



**MEDICARE-MEDICAID COORDINATION OFFICE**

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**DATE:** August 1, 2018

**TO:** Medicare Advantage Organizations Offering Dual Eligible Special Needs Plans

**FROM:** Sharon Donovan, Director  
Program Alignment Group

**SUBJECT:** Guidance on the Process for Implementing Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dual Eligible Beneficiaries

This memorandum provides guidance to specified integrated Dual Eligible Special Needs Plans (D-SNPs) on the new D-SNP passive enrollment authority established in CMS-4182-F (83 FR 16502 through 16507, April 16, 2018).

Under this limited expansion of the passive enrollment authority at 42 C.F.R. § 422.60(g)(5), CMS may passively enroll full-benefit dual eligible beneficiaries enrolled in an integrated D-SNP into another integrated D-SNP in situations when integrated Medicare and Medicaid coverage would otherwise be disrupted. These situations include, for instance, when an enrollee's integrated D-SNP is non renewed or when a state re-procures a Medicaid managed care contract and, absent passive enrollment, a currently aligned<sup>1</sup> dual eligible beneficiary would receive Medicaid and Medicare benefits through separate health or drug coverage offered by distinct entities. CMS expects the use of this type of passive enrollment to be limited, and impact a relatively small number of enrollees.

Under the amended regulation, the following requirements apply effective June 15, 2018:

1. CMS must consult with the applicable state.
2. CMS must determine that the passive enrollment will promote integrated care and continuity of care for a full-benefit dual eligible beneficiary who is currently enrolled in an integrated dual eligible special needs plan.
3. The applicable MA plan must meet certain requirements related to integration, coverage and cost, quality ratings, ability to enroll, and operational capacity, and agree to receive passive enrollments.

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<sup>1</sup> "Currently aligned dual eligible beneficiary" means an individual enrolled in a Medicaid MCO and Medicare D-SNP that are offered by the same organization or parent organization.

4. Enrollees are provided an opt-out period.
5. Enrollees are provided two notices as described in the regulation.

The following sections describe the steps in the process for assessing when passive enrollment under this authority can occur. The timing and order of the activities to identify one or more D-SNPs will vary based on the circumstances for the passive enrollment decision and with the applicable state.

### **State Consultation**

Under 42 C.F.R. § 422.60(g)(1)(iii), CMS may only authorize passive enrollment after consulting with the state Medicaid agency contracting with the integrated D-SNP(s). CMS will use that consultation to help determine whether passive enrollment would promote continuity of integrated care for full-benefit dual eligible beneficiaries. Such consultation will include collaboration between CMS and the applicable state Medicaid agency on issues such as identifying plans that meet the requirements in 42 C.F.R. § 422.60(g)(2), decisions about enrollee assignment, and communications with impacted plans.

### **Plan Eligibility Requirements for Passive Enrollment**

To be eligible to receive passive enrollment, a D-SNP must:

- Meet specified criteria for the integration of Medicare and Medicaid benefits;
- Have substantially similar provider and facility networks and Medicare- and Medicaid-covered benefits as the plan(s) from which they are receiving passive enrollment;
- Have an overall quality rating of at least 3 stars, unless the D-SNP's contract is too new or has too few enrollees to have a star rating;
- Not be subject to CMS sanctions prohibiting new enrollment;
- Have premiums and cost sharing appropriate for full-benefit dual eligible beneficiaries; and
- Have the operational capacity to receive passive enrollment and agree to receive passive enrollment.

We provide guidance on each of these criteria below.

### ***Integration Requirements***

CMS will determine a receiving D-SNP meets the integration requirements as follows:

- The D-SNP has already received CMS designation as a Fully Integrated D-SNP based on the requirements in 42 C.F.R. § 422.2, which are described at § 20.2.5 of Chapter 16b of the Medicare Managed Care Manual;

OR

- Work with the state to determine that the Medicaid benefits offered by the receiving D-SNP's aligned Medicaid Managed Care Organization (MCO) are sufficient to be approved by CMS § 422.102(e) as meeting the Medicare-Medicaid integration criteria required for eligibility for benefit flexibility (additional guidance is available at §20.2.6.1 of Chapter 16b of the Medicare Managed Care Manual).

### ***Network Comparability Requirements***

As part of the criteria to receive passive enrollment at 42 C.F.R. § 422.60(g)(2)(ii), a receiving D-SNP's Medicare Advantage (MA) network must be substantially similar to that of the relinquishing D-SNP. Using National Provider Identifier (NPI) numbers, CMS will compare the MA network of the relinquishing D-SNP to that of a receiving D-SNP to assess overlap in provider and facility specialty types with the highest utilization by dual eligible beneficiaries.<sup>2</sup> Relinquishing and potential receiving D-SNPs should refer to Attachment B of this memo for specific instructions on the network comparability submission.

This network comparability review is not an assessment of MA network adequacy; it is strictly for purposes of CMS' determination of a receiving D-SNP's eligibility to accept passive enrollment. Therefore, it does not replace or count toward the MA triennial network adequacy review. It is only for purposes of determining compliance with 42 C.F.R. § 422.60(g)(2)(ii).

### ***Benefits Comparability Requirements***

A receiving D-SNP must have substantially similar Medicare- and Medicaid-covered benefits as the relinquishing D-SNP. Receiving D-SNPs will meet the Medicare benefit comparability requirements provided they have an approved Plan Benefit Package (PBP) submission for the applicable Contract Year for which the passive enrollment takes place. CMS will not consider the receiving or relinquishing D-SNPs' supplemental benefits as part of our analysis of benefit comparability. CMS will consult with the applicable state Medicaid agency to ensure that affected enrollees' Medicaid benefits under the various available MCO options are substantially similar to the benefits under their current Medicaid coverage.

### ***Quality Ratings Requirements***

A receiving D-SNP must have an overall quality rating of at least 3 stars under the rating system described in 42 C.F.R. §§ 422.160 through 422.166, from the most recently issued ratings prior to CMS' determination of eligibility to receive passive enrollment, or be a low enrollment contract or new MA plan as defined in 42 C.F.R § 422.252.

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<sup>2</sup> CMS will determine this subset of providers and facilities by analyzing claims data across the Medicare Fee-For-Service, MA, and Medicare-Medicaid Plans.

### ***Enrollment Sanctions Requirements***

A receiving D-SNP will be ineligible for passive enrollment if its MA organization is prohibited from enrolling new members as part of an intermediate sanction under 42 C.F.R. § 422.750(a)(1) prior to CMS' determination of eligibility to receive passive. Ineligibility for passive enrollment lasts as long as the prohibition on enrolling new members is in place.

### ***Premium and Cost Sharing Requirements***

A receiving D-SNP must have limits on premiums and cost sharing appropriate for full-benefit dual eligible beneficiaries, including:

- A beneficiary premium of zero dollars after application of the Part D low-income premium subsidy; and
- Identification in HPMS as a zero-dollar cost sharing D-SNP as described in § 20.2.4.2 of Chapter 16b of the Medicare Managed Care Manual;

OR

- Limit passive enrollment to full-benefit dual eligible individuals who are Qualified Medicare Beneficiaries and thus would not pay cost sharing for Medicare services covered under the D-SNP.

### ***Operational Capacity Requirements***

To qualify to receive passive enrollment, a receiving D-SNP must have the operational capacity to passively enroll beneficiaries and agree to receive such enrollments as required at 42 C.F.R. § 422.60(g)(2)(vi).

CMS will scale the review of operational capacity based on the overall volume of passive enrollment and presence of other risk factors. For example, the review of operational capacity will be more extensive for a new plan that is scheduled to receive high enrollment volume than for a plan with experience and high performance metrics that is scheduled to receive low enrollment volume. CMS will assess several factors to determine operational capacity. These factors may include, but are not limited to:

- Current enrollment in relation to the projected volume of passive enrollment;
- Available Parts C and D performance metrics;
- Recent Medicare program audits;
- Other compliance and enforcement activity; and
- Other factors identified or requested by the state.

Each receiving D-SNP must also complete and return to CMS Attachment A of this memo (the D-SNP Passive Enrollment Attestation form) to receive passive enrollments if CMS determines the D-SNP meets the criteria set forth in this memo.

In some instances, a receiving D-SNP is operating, or may start to operate, a Medicaid MCO prior to CMS' determination of eligibility to receive the passive enrollment. CMS will review operational criteria and related information from the respective state Medicaid agency as part of its determination. CMS may reference the most recent state external quality review organization (EQRO) findings as described at 42 C.F.R. § 438.364, state readiness reviews as described at 42 C.F.R. § 438.66(d)(1), and state compliance actions taken against the MCO as described at 42 C.F.R. Subpart H. To the extent there are state-required care coordinator-to-enrollee ratios, CMS may also assess a receiving D-SNP's care coordination staff against the projected volume of passive enrollment.

## **Notice Requirements**

### ***Current D-SNP***

CMS encourages a relinquishing D-SNP to share information about their enrollees' language and accessibility preferences with receiving D-SNPs to facilitate a receiving D-SNP's provision of information in non-English languages and alternate formats.

CMS will request the D-SNP that is relinquishing members to send tailored non-renewal notices based on model language CMS will make available. Please note there may be two notices: one for members who will be passively enrolled into another integrated D-SNP; a second for those not passively enrolled and who instead will be included in the annual year-end reassignment by CMS or ongoing auto-enrollment to a stand-alone Prescription Drug Plan (see 42 CFR 438.34(c)).

### ***Receiving D-SNP***

A receiving D-SNP must send passively enrolled beneficiaries at least two advance notices of the pending enrollment. Specifically, a receiving D-SNP must send:

- The first passive enrollment notice no fewer than 60 days prior to the passive enrollment effective date; and
- The second passive enrollment notice no fewer than 30 days prior to the passive enrollment effective date.

Both notices must include the following information:

- A description of the costs and benefits offered by the receiving D-SNP;
- The process of accessing care under the receiving D-SNP; and
- An explanation of the enrollee's ability to decline the passive enrollment or to choose another plan, and how to take that action and by when (i.e., the right to opt-out of the passive enrollment).

Notice language must be approved by CMS. To help lessen burden to plans, CMS is currently developing model 60- and 30-day D-SNP passive enrollment notices. We expect that the notice will include information about available resources for counseling to assist beneficiaries in the impacted service area, including State Health Insurance Assistance Programs, 1-800-Medicare, and Medicare Plan Finder. We plan to consumer test these notices in the future. We will issue the model notices later this year and will work with states to tailor notice language to the specific circumstances of the passive enrollment. We will provide additional instructions about submission and review of populated notices upon release of the model notices.

We encourage receiving D-SNPs to conduct additional telephonic outreach to members who will be passively enrolled into their plans to ensure they understand the benefits of the D-SNP as well as their enrollment choices.

### **Potentially Affected D-SNPs**

CMS will contact those D-SNPs that would relinquish members to passive enrollment, as well as to integrated D-SNPs that could potentially qualify to passively enroll these individuals on next steps.

### **For Further Information**

For further information or any questions please contact [MMCOCapsModel@cms.hhs.gov](mailto:MMCOCapsModel@cms.hhs.gov).

Attachments (2)

## Attachment A: Dual Eligible Special Needs Plan Passive Enrollment Attestation

A receiving Dual Eligible Special Needs Plan must submit a PDF of the following document to the [MMCOCapsModel@cms.hhs.gov](mailto:MMCOCapsModel@cms.hhs.gov), thereby agreeing to accept passive enrollments and acknowledging and committing to compliance with the requirements for the passive enrollment process under 42 C.F.R. § 422.60(g).

### Passive Enrollment Certification

I, \_\_\_\_\_, on behalf of \_\_\_\_\_ certify that I will:

(NAME & TITLE)

(Name of D-SNP/MAO)

- Provide CMS and its contractors with information identified as necessary for the determination of passive enrollment.
- Should the Medicare Advantage (MA) dual eligible special needs plan (D-SNP) be approved to receive passive enrollment pursuant to 42 C.F.R. § 422.60(g)(1)(iii), to:
  - Submit related transactions necessary for the D-SNP to process the applicable enrollments from the relinquishing D-SNP into my organization's D-SNP;
  - Provide written notice to each passively enrolled beneficiary at least 60 days and again 30 days prior to the effective date of enrollment using the CMS-developed models;
  - Provide the beneficiaries with a Part D transition period in accordance with 42 C.F.R. § 423.120(b)(3) and the sponsor's approved transition policy attestation.
  - Ensure that sufficient sponsor resources are dedicated to assisting newly enrolled beneficiaries with the transition process;
  - Coordinate with CMS and the state on ensuring that the plan's customer service representatives (CSRs), websites, and other communications channels effectively support beneficiaries who will be passively enrolled. This includes special scripts, instructions, and training, to help the CSRs to appropriately use the Complaints Tracking Module (CTM);
  - Respond to all beneficiary inquiries regarding their options for enrolling in another plan, and how to get additional information and support for doing so; and
  - To the extent this agreement conveys any confidential information, such as market-sensitive information, agree to keep such information and any related CMS documents and data confidential with respect to any public disclosure until CMS indicates they can be released.

I further certify that I am an authorized representative, officer, chief executive officer, or general partner of the business organization that is seeking to obtain approval for the receipt of passive enrollments into its MA D-SNP contract with CMS.

On behalf of [Name of Entity], I agree to the above responsibilities:

_____	_____
Authorized Representative Name (printed)	Title
_____	_____
Authorized Representative Signature	Date (MM/DD/YYYY)

## Attachment B – Dual Eligible Special Needs Plan Passive Enrollment Network Comparability Submission Instructions

To the extent possible, CMS will use the latest network submission on file from the relinquishing and receiving Medicare Advantage (MA) dual eligible special needs plan(s) (D-SNP(s)).

Receiving and relinquishing D-SNPs that are not currently undergoing an MA triennial review will receive an automated e-mail from the CMS Health Plan Management System (HPMS) with instructions on when to submit Health Service Delivery (HSD) tables into the HPMS Network Management Module (NMM) for the subset of Medicare providers being assessed. Specifically,

- After the determination that a D-SNP will either be relinquishing or receiving members due to meeting one of the criteria for passive enrollment set forth in 42 C.F.R. § 422.60(g)(1)(iii), CMS will confirm whether the full network is going through a current MA triennial review.
- Upon CMS determination that a network submission is necessary, the D-SNP will receive an automated notification for an ad-hoc event to upload its current MA network via its provider and facility HSD tables into the HPMS NMM.<sup>3</sup>
- In the HPMS NMM, upload the provider HSD table for the impacted counties in the upcoming contract year for the following provider specialty types:
  - 001 – General Practice
  - 002 – Family Practice
  - 003 – Internal Medicine
  - 004 – Geriatrics
  - 005 – Primary Care – Physician Assistants
  - 006 – Primary Care – Nurse Practitioners
  - 008 – Cardiology
  - 023 – Ophthalmology
  - 025 – Orthopedic Surgery
  - 029 – Psychiatry
- In the HPMS NMM, upload the facility HSD table for the impacted counties in the upcoming contract year for the following facility specialty types:
  - 040 – Acute Inpatient Hospitals
  - 049 – Physical Therapy

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<sup>3</sup> CMS will not request an upload of the HSD table if the organization is in the process of an application or triennial network review for the same service area. Instead, CMS will pull the data from the mid-June submission.