

Medicare Managed Care Manual

Chapter 2 – Enrollment

(EXCERPT)

20 - Eligibility for Enrollment in M+C Plans

In general, an individual is eligible to elect an M+C plan when each of the following requirements are met. More specific detail regarding these requirements follows.

1. The individual is entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan (see exceptions described under §20.6);
2. The individual has not been medically determined to have ESRD prior to completing the enrollment form (see exceptions described under §20.2);
3. The individual permanently resides in the service area of the M+C plan (see exceptions in §20.3 for persons living outside the service area at the time of election);
4. The individual or his/her legally authorized representative completes an enrollment form and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS (refer to Exhibit 25 for a list of items required to complete the enrollment form, and §40.2.1 for who may sign election forms);
5. The individual is fully informed of and agrees to abide by the rules of the M+CO that were provided during the election process; and
6. The individual makes the election during an election period, as described in §30.

An M+CO must not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in an M+C plan and continues to be enrolled in his/her employer's or spouse's health benefits plan, then coordination of benefits rules apply.

An M+C eligible individual may not be enrolled in more than one M+C plan at any given time. Procedures for handling multiple transactions, cancellations, and reinstatements are described under §60.

20.1 - Entitlement to Medicare Parts A and B

To be eligible to elect an M+C plan, an individual must be entitled to Medicare Part A and enrolled in Part B, and must be entitled to Medicare Part A and Part B benefits as of the effective date of coverage under the plan. Exceptions for Part B-only "grandfathered"

members are outlined in §20.6. Part B only individuals currently enrolled in a §1833 or §1876 of the Social Security Act, (the Act,) plan are not considered to be "grandfathered" individuals, and must purchase Medicare Part A through the Social Security Administration to become eligible to enroll in an M+C plan.

An M+CO has the option to continue to offer Part A-equivalent coverage to Medicare Part B-only "grandfathered" members, as described in §20.6. However, an M+CO may not offer Part A-equivalent coverage to other individuals enrolled only in Medicare Part B (and not entitled to Part A) in order to make them "eligible" for enrollment in an M+C plan. Eligibility requirements are met based on Part A entitlement through Medicare and not through the purchase of Part A-equivalent benefits through the M+CO. The M+CO may refer the individual to SSA if the individual wishes to enroll in Medicare Part A in order to be eligible to enroll in the M+C plan.

While desirable, it is not necessary for an individual to prove Medicare Part A entitlement or Part B enrollment **at the time** he/she completes the enrollment form, i.e., the M+CO may not deny the enrollment if the individual does not have the evidence when filling out the enrollment form or does not include it with the form when he/she mails it to the organization. However, the organization may consider the enrollment form to be incomplete until it can verify such entitlement or enrollment. Section 40.2.2 provides more information on the steps the organization can take to verify Medicare coverage. In addition, the definition of "Evidence of Part A and Part B Coverage" in §10 lists some of the type of information that can be used to verify coverage.

20.2 - End Stage Renal Disease (ESRD)

Except as provided under exceptions discussed below, an individual is not eligible to elect an M+C plan if he/she has been medically determined to have ESRD.

An individual who receives a kidney transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of M+C eligibility. Such an individual may elect to enroll in a M+C plan, if he/she meets other applicable eligibility requirements. If an individual is only eligible for Medicare on the basis of ESRD (i.e., not based on disability or age), the individual would only be permitted to remain enrolled as an M+C enrollee during his or her remaining months of Medicare eligibility.

The M+CO is permitted to ask at the time of the election whether the applicant has ESRD. This question is not considered impermissible health screening since the law does not permit a person with ESRD to elect an M+C plan, except as provided in the following paragraphs. An M+CO must deny enrollment to any individual medically determined to have ESRD, except as provided in the following paragraphs. CMS will reject the enrollment if Medicare records indicate the applicant has ESRD, and no exception permitting enrollment applies.

Procedures for identifying whether an individual is medically determined to have ESRD are included in §40.2.4.

20.2.1 - Background on ESRD Entitlement

When an individual files for Medicare based upon ESRD, entitlement can begin:

- The first day of the third month after the month dialysis begins (i.e., the first day of the fourth month of dialysis), or
- The first day of the month dialysis began if the individual trains for self-dialysis, or
- Up to 12 months prior to the month of filing (if dialysis began more than 12 months before) or
- Prospectively.

The Medicare entitlement date is usually the month an individual receives a transplant or 3 months after the month the individual begins dialysis (i.e., the first day of the fourth month of dialysis). For example, if an individual begins dialysis in January, Medicare entitlement is effective April 1. Therefore, for these individuals, the initial coverage election period (ICEP) would be the time between when dialysis begins and the Medicare entitlement date - the 3-month waiting period for Medicare entitlement.

There are individuals who are approved to perform **self-dialysis**. If an individual is approved for self-dialysis, SSA will waive the 3-month waiting period to begin Medicare entitlement. In cases of self-dialysis, Medicare entitlement is effective the month dialysis begins, rather than the customary 3 months from the month the individual begins dialysis.

EXAMPLE:

Medicare record is established in January for an April 1 entitlement effective date. Since the individual has 3-month waiting period waived, SSA submits a changed record for a January 1 Medicare entitlement effective date.

Medicare pays nothing until individual files for benefits and Medicare coverage becomes effective.

Individuals sometimes elect a prospective effective date to coordinate with the end of their 30-month coordination period. In the case of an **individual in a group health plan**, the group plan is required to be the primary payer for the first 30 months of Medicare eligibility or entitlement (also known as the 30-month coordination of benefits period), as long as the individual chooses to be enrolled in the group health plan. There is nothing to require an individual to file for Medicare immediately upon starting dialysis. The group health plan is primary during the coordination of benefits period, without regard to the number of individuals employed and irrespective of current employment status.

Since an ICEP relates to when an individual becomes entitled to Medicare Part A and B, when possible, the group or M+C organization should coordinate with the individual so that he/she will not be adversely impacted if he/she has the option to elect an M+C plan.

20.2.2 - Exceptions to Eligibility Rule for Persons Who Have ESRD

- **Conversions upon ICEP:** Individuals who developed ESRD while a member of a health plan offered by an M+CO and who are converting to Medicare Parts A and B, can elect an M+C plan in the same organization (within the same State, with exceptions) as their health plan during their ICEP. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2). The individuals must meet all other M+C eligibility requirements and must fill out an election

form to join the M+C plan.

▪ **Conversions other than ICEP:**

1. If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an M+C plan during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an M+C plan offered by the M+C organization, as long they were in a health plan offered by the same M+C organization the month before their entitlement to Parts A and B, developed ESRD while a member of that health plan, and are still enrolled in that health plan. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who performs self-dialysis will have his/her entitlement date adjusted to begin at the time of dialysis, rather than the customary 3 month period **after** dialysis begins.

These individuals will be given a special election period. See §30.4.4 for additional instructions.

2. Individuals who are members of a group health plan and are in their 30-month coordination period will have the opportunity to elect an M+C plan at any time during this 30-month period if certain conditions are met. The individual must have been a member of a health plan offered by the M+C organization the month before his/her entitlement to Parts A and B, and must continue to be enrolled in that health plan. The individual must also choose to elect an M+C plan offered by that M+C organization, and must meet all other M+C eligibility requirements.

These individuals will be given a special election period. See §30.4.4 for additional instructions.

3. An individual who elects an M+C plan and who is medically determined to first have ESRD **after** the date on which the enrollment form is signed (or receipt date stamp if no date is on the form, per §40.2), but **before** the effective date of coverage under the plan is still eligible to elect the plan.
4. An individual who develops ESRD while enrolled in an M+C plan may continue to be enrolled in the M+C plan.
5. Once enrolled in an M+C plan, a person who has ESRD may elect other M+C plans in the same M+CO (and during allowable election periods, as described under §30.0). However, the member would not be eligible to elect an M+C plan in a different M+CO or a plan in the same M+CO in a different State (with exceptions).
6. An individual with ESRD whose enrollment in an M+C plan was terminated on or after December 31, 1998 as a result of a contract termination, non-renewal, or service area reduction can make one election into a new M+C plan following such termination. The individual must meet all other M+C eligibility requirements, and must enroll during an M+C election period. Once an individual has exhausted his

one election, he will not be permitted to join another M+C plan, unless his new plan is terminated.

20.3 - Place of Permanent Residence

An individual is eligible to elect an M+C plan if he/she permanently resides in the service area of the M+C plan. A temporary move into the M+C plan's service area does not enable the individual to elect the M+C plan; the M+CO must deny such an election.

EXCEPTIONS

1. A member who permanently moves from the service area of the M+C plan to an approved continuation area of the M+CO, and who chooses the continuation of enrollment option offered by the M+CO, may continue to be enrolled in the M+C plan (refer to §60.7 for more detail on the requirements for the continuation of enrollment option).
2. Conversions: Individuals who are enrolled in a commercial health plan of the M+CO and are converting to Medicare Parts A and B can elect an M+C plan offered by the same M+CO during their ICEP even if they reside in the M+CO's continuation area. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2).
3. A member who was enrolled in an M+C 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 M+C plan while living outside the plan's new reduced service area if:
 - There is no other M+C plan serving the area;
 - The M+CO offers this option; and
 - The member agrees to receive services through providers in the M+C plan's service area.

The M+CO has the **option** to also allow individuals who are converting to Medicare Parts A and B to elect the M+C 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 M+C access requirements in 42 CFR §422.112 are met for that individual through the M+C plan's established provider network providing services in the M+C 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 employer group members of the M+CO.

Individuals who do not meet the above requirements may not elect the M+C plan. The M+CO 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 M+CO may request additional information such as voter's registration records, driver's license records, 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 M+CO must contact the individual to determine place of permanent residence, unless the person is homeless (see below). If there is a dispute over where the individual permanently resides, the M+CO should determine whether, according to the law of the M+CO's State, whether 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.

20.4 - Completion of Enrollment Form

An eligible individual or authorized individual must fill out an election form to enroll in an M+C plan, **even if that individual is electing an M+C plan in the same M+CO in which he/she is enrolled.**

Unless otherwise specified by CMS, an eligible individual can elect an M+C plan only if he/she completes and signs an enrollment form, provides required information to the M+CO within required time frames, and submits the properly completed form to the M+CO for enrollment. Model enrollment forms are included in Exhibits 1, 2, and 3.

An individual who is a member of an M+C plan, and who wishes to elect another M+C plan offered by the same M+CO, must complete a new enrollment form to enroll in the new M+C plan; however, that individual may use a short enrollment form (refer to Exhibit 3 for a model short enrollment form) to make the election in place of the comprehensive individual enrollment form.

An M+CO must deny enrollment to any individual who does not properly complete the enrollment form within required time frames. Procedures for completing the enrollment form are provided in §40.2 and Exhibit 25. Refer to §10 for a definition of "completed election form."