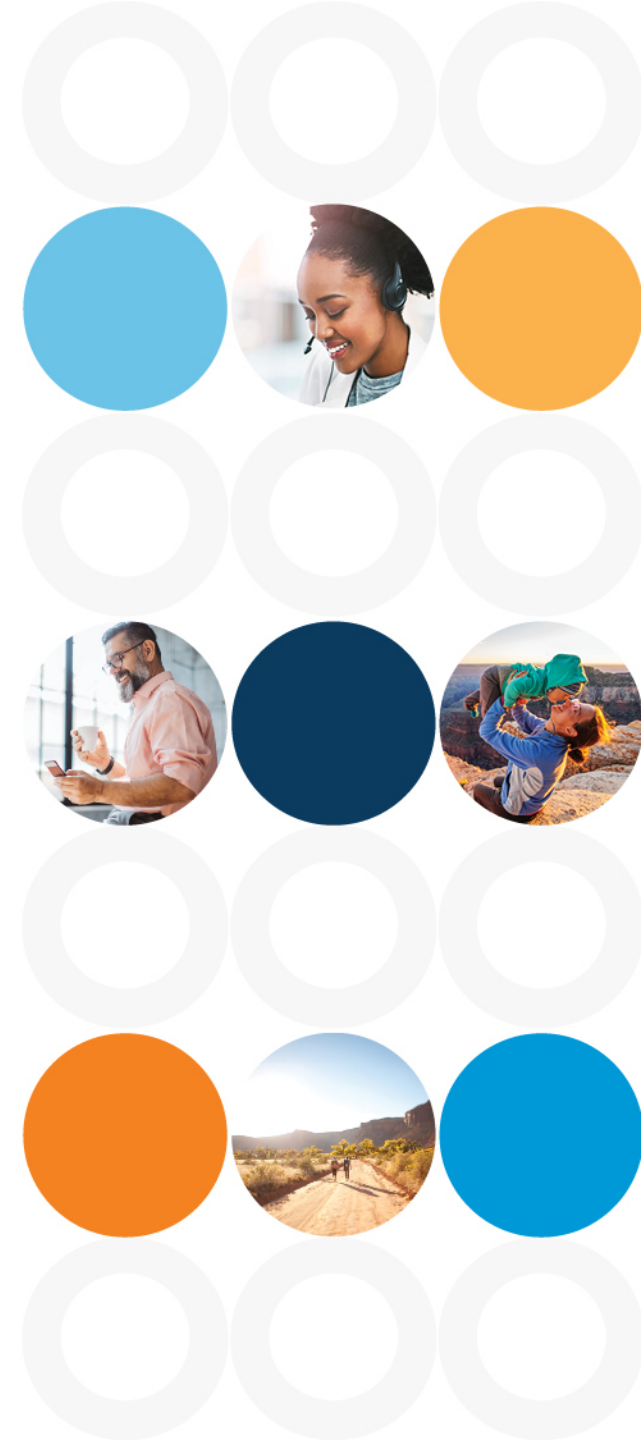




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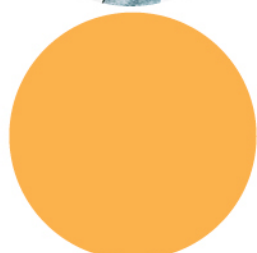
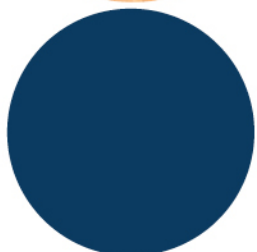
AZ Blue Medicare Advantage Enrollment & Disenrollment Process Broker Training

CY2025



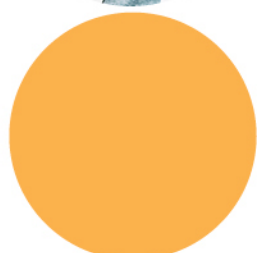
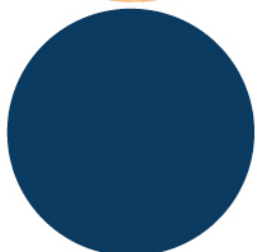
Introduction

- This course provides information about the CMS designated enrollment and disenrollment requirements and processes for Medicare Advantage Prescription Drug Plans (MAPDs). Due to limited enrollment timeframes, it is critical to understand the opportunities available to beneficiaries to enroll, disenroll or make plan changes.
- Information in this course is based on Chapter 2 – Medicare Advantage Enrollment and Disenrollment of the Medicare Managed Care Manual and CY 2025 Agent and Broker Training & Testing Guidelines issued by CMS.
 - Refer to this chapter for additional information. To print a copy of Chapter 2, go to the following link: <https://www.cms.gov/files/document/cy-2024-ma-enrollment-and-disenrollment-guidance.pdf>
 - To print a copy of the CY 2025 Agent and Broker Training & Testing guidelines, go to the following link: <https://www.cms.gov/files/document/cy2025-agent-broker-training-testing-guidelines.pdf>



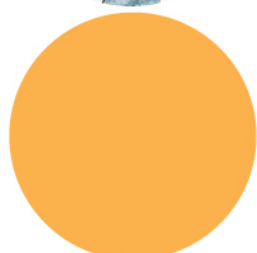
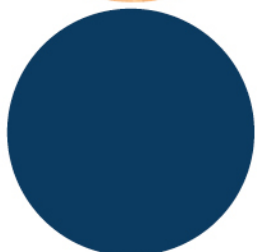
Certification

- The Centers for Medicare & Medicaid Services (CMS) require plan sponsors to provide training and testing on Medicare rules, regulations, and compliance-related information on the products they intend to sell. Specifications for training/testing criteria are provided annually by CMS.
- As a producer or employee of Blue Cross® Blue Shield® of Arizona (AZ Blue) with responsibility for some aspect of marketing, sales, and/or service, you are required to complete certification.
- In addition, all selling producers must be qualified. This means producers must be licensed, appointed (according to state laws) and certified on the products they intend to sell. Please contact the AZ Blue Medicare Broker Support Team, BCBSBRKSUPPORT@azblue.com, if you have any questions regarding these requirements.



Learning Objectives

- Demonstrate knowledge of the following:
 - How to determine product suitability
 - Sequential enrollment process
 - Federal guidance
 - What to communicate to beneficiaries regarding the enrollment process, disenrollment requests, and enrollment and disenrollment periods
- Demonstrate understanding the importance of accurately completing and submitting enrollment requests
- Demonstrate the ability to provide beneficiaries with the next steps to occur after submitting an enrollment request
- Demonstrate understanding the limited instances in which disenrollment requests should be made



Meet Isabelle

She is currently covered by her former employer's group retiree medical plan, but she is considering other options. Recently, she met with her health insurance producer for more information. Follow Isabelle's story on the next few screens.



Product Suitability

For beneficiaries (like Isabelle) with non-Medicare coverage, producers must consider:

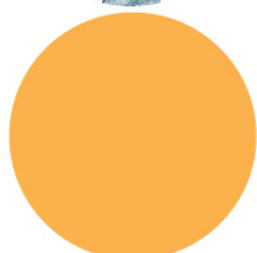
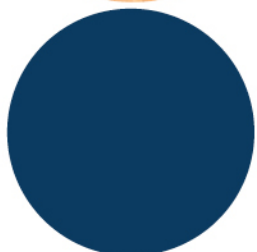
- The suitability of a plan change
- Current carrier disenrollment requirements (this can vary depending upon if Medigap, Commercial, Medicare, etc.)
- The impact a new Medicare health plan election may have on the beneficiary's other coverage
- Whether coordination of other health care and/or prescription drug benefits needs to be considered



Considerations Related to Other Coverage

Medicare beneficiaries may be enrolled in only one Medicare Advantage (MA) plan at any given time. Individuals enrolled in a Medicare Advantage plan may not concurrently enroll in a stand-alone PDP except for individuals enrolled in a Medicare MSA plan or individuals enrolled in a PFFS plan that does not offer Medicare prescription drug coverage.

Generally, enrollment in a new Medicare health plan will result in disenrollment from other Medicare health plans. Beneficiaries currently enrolled in a non-Medicare prescription drug or health plan (i.e., Employer Group Plan) must contact their current carrier to determine the impact of enrollment in new coverage while enrolled in their current coverage (e.g., inability to re-enroll, duplication of benefits, etc.), as well as to get information on the required steps to take to disenroll from all or part of the current coverage.





Medicare Advantage Enrollment & Disenrollment Periods

For a Plan Sponsor to accept an enrollment request, it must be made during a valid election period. There are types of election periods in which an individual may make enrollment and disenrollment requests:

- Annual Enrollment Period (AEP)
- Initial Coverage Election Period (ICEP)
- Initial Enrollment Period for Part D (IEP for Part D)
- Medicare Advantage Open Enrollment Period (MA OEP)
- The Open Enrollment Period for Institutionalized Individuals (OEPI)
- Special Election Periods (SEP) – There are various types of SEPs which include but are not limited to:
 - Moving in or out of the service area
 - Plan termination
 - Dual eligibility (Medicare & Medicaid)
 - Change to a 5-Star plan
 - Beneficiaries with a special needs status, etc.
 - Beneficiaries affected by a weather-related emergency or major disaster

Did you know?

A member may be new to Medicare Part B but is NOT new to Medicare. In many cases, a member has been eligible for Medicare for years, but may just be new to Medicare Part B. A sales agent should understand this important distinction to avoid enrollment errors.

The effective date of coverage may vary depending on which election period is used for enrollment.

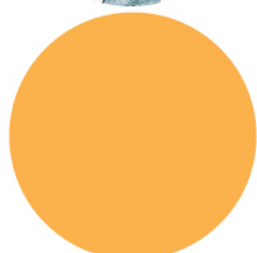
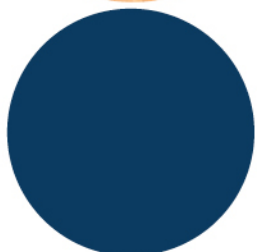


Blue Cross Blue Shield of Arizona Medicare Advantage Plans 2025 (HMO)

AZ Blue is a Medicare Advantage Organization (MAO) with a Medicare contract. AZ Blue Advantage is a wholly owned subsidiary of AZ Blue and offers Best Life Classic and Plus HMO Medicare Advantage plans. AZ Blue Advantage's products will remain marketed as AZ Blue products for 2025.

Health Maintenance Organization (HMO):

HMO members must select a Primary Care Provider (PCP) to coordinate all their healthcare needs within the plan network of providers. The PCP is responsible for referring the member to specialty care services. MA organizations must pay for emergency and urgently needed care in or out of the service area. Renal dialysis and post-stabilization care following an emergency are covered when the member is temporarily away.



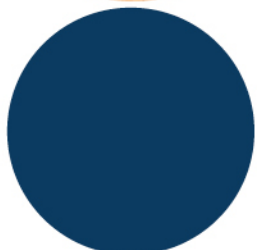
AZ Blue Medicare Advantage 2025 Eligibility Requirements

Available to all eligible Medicare beneficiaries who:

- Are enrolled in Medicare Part A, enrolled in Part B, and
- Permanently reside in the AZ Blue service area

HMO Plans

- Blue Best Life Classic (Maricopa, Pinal and Pima counties)
- Blue Best Life Plus (Maricopa and Pinal counties)



Isabelle's Decision

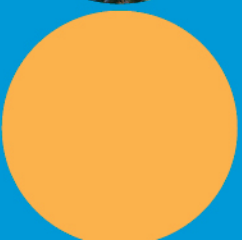
Isabelle does meet all the plan's eligibility requirements. However, while talking with her current plan's administrator, she discovers that if she elects any other plan, she will not be able to return to her employer's retiree plan at a later date. So, she decides not to enroll in an AZ Blue Medicare Advantage plan.





The 6-Step Enrollment Process

But what if Isabelle did decide to enroll in an AZ Blue Medicare Advantage plan? What would the enrollment process look like? Isabelle and her producer would first determine all criteria are met before beginning the 6-step enrollment process. On the next few screens, you will learn about the different steps and the federal guidance behind the process. The steps in the enrollment process include:



1. **Completion of enrollment request**
2. **Receipt of enrollment request by the plan**
3. **Determination of enrollment eligibility**
4. **Submission to CMS**
5. **CMS approval**
6. **Confirmation of enrollment notice**

Step 1: Completion of Enrollment Request

AZ Blue has both an Individual and Short Enrollment Form available for use. For proper use of these forms, the producer must follow the guidelines below:

- **Individual Enrollment Form:** This enrollment form is to be used for any MAPD applicants who are **not** currently enrolled in an AZ Blue Medicare Advantage HMO plan.
- **Short Enrollment Form:** This is a plan change form, and it may be used in place of the Individual Enrollment Form.
 - It is used when a member of an MAPD HMO plan is enrolling into another MAPD HMO plan offered by AZ Blue (i.e., Classic to Plus).

Both enrollment forms are available in paper, telephonic and online at **[AzBlue.com/Medicare/Medicare-advantage](https://www.AzBlue.com/Medicare/Medicare-advantage)**.



Determine the Method of Enrollment

- The preferred method of enrollment is online. Online enrollment can occur in the following ways:
 - <https://azblue2.destinationrx.com/PC/Agent/Account/Login>
- Beneficiary completes online enrollment on their own, with or without a producer present.
- Producer submits paper application via AZBlue.com/Medicare/Medicare-advantage without the beneficiary present.
 - Paper enrollment forms and confirmation sheets must be kept by the health plan for the current year plus 10 years (11 tears total) and must be provided to CMS upon request.
 - Enrollment is responsible for scanning completed and processed forms.
 - <https://azblue2.destinationrx.com/PC/Agent/Account/Login>

Benefits of Online Enrollment:

- Reduces errors and delays due to missing or incomplete information
- Allows immediate receipt of enrollment requests without delays
- Provides immediate confirmation of submission
- Allows producer and plan to meet CMS timelines for submitting enrollment transactions and Outbound Enrollment & Verification (OEV) calls



Paper Enrollment



Paper enrollment forms may be submitted online

- Upon receipt of a paper enrollment, producers should immediately enter and submit the information online. Paper enrollment forms and confirmation sheets must be kept for the current year plus 10 years (11 years total) and must be provided to the health plan or CMS upon request.

Alternatives to Online Submission:

- Mail paper applications via overnight mail.
- Fax paper applications to **602-544-5623**.

Premium payments should NOT be included with the enrollment form

- Premiums will be collected via the billing method the member selected, after CMS approval and the plan becomes effective. Inform the beneficiary that Electronic Funds Transfer (EFT) and Social Security/Railroad forms will be sent to the member in the interim.



Telephonic Enrollment



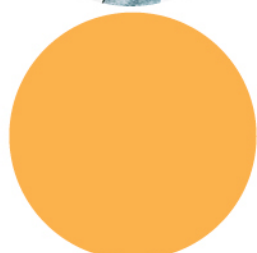
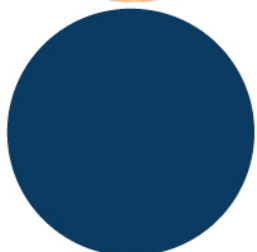
- **Plan Sponsors may accept telephonic enrollment requests via an incoming telephone call from a beneficiary to complete enrollment.**
 - Telephonic enrollment request must be effectuated entirely by the beneficiary or his/her authorized representative.
 - No other producers, brokers, or agents can be physically present or present on the phone at the time of this call.
 - Producers, brokers, and agents may be on the call with the pre-enrollment call center and the member to provide identifying information, but then must disconnect from the call prior to the enrollment of the member.
- **Telephonic enrollments must be recorded using a CMS-compliant script to ensure that beneficiaries:**
 - Understand they are being recorded
 - State the appropriate Third Part Marketing Organization (TPMO) disclaimer:
 - TPMOs that do **not** sell for all MA and/or Part D plans within a service area - *“We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options.”*
 - TPMOs that sell **all** MA and/or Part D plans within a service area - *“Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices.”*
 - Are attesting to the accuracy of required elements
 - Understand they are completing an enrollment
 - Are attesting to their intent to enroll



Common Errors on Enrollment Forms

Common errors that delay processing and may impact effective dates include:

- Not using the beneficiary's legal name as identified by Social Security Administration
- Missing or incorrect date of birth
- Missing, incorrect, or incomplete Medicare Beneficiary Identifier (MBI)
 - Must include all letters and numbers
- No plan option selected
- Not listing complete physical or mailing address
- Missing beneficiary signature (or signature of authorized legal representative)
- Election period not identified
- For HMO plans specifically, not selecting a primary care provider (PCP) on the enrollment form (which can lead to enrollment processing delays)





See What You Know

If you were to meet with Isabelle, what would you ensure (as a producer) before requesting Isabelle to sign the enrollment form or before you submit the form? Think about your answers and see if they match with the correct ones on the next screen.

- A. You must answer all the beneficiary's questions about statements and notices on the enrollment form and about the plan.
- B. Get Isabelle's permission to sign on her behalf if she is not available.
- C. Take Isabelle's word that you are her "authorized representative" and complete part of the enrollment request.
- D. None of the above.



Answers

A. You must answer all the beneficiary's questions about statements and notices on the enrollment form and about the plan.

Correct! Isabelle, as the beneficiary, is responsible for reviewing statements and notices on the enrollment form. However, as the producer, you must answer all her questions about these statements, including the non-discrimination, (and the plan) before requesting a signature or submitting an enrollment form.

B. Get Isabelle's permission to sign on her behalf if she is not available.

Not quite. Isabelle or her "authorized representative" must sign the form. An "authorized representative" is someone with a legal designation to act on behalf of the beneficiary such as power of attorney or legal guardianship. Producers are not considered "authorized representatives" and may not complete this part of an enrollment form. Isabelle's (or a beneficiary's) electronic or written signature on an enrollment form is verifying her intent to enroll, the personal information provided is accurate and truthful, a plan option is elected, a billing option is selected, and there is an understanding and acceptance of all statements and notices on the enrollment form.



Answers Continued.....

C. Take Isabelle's word that you are her "authorized representative" and complete part of the enrollment form.

Not quite. No matter what Isabelle tells you, you are not her "authorized representative." An "authorized representative" is someone with a legal designation to act on behalf of the beneficiary such as power of attorney or legal guardianship. Producers are not considered "authorized representatives" and may not complete this part of an enrollment form.

D. None of the Above.

Incorrect. Isabelle, as the beneficiary, is responsible for reviewing statements and notices on the enrollment form. However, as the producer, you must answer all her questions about these statements (and the plan) before requesting a signature or submitting an enrollment form.



Beneficiary Signature

A beneficiary's electronic or written signature on an enrollment request is verifying:

- Their intent to enroll
- The personal information provided is accurate and truthful
- The plan option that was selected
- The requested effective date
- The billing option that was selected
- Understanding and acceptance of all statements and notices on the enrollment request

Producers must not sign and date an enrollment request until it is complete, the enrollee signs, and the producer is ready to submit the application.

Doing so could adversely affect the enrollment process

- May enter producer name and broker of record number prior to enrollee signature



Step 2: Acknowledgement of Receipt of Enrollment Request

CMS gives Plan Sponsors very short time frames for processing enrollment applications and considers receipt of an application by a producer to be the plan receipt date, therefore:

- Applications should be submitted immediately following receipt.
- Applications submitted to AZ Blue within two calendar days of receipt are considered timely.
- Applications submitted to AZ Blue three or more calendar days after receipt date are considered untimely and will result in corrective action.

Keep Confirmation of Enrollment Submission

- Online: Print the confirmation of the enrollment submission; email confirmation may also be requested.
- Fax: Keep the fax transmission receipt
- Overnight mail: Keep all receipts and tracking information.
- Telephonic: pre-enrollment call center provides confirmation number to beneficiary.



Enrollment Form “Application Date”

- CMS defines the enrollment form “application date” as the date that the enrollment form is received by the plan. Receipt by the producer is considered receipt by the Plan Sponsor.
- Receipt of the application by the plan is considered to be:
 - The date the producer signs and dates the enrollment form;
 - The **earlier** of the date stamp and/or signature date of the producer or the agency;
 - or if there is no producer signature on the enrollment form, the Plan Sponsor’s mailroom receipt date.
- Online and telephonic submissions are electronically date-stamped to identify the application date.
- Paper enrollment forms mailed by a beneficiary directly to the processing centers are date stamped the day they are received.



Within 7 calendar days of the application receipt date the beneficiary will be mailed:

- Enrollment form and verification of submission (this may be used as proof of coverage until member materials arrive)

OR

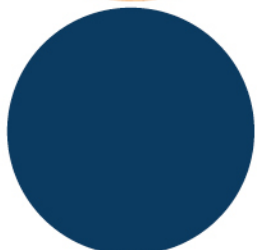
- A letter requesting missing or additional information

OR

- A written notice of denial based on determination by the plan sponsor that the beneficiary is ineligible

Within 15 calendar days of the application receipt date the beneficiary will be mailed:

- An Outbound Enrollment Verification (OEV) call will be made, or a letter sent to the beneficiary to verify he or she understands the plan rules.



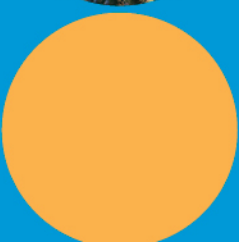


Producer Do's and Don'ts

As a producer, what are the application Do's and Don'ts that you should keep in mind?

Producer Do's:

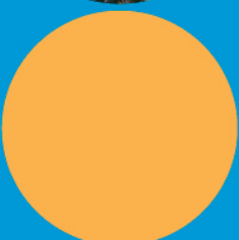
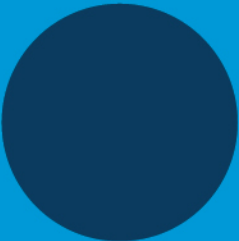
- Keep original applications, Scope of Appointment (SOA) forms, and a copy of all confirmation sheets (fax, online, overnight) for the current year plus 10 years (11 years total) for verification.
- Make sure to understand marketing rules, including what an SOA is, when a SOA form is required, and how to properly complete the form.
 - Remember an SOA must be obtained 48 hours prior to the scheduled appointment with the beneficiary. CMS does provide two exceptions to the 48-hour rule: (1) if beneficiary is approaching the end of a valid enrollment period (last 4 days of the election period), or (2) walk-ins – beneficiaries who walk into the plan's office, Producer's office, or kiosk.
- **Within 60 seconds of a Sales appointment call, state the appropriate Third Party Marketing Organization (TPMO) disclaimer:**
 - TPMOs that do **not** sell for all MA and/or Part D plans within a service area -
 - o *"We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options."*
 - TPMOs that sell **all** MA and/or Part D plans within a service area -
 - o *"Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices."*





Producer Do's continued.....

- Put your Broker of Record number on all enrollment forms mailed or left with enrollee to ensure receipt of commissions.
- Submit applications immediately upon receipt in order to remain compliant and avoid corrective action. Include beneficiary's best telephone number on the application so Plan Sponsor can contact beneficiary for the OEV call or if there is missing or incomplete information.
- Submit applications online via **AzBlue.com/Medicare/Medicare-advantage.**
 - <https://azblue2.destinationrx.com/PC/AGENT/Account/Login>
- As a producer for AZ Blue, you must comply with the AZ Blue non-discrimination policy:
 - AZ Blue complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- Provide a description of the outbound enrollment & verification (OEV) process and inform enrollees they will receive an OEV call or a letter from the Plan Sponsor within 15 calendar days of application.
- Plan Sponsors are required to conduct OEV calls for enrollments effectuated by producers to ensure the individual understands plan rules.
 - Note: The OEV call process will NOT delay processing of the enrollment application.
- Ensure that all individual marketing/sales calls are recorded and stored for the current year plus 10 years (11 years total).





Producer Do's continued.....

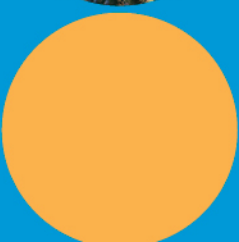
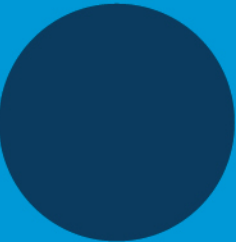
- Review specific information with the beneficiary:
 - What kind of health plan does the beneficiary wish to enroll in (such as low premium and higher copay, or vice versa)?
 - Are the beneficiary's current providers (primary care physician and specialist(s)) in-network?.
 - Is the beneficiary's current pharmacy in-network? If not, explain that they will need to choose a new pharmacy.
 - Are the beneficiary's prescriptions on the formulary? If not, explain that they may have to pay the full price of the prescription.
 - Does the beneficiary require hearing, dental, and/or vision coverage?
 - Does the beneficiary have any other healthcare needs, such as durable medical equipment or physical therapy?
 - Is the beneficiary's preferred hospital in-network? If not, explain that they will need to pick a new one.
 - Are there other preferred facilities that need to be in-network?
 - Does the beneficiary have any other specific healthcare needs?





Producer Don'ts

- Do not sign and date the enrollment form **BEFORE** the enrollee.
- Do not mail paper enrollment forms via the United States Postal Service (USPS) regular mail.
 - Paper enrollment forms can only be entered and submitted online with the beneficiary's permission, faxed, or sent via overnight mail.
- Do not hold an enrollment form for a future effective date.
 - Form must be submitted immediately upon receipt from the enrollee.
- Do not hold and batch enrollment requests.
 - Form must be submitted immediately upon receipt from the enrollee.
- Do not solicit enrollment applications prior to the start of the Annual Enrollment Period.
- Do not provide meals at Marketing and Sales Events.
- Do not require beneficiary information as a prerequisite for events.
- Do not make unsolicited calls, including contacting beneficiaries under the guise of selling a non-Medicare Advantage (MA) or non-Prescription Drug Plan (PDP) product.
 - Producers must secure a documented scope of appointment (SOA).



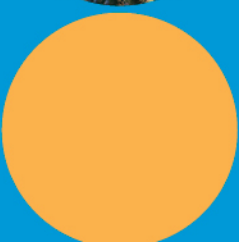


Producer Don'ts continued.....

- Do not conduct marketing/sales activities in healthcare settings except in common areas. Restricted areas include, but are not limited to exam rooms, hospital patient rooms, dialysis and pharmacy counter areas.
- Producers and TPMOs are not to distribute personal beneficiary data they have collected to another TPMO without prior express written consent from beneficiary. Prior express written consent from the beneficiary to share the data and be contacted for marketing or enrollment purposes must be obtained through a clear and conspicuous disclosure that lists each entity receiving the data and allows the beneficiary to consent or reject to the sharing of their data with each individual TPMO.

****IMPORTANT****

Potential consequences of engaging in inappropriate or prohibited marketing and communications activities will result in disciplinary action(s) and/or termination(s).



Step 3: Determination of Enrollment Eligibility

The Plan Sponsor reviews the enrollment requests to verify that the beneficiary meets all CMS eligibility requirements.

Plan Sponsor's Denial of Beneficiary's Election

The Plan Sponsor may deny elections based on:

- Missing or clarifying information not being provided within the required timeframe
- Determination of ineligibility, including that the beneficiary:
 - Does not reside in the service area
 - Does not have a valid election period
- Under these circumstances, the Plan Sponsor is required to request the information and hold the application. Application can only be denied if the beneficiary does not respond or responds with a confirmation that they are ineligible.
- Denial of an enrollment means the enrollment request was not submitted to CMS because the Plan Sponsor identified that the election was not valid.



What Cannot Be Sent to CMS

Enrollment forms with missing or incomplete information cannot be sent to CMS for approval.

- The beneficiary will be contacted via telephone or in writing within 10 calendar days of the application receipt date to request missing information or clarifying documentation.
- If the missing information is received within the allowable timeframe-and the election is deemed “complete,” the plan will forward the election to CMS.
- If the missing information is not received within the allowable timeframe, the enrollment request will be denied.
- For Annual Enrollment Period (AEP) enrollment requests, additional documentation must be received by December 7, or within 21 calendar days of the request for additional information (whichever is later).
- For all other enrollment periods, additional documentation must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).



Step 4: Submission to CMS

- Submission to CMS is an electronic transaction once Enrollment determines the individual is eligible.
- The Plan Sponsor must submit enrollment data to CMS within **seven calendar days** from receipt of the completed application for submission.
- Once the Plan determines eligibility, the election is submitted to CMS. CMS then confirms the transaction.

Step 5: CMS Confirmation

- CMS then processes the transaction and responds to the Plan Sponsor with the confirmation of enrollment.



Step 6: Confirmation of Enrollment Notice

- The Plan Sponsor must mail the beneficiary notification of CMS' response within 7 calendar days.
- A member ID card will arrive, and the member should use this card for prescription purchases and/or medical services beginning on the effective date.
- Additional member information will arrive separately and includes important plan information such as the Evidence of Coverage (EOC).
- All plan materials (including the EOC) are posted online at **AzBlue.com/Medicare/Medicare-advantage** under Resources, Plan Documents & Forms.



Disenrollment from Medicare Advantage Plans

Members who would like more information on how to disenroll from a Medicare Advantage plan may:

- Call the Customer Service number on the back of the ID card or the number listed in the EOC.
- Find information in the *Medicare & You* handbook.
- Contact Medicare at **1-800-MEDICARE**.

Where there is no associated enrollment into a new Medicare HMO managed care plan, all disenrollment requests must be submitted in writing and signed by the beneficiary.



Disenrollment

Below are some examples where Isabelle may have the opportunity to disenroll:

- Once a plan option has been elected and is effective; the enrollee must remain in the plan for the remainder of the calendar year, unless they are eligible for an SEP or makes a change during OEP.
- Submission of an enrollment into a PDP will result in the enrollee's enrollment in Original Medicare.
- Enrollment into a Medicare Advantage or COST plan or drug plan during a valid enrollment period will automatically disenroll the member from another Medicare Advantage plan.
- An enrollee must notify the health plan if they have permanently moved out of the service area.
- An enrollee may enroll/disenroll from a Medicare Advantage plan if he/she moves in or out of an institution (e.g., long-term care facility).

Refer to Chapter 2 of the Medicare Managed Care Manual for more information on eligibility, enrollment and disenrollment periods, and effective dates.



Voluntary Disenrollments

A beneficiary may request to disenroll during the following times:

- Medicare Advantage Open Enrollment Period (OEP)
- Electing to disenroll during the Annual Enrollment Period (AEP) without electing another MA, MAPD or PDP option
- Newly eligible for group or union health benefits due to change of employment status
- Loss of dual-eligibility

The “limited instances” when a beneficiary may disenroll are enrollment and disenrollment election periods. Election period determines the effective date of disenrollment.

Beneficiaries may disenroll from a Medicare Advantage plan during the above stated times by sending a written, signed request to the health plan.

Refer to Chapter 2 of the Medicare Managed Care Manual for more information on eligibility, enrollment and disenrollment periods, and effective dates.



Involuntary Disenrollments

The plan sponsor is responsible for submitting involuntary disenrollment transactions to CMS in a timely, accurate fashion. Examples of involuntary disenrollments include:

- Moving out of the service area
- Loss of dual eligible status
- Loss of Part A and or Part B, etc.

The plan sponsor must maintain a system for controlling and processing involuntary disenrollments from the MA plan. This includes:

- Maintaining documentation leading to the decision to involuntarily disenroll the member.
- For all involuntary disenrollments, except disenrollments due to death and loss of entitlement to Medicare Parts A and/or B, the health plan must notify the member in writing of the upcoming involuntary disenrollment, including providing information on grievance rights, as provided in Chapter 2 of the Medicare Managed Care Manual.
- In addition, plan sponsors must send confirmation of involuntary disenrollment to the member. This is to ensure the member discontinues use of sponsor services after the disenrollment date.

Refer to Chapter 2 of the Medicare Managed Care Manual for more information on eligibility, enrollment and disenrollment periods, and effective dates.



Course Summary

- A. Producers assisting beneficiaries with submission of an enrollment form must determine if the beneficiary is enrolled in other medical or prescription drug coverage AND determine the impact of the current plan by enrollment in a Medicare Advantage plan.
- B. An SOA must be obtained 48 hours prior to the scheduled appointment with the beneficiary. CMS does provide two exceptions to the 48-hour rule: (1) if beneficiary is approaching the end of a valid enrollment period (last 4 days of the election period), or (2) walk-ins – beneficiaries who walk into the plan's office, agent's office, or kiosk.
- C. Product advantages and limitations should also be discussed to assist beneficiaries with selecting the product that best suits their needs.
- D. Once suitability and enrollment eligibility has been determined, the steps in the enrollment process include:
 - 1. Completion of enrollment form
 - 2. Receipt of enrollment form by Az Blue
 - 3. Determination of enrollment eligibility
 - 4. Submission to CMS
 - 5. CMS confirmation
 - 6. Confirmation of enrollment notice
- E. Producers assisting beneficiaries with enrollment need to utilize options to expedite receipt of a complete enrollment request and reduce errors.
- F. Acknowledgement of receipt of an enrollment form is required within 7 calendar days of the application date.



Course Summary *continued.....*

- G. Plan must issue notice of approval or rejection within 7 calendar days. CMS approval generates a member ID card and other important member materials.
- H. OEV call(s) will be made, or a letter will be sent to the beneficiary within 15 calendar days of the application receipt date to verify he or she understands the plan rules.
- I. Once a plan option has been elected and is effective, the enrollee must remain in the plan for the remainder of the calendar year, unless they are eligible for a SEP or makes a change during OEP.
- J. Submission of an enrollment into a PDP will result in the enrollee's enrollment in Original Medicare.
- K. Enrollment into a Medicare Advantage or COST plan or drug plan during a valid enrollment period will automatically disenroll the member from another Medicare Advantage plan. It will not disenroll the member from a Medicare Supplement policy.
- L. Please note that a Medicare beneficiary CANNOT be enrolled into a Medicare Advantage Plan and a Medicare Supplement policy at the same time. A beneficiary may request to disenroll during the following times:
 - Medicare Advantage Open Enrollment Period (OEP)
 - Electing to disenroll during the Annual Enrollment Period (AEP) without electing another MA, MAPD or PDP option
 - Newly eligible for group or union health benefits due to change of employment status
 - Loss of dual-eligibility



Course Summary *continued....*

- M. The “limited instances” when a beneficiary may disenroll are enrollment and disenrollment election periods. Election period determines the effective date of disenrollment.
- N. When there is no associated enrollment into a new Medicare health plan, all disenrollment requests must be submitted in writing and must be signed.
- O. AZ Blue complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. As a producer of AZ Blue, you must comply with the AZ Blue non-discrimination policy.
- P. Within 60 seconds of a Sales appointment state the appropriate Third Part Marketing Organization (TPMO) disclaimer:
 - TPMOs that do not sell for all MA and/or Part D plans within a service area - “We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options.”
 - TPMOs that sell all MA and/or Part D plans within a service area - “Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices.”





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