50.2 – Required Involuntary Disenrollments

(Rev. 38, 10-31-03)

The cost plan must disenroll a member from the plan in the following cases:

- A permanent change in residence out of the plan's service area (§50.2.1), or a temporary absence from the plan's service area for more than 90 consecutive days (except as described in §50.2.1.1);

- Death of the member (§50.2.2);
- Member's loss of entitlement to Medicare Part B (§50.2.3); and
- Termination or non-renewal of the cost plan's contract (§50.2.4).

50.2.1 – Permanent Move Out of the Plan's Service Area

(Rev. 38, 10-31-03)

A beneficiary must be disenrolled if he or she permanently moves out of the plan's service area and does not voluntarily disenroll. The plan must initiate disenrollment as soon as it becomes aware that the beneficiary has permanently moved outside the service area. An uninterrupted absence of more than 90 days is deemed to be a permanent move (see the exception in §50.2.1.1). A written statement from the beneficiary or other reasonable evidence establishes that the beneficiary has moved out of the service area. Even if the beneficiary has not informed the plan of his or her new address, the plan must attempt to provide the beneficiary written notice of enrollment termination. The CMS encourages the plan to send final confirmation of disenrollment to the member.

50.2.1.1 - Retention of Members Who Temporarily Leave the Plan's Service Area

(Rev. 38, 10-31-03)

Cost plans are allowed to retain a Medicare member under either of the two options described below if the member leaves the plan's service area for an **extended absence.** An extended absence is one that is over 90 days, but not more than 1 year, and where the member intends to return to the service area within the 1 year period. The extended absence option is available only to members remaining in the United States.

Option 1 – General Retention Option

The cost plan may choose to cover all out-of-area routine services for anyone who leaves the service area for an extended absence. If the plan offers such a service, it must advise all members of its availability. When an individual who has taken advantage of this policy returns to the service area, he or she must resume obtaining medical services through network providers in order for services to be covered in full. However, the member can still elect to obtain services from non-network providers, but he or she will be responsible for any applicable Medicare coinsurance and deductibles. If the member elects to obtain care from non-network providers, those providers can submit bills to Original Medicare for payment consideration.

The cost plan may place restrictions on the services received out-of-area for individuals who take advantage of the extended absence option, as long as the Medicare beneficiary agrees to the restrictions and the full scope of contracted benefits is available to the member in the extended service area. Possible restrictions on services include obtaining

medical care through designated providers or requiring prior authorization. Non-designated providers or those seen without prior authorization (where required) would submit bills to Original Medicare.

Additionally, the cost plan remains financially liable for emergency and out-of-area urgently needed services.

Option 2 – Retention of Enrollment With Services Provided Through Affiliated Organization

If the cost plan is affiliated with another organization (by common ownership or control, or written agreement), the plan may make the extended absence option available only to members who move to the affiliate's service area during an extended absence. The members must agree to obtain services exclusively through the affiliated organization. The cost plan may retain such individuals as Medicare members of its plan for up to one year. This option must be made available to anyone moving to the affiliated organization's service area during an extended absence, and all plan members must be advised of the availability of this service.

Also, the cost plan is financially responsible for emergency and out of area urgently needed services. For this extended absence option, urgently needed services obtained while temporarily absent from the geographic area and needed while the member is present in the affiliate organization's service area are the responsibility of **the affiliate organization** responsible for providing services to the member during the extended absence.

The CMS approves extended absence options as part of the cost plan's initial Medicare application, or as such options are developed. The CMS also reviews marketing materials and membership rules to ensure that the options are clearly explained and beneficiaries are advised of the distinction between authorized and unauthorized out-of-plan service use.

If a plan wants to offer an extended absence option, CMS suggests that the cost plan have the individual sign an agreement which states any restrictions on services imposed, where and how to obtain services, and how billing is accomplished.

Supplemental benefits for which the member is paying a premium may be discontinued upon his or her leaving the service area, as long as the member is not required to continue paying the premium or portion of a premium that corresponds to these services.

If a member takes advantage of the extended absence option, but fails to return to the service area within one year, the plan must disenroll him or her effective the first day of the month following the 1 year anniversary date of the original departure from the service area. The plan should notify the beneficiary regarding the upcoming disenrollment before it occurs.

50.2.2 – Death

(Rev. 38, 10-31-03)

The CMS will disenroll deceased members effective the month immediately following the month of death and notify the cost plan that the member has expired. Monthly interim per capita payments end with that month. The plan should send a notice to the member or his or her estate so that any disenrollment due to an erroneous report of death can be corrected as soon as possible (Exhibit 9).

50.2.3 – Loss of Entitlement to Part B

(Rev. 38, 10-31-03)

The member is disenrolled by CMS the month immediately following the month that enrollment in Part B ends. Monthly interim per capita payments made on behalf of the beneficiary terminate effective the month immediately following the last month of entitlement to benefits under Part B. The plan should send a notice to the member so that any disenrollment due to erroneous information can be corrected as soon as possible (Exhibit 10). The beneficiary may remain a member of the organization if a non-Medicare option is available.

If a member loses entitlement to benefits under Part A, but remains entitled to benefits under Part B, he or she remains a member of the cost plan. The member is entitled to receive and have payment made for Part B services only, beginning with the month immediately following the last month of his/her entitlement to Part A. The cost plan may offer all or partial Medicare Part A benefits.

50.2.4 – Plan Termination/Non-Renewal or Reduction of Plan Service Area

(Rev. 38, 10-31-03)

A cost plan must disenroll members from its plan if the contract is terminated, if the organization discontinues offering the plan, or if the plan does not renew in any portion of the area where it had previously been available.

A member who is disenrolled from a cost plan under these provisions is allowed to choose another cost plan or an M+C plan (if one is available and he/she meets applicable eligibility requirements), or original Medicare. If no other choice is made, the individual will automatically return to Original Medicare by default.

Notice Requirements: In most cases, the plan terminating the contract must send a written notice to all Medicare members enrolled in the organization at least 60 days before the effective date. However, if CMS initiates a termination, it notifies members 30 days before the effective date.

The notice must be reviewed by CMS prior to issuance. The plan must submit the proposed notices for review in sufficient time to meet all deadlines, and provide final copies of the notices sent to beneficiaries to the CMS Regional Office Plan Manager.

The termination, non-renewal, or partial non-renewal of a contract between the plan and CMS, whether by mutual consent or by unilateral action of either party, ends the liability of CMS to make monthly interim per capita payments on behalf of Medicare beneficiaries. The CMS liability ends effective the first day of the month following the last month the contract is in effect.

If the cost plan defaults on its contract with CMS prior to the close of the contract year due to bankruptcy or other reasons, CMS will establish the month in which interim per capita payments end for all enrolled Medicare beneficiaries. The CMS will notify the cost plan and all affected Medicare enrollees in writing as soon as practical.