Medicare-Medicaid Plan (MMP) Enrollment -- Overview

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Agenda

- Overview of final Enrollment Guidance
  - Enrollments
    - Passive
    - Voluntary
  - Cancellations, Disenrollments, and “Opting Out”
    - Beneficiary-initiated
    - Involuntary
  - Emphasis on policy/procedures
    - With notes on operations

References Cited

- References in each slide's header
  - "§" refers to section number in the Enrollment Guidance itself
- "Days" means calendar days

Overall Framework

- States will be responsible for enrollment process
  - "State" includes State's enrollment broker
  - In limited instances and with CMS approval, may delegate certain functions to Medicare-Medicaid Plans (MMPs), but cannot delegate
    - Passive enrollment
    - Collecting health-related information during voluntary enrollment process
    - Involuntary disenrollments
  - Exceptions – 1-800-MEDICARE will process requests for disenrollments, cancellation of disenrollments, and opt-outs
    - They will refer all other enrollment-related requests to the State
- Guidance is national level
  - State-specific variations will be in Appendix 5

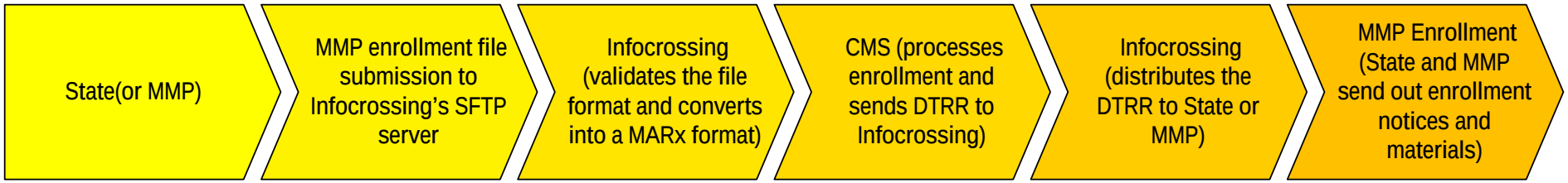
Operational Notes

- States need to send enrollment-related notifications to CMS' MARx enrollment system
- Will use CMS-designated enrollment vendor (Infocrossing)
  - If State delegates any enrollment functions to an MMP, that MMP must also use Infocrossing

CMS Transaction Processing

- CMS system processes transactions daily
  - Provides a daily transaction reply report (DTRR)

- Basic flow of enrollment transactions:



Passive Enrollment

Identify Passive Enrollees
(§§ 10, 30.1.4.A)

- Have Medicare Part A and Part B
- Are eligible to enroll in a Medicare Part D plan
- Have full Medicaid eligibility
- Permanently reside in MMP service area
- Meet additional State-specific inclusion criteria (Appendix 5)

  Note: If State permits individuals with ESRD to enroll, see additional procedures in §30.2.4

Excluding Individuals from Passive Enrollment (§30.1.4.A)

- Are enrolled with a PACE organization
- Have employer or union sponsored health or drug coverage – **see §30.2.6**
- Have a Medicare Retiree Drug Subsidy (RDS) – **see §30.2.5**
- Are confined in a correctional facility
- Have opted out from passive enrollment or Part D auto-enrollment
- Meet additional State-specific exclusion criteria (Appendix 5)

Ways to Check Medicare Eligibility
(§§ 20.1, 30.1.4 F., 30.2)

- Infocrossing provides a Medicare eligibility query service to confirm Medicare entitlement status
- State may also use:
  - ❖ State Medicare Modernization Act (MMA) Response – batch process
  - ❖ Territory Beneficiary Query (TBQ) Response – ad hoc query option – batch process
  - ❖ MARx online query –State who have been given access to CMS MARx system can see real-time Medicare data (but only one Medicare record at a time)

Optional Initial Outreach Notice
(§ 30.1.4.B)

States may send an initial outreach notice to potential enrollees

- Introduce the program
- Identify resources, e.g., State/enrollment broker, Ombudsman, SHIP, ADRC

Assign to MMP
(§30.1.4 B)

- State attempts to assign beneficiaries to an MMP that best meets their needs, based on more frequently and recently used providers
  - If person already enrolled in Medicare Advantage plan or Medicaid Managed Care Organization that also offers MMP in same service area, State may enroll person in that MMP
- May not passively enroll individuals in MMP with poor past performance in Medicare

State Notifies Beneficiary (§30.1.4.D)

- 60 days before effective date
  - State notify beneficiary of passive enrollment, including:
    - MMP assigned
    - Other options
    - How to opt out of passive enrollment
    - Who to contact for more support and information

State Submits Files to CMS and MMP (§30.3)

- 60 days before passive enrollment effective date, State
  - Sends enrollment file to Infocrossing to send CMS
    - » Enrollment source code = J (State-submitted passive enrollment)
    - » Application date
      - If passive effective date is January 1, use October 14
      - Otherwise, use date of transaction submission to CMS
    - » See MMP Technical Manual for additional details
- Submits 834 Benefit Enrollment and Maintenance file to MMP, with address

Infocrossing Batch Transaction Processing

- Infocrossing performs:

- File format check and data validation
  - Sends back rejected records to States that have errors or mismatchs for correction and re-submission
- Eligibility check against the Medicare Beneficiary Database (MBD)
  - Sends back records determined ineligible to States
- Once the record passes these checks, Infocrossing creates an enrollment transaction (TC 61) in MARx format and send it to CMS

CMS Processing and Response

- CMS returns a DTRR to Infocrossing
  - Infocrossing sends to State and MMP simultaneously
- DTTR has Transaction Reply Codes (TRCs) indicating if record was processed successfully, or rejected
  - Accepted: State and MMP should update their records, as appropriate
  - Rejected: TRC indicates why enrollment could not processed and whether an action is needed by State or MMP
- Infocrossing also updates their Web Portal to allow State or MMP users to view the DTRR
- For details on DTRR file layout and valid values, please see PCUG Main Guide and Appendices

Transaction Rejects

- Transaction Reply Code (TRC)
  - Refer to TRC table (page I-2) of the PCUG Appendices
    - » Shows recommended action, to either
      - Take corrective action and re-submit the transaction, or
      - Understand why enrollment cannot be processed based on reason shown in TRC
- Required beneficiary notices
  - See Appendix 4 for required notices and timeframes

MMP submits 4Rx Data (§30.1.4.J.)

- 4Rx Data – Beneficiary-specific billing codes generated by each MMP
- State may opt to submit 4Rx data to CMS with enrollment transaction
  - But State would have to obtain 4Rx data from MMP prior to sending an enrollment file.
- State may want instead to delegate sending of the 4Rx data to MMPs
  - If DTRR shows no 4Rx data, MMP must submit 4Rx data to CMS directly within 72 hours
  - Transaction Code 72

State and MMP Notify Beneficiary
(§30.1.4.D., 30.4.1.B)

- 30 days before effective date
  - State send reminder letter (Exhibit 5)
  - MMP send welcome letter (Exhibit 5a) and
    - MMP-specific Summary of Benefits
    - Formulary
    - Provider and Pharmacy Directory
    - Proof of health insurance coverage

MMP Sends Remaining Material (§30.4.1)

- No later than the last calendar day of the month before passive enrollment effective date, MMP sends
  - Single ID card to access all covered services
  - Member Handbook (Evidence of Coverage)

Coordinating Passive Enrollment with other CMS activities (§30.1.4)

- Passive enrollment is coordinated with LIS auto-enrollment and reassignment
  - Ensure enrollment change happens only once per benefit year that is not initiated by an eligible individual
- The only circumstances in which a beneficiary may be passively enrolled more than once in the same year are:
  - when MMP contract terminates, or
  - when it is determined that remaining in the MMP poses potential harm to members

Voluntary Enrollment

Individual Requests Enrollment
(§§ 30.1.4, 30.2, Appendix 1)

- Individual requests enrollment via
  - Telephone
  - Internet
  - Paper enrollment form

    Note: State may prefer other enrollment request mechanisms over paper form, but State must accept paper enrollment requests if received by mail, in person or by fax.
- State must provide the evidence of the enrollment request to the beneficiary , e.g.,
  - copy of completed enrollment form
  - confirmation number (for telephonic or on-line enrollment)
- State must ensure enrollment request is “complete”
  - Appendix 1 lists all the elements needed
- Optional – State may send acknowledgement letter (Exhibit 3)
  - Within 10 days of initial enrollment request
  - But, may wait until next steps and combine with other notices

State Determines MMP eligibility
(§§ 10, 30.2, 30.2.2, 30.2.3, 30.4.1)

- Check available systems to ensure the individual meets the basic MMP eligibility
  - E.g., State systems, Infocrossing eligibility check system, MMA Response file, TBQ response file, or MARx online query
  - If any information is missing but State or CMS system provides the missing information, must use that source to complete the enrollment application.
- Health related questions may be asked during the enrollment request
  - To support successful transition of care
  - Not to be used to determine if an individual is eligible to enroll in an MMP, except if individuals with certain conditions are excluded from enrollment
  - Information collected must be securely and electronically forwarded

When Enrollment Is Complete
(§ 30, 30.4.2)

- State notifies beneficiary enrollment is confirmed
  - If acknowledgement notice sent, send enrollment confirmation notice within 10 calendar days of the receipt of DTRR (Exhibit 7)
  - If acknowledgement notice not sent earlier, then send combined acknowledgement/confirmation notice within 7 calendar days of the receipt of DTRR (Exhibit 4)
- If CMS rejects the enrollment transaction, State must send a notice of rejection within 7 calendar days of receiving the DTRR (Exhibit 10)

If Enrollment Is Incomplete (§30.2.2)

- "Incomplete" means missing required information
  - See Appendix 1
- State has 10 days from initially receiving request to
  - notify the beneficiary the request is incomplete and
  - request the needed information (Exhibit 6, or may request information verbally)
- Beneficiary has 21 days to provide requested information
    - If received within that timeframe and enrollment can be considered complete, state has (from date of receipt)
      - 7 days from date enrollment considered complete to submit transaction to CMS
      - 10 days from receipt of DTRR to notify beneficiary enrollment is confirmed
        - If acknowledgement notice sent, send enrollment confirmation notice (Exhibit 7)
        - If acknowledgement notice not sent earlier, then send combined acknowledgement/confirmation (Exhibit 4)

Denying An Enrollment Request
(§§ 30.2.2, 30.2.3)

- Enrollment denial happens before transmitting enrollment file to CMS
- Two reasons for denial:
  - Determined ineligible
  - Expiration of the timeframe (21 days) for receipt of requested additional information
- Timeframe to send denial notice – 10 calendar days from:
  - Receipt of an enrollment request, or
  - Expiration of the 21-day timeframe for beneficiary to provide missing information
- Denial must be in writing (Exhibit 9)

Application Date and Effective Date
(§§ 20.1, 30, 30.1.1, 30.2 I., 30.2.3, 30.4.1, Appendix 2)

- Application date – date request is initially received
  - See Appendix 2 for details
- Effective date is usually the 1st of the following month of the receipt of the completed enrollment request.
  - Exception for those whose MMP eligibility is further in the future
  - Effective date cannot be prior to application date
  - Effective date rule holds even if request timeframes push determining if enrollment is complete until after effective date
    - » E.g. May 20 – Beneficiary requests enrollment (so effective date is June 1); May 30 – State sends notice requesting missing information; June 20 – Beneficiary submits missing information. Effective date is still June 1.
- State may establish a voluntary enrollment cutoff date no more than 5 calendar day before the end of the month.
  - The effective date for those who submit a voluntary enrollment request after the cutoff date will be the first day of the second month after receipt of the request.

Voluntary Enrollment Transaction Flow

- Same as passive enrollment:
  - Enrollment File submission to Infocrossing
  - File format/Data Validation, Eligibility Check, and TC 61 to CMS
  - MARx processes TC 61 and returns a DTRR to State and MMP via Infocrossing
  - State and MMP update their enrollment records; State and MMP sends enrollment notices/materials to the beneficiary.
  - If no 4Rx data present in the DTRR, MMP promptly submits TC 72 to CMS via Infocrossing
    - State and MMP receive another DTRR that TC 72 has been processed by CMS and updates their system.
- Rejects: DTRR has TRC indicating why enrollment was not processed and what action is needed (See page I-2 of the PCUG Appendices)
- See also MMP Technical Manual

MMP Sends Plan Materials
(§30.4.1)

- MMP must provide the following materials by end of the month before the effective date
  - Exception – if DTRR received less than 10 days before the end of the month, then MMP has 10 days from receipt of DTRR to send
- Required materials:
  - Formulary
  - Provider and Pharmacy Directory
  - Member ID card
  - Member Handbook (Evidence of Coverage)

Cancellation, Disenrollment, and Opt-Outs

Cancellation Request
(§ 30.1.4, 50.2, 50.2.2)

- Beneficiary may cancel an enrollment (or disenrollment) request by contacting the State any time **prior** to the effective date of enrollment (or disenrollment)
  - State may require a cancellation request in writing for their records
  - But must not delay and must accept any verbal requests to cancel a voluntary enrollment, disenrollment, or opt out
- Medicare will attempt to automatically return person to Medicare health or drug plan in which the person was previously enrolled

Cancellation Request (Continued)

- Cancelling passive enrollment -- within 10 calendar days of receiving request
  - Submit to CMS via Infocrossing:
    - » Enrollment cancellation transaction (TC 82), and
    - » Opt-out transaction (TC 83)
  - Send written notice to beneficiary (Exhibit 11)
- Cancelling voluntary enrollment -- within 10 calendar days of receiving request
  - Submit TC 82 (enrollment cancellation) to CMS via Infocrossing
  - Send written notice to beneficiary (Exhibit 11)

Cancellation Request (Continued)

- Cancelling voluntary disenrollment
  - Within 10 calendar days of receiving request
    - » Submit TC 81 (cancellation of disenrollment) to CMS via Infocrossing
    - » Send written notice to beneficiary confirming request received (Exhibit 18)
  - Within 10 days of DTRR, send notice to beneficiary confirming re-instatement in MMP (Exhibit 27)
  - See also MMP Technical Manual, PCUG Appendices
- Individuals may call 1-800-MEDICARE to request disenrollment from MMP, so would contact them to cancel the request
  - 1-800-Medicare will process and submit directly to MARx
  - States will be notified via DTRR
    - » Look for TRC 288 on DTRR
  - Send Exhibit 18 within 10 days of receiving DTRR

Disenrollment Request
(§§ 40, 40.1, 40.2)

- Disenrollment are those a beneficiary makes **after** the effective date of enrollment
- There are two types of disenrollment - Voluntary and Involuntary
- An individual may voluntarily disenroll in any month and for any reason by:
  - Enrolling in another Medicare health or Part D plan, including a PACE organization
  - Enrolling in another MMP
  - Giving or faxing a signed written disenrollment notice to the State/MMP
  - Calling 1-800-MEDICARE
  - Calling the State's enrollment broker
  - Other State-specific methods as identified in Appendix 5 (if applicable)

Processing Voluntary Disenrollment

- For beneficiary request that is complete
  - Within 7 days, submit to CMS via Infocrossing a TC 51 (disenrollment transaction)
    - » Put a **"Y"** in the MMP Opt Out Flag field (position 202)
  - Within 10 days, send written notice to beneficiary (Exhibit 14)
- If incomplete, request missing information from beneficiary within 10 calendar days (Exhibit 15)
- Denying disenrollment request
  - Request is
    - Incomplete (and missing information not received after requested)
    - Made by someone who is not beneficiary's legal representative
  - Send written notice to beneficiary within 10 calendar days (Exhibit 17)

Voluntary Disenrollment, continued

- If first notified by DTRR
  - » Because person enrolled in another Medicare plan
  - » Because person requested disenrollment directly from 1-800-MEDICARE
  - – Within 10 days, send written notice to beneficiary (Exhibit 16)
  - – DTRR will include Medicare health or drug plan into which person enrolled (if applicable)

- Effective date is first day of month after request received
  - – No early cut-off permitted for beneficiaries to request disenrollments

Involuntary Disenrollment – Mandatory (§§40.2, 40.2.3.2)

- Mandatory disenrollments
  - Move out of MMP service area (Exhibits 19, 20)
  - No longer meets MMP eligibility criteria (Exhibit 21, 24)
  - Death (Exhibit 23)
  - Contract termination/service area reduction
  - Beneficiary materially misrepresent information on third party coverage
  - NOTE: In some cases (e.g., loss of Medicare), State will not send disenrollment transaction to CMS, but instead be informed via the DTRR of CMS-initiated disenrollment. However, State must still send a letter to the beneficiary notifying him/her of the disenrollment from the MMP.
- Deemed continuous eligibility for short term loss of Medicaid
  - MMP option
  - For two months
  - Must continue to cover all MMP-covered services, even if not receiving Medicaid capitation payment

Involuntary Disenrollments – Optional (§40.3)

- Disruptive behavior
- Fraudulent information on enrollment request
- Abuse of enrollment card

MMP Opt Out Request
(§§ 30, 30.1.4 B., 30.1.4 E.)

- MMP Opt Out
  - Indicates person should be excluded from passive enrollments for life of the demonstration
  - Does not preclude individual from voluntarily enrolling in MMP
- If individual opt-out prior to being in an MMP, submit the opt-out transaction (TC 83)
- When individual voluntarily disenrolls from MMP, State should also set the opt-out indicator
  - Submit TC 51 (disenrollment transaction) and indicate a **"Y"** in the MMP Opt Out Flag field (position 202)
  - Send an opt out acknowledgement notice (Exhibit 28) with the disenrollment notice within 10 calendar days

Other Resources

Transaction Reply Codes (TRC)

Most common TRCs

TRC	Definition
ENROLLMENT TRCs	
011 A	ENROLLMENT ACCEPTED AS SUBMITTED
015 A	ENROLLMENT CANCELLED
016 I	ENROLLMENT ACCEPTED, OUT OF AREA
022 A	TRANSACTION ACCEPTED, CLAIM NUMBER CHANGE
023 A	TRANSACTION ACCEPTED, NAME CHANGE

Enrollment TRCs - Continued

ENROLLMENT TRCs	
307 A	MMP PASSIVE ENROLLMENT ACCEPTED
308 R	MMP PASSIVE ENROLLMENT REJECTED
309 I	NO CHANGE IN MMP OPT-OUT FLAG
310 R	MMP OPT OUT REJECTED, INVALID OPT-OUT CODE
311 A	MMP OPT-OUT ACCEPTED
312 A	MMP ENROLLMENT CANCELLATION ACCEPTED
313 R	MMP ENROLLMENT CANCELLATION REJECTED
314 R	INVALID CANCELLATION TRANSACTION

Disenrollment TRCs

The following TRCs are the most common disenrollment TRCs to be received by States and MMPs

DISENROLLMENT TRCs	
013 A	DISENROLLMENT ACCEPTED AS SUBMITTED
014 A	DISENROLLMENT DUE TO ENROLLMENT IN ANOTHER PLACE
018 A	AUTOMATIC DISENROLLMENT

To see a full list of TRCs, See page I-2 (Table I-2) of the Appendices of PCUG

Additional Resources

- MMP Enrollment and Disenrollment Guidance http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf

- MMP Technical Manual http://www.chcs.org/usr_doc/MMP_EE_Guide.pdf

Additional Resources

- **PCUG Main Guide:**
  - http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Downloads/PCUG_v70_Main_Guide_Final_03012013.pdf
- **PCUG Appendices:**
  - http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Downloads/PCUG_v70_Appendices-Final_03012013.pdf

Questions?

- Send enrollment policy and procedure questions to CMS MMCOCapsmodel@cms.hhs.gov
- Send questions related to Infocrossing MCareSupport@wipro.com

  (877) 833-3499