50.3 – Other Involuntary Disenrollments

(Rev. 38, 10-31-03)

50.3.1 – Failure to Pay Premium

(Rev. 38, 10-31-03)

Cost plans have the following options when a member does not pay his/her basic monthly premium. The cost plan should outline its policy in its policy and procedures and apply the option chosen consistently among all members.

1. Do nothing, i.e., allow the member to remain enrolled in the same premium plan; or

2. Disenroll the member after proper notice.

The cost plan may disenroll a Medicare beneficiary who fails to pay his/her basic monthly premiums, or other charges imposed by the cost plan for Medicare deductible and coinsurance amounts for which he or she is liable. However, the cost plan must demonstrate to CMS that a reasonable effort was made to collect the unpaid amount and that the plan gave the beneficiary written notice of disenrollment before notifying CMS. Since it is possible that the beneficiary believes that nonpayment of premiums is a way to disenroll, the cost plan may wish to include in its payment reminder notices an explanation of the proper way to disenroll. The CMS will consider the cost plan to have demonstrated reasonable effort in collecting unpaid premiums if the plan mails a notice of disenrollment for nonpayment of premium to the beneficiary at least 20 days before the effective date of disenrollment. This allows 5 days for mailing time and 15 days for the beneficiary to act on the notice. Disenrollment for nonpayment of premium will be effective as of the last day of the month in which the 20-day period expires. The plan should include an explanation of the member's rights to a hearing under its grievance

procedures. The cost plan may not notify CMS until after the plan has notified the beneficiary.

NOTE*:* If the member fails to pay the premium for optional supplemental benefits, but pays the premium for the basic benefits, the cost plan may not disenroll him or her. The cost plan may discontinue the optional benefits, but may not disenroll the member.

50.3.2 – Fraud in Enrollment or Abuse of Membership Cards

(Rev. 38, 10-31-03)

A Medicare beneficiary may be disenrolled if he/she commits fraud in connection with his or her enrollment or permits abuse of the membership card, e.g., the beneficiary knowingly provides fraudulent information on the application form, which materially affects eligibility for enrollment, or a Medicare beneficiary permits others to use his/her membership card to receive services. This category includes any abuse relating to cost plan membership or the Medicare program.

In the case of fraud or abuse, the plan must send the beneficiary written notice of termination prior to submission of the disenrollment notice to CMS. The plan must include an explanation of the member's rights to a hearing under grievance procedures established by the organization, and also notify the RO so that the Office of the Inspector General may initiate its own investigation of the alleged fraud or abuse.

50.3.3 – Disenrollment for Cause

(Rev. 38, 10-31-03)

A cost plan has the right to initiate procedures to disenroll a Medicare member if his/her behavior is disruptive, unruly, abusive, or uncooperative to the point that his or her continuing membership seriously impairs the ability to furnish services to either him/her or other members. The cost plan must ascertain that the enrollee's behavior is not related to the use of medical services or to mental illness. The cost plan may not initiate disenrollment because the beneficiary exercises his or her option to make treatment decisions with which the cost plan disagrees, e.g. refuses aggressive treatment for cancer.

Before beginning the disenrollment for cause process, the plan must make a serious effort to resolve the problem presented by the member. It must inform the member that his/her continued behavior may result in termination of membership in the organization. If the problem cannot be resolved, the plan must give the member written notice of its intent to request disenrollment for cause. In this notice, explain the member's right to a hearing under the organization's grievance procedures.

50.3.3.1 – Proposed Notice for Disenrollment for Cause

(Rev. 38, 10-31-03)

Once the grievance process has been completed or the member has chosen not to use this process, the cost plan must submit a proposed disenrollment notice to the Regional Office stating reasons for the termination of enrollment and the proposed effective date. Also, the cost plan must summarize the case and submit documentation to the Regional Office, including:

- The reason that the plan is requesting disenrollment for cause;
- A summary of plan efforts to explain these issues to the member and the other types of options presented before disenrollment was considered;
- A description of the member's age, diagnosis, mental status, functional status, and social support system; and
- Separate statements from primary providers describing their experiences with the member.

50.3.3.2 – Regional Office Review of Disenrollment for Cause

(Rev. 38, 10-31-03)

The Regional Office will review the cost plan's request based on the documentation submitted and make a decision within 20 business days of receipt of complete documentation. The Regional Office will notify the plan within 5 business days after the decision is made.

When the cost plan receives the decision it must inform the enrollee of the determination. If membership is being terminated, the cost plan must send a notice that contains the reason for disenrollment, the effective date of termination, and a statement that this action was approved by CMS.

50.3.3.3 – Effective Date of Disenrollments for Cause

(Rev. 38, 10-31-03)

If CMS permits a cost plan to disenroll a member for cause, the disenrollment takes effect on the first day of the calendar month after the month in which the plan serves written notice of termination to the member and the grievance period has expired. The liability of CMS to make payments ends on that date. The cost plan must retain copies of its documentation, the proposed disenrollment notice, the approval letter from CMS, and the notice to the beneficiary in its files for verification purposes.