



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

Real Time Caption Transcript

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Auto/Facilitated Enrollment & Reassignment Process Tracey Baker, CPC/MEAG/DMEC

Tracey Baker

Good afternoon, everyone. I hope you had a good lunch and a good weekend. I'm going to be talking about auto and facilitated enrollment process today.

CMS enrolls [Indiscernible] into the Part D plans. We also facilitate enrollment into -- for low income and others -- for low income subsidy, I'm sorry, for partial duals and also those that are CMS only. For auto enrollment it only applies for full benefit dual eligibles. They equally for LIS automatically. We only enroll them into PDPs, Prescription Drug Plan, that's the focus of this presentation. We only enroll beneficiaries into stand alone PDPs. As far as the source of data, we identify beneficiaries with information from state agencies, as well as SSA and CMS processes these files daily. If they don't have a Part D plan they are auto facilitated into that stand alone plan. CMS performs the following steps to auto or facilitate enroll those beneficiaries. We first identify the beneficiaries that need to be assigned to the Prescription Drug Plan. We identify the Prescription Drug Plan that needs to qualify, we randomly assign the beneficiaries into the PDPs. When we identify the beneficiaries it includes those in 50 states and DC, those that receive Medicare, cost plans, and 1833 healthcare prepayment plans. We exclude individuals that live in the five territories or any foreign country, also that those that are inmates at correctional facilities. We also exclude those -- faith organizations and those that get it through MA or cost plans. Wees exclude beneficiaries have the retiree drug coverage subsidy.

The list of qualified PDPs is determined each year for the upcoming plan year. When determining what plans qualify for that list we use the following criteria: I'm sorry, could you go back? Thank you. We assign to PDPs and regions with premiums that are below the benchmark for that region and also for that year. We also assign to a plan -- basic alternative benefit package. Even if a plan has an enhanced alternative benefit, we won't use that plan, even if the premium is at or below the PS amount for that region and that year. PDPs need to meet a number of other qualifications before they can make the list. That includes a number of items that we have listed here on this slide. They must process LIS biweekly matching in 72 hours, timely call center performance, they must have a transition period, prescriptions filled at the point of service and successful testing of enrollment data with CMS.

We exclude PDPs, we don't assign to plans with enhanced benefits, which is what I mentioned before. We also don't assign to plans that have volunteered to -- at deminimus. The Affordable Care Act allows voluntary dy minute muss, it prevents plans from losing through reassignment, which I will talk about. It doesn't allow them to gain auto and facilitated enrollees. Let's talk a little bit about how we reassign to plans. First, it's a two-step process. We randomly assign to those PDPs that made that list that I talked about, we look at the sponsoring organization. And they must have at least one qualifying PDP in that region. Secondary, -- normally results in the same number at the organization level. Within each organization the same number among contracts and PDPs within that contract.



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This slide here is an example of what I'm referring to. If you have four sponsoring organizations, A, B, C, and D. We're going to enroll 10,000. What happens in that second column, that's the first step. We take the 10,000 and divide it by the number of sponsoring organizations, four, you will see that each gets 2500 beneficiaries randomly assigned to them.

Now in the third column you see the number of PDPs that organization could potentially have. Depending on that number we take that 2500 from the second column and divide it equally among the benchmark PDPs. As you see in organization A, they only have one PDP, they get all of the beneficiaries. But if you jump down to sponsoring organization D they have four PDPs, each of those would receive 25% of that 2500 that was assigned to sponsoring Part D. When we have sponsoring organizations that are owned by the same organization they're treated as a single sponsor. We do the same thing. But this first step, um, is changed just a bit. You will see in this example where A and B are owned by Alphabet Organization. Okay. This is the same methodology that we use when we do reassignment, as well. Once a person is assigned to a plan CMS creates an enrollment transaction and submit it to MARx, which I'm sure you are all familiar with. Right now the application date is set to 1/1/2003. If they make an election tomorrow or next week they can get out of the plan that they've been auto/facilitated into it. As far as the effective date, we calculate this date and include on the TRR when it's sent to you. It's usually the first date of the second month. For dual eligibles though the date is the latter of the full dual status, which could be retroactive, or the day after their disenrollment effective date from a previous Part B plan. Here's the scenario on how we determine an effective date.

If a person in 2009 has Medicaid all year, their effective date is April 30, 2009, the Medicaid drug coverage will end. May 1 is their auto enrollment date. For the retroactive date they will go into the low income net program, which is a new demonstrate program that started in January of 2010. It's a single PDP to cover all periods of retroactive auto enrollment. The dual effective date would be October 1. The rest of their coverage would be in LI Net, okay.

After a beneficiary is auto enrolled we send notices to the beneficiaries. I'm sure that most of you are familiar with the notices that we send on colored paper. The auto process is part of the colored notice process. Auto enrollment, they receive their notice on yellow paper. If the beneficiary is facilitated they will receive the notice on green paper. This slide also includes a link of where to see the notices. It's actually a chart of the various notices that we have and the various colors.

When the beneficiary receives a notice the notice will include the plan name, the number and the website of the plan that they're going to be auto facilitated enrolled in. The health plan management system has customer service numbers. Your information for your plan must be in HPMS by August 30, 2010 to be included in the reassignment. You should have already gotten instructions about this and made sure that your information was correct in HPMS in order for it to be correct on the notices. The notices will include the effective date of enrollment and instructions on opting out or declining the auto matic enrollment into the plan.

One thing that we want to note is that if the beneficiary has a retroactive period that information is as referenced into the letter. If they have questions I do believe there is a number on the letter they can call. In addition to notifying the beneficiaries, we also notify PDPs. So we notify the PDPs in two ways. First, our internal system notifies PDPs through the PDP notification file. This is a preliminary notification of assignment that will be sent to plans before they receive the



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weekly TRR. It will give notice of the levels that the beneficiary has, it will also give the beneficiary address, which is not included on the TRR. CMS doesn't have phone data, but it does give beneficiary address information. PDP notification file will come every date that the state or SSA file is received in identifying new dual or LIS eligibles.

The layout of the auto enrollment PDP file can be found in the user guide, that is available on the web. It's item E4. You can take a look at that if you are not familiar with it.

The purpose of the PDP notification file is for the plans to use the file to ensure that the reps can assist enrollees during the interim period and also to obtain address information for the confirmation letter. Also, the second way that CMS notifies PDPs is we have MARx generating a transaction report. These are processed by MARx, they will be included on the next regular TRR, which is generated on Sundays. They will receive the weekly TRR with auto and facilitated enrollments no more than seven days after the assignment occurs.

This slide has a lot of information, some of which is missing. [Laughter] Okay. Which is different than what I have. First, I wasn't going to read this slide, I guess I have to since some of the information is missing. You have to be able to distinguish on the TRR the auto and facilitated enrollments. You will have field 15 and 117 is auto enrollment. 118 is facilitated. 212 is reassignment. Those are the three you should be looking for when plans are automatically assigned to you. Field 18 you see the effective date. Field 30 you see the application date that I talked about, that is artificially early, so beneficiary choice would supersede. What is not on this slide is field 36, election type, it will be set to S. Field 27 is the enrollment source, it will be set to one of three values. A is for auto enrollment. B is for facilitated. H is for reassignment. Field 39 you have the premium withhold options, D for direct billing. Okay.

Once a plan receives this information they should be submitting data within 72 hours of receiving the weekly TRR confirming that enrollment. Okay. You should do so with a 72 transaction.

The plans also have to send confirmation within ten calendar days after receiving the TRR, exhibit 24 or 25, PDP enrollment guidance. You should also include the effective date of coverage and how to obtain services prior to receiving the ID card and a summary of benefits. After the beneficiary receives this notice of auto enrollment they may opt-out. They may choose another plan, they can do it prior to auto enrollment, they also could do it after the effective date. They can contact the PDP and exhibit 26 is an example of the response. They also can contact the 1-800-Medicare number to let them know they want to opt-out. When a beneficiary opts out they contact the PDP, whoever is contacted will submit a 51 transaction, field 14 on the effective date you set it to the first date of the month that the PDP receives the request. If they call you today you would set it to September 1, 2010. We also do a monthly sweep of beneficiaries not in plan they will not be picked up for being put back into a PDP if they opt-out. So the PDP is notified of the opt-out by the CRR. Field 18, you see the effective date date. Field 38 you see the flag set to Y, that way you know that the beneficiary opted out of being auto enrolled. One of the things we want to make sure to note is that beneficiaries when they opt-out they don't surrender their right to enroll in a Part D. Instead, it only ensures that beneficiaries are not included in future auto facilitated enrollments. To obtain benefits in the future they can enroll in any plan, they can also call 1-800- and decide to opt back in if they want to. Beneficiaries are also able to change plans. Their effective date is the first date of the month after the request is made. So if they call today it would be October 1, 2010. When they're facilitated enrolled they may request an effective day that is earlier, if they were facilitated today it would be November



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1, they can call you up and ask to be enrolled October 1 instead of November 1. They can request it to be earlier. There's an example there. The plan will submit a 61 transaction with that earlier effective date.

The other thing to note is that all LIS beneficiaries have a continuous special election period. They may enroll, disenrollment or change plans at any time of the year outside of the annual enrollment period. They can change whenever they want. You can see the enrollment guidance, chapter 3, section 30.3.2 and 30.3.8.7.

So as far as timing, we perform, like I said, auto enrollment daily. October 1 is first time we will do it for 2011, that's when plans will begin to see their auto enrollments for January 1, that will appear on the November TRR.

The next slide is just a sample timeline of when plans -- the entire process that I described that. Again, we receive the file, the person is deemed auto facilitated on May 6, we mail the yellow and/or green notice to the beneficiaries on May 9, when PDPs receive the enrollments on the next TRR then they submit the 72 transactions, plans send a confirmation notice within ten days of receiving the notice. That's it for auto assignment.

We will turn our attention to reassignment. Reassignment is the annual process whereby we reassign beneficiaries -- auto enrollees into those with 100% premium subsidy into a new PDP. We reassign them for several reasons: If the PDP is terminated, we need to reassign the beneficiaries in that PDP. Two, if the PDP has a premium increase, they're going over the regional benchmark. Or if they're converting to the enhanced best benefit. We also reassign LIS beneficiaries that are in a MA plan that is terminated. The member has LIS, but they don't have PDP enrollment. When we reassign we send them notices. There's three versions of the notice. The first is send in early November, version 1 is for when your plan is terminating. Your plan is going away, we will reassign you into a plan effective January 1, 2011, unless you choose another plan. The beneficiary doesn't -- accepts their enrollment, they can keep the notice, compare the plan with others. They can also choose to change plans at that time. The second version of the notice tells them that their plan's premium is going over the LIS benchmark, they will be reassigned to a plan the next year. Also included with these notices are other below benchmark plans that they can choose from. They can choose another plan if they like, be it the plan that we've included in the list, or another plan altogether. The third version of the notice, their current plan is leaving Medicare, their coverage will revert back to original Medicare. If they are LIS they will be assigned to a PDP plan, unless they join another plan. They take the same sort of steps as before.

Now there are some changes that the Affordable Care Act had, it impacted the reassignment process. Those were requirements that impacted the reassignment process. The first one is voluntary deminimus. The notice will be send in December, that also will be on blue paper. For voluntary deminimus, plans can volunteer to waive the deminimus. If you were familiar with the previous process, it was mandatory. Now plans can voluntary to waive the deminimus or not. When plans volunteer for it they will not lose LIS members through reassignment. When we look at plans that have gone above the benchmark if they decide to waive the deminimus amount they won't lose their LIS members through reassignment. It at allows them to be listed as a zero premium plan. But it does not mean that those beneficiaries will -- those plans will receive auto enrollments, okay.

The Affordable Care Act notice tells those members that are reassigned the differences



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between the 2010 plan and the 2011 plan that we've reassigned them to based on that individual's drug utilization. It explains an exception, the appeal process and each letter is specific to that individual.

Another group of individuals that are not reassigned, but we include as part of the process are the choosers. Those are the beneficiaries with 100% premium subsidy that chose their current plan and they may have some premium liability. We honor the beneficiary's choice by conducting outreach instead of reassignment. Those letters that are sent are on tan paper. One of the new things that we did this year is that we normally send out the fall tan notice to those beneficiaries telling them that they will have a premium liability in 2011, they will be responsible for paying a portion of that premium unless they join a new plan. But also in the spring of each year we are sending to beneficiaries a reminder that there are zero-premium plans available to them. It's also on tan paper. It tells the beneficiaries that they may want to look for a new plan. They're able to change at any time during the year, it may be a value to them.

This timeline that I included is specific to those PDPs that will qualify for auto and facilitated enrollment in 2011. October is when we do the reassignment, I believe earlier Randy talked about the end of year timeline. Randy's group and mine work closely to make sure that those dates are synchronized and coordinated so it's all part of the same process. PDPs that qualify for auto and facilitated enrollments in 2011 will receive reassignments. CMS informs reassignments on October 4. The blue letter will be sent to the beneficiaries in November. PDPs that MA reassignments will appear on the special TRR that we send to those plans on November 3rd. On November 6 plans must submit their 72 transactions with the data for their reassignments. On November 16, ten days after the TRR, they send their confirmation to the reassignments, exhibit 29. And in December we send the Affordable Care Act notice to those that were reassigned, they should be received by the beneficiaries. The new plan assignments will be effective on January 1, 2011.

This is a timeline, this is actual dates of when this will happen. So a lot of plans tell me this is really useful to them.

The last slide is resources that can you go to. 40.1.4 talks about auto and facilitated enrollment. Section 40.1.5 is reassignment information. Most plans receive HPMS memo dated August 13, 2010, that talked about reassignment. And Jill, I believe that we can take some questions. Thank you. We're good at this, people are waiting. You're good, have a seat. Wonderful. All right. We have one person waiting with a question. You know you are all invited down. If you can't get to the mic in the aisle just raise your hand. Go ahead.

My question has to do with the notice of formulary differences. I'm curious as to why the target date is so late in December. It doesn't seem to give people too much time to think about whether or not they want to remain in the plan into which they've been reassigned.

Um, the date has to do with the way we determined what the drug utilization is for the beneficiary. And so that needs to be analyzed. We don't do the reassignments until October. So the beneficiaries that are being reassigned we don't have that information until October. That's when we gather that information. It has to do with analyzing the data and when we get it back and quality checking it, that sort of thing. It has more to do with that, than waiting until the last minute. Does that answer your question?

I still think that it's -- it's a problem, the problem is still there. The beneficiaries would probably benefit from an additional week to look over the new information, which they may not have been



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aware of, and decide whether this is the -- give them a chance to see if there's some other eligible plan that covers their medications. Thank you for your answer.

Thank you.