Managing Managed Care

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Speaker Disclosure

Has no Relevant Financial Relationship to disclose.

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Content Disclaimer

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Maureen McCarthy, RN, BS, RAC-MT, QCP-MT, DNS-MT, RAC-MTA

Maureen is the President and CEO of **Celtic Consulting**, **LLC**, nationally recognized as a luminary amongst long term care operators and clinicians for Reimbursement and Regulatory matters, Audits, and Analysis, Enhancing Operational Efficiency and Education and Litigation Support. Maureen combines her clinical expertise in long-term care and her regulatory acumen to assist clients with developing and executing, sustainable remediation plans. She is a registered nurse with over two decades of work experience, including direct patient care, MDS Coordinator, Director of Nursing, and Rehab Director, and Medicare biller.

Maureen and her team are sought for their collective deep subject matter expertise for the Long Term Care industry, providing consulting services for **PDPM/PPS/MDS/CMI** Service, Payroll-Based Journal (**PBJ**) Reporting, 5-Star Quality Improvement Programs (**QAPI**), Quality Auditing, Clinical Care Management, Compliance Solutions, including Medicare Compliance Auditing and Custom Education. As well as litigation support for the legal community defending providers, against allegations of fraud from upcoding, provision of medically unreasonable services, and improper billing.

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Objectives

- Explain the differences between Medicare, managed care, and Medicare Advantage
- Show the increase in managed care utilization for beneficiaries
- Display the impact on revenue that Managed Medicare has
- Provide best practices to address or 'fight' managed care denials

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Managed Care/Medicare Advantage

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Medicare vs. Medicare Advantage

- People new to Medicare can receive their Medicare benefits through either traditional Medicare or private plans, such as HMOs or PPOs, known as Medicare Advantage plans.
- Older adults and younger beneficiaries with disabilities have said that they make this choice based on premiums and out-of-pocket costs, access to desired providers, the reputation of the company offering the plan, ads and other marketing materials, recommendations from others.

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What Do MA Plans Cover?

- Medicare managed care plans are alternative options to Part A and Part B. Most managed care plans provide additional benefits for services that Original Medicare doesn't include. Benefits can include routine vision, dental and hearing services.
- Additionally, managed care plans offer prescription drug coverage.

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Pros and Cons of Managed Care Plans

- Medicare Managed Care plans include equivalent coverage as Parts A and B. Plus, these plans include extra benefits like routine vision, hearing, and dental services. Some even include membership in fitness programs and prescription drug coverage. Benefits, as well as cost amounts, vary among plans.
- On the other hand, managed care plans may limit beneficiaries to only the doctors within the plan's network. If having the freedom to see any healthcare provider of choice is important, remember that MA plans limit provider options.

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Pros and Cons of Managed Care Plans

- Plan administrators must agree the treatment/service is medically necessary. Otherwise, they may deny approval for the service.
  - Waste prevention vs. access to care
- Lastly, HMOs have limited appeal rights. Members have limited rights to appeal a decision the plan makes. If a patient disagrees with a decision, filing an appeal may be difficult; or a waste of time. HMO plan employees review member appeals.
  - CMS oversight is needed immediately

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MA Plan Advantages

- Some of the advantages that are specific to individual plans:
  - No three (3) day hospital stay,
  - Renewing 100-day benefit periods,
  - Additional coverage for ancillary/Part B items

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Open Enrollment
October 15–December 7

Change from Original Medicare to a Medicare Advantage Plan.

- Change from a Medicare Advantage Plan back to Original Medicare.
- Switch from one Medicare Advantage Plan to another Medicare Advantage Plan.
- Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage.
- Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage.
- Join a Medicare Prescription Drug Plan.
- Switch from one Medicare Prescription Drug Plan to another Medicare Prescription Drug Plan.
- Drop your Medicare prescription drug coverage completely.

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Medicare Advantage Disenrollment Period

January 1–February 14

- If you're in a Medicare Advantage Plan you can leave your plan and switch to Original Medicare. Your Original Medicare coverage will begin the first day of the following month.
- If you switch to Original Medicare during this period, you'll have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Your prescription drug coverage will begin the first day of the month after the plan gets your enrollment form.

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Criteria for Changes to Medicare Plans

(outside disenrollment period)

Under certain circumstances that qualify you for a Special Enrollment Period (SEP), like:

- You move.
- You're eligible for Medicaid.
- You qualify for Extra Help with Medicare prescription drug costs.
- You're getting care in an institution, **like a skilled nursing facility** or long-term care hospital.
- You **must** have Medicare Part A and Part B to join a Medicare Advantage Plan.
- In 2022, if you have End-Stage Renal Disease (ESRD), you may be eligible to join a Medicare Advantage Plan.

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Disenrolling from MA Plans

Facility/facility staff MAY NOT:

- Disenroll a resident from a Medicare Advantage, Medicare Medicaid Plan or Prescription changes in that care or treatment that may affect the resident's well-being" (42 CFR &483.10(d)(2)); or
- Require, request, coach, or steer residents to change their plans.

Facility/facility staff MAY:

- Provide information and education to residents (CMS Survey & Certification policy memorandum 06-16 on Nursing Homes and Medicare Part D);
- Develop policies and procedures regarding staff ability to provide necessary information to residents and their representatives and educate them that the right to change plans ultimately rests with the resident and their representative; and
- Collect information on who the state allows to make health insurance decisions for a resident, so they may contact the person should an insurance change be necessary for the resident.

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Recommendations for SNF Documentation to Reflect Assistance with Disenrollment

- Document an account of the allowable assistance provided to the beneficiary and representative; and
- Retain the information as a resource to support the validity of the enrollment/disenrollment and as confirmation that the staff acted in accordance with policies/procedures and within regulatory guidelines
- In the case of any retrospective review of resident health plan changes, **the facility must be able to present documentation of the resident's request to change enrollment**. If documentation is not available or does not support that the change was at the request of the resident or resident's representative, CMS will consider the change invalid.

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What Are the Differences?

- Managed Care (commercial) vs. Medicare Advantage Plans
  - Most plans have some type of case management to manage cost. "Gatekeeper"
  - Commercial plans that are not Medicare Advantage do not have the same covered services

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Medicare Advantage Is On the Rise

- CMS is encouraging beneficiaries to enroll in managed care plans
  - Marketing efforts increased for seniors, or those approaching
  - More and more beneficiaries are choosing MA plans

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MAO Denials on the Rise

- Light needs to be shed on provider issues involving MA plan denials
  - Case managers 'choosing' PDPM scores and requiring MDSC to falsify MDS coding to match their PDPM scores
  - Misinterpretation of RAI guidelines to deny coding, assessment types, ARDs, completion dates, and submission dates

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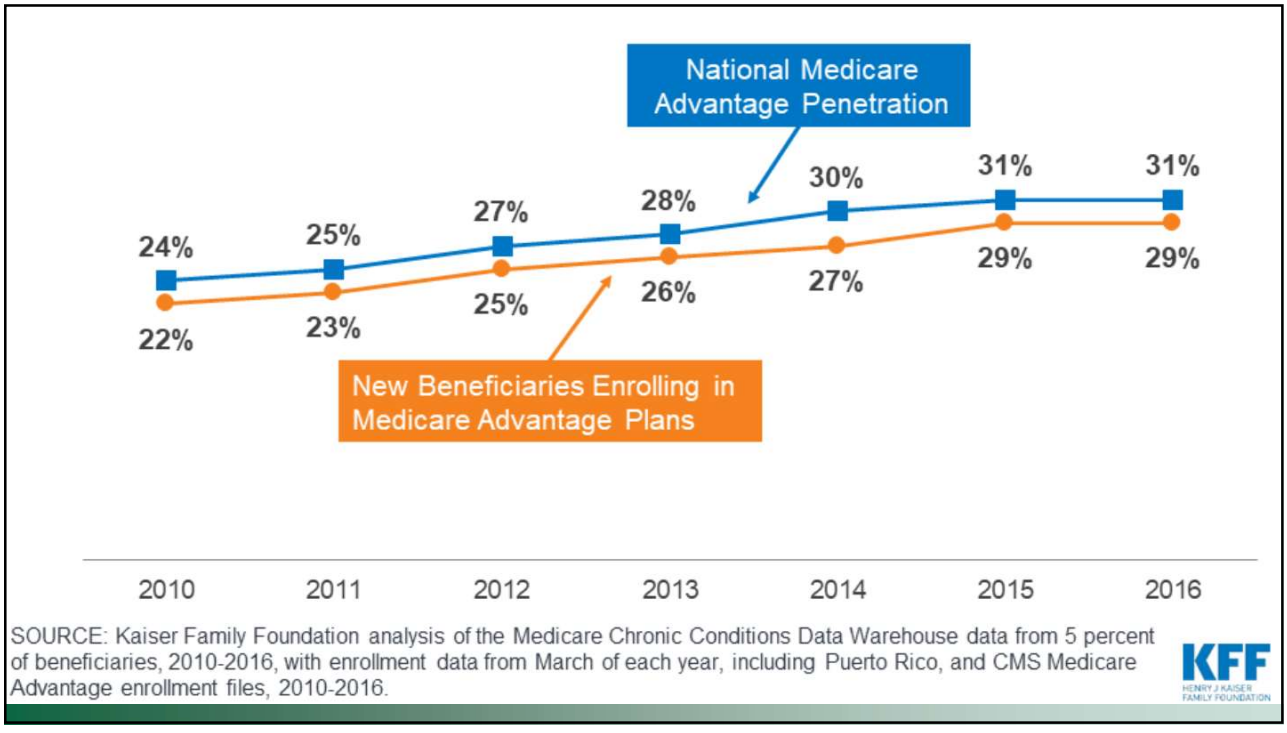

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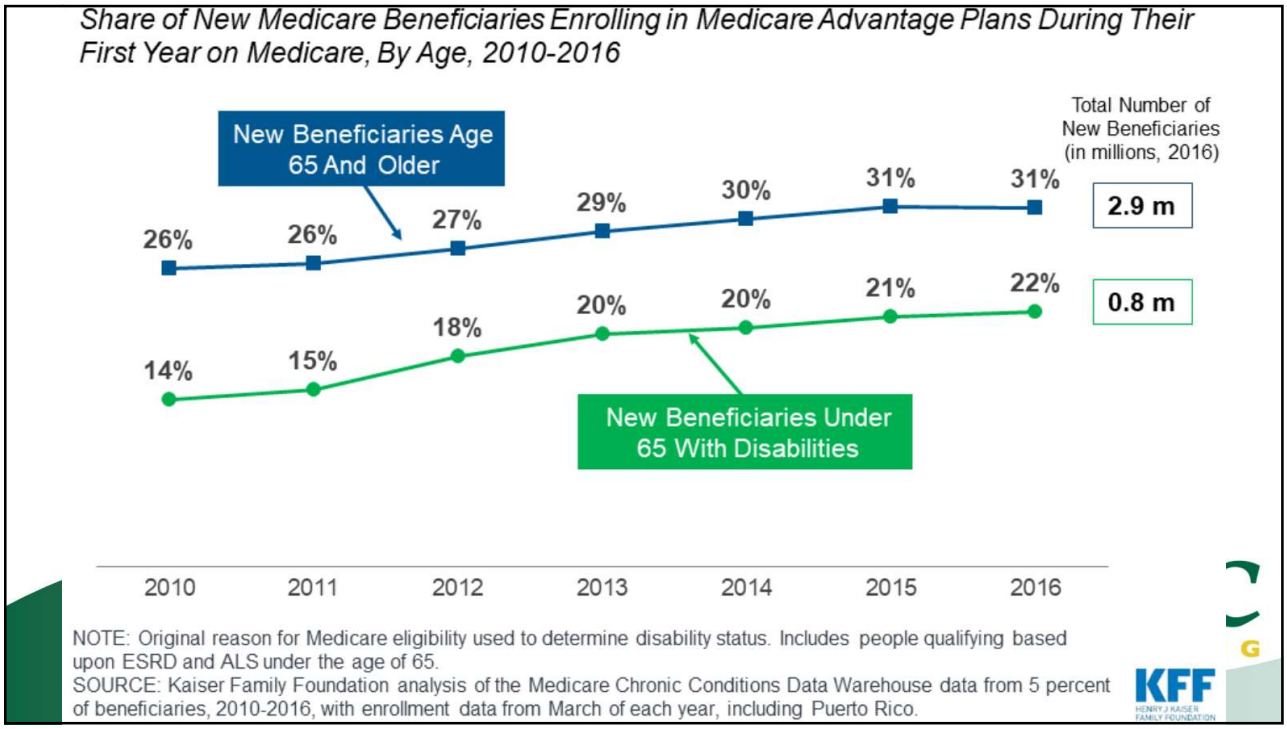
Share of New Medicare Beneficiaries Enrolling in Medicare Advantage Plans During Their First Year on Medicare, By Age, 2010-2016
New Beneficiaries Age 65 And Older
Total Number of New Beneficiaries (in millions, 2016)
26%
26%
27%
29%
30%
31%
31%
2.9 m
14%
15%
18%
20%
20%
21%
22%
0.8 m
New Beneficiaries Under 65 With Disabilities
2010
2011
2012
2013
2014
2015
2016
NOTE: Original reason for Medicare eligibility used to determine disability status. Includes people qualifying based upon ESRD and ALS under the age of 65.
SOURCE: Kaiser Family Foundation analysis of the Medicare Chronic Conditions Data Warehouse data from 5 percent of beneficiaries, 2010-2016, with enrollment data from March of each year, including Puerto Rico.
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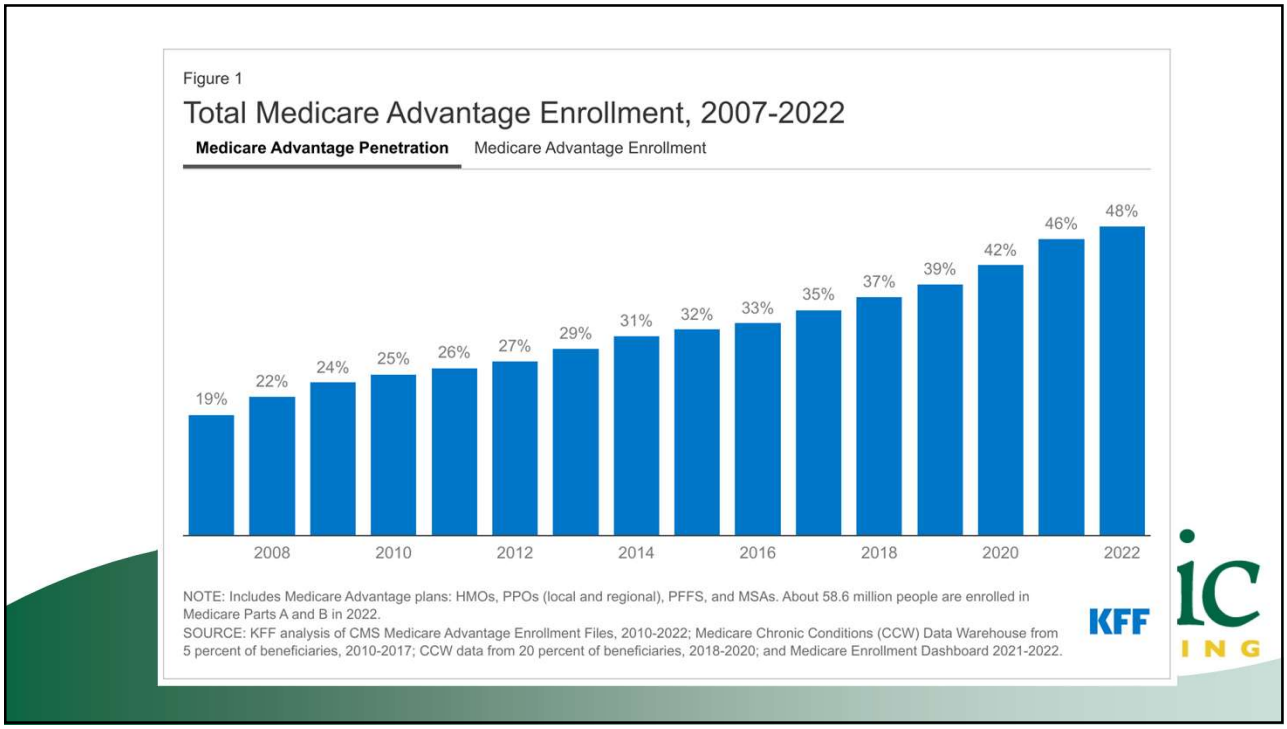
Figure 1
Total Medicare Advantage Enrollment, 2007-2022
Medicare Advantage Penetration
Medicare Advantage Enrollment
19%
22%
24%
25%
26%
27%
29%
31%
32%
33%
35%
37%
39%
42%
46%
48%
2008
2010
2012
2014
2016
2018
2020
2022
NOTE: Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 58.6 million people are enrolled in Medicare Parts A and B in 2022.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2022; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018-2020; and Medicare Enrollment Dashboard 2021-2022.
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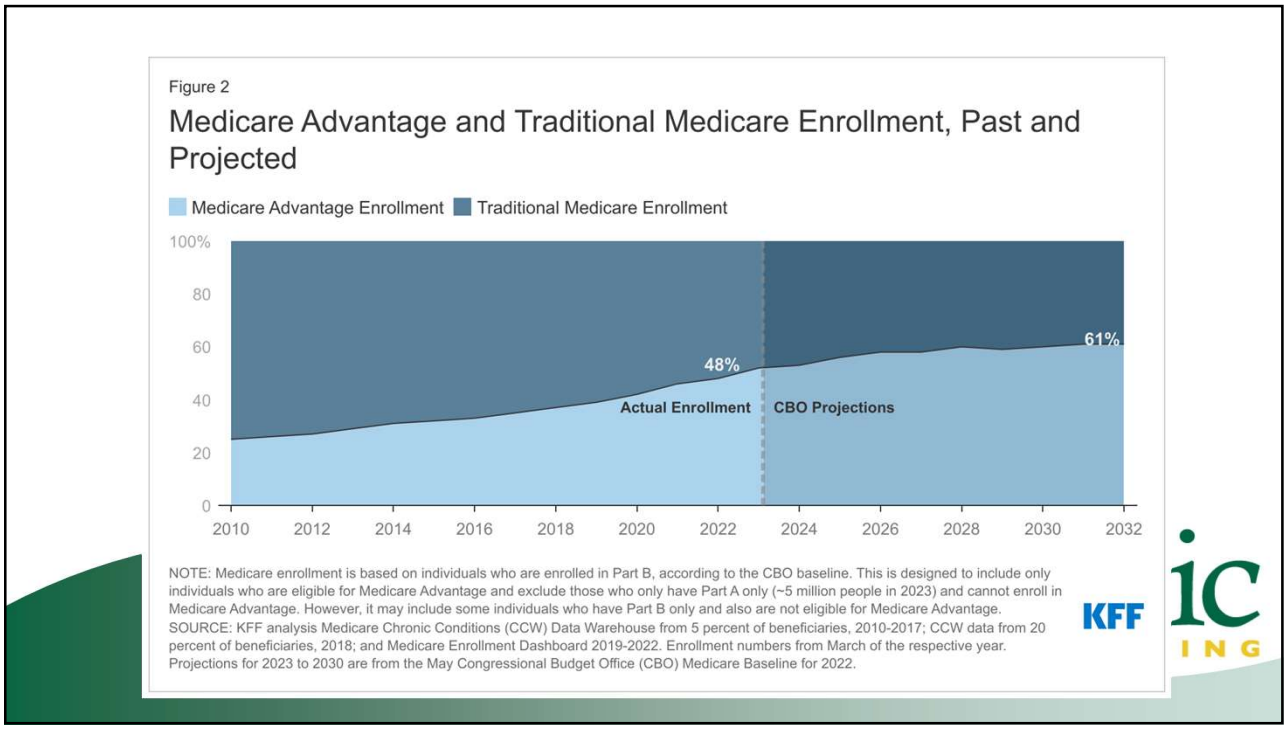
Figure 2
Medicare Advantage and Traditional Medicare Enrollment, Past and Projected
Medicare Advantage Enrollment
Traditional Medicare Enrollment
100%
80
60
40
20
0
48%
61%
Actual Enrollment
CBO Projections
2010
2012
2014
2016
2018
2020
2022
2024
2026
2028
2030
2032
NOTE: Medicare enrollment is based on individuals who are enrolled in Part B, according to the CBO baseline. This is designed to include only individuals who are eligible for Medicare Advantage and exclude those who only have Part A only (~5 million people in 2023) and cannot enroll in Medicare Advantage. However, it may include some individuals who have Part B only and also are not eligible for Medicare Advantage.
SOURCE: KFF analysis Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018; and Medicare Enrollment Dashboard 2019-2022. Enrollment numbers from March of the respective year. Projections for 2023 to 2030 are from the May Congressional Budget Office (CBO) Medicare Baseline for 2022.
KFF

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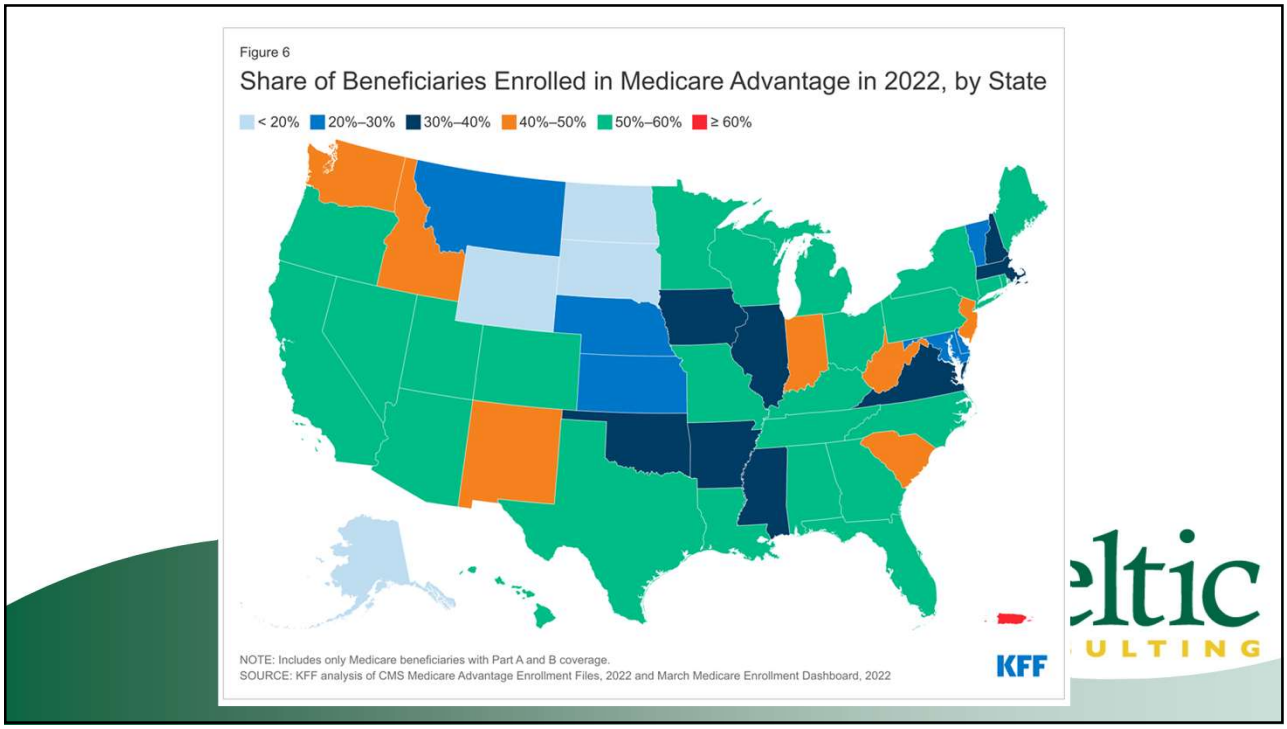
Figure 6
Share of Beneficiaries Enrolled in Medicare Advantage in 2022, by State
< 20%
20%–30%
30%–40%
40%–50%
50%–60%
≥ 60%
NOTE: Includes only Medicare beneficiaries with Part A and B coverage.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022 and March Medicare Enrollment Dashboard, 2022
KFF

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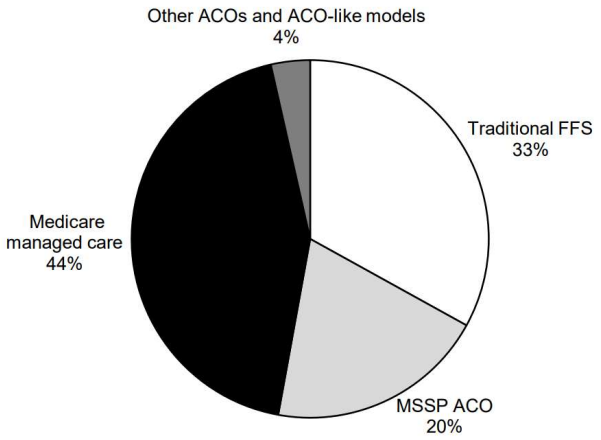
Where Are All the Medicare Beneficiaries Going?



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Average Reimbursement per Payer
(through May 2022)

Revenue Per Patient Day		
Medicaid	$248	-0.4%
Medicare	$573	0.4%
Managed Medicare	$454	-0.4%
Private	$302	0.1%

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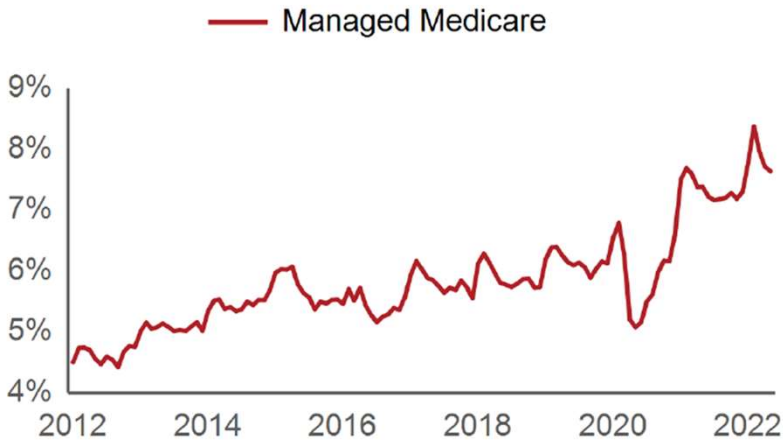
Medicare Advantage Patient Day Mix (May 2022)



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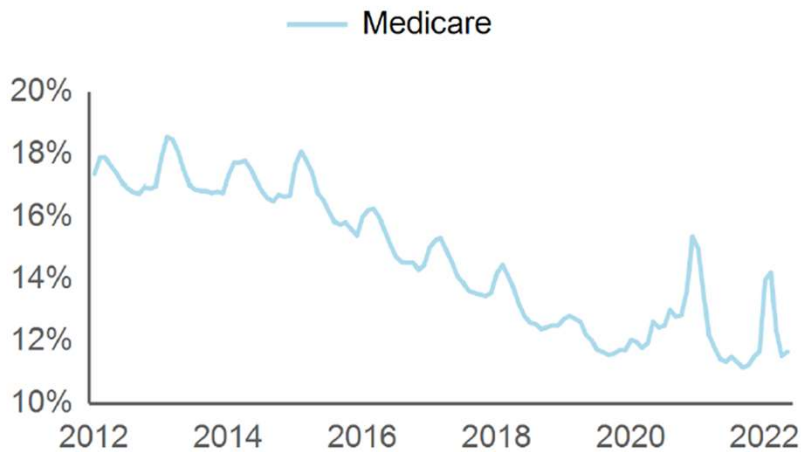
Medicare Patient Day Mix (May 2022)



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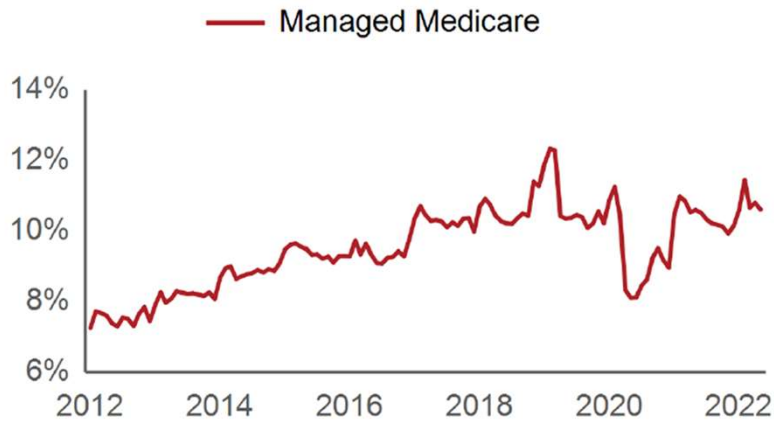
Medicare Advantage % of Daily Revenue (May 2022)



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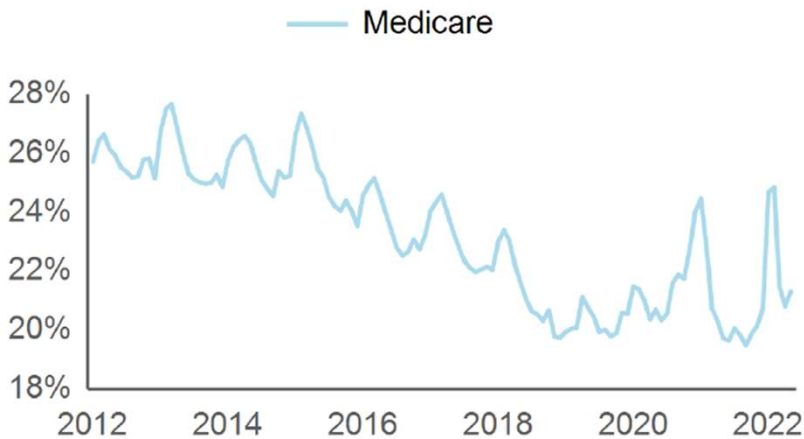
Medicare % of Daily Revenue (May 2022)



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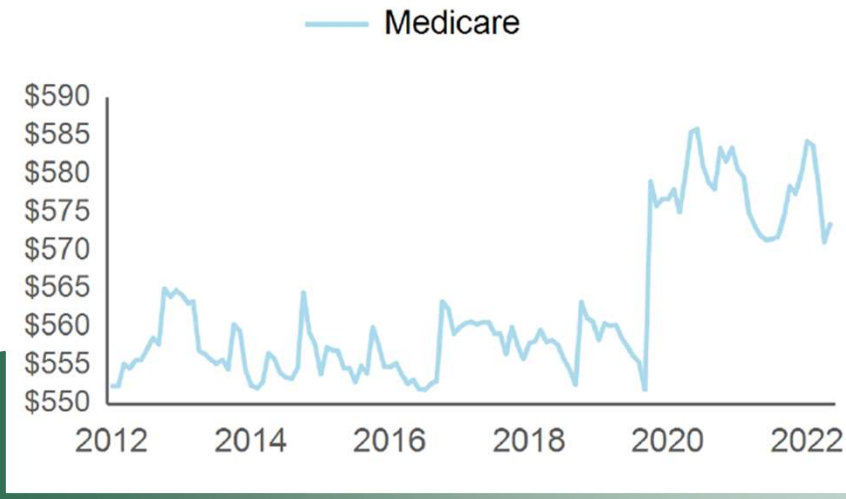
Average Daily Rate (May 2022)



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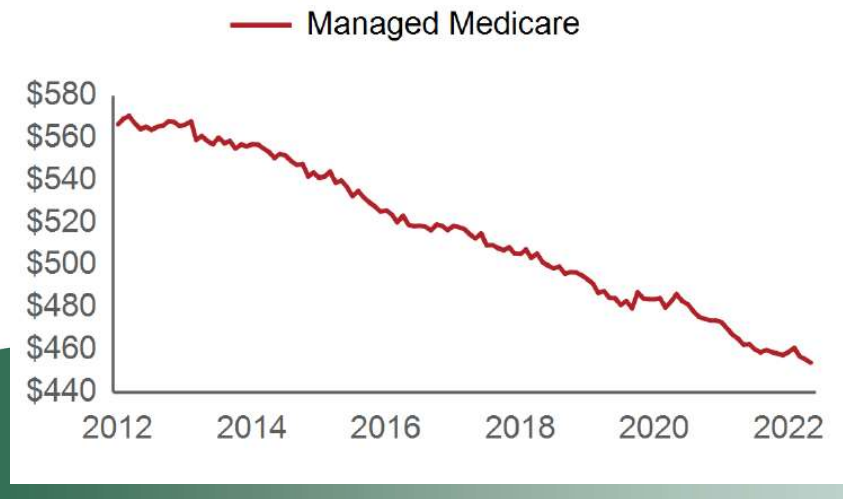
Average Daily Rate (May 2022)



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Office of Evaluations and Inspections (OEI) 4/27/22 Report Finds Delays and Denials of Medicare Covered Services

- Medicare Advantage Organizations (MAO) are incentivized to deny beneficiaries access to care and deny payments to providers to increase profit margins
- CMS audits have revealed widespread and persistent problems related to inappropriate denials of service and payment

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What the Study Showed

- 250 cases of denied care and 250 payment denials by 15 of the largest MAOs were audited
- Claims review period (6/1/19- 6/7/19)
  - Claims for services that meet Medicare coverage and regulatory guidelines were denied
  - Claims that met both Medicare and MAO billing regulations were denied
  - Additional administrative burden was created by the MAO that required the provider to perform 'extra steps'

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What the Study Showed

- 13% of denied prior authorization requests met coverage guidelines and would have been paid for under FFS Medicare
- 18% of denied payments met Medicare coverage regulations
  - MAOs payment systems were not updated causing system processing errors
  - Manual claims reviews "missing documents" included for review by the provider

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Common Causes Identified for Denials

- MAOs using clinical criteria not contained in Medicare coverage rules
  - 'Making up their own rules'
- Denying based on 'lack of supportive documentation', which was included as part of the medical record
  - Medical necessity was clearly present, yet payment denied
  - Not accepting the documentation provided

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OEI Recommendations to CMS

- CMS to issue guidance to MA plans on appropriate use of clinical criteria to meet medical necessity
- MAOs to update protocols on auditing claims particularly for post acute facility stays, which had been one of the two top providers for denied care
- MAO to take additional step to identify and address the issues found in the report

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Examples of Payment Denials

Requests and Responses Staff May Receive from the MAO

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Fighting the Good Fight-Best Practices

- MA plans must pay 90% of claims per batch in 30 days
- Fight claims through CMS, don't just end at the insurer
- CMS reacts quicker if beneficiaries are affected
  - Prove they are experiencing hardship

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Why Aren't Providers Fighting Against MAOs?

- While some providers are publicly vocal in their frustrations with MA plans' denial practices, most providers are reluctant to fight the plans and publicly air their grievances out of concern about threatening ongoing business from the plans and existing contractual obligations.

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UHC PDPM Review Notice

Audit ID	Patient Name	Date of Birth	Service Start	Service End
[redacted]	[redacted]	[redacted]	01/21/2020	01/31/2020
[redacted]	[redacted]	[redacted]	02/01/2020	02/15/2020

Requested Documents for Medical Review

Please submit the following requested documents:

- The UB04 for all services billed for the specified timeframe.
- Copy of each MDS corresponding to the HIPPS (PDPM) codes being reviewed on the claim.
- All supportive documentation used to complete the MDS reflected on the original UB-04 claim, including, but not limited to, the following:

a. Physician's orders, progress notes, H&P's, nurse's notes, MAR's/TAR's, wound documentation, therapy documentation, etc. to support the coding of any diagnoses or other payment-related items coded on the MDS(s).
b. Copy of hospital records utilized to support coding of any IV fluids or diagnoses coded on the MDS(s), such as Discharge Summary.
c. Documentation to support the coding of Section GG or Functional Status items on the MDS(s).
d. Documentation to support the coding of any interrupted stays.

If you have any questions or need further assistance, please call 844-394-5130, ext. 665, Monday through Friday between 8 AM and 8 PM Eastern time.

For more information on medical record submission, visit our website at:

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Section GG Denials

Claim ID	Patient DOB	Service Start Date	Service End Date	Billed HIPPS / Revenue Code	Validated HIPPS / Revenue Code
[redacted]	[redacted]	01/21/2020	01/31/2020	KAPE1	LAQE1

CMS Reference Denial Reason 4 - Unable to validate coding of Section GG

Rationale 5 day assessment, ARD 1/28/2020 paying for 1/21/2020-1/31/2020. Billed PDPM score KAPE1 x 11 days. Validated PDPM score LAQE1 x 11 days. As per CMS RAI User Manual Chapter 6.6, the documentation provided does not support coding of all Section GG payment items which results in a reduction of the PT/OT and nursing components of the validated PDPM score.

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Responding to Appeals

During a recent audit, we identified claims for which the billing codes were not validated in the medical record documentation. Outlined on the attached report are the claims that our records indicate has been inaccurately coded. We request you review our findings within 30 days of this notice.

Your signature on this form indicates your agreement with the audit findings. Please return this signed document to the fax number indicated below for the identified overpayment. United Healthcare will adjust the claim(s) in question within 45 days from the date of your agreement.

If you disagree with our findings, please indicate as such on the audit findings form and return it to the fax number indicated below.

Disagreement with audit findings must be received within 30 days of this notification. Please note any new or material supporting documentation must be provided at this time.

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The RAI Manual Identifies the Following Reasons For Payment Penalty:

- Non-compliance with the PPS Schedule is defined as:
  - Early PPS Assessment
  - Late PPS Assessment
  - Missed PPS Assessment
- The RAI Manual does not indicate a payment penalty for late signature(s) at Z0500

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CMS Response to Late MDSs (12/12/2019)

- The instructions on pages 6-52 – 6-53 in chapter 6 of the *RAI User's Manual* that discuss noncompliance with the SNF PPS assessment schedule "are all specific to the ARD," they noted. "The ARD has to be set prior to the person's leaving the Part A stay. As long as the ARD is set timely, just from a payment policy perspective, you're fine"
- From a survey perspective, providers also must meet the 14-day completion window and the 14-day submission window, said officials. "There are potential survey implications if you are completing assessments in a non-timely manner. But from a payment policy perspective, the only time that a late penalty or provider liability would kick in is if the ARD is not set within the appropriate window"

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Best Practice to Address (No MDS)

- **Paid by Contract Level, Not PDPM/RUG Level**
- CMS memorandum September 26, 2019 & RAI manual Chapter 2; section 2.3 - resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required
- Chapter 5, section 5.1 - Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage Plans

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER FOR MEDICARE
MEDICARE PLAN PAYMENT GROUP

TO: All Medicare Advantage Organizations (MAOs), PACE Organizations, Cost Plans, and certain Demonstrations

FROM: Cheri Rice, Director
Medicare Plan Payment Group

SUBJECT: Additional Guidance Regarding Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System

DATE: December 4, 2014

As noted in the May 23, 2014 HPMS memo, "Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System," MAOs must submit a HIPPS code on a Skilled Nursing Facility (SNF) and Home Health Agency (HHA) encounter with "from" dates July 1, 2014 or later. Specifically, HIPPS codes should come from the initial OBRA-required comprehensive assessment (Admission assessment) and Outcome and Assessment Information Set (Start of Care assessment), respectively.

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Stays of 14 days or less – If there was no Admission assessment completed before discharge for a stay of less than 14 days, MAOs must submit to CMS a HIPPS code by following the guidance in the order they are listed below.

A. Submit the HIPPS code from another assessment from the stay
If no OBRA Admission assessment was completed for a SNF stay of less than 14 days, the MAO shall submit to CMS the HIPPS code from any other assessment that was completed during the stay that produces a HIPPS codes.[1]

B. Submit a default HIPPS code of 'AAA00'
MAOs may submit a default HIPPS code for SNF encounter submissions to CMS only if (1) the SNF stay was less than 14 days within a spell of illness, (2) the beneficiary has been discharged prior to the completion of the initial OBRA Admission assessment, and (3) no other assessment was completed during the stay.[2] To submit a default HIPPS code to the Encounter Data System, MAOs should use the default Resource Utilization Group (RUG) code of "AAA" and Assessment Indicator "00" on encounter data submissions starting with "from" dates of service July 1, 2014.

MAOs may not use this default code in other situations, such as to avoid collecting the proper HIPPS code, or when the MAO's systems are not prepared to submit the HIPPS code to CMS.

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER FOR MEDICARE

DATE: September 26, 2019

TO: All Medicare Advantage Organizations, PACE Organizations, Medicare-Medicaid Plans, Section 1833 Cost Contractors, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: Updated Information on Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Medicare Advantage Encounter Data System – September 2019

This memorandum provides updated information on the submission of Health Insurance Prospective Payment System (HIPPS) Codes. Guidance was first issued in the May 23, 2014 Health Plan Management System (HPMS) memorandum with the subject line: "Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System" with additional guidance provided in the December 4, 2014 HPMS memorandum with the subject line: "Additional Guidance Regarding Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System."

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For SNF stays lasting 14 days or less in which an Admission assessment was not completed prior to discharge, MAOs should follow the guidance outlined in the December 4, 2014 HPMS memorandum with the subject line: "Additional Guidance Regarding Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System." As noted in that memo, MAOs may submit the HIPPS code from another assessment that took place during the stay or submit a default HIPPS code.

- The default HIPPS code for encounters with a "from" date of service prior to October 1, 2019 is "AAA00." The default HIPPS code for encounters with a "from" date of service on or after October 1, 2019 is "ZZZZZ."

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HIPPS vs. MDS Requirement

How will UnitedHealthcare adhere to this new HIPPS requirement?

UnitedHealthcare will require in- and out-of-network SNF and home health care providers to submit HIPPS codes for all inpatient SNF and home health care services provided to our Medicare Advantage members. United Healthcare will comply with this requirement and may reject/deny claims without appropriate HIPPS coding on either the uniform bill (UB-04 -paper) version or 837i (electronic) submission.

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HIPPS on Claims for Managed Care

How does the HIPPS requirement impact billing for SNF and home health providers?

SNFs must include a line item on the claim that includes the 0022 revenue code, the appropriate HIPPS code and a zero dollar charge amount for all inpatient admissions.

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HIPPS vs. MDS

Will the HIPPS code requirement impact provider reimbursements?

SNF reimbursements will not be affected. In-network SNF providers will continue to be reimbursed per their contracted rates. The addition of HIPPS coding will be used for UnitedHealthcare's encounter data reporting and will not change payment to the SNF.

All SNF providers contracted using the Prospective Payment System (PPS) - Resource Utilization Groups (RUG) reimbursement will continue to submit claims as they have in the past.

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Best Practices for Admissions Process

- What is your Pre-Admission screening process?
  - Financial Verification
  - What type of plan is it?
- Medicare Advantage vs. Commercial insurance
  - Are you contracted with the insurance company?
    - In Network vs Out of Network Benefits

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Best Practices for the IDT

- Admissions and Authorizations
- Managed care contracts
- Exclusions to the contract
- The billing process
- Follow up
- Relationship with your managed care provider

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Best Practices for Expense Control

- What active contracts do you have in-house?
- Educate the IDT to what deliverables are required.
  - Rehab minutes
  - PDPM payments
  - Level payments
  - Number of coverable/approved days
  - Next scheduled update to case manager

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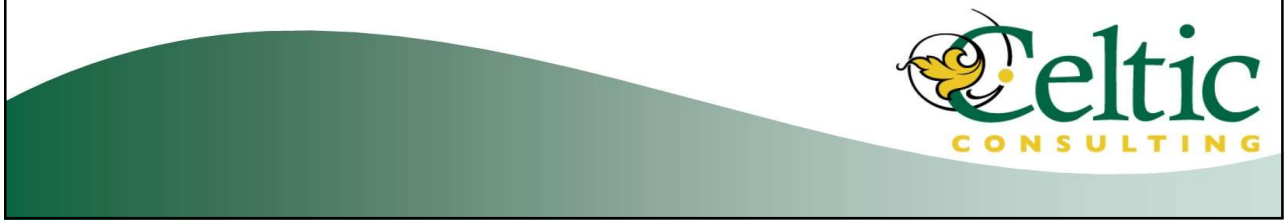
Best Practices for Billing Staff

- Become familiar with CMS regulations for Medicare HMOs
- Understand the importance of developing a system of Case Management for SNF providers
- Identify Billing challenges and coverage for Medicare HMO and Insurance companies
- Keep track of percentage of MA denials



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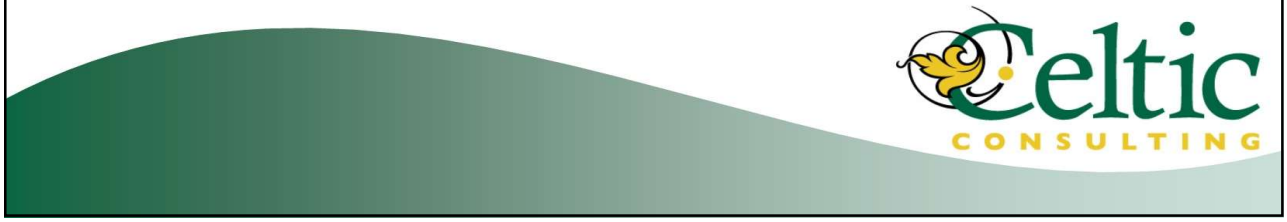
Best Practices to Monitor MA Denials

- Additional 'hoops' to jump through
  - Revenue codes on claim rejected
  - Primary diagnosis code on claim
    - Paying for authorized code only, regardless of care or treatment
  - Late completed or submitted MDSs
    - Regulatory issue, not a reason for non-payment
    - Use the RAI to support your argument



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Best Practices to Manage Managed Care

- In 2015 CMS cited **56%** of audited contracts for making inappropriate denials.
- CMS also cited 45% of MA plans for sending denial letters with incomplete or incorrect information.
- Because Medicare Advantage covers so many beneficiaries (more than 20 million in 2018), even low rates of inappropriately denied services or payment can create significant problems for many Medicare beneficiaries and their providers.
- Only **1%** of denied claims were appealed between 2014-2016.

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Medicare Advantage Denial Notices

How MAOs Pushed Liability to the Providers

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NOMNC Delivery by SNF

All enrollees must receive an NOMNC, even if they agree that services should end. The notice must be delivered no later than 2 days prior to the proposed termination of services. Although M+C organizations are responsible for either making or delegating the decision to end services, SNFs, HHAs, and CORFs are responsible for delivering the notices to enrollees. A provider may formally delegate to an agent the delivery of the NOMNC under the following conditions:

1. *The agent must agree in writing that it will deliver the notice on behalf of the provider.*
2. *The agent must adhere to all preparation, timing and valid delivery requirements for the notice as described in sections 90.4 and 90.5 of this chapter.*
3. *The provider remains ultimately responsible for the valid delivery of the NOMNC.*

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Telephone Notice: Page 13 of Managed Care Manual

- When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. Place a copy of the notice in the enrollee's medical file, and document the attempted telephone contact to the members' representative.
- The documentation should include: the name of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called.
- When the return receipt is returned by the post office, with no indication of a refusal date, then the enrollee's liability starts on the second working day after the M+C organization's enrollee's liability starts on the second working day after the M+C organization's mailing date.

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Questions?

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