Integrated Care Resource Center

Enrollment Processing and Strategies to Grow Enrollment for States Participating in the Capitated Model Financial Alignment Initiative

Presented by: Medicare-Medicaid Coordination Office (MMCO)

February 22, 2018

2:00-3:00 pm Eastern Time

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.

Agenda

- Introduction - Enrollment in the MMPs for the Capitated Model Financial Alignment Initiative (FAI) “Duals Demonstrations”
- Enrollment Related Transaction Processing
- Passive Enrollment of Newly Eligible Dual Beneficiaries:
  - “Medicaid first” (those gaining Medicare)
  - “Medicare first” (those gaining Medicaid)
  - Other newly eligible beneficiaries
- Reconciliation
- Strategies to Grow Enrollment
- Questions

Integrated Care Resource Center

Presenters

- Anne Gilbert, MMCO
- Andrea Cunningham, MMCO

Integrated Care Resource Center

Introduction - Enrollment in the MMPs for the Capitated Model Financial Alignment Initiative (FAI) “Dual Demonstrations”

Background

- To enroll individuals into Medicare-Medicaid Plans (MMPs), states participating in the Capitated Model of the Financial Alignment Initiative (FAI) exchange enrollment related transactions with the Centers for Medicare & Medicaid Services' (CMS') Medicare Advantage Prescription Drug (MARx) System to complete the enrollment process
- This presentation provides an operational overview of enrollment processing and strategies to grow enrollment
- Information on enrollment policy and further guidance pertaining to enrollment processing can be found in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPEnrollmentManual090216.pdf

Enrollment Related Transaction Processing

Enrollment Transaction Background

- When a state/enrollment broker submits an enrollment file to the CMS MARx system (via the demonstration enrollment vendor), the enrollment file contains a transaction code (TC) designating the type of action, such as enrollment or disenrollment, being requested
- The CMS MARx system processes the TC per the action requested and sends back a Daily Transaction Reply Report (DTRR) within 24 hours
- The DTRR includes responses – called transaction reply codes (TRCs) – to the transactions submitted by the state, as well as transactions generated by MARx that need to be reviewed by the state
  - The TRCs for the transactions may indicate additional updates in information or may require immediate action from the state

MARx Enrollment TCs and TRCs

TCs submitted by States/Enrollment Brokers include:

Transaction Code	Description
51	Disenrollment
61	Enrollment
81	Cancellation of Disenrollment
82	MMP Enrollment Cancellation
83	MMP Opt-Out Update

Examples of TC/TRC Combinations

TC	TRC	Initiated	Type	Definition	Action as necessary
61	011	State	Accepted	This TRC is a successful MMP enrollment Opt-in transaction.	The beneficiary is enrolled in coverage. No action necessary from the State
61	016	State	Informational	The beneficiary's residence state and county codes placed the beneficiary outside of the Plan's approved service area.	The beneficiary is enrolled in coverage. State should confirm beneficiary's residence state and county codes.
51	013	State	Accepted	This TRC indicates a successful disenrollment transaction.	The beneficiary is disenrolled from coverage. No action is necessary from the State.
81	022	State	Informational	The Medicare claim number for this beneficiary has changed. Use the new claim number going forward.	The disenrollment has been successfully cancelled. State should use the new Medicare claim number going forward.
82	312	State	Accepted	This TRC is a successful MMP cancellation transaction. When an enrollment is cancelled, it means that the enrollment never occurred.	The beneficiary has been successfully cancelled. No action necessary from the State.
83	311	State	Accepted	The MMP Opt-Out Flag was accepted.	The beneficiary has opted-out from MMP passive enrollment.

MMP Opt-Out Flag

- Individuals may request to opt-out from passive enrollment, which would remove the individual from coverage, and individuals may request to be excluded from passive enrollment.
- For individuals who request to cancel enrollment at any point prior to the passive enrollment effective date, the State must send:
  - An enrollment cancellation transaction (TC 82) to cancel the passive enrollment; and
  - An MMP opt-out flag data element set to "Y" in position 202 to request to be excluded from future passive enrollments into an MMP.
- Individuals may request to be excluded from passive enrollment at any time. States should either:
  - Include the MMP opt-out flag as a data element on a TC 51, 61, 81 or 82; or
  - Submit a TC 83 with the MMP opt-out flag.
- In all cases, states must store MMP opt-out flags in their state system to exclude the individuals from future passive enrollments, including when a state system is unable to submit a MMP opt-out flag to CMS.
  - States must carve out individuals with MMP opt-out flags from passive enrollments.

Enrollment Transaction Resources

- Guidance on how to submit transactions can be found in the MMP Enrollment Technical Guidance at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPEnrollmentTechnicalGuidance28.pdf

- The full list of all TCs and TRCs (including those that do not apply to MMPs) as well as transaction requirements, file layouts, and reports is available in the Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) at: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html

- An Enrollment Reconciliation Toolkit is available that includes a TC/TRC mapping chart as well as a "cheat sheet" of common TR/TRC combinations for MMPs. The toolkit is available on the InfoCrossing website: https://www.medicare-solution.com/mss/home/Index.jsp

Passive Enrollment of Newly Eligible Dual Beneficiaries

On-Going Passive Enrollment Opportunities

- Each month over 100,000 individuals become newly Medicare-Medicaid eligible
- In addition, existing dually eligible individuals may become newly eligible for passive enrollment
  - Newly eligible to enroll in Medicare-Medicaid Plans (MMPs)
  - Newly re-eligible for passive enrollment
- Passive enrollment connects them with integrated care

Those Who May Be Passively Enrolled

States may passively enroll certain groups, on monthly basis or greater, throughout the year. These groups include:

- Individuals who have "Medicaid first":
  - Individuals who already have Medicaid
  - Age into Medicare (turning age 65) or
  - Reach the end of their Medicare 24-month disability waiting period
- Individuals who have "Medicare first":
  - Individuals who already have Medicare
  - Apply and qualify for Medicaid
  - Comprise the majority of new Medicare-Medicaid eligible individuals
- Existing dually eligible individuals who become newly eligible to enroll in MMPs:
  - Move into a demonstration service area, and were not auto-enrolled or re-assigned by Medicare effective the current calendar year; or
  - Are no longer in an excluded category for passive enrollment (examples vary by state, but can include a change in the Medicaid eligibility category, such as no longer in Medicaid spend-down status).

Those Who Can Be Passively Enrolled the Next Calendar Year

- For other groups, States must wait until close to the end of the current calendar year due to the policy of only passively enrolling a person once a year.

- This also includes individuals who:
  - Were passively enrolled and involuntarily disenrolled from an MMP during the current calendar year, e.g., due to short term loss of Medicaid;
  - Had been reassigned by Medicare effective January 1st of the current year;
  - Are newly dually eligible and had been auto-enrolled by Medicare into a Prescription Drug Plan during the current year.

"Medicaid First" Passive Enrollments

- Individuals enrolled in Medicaid who gain or "age in" to Medicare may be passively enrolled
- What's different about "Medicaid first" passive enrollments:
  - Effective date = Start date of Medicare A&B
  - Timing of passive transaction to CMS' MARx enrollment system is slightly different:
  - 63 days or more in advance of effective date (Otherwise, passive enrollment will be trumped when CMS auto-enrolls the individual into a PDP starting day 62)
- What remains the same:
  - Identify eligible individuals; carve out ineligible individuals (including those who have an MMP opt-out flag)
  - Send 60-day and 30-day passive enrollment letters
  - Individuals retain the right to opt-out
  - Application date = date of submission to MARx

Identifying Those Gaining Medicare

- States should submit a Batch Eligibility Query (BEQ) Request File to obtain eligibility information for prospective MMP enrollees.
  - The file is used to conduct initial eligibility checks against the CMS MBD system to verify an individual is Part A, B, and Part D as well as further screen to determine if an individual is eligible for passive enrollment.
- States are also able to submit a Territory Beneficiary Query (TBQ) Request File in order to request eligibility information. The file is available between CMS and states only.
- States may leverage the following files containing early notification of individuals gaining Medicare (Part A, B, and eligible for Part D) to identify Medicare first or prospective dual individuals:
  - MMA "PRO" record file – CMS returns any upcoming Medicare eligibility, usually 4-5 months in advance of the start date;
  - The dual demonstration's prospective dual file – This tool provides a list of dual eligible individuals 3-5 months in advance of the Medicare start date.

Dual Demonstration
Prospective Duals File

- The capitated financial alignment model prospective duals file is designed to provide a list twice a month of new dual eligible beneficiaries in a given state.
- The state would then further screen to determine if an individual is eligible for passive enrollment (e.g., in the service area, not in an excluded population, has not been auto-enrolled by CMS into a PDP)
- The capitated financial alignment model prospective duals file includes three key data elements:
  - Medicare Part A start date
  - Medicare Part B start date
  - Enrollment Source Code
- The file is transmitted twice a month (1st and 15th of the month)
- The file is available at https://www.medicare-solution.com
- For more information on the capitated financial alignment model prospective duals file, see ICRC's November 2016 webinar:
  - http://www.integratedcareresourcecenter.com/PDFs/ICRC_SHC_Prospective_New_Duals_Process_11-17-16%20for%20508.pdf (Slides)
  - https://chcs.webex.com/chcs/lsr.php?RCID=e8c251583f5c4c3db3c46ea845420e68 (Recording)
  - http://www.integratedcareresourcecenter.com/PDFs/NewDualsID_FAQ_04-04-17.pdf (FAQ document)

"Medicare First" Passive Enrollments

- Individuals in Medicare (Part A, B, and eligible for Part D) who gain Medicaid eligibility
- What's different about "Medicare first" passive enrollments:
  - Individuals who were auto-enrolled by CMS into a Part D plan for the current calendar year or reassigned by CMS as of January 1st into a PDP cannot be passively enrolled until the following year
- What remains the same:
  - Identify eligible individuals; carve out ineligible individuals (including those who have an MMP opt-out flag)
  - Send 60-day and 30-day passive enrollment notices
  - Individuals retain the right to opt-out
  - Application date = date of submission to MARx

Identifying Those Currently in Medicare

- Each month, identify those who already have a Part D plan
- Use MMA Response file or TBQ query or BEQ query
- Select those with enrollment source code = B, D, G, or I

Data Field	Position	Length	Valid Values
Beneficiary Enrollment Type Code	2425	1	B – Beneficiary election D – System-generated enrollment (Rollover) G – Point of sale (POS) submitted enrollments I – Assigned to plan submitted transactions with enrollment source other than any of the following: B, E, F, G, H, and blank

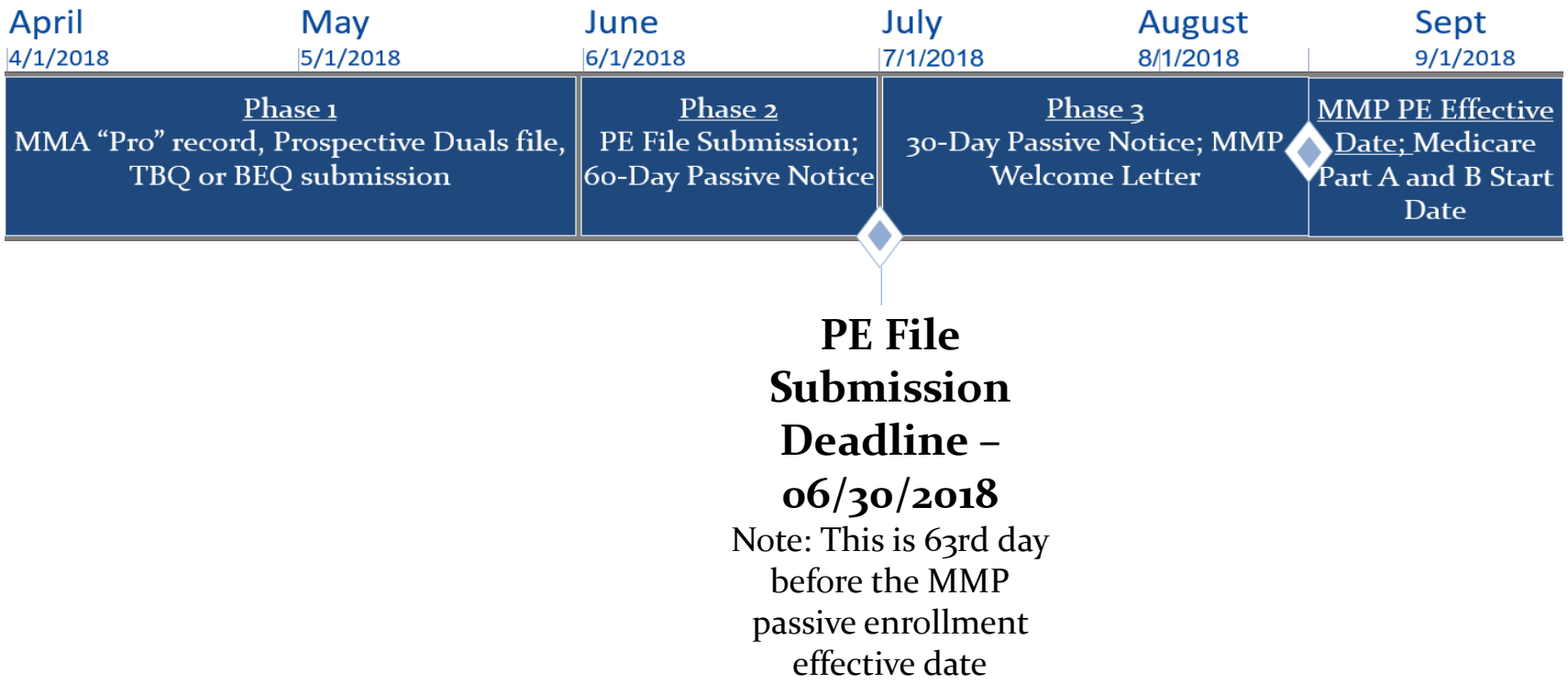
- Identify those who are demonstration eligible (e.g., service area), and exclude those who need to be carved out of passive enrollment (e.g. MMP opt-out flag)
- Follow standard passive enrollment process of sending passive transaction to CMS, and 60-day and 30-day notices to beneficiaries in advance of effective date

Existing Beneficiaries Who Are Newly Eligible for Passive Enrollment

- Apply the same processes for existing beneficiaries who are newly eligible as for passively enrolling existing Medicare-Medicaid beneficiaries:
  - Identify demonstration eligible individuals, and carve out those excluded from passive enrollment
  - Submit passive transaction to CMS and send 60-day and 30-day notices to beneficiary in advance of the effective date
  - State and CMS coordinate on enrollment actions taken on behalf of beneficiary to only move them once in a calendar year

Overview of Passive Enrollment Timeline

- Example: Passive Enrollment (PE) Effective Date – 9/1/2018



Passive Enrollment Phase 1

April	May	June	July	August	Sept
4/1/2018	5/1/2018	6/1/2018	7/1/2018	8/1/2018	9/1/2018
Phase 1 MMA "Pro" record, Prospective Duals file, TBQ or BEQ submission		Phase 2 PE File Submission; 60-Day Passive Notice	Phase 3 30-Day Passive Notice; MMP Welcome Letter		MMP PE Effective Date; Medicare Part A and B Start Date

- Begins 4-5 months before the PE effective date
- The key to successfully identifying individuals is the timing of MMA "Pro" record, Prospective Duals file, TBQ or BEQ files. **Please request files as close to the date of the passive enrollment (PE) submission as possible or check updated files before submitting the PE file.**
- Include the following individuals:
  - Full Medicaid eligible beneficiaries age 64 and 7 months or more
  - Individuals eligible for Medicaid because of disability (This is to identify individuals who are nearing the end of their Medicare 24 month disability waiting period)
- Identify those who are demonstration eligible (e.g., service area), and exclude those who need to be carved out of passive enrollment

Passive Enrollment Phase 2

April	May	June	July	August	Sept
4/1/2018	5/1/2018	6/1/2018	7/1/2018	8/1/2018	9/1/2018
Phase 1 MMA "Pro" record, Prospective Duals file, TBQ or BEQ submission		Phase 2 PE File Submission; 60-Day Passive	Phase 3 30-Day Passive Notice; MMP Welcome Letter		MMP PE Effective Date; Medicare Part A and B Start Date

- Once states have determined MMP eligibility, plan to submit the passive enrollment (PE) file between 63-90 days in advance of the MMP enrollment effective date
  - "Medicaid first"/new duals gaining Medicare no later than the 63rd day in order to beat the CMS auto-enrollment into a PDP, which begins on the 62nd day
- Application date must be the date of submission to MARx for this PE file submission
- States mail the 60-day passive notices 60 days in advance of the MMP Passive Enrollment Effective Date

Passive Enrollment Phase 3

April	May	June	July	August	Sept
4/1/2018	5/1/2018	6/1/2018	7/1/2018	8/1/2018	9/1/2018
Phase 1 MMA "Pro" record, Prospective Duals file, TBQ or BEQ submission		Phase 2 PE File Submission; 60-Day Passive Notice	Phase 3 30-Day Passive Notice; MMP Welcome Letter		MMP PE Effective Date; Medicare Part A and B Start Date

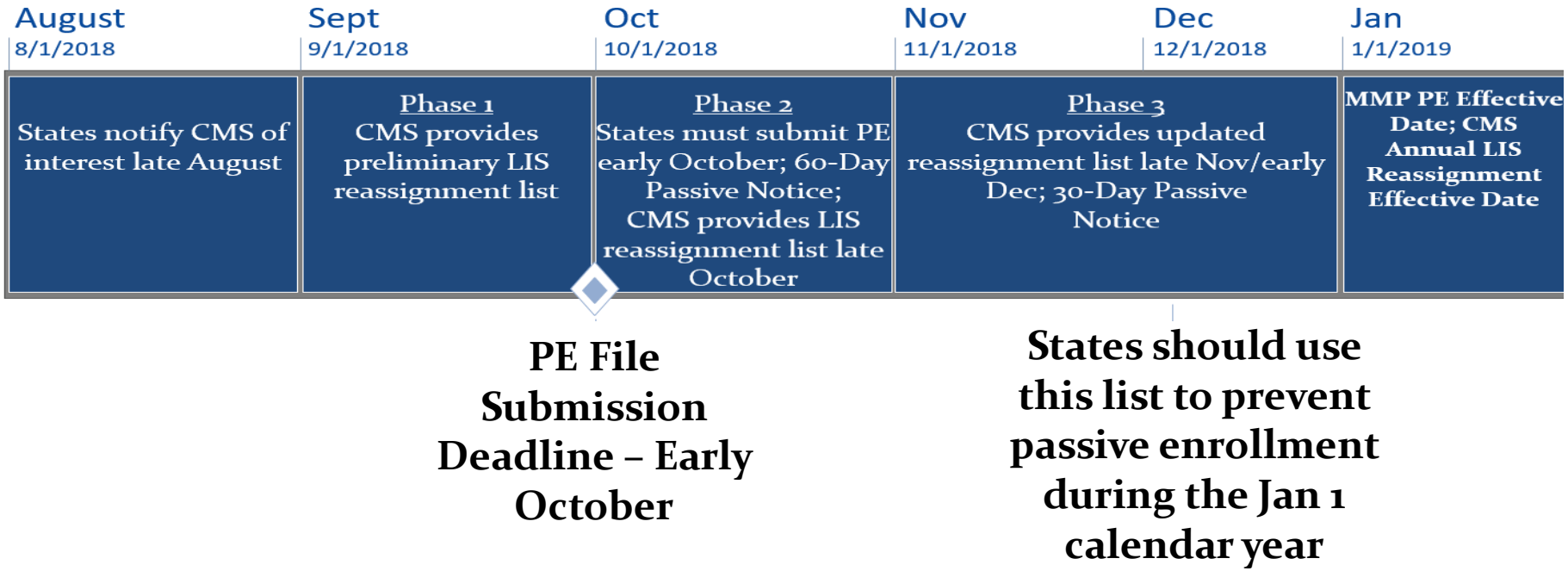
- Individuals have two months to learn about the MMP and what benefits/services are offered
  - Individuals can call the state call centers, ombudsman, and SHIP to ask questions and discuss other plan choices or make changes (e.g., choose another MMP and/or choose to opt-out)
- States mail the 30-day passive notices 30 days in advance of the MMP passive enrollment (PE) effective date
- MMPs mail the Welcome Letter from the plan
- Individuals can choose another MMP or opt-out up until the day before the PE effective date, i.e. until midnight 8/31/2018

Annual Passive Enrollments

- States may conduct passive enrollments on an annual basis for individuals newly eligible or re-eligible for MMP enrollment
- In addition, States may coordinate passive enrollment with the CMS annual LIS reassignment in order to passively enroll eligible beneficiaries into MMPs for January 1
- If a beneficiary is identified as being reassigned to a PDP as part of CMS LIS reassignment, and a state intends to passively enroll the same beneficiary into an MMP effective for any month after January 1 within the same calendar year, the State must either:
  - "Move up" the passive enrollment of that beneficiary to be effective January 1, and include the transaction in the early October enrollment submission window for LIS reassignment coordination, or;
  - Wait to passively enroll the beneficiary until the next calendar year.

Overview of PE Coordination with Annual LIS Reassignment Timeline

- CMS releases guidance yearly during the summer on the annual LIS coordination.
- Example: Passive Enrollment Effective Date for Coordination with Annual LIS Reassignment – 1/1/2019



PE Coordination Phase 1

- CMS provides the preliminary list of re-assignees to States
- States match their eligible population for passive enrollment to this list
- States may also include in the annual passive enrollment for the new plan year the following:
  - Those who were involuntarily disenrolled from an MMP during the previous calendar year, e.g., due to short term loss of Medicaid;
  - Those who were reassigned by CMS to a PDP effective January 1 of the current calendar year and do not have an MMP opt-out flag; or
  - New dually eligible individual auto-enrolled by CMS to a PDP effective any month in current calendar year (reference in section above as needing to be carved out of any monthly passive enrollment for those newly dually eligible who already have Medicare).
- Additionally States can include "Medicaid-first", "Medicare-first", and newly eligible individuals

PE Coordination Phase 2

- Once states have identified those to be included, target the PE file enrollment submissions in early October
  - Need to beat the timing of Medicare reassignment
  - Application date = date of submission to MARx
  - Effective date must be January 1st for this PE file submission
- States must review DTRR responses to submitted transactions and resubmit corrections as needed by indicated cutoff date
- **States send their 60-day passive notices earlier, around day 90**
  - Coincide with transaction submitted to MARx
  - Ensure the passive enrollment notice arrives before PDP disenrollment letter is sent to beneficiary

PE Coordination Phase 3

- In mid to late October, states will receive the annual LIS reassignment list of those beneficiaries auto-enrolled by CMS to a PDP for Jan 1
- Up until the day before the effective date – beneficiaries have three months to learn about the MMP and what benefits/services are offered. Beneficiaries can call the state call centers, ombudsman, and SHIP to ask questions and discuss other plan choices
- Beneficiaries can makes changes, such as to choose another MMP or opt-out
- In late October/early December, States will receive a updated list of CMS reassigned beneficiaries
  - State must not passively enroll anyone on this list until an effective date of January 1 the year after
- States send their 30-day passive notices 30 days in advance

Reconciliation

States Role in Reconciliation

- Reconciliation involves states identifying and remediating outstanding enrollment discrepancies on at least a monthly ongoing basis in order to align CMS' MARx enrollment system and States'/enrollment brokers' enrollment systems
  - States should also engage with MMPs to identify enrollment discrepancies
- States should utilize the DTRR as well as additional resources such as:
  - State created databases: Such as a Microsoft Access database, information is available at: http://www.integratedcareresourcecenter.com/PDFs/ICRC%20SHC%20Using%20Microsoft%20Access%20(Final)%20for%20508%20review.pdf.
  - Full Enrollment File (FEF): A monthly file providing a list of beneficiaries CMS has as enrolled in an MMP. Available for download through MARx https://eidm.cms.gov
  - "Enroll Recon" tool: An ad hoc "recon file" that contains a point-in-time snapshot of Plan enrollment for each month retroactive to the start of a State's demonstration https://www.medicare-solution.com
- Reconciliation includes putting in place procedures to quickly identify any new discrepancies that may arise in the future

Reconciliation Processing

- States should submit the necessary transactions to resolve discrepancies as soon as the discrepancy is identified
  - Discrepancies needing to be corrected in the MARx system, and identified within 60 days of the transaction occurring, can be resolved by submitting transactions to CMS MARx
  - Discrepancies within MARx occurring more than 60 days prior require a retroactive file submission to the CMS Retroactive Processing Contractor (RPC), Reed & Associates

Retroactive Enrollment Processing

- States/enrollment brokers should use the eRPT system to submit retroactive enrollment changes
- The Reed & Associates website has more information about the retroactive submission process, see: http://www.reedassociates.org/
- A training webinar conducted by the CMS Retroactive Processing Contractor (RPC), Reed & Associates, has information on submitting retroactive enrollment requests via eRPT, see: https://chcs.webex.com/chcs/lsr.php?RCID=0a25204542da463193b658ea5812209c

Strategies to Grow Enrollment

State Activities to Grow Enrollment

- States have a range of options to sustain and grown enrollment in MMPs. Below is a snapshot of those underway to date.

Gray = Currently Operational
White = Not Operational

State	Ongoing Passive Enrollment	Annual Passive Enrollment Jan 1	State Outreach to Those Who Elected to Opt Out of Passive	Early MMP Welcome Call/Outreach to Passive Enrollees*	Deeming	Rapid Re-Enrollment
California						
Illinois	Monthly					
Massachusetts	Quarterly					
Michigan	Monthly					
New York FIDA						
New York FIDA-IDD						
Ohio	Monthly					
Rhode Island	Quarterly					
South Carolina	Monthly					
Texas	Monthly					

*Early welcome calls/outreach is for communication with the beneficiaries on the upcoming coverage change and does not include early Health Risk Assessments.

Resources

- **Medicare-Medicaid Plan (MMP) Enrollment and Disenrollment Guidance**: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPEnrollmentManual090216.pdf
- **Monthly Ongoing Passive Enrollment (PE):** Information on monthly ongoing passive enrollment can be found in § 30.2.5 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, specifically § 30.2.5.C, page 23. Please note in particular the following sub-sections under § 30.2.5:
  - K (page 29) For States That Conduct Passive Enrollment For Effective Dates After January 1 (Non-January Effective Dates);
  - L (page 29) Newly Dually Eligible Individuals Who Had Medicaid First; and
  - M (page 29-30) Newly Dually Eligible Individuals Who Had Medicare First.
- **Annual Passive Enrollment (PE):** In lieu and/or in addition to monthly ongoing passive enrollment, states may participate annually in submitting passive enrollments effective January 1st. Information on annual passive enrollment can be found in § 30.2.5.D, pages 23-24 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. Please note in particular the following sub-sections under § 30.2.5:
  - J (page 27) Coordinating enrollment into Medicare-Medicaid Plan (MMP) with Medicare Prescription Drug Plan (PDP) Reassignment,
  - K (page 29) For States That Conduct Passive Enrollment For Effective Dates After January 1 (Non-January Effective Dates);
  - L (page 29) Newly Dually Eligible Individuals Who Had Medicaid First; and
  - M (page 29-30) Newly Dually Eligible Individuals Who Had Medicare First.

Resources Continued

- **State Outreach to Those Who Elected to Opt Out of Passive Enrollment:** States may conduct outreach and education on the benefits of enrolling in an MMP to those who have previously opted-out of passive enrollment into an MMP. Please see section §30.2.4, page 19, of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance for more information.

- **Early MMP Welcome Call/Outreach to Passive Enrollees:** for guidance regarding Telephonic Contacts please see § 70.6, pages 45-46, of the Medicare Marketing Guidelines at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2017MedicareMarketingGuidelines2.pdf; as well as relevant sections of state-specific MMP marketing guidance. As a reminder, MMPs may not complete Health Risk Assessments at the same time as the Early Welcome Call. Please refer to §30.3.E, pages 33-34, of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance for more details about HRA.

- **Deeming:** An MMP may choose to provide a deemed continued eligibility period for individuals who lose Medicaid eligibility, as long as the individual can reasonably be expected to regain Medicaid eligibility within specified period outlined in each State's Appendix 5. Details can be found at § 40.2.3.2, pages 56-57, of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

- **Rapid Re-Enrollment:** If an individual is involuntarily disenrolled due to a loss in Medicaid, States may rapidly re-enroll the individual back into his/her original MMP. Rapid re-enrollment can only occur if the individual regains their Medicaid no more than 2 months from the effective date of disenrollment. Please see §40.2.3.3, pages 57-58, of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance for more information.

Contacts

- Send enrollment policy and operations questions to your MMCO enrollment lead or to MMCOEnrollment@cms.hhs.gov
- Send questions related to the CMS capitated financial alignment model enrollment processing vendor (InfoCrossing) to MCareSupport@wipro.com or call (877) 833-3499

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

ICRC
Integrated Care Resource Center