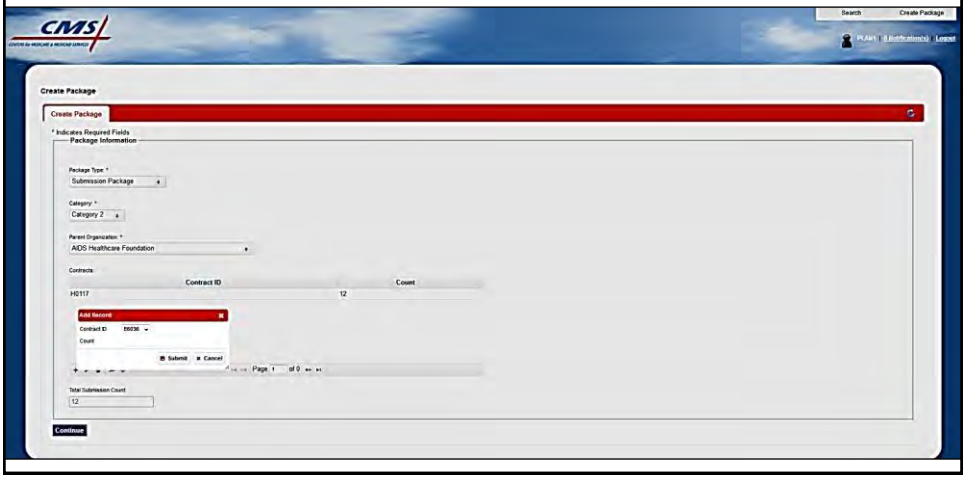
Create Package – Submission Package (continued)

For a Plan User, the contract ID will be populated automatically based on the contracts that the Plan User has access to as shown below.



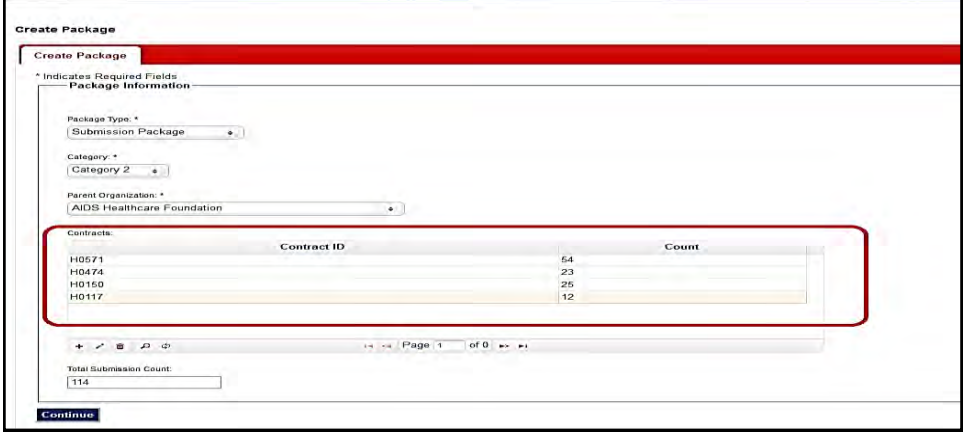
Create Package – Submission Package (continued)

- Select the Contract from the drop down for "***Contract ID***".
- Enter the number of transactions in the "***Count***" field.
- Click the "***Submit***" button.
- The contract information will be added in the Contracts grid as shown below.



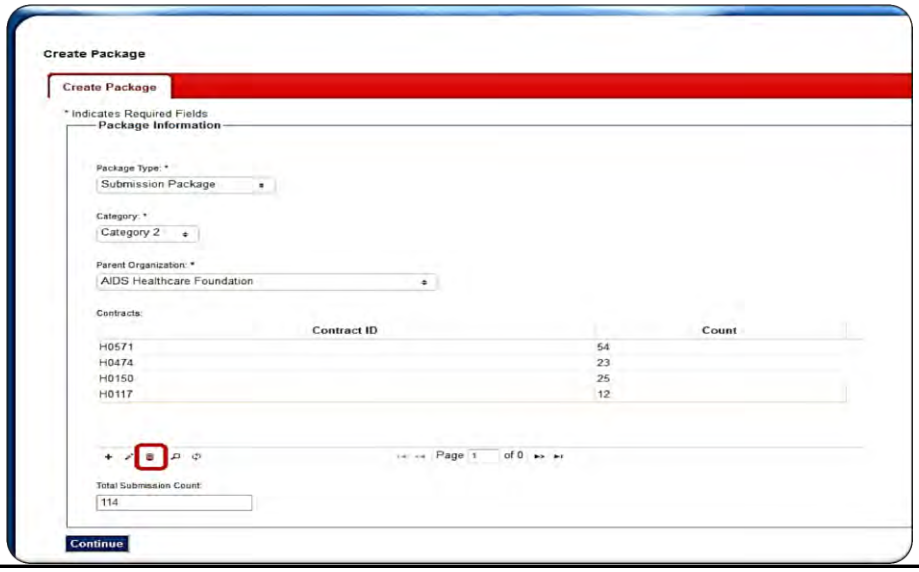
Create Package – Submission Package (continued)

- Click the "***Cancel***" button, or click the "***X***" on the Add Contracts pop-up window to exit.
- To delete any contract information added in the contracts grid, complete the following steps:
  - Select Contract row in the contracts grid.
  - The Contract row will be highlighted as shown below.



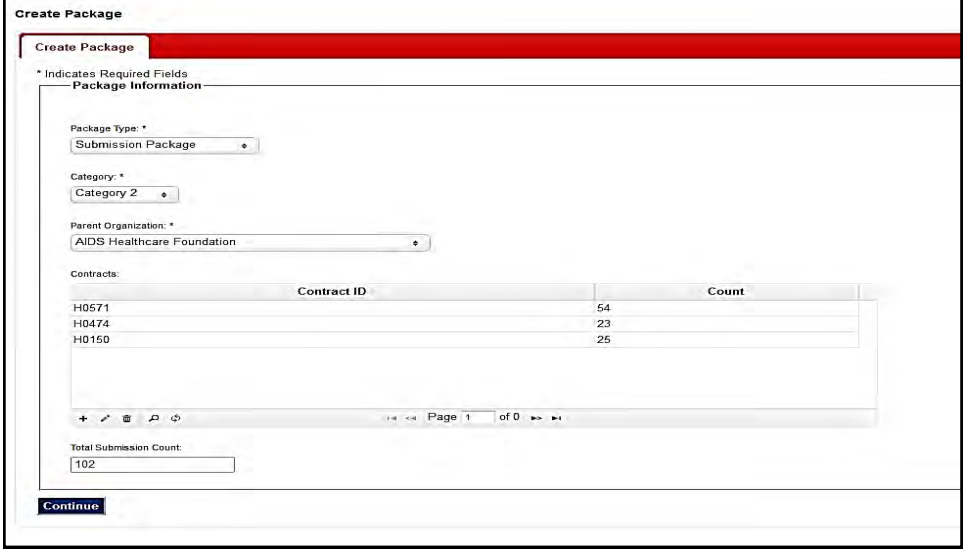
Create Package – Submission Package (continued)

Click the delete icon (trash can) as shown below to delete the contract.



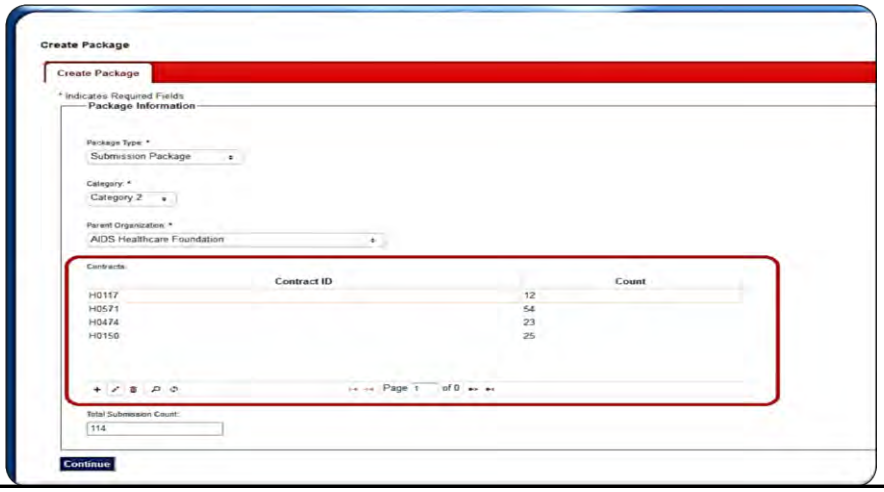
Create Package – Submission Package (continued)

The contract information will be deleted as shown below.



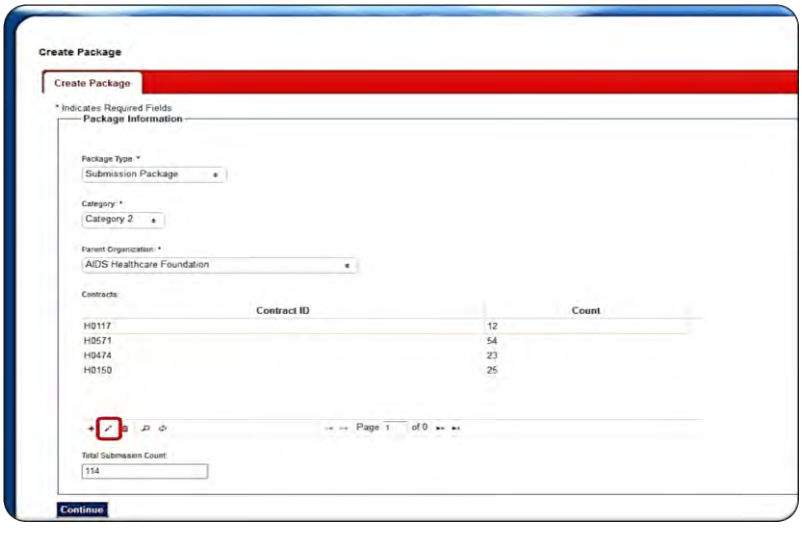
Create Package – Submission Package (continued)

- To edit any contract information added in the contracts grid, complete the following steps:
  - Select the contract row in the contracts grid.
  - The contract row will be highlighted as shown below.



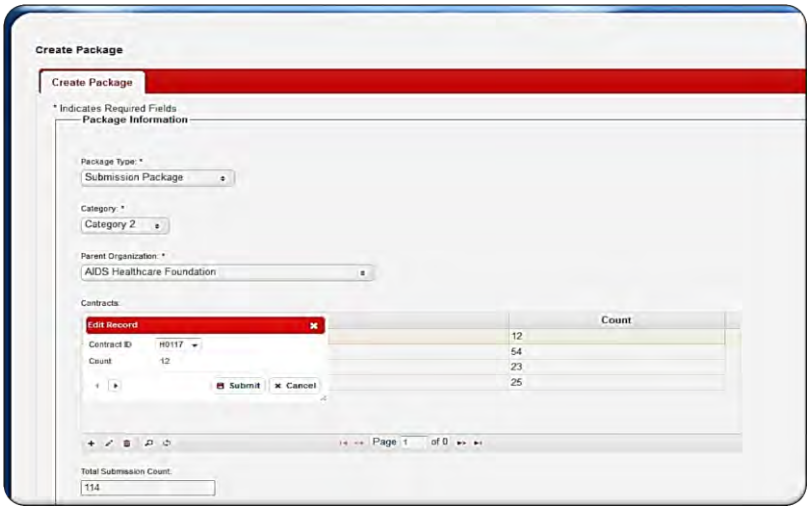
Create Package – Submission Package (continued)

Click the edit icon (pencil) as shown below to edit the contract information.



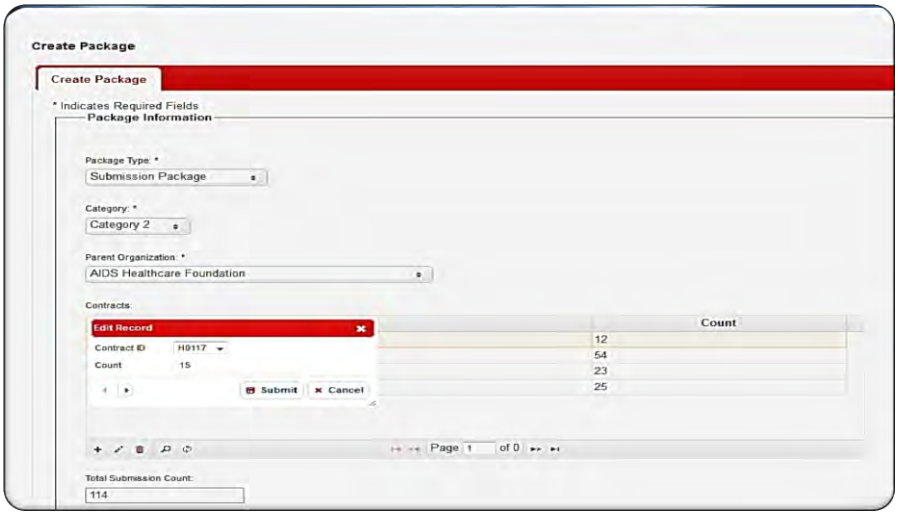
Create Package – Submission Package (continued)

The Edit Record pop-up window will appear on the screen as shown below.



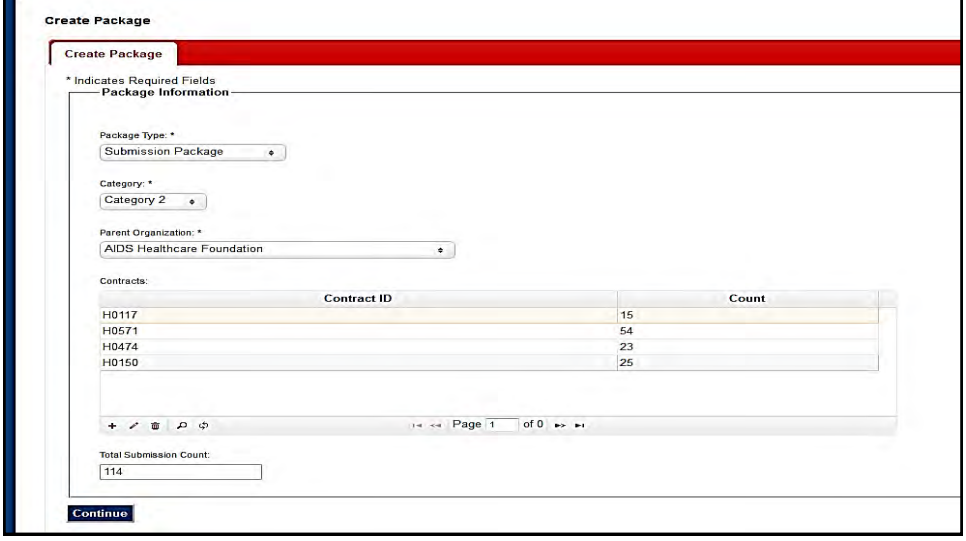
Create Package – Submission Package (continued)

Update the contract information as required. In this example, we will update the count to 15 and click the ***"Submit"*** button.



Create Package – Submission Package (continued)

The user will be able to see the updated information in the contracts grid as shown below.

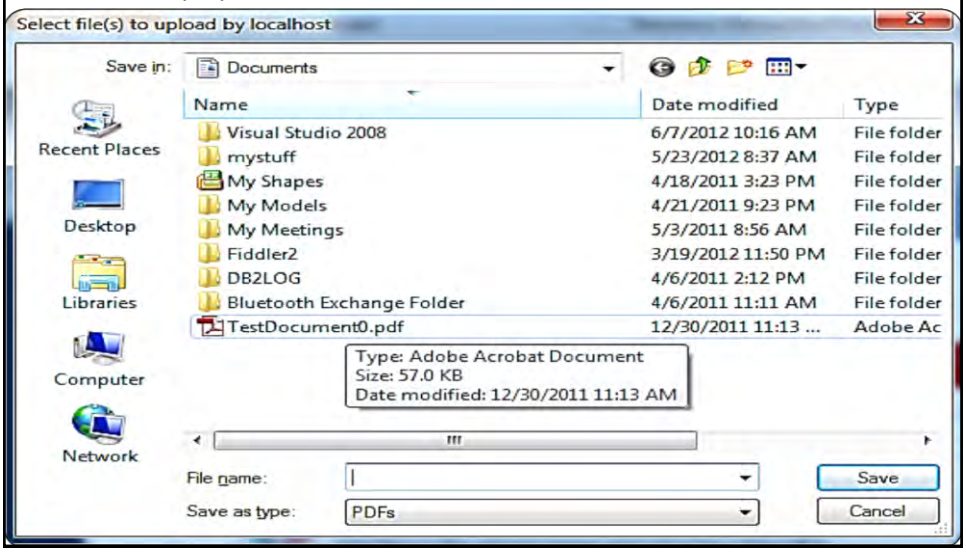


Create Package – Submission Package (continued)

- After entering all the information required for package creation, click the "**Continue**" button.
- The user can upload the documents to a package using the options available on the Documentation screen.

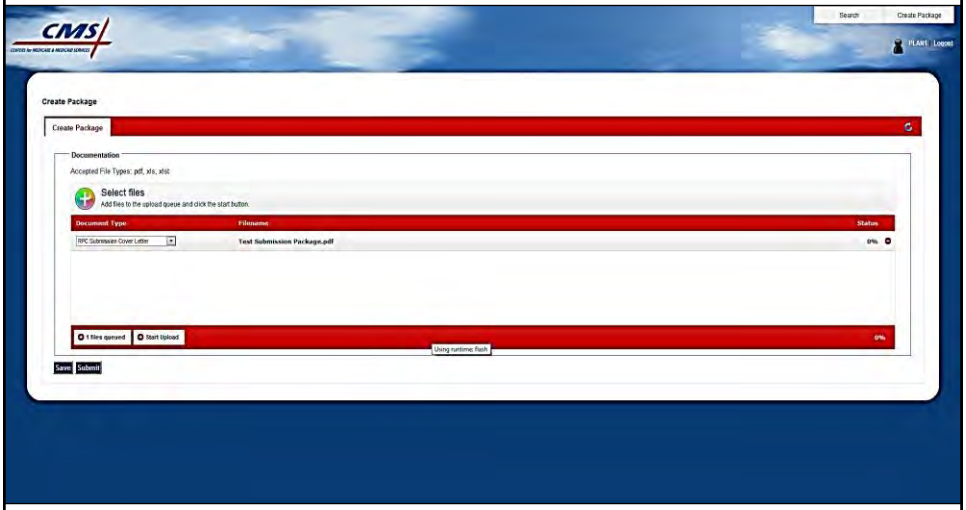
Create Package – Submission Package (continued)

Click the "***Add Files***" button. The Windows Explorer pop-up window will be displayed for the user to select the documents as shown below.



Create Package – Submission Package (continued)

Select the files you want to add to the package and click the "***Save***" button. The selected documents will display in the user interface as shown below.

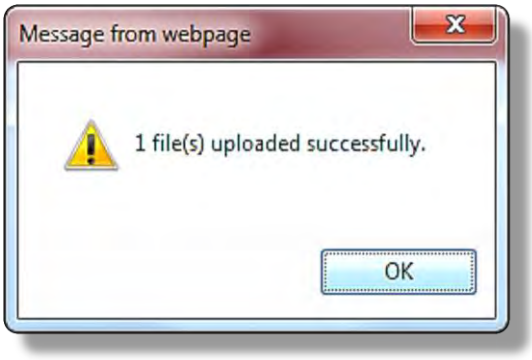


Create Package – Submission Package (continued)

- Select the appropriate document type value from the dropdown for each document.

  Note : For creating a submission package, the default value for all the documents will be "RPC Submission Spreadsheet". The default document type value will vary based on the package type and the step in the process.

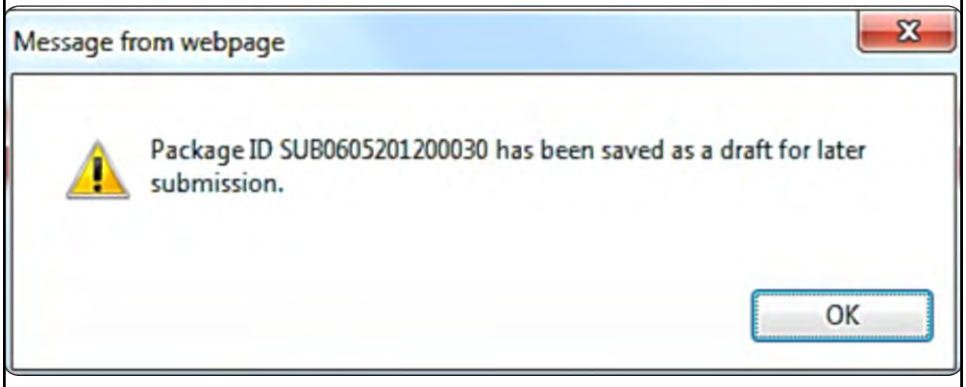
  Note: If a user needs to submit a submission package, they should upload a minimum of one document for each of the following document types:



  - RPC Submission Cover Letter;
  - RPC Submission Spreadsheet; and
  - RPC Supporting Documentation.
- Click the "***Start Upload***" button.
- Upon successfully uploading the documents, this message will be displayed to the user.

Create Package – Submission Package (continued)

- Click the "***OK***" button.
- Now the user can either 'Save' the package or 'Submit' the package by clicking the respective button.
  Note: For saving the package, the user does not need to upload any documents.
- To save a package, the user will need to click the "***Save***" button. The following message will be displayed to the user.

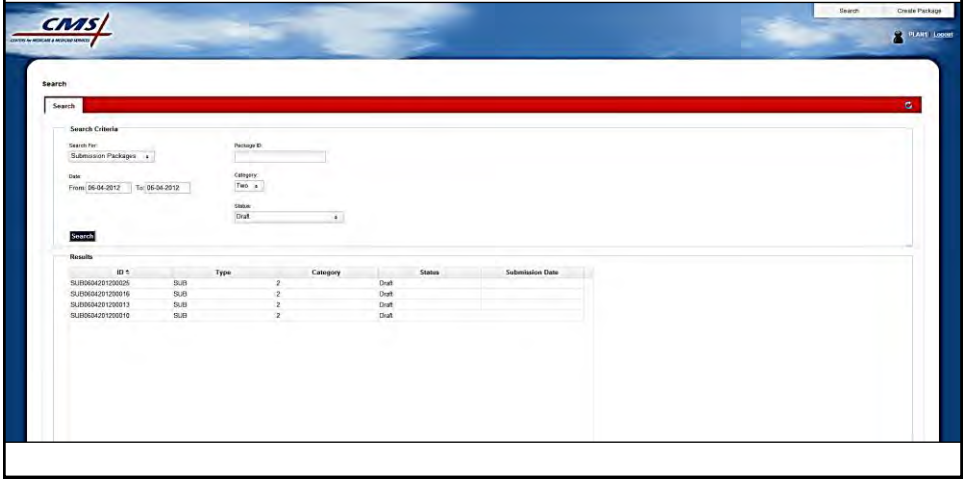


Update Submission Package

Login to the eRPT application, and select the "***Search***" menu option on the top right corner of the screen as shown below.

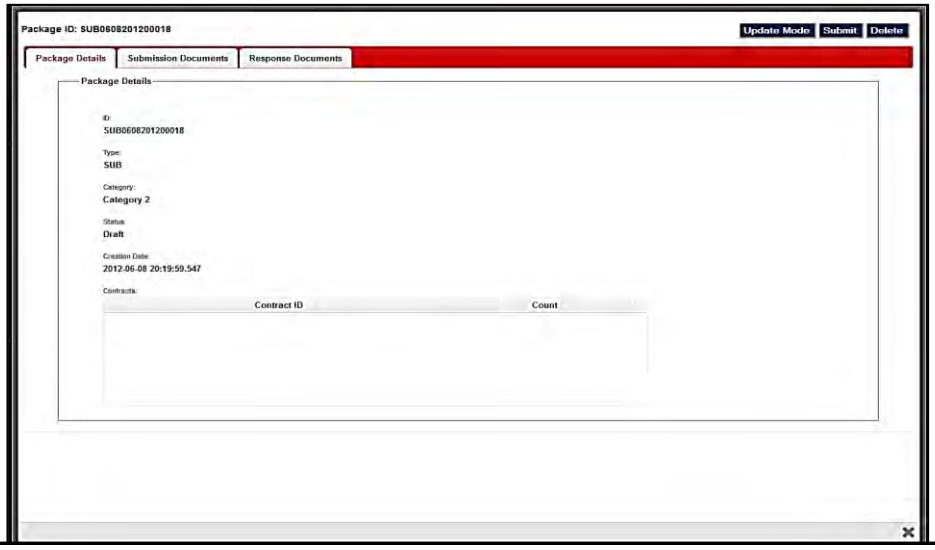
Update Submission Package (continued)

- Enter the search criteria to retrieve the package.
- Click the "***Search***" button.
- The search results will be displayed in the results grid as shown below.



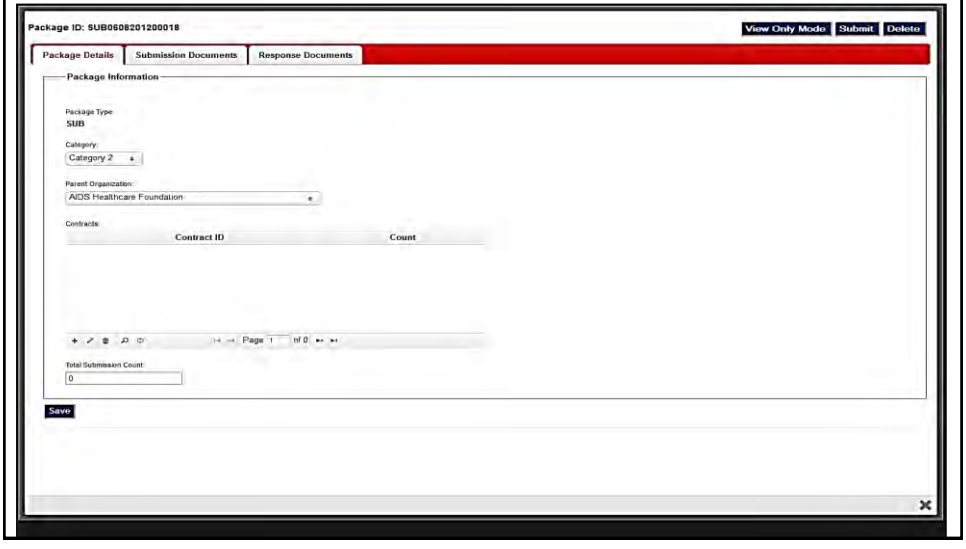
Update Submission Package
(continued)

Open the package that you want to update by double clicking on the package in the results grid as shown below.



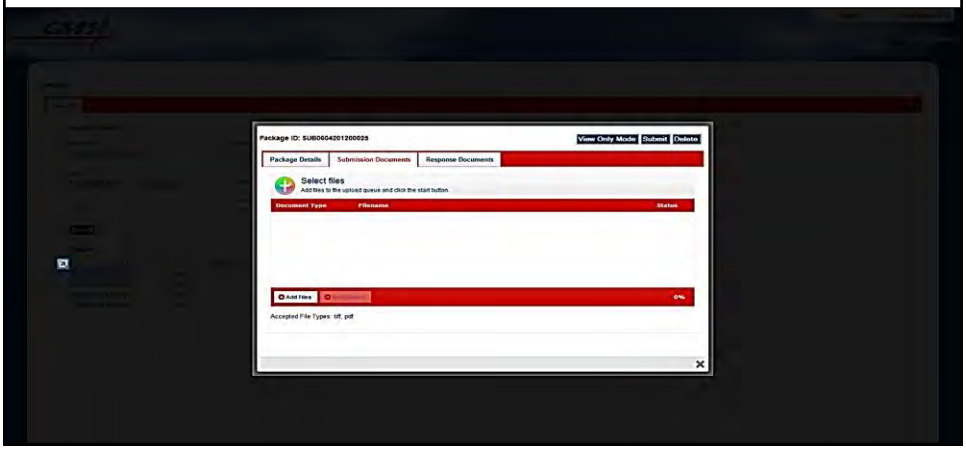
Update Submission Package
(continued)

Click the "***Update Mode***" button from the top right corner of the package screen as shown below.



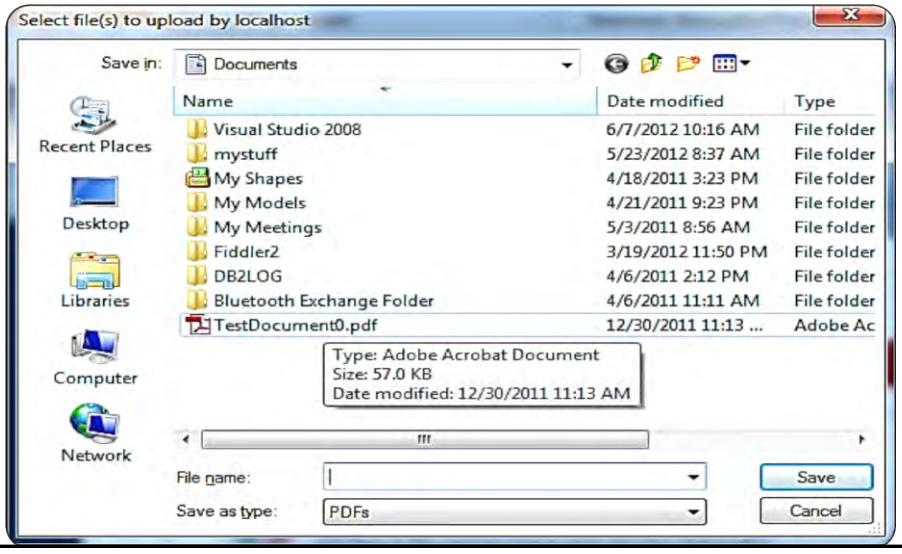
Update Submission Package
(continued)

- If a user needs to update the package attributes, they should select the "***Package Details***" tab.
- Update the attributes, and click the "***Save***" button to save the changes.
- To add additional documents, select the Submission Documents tab as shown below.



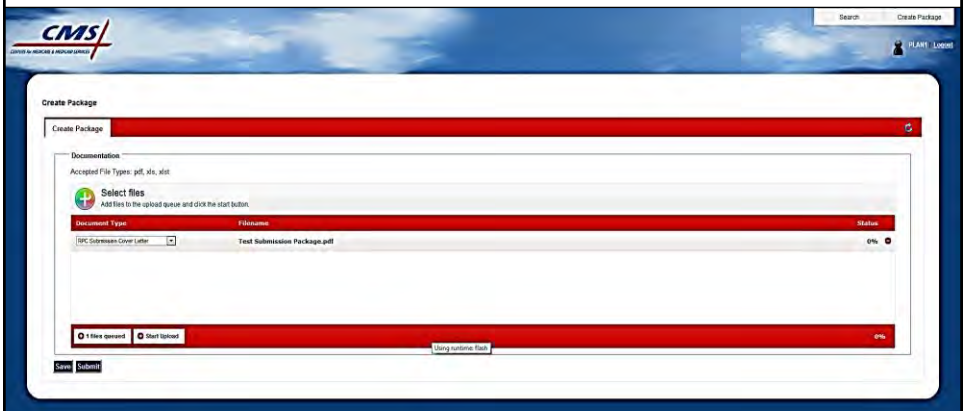
Update Submission Package
(continued)

Click the "***Add Files***" button. The Windows Explorer pop-up window will be displayed for the user to select the documents as shown below.



Update Submission Package
(continued)

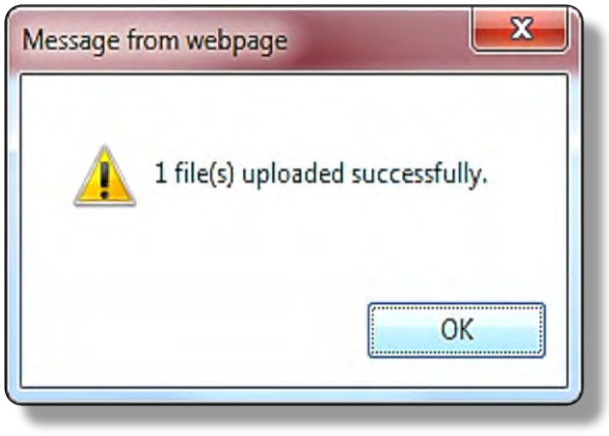
Select the files you want to add to the package, and click the "***Save***" button. The selected documents will display on the user interface as shown below.



Update Submission Package
(continued)

Select the appropriate document type value from the drop-down, and click the "***Start Upload***" button. Upon successful upload, the user interface will display the following message.

Note: The message in the pop-up window will display the number of documents that were uploaded into the package.

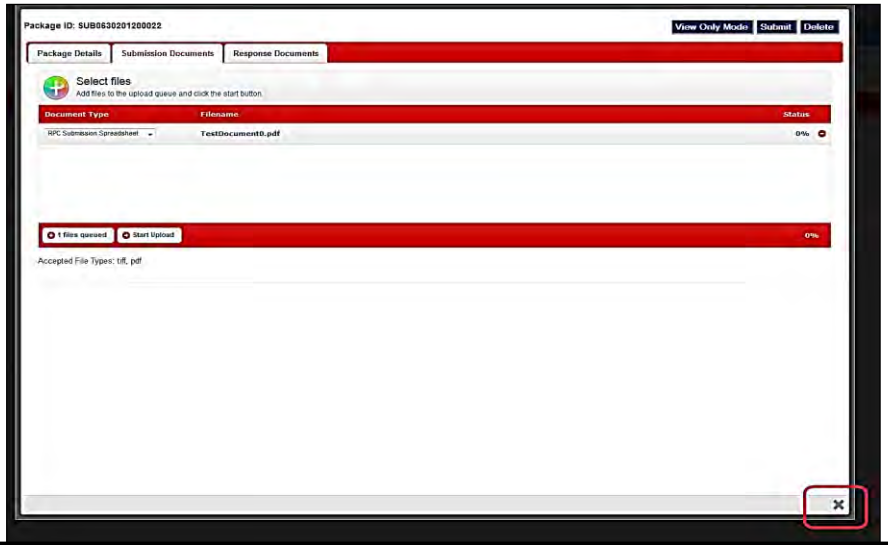


Update Submission Package
(continued)

- The User can select one of the following actions:
  - Submit the package.
  - Close the package screen.
  - Switch back to the View Mode.
  - Delete the package.
- To submit the package, click the **"*Submit*"** button on the top right corner of Package Screen as shown below.

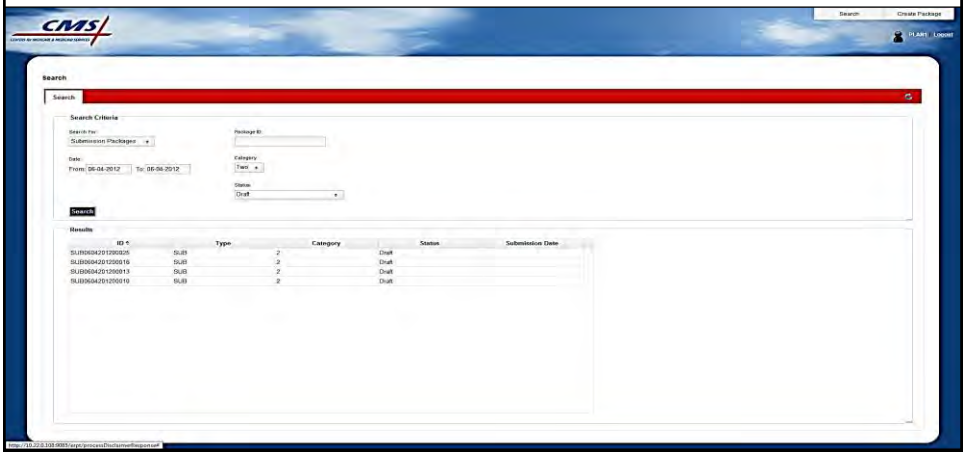
Update Submission Package
(continued)

To close the package screen, click the "***X***" at the bottom right corner of the screen as shown below.



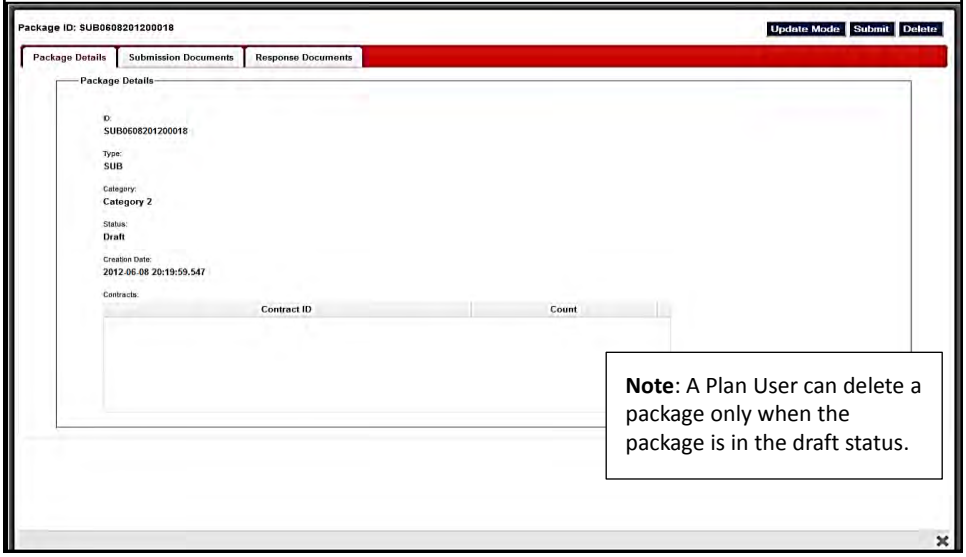
Delete Submission Package

- Login to the eRPT application.
- Select the "***Search***" menu option on the top right corner of the screen.
- Enter the search criteria to retrieve the package.
- Click the "***Search***" button.
- The search results will be displayed in the results grid as shown below.



Delete Submission Package (continued)

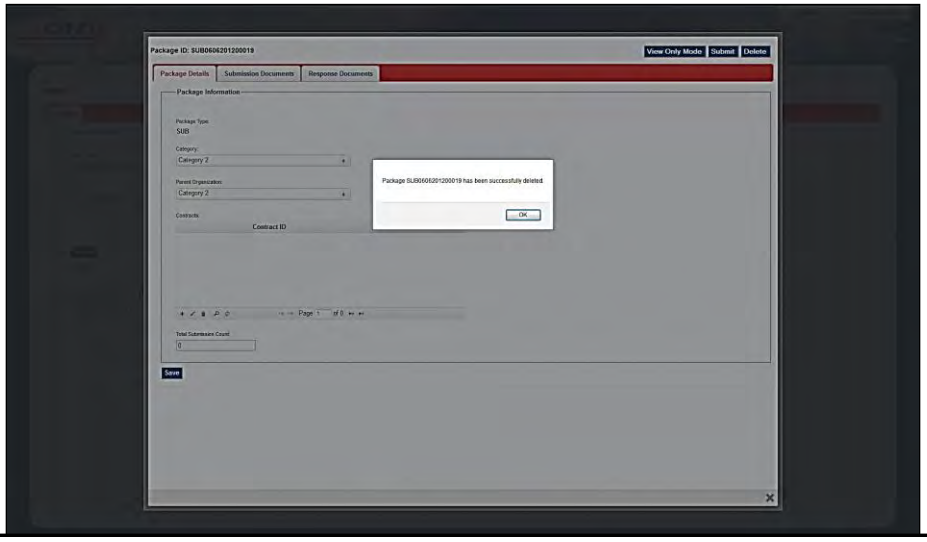
Open the package that you want to delete by double clicking on the package.



Note: A Plan User can delete a package only when the package is in the draft status.

Delete Submission Package (continued)

Click the "***Delete***" button on the top right corner of the screen.
The following message will be displayed.



Create Package – Transaction Inquiry

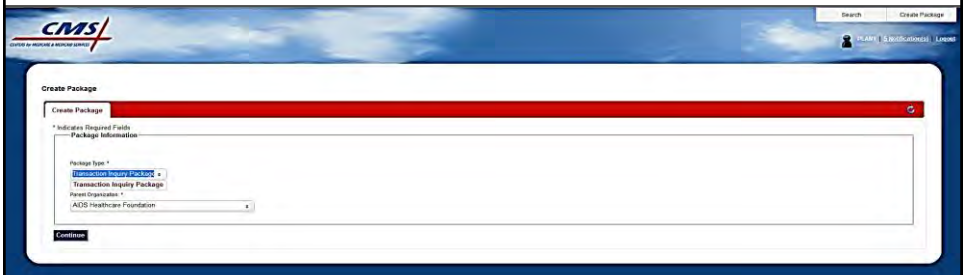
- Login to the eRPT application.
- Select the "***Create Package***" menu option on the top right corner of the screen.

  Note: Based on the Package Type selection, the fields that need to be populated will vary.

Create Package – Transaction Inquiry (continued)

The Create Package screen allows the user to enter the details for the Transaction Inquiry Package.

- ***Package Type*** - Select Transaction Inquiry from the drop down.
- ***Parent Organization*** - Select the Parent Organization to which the package belongs.



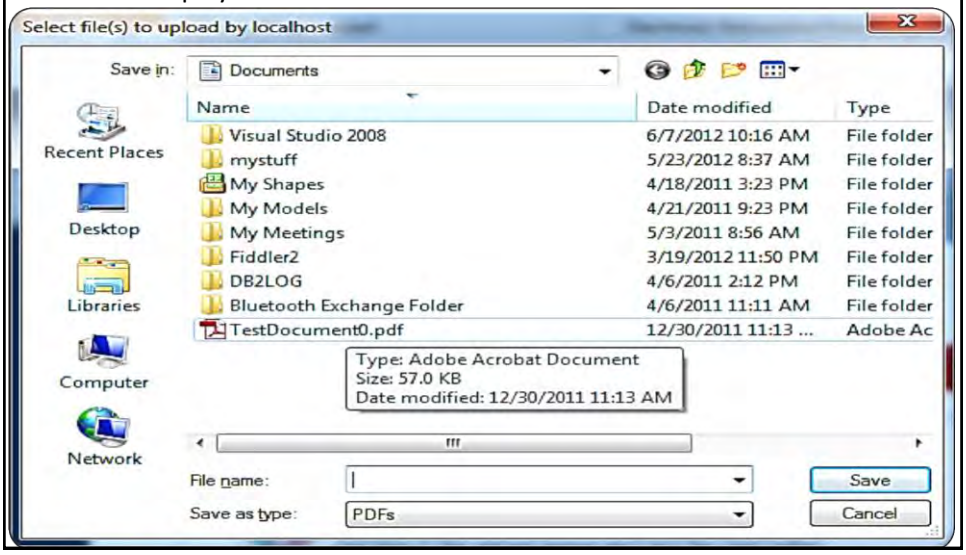
Note: If the User Parent Organization is not available in the drop down, please contact the eRPT Business Owner.

Create Package – Transaction Inquiry (continued)

- After entering all the information required for the package, click the "***Continue***" button.
- The user can add documents to a package using the options available on the Documentation screen as shown below.

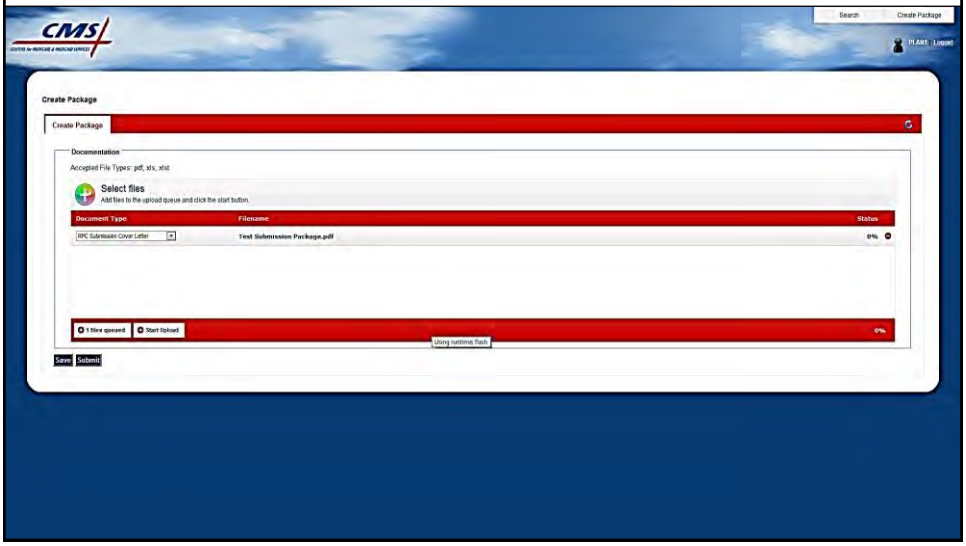
Create Package – Transaction Inquiry (continued)

Click the "***Add Files***" button**.** The Windows Explorer pop-up window will be displayed for the user to select the documents as shown below.



Create Package – Transaction Inquiry (continued)

Select the files you want to add to the package, and click the "***Save***" button. The selected documents will display on the user interface as shown below.

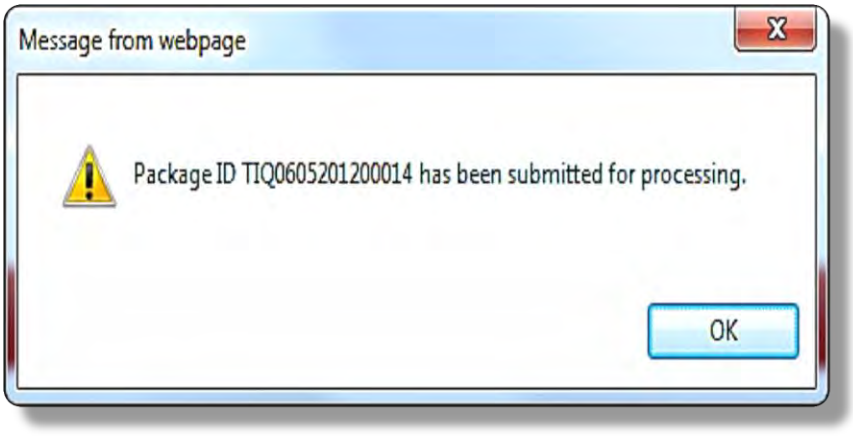


Create Package – Transaction Inquiry (continued)

Click the "***Start Upload***" button. Upon successful upload, the user interface will display the following message.

Create Package – Transaction Inquiry (continued)

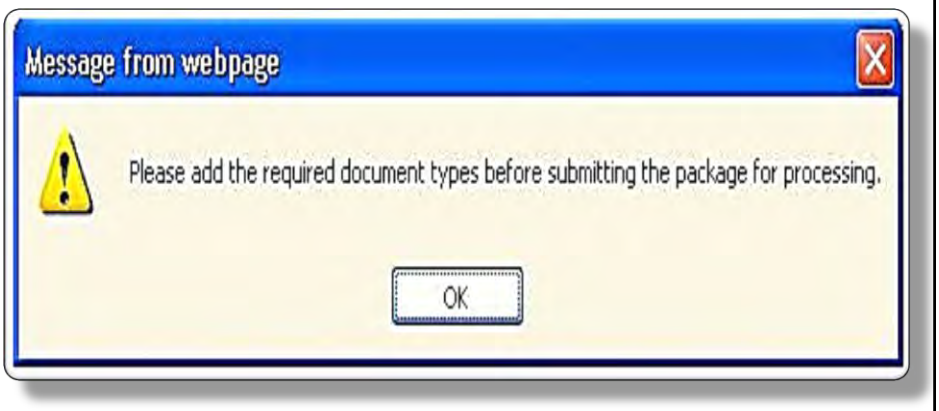
To submit a package, click on the "***Submit***" button. The user will see the following screen.



Note*:* A submitted package can be retrieved on the Search screen by searching for packages with 'Open' status.

Create Package – Transaction Inquiry (continued)

If all required documents for the package have not been added by the user prior to submission, the following pop-up message will be displayed.



Search

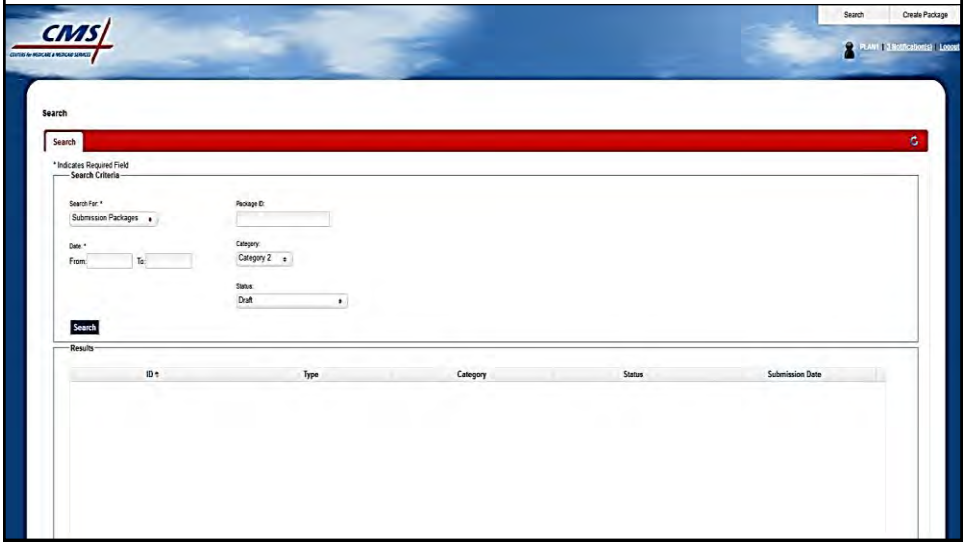
- The search screen provides the user with the following search criteria and options to select:
  - **Search For:**
    - Submission Packages
    - Transaction Inquiry Packages
    - Review Packages
    - Final Disposition Reports
    - Error Reports
    - RO Letters
  - **Date (Date From – Date To):** Enter the date ranges based on package creation or submission

Search (continued)

- **Package ID:** Provides the ability to search for packages based on the unique ID.
- **Category:** Provides the ability to search for packages based on a specific category.
- **Status:** Provides the ability to search for packages based on a specific status.
- **Parent Organization:** Provides the ability to search for packages based on a specific parent organization.

Search (continued)

Login to the eRPT application, then select the "***Search***" menu option on the top right corner of the screen as shown below.

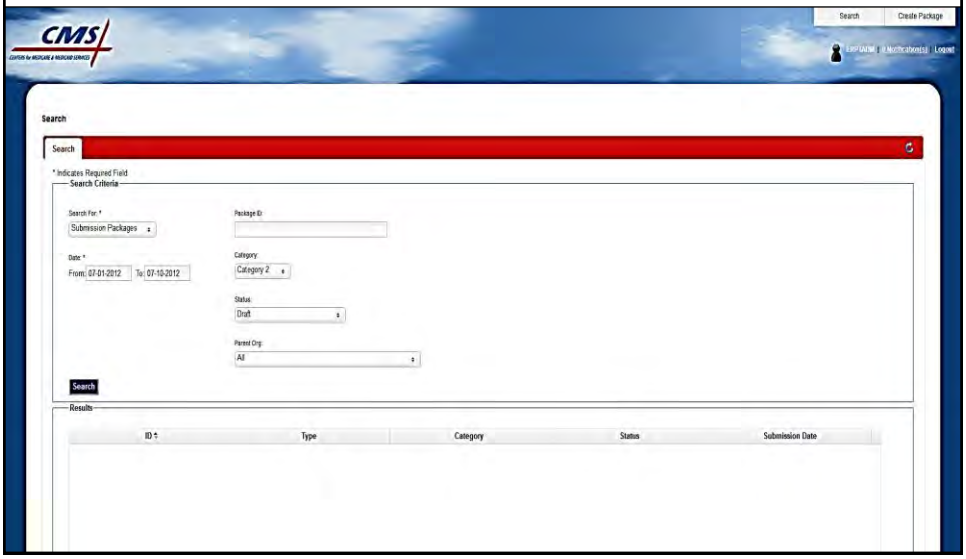


Search (continued)

- For this presentation, we will walk through the following options on the Search Criteria page.
  - ***Search For*** - Select Submission Package from the dropdown.
  - ***Date***
    - ***From*** - Enter the beginning date for search
    - ***To*** - Enter the end date for search
  - ***Package ID*** - If required. In this example we will leave it blank.
  - ***Category*** - In this example we will select Category 2.
  - ***Status*** - In this example we will select Draft from the dropdown.
  - ***Parent Organization*** - In this example we will leave it blank.

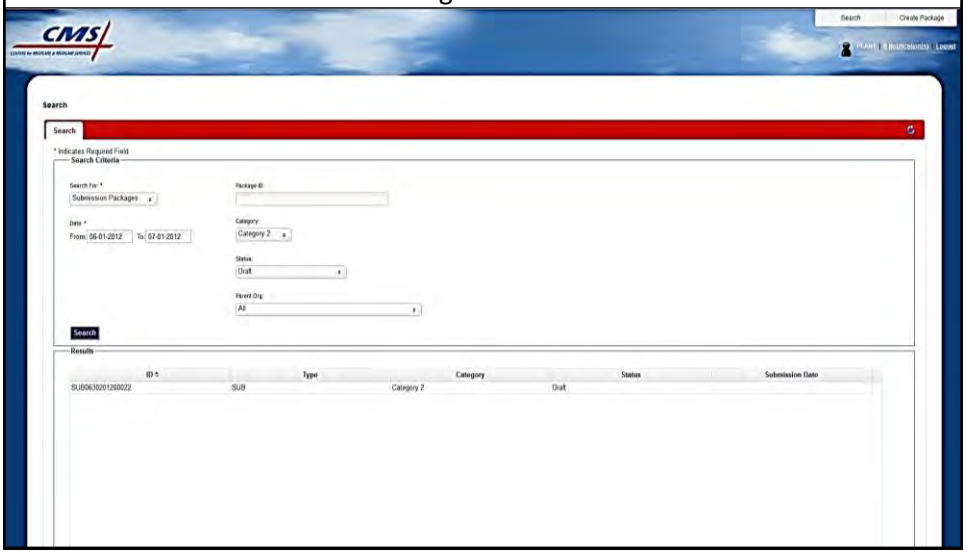
Search (continued)

Click the "***Search***" button as shown below.



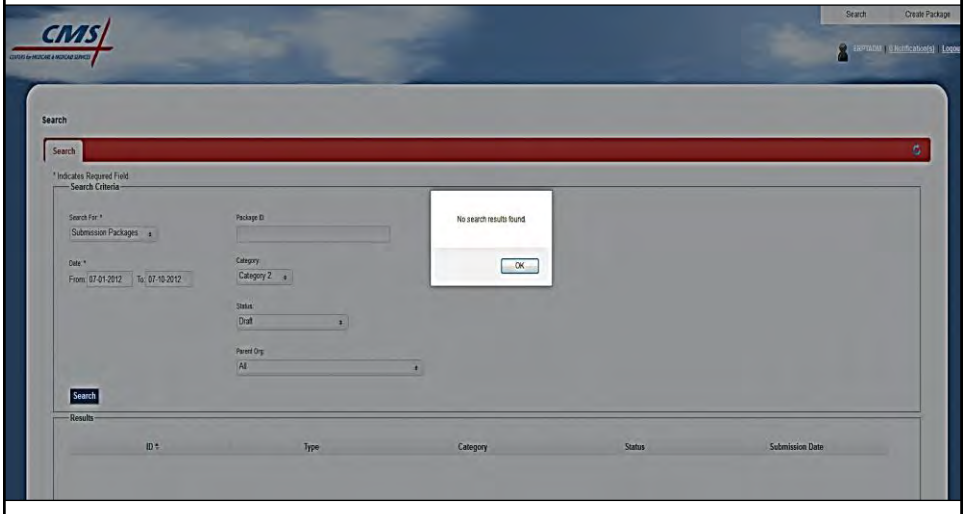
Search (continued)

The matching search results will be displayed in the results grid as shown below.



Search (continued)

If the search criteria does not have any matching results, the following pop-up window will be displayed as shown below.

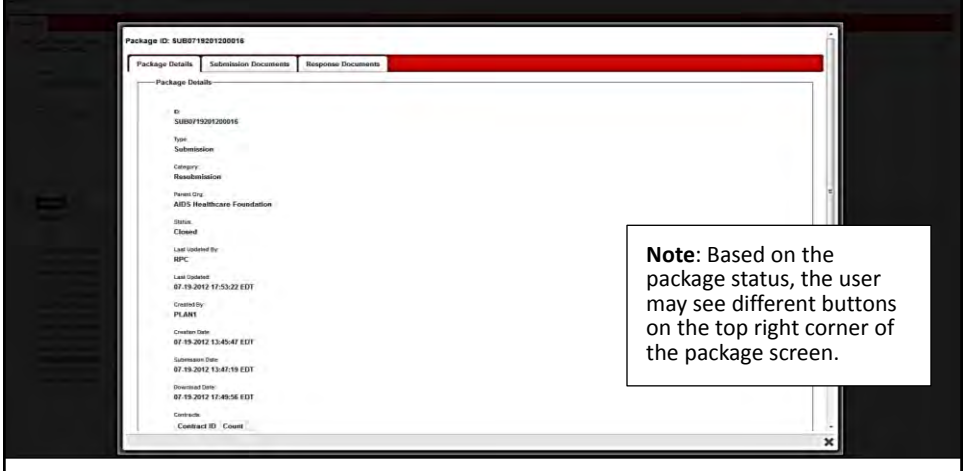


View Package

- Login to the eRPT application.
- Select the "***Search***" menu option on the top right corner of the screen.
- Search for Packages based on your search criteria.

View Package (continued)

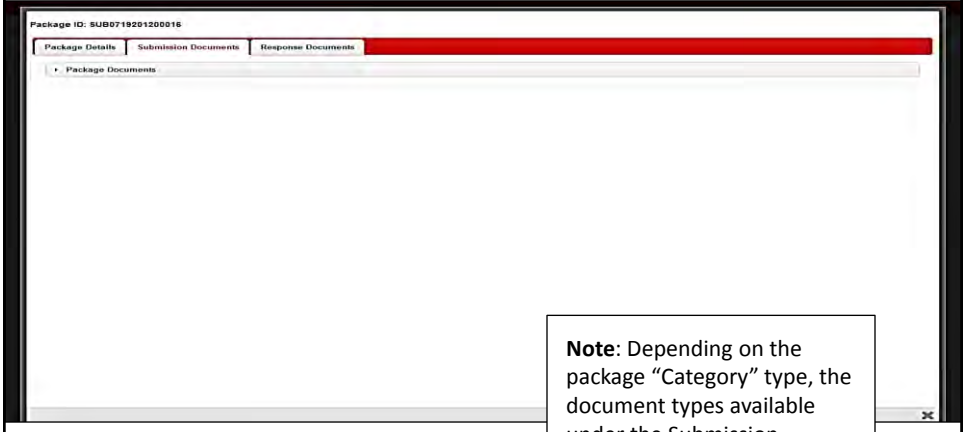
Double click on package in the results grid to view it.
The "***Package Details***" tab will be displayed as shown below.



Note: Based on the package status, the user may see different buttons on the top right corner of the package screen.

View Package (continued)

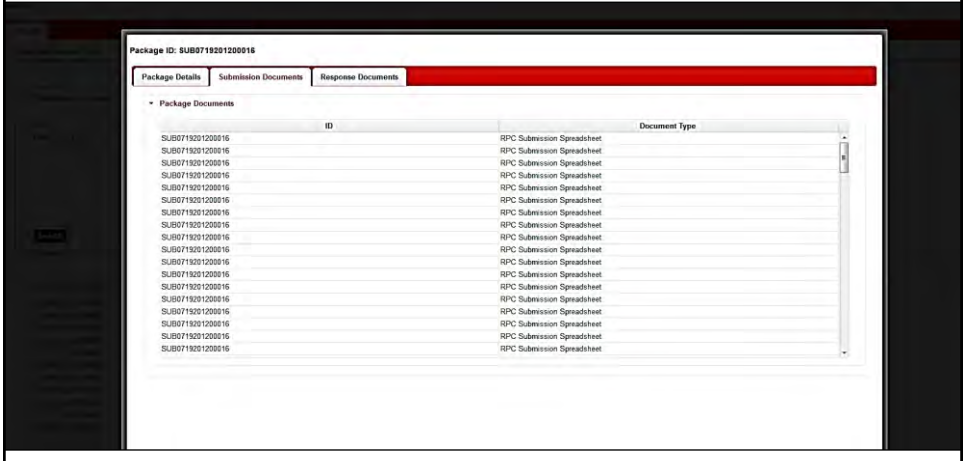
Select the "***Submission Documents***" tab to view all the documents that were submitted during package submission.



Note: Depending on the package "Category" type, the document types available under the Submission Documents tab may vary.

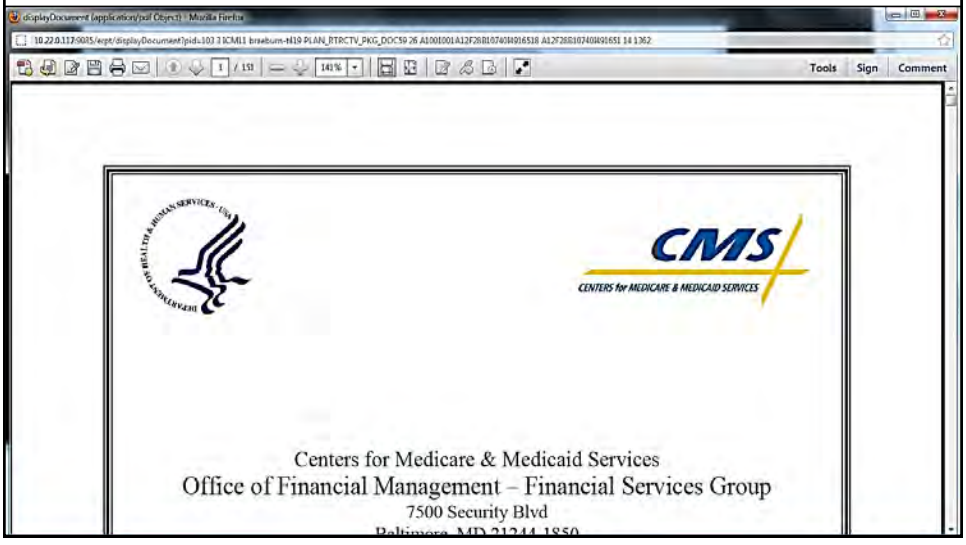
View Package (continued)

To view all the documents, the user can select "***Package Documents***" to expand the selection as shown below.



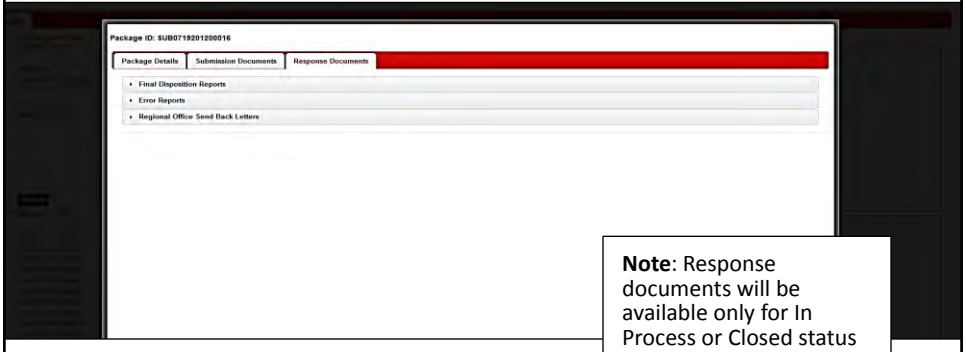
View Package (continued)

The user can double click on a specific document in the list to open and view the document which will open as shown below.



View Package (continued)

Select the "***Response Documents***" tab to view all the Response Documents submitted by the RPC contractor as shown below.



Note: Response documents will be available only for In Process or Closed status packages. The response documents will also be visible if the user has access to the documents.

View Package (continued)

To view the documents, the user can select one of the following to expand the selection as shown below:

- Final Disposition Reports;
- Error Reports; or
- Regional Office Send Back Letters.

Add Response Documents to Review Package

- An Enrollment Data Validation Review Request is referred to as a Review Package in the eRPT application.
- When a new Enrollment Data Validation Review Request is created by the RPC, the Plan User will receive a notification.
- In this section, we will discuss on how a Review Package can be responded to and submitted by a Plan User.
- A Plan User can find his or her respective Review Package through Search or notifications. For the presentation, we will show this functionality via Search.

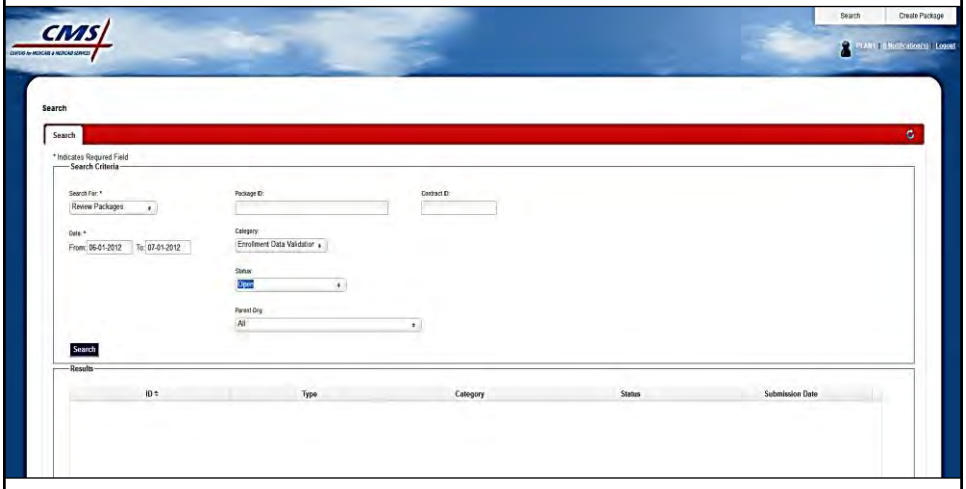
Add Response Documents to Review Package (continued)

- Login to the eRPT application.
- Select the "***Search***" menu option on the top right corner of the screen.
- Enter the following search criteria to find the Review Packages.
  - ***Search For***: Select Review Package from the drop down.
  - ***Date***: Select the date range for the search.
  - ***Package ID***: Enter the Package ID. The Package ID can be located in the notifications.
  - ***Category***: Select the appropriate Category Code.
  - ***Status***: Select Open from the drop down.
  - ***Parent Org***: Select the Parent Organization from the drop down.
  - ***Contract ID***: This is an optional field.

Note: All review packages are mapped to a Contract, and only the users who have access to the contract can view the respective Review Package.

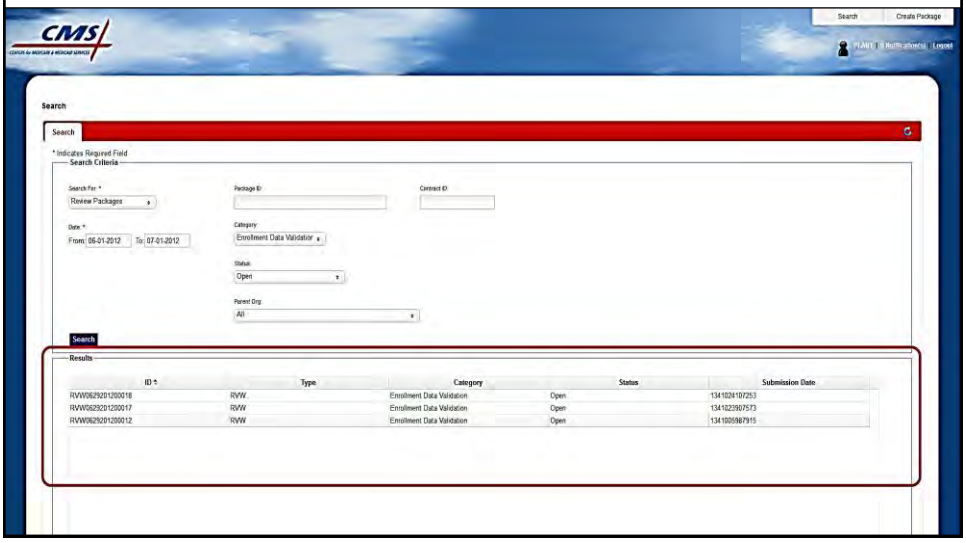
Add Response Documents to Review Package (continued)

Click the "***Search***" button.



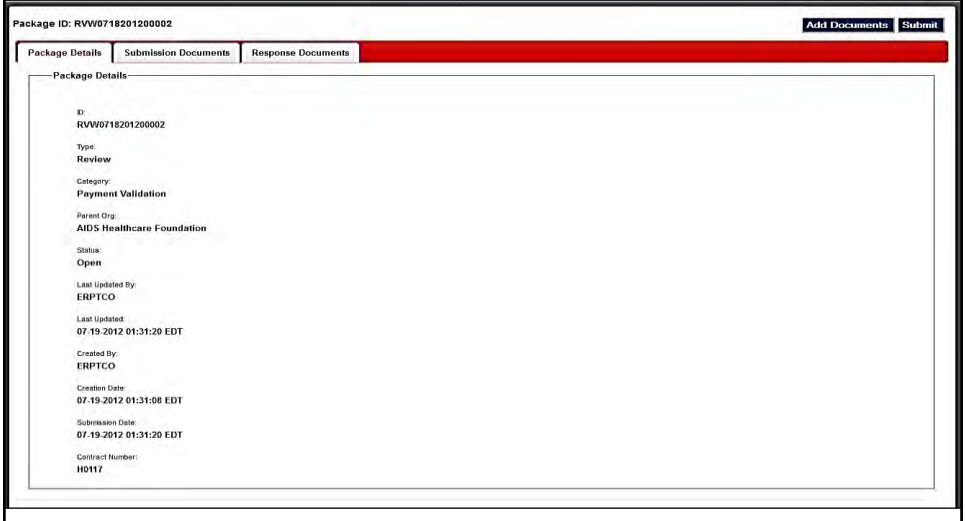
Add Response Documents to Review Package (continued)

The search results will be displayed in the results grid as shown below.



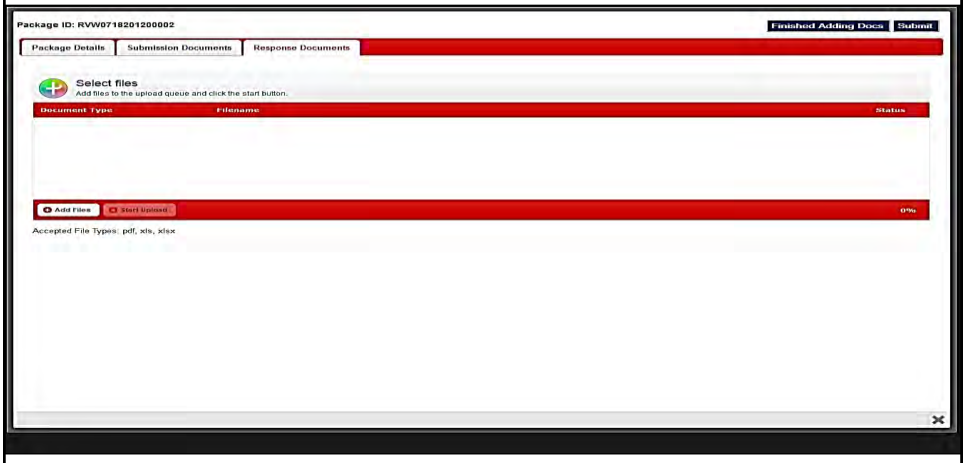
Add Response Documents to Review Package (continued)

Double click on the Package to open and view the package as shown below.



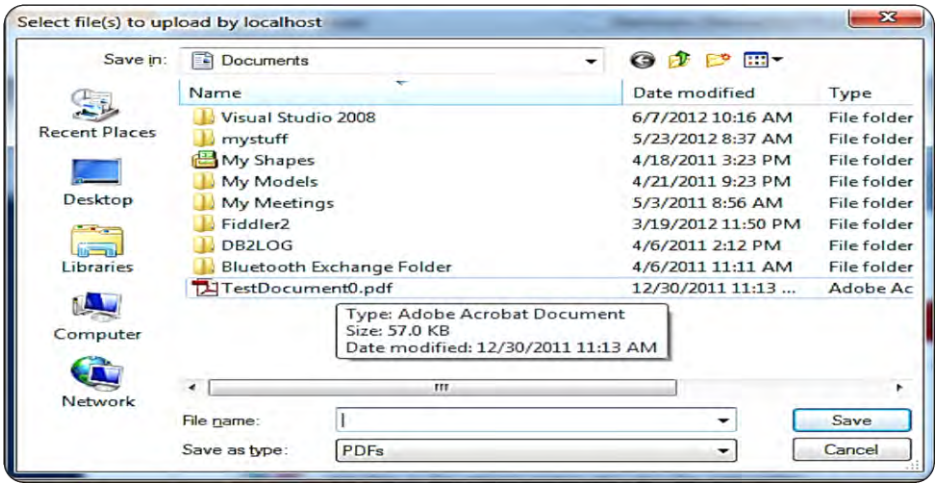
Add Response Documents to Review Package (continued)

Click the "***Add Documents***" button on the top right corner of the screen. The following window will be displayed.



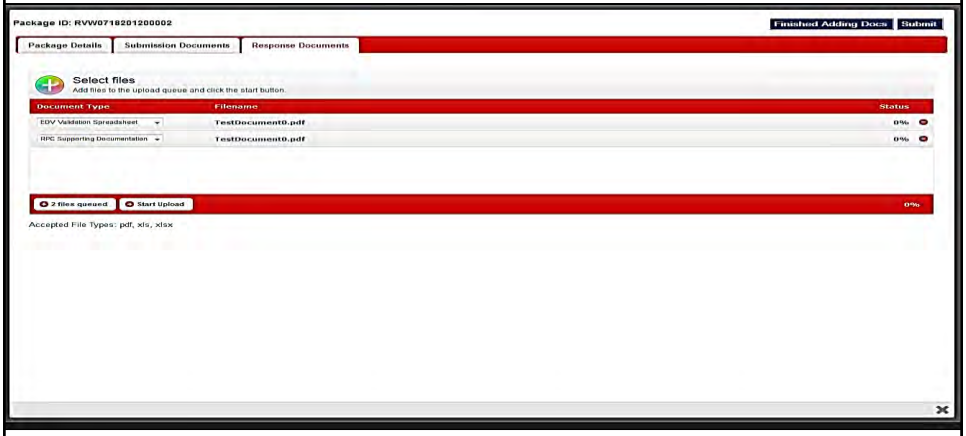
Add Response Documents to Review Package (continued)

Click the "***Add Files***" button. The Windows Explorer pop-up window will be displayed to the user to select the documents as shown below.



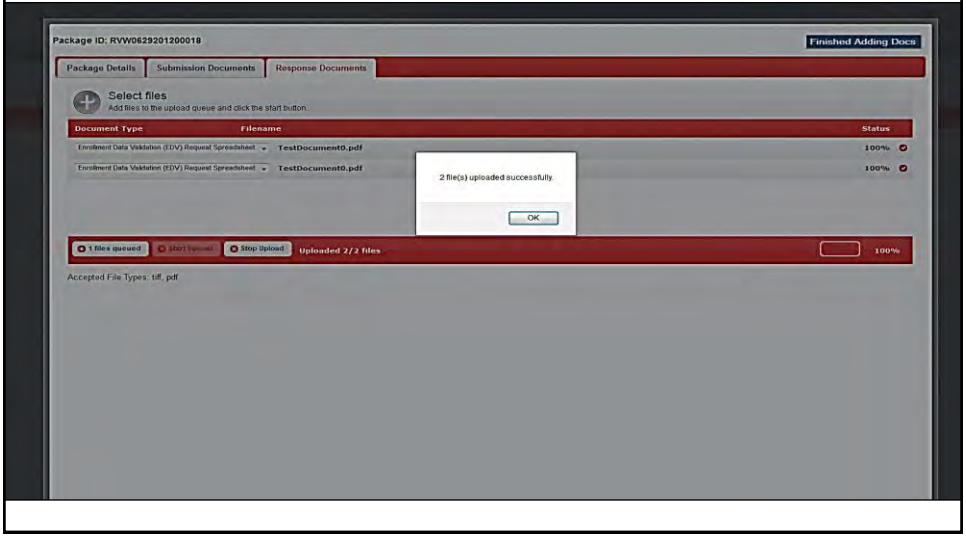
Add Response Documents to Review Package (continued)

Select the files you want to add to the package, and click the "***Save***" button. The selected documents will display on the user interface as shown below.



Add Response Documents to Review Package (continued)

Select the appropriate ***Document Type***, and click the "***Start Upload***" button.

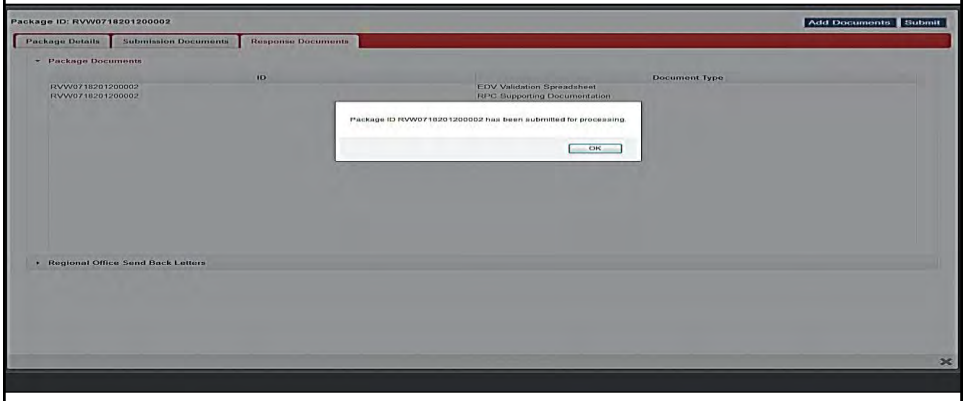


Add Response Documents to Review Package (continued)

Now the user can either:

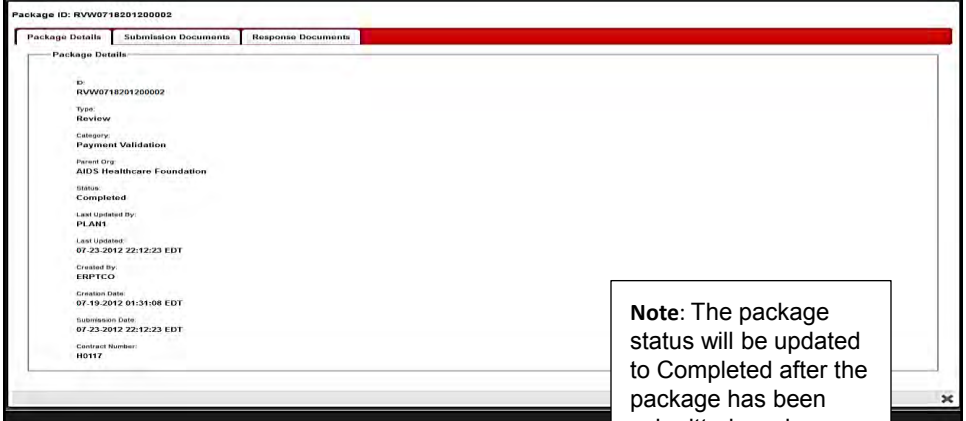
- Click the "***Finished Adding Docs***" button to switch to the View Only Mode, or
- Submit the package by clicking on the "**Submit**" button.

The following pop-up message will be displayed as shown below.



Add Response Documents to Review Package (continued)

Click the "***OK***" button.



Note: The package status will be updated to Completed after the package has been submitted as shown below.

Track Package

A package can be tracked in the eRPT application by referring to the status of the package. The following are the status values and descriptions of the statuses that are supported in the eRPT application.

Package Status	Package Description
Draft	When a package is created but not yet submitted to the eRPT application.
Pending RO Approval	When a package is submitted by the Plan Users but waiting for the Regional Office (RO) Approval Letter from the Regional Office Account Manager. This status is applicable only for Category 3. -> Submission Package

Note: The status value on a package is dependent on the Package Type and Package Category.

Track Package (continued)

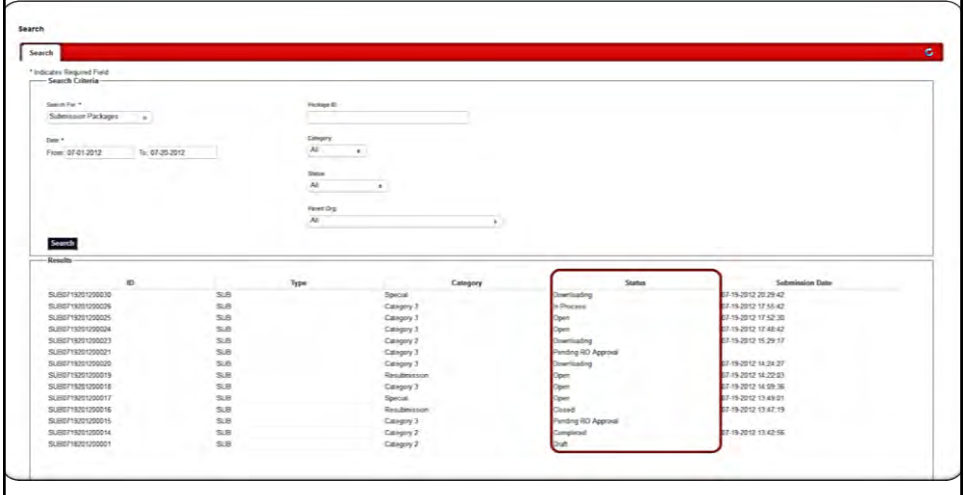
Package Status	Package Description
Open	When a submission package is submitted to eRPT and ready for the Retroactive Processing Contractor (RPC) to download or when a review package is uploaded for a Plan User to respond.
Completed	When a review package is submitted by the Plan User with all the response documents.
Downloading	When the Retroactive Processing Contractor (RPC) is downloading the package.
In Process	When the Retroactive Processing Contractor (RPC) is processing the package.

Track Package (continued)

Package Status	Package Description
Closed	When a retroactive package processing has been completed by the Retroactive Processing Contractor (RPC), the package status will be marked has closed.

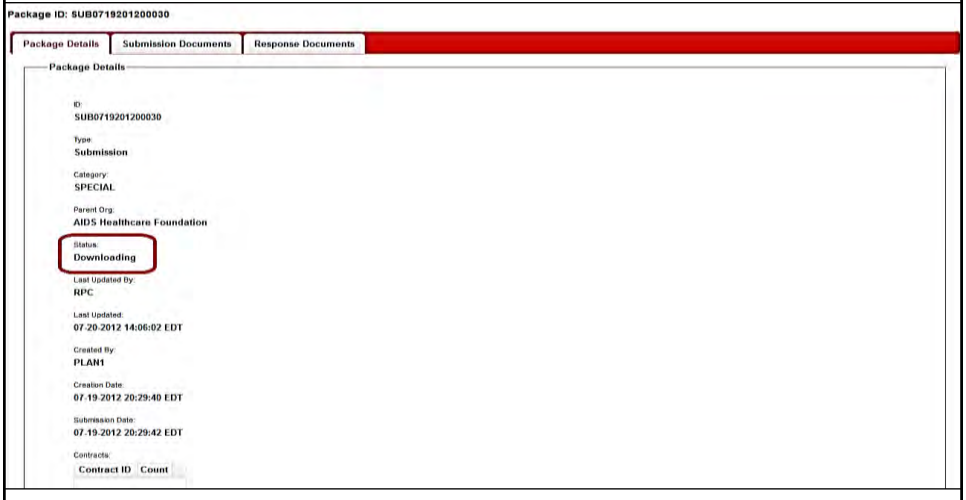
Track Package (continued)

A Plan User can view the status of a package in the Results grid as shown below.



Track Package (continued)

A Plan User can also view the status of a package on the "***Package Details***" tab as shown below.

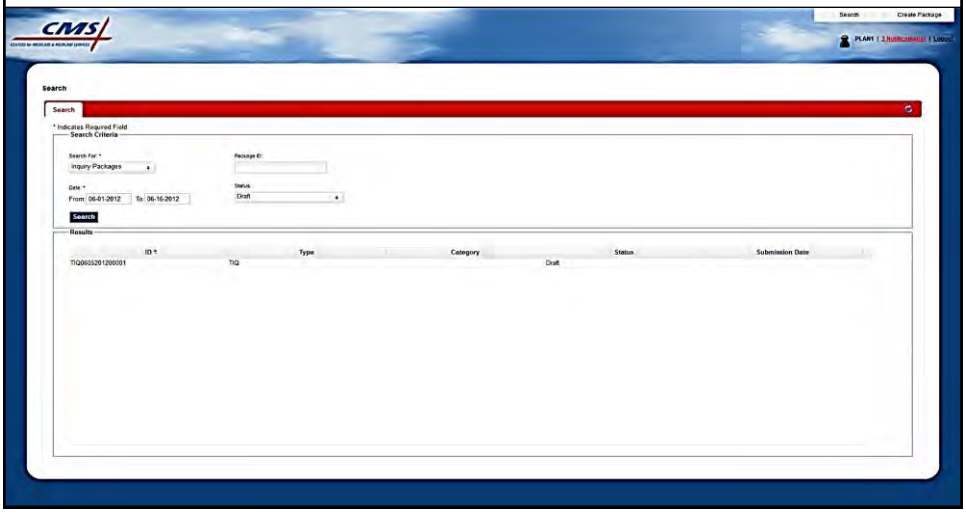


Notifications

- Notifications are usually created in eRPT when a response document is added by the RPC for a Plan User or CMS Regional Office user to review.
- Notifications are also created when a Category 3 package is rejected by the CMS Regional Office user, or if a CMS Central Office user deletes a package created by a Plan User.

View Notifications

Login to the eRPT application, and click the "***Notifications***" link on the top right corner of the screen as shown below.



View Notifications (continued)

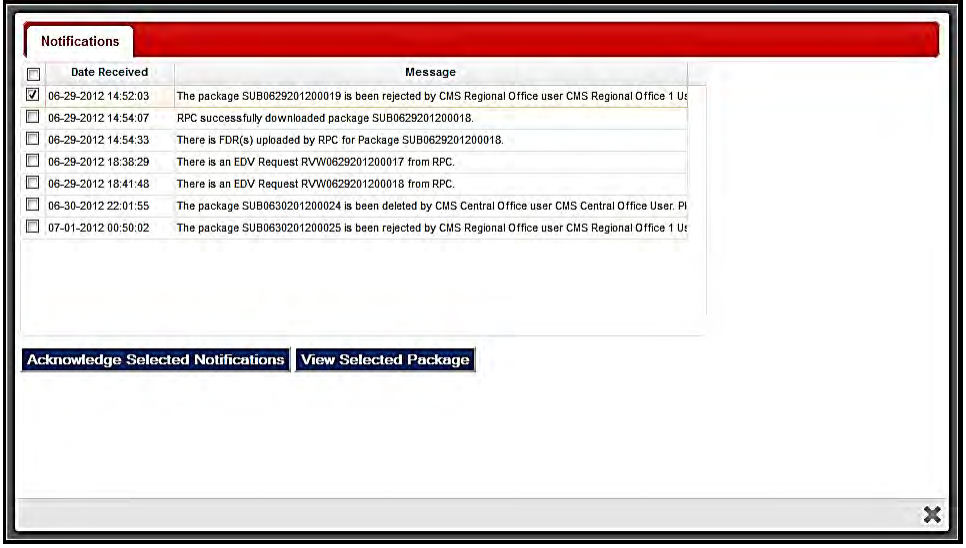
The following pop-up window will display all the Notifications for the logged in user as shown below.

Acknowledge Notifications

- Login to the eRPT application.
- Click the "***Notifications***" link on the top right corner of the screen.
- Open the Notifications window as shown below.

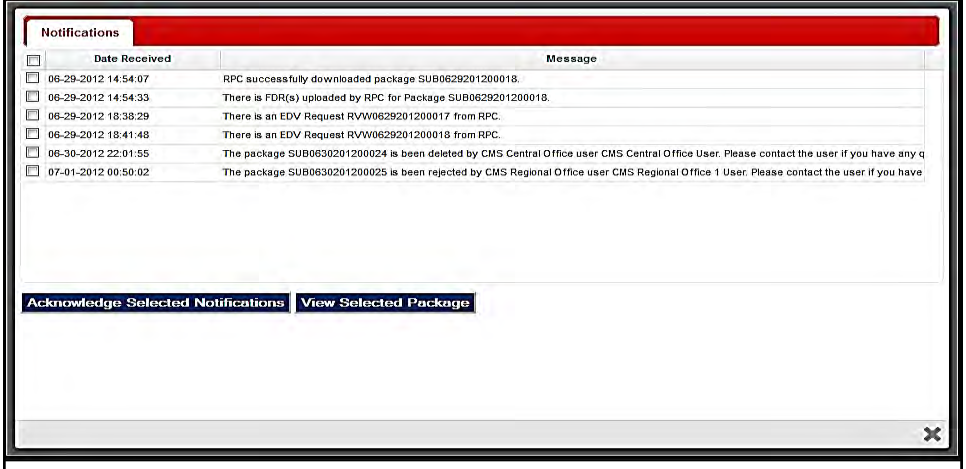
Acknowledge Notifications
(continued)

Select the checkbox of a notification you want to Acknowledge as shown below.



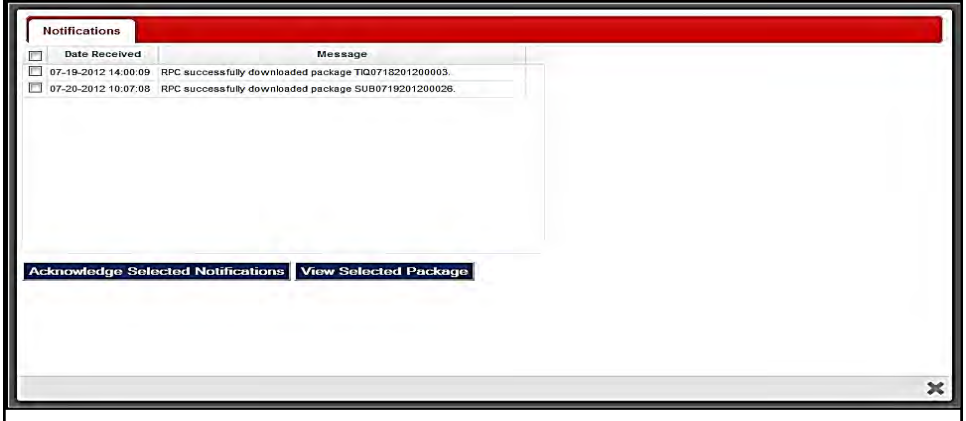
Acknowledge Notifications
(continued)

Click the "***Acknowledge Selected Notifications***" button as shown below.



View Selected Package

- Login to the eRPT application.
- Click the "***Notifications***" link on the top right corner of the screen.
- Open the Notifications window as shown below.



View Selected Package
(continued)

- The user should select a Notification checkbox for the package that they would like to view.
- Click the "***View Selected Package***" button.
- The package will be displayed as shown below.

eRPT Application Training

- There are 10 sessions of webinar training available for Plan Users. Additional information regarding training will be provided by the MAPD Helpdesk.
- Plan Users will need to send an email to the eRPT mailbox at CMS_eRPTinquiries@cms.hhs.gov to request a time slot for training.

eRPT Application Training (continued)

- The training slots will be provided to Plan Users on a first-come-first-serve basis. Due to the limited number of slots, we recommend one participant per Plan.
- A Train-the-Trainer approach will be used for Plan User training. In Train-the-Trainer, the Plan User who attends the training should be able to train other users within the organization.
- Each session is limited to 75 users.

eRPT Availability

- eRPT application will be available for all Plan Users on October 22nd to start creating retroactive and inquiry submissions.

Note: Plans will be able to track only the packages that were submitted using the eRPT application.

eRPT Support

- For any eRPT functionality questions, users can send an email to the following email address:
  - CMS_eRPTinquiries@cms.hhs.gov
- To report any support issues (i.e., login issues) related to the eRPT application, the users will need to contact MAPD Helpdesk at 1-800-927-8069 or mapdhelp@cms.hhs.gov after October 22nd.
- The eRPT Business Owner will provide the link to eRPT Training Material and User Manual for guidance.

Questions?

Evaluation

Please take a moment to complete the evaluation form for the following module:

Electronic Retroactive Processing Transmission (eRPT)

Your Feedback is Important!

Thank you!

2012 Regional Technical Assistance

Enrollment

Number of Uncovered Months

Purpose

- Understand the policy for calculating and submitting the number of uncovered months for Part D enrollees.
- Introduce the number of uncovered months calculation tool.

Learning Objectives

- Understanding the Part D Late Enrollment Penalty
- Defining Creditable Coverage
- Making the Creditable Coverage Period Determination
- Reporting the Number of Uncovered Months to CMS
- Calculating and Reporting the Part D Late Enrollment Penalty to Plans

What is the Part D Late Enrollment Penalty (LEP)?

- §1860D-13(b)(6)(C) of the Social Security Act
- A penalty charged to beneficiaries who incur a gap in creditable prescription drug coverage for a period of 63 days or more after their first opportunity to join Part D
- 1% of the National Base Beneficiary Premium calculated annually for each full month the beneficiary was eligible for Part D but not enrolled by the end of his/her Initial Enrollment Period, and did not have other creditable prescription drug coverage

What is Creditable Coverage?

- Coverage that meets Medicare's minimum standards (coverage expected to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- Examples include: VA, Tricare, and employer-sponsored coverage that meets actuarial standards (commercial and/or RDS)

Process for Making the Creditable Coverage Determination

42 CFR 423.46, Chapter 4 - §10.2

- Sponsors are required to determine if there is a period in question
- Query CMS Systems
- Sponsor sends the attestation form if a gap in coverage exists
  - Beneficiary has 30 days to respond
  - Sponsors cannot request evidence of coverage

Process for Making the Creditable Coverage Determination

Chapter 4 - §50.1

- Sponsors report the creditable coverage determination to CMS via MARx
- CMS calculates the LEP and provides the dollar amount to the sponsor to add to the monthly premium
- The sponsor must notify the member in writing of the LEP amount within 10 days of notification from CMS
- The notice must also include the member's ability to request a reconsideration (review) of the LEP

Reporting the Number of Uncovered Months

Sponsors report creditable coverage determinations as a number of full, uncovered months applicable to the period in question.

Example: Mrs. Smith's IEP ended on 5/31/11. She enrolled in a PDP during the AEP, effective 1/1/12. The plan identifies a possible gap in coverage while processing the enrollment request and completes the attestation process. It is determined that Mrs. Smith did not have creditable coverage prior to her enrollment in this plan. The plan submits (7) seven uncovered months to CMS.

Reporting the Number of Uncovered Months

Chapter 4 - §30.3.2, 30.3.3, and 30.3.4

Timeframes:

Enrollment Transaction	Within seven (7) days of receipt of complete enrollment request
Complete Attestation	Within fourteen (14) days of receipt of complete attestation
Incomplete Attestation	Within twenty-eight (28) days of receipt of incomplete attestation—plans have additional time to gather missing information from beneficiary
Missing Attestation	Within fourteen (14) days of deadline date on attestation request letter
Reconsideration Transaction	Within fourteen (14) days of receipt of reconsideration decision from IRE
Notification to Beneficiary of LEP	Within ten (10) days of notification from CMS

Calculating and Reporting the LEP to the Plans

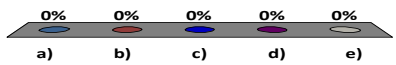
Chapter 4 - §40.1

- CMS calculates the LEP
  - Only CMS may calculate the LEP amount
  - LEP = 1% X the National Base Beneficiary Premium (calculated annually)
  - Amount rounded to the nearest ten cents

Question

The Part D Plan sponsor must take the appropriate action and report the revised number of uncovered months to CMS within ___ calendar days of receiving a reconsideration decision from CMS' IRE.

a) 30
b) 60
c) 14
d) 7
e) After member complains



References

- §1860D-13(b) of the Social Security Act
- 42 CFR §423.46, 423.56(g)
- Prescription Drug Benefit Manual, Chapter 4 – Creditable Coverage Determinations and Late Enrollment Penalty
- Prescription Drug Benefit Manual Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals

Where to Find NUNCMO

Eligibility M232

Number of Uncovered Months — View Audit

Start Date	Indicator	Number of Uncovered Months	Total Number of Uncovered Months	Record Add-Time Stamp	Record Type
01/01/2007		0	0	04/09/2012 0:0:0	V

Update Premiums M2

Number of Uncovered Months (Current Total NUNCMO : 0)

	Contract	PBP	Start Date	Incremental Uncovered Months	Total Uncovered Months	Indicator
New				0		R - Reset
1	S5596	007	01/01/2007	0	0	I - Incremental

Submitting NUNCMO

- Transaction Types
  - TC 73 Transaction – NUNCMO
    - Can be submitted in normal batch, even if retro
  - TC 61 Transaction - Enrollment
- Effective Date
- Creditable Coverage Flag
  - Y, N, R, U (Yes, No, Reset, Undo)
- Number of Uncovered Months

When You Can Submit NUNCMO

- The effective date must match a Part D enrollment effective date.
- Contracts can submit for their contract's effective date and all prior Part D enrollment effective dates.

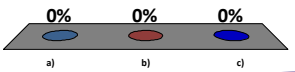
Correcting NUNCMO

- TC 73 Transaction
- Simply resubmit the transaction with the correct information
- Same process used for an update

Question

I submitted five (5) NUNCMO, and it should be ten (10) instead. What should I do?

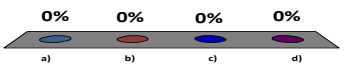
- a) Submit a 73 Transaction with 10 NUNCMO and the flag set to "N" with the same effective date.
- b) Submit a 73 Transaction with the flag set to "R" and then resubmit NUNCMO.
- c) Submit a 73 Transaction with the flag set to "U" and then resubmit NUNCMO.



Question

A previous plan submitted (5) five NUNCMO, but the beneficiary had creditable coverage. The beneficiary is now enrolled in my plan. What do I do?

- a) Submit "R" for old enrollment.
- b) Submit "U" for old enrollment.
- c) Submit "Y" and 0 with the effective date for my enrollment.
- d) Submit "Y" and 0 with the effective date for old enrollment.



Reset NUNCMO

- Automatically done by MARx
- Sets total NUNCMO to “0”
- LIS and subsequent IEP
- Manually submit via TC 73 Transaction
- Remove a Reset with “U”
  - Removing resets is the only function of “U”

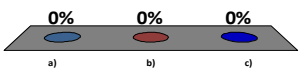
Question

A beneficiary with an LEP enrolled in my plan has gained LIS status. What should I do?

a) Submit a NUNCMO record update transaction (73) with the flag set to “N” and NUNCMO of 0.

b) Submit a NUNCMO record update transaction (73) with the flag set to “R” and NUNCMO of 0.

→ c) Review the DTRR for CMS generated Reset.



Reports

- Daily Transaction Reply Report (DTRR)
  - Changes to NUNCMO
  - Changes to Premium Withhold
- LIS/LEP Report
  - Amount of LEP to collect for Direct Bill enrollees
- Monthly Premium Withholding Report
  - Amount of LEP to collect for Premium Withhold enrollees

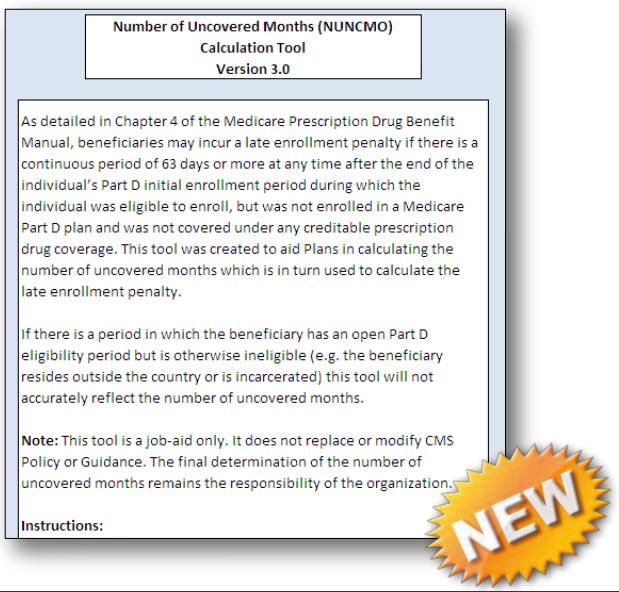
TRC(s)

TRC(s)	Description
124	Reject: Check your flag and NUNCMO values, and resubmit
141	Accept: NUNMCO successfully changed
187	Reject: Duplicate NUNCMO submitted (no change)
215	Reject: Check your effective date
217	Reject: Effective date matches a reset - Submit a “U” first if necessary

TRC(s) (continued)

TRC(s)	Description
216	Reject: Look for LIS or IEP, recalculate
300	Informational: Look for LIS or IEP, recalculate
218/219	Accept: Successful Reset/Undo
290/295	Automatic Reset
716	UI Changed NUNCMO

NUNCMO Tool



Number of Uncovered Months (NUNCMO) Calculation Tool
Version 3.0

As detailed in Chapter 4 of the Medicare Prescription Drug Benefit Manual, beneficiaries may incur a late enrollment penalty if there is a continuous period of 63 days or more at any time after the end of the individual's Part D initial enrollment period during which the individual was eligible to enroll, but was not enrolled in a Medicare Part D plan and was not covered under any creditable prescription drug coverage. This tool was created to aid Plans in calculating the number of uncovered months which is in turn used to calculate the late enrollment penalty.

If there is a period in which the beneficiary has an open Part D eligibility period but is otherwise ineligible (e.g. the beneficiary resides outside the country or is incarcerated) this tool will not accurately reflect the number of uncovered months.

Note: This tool is a job-aid only. It does not replace or modify CMS Policy or Guidance. The final determination of the number of uncovered months remains the responsibility of the organization.

Instructions:

NUNCMO Tool

Potential Number of Uncovered Months Calculation Tool	
Birth Date	
Last Part D Enrollment **End Date** (e.g. 01/31/2009)*	
End of most recent LIS Period (e.g. 01/31/2009)**	
Part D Eligibility start date	
Effective Date of New Part D Enrollment	
Potentially newly accrued uncovered months	
Note: This tool is a guide and cannot be used in place of CMS guidance or regulations.	

☐ No previous Creditable Prescription Drug Coverage

☐ No LIS Periods

All fields are required. Use checkboxes if data is not applicable.

*Enter the latest Part D Enrollment End Date discovered in the Beneficiary Eligibility Query.

**If a beneficiary has an open LIS Period as of the effective date of the Part D Enrollment in question, no uncovered months are accrued. No further action is needed.

NUNCMO Tool

Applicable Number of Uncovered Months Calculation Tool	
Birth Date	
Last Part D Enrollment **End Date** (e.g. 01/31/2009)*	
End of most recent LIS Period (e.g. 01/31/2009)**	
Number of Creditable Months discovered during Attestation***	
Part D Eligibility start date	
Effective Date of New Part D Enrollment	
Newly accrued uncovered months	
Note: This tool is a guide and cannot be used in place of CMS guidance or regulations.	

☐ No previous Creditable Prescription Drug Coverage

☐ No LIS Periods

All fields are required. Use checkboxes if data is not applicable.

*Enter the latest Part D Enrollment End Date discovered in the Beneficiary Eligibility Query.

**If a beneficiary has an open LIS Period as of the effective date of the Part D Enrollment in question, no uncovered months are accrued. No further action is needed.

***Enter the number of months that the beneficiary had creditable coverage during the gap in question. This is found during the beneficiary attestation process described in Chapter 4.

Scenario #1

Mr. Jones enrolled in “Old Health Plan” effective 1/1/12. He moved out of the service area and disenrolled effective 2/29/12. Mr. Jones enrolled in “New Health Plan” effective 3/1/12. “Old Health Plan” completed its creditable coverage determination on 3/9/12 and determined that Mr. Jones had eight (8) uncovered months.

Scenario #1 (continued)

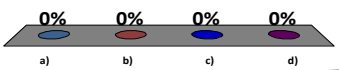
What action should the “Old Health Plan” take?

a) Contact Mr. Jones and verify that he had eight (8) uncovered months.

b) Submit a NUNCMO Record Update transaction (73) to change the NUNCMO to “008” and set the creditable coverage flag to “N” with an effective date of 1/1/12.

c) Contact Mr. Jones and strongly encourage him to change his answer on the attestation form.

d) None of the above.



Scenario #1 (continued)

- "Old Health Plan" received authorization from CMS, submitted the change as directed, received a Transaction Reply Code (TRC) from CMS that the change was accepted, and another TRC from CMS showing the LEP amount changed.
- "Old Health Plan " then notified Mr. Jones that he owes an LEP. His current plan, "New Health Plan," received the information on the LIS/LEP report (because he is in Direct Bill status at "New Health Plan") and notified Mr. Jones that his plan premium was increased as a result of the LEP.

Scenario #2

Ms. Virago is currently enrolled in "Her Favorite Health Plan." She received notification from "Her Favorite Health Plan" that she was assessed an LEP. Mrs. Virago requested a reconsideration, and received a fully favorable decision eliminating the LEP she was assessed.

Scenario #2 (continued)

What should "Her Favorite Health Plan" do to remove the LEP?

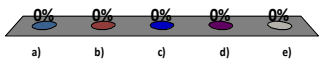
a) Contact CMS's IRE to ensure the reconsideration decision is correct.

b) Submit a NUNCMO record update transaction (73) with the creditable coverage flag "Y", set the number value to zero (0) and the effective date of the member's enrollment in the plan.

c) Contact the member and ask for proof of creditable coverage.

d) Submit a NUNCMO record update transaction (73), set the creditable coverage flag to "N", set the number value to zero (0) and the effective date of the member's enrollment in the plan.

e) None of the above



Summary

- Part D plan sponsors are required to determine if there is a qualifying gap in coverage.
- CMS is the only entity allowed to calculate the LEP.
- If you do not receive attestation within the required timeframe, remember to follow–up with the member.

Evaluation

Please take a moment to complete the evaluation form for the following module:

Number of Uncovered Months

Your Feedback is Important!
Thank you!

MODULE 6 – NUMBER OF UNCOVERED MONTHS

Purpose

The Law requires that individuals who do not have Part D or other creditable coverage for sixty-three (63) days or more be charged a Part D late enrollment penalty for each complete month they were eligible but did not have such coverage. The purpose of this module is to better understand the policy for calculating and submitting the number of uncovered months for members. In addition, this module will introduce the number of uncovered months calculation tool.

Learning Objectives

At the completion of this module, participants will be able to:

- Understand the Part D Late Enrollment Penalty;
- Define Creditable Coverage;
- Make the Creditable Coverage Period Determination;
- Report the Number of Uncovered Months to CMS; and
- Calculate and Report the Part D Late Enrollment Penalty to Plans.

ICON KEY

Definition

Example

Reminder

Resource

6.1 Timelines for Reporting the Number of Uncovered Months

Table 6A provides the timelines for reporting the number of uncovered months (NUNCMO).

TABLE 6A – TIMELINES FOR REPORTING THE NUMBER OF UNCOVERED MONTHS

ACTION	REPORTING TIMELINE
Enrollment Transaction	Within seven (7) days of receipt of complete enrollment request
Complete Attestation	Within fourteen (14) days of receipt of complete attestation
Incomplete Attestation	Within twenty-eight (28) days of receipt of incomplete attestation—plans have additional time to gather missing information from beneficiary
Missing Attestation	Within fourteen (14) days of deadline date on attestation request letter
Reconsideration Transaction	Within fourteen (14) days of receipt of reconsideration decision from IRE
Notification to Beneficiary of Late Enrollment Penalty (LEP)	Within ten (10) days of notification from CMS

6.2 Reports to Plans Related to LEP/NUNCMO

Table 6B identifies the reports to plans that are related to LEP/NUNCMO.

TABLE 6B – REPORTS TO PLANS RELATED TO LEP/NUNCMO

REPORT	DESCRIPTION
Daily Transaction Reply Report (DTRR)	Reflects changes to the NUNCMO/LEP and Payment With hold
Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Report	Reflects the amount of LEP to collect for members in Direct Bill Status
Monthly Premium Withholding Report (MPWR)	Reflects the amount of LEP to collect for members in Premium Withhold Status

6.3 Questions

6.3.1 Question #1

The Part D Plan sponsor must take the appropriate action and report the revised number of uncovered months to CMS within ___ calendar days of receiving a reconsideration decision from CMS' Independent Review Entity (IRE).

a) 30
b) 60
c) 14
d) 7
e) After the member calls and complains

Answer: _____

Notes: _____

_____

_____

6.3.2 Question #2

I submitted five (5) NUNCMO, and it should be ten (10) instead. What should I do?

a) Submit a 73 transaction with ten (10) NUNCMO and the flag set to "N" with the same effective date.
b) Submit a 73 transaction with the flag set to "R" and then resubmit NUNCMO.
c) Submit a 73 transaction with the flag set to "U" and then resubmit NUNCMO.

Answer: _____

Notes: _____

_____

_____

6.3.3 Question #3

A previous plan submitted five (5) NUNCMO, but the beneficiary had creditable coverage. The beneficiary is now enrolled in my plan. What should I do?

a) Submit "R" for old enrollment.
b) Submit "U" for old enrollment.
c) Submit "Y" and 0 with the effective date for my enrollment.
d) Submit "Y" and 0 with the effective date for old enrollment.

Answer: _____

Notes: _____

_____

_____

6.3.4 Question #4

A beneficiary with an LEP enrolled in my plan has gained LIS status. What should I do?

a) Submit a 73 transaction with the flag set to "N" and NUNCMO of 0.
b) Submit a 73 transaction with the flag set to "R" and NUNCMO of 0.
c) Review DTRR for CMS generated Reset.

Answer: _____

Notes: _____

_____

_____

6.4 Excerpts from Chapter 4 of the Medicare Prescription Drug Benefit Manual

6.4.1 Reporting Adjustments to Creditable Coverage Period Determinations Previously Reported to CMS

Chapter 4 - Section 30.4 F

Reconsideration decisions may uphold, increase, decrease or eliminate the number of uncovered months previously submitted by a Part D plan sponsor. If the member is still enrolled in the Part D plan sponsor that imposed the number of uncovered months to be adjusted, the Part D plan sponsor shall take the steps outlined below to remove or adjust the number of uncovered months previously reported:

- To remove the LEP, the Part D plan sponsor shall:
  1) Submit a NUNCMO Record Update transaction (73) with the creditable coverage flag "Y";
  2) Set the number value to zero ("000"); and
  3) Set the effective date of the transaction equal to the effective date of the member's enrollment in the plan.
- To adjust the number of uncovered months to a number other than "0", the Part D plan sponsor shall:
  1) Submit a NUNCMO Record Update transaction (73) with the creditable coverage flag "N";
  2) Set the number value equal to the number of uncovered months; and
  3) Set the effective date of the member's enrollment in the plan.

The Part D plan sponsor shall take the appropriate action and report the revised number of uncovered months to CMS within fourteen (14) calendar days of receiving a reconsideration decision from CMS's IRE.

If the member is no longer enrolled in the Medicare Part D plan sponsor that imposed the number of uncovered months to be adjusted, the Part D plan sponsor shall follow the steps in §30.2 of this chapter.

The Part D plan sponsor that imposed the number of uncovered months to be removed shall notify its member (or former member in cases where the member has disenrolled prior to the outcome of the reconsideration request) of any adjustment to his/her LEP as a result of a reconsideration decision by CMS's IRE. The Part D plan sponsor shall use Exhibit 7: Model Notice—Confirm Adjustment of Premium Based on Reconsideration of Late Enrollment Penalty or create its own form using the requisite elements shown in the model, subject to CMS's marketing review procedures. If the Part D plan sponsor that imposed the number of uncovered months collected an LEP based on the previous uncovered months, it shall issue a refund to the member in accordance with §60.3.

In cases where the Part D plan sponsor that imposed the number of uncovered months to be removed receives notice of a partially or fully favorable LEP reconsideration on behalf of a deceased member, the Part D plan sponsor shall submit a NUNCMO Record Update transaction and send the beneficiary's estate notification in accordance with this Chapter 4 of the Medicare Prescription Drug Manual.

6.4.2 Reporting NUNCMO for Individuals Who Are Disenrolled from the Plan

Chapter 4 Section 30.2
The Part D plan sponsor shall report a creditable coverage period determination for a member who has since disenrolled from the Part D plan sponsor in cases that include, but are not limited to, the following:

1) The Part D plan sponsor did not make or adjust a creditable coverage period determination (see §10.3.1 and §30.4) prior to the effective date of the member's disenrollment from that plan;
2) CMS's Independent Review Entity (IRE) has made a reconsideration decision that requires an adjustment to the number of uncovered months previously reported by the Part D plan sponsor (see §30.4.F); or
3) The Part D plan sponsor realizes it made an error in making and/or reporting its creditable coverage determination to CMS while the member was enrolled in its plan.

The Part D plan sponsor can make changes to the number of uncovered months for a disenrolled member for any time period up through the last day of the member's enrollment in the plan.

In order to report NUNCMO information for a member after the effective date of disenrollment, the Part D plan sponsor shall take the following steps:

1) Submit a NUNCMO Record Update (73) transaction via a retroactive batch file. The header date of the retroactive file must reflect a date that the member was enrolled in the Part D plan sponsor that is adjusting an existing or reporting a new creditable coverage determination and be in the month/year format (mm/yyyy). You must obtain approval from CMS to submit.
2) Contact the MMA Help Desk to obtain a ticket number to request the submission of a batch retroactive file to report these transactions. CMS Central Office staff will review each ticket and contact the requesting Part D plan sponsor regarding the request.

The Part D plan sponsor submitting the change to the uncovered months will receive a transaction reply code (TRC) on the DTRR regarding the uncovered months and a recalculated LEP amount on the LIS/LEP Report for members in direct bill status and the Monthly Premium Withholding Report/Data file (MPWRD) for members in premium withhold status. Additionally, the disenrolled member's subsequent plan(s), including the member's current plan, will be impacted by this change to the uncovered months. Therefore, the member's subsequent plan(s) will receive information regarding changes to the uncovered months and recalculated LEP **only** on the LIS/LEP Report for members who are in direct bill status and the MPWRD for members in premium withhold status.

The plan that submits the change to an individual's uncovered months will be the entity that receives a transaction reply on the DTRR. The affected plans will see the change on the LIS/LEP for members in direct bill status and on the MPWRD for members in premium withhold status.

In cases where the former plan sponsor reports a creditable coverage determination (or an adjustment to a previous determination) that results in the imposition of or increase in the LEP amount, the former plan sponsor shall notify the member of the LEP amount in accordance with §50 of Chapter 4 of the Medicare Prescription Drug Benefit Manual.

Example

Mrs. Johnson enrolled in Plan KLM effective 1/1/08. She disenrolled from Plan KLM with a coverage end date of 2/28/08 and enrolled in Plan BCD effective 3/1/08. Plan KLM completed its creditable coverage period determination on 3/10/08, and determined that Mrs. Smith had three (3) uncovered months. Plan KLM contacted the MMA Help Desk and asked to submit a batch retro file that contained a valid plan change (73) transaction changing the number of uncovered months from "000" to "003", setting the creditable coverage flag to "N," and using a header date of "012008" (January 2008) or "022008" (February 2008).

Plan KLM received authorization from CMS and submitted the change as directed and received a transaction reply code (TRC) from CMS showing that the change was accepted and another TRC from CMS showing that the LEP amount had changed.

Plan KLM then notified Mrs. Johnson that she owes an LEP. Since Mrs. Johnson is in premium withhold status, her current plan, Plan BCD, received this information on the MPWRD and then notified Mrs. Smith that her plan premium was increased accordingly, as a result of the LEP.

6.5 Scenarios

6.5.1 Scenario #1

Mr. Jones enrolled in "Old Health Plan" effective 1/1/12. He moved out of the service area and disenrolled effective 2/29/12. Mr. Jones enrolled in "New Health Plan" effective 3/1/12. "Old Health Plan" completed its creditable coverage determination on 3/9/12 and determined that Mr. Jones had eight (8) uncovered months.

What action should the "Old Health Plan" take?

a) Contact Mr. Jones and verify that he had eight uncovered months.
b) Submit a NUNCMO Record Update transaction (73) to change the NUNCMO to "008" and set the creditable coverage flag to "N" with an effective date of 2/1/12.
c) Contact Mr. Jones and strongly encourage him to change his answer on the attestation form.
d) None of the above

Answer: _____

Notes: _____

_____

_____

6.5.2 Scenario #2

Mrs. Virago is currently enrolled in "Her Favorite Health Plan." She received notification from "Her Favorite Health Plan" that she was assessed an LEP. Mrs. Virago requested a reconsideration, and received a fully favorable decision eliminating the LEP she was assessed.

What should "Her Favorite Health Plan" do to remove the LEP?

a) Contact CMS's IRE to ensure the reconsideration decision is correct.
b) Submit a NUNCMO Record Update transaction (73) with the creditable coverage flag "Y", set the number value to zero and the effective date of the member's enrollment in the plan.
c) Contact the member and ask for proof of creditable coverage.
d) Submit a NUNCMO Record Update transaction (73), set the creditable coverage flag to "N", set the number value to zero, and set the effective date of the member's enrollment in the plan.
e) None of the above

Answer: _____

Notes: _____

_____

_____

2012 Regional Technical Assistance

Enrollment

Part D Low Income Subsidy (LIS) & Best Available Evidence (BAE)

Purpose

- Provide a general overview of the Part D Low Income Subsidy.
- Review Best Available Evidence (BAE) policy.
- Review the process to request BAE corrections.

What is Low Income Subsidy (LIS)?

- LIS provides beneficiaries with limited income and resources "extra help" with their Medicare prescription drug plan costs, including their premium, deductible, and cost sharing.
- A beneficiary must enroll in a Medicare drug plan such as a PDP or MA-PD to receive this assistance. There is no LIS for Retiree Drug Subsidy (RDS) enrollees.

How Do Beneficiaries Qualify for LIS?

Medicare Beneficiaries with ...	Basis	Data Source	Changes During the Year
Medicaid benefits • Full Medicaid benefits • Medicare Savings Program (Partial Duals)	Automatically qualify for LIS and are Deemed by CMS	States	Deemed for a full calendar year Generally only change LIS level if favorable to beneficiary
SSI benefits		SSA	
Limited income and resources	Must apply	SSA (most) or states	Subsidy changing events may impact status mid-year (both favorable and unfavorable changes)

LIS Processes

Medicare Beneficiaries with ...	Enrollment Type	LIS Subsidy Eligibility/Review	Re-Assignment
Full Medicaid benefits (Deemed)	Auto Enrollment	Deeming/Re-Deeming Conducted by CMS	Yes
•Medicare Savings Program (Partial duals) •SSI benefits (Deemed)	Facilitated Enrollment		
Limited income and resources (LIS Applicants)		Redetermination Conducted by SSA	Only those with 100% premium subsidy; there are other exceptions

Best Available Evidence (BAE): Background

- CMS relies on eligibility files from states and Social Security (SSA) to establish an individual's low-income subsidy, deemed eligibility, and appropriate cost-sharing level.
- In certain cases, CMS systems do not reflect a beneficiary's correct LIS deemed status.
  - This may occur, for example, because a state has been unable to successfully report the beneficiary as Medicaid eligible or is not reporting him/her as institutionalized.
- BAE policy is used when the low-income subsidy information in either plans' and/or CMS' systems are incorrect.

BAE: Purpose

- Provides beneficiaries access to Part D drugs at a lower cost-sharing level (or $0 cost-sharing if BAE also verifies beneficiary's institutional or Home and Community-Based Services [HCBS] status).
- Includes a process to correct a beneficiary's LIS status in plans' and CMS' systems.
- Involves action by the Part D sponsors and CMS.

BAE: Process

- **Sponsors must:**
  - Accept one of the established forms of BAE evidence.
  - Update internal Plan Systems.
  - Provide beneficiary access to Part D drugs at a reduced or $0 cost-sharing level, as appropriate.
  - Send an LIS Deeming request to the Retroactive Processing Contractor (RPC) to correct, if necessary.
  - Receive information via Transaction Reply Report (TRR).
  - Send an Evidence of Coverage (EOC) rider.

BAE: Documentation

- Establishes deemed LIS status.
- Establishes $0 Institutional or HCBS cost-sharing.
- Establishes LIS status of LIS applicants.

BAE: Sponsor Requirements

Sponsors must:

1. Provide the beneficiary access to covered Part D drugs at a reduced cost-sharing as soon as BAE is presented.
2. Update their systems within 48 to 72 hours of receipt of BAE documentation.
   - Reflect correct LIS status.
   - Override standard cost-sharing.
   - Maintain exceptions process for the beneficiary.
3. Have appropriate member services and pharmacy help desk scripting to triage these cases, as well as have procedures to address urgent cases.

Complaint Tracking of BAE

- A category in the Complaint Tracking Module (CTM) has been established to record instances where Plans fail to have a BAE process in place or will not honor acceptable evidence provided by the beneficiary or someone on his/her behalf.
- CMS will take compliance action based on the CTM data.

BAE: Sponsor Requirements

- Once a sponsor corrects a beneficiary's cost-sharing level, they must verify that CMS systems do not already reflect correct LIS status.
- If CMS systems are not correct, sponsor should wait 30 to 60 days for CMS data to auto-correct.

Record Retention Requirements

- Since BAE is related to payment, sponsors must retain the documentation for 10 years.
- Documentation must be available to accommodate subsequent periodic Government audits.

BAE: Sponsor Requirements

- If CMS data do not auto-correct, the sponsor must send the following to the RPC for deemed beneficiaries only:
  - A signed cover letter from the organization attesting to the accuracy of the information being reported
  - The RPC submission spreadsheet containing LIS deeming correction transactions
  - Copies of the BAE documentation for each beneficiary supporting the documentation supporting the deemed correction transaction

Note: To protect the above PHI files while in transit, place them in a ZIP file within a password protected ZIP file prior to copying to a CD or flash drive.

RPC Toolkit/LIS SOP -
http://www.reedassociates.org/documents/sop/LIS_Deeming_Update_SOP.pdf

Manual Correction Requests

- Manual correction of LIS status in CMS systems applies only to corrections for deemed beneficiaries.
- Currently, there is no process to correct the LIS status of LIS applicants,

BUT …

Sponsors must accept and use BAE to update their own systems for these beneficiaries.

Manual Correction Requests (continued)

- August 2009 – June 2012: 27,002 transactions were sent to the RPC.
- 37% of manual requests were not processed as requested.
- Top reasons for invalid findings:
  - The BAE provided does not support the requested LIS copayment level.
  - The LIS deeming information had previously been entered into the CMS System.
  - The BAE provided does not support the requested effective date.
  - The transaction is a duplicate because the period requested has already been submitted by the organization.

Acceptable Documentation

- Shows the beneficiary's identifying information.
- Shows Medicaid eligibility and/or Medicaid payment to a facility for an institutionalized beneficiary for a month or receipt of HCBS after June of the previous year.
- Clearly shows the source of the documentation to establish the information is directly tied to State or SSA systems.

Acceptable Documentation (continued)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

<BENEFICIARY FULL NAME>
<ADDRESS>
<CITY STATE ZIP>

HICN <1234>
<file creation date>

Please keep this notice for your records. You're getting this notice because you automatically qualify for Extra Help paying Medicare prescription drug coverage costs.

What does it mean to automatically qualify for Extra Help?

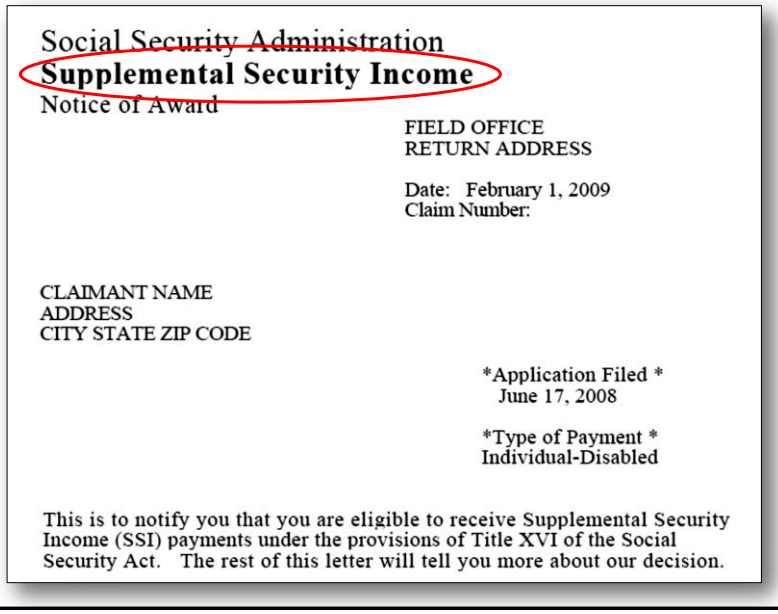
You get Extra Help and don't need to apply for it. If you applied, your application won't be processed because we already know you qualify. Getting Extra Help means you will pay no more than <gen_amt> for a generic drug and no more than <brd_amt> for a brand-name drug in a Medicare drug plan in 2010. These amounts may increase each year. You qualify for this help beginning <effective date> at least until December 31, <year>.

Note: You can only get Extra Help if you live in one of the 50 states or Washington D.C.

Be sure to bring this purple notice when you get a prescription filled, so the pharmacist knows you qualify for Extra Help.

CMS Product – 11166 PURPLE

Acceptable Documentation (continued)



Social Security Administration
Supplemental Security Income
Notice of Award

FIELD OFFICE
RETURN ADDRESS

Date: February 1, 2009
Claim Number:

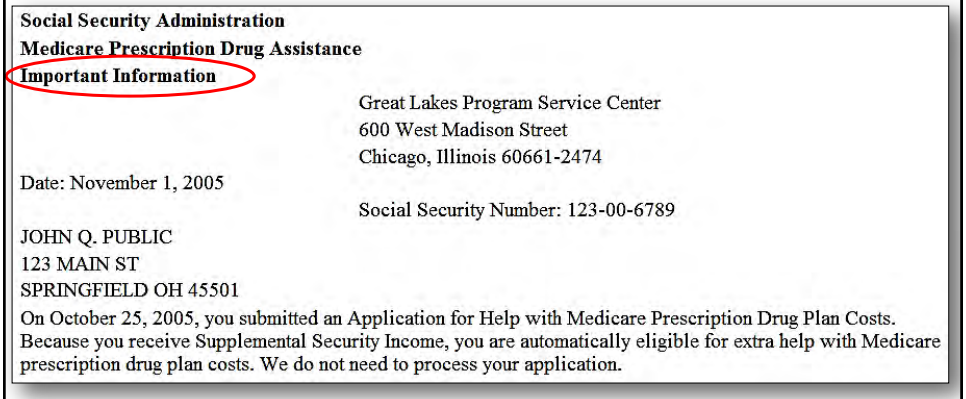
CLAIMANT NAME
ADDRESS
CITY STATE ZIP CODE

*Application Filed *
June 17, 2008

*Type of Payment *
Individual-Disabled

This is to notify you that you are eligible to receive Supplemental Security Income (SSI) payments under the provisions of Title XVI of the Social Security Act. The rest of this letter will tell you more about our decision.

Acceptable Documentation (continued)



Social Security Administration
Medicare Prescription Drug Assistance
Important Information

Great Lakes Program Service Center
600 West Madison Street
Chicago, Illinois 60661-2474

Date: November 1, 2005

Social Security Number: 123-00-6789

JOHN Q. PUBLIC
123 MAIN ST
SPRINGFIELD OH 45501

On October 25, 2005, you submitted an Application for Help with Medicare Prescription Drug Plan Costs. Because you receive Supplemental Security Income, you are automatically eligible for extra help with Medicare prescription drug plan costs. We do not need to process your application.

- **Notice for Application Filed By Deemed Eligible -** Advises the beneficiary that he is already deemed eligible as a result of being on SSI
- **Social Security Administration Publication** - HI 03094.605
- **Sample Notice at** https://secure.ssa.gov/poms.NSF/lnx/0603094605

Invalid Documentation

- Transaction Reply Reports from CMS
- Printouts from MARx with beneficiary eligibility information
- Printouts from sponsor systems reflecting beneficiary eligibility information
- Reprint letters from the SSA field office

Always refer to the latest list of BAE in Chapter 13 §70.5.2 - Required Documentation and Verification

BAE Assistance: Overview

- Beneficiary is unable to locate the appropriate documentation to establish LIS eligibility or award.
- Sponsors and Regional Offices work together to assist the beneficiary in obtaining the documentation.

BAE Assistance: Plan Actions

- The Part D Sponsor completes columns A through F of the new BAE worksheet and sends it via an encrypted email to CMS Regional Office (RO) Part D mailbox based upon the region **in which the individual resides, not the lead region.**
- Sponsors will identify these requests by including the subject line "Immediate BAE Assistance Needed" or "Non-Immediate BAE Assistance Needed".

Subject Line	Timeframe
Immediate Need	less than 3 days
Non-Immediate	3 days or more

BAE Assistance Requirements

- Members' LIS level DOES NOT change in plan system at this stage.
- CMS will attempt to secure BAE and respond to sponsors.
  - If Member is subsidy eligible, sponsors must follow BAE Process (Slide 8).
- Sponsors are to notify members if BAE is not available or unable to be obtained.
- Applies to **deemed beneficiaries only**.

BAE Assistance: Outcome

- When RO responds, Sponsor must:
  - Notify beneficiary of the results of CMS inquiry as outlined in the Medicare Prescription Drug Benefit Manual - Chapter 13 §70.5.3; Steps 5a – 5d.
  - Provide the beneficiary access to covered Part D drugs at a reduced (or $0, as appropriate) cost-sharing level as required under existing BAE guidance.
  - Submit a manual correction transaction to the RPC as described on Slides 15-16.

Recap Current BAE Policy

- Members' LIS Level is verified and changed in Sponsor's system.
- Beneficiary or someone acting on his/her behalf provides information to the sponsor.
- Notification of LIS status is required via the EOC rider.
- Applies to all LIS beneficiaries.

QUESTIONS?

Evaluation

Please take a moment to complete the evaluation form for the following module:

Part D LIS and BAE

Your Feedback is Important!
Thank you!