Memo to Long Term Care Facilities on Medicare Health Plan Enrollment
October 2021

ISSUE:

CMS continues to hear reports of the unacceptable practice of nursing facilities or skilled nursing facilities (collectively, long-term care or LTC facilities) disenrolling beneficiaries from Medicare health plans (Medicare Advantage plans with and without Part D, Medicare-Medicaid plans, or Programs of All-Inclusive Care for the Elderly (PACE)) without the beneficiary's or the beneficiary's representative's request, consent, knowledge, and/or complete understanding. **Only a Medicare beneficiary, the beneficiary's authorized or designated representative, or the party authorized to act on behalf of the beneficiary under state law can request enrollment in or voluntary disenrollment from a Medicare health or drug plan.**

This applies equally for beneficiaries receiving care in a nursing facility or skilled nursing facility. It also applies equally whether the enrollment or disenrollment action relates to a Medicare Advantage plan without Part D (MA-only), an MA plan with Part D (MA-PD), a Medicare-Medicaid plan (MMP) as part of a demonstration under the Financial Alignment Initiative,[1] or a PACE organization.[2]

BACKGROUND:

CMS has received complaints from beneficiaries and their representatives, typically after the beneficiary has already been discharged from the LTC facility, alleging they have been disenrolled from their Medicare health plan without their consent. The discharged beneficiary finds out their plan coverage was terminated when he or she tries to access services and/or starts receiving bills for services that he or she believed the Medicare health plan should cover, or has been covering. It is sometimes only at this point that the beneficiary learns that their enrollment has changed.

FACILITY'S RESPONSIBILITY:

Changes in a beneficiary's health care coverage generally must be initiated by the beneficiary or their representative. If a beneficiary or their legal representative requests assistance from the LTC facility in changing the beneficiary's health care coverage, the LTC facility should take the following steps to help ensure changes to a beneficiary's health care coverage comply with regulations regarding enrollment/disenrollment and resident rights:[3]

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[1] Nine states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas) currently participate in demonstrations in which MMPs enter into three-way contracts with CMS and the state to provide all services covered by Medicare Parts A, B, and D and Medicaid services, including skilled nursing facility and nursing facility care. MMPs are required to coordinate delivery of Medicare and Medicaid services in order to improve the quality of care and the beneficiary's experience.

[2] The PACE program is a unique model of managed care service delivery for the frail elderly, most of whom are dually-eligible for Medicare and Medicaid benefits, and all of whom are assessed as being eligible for nursing home placement according to the Medicaid standards established by their respective states

[3] 42 CFR 483.10(g)(18)(i) and (g)(18)(ii); 42 C.F.R. Part 460, Subpart I.

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1) Explain **orally** and **in writing** the impact to the beneficiary if they change coverage (e.g., to a stand-alone prescription drug plan (PDP) and Original Medicare, or to a different Medicare health plan). At a minimum, information should include:

- A clear explanation, where applicable, that the beneficiary would no longer be a member of the Medicare health plan (i.e., MA-only, MA-PD, MMP, or PACE[4]).
- An explanation that medical services will be billed to Original Medicare and/or Medicaid if the beneficiary is disenrolled from a Medicare health plan, and what this means regarding deductibles and co-pays/coinsurances and/or loss or lack of supplemental coverage for the beneficiary.
- The name of the PDP that will cover the beneficiary's medications, including the deductible and co-pays/coinsurances, especially related to their current drug therapy.
- Specific information regarding the beneficiary's opportunities to change Medicare plans and Medicare prescription drug coverage while in the facility (i.e., every month) and when discharged (i.e., for two months following the month of discharge)[5] or by virtue of being eligible for Medicare and Medicaid (i.e., once in each of the first three quarters of the year).[6]
- An explanation that enrollment in the new Medicare health or drug plan will be effective the first day of the month following the plan's receipt of the enrollment request.
- An explanation that, in particular cases, the beneficiary may not be able to re-enroll into the MA-only plan, MA-PD plan, MMP, or PACE program the beneficiary previously had (e.g., employer-sponsored MA plans have discretion whether or not to accept a beneficiary back into the plan).

2) Develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage. At a minimum, information should include:

- The circumstances under which the facility can assist a beneficiary with a plan change.

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[4] LTC facilities should also be aware of the additional requirements applicable under PACE. For example, PACE participants are specifically afforded the right to receive accurate, easily understood information and to receive assistance in making informed health care decisions (42 C.F.R. § 460.112(b)). PACE organizations have a responsibility to protect and provide for the exercise of participant rights under 42 C.F.R. § 460.110(c). Further, PACE organizations must have established documented procedures to respond to and rectify a violation of a participant's rights (42 C.F.R. § 460.118).
[5] 42 CFR 422.62(a)(4); 42 CFR 423.38(c)(15) and (c)(25)(i); see also Medicare Managed Care Manual, Chapter 2; section 30.3 - Open Enrollment Period for Institutionalized Individuals (OEPI).
[6] 42 CFR 423.38(c)(4); see also Medicare Managed Care Manual, Chapter 2; section 30.4.4.5 – Special Enrollment Period (SEP) for Dual-eligible Individuals and Other LIS-Eligible Individuals.

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- The need to obtain a document signed by the beneficiary or representative that acknowledges that the specific information regarding the impact of a change in coverage was provided to them orally and in writing, and that that the beneficiary and/or the representative understand the information.
- The need to obtain an attestation signed by the facility staff member that assisted with the change in enrollment, attesting that the beneficiary or representative requested the change and that the beneficiary or representative (as applicable) received and understood the minimum required information listed above. In cases where beneficiaries request disenrollment from PACE, LTC facilities that are contracted with PACE organizations[7] should work directly with the PACE organization and the participant's interdisciplinary team to ensure the PACE participant receives the information required under the PACE regulations and to coordinate the transition of care, including as specified in their contract requirements.

CONSEQUENCES OF BENEFICIARY DISENROLLMENT BY A LTC FACILITY:

If a LTC facility cannot provide documentation of a beneficiary's request to change enrollment, this may suggest that the enrollment action was not initiated by the beneficiary or their legal representative and therefore was not legally valid. Where an enrollment action is not legally valid, CMS may cancel the enrollment action and, if necessary and appropriate, reinstate the beneficiary's coverage in the plan in which he or she was originally enrolled (42 CFR §§ 422.66(b)(5)(i) and 423.36(c)(1); Medicare Managed Care Manual, Chapter 2, section 40.6).[8] CMS will be reporting these incidents to the Medicare Drug Integrity Contractor (MEDIC) that investigates fraud and abuse incidents.

REMINDER FOR FACILITIES CONTRACTED WITH I-SNPS:

LTC facilities contracted with an Institutional Special Needs Plan (I-SNP), or that are the owner or sponsor of an I-SNP, should familiarize themselves with applicable Medicare managed care marketing rules, including restrictions on marketing activities at 42 CFR 422.2264(c)(1)(iv) and 42 CFR 422.2266(f), so that facility staff, especially if acting as both providers and I-SNP representatives, remain in compliance with those rules when acting on behalf of the I-SNP.

ENROLLMENT PERIODS:

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[7] LTC facilities should also be mindful of the contracting requirements associated with providing services for PACE participants; see for example 42 C.F.R. § 460.70.

[8] Because LTC facilities providing services to PACE participants are doing so under contract with the PACE organization, those facilities are subject to all relevant contractual and regulatory obligations relating to disenrollment, including 42 C.F.R. § 460.162(c), which states that a PACE organization must ensure that its employees or contractors do not engage in any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of participants due to a change in health status.

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An institutionalized beneficiary has a continuous open enrollment period (OEPI) for purposes of changing enrollment in MA-only/MA-PD plans; this period does not end until two months after the month the beneficiary moves out of the institution (42 CFR §§ 422.62(a)(4), 423.38(c)(25)).

Other special enrollment periods apply for beneficiaries dually eligible for Medicare and Medicaid, for individuals disenrolling from PACE, and other purposes. Chapter 2 of the Medicare Managed Care Manual has a full description of the relevant MA special enrollment periods.[9] See Chapter 4 of the PACE Manual[10] and 42 C.F.R. Part 460, Subpart I for information on the requirements applicable to PACE enrollment and disenrollment.

DOCUMENTATION OF BENEFICIARY ABILITY TO UNDERSTAND ENROLLMENT CHANGES:
If the facility has the beneficiary sign documentation regarding their understanding of an enrollment change, CMS will expect to find that the beneficiary's assessed cognitive function also supports an ability to understand this type of information. If CMS becomes aware of enrollment actions that the beneficiary alleges were taken without their request, consent, knowledge, and/or complete understanding, CMS will expect the facility to provide the above noted documentation to support that it appropriately assisted the beneficiary with their choice to change coverage, including that the beneficiary's cognitive function supports such decision-making.

COMPLIANCE WITH REGULATIONS ON RESIDENTS' RIGHTS:
State Survey Agencies will continue to monitor LTC facilities for compliance with regulations at 42 CFR Part 483, subpart B using the accompanying surveyor guidance in Appendix PP of the State Operations Manual (SOM). If, during a standard survey or complaint investigation, a surveyor determines that a facility has changed a resident's Medicare health plan enrollment or disenrolled a resident from their Medicare health plan, the surveyor should consider the facility's compliance with the following federal regulations, as applicable:

- 42 CFR 483.10(b)(3) and (7): (3) *In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law… (7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.*
    - Facility staff should obtain documentation that the resident's representative has been delegated the necessary authority to exercise the resident's rights and should verify that a

[9] https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf
[10] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c04.pdf

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court-appointed representative has the necessary authority for the decision-making at issue as determined by the court. Additionally, the facility should make reasonable efforts to ensure that it has access to documentation of any change related to the delegation of rights, including a resident's revocation of delegated rights, to ensure that the resident's preferences are being upheld. The surveyor may consider F551 in Appendix PP of the SOM if someone other than the appointed or designated representative is making decisions for the resident. (SOM, App. PP, Tag F551)

- 42 CFR 483.10(c)(1), 42 CFR 483.10(g)(18)(i) and (ii): (c)(1)*The resident has the right to be informed of, and participate in, his or her treatment, including…his or her total health status…(g)(18)(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible...(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.*
    - A change in health insurance coverage may affect a resident's medical care and treatment. Discussion at F552 in Appendix PP of the SOM provides guidance on the resident's right to be informed of health status, care and treatment. It notes that health information and services must be provided in ways that are easy for the resident and/or the resident's representative to understand. The physician or other practitioner or professional must inform the resident or their representative in advance of treatment risks and benefits, options, and alternatives. The information should be communicated at times it would be most useful to them, such as when they are expressing concerns, raising questions, or when a change in treatment is being proposed.

- 42 CFR 483.15(a)(2)(i): *The facility must not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid.*
    - Surveyor guidance at F620 in Appendix PP of the SOM clarifies that facilities must not request residents for a direct or indirect waiver of rights to Medicare or Medicaid benefits. Facilities must not seek or receive any kind of assurances that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

See also the letter from the Center for Medicaid and State Operations/Survey and Certification Group (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter06-16.pdf) for information regarding surveyors' responsibilities related to LTC facilities and Medicare Part D.

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RESOURCES - applicable regulations/requirements and manual directives:

- **Medicare Managed Care Manual**, Chapter 2; section 30.3 - Open Enrollment Period for Institutionalized Individuals (OEPI); section 30.4.4.5 - Special Enrollment Period for Dual Eligible Individuals (Medicare-Medicaid Enrollees); section 30.4.4.4 - Special Enrollment Period for Individuals in the Program of All-inclusive Care for the Elderly (PACE).
- **Medicare Managed Care Manual**, Chapter 2; section 40.2.1 - Who May Complete an Enrollment or Disenrollment Request
- **42 CFR 422.60(c)**: (c) *Election forms and other election mechanisms.* (1) The election must comply with CMS instructions regarding content and format and be approved by CMS as described in §422.2262. The election must be completed by the MA eligible individual (or the individual who will soon become eligible to elect an MA plan) and include authorization for disclosure and exchange of necessary information between the U.S. Department of Health and Human Services and its designees and the MA organization. Persons who assist beneficiaries in completing forms must sign the form, or through other approved mechanisms, indicate their relationship to the beneficiary.
- **42 CFR 423.32(b)(1):** The enrollment must be completed by the individual and include an acknowledgement by the beneficiary for disclosure and exchange of necessary information between the U.S. Department of Health and Human Services (or its designees) and the PDP Sponsor. Individuals who assist beneficiaries in completing the enrollment, including authorized representatives, must indicate they have provided assistance and their relationship to the beneficiary.
- **42 CFR 460 Subpart I: Participant Enrollment and Disenrollment.** This section of the PACE regulations includes the various enrollment, disenrollment and care coordination requirements for PACE organizations.
- **SOM, Appendix PP – Guidance to Surveyors for Long Term Care Facilities:** This appendix includes the federal requirements an institution must meet to qualify for participation in the Medicare and Medicaid Programs as an LTC facility and provides guidance to aid surveyors in interpretation of these requirements, https://www.cms.gov/regulations-and-guidance/legislation/cfcsandcops/downloads/som107ap_pp_guidelines_ltcfpdf.
- **State-specific information on the Financial Alignment Initiative**, including information for providers, is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.

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