2016 Enrollment and Disenrollment

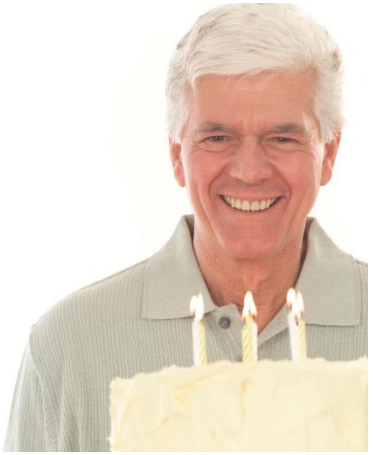
Module 4

UPMC *for Life*

UPMC Health Plan Medicare Program

Medicare Advantage Eligibility

- **An individual must meet the following criteria to join a Medicare Advantage (MA) plan:**
  - An individual must be 65 or older or disabled.
    - An individual qualifies for Medicare after he or she has been receiving disability benefits for 24 months.
    - Typically, there is a five month waiting period before a person begins receiving disability benefits. So the total elapsed time prior to Medicare eligibility is 29 months.
    - Disabled individuals accounts for 15% of Medicare beneficiaries.
  - An individual must be entitled to Medicare Part A and enrolled in Part B.
    - Individual must continue to pay his or her Part B premium to remain enrolled in a MA plan.
  - The individual must reside in the plan's service area.
    - Individuals cannot be incarcerated or live abroad.
  - An individual cannot have End Stage Renal Disease (ESRD).
  - The individual must enroll during a valid enrollment period.



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UPMC Health Plan Medicare Program

Medicare Advantage Eligibility

End Stage Renal Disease (ESRD) Eligibility Rules

- If an ESRD member is enrolled in a plan's commercial product and becomes eligible for Medicare upon his or her Initial Coverage Election Period; he/she can enroll in a MA plan offered by that same company.
  - The person must have no breaks in coverage from the commercial plan to the Medicare Advantage plan.
- If a person develops ESRD once he/she is enrolled in the MA plan he/she cannot be asked to leave the plan.
  - The individual may switch to other Medicare Advantage plans offered by the same Medicare Advantage plan during a valid enrollment period (e.g., HMO to PPO, or HMO to HMO plan).
- If a plan is discontinued the retiree can make one election to join a new MA plan offered within the same service area.
  - The individual can have no breaks in coverage.

Enrollment Guidelines

❑ Enrollment Procedures

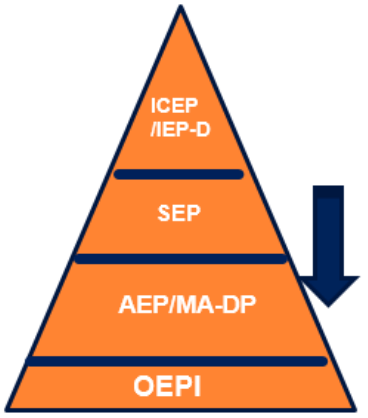
- ❑ A MA plan must accept enrollment requests received in a face-to-face meeting, by mail, by fax, or through other CMS approved mechanisms, such as CMS on-line enrollment.
- ❑ An individual must complete an enrollment request mechanism to enroll in a Medicare Advantage or Prescription Drug Plan during a valid enrollment period. The individual cannot be enrolled in more than one Medicare Advantage plan at any given time.
- ❑ Upon receiving an enrollment request a MA plan must provide one of the following responses within 10 calendar days:
  - ❑ Acknowledgement notice or notice of denial.
  - ❑ Request for additional/missing information.
- ❑ Effective date of coverage is normally the 1st of the month after receipt of the request (except for AEP elections)

❑ Medicare Advantage Election Periods:

In order for a MA plan to accept an Election, a valid request must be made by the enrollee during an Election Period. The appropriate election period must be selected according to CMS' hierarchy, if more than one election exists for a member.

Medicare Advantage Plans have five enrollment election periods:

- Initial Coverage Election Period and Initial Enrollment for Part D (ICEP AND IEP for Part D)
- Annual Election Period (AEP)
- Special Election Periods (SEP)
- Medicare Advantage Disenrollment Period (MADP)
-Open Enrollment Period for Institutionalized Individuals (OEPI)



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UPMC Health Plan Medicare Program

Enrollment Guidelines

❑ Initial Coverage Election Period (ICEP)

- ❑ The period during which an individual newly eligible for Medicare may make an initial enrollment request to enroll in a Medicare Advantage plan.
  - ❑ Often times this election occurs when an individual turns 65.
  - ❑ Individuals that are eligible for Medicare prior to age 65 (such as for disability) will have a second Initial Coverage Election Period upon attaining age 65.

- When is the ICEP?
  - The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility.
- How often can a beneficiary request to use the ICEP?
  - One time - Once an ICEP enrollment request is made and enrollment takes effect, the ICEP election has been used.
- What is the effective date of the ICEP?
  - First day of the month of entitlement to Medicare Part A and Part B – or-
  - The first of the month following the month the enrollment request was made if after entitlement has occurred.
- What if the Part B is delayed?
  - When a beneficiary wants to use the ICEP Election but delays Part B this changes the timeframe of this election.
  - Delaying Part B eliminates the 7 month open window and narrows it down to only the **3 MONTHS BEFORE/preceding the beneficiary's Part B**.

Enrollment Guidelines

Comparison: Time Frames & Usage of the ICEP

- When all parts match

- When Part B is delayed

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Enrollment Guidelines

- **Initial Enrollment Period (IEP for Part D)**
  - The period during which an individual is first eligible to enroll in a Part D plan, it typically coincides with the individual's Part B eligibility.
    - In general, an individual is eligible to enroll in a Part D plan when he or she is entitled to Part A OR is enrolled in Part B
      - AND permanently resides in the service area of a Part D plan. Ultimately, CMS provides a part D eligibility effective date and maintains it in CMS systems. *(MARX)*
    - Generally, individuals will have an IEP for Part D that is the same period as the Initial Enrollment Period for Medicare Part B. (ICEP)
      - The ICEP and the IEP for Part D occur together as one period when a newly Medicare eligible individual has enrolled in BOTH Part A and B at first eligibility.
    - Should an individual delay enrollment in Part B to a later time, the ICEP and IEP for Part D become separate with the ICEP changing to then occur as the 3 months immediately preceding entitlement to BOTH parts A and B.

- How often can a beneficiary request to use the IEP?
  - During the IEP for Part D, individuals may make **one** Part D enrollment choice, including enrollment in an MA-PD plan.

- What is the effective date of the IEP?
  - First day of the month of entitlement to Medicare Part A and Part B – or-
  - The first of the month following the month the enrollment request was made if after entitlement has occurred.

Enrollment Guidelines

- **2017 Annual Election Period (AEP)**
  - **In 2016, this Annual Election Period will take place from October 15 to December 7.**
    - The enrollee's plan coverage will begin on January 1, 2017.
    - An individual can make an election during this time. If he/she signs up for multiple plans the last application date submitted is considered to be their final election.
    - Except in very limited circumstances (e.g., qualified special election periods) individuals cannot make plan enrollment changes outside of the annual election period.
    - Individuals can make any type of election during this timeframe. Example: Original Medicare to MA, MA to MAPD, MAPD to MA, etc.
  - **Plans <u>cannot</u> solicit applications from an enrollee prior to October 15.**
    - Brokers/agents should remind beneficiaries that they cannot submit enrollment requests prior to the start of the Annual Election Period. Brokers may not hold applications for members until the AEP begins.

Enrollment Guidelines

- **2016 Annual Election Period (AEP) *(continued)***
  - If a Medicare Advantage plan receives unsolicited paper applications prior to the start of the Annual Election Period it must retain and process the application:
    - Written notice that acknowledges receipt of the application must be sent to the enrollee.
    - The plan must submit the enrollment request to CMS on the first day of Annual Election Period, October 15th with an "application date" of the same date.

Enrollment Guidelines

❑ Enrollment Application Requirements *(paper, phone or online)*

- ❑ The following information **MUST** be reviewed and acknowledged **by the enrollee***:
  - ❑ Understanding of the requirement to continue to keep Medicare Part A and B.
  - ❑ Agreement to abide by the Medicare Advantage plan's membership rules, as outlined in member materials (e.g., Evidence of Coverage).
  - ❑ Consent to the disclosure and exchange of information necessary for the operation of the Medicare Advantage program.
  - ❑ Understanding that he or she can be enrolled in only one Medicare health plan and that enrollment in the Medicare Advantage plan automatically disenrolls him or her from any other Medicare health plan and/or prescription drug plan.
  - ❑ Understanding of the rights to appeal services and payment denials made by the Medicare Advantage plan.
  - ❑ Understanding of the plan benefits, plan premiums (if applicable) and plan star ratings information.

*Most of this information is included in the enrollment application in the "Rights and Responsibilities Section."

Enrollment Guidelines

❑Special Election Periods (SEPs)

- ❑ Special Election Periods are election periods outside of the usual Medicare Advantage enrollment timeframes, when an individual may elect a plan or change his or her current election. Once an individual elects a new plan the Special Election Period ends even if the timeframe for the Special Election Period has not expired.
  - ❑ There are very limited circumstances when a beneficiary can make mid-year changes.
- ❑ It is the responsibility of the Medicare Advantage Organization to determine if a Special Election Period applies to the enrollee and if the SEP is still within the allowable timeframe.
  - ❑ We must ensure that the brokers are using the correct elections especially the MCC/SPAP elections.
  - ❑ Also, make sure to obtain the needed dates, for example, the date the member moved if using the MOV election.
  - ❑ See next slide for SEP definitions.

Enrollment Guidelines

- Examples of Special Election Periods include (but are not limited to):
  - Enrollees in an employer group health plan is retiring. (LEC)
  - Changes in residence outside the plan's service area; including if an individual is out of the service area for over six months. Member recently moved into the service are and the plan is a new option. (MOV)
  - If an individual loses dual eligibility status, low income subsidy, or special needs status. (LIS)
  - I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) (LCC)
  - Significant Change in Provider Network – established by CMS on a case by case basis if it determines a network change to be significant.
  - If a plan has a CMS contract violation, or terminates their contract with CMS.
  - The member recently moved into a nursing home.
  - If an individual becomes eligible or loses eligibility in a state pharmaceutical assistance program (SPAP), such as PACE/PACENET.
  - **NOTE**: SPAP SEP cannot be used to enroll in a Medicare Advantage No Rx Plan if coming from Original Medicare/PDP. SPAP is to enroll into an RX plan, MCC is to disenroll from an Rx plan into no Rx

Enrollment Guidelines

Distinguishing between the SPAP & MCC

SPAP

- The SPAP Election allows a beneficiary to sign up with a Drug Plan while using their Pace or PaceNet.
- These beneficiaries DO NOT have to be signed up in a contract prior through SSA.
- Can enroll in a Part D plan.
- One election per calendar year.
- If member loses eligibility, an SEP will start the earlier of the notification of loss or the actual loss of eligibility and ends 2 months after the notification or the actual loss of eligibility, whichever is later.

MCC

- When using the MCC election the beneficiary must ALREADY be signed up in an “H” Contract with drug coverage (the “Y” Flag) under Drug Plan in MARX.
- Individuals may disenroll from a Part D plan (including PDPs and MA-PDs) to enroll in or maintain other creditable drug coverage (such as TriCare or VA coverage).
  - Note: This election allows the beneficiary to enroll into a no Rx plan and maintain their other Rx coverage.
- Can enroll in an MA-only plan (if coming from an MAPD plan).
- Can disenroll from a Part D plan in order to enroll in or maintain creditable coverage (VA, TriCare, PACE/PACENET).

Enrollment Guidelines

❑ Special Election Period to Enroll in a 5-Star Plan

- ❑ **An eligible individual may use this Special Election Period to enroll in a 5-Star plan during the year that the plan has a 5-Star rating.**
  - ❑ The 5-Star rating will apply to a plan for a calendar year (January to December).
    - ❑ Star Ratings are released by CMS in October of each year. If a plan was assigned a 5-Star Rating this Special Election period would apply to the upcoming year.
  - ❑ Individuals can switch from an MA plan, a PDP, a cost plan or Original Medicare to an MA-only plan, an MA-PD plan, a PDP or a cost plan that has a 5-star overall rating.
    - ❑ NOTE: If an individual would leave a plan with Part D coverage to enroll in a 5-Star MA plan (no-Rx), he or she would lose their Part D prescription drug coverage and would NOT be able to enroll in another Part D plan until a qualified subsequent election period (e.g., Annual Election Period). Late enrollment penalties might also apply.
- ❑ **The enrollment effective date when enrolling into a 5-Star plan is the first of the month following the month in which the 5-Star Plan receives the enrollment request.**
  - ❑ An individual may use this SEP only one time from December 8 (prior year) through November 30 of the year in which the organization has been granted a 5-star overall rating.

Common SEP's

SEP	DEFINITION
MOV-IN	I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me *Members can pick their effective date*
MOV	I recently moved and this plan is a new option for me *Members can pick their effective date*
LEC	I am either losing or leaving my employer or union group coverage *Members can pick their effective date*
MDE	I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums. (Partial Medical Assistance)
LIS	I get extra help paying for Medicare prescription drug coverage or I no longer qualify for extra help paying for my Medicare prescription drugs
SPAP	I belong to a pharmacy assistance program provided by my state or I recently left a pharmacy assistance program

Common SEP's

SEP	DEFINITION
LCC	I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's)
EOC	My plan no longer covers the county in which I reside OR my plan terminated it's contract with Medicare
SNP/LOST MA	I am no longer eligible for my SNP plan
MCC	I am dropping a Part D plan in order to maintain my other creditable coverage
EGHP	I am eligible to enroll into an employer/union group sponsored health plan

SEP Cheat Sheet-what do you need

Applicable Statement	Date Needed	YES	SEP
Have you recently moved outside of the service area for your current plan or recently moved and this plan is a new option for you?	Date of Move	OEV	MOV-IN/ MOV
Have you recently returned to the United States after permanently living outside of the US?	Date of Move	OEV	RUS
Are you either losing or leaving employer or union group coverage	Date member lost coverage	OEV	LEC
Do you have both Medicare and Medicaid or does the state help pay for your Medicare premiums?		OEV	MDE
Do you get extra help paying for your Medicare Prescription Drug coverage or do you no longer qualify for extra help with your drug costs?	Date member gained or lost LIS	OEV	LIS
Do you belong to a pharmacy assistance program provided by the state, like PACE? Or, have you recently left a program such as PACE?	No, however must be enrolling into plan w Rx coverage and have PACE/ PACENet	OEV	SPAP
Have you recently involuntarily lost credible prescription drug coverage?	Full date member lost coverage	OEV	LCC
Does your current plan no longer cover the county in which you reside or has your current plan terminated its contract with Medicare?	Date of proposed termination	OEV	EOC
Are you no longer eligible for your SNP plan?	Date of status change	OEV	SNP/ LOST MA
Are you dropping your Part D plan to maintain other credible coverage?	No, however member must be currently active in MAPD and applying for no Rx.	OEV	MCC
Are you moving to, live in, or have recently moved out of a long term care facility, like a nursing home?	Date of Move	OEV	OEPI

Elections that can pick their effective date vs can't

Can't Select:

- MCC
- SPAP
- LIS
- MDE
- EOC
- SNP/Lost MA

Even though these are not SEP's the following also can not select:

- AEP
- MADP
- ICEP/IEP

Can Select:

- MOV
- LEC
- LCC
- EGHP

Enrollment Guidelines

❑ Open Enrollment Period for Institutionalized Individuals (OEPI)

- ❑ The Open Enrollment Period for Institutionalized Individuals is continuous for eligible institutionalized individuals.
  - ❑ For purposes of the Open Enrollment Period for Institutionalized Individuals to apply, an institutionalized individual is defined as an individual who moves into, resides in, or moves out of an institution.
  - ❑ Most plans will not have a huge volume of this type of enrollment.
- ❑ The Open Enrollment Period for Institutionalized Individuals ends two months after the month the individual moves out of the institution.
- ❑ A Medicare Advantage eligible individual can make an unlimited number of enrollment requests during the Open Enrollment Period for Institutionalized Individuals.
  - ❑ A Medicare Advantage plan is not required to accept requests to enroll into its plan during the Open Enrollment Period for Institutionalized Individuals, but if it is open for these enrollment requests, it must accept all requests for this type of enrollment.

Enrollment Guidelines

❑ Medicare Advantage Disenrollment Period (MADP)

- ❑ Enrollees that join a Medicare Advantage plan and wish to disenroll can do so during the Medicare Advantage Disenrollment Period period and return to Original Medicare.
  - ❑ Individuals CANNOT switch to another Medicare Advantage plan during this period.
- ❑ The Medicare Advantage Disenrollment Period is from January 1 through February 14 each year.
- ❑ The beneficiary must send in a signed written correspondence they wish to disenroll.
  - ❑ If outside of the MADP the beneficiary must not only send a signed written request but also include a reason as to why they are trying to disenroll.
- ❑ The effective date of a disenrollment request made using the Medicare Advantage Disenrollment Period will be the first of the following month.
  - ❑ Example: If an enrollee would submit a request to disenroll on February 8, the effective date would be March 1, 2017.

Enrollment Guidelines

- **Types of Disenrollment**
  - **Two types of disenrollment – Voluntary and Involuntary**
    - There are times when an enrollee will request to disenroll from a plan and there are instances when a plan is required to disenroll a member.
  - **Voluntary disenrollment by the member**
    - A member may request disenrollment from a Medicare Advantage plan during a valid election period. The member may disenroll by:
      - Enrolling in another plan (during a valid enrollment period).
      - Giving or faxing a written notice to the Medicare Advantage plan.
      - Submitting a request via the internet to the Medicare Advantage plan.
      - Calling 1-800-MEDICARE.
    - The disenrollment request must be signed and dated.
    - The Medicare Advantage plan must provide the member with a notice of disenrollment within ten calendar days after receipt.

Enrollment Guidelines

Types of Disenrollment *(continued)*

Involuntary Disenrollment

- An organization must disenroll a member under the following circumstances:
  - A change in residence that makes the individual ineligible to remain enrolled in the plan (e.g., moves outside of the plan's service area)
  - The member is away from the service area for more than 6 months
  - The member loses entitlement to Medicare Part A or Part B.
  - A Special Needs Plan enrollee that loses his or her special needs status.
  - Depending on the plan's policy, failure of the member to pay the plan premium.
  - Falsifying or withholding information from the plan (e.g., allows someone else to use their ID card)
  - The Medicare Advantage plan contract is terminated or the service area of the plan is reduced.
  - The member dies.
  - Incarceration
  - Failure to pay Part D IRMAA

Enrollee rights

- Medicare Advantage enrollees have the right to make a complaint if the plan ends his or her membership.
- When the plan ends a member's enrollment it must explain the disenrollment reason in writing and explain how the enrollee may file a complaint (e.g., failure to pay premium).

Disenrollments outside of MADP

Below are the questions the member's are asked on a letter sent to them regarding disenrolling

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I am joining a PACE program on (insert date) _____.
- ☐ I am joining employer or union coverage on (insert date) _____.

Enrollment Guidelines

- **Enrollment Application Requirements *(paper, phone or online) (continued)***
- **CMS will not accept an application unless the following fields are completed:**

Required Fields	
Enrollee name	Plan name (plan selection)
Enrollee date of birth	Plan premium option *
Enrollee sex	ESRD question response
Enrollee permanent residence address	Enrollee signature and signature date (or Rep)
Enrollee's Medicare number	Authorized representative contact information **

*If premium option is not completed, the enrollee is defaulted to direct bill. This is not a CMS requirement.

** Authorized representative information needs to be completed if he/she signed the application on behalf of the enrollee. Meaning we need the auth rep's name, address, phone and relationship to enrollee.

Applications

- An enrollment application must be used to enroll an individual with a Medicare Advantage plan for the first time (this includes electronic, paper or telephonic enrollment).

- **Note: Please make sure the paper applications are filled out completely and neatly.
  - Not being able to read applications can cause outreaches to the member which can lead to member dissatisfaction.

- If an existing plan member would like to change to a different plan during the annual election period the following rules must be followed:
  - If a member wants to move to a different plan offering of the same plan type (e.g., HMO plan to a different HMO plan), then a plan change form (or short enrollment form) can be completed and signed by the member.
  - If a member wants to move to a different plan offering and different plan type (e.g., PPO plan to an HMO plan); then a new enrollment application must be completed and signed by the member.

- **NOTE:** Please confirm a beneficiary's practitioners, ancillary providers and DME suppliers, including oxygen suppliers, network status and inform the beneficiary prior to submitting an application.

Applications

Premium Withholding Language Updated–

The CMS model application language implies that Social Security or the Railroad Retirement Board “will” deduct all premiums due from the members effective date.

- This is not always the case, and sometimes members are billed for premiums not deducted by Social Security or the RRB. This has been generating complaints from our membership, so the language has been updated.

- “Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. If Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check **should** include all premiums due from your enrollment effective date up to the point withholding begins**. If the first deduction does not include all premiums due from your enrollment effective date, we will send you a letter letting you know the amount you owe UPMC for Life for any premiums not deducted by Social Security or RRB.** If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)”

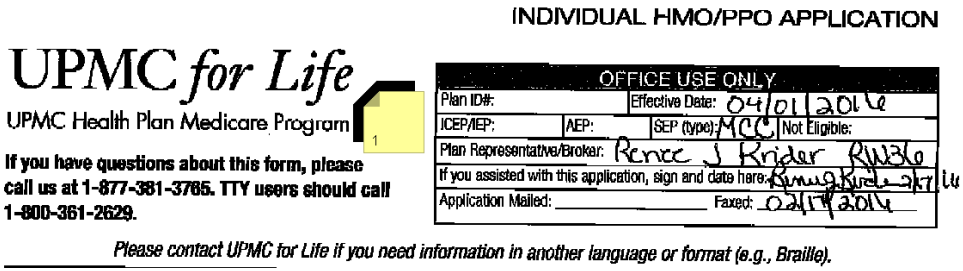
Applications

Enrollment Application Dating

- Completed applications must be forwarded to UPMC Health Plan **within 48 hours** of receipt.
  - Late applications may not be eligible for commission.
- An enrollment application enrollee's signature date must NEVER be altered by a agent/broker.
  - The application enrollee signature date **cannot** be back-dated or changed in any way.
- If an agent/broker leaves an application with a potential enrollee the application **cannot** be dated in the Office Use Only box.
  - Only date an application in the "Office Use Only" box when the enrollee has completed it and you are taking possession of the application.
  - The plan's receipt date is the date the broker receives the signed application from the beneficiary when meeting face to face, in the agency/ office etc.
- Broker Disciplinary Actions for untimely submission of applications is outlined in an internal UPMC policy.
  - Please contact your broker manager with any questions.

Receipt Dates

- **Receipt dates are critical to our compliance.**
  - Correct receipt dates ensure that we remain compliant so nothing could trigger an Audit
- **The office use only box is very important!**
- A sales agent or a broker can provide valuable information here including:
  - The receipt date of the application
  - The requested effective date
  - The election type the member wishes to use



INDIVIDUAL HMO/PPO APPLICATION

UPMC *for Life*
UPMC Health Plan Medicare Program

If you have questions about this form, please call us at 1-877-381-3765. TTY users should call 1-800-361-2629.

OFFICE USE ONLY			
Plan ID#:		Effective Date: 04/01/2016	
ICEP/IEP:	AEP:	SEP (type): MCC	Not Eligible:
Plan Representative/Broker: Renee J Krider RN380			
If you assisted with this application, sign and date here: Renee Krider 2/7/16			
Application Mailed: _____		Faxed: 02/7/2016	

Please contact UPMC for Life if you need information in another language or format (e.g., Braille).

****This box potentially saves an application from going incomplete

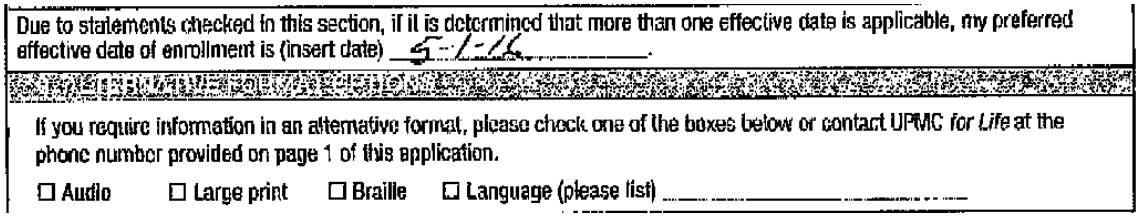
Applications

- Once an application is received by either the selling agent or UPMC *for Life*, UPMC has seven days per CMS guidelines in order to process the application.
- The application receipt date is difficult to identify sometimes when the application is marked face-to-face and the beneficiary's signature on the application is different then what is marked next to broker name/code in the office use only box.
- If the beneficiary submits the application to you in person, via mail or fax, you would put the current date beside your name in the office use only box. It is imperative that you add a note on the first page at the top of the application explaining how the application was received and what date it was received.

- These notes are examples of what you could use:
  - ***Beneficiary delivered application into office on mm/dd/yyyy.***
  - ***Beneficiary mailed application to me, received in mail on mm/dd/yyyy.***
  - ***Beneficiary faxed application to me, received via fax on mm/dd/yyyy.***

Effective Dates

- It is <u>imperative</u> that an effective date is listed on an application. This could potentially keep an application going to the incomplete status.
- Advising a member they can select an effective date that they can not select is against member satisfaction.
- Ex. Their parts do not start until 10.1.16 however they wish to enroll for 9.1.16. OR allowing them to select an effective date when the election they are using only gives them the option of the 1st of the month following the receipt of request.



Due to statements checked in this section, if it is determined that more than one effective date is applicable, my preferred effective date of enrollment is (insert date) 5-1-16.

If you require information in an alternative format, please check one of the boxes below or contact UPMC *for Life* at the phone number provided on page 1 of this application.

☐ Audio ☐ Large print ☐ Braille ☐ Language (please list) _____

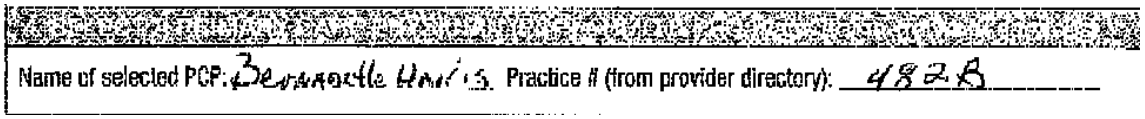
Applications

Enrollment via Telephone

- Telephonic enrollment requests may be accepted ONLY during an incoming (or in-bound) telephone call from a beneficiary.
- The Medicare Advantage plan must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his/her authorized representative.
- Individuals must be advised that they are completing an enrollment request.
- Each telephonic enrollment request must be recorded (audio) and include a statement of the enrollee's agreement to be recorded, and a verbal attestation of the intent to enroll.
- Collection of financial information (e.g. a credit card or bank account number) is prohibited at any time during the application enrollment call.

Primary Care Physicians (PCP)

- It is important to encourage each and every prospective member to select a Primary Care Provider. Please encourage your prospective members to consider this aspect of their enrollment important to UPMC's commitment to them and the quality of the care they receive.
- We need to have a PCP on file for the member (HMO/SNP plans) so if one is not initially selected Enrollment will then have to outreach and or auto assign for the member.
  - It is important to **ALWAYS** enter PCP information when it is provided on the application, in order to prevent downstream effects.



Why do they need a PCP?

- Selecting a Primary Care Physician is a **very** important step in taking proactive measures regarding their quality of life.
  - PCPs are trained to treat the whole person — not just a disease or an organ system.
- While PCPs are oriented toward maintaining good health and preventing diseases, they also can assist them with serious illnesses.
  - Because their PCP gets to know them and their personal preferences, their PCP can consider their medical history, personal history and life circumstances when providing care and recommending treatment.
- And since PCPs manage all aspects of their patients' medical care, they can refer patients to specialists when necessary and help coordinate the care patients receive from other providers.
  - Their PCP is their personal physician, health advocate and wellness advisor.

What if the member doesn't select a PCP now?

- We encourage you to select a PCP as soon as possible so we are able to support you and your provider from your very first day of coverage.
- We recognize this is an important decision for you and once you have made that decision, please call our Member Services department to have your records updated.
  - If you do not select a PCP, once your plan is effectuated, you may receive a call from our Member Services team who can help you to select a PCP.

PCP FAQ's

- Do I need to select a PCP now?
  - **It is important to have a PCP from the very first day of coverage with UPMC for Life. Your PCP** will be your main healthcare provider for your most common medical problems
    - But should also be looking out for your overall health, recommending screenings, making referrals, encouraging healthy habits and much more.

- Can I change my mind?
  - Yes, you have the right to select a PCP of your choice and if you are dissatisfied for any reason with the PCP initially chosen, you should choose another available PCP.
    - You can do so by contacting Member Services.

Applications

❑ Outbound Enrollment and Verification

- ❑ All plan sponsors are required to maintain a system to ensure beneficiaries are enrolled into the plan they requested and understand the rules applicable to that plan. This verification includes enrollment applications from agents and brokers.
  - ❑ The plan has the option to complete the enrollment verification process by telephone, email (if beneficiary opted-in for email) or direct mail.
  - ❑ The beneficiary must be contacted within fifteen (15) calendar days of receipt of the enrollment request.
  - ❑ Plans/Part D Sponsors are not expected to delay processing the enrollment request (including, but not limited to, activation of benefits and submission of enrollment request data to CMS) while completing the enrollment verification process.
  - ❑ The verification letter must inform beneficiaries that they are expected to notify the Medicare Advantage Organization (MAO) of an intent to cancel the processing of their enrollment within seven calendar days from the date of the letter or phone call or by the day before the enrollment effective date, whichever is later.

- ❑ Enrollment verifications must be after the sale has occurred; NOT at the point of sale.
  - ❑ Enrollment verifications cannot be conducted by agents or brokers.
  - ❑ The agent or broker cannot be present with the enrollee if we are calling or emailing the applicant.

Outbound Enrollment Incomplete Calls

If any of the required application information should be missing from the initial request, Medicare Enrollment must outreach to the member to obtain the missing information.

Leaving an application incomplete can delay the enrollment process as well as potentially denying an application due to not receiving the required information.