Integrated Care Resource Center

Aligning Coverage for Dually Eligible Beneficiaries Using Default and Passive Enrollment

Presented by: Center for Medicare and the
Medicare-Medicaid Coordination Office (MMCO)
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The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services' Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica Policy Research and the Center for Health Care Strategies.

Presenters

- **Sharon Donovan**, MMCO
- **Thomas Heiser**, Arizona Health Care Cost Containment System, Division of Health Care Management
- **Patti Killingsworth**, Bureau of TennCare, Long-Term Services and Supports

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Agenda

- Welcome and Introductions
- Overview of Medicare's Default Enrollment Process
    - Background/history of seamless conversion
    - New default enrollment starting 2019
    - State roles
    - Identifying upcoming Medicare eligibility
- Arizona's and Tennessee's Experiences
- Passive Enrollment to Retain Access to Integrated Care
- Questions and Answers
- Concluding Remarks

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Overview of Medicare's Default Enrollment Process

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Aligning Coverage for Newly Dually Eligible

- Default enrollment (formerly known as seamless conversion) is a tool for states who want to align coverage for dually eligible individuals
- Focus is on when Medicaid-only individual becomes Medicare eligible
- Connect them to the D-SNP offered by the same organization as the Medicaid MCO the person is (and will continue to be) enrolled in

Background/History of Seamless Conversion

- The Medicare Advantage seamless conversion enrollment option for newly Medicare eligible individuals was introduced in the 2006 Call Letter
  - Medicare Advantage Organizations (MAOs) were allowed to request CMS approval for a process to provide seamless enrollment in a MA plan for newly Medicare eligible individuals who are currently enrolled in other health plans offered by the MA organization (such as commercial or Medicaid plans) at the time of their conversion to Medicare
  - Had to:
    - Identify individuals 90 days in advance of Medicare eligibility
    - Send a notice 60 days before eligibility
    - Provide the ability to opt-out of the enrollment
- April 2016 – Highlighting seamless conversion as tool for integrating care
  - In the 2016 Advance Notice, CMS encouraged seamless conversion to align care for newly dually eligible individuals
    - Specifically for when an organization that offers a Medicaid Managed Care Organization (MCO) also offers a D-SNP
  - Provided guidance for how MAOs may request CMS approval, and how to work with state Medicaid agencies to receive advance notice of individuals' eligibility via the "State MMA" file exchange with CMS
- October 2016 – Moratorium on new seamless conversion proposals
  - CMS temporarily suspended its acceptance of any new seamless enrollment proposals, but permitted those already approved to continue seamless conversion (10/21/16 HPMS memo)

New Default Enrollment Starting 2019

- CMS promulgated regulations in April 2018, for 2019 contract year
  - 42 CFR 422.66(c)(2)
  - "Seamless conversion" is now "default enrollment"
  - Will be limited to
    - D-SNPs whose sponsoring organization also offers a Medicaid MCO
    - Individual in a Medicaid MCO will stay enrolled in that plan for Medicaid benefits when the individual is default enrolled into the D-SNP for Medicare benefits

Requirements for Default Enrollment

- Plans will submit request to CMS Account Manager via Medicare's Health Plan Management System (HPMS), to include verification that:
  - Person will remain in the affiliated Medicaid MCO offered by the parent organization upon becoming Medicare-eligible
  - State has approved use of default enrollment in their State Medicaid Agency Contract (sometimes called the "MIPPA" contract) with the D-SNP
  - State will provide information to the D-SNP to identify Medicaid MCO enrollees about to become Medicare-eligible

Requirements for Notifying Beneficiary

- D-SNP will provide enrollment notice to beneficiaries that includes:
  - Information on difference in premiums, benefits, and cost-sharing between beneficiary's current Medicaid MCO and the D-SNP
  - Beneficiary's ability to decline default enrollment up to day before effective date
  - Beneficiary's ability to enroll in Original Medicare and a stand-alone Prescription Drug Plan, or choose another Medicare Advantage plan
  - General description of alternative Medicare health and drug plan options
- D-SNP must be able to send the beneficiary the notice no later than 60 days before effective date

Other Default Enrollment Requirements

- D-SNP must meet the following criteria:
  - Have a minimum quality criteria of at least three stars as defined in 42 CFR 422.252
    - Or have no stars due to low enrollment or being a new plan
  - Not be prohibited by CMS to accept new enrollments

State Roles

- As noted above, MA organizations can only apply default enrollment where
  - The state approves the use of the default enrollment process through the State Medicaid Agency Contract (SMAC) with the D-SNP.
    - MA organizations seeking to offer a D-SNP must have a contract with the state Medicaid agency
    - This contract is a written, formal agreement between the D-SNP and the state Medicaid agency documenting each entity's roles and responsibilities with regard to dual-eligible individuals (see 42 CFR 422.107)
    - Default enrollment can be explicitly identified, or state may affirm its interpretation of the contract that it allows default enrollment
  - The state agrees to provide to the plan prospective Medicare eligibility information on its MCO enrollees on a monthly basis.

State Roles, continued

- If interested in pursing default enrollment with D-SNPs in your state
  - Contact MMCO early in the process for technical assistance
    - MMCOCapsModel@cms.hhs.gov
  - Reach out to the plan(s) in your state that you would like to participate in default enrollment to begin the process. This process would include:
    - Update the SMAC, or determine that the state interprets the SMAC to approve it
    - Support the plan in preparing its request package to CMS for approval
  - Determine how you will share data on upcoming Medicare eligibility for existing MCO enrollees

Identifying Upcoming Medicare Eligibility

- Challenges with identifying individuals eligible for default enrollment
  - The key challenge for states and plans has been to identify upcoming Medicare eligibility of Medicaid plan members via CMS data files in time to meet the default enrollment deadlines, i.e., sending affected beneficiaries notice of pending enrollment 60 days prior to the enrollment effective date
    - Default enrollment must be effective the first day of the month the beneficiary is eligible for Medicare Part A and enrolled in Medicare Part B
    - This has been especially challenging for those about to become eligible for Medicare because they are reaching the end of their 24-month disability waiting period
- In addition, not all Medicaid MCO enrollees will remain in the MCO once they become Medicare eligible
  - Some states complete a re-determination of Medicaid eligibility when an individual turns 65 or otherwise becomes Medicare-eligible
  - Such redeterminations must be completed in time to identify individuals who will be dually eligible for Medicare and Medicaid so the D-SNP can send the required notice 60 days prior to the effective date of Medicare eligibility
  - For example, if a Medicaid MCO enrollee has Medicare eligibility effective October 1, any state Medicaid redeterminations would need to be completed by July so that the D-SNP could send the notice by August 1.

Data to Identify Upcoming Medicare Eligibility

- The at-least-monthly "State MMA" file exchange with CMS has prospective Medicare eligibility
- CMS also provides other ad hoc, batch query options including the Medicare Enrollment Data Base (EDB) file, the Territory Beneficiary Query (TBQ) file, and Medicare-Medicaid Coordination Prospective Dual File.
- To learn more about each of these files, please contact MMCOEnrollment@cms.hhs.gov
- Once the state determines which data source to use, it should review the file at least monthly to identify the Medicaid MCOs enrollees who have a future Medicare eligibility date for both Parts A and B (as both are required for enrollment in a D-SNP)
- Finally, the state needs to determine the frequency and mechanism for sharing the data with the D-SNPs
  - It is important to establish a process that sends data on potentially eligible beneficiaries to D-SNPs in time for them to send the notice 60 days prior to the date of initial Medicare eligibility

Arizona's and Tennessee's Experiences

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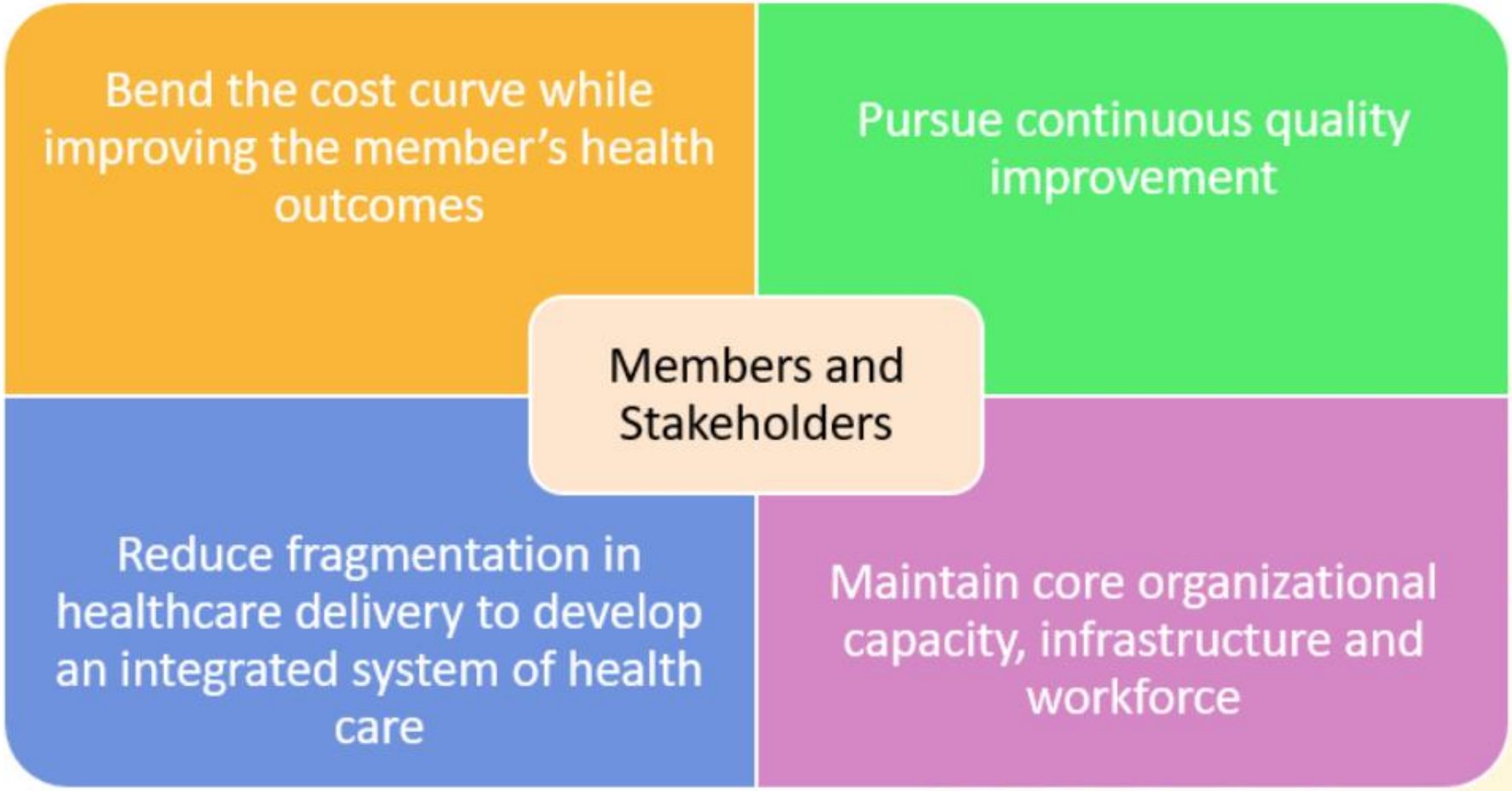
AHCCCS
Arizona Health Care Cost Containment System

Aligning Coverage for Dually Eligible Beneficiaries Using Default and Passive Enrollment

Integrated Care Resource Center Study Hall Call

Tom Heiser
Operations Compliance Officer for Medicare
Arizona Health Care Cost Containment System
July 31, 2018

AHCCCS Strategic Goals



Dual Eligibles Complexity and Fragmentation

- Fragmentation results in:
  - The member navigating multiple and confusing delivery systems
  - A lack of real-time clinical data that frustrates those trying to coordinate services on behalf of duals
  - Higher costs and poorer member health outcomes
  - Diffused accountability = Lack of accountability
  - Program cost shifting incentives, not integrated care coordination

Dual Eligibles Strategic Alignment Objectives

- Improve member health outcomes and satisfaction
- Integrate services – Single accountable entity improves care coordination
- Promote program simplicity for members/providers (single point of contact)
- Enhance appropriate community placement and services for members at risk of institutionalization
- Achieve payment modernization – Single entity encourages incentives alignment
- Impact cost curve positively (budget savings)

Arizona Duals Alignment Success

Avalere Study of Mercy Care Plan Dual Eligibles

- 31% lower rate of hospitalizations
- 21% lower rate of readmissions
- 43% lower hospital days
- 9% lower Emergency Department utilization

Default Enrollment (Seamless Conversion)

- AHCCCS identifies members who will be newly Medicare eligible for both 'age-in' and disability reasons 90+ days in advance of their Medicare effective enrollment date
- Plans are notified via the monthly 834 enrollment file
- Plans then notify potentially aligned members within 60 days of their effective enrollment date, with opt-out opportunities
- Those who opt-out of plan alignment are excluded from future alignment contact
- Since inception in 4Q2016, have successfully transitioned >7,000 default enrolled and aligned duals

Default Enrollment Process

- Why is the ability to leverage default enrollment (i.e., seamless conversion) important to your state? How does it support your policy goals?
- In what ways have you supported your D-SNPs to help them obtain CMS approval for default enrollment? What steps did you take to help plans get ready to apply?
- How have you communicated with beneficiaries about default enrollment? Do you do any education around the benefits of enrolling in aligned D-SNPs and Medicaid plans?

Default Enrollment Process Opportunities

- What challenges have you encountered in sharing data with the plans that will allow them to identify newly dually eligible beneficiaries within the timeframes required for default enrollment? How have you overcome them? Are there lessons you can share with other states?

- Have you encountered other operational challenges? Have you needed to modify Medicaid redetermination processes or timeframes?

Passive Enrollment

- Currently participating with MMCO to develop and implement tools and criteria to implement effective January 2019
- Process and procedures to be available to interested states
- Request to implement is result of AHCCCS Medicaid MCO reprocurement contract awards earlier in 2018
- Opportunity to support currently integrated duals' alignment in the D-SNP model by assigning beneficiaries to new Medicaid MCO's companion D-SNP in transitioning counties

Thank you

www.azahcccs.gov
thomas.heiser@azahcccs.gov

AHCCCS
Arizona Health Care Cost Containment System

Reaching across Arizona to provide comprehensive quality health care for those in need

Default Enrollment ("Seamless Conversion") in Tennessee

ICRC Study Hall Call - July 31, 2018

Service Delivery System in Tennessee

- TennCare managed care demonstration began in 1994
- Operates under the authority of an 1115 demonstration
- *Entire* Medicaid population (1.4 million) in managed care since 1994 (including dual eligibles and people with disabilities)
- Three health plans (MCOs) operating statewide
- Physical/behavioral health integrated beginning in 2007
- Managed LTSS began with the Statewide ***CHOICES*** program in 2010
  - Older adults and adults with physical disabilities *only*
- 3 Section 1915(c) waivers and ICF/IID services for individuals with I/DD carved out; operated by State I/DD Department (people carved in for physical and behavioral health services)
- New Statewide MLTSS program for individuals with I/DD began July 1, 2016: ***Employment and Community First CHOICES***


Key Goals

Tennessee's Policy Goals for Dual Alignment

- Improved coordination/accountability for primary/preventive, acute, behavioral, and LTSS for FBDE members
- Promote use of HCBS alternatives to institutional care
  - Vast majority of LTSS users are FBDE members
  - Medicare SNF benefit is single largest driver of Medicaid NF utilization
- Achieve measurable improvements in health and quality of life outcomes
- Slow the rate of growth of Medicaid and Medicare expenditures for FBDE members
- Most importantly, improve care and experience for FBDE members that is sensitive to member needs and preferences

Dual Alignment

- Tennessee leverages Medicare Part C authority and the D-SNP platform to align enrollment of full benefit dual eligible (FBDE) members in the same health plan for Medicare and Medicaid benefits
- TennCare MIPPA Agreements with Medicaid MCOs for their D-SNPs since:
  - 2010 – United HealthCare
  - 2010 – Amerigroup/Anthem (limited geographic area initially)
  - 2012 – Blue Cross Blue Shield of Tennessee

Dual Alignment

- As part of most recent Medicaid procurement in late 2013 (effective January 1, 2015):
  - Tennessee requires Medicaid MCOs to offer companion D-SNPs
  - Alignment of enrollment for FBDE members was prioritized for FBDE members, reassigning FBDE members to a Medicaid acute and MLTSS plan aligned with their Medicare D-SNP, whenever possible (with opt out permitted)
- All 3 Medicaid MCOs' companion D-SNPs approved for and seamlessly enroll Medicare members into their aligned D-SNP product upon the member's attaining Medicare eligibility as of:
  - 2015 – Amerigroup/Anthem
  - 2016 – Blue Cross Blue Shield of Tennessee
  - 2017 – United HealthCare

Default Enrollment

- Default enrollment has been a critical aspect of achieving enrollment alignment
- TennCare encourages/supports, but does not contractually require default enrollment
  - Reviewed plan's applications prior to CMS submission
  - Upon approval and prior to implementation, conducted extensive readiness review process to ensure plans could satisfy required timelines for beneficiary notification, etc.

Tracking D-SNP Enrollment and Alignment

- Began tracking in December 2013
- D-SNP Enrollment
  - 66% increase 4 ½ years
  - 39,941 as of 12/31/13 to 66,204 as of 7/1/18
  - 29.6% of FBDEs to 46.7% of FBDEs

- Medicaid MCO/D-SNP Alignment
  - Number and percent of duals in an aligned D-SNP has also increased
  - 77% increase in aligned duals
  - 23,271 as of 12/31/13 to 41,096 as of 7/1/18
  - Of FBDEs in a D-SNP, 62.1% are aligned

Tracking D-SNP Enrollment and Alignment

- D-SNP enrollment and alignment vary significantly by plan:

MMCO/D-SNP	D-SNP Members	% of D-SNP members aligned
Amerigroup/Anthem	16,353	43.3%
BlueCare	20,247	40.4%
United HealthCare	29,604	**87.3%**

- ~500 members enrolled per month
- Opt outs prior to enrollment date and rapid cycle disenrollments (occurring in the first 90 days post enrollment) vary by plan and month, but overall very low

What is TennCare's Role?

Role of the State Medicaid Agency

- **TennCare takes an active role in supporting default enrollment processes:**
  - Obtain prospective Medicare enrollment dates for FBDEs from CMS
  - Provide prospective Medicare enrollment dates for FBDEs to Medicaid MCOs/D-SNPs
  - Send a letter to prospective duals advising of default enrollment, benefits of alignment, ability to opt out (prior to enrollment or at any time)
  - Send an education letter if default enrollment cannot be effectuated timely

Role of the State Medicaid Agency

TennCare also leverages MIPPA agreements to help ensure continuity of care for FBDEs at default enrollment:

- 30 day continuity of care period for all FBDEs seamlessly enrolled (regardless of providers' network participation), extended as necessary to allow time for completion of Health Risk Assessment, network contracting, or seamless transition to network providers
- Requirement to develop a provider network that specifically targets substantial overlap of D-SNP providers with its TennCare MCO to ensure seamless access to care for FBDE members who are seamlessly enrolled in the D-SNP plan
  - Ongoing monitoring of network overlap by TennCare
  - High degree of network overlap, especially among PCPs
  - 98%+ continuity of PCPs at expiration of COC period
  - Continuity of care for specialty providers also high (after targeted network enrollment, single case agreements, etc.)

Role of the State Medicaid Agency

TennCare also leverages MIPPA agreements to help ensure continuity of care for FBDEs at default enrollment:

- Required reporting of continuity of care for Primary Care Providers and certain Specialists for members seamlessly enrolled
  - Cardiologist
  - GI
  - Pulmonologist
  - Endocrinologist
  - Nephrologist
  - Oncology/Radiation
  - Infectious disease
  - Rheumatology
  - Wound Care Specialist

Operational Challenges

- Identifying complete information on disabled members from the CMS files in order to effectuate default enrollment timely
  - Continuing to work with CMS to improve data processes
  - Transition from SSN/HICN to MBI

Passive Enrollment to Retain Access to Integrated Care

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New Passive Enrollment Authority for 2019

- CMS promulgated regulations in April 2018, for 2019 contract year
  - 42 CFR 422.60(g)
  - Expanded authority for CMS to conduct passive enrollment, after consulting with the state Medicaid agency, to promote integrated care and continuity of care for a full-benefit dual eligible beneficiaries who are currently enrolled in an integrated dual eligible special needs plan.

Passive Enrollment

- Intended to address the limited circumstance in which integrated care coverage would otherwise be disrupted, such as:
  - during a state re-procurement of Medicaid managed care contracts that results in current Medicaid managed care plans not being renewed,
  - when beneficiaries are enrolled in an integrated D–SNP that non-renews its MA contract at the end of the contract year, or
  - When D-SNP eligibility criteria change and certain enrollees no longer meet them
- This authority does not apply when dually eligible individuals are in Medicaid and/or Medicare fee-for-service
  - Cannot use it to newly move individuals into managed care

Plan Requirements for Passive Enrollment

- Operate as a fully integrated special needs plan as defined in 42 CFR 422.2, or a dual eligible special needs plan that meets a high level of integration, as described in §422.102(e).
- Have substantially similar provider and facility networks and Medicare- and Medicaid-covered benefits as the plan (or plans) from which the beneficiaries are passively enrolled.
- Have an overall quality rating from the most recently issued ratings, under the rating system described in 42 CFR 422.160 through 422.166, of at least 3 stars or is a low enrollment contract or new MA plan as defined in §422.252.
- Not have any prohibition on new enrollment imposed by CMS.
- Have limits on premiums and cost-sharing appropriate to full-benefit dual eligible beneficiaries.
- Have the operational capacity to passively enroll beneficiaries and agree to receive the enrollments.

Requirements for Notifying Beneficiary

- The MA plan must provide two notices, one no fewer than 60 days and the second no fewer than 30 days in advance of the enrollment effective date.
- Each notice must describe the costs and benefits of the plan and the process for accessing care under the plan and clearly explain the beneficiary's ability to decline the enrollment or choose another plan.

Resources

- For additional details please see:
  - Medicare Managed Care Manual, Chapter 2: Medicare Enrollment and Disenrollment (note: these sections will be updated in the near future for the new regulator requirements)
    - Section 40.1.4 Default Enrollment Option for Medicaid Managed Care Plan Enrollees who are Newly Eligible for Medicare Advantage
    - Section 20.4.2 Passive Enrollment by CMS
  - Default Enrollment FAQs
  - CMS Files That Provide Data to States on Upcoming Medicare Eligibility

About ICRC

- Established by CMS to advance integrated care models for dually eligible beneficiaries
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send other ICRC questions to: integratedcareresourcecenter@chcs.org

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