

Medicare Advantage Enrollment Processes: D-SNP New Entries, Service Area Changes, Terminations, Non-Renewals, and Seamless Conversions

Purpose/Overview

The Integrated Care Resource Center (ICRC) is a national initiative of the Centers for Medicare & Medicaid Services (CMS) to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The ICRC provides frequent opportunities for states working on integrated care initiatives to come together to discuss topics of interest with other states and CMS.

This document summarizes a March 2014 discussion about Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP) non-renewals, service area changes, terminations, new entries, seamless conversions, and passive enrollment. Participants in the discussion included staff from seven states, CMS, ICRC, and the National Association of Medicaid Directors (NAMd). The discussion drew on two background documents (a technical assistance tool and a summary of seamless conversion requirements) that are available on the ICRC website: <http://www.integratedcareresourcecenter.com/icmmedicareneedsplans.aspx>.

D-SNP New Entries, Service Area Changes, Terminations, Non-Renewals, and Seamless Conversions

Service Area Expansions

- To participate as a Medicare Advantage Organization (MAO) or be eligible to expand a plan's service area, an organization must first submit a Part C application, due annually in February, to contract with CMS. A D-SNP can be one of several products offered by the MAO or the only plan under the MAO's contract.
- MAOs offering D-SNPs must submit a Notice of Intent to Apply (NOIA) by November in the year prior to the year in which they will be applying for a new contract or service area expansion (i.e., an MAO applying for a 2016 contract would submit the NOIA by November 2014).
- For details, see 42 CFR §422.501.

Service Area Reductions

- MAOs may implement service area reductions at the contract or plan benefit package (PBP) level. CMS must be notified by the first Monday in June in the year before the service area reduction will take effect. Beneficiaries who will be disenrolled by the end of the year must be notified on or after October 1st.
- For details, see CMS Final Call Letter for CY 2012 for Medicare Advantage Plans, Appendix A-1, Guidance for Contract Plan Renewals, April 4, 2011.

Non-Renewals

- If an MAO intends to voluntarily not renew its contract, it must notify CMS in writing by the first Monday in June in the year before the non-renewal will take effect (i.e., an MAO not renewing its 2015 contract would submit its notification by June 2014). The MAO must: (1) notify enrollees at least 90 days prior to the contract end date; (2) provide a CMS-approved description of alternative Medicare Advantage Prescription Drug (MA-PD) plans and Prescription Drug Plans (PDP) available; and (3) notify enrollees via mail to inform them of their coverage options. Except under special circumstances, CMS will not enter into another contract with a non-renewing organization for two years. Because non-renewals are applied at the contract level, if an MAO with a D-SNP non-renews its contract, the D-SNP and any other plans under that contract would be discontinued and the MAO would face the penalty.
- For details, see 42 CFR §422.506.

Mid-Year Terminations

- Mid-year terminations are at the contract level. Reasons for mid-year terminations may include: (1) termination for cause; (2) mutual termination; and (3) enforcement termination, in cases of potential beneficiary harm or breach of contract.
- When a mid-year termination is initiated by an MAO, the MAO must give CMS at least 90 days' notice and the general public 60 days' notice of the termination. The MAO is also responsible for giving the general public 60 days' notice when the termination is by mutual agreement between CMS and the MAO. For terminations initiated by CMS for cause, CMS is responsible for notifying enrollees of the termination and their coverage options. State Medicaid agencies may also require D-SNPs with which they contract to notify the state of a mid-year termination to avoid disruptions in enrollees' care.
- Mid-year terminations initiated by an MAO or mutually initiated by CMS and the MAO would result in a two-year ban by CMS on contracting with the organization. In the case of CMS-initiated terminations and non-renewals, CMS may decide not to contract with the MAO for a period of 38 months.
- For details, see 42 CFR §422.508, 422.510, and 422.512.

Seamless Conversion

- Seamless conversion is an optional enrollment mechanism offered by an MAO that operates both Medicare and non-Medicare (e.g. commercial, Medicaid) lines of business whereby it identifies and notifies individuals that the MAO will convert their enrollment from the non-Medicare plan into the Medicare plan as of the date they become eligible for Medicare for the first time.
- An MAO offering a D-SNP may submit a proposal to seamlessly enroll newly Medicare-eligible individuals, including those whose Medicare eligibility is based on disability as well as age, to the CMS regional office (RO) account manager, and their proposals must be approved by CMS.
- The MAO must identify all newly eligible individuals at least 90 days prior to the date of initial Medicare eligibility (i.e., the conversion date) and must send individuals advance notice of the conversion opportunity at least 60 days prior to the conversion date. CMS has a model notice available for MAO use for this purpose.
- If approved by CMS, the seamless conversion enrollment mechanism allows the MAO to enroll an individual in one of their Medicare plans unless the individual opts out. Individuals must be notified that they may opt out of seamless conversion up until the day before the enrollment becomes effective.
- If an individual actively declines seamless conversion, the MAO must submit an enrollment cancellation transaction to CMS.
- Seamless conversion may not be used to move an individual already enrolled in an MA plan into another MA plan, including a D-SNP, offered by the same organization.
- Seamless conversion is not an enrollment option available to standalone PDPs.
- For details, see Social Security Act, Section 1851; 42 CFR §422.66; and Medicare Managed Care Manual, Chapter 2, Sec. 40.1.4 (August 30, 2013).

Passive Enrollment

- Passive enrollment is an enrollment mechanism exclusively initiated by CMS. It is similar to seamless conversion in that the enrollee would be enrolled in the new Medicare health or drug plan unless he or she opts out or makes a different plan choice, but different because it only occurs when CMS determines that continued enrollment in the current plan has the potential to cause enrollee harm or continued enrollment is not possible due to an immediate termination.
- For example, when an MAO or Part D sponsor goes out of business, normally its enrollees would default into FFS Medicare. But passive enrollment allows CMS to assign them to another MAO or Part D plan with the option to opt out of the passive enrollment or choose a different plan.
- CMS may passively enroll beneficiaries who are currently in a PDP or MA plan.
- CMS provides a special enrollment period for those being passively enrolled to opt out into Medicare FFS or to choose another MA plan or PDP.
- For details, see 42 CFR §422.60(g).

Novation

- Novation is a process that happens where ownership of an MA plan transfers from one organization to another. For example, novation can happen when one plan goes out of business or it decides to get rid of their MA line of business.
- The acquiring entity must already be operating a MA product in the same service area as the one in which the current product is operating. CMS requires that the new organization has the financial and operational capability to operate the new contract.
- Novation agreements must be approved by CMS; they document a change in ownership of an MAO. MAOs can only novate an entire contract (not individual plans).
- In cases where a the contract(s) being novated have a D-SNP, CMS works with a state to make sure the MIPPA agreement the state has with the MAO is transferable to the new entity taking over the business, and that the new entity has the appropriate capabilities.
- CMS requires 60 days notice prior to any change of ownership requiring novation.
- For details, see 42 CFR §422.550 and 422.552.

State Questions/Discussion

State Question	CMS Response
Is there a timeframe for the approval of seamless conversion proposals?	There is no required timeframe for conducting seamless conversions. Once an MAO receives approval of its proposal, it may use the seamless conversion enrollment mechanism indefinitely until CMS or the MAO has cause to change it.
Do STAR ratings factor into the seamless conversion approval process?	No, they do not.
Can a state initiate a mid-year termination?	States cannot initiate termination of a plan's Medicare Advantage contract. Only the MAO or CMS can do this. If, due to insolvency, a state is awarded receivership of an MAO's Medicare Advantage business, then the state may enter a mutual termination of the contracts under that business with CMS. However, if a state terminated a MIPPA contract, the D-SNP would not be in compliance with CMS requirements, so the D-SNP would have to be terminated. If the D-SNP was one of multiple plans under the contract, only the D-SNP (not the entire contract) would be terminated. If the D-SNP is the only plan under the contract, CMS would work with the state to do a mutual termination and notify enrollees of alternatives. However, the MAO may incur a penalty for mutual termination.
In the case of evergreen MIPPA contracts, the only state option to insert new requirements may be to cancel the contract and renegotiate it to incorporate new requirements. When would the new contract with the D-SNP have to be in place in order to conform to required CMS timeframes for MIPPA contract submissions and notifications of MAO contract non-renewals or terminations?	CMS requires that a current MIPPA contract be submitted to CMS by July 1 of the year prior to that in which the D-SNP intends to operate. MAOs must submit notices of contract non-renewal or terminations to CMS by the first Monday in June of the year prior to the contract year that would be affected.

State Question	CMS Response
Does seamless conversion apply both to those who are aging into Medicare eligibility at age 65, and those under 65 in a Medicaid disability eligibility category who will become eligible for Medicare only at the end of a two-year waiting period?	Seamless conversion is only available to those who are about to become newly Medicare eligible. In the case of MAOs that offer a Medicaid-only product and an MA product, to be approved for seamless conversion they must include both those about to qualify for Medicare because of age and those who qualify for Medicare by reason of a disability. Plans must have the means to identify all those who are potentially eligible in advance of seamless conversion, including both the aged and individuals with a disability.
CMS noted that states can provide MAOs with a list of individuals approaching eligibility for conversion. Does CMS have any recommendations regarding how states might identify disabled individuals who are approaching their conversion date?	CMS has been having discussions with states about data sharing between state agencies and MAOs. The duals office is working on building the infrastructure to enhance state ability to access the necessary data. States can request technical assistance on accessing Medicare data from the State Data Resource Center (more information available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/State-Data-Resource-Center.html).
Some states have D-SNPs that are specific to a particular population group, such as those aged 65 and older. It would not be appropriate to seamlessly convert all individuals for this reason if the companion D-SNP plan was not appropriate for them.	Plans may not limit eligibility for seamless conversion on the basis of their eligibility for Medicare. CMS acknowledged this consideration, but noted that this concern is more of an exception than the rule.
Can a state help to facilitate seamless conversion?	Currently this process is led by the MAOs. However, CMS agrees that states can play an important role in seamless conversion by providing plans with data on eligible individuals.
How does CMS process a seamless conversion when there is a voluntary enrollment request pending with another plan?	Beneficiary-initiated enrollment takes precedence over seamless conversion, so that the beneficiary's choice is honored.
If the enrollee is entitled to only Medicare Part A or B, can they be seamlessly converted?	No, all of the basic requirements of Medicare Advantage (Part C) apply to seamless conversion, including eligibility for both Part A and B, so the enrollee must be eligible for both.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided within the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.