Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Beneficiaries

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States are increasingly promoting coordinated service delivery for individuals dually eligible for Medicare and Medicaid by aligning their enrollment in Medicaid managed care organizations (MCOs) and affiliated Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs) offered by the same organization. In some circumstances, states can promote the use of "default enrollment" to increase aligned enrollment into D-SNPs and affiliated MCOs when existing Medicaid managed care enrollees become newly eligible for Medicare by virtue of age or disability. Under default enrollment, D-SNPs that receive approval from the Centers for Medicare & Medicaid Services (CMS) may offer automatic enrollment to newly Medicare-eligible individuals if those individuals are enrolled in an affiliated Medicaid managed care plan and will remain enrolled in an affiliated Medicaid managed care plan upon becoming Medicare eligible.

This fact sheet summarizes beneficiary eligibility standards, state roles in the default enrollment approval and implementation process, and D-SNP default enrollment requirements. It also provides references to additional resources for more detail and context that can inform states interested in working with D-SNPs and CMS to establish this process.

Beneficiary Eligibility

Beneficiaries enrolled in Medicaid managed care plans would be eligible for default enrollment into an approved D-SNP if they:

- Are newly eligible for Medicare Parts A and B (default enrollment must be effective the month the beneficiary is first eligible for Medicare Parts A and B);
- Are enrolled in an affiliated Medicaid managed care plan operated either by the legal entity that offers the D-SNP or by another entity that has the same parent organization as the organization operating the D-SNP;
- Retain eligibility for full Medicaid benefits after becoming Medicare eligible; and
- Remain enrolled in an affiliated comprehensive Medicaid managed care plan upon default enrollment into the D-SNP.

State Roles in Default Enrollment[1]

This section covers initial state considerations on using default enrollment, how states can demonstrate their approval of a D-SNP to conduct default enrollment, and how states can coordinate with plans to share Medicaid eligibility data and redetermination information to effectuate this enrollment process.

Initial considerations for states. States can determine which D-SNPs to approve for default enrollment based on their state goals for integration. To implement default enrollment, states should begin by engaging

stakeholders such as beneficiary advocates and interested plans. States may contact the Medicare-Medicaid Coordination Office for technical assistance at: MMCO_DSNPOperations@cms.hhs.gov.

States should bear in mind the following criteria for CMS approval of D-SNPs for default enrollment:

- **Types of Medicaid plans that D-SNPs may draw from for default enrollment.** D-SNPs may only enroll beneficiaries from comprehensive MCOs. D-SNPs may not enroll beneficiaries from limited Medicaid plans, such as prepaid inpatient health plans and prepaid ambulatory health plans, or from managed fee-for-service models, including primary case management, health homes, or accountable care organizations.
- **Post-default enrollment Medicaid coverage.** Beneficiaries may remain enrolled in the same Medicaid managed care plan for Medicaid benefits upon default enrollment, or may transition into receiving Medicare and Medicaid coverage through an affiliated D-SNP that contracts with the state to provide Medicaid benefits.
- **Extent of Medicaid coverage required**. Post enrollment, the plan must cover a substantial range of Medicaid benefits that results in a high level of integrated coverage for the beneficiary. D-SNPs that provide coverage of Medicare cost sharing as their only Medicaid benefit do not qualify for default enrollment.

How states can demonstrate their approval for default enrollment. States that would like D-SNPs to implement default enrollment must provide their approval. A state can provide approval in three ways:

- Include a provision for default enrollment and state provision of prospective Medicare eligibility data in the State Medicaid Agency Contract (SMAC) with the D-SNP;
- Interpret its current SMAC to cover default enrollment and state provision of prospective Medicare eligibility data; or
- Create a legally binding adjunct to its SMAC that includes default enrollment and state provision of prospective Medicare eligibility data.

Arizona was one of the first states to use default enrollment to encourage aligned enrollment of dually eligible beneficiaries into D-SNPs and affiliated Medicaid MCOs. The call out box ***Arizona's CY 2020 D-SNP Contract Provisions on Default Enrollment*** on the next page provides an example of the type of language that other states could add to their own D-SNP contracts.

How states can share Medicare eligibility data with D-SNPs. To effectuate default enrollment, states should work with D-SNPs to establish a default enrollment data sharing and implementation plan. The state must agree to provide timely, prospective Medicare eligibility information for its Medicaid managed care beneficiaries. A state should take the following steps to obtain and share Medicare eligibility data with D-SNPs:

- **Source(s) of Medicare data.** The state should identify the CMS data exchange it plans to use to identify Medicaid enrollees who will become eligible for Medicare. CMS data exchange options include the Medicare Modernization Act (MMA) file exchange; more frequent submission of these data support early identification of individuals who may quality for default enrollment. In addition, CMS offers ad hoc, batch query options, such as the Medicare Enrollment Beneficiary Database (EDB) file and the Territory Batch Query (TBQ) file.[2] The state will need to supply the Medicare Beneficiary Identifier (MBI) and the Medicare A/B start date to the D-SNP.

- **State review of the data.** Once the state determines which data source to use, it should review the file at least monthly to identify the Medicaid MCO enrollees who have a future Medicare eligibility date for both Parts A and B. Default enrollment requires eligibility for Medicare and continued eligibility for full Medicaid benefits.
- **Sharing the data with D-SNPs.** The state should then determine the frequency and mechanism (e.g., 834 enrollment file to a Medicaid MCO, or a separate file) for how it will share data with the D-SNP. The data should be shared on at least a monthly basis to meet CMS requirements and allow default enrollment to occur on a monthly basis. More frequent data sharing will allow more complete identification of individuals eligible for default enrollment. The state should establish a process in which it provides D-SNPs with enough time to: (1) review the Medicare eligibility data; (2) validate beneficiary eligibility for default enrollment into the D-SNP; (3) and send default enrollment notices to beneficiaries no fewer than 60 days prior to the start of their Medicare eligibility.

Arizona's CY 2020 D-SNP Contract Provisions on Default Enrollment

"2.1.11 Default Enrollment Process - On behalf of currently enrolled AHCCCS categorically eligible members who receive full medical assistance benefits, and who become newly Medicare eligible either by age or disability, and that such Medicare eligibility results in Full Benefit Dual Eligible status for such members , MAO shall perform the default enrollment process as provided by 42 CFR 422.66 and 422.68.

Through this Agreement, in conformance with 42 CFR 422.66(c)(2)(i)(B) and 42 CFR 422.107, AHCCCS approves MAO's implementation of the default enrollment process subject to CMS' prior approval as per the requirements of 42 CFR 422.66(c)(2)(i)(E), (F), and (G) inclusive; 422.66(c)(2)(ii); and other CMS-published regulatory guidance as applicable. MAO shall be responsible for timely obtaining initial default enrollment process approval from CMS no later than 120 calendar days prior to the Effective Date of this Agreement as specified in paragraph 3.1: Term of Agreement. MAO shall coordinate with AHCCCS regarding those activities necessary to obtain such CMS prior approval. MAO shall forward to AHCCCS a copy of CMS' default enrollment process prior approval notification or correspondence to the MAO within 10 calendar days of receipt, in accordance with the requirements of Attachment 1: Chart of Deliverables.

MAO shall also be responsible for coordinating those necessary activities to renew any existing default enrollment process approval(s) with CMS, as per the requirements of 42 CFR 422.66(c)(2)(ii), so that any such subsequent CMS approval(s)/renewal(s) of an existing approved default enrollment process shall be effective no later than 120 calendar days prior to the expiration of the existing CMS approval requested to be renewed. MAO shall coordinate with AHCCCS regarding those activities necessary to obtain such CMS renewal approval(s) of an existing default enrollment process. MAO shall forward to AHCCCS copies of its default enrollment process renewal notification and materials to CMS, and CMS' renewal approval(s) notification or correspondence to the MAO, within 10 calendar days of receipt, in accordance with the requirements of Attachment 1: Chart of Deliverables.

MAO shall maintain a minimum 3.0 overall plan Star rating as assigned by CMS to implement the default enrollment process. MAO implementation of the default enrollment process shall be revoked by CMS if a minimum 3.0 overall plan Star rating is not maintained, and default enrollment cannot be re-applied for with CMS until the MAO has subsequently achieved this minimum Star rating. See paragraph 2.11: Medicare Star Ratings for additional Star rating requirements. Through implementation of the default enrollment process, AHCCCS shall provide MAO with information necessary to prospectively identify those AHCCCS categorically eligible members who are or will be in their Medicare Initial Coverage Election Period. On an informational basis only, MAO shall report monthly to AHCCCS of its default enrollment process activities and results, as specified in Attachment 1: Chart of Deliverables and Attachment 5: Default Enrollment Process Reporting Requirements."

Timing of eligibility re-determinations. States that re-determine beneficiary Medicaid eligibility when an individual becomes dually eligible should complete their redeterminations in advance of the default enrollment process. Specifically, a state should re-determine a beneficiary's Medicaid eligibility far enough in

advance of his or her Medicare eligibility so that the state can notify the D-SNP of the beneficiary's upcoming Medicare eligibility and confirm that the beneficiary will remain eligible for Medicaid. For example, if a Medicaid beneficiary will become eligible for Medicare effective October 1st, the state should complete its redetermination by July in order for the D-SNP to confirm the beneficiary's eligibility, submit the transaction to CMS, and provide the beneficiary with a default enrollment notice no later than August 1st. Similarly, any other state-specific D-SNP eligibility criteria, such as assessments for nursing home level of care, must be completed in time for the D-SNP to submit the enrollment transaction and send the required beneficiary notice at least 60 days before the month of Medicare eligibility.

D-SNP Requirements and Responsibilities

This section covers D-SNP eligibility, data sharing, and beneficiary notification requirements, as well as the default enrollment transaction process.

D-SNP eligibility criteria. D-SNPs must satisfy a range of requirements in order to conduct default enrollment. To earn CMS approval, D-SNPs[3] must:

- Have a minimum overall quality rating of least 3 stars. D-SNPs that are too new or have insufficient enrollment to receive a star rating are exempt from this requirement;
- Not be prohibited by CMS from enrolling new beneficiaries;
- Demonstrate state approval to operate default enrollment. Refer to the "How states can demonstrate their approval for default enrollment" section above for details.
- Document the state's agreement to provide the information necessary for the D-SNP to identify, on a monthly or more frequent basis, individuals in its Medicaid MCO who are in their MA initial coverage election period.

D-SNP data sharing requirements. To be approved for default enrollment, D-SNPs must submit a description of the data sharing process with the state to timely identify individuals in their Medicaid MCO who are approaching their initial MA coverage election period. Refer to the "How states can share Medicare eligibility data with D-SNPs" section above for data sharing details.

Beneficiary notification. D-SNPs approved for default enrollment must notify beneficiaries in writing at least 60 calendar days before enrollment into the plan. These notices must include:

- Information on the differences in premiums, benefits, and cost sharing between the beneficiary's current Medicaid managed care plan and the D-SNP, and the process for accessing care through the D-SNP;
- Information on how the beneficiary can opt out of or decline default enrollment, up to and including the day prior to the enrollment effective date, and either enroll in Original Medicare or another MA plan. The opt-out or decline process must include the opportunity to contact the D-SNP either in writing or by telephone to a toll-free number. D-SNPs should process opt-outs as enrollment cancellations; and
- Information on alternative Medicare health and drug coverage options available to the beneficiary during his or her initial MA coverage election period.

A model beneficiary notice for optional use by approved D-SNPs is located at: https://www.integratedcareresourcecenter.com/resource/default-enrollment-model-notice

Default enrollment process. D-SNPs approved for default enrollment must submit enrollment transactions no later than 60 days prior to the enrollment effective date, which is the first day of the month the beneficiary is eligible for Medicare Parts A and B.

- Beneficiaries have the right to opt out of default enrollment, choose Original Medicare, or another Medicare health or drug plan.
- Beneficiaries may use a Special Election Period to make another Medicare health or drug plan choice for three months following default enrollment.

Additional Resources

For more information about default enrollment, see:

- **Default Enrollment FAQs** (CMS, February 2019). This FAQ document provides states and plans with default enrollment information. https://www.integratedcareresourcecenter.com/sites/default/files/HPMS%20Level%201%20Memo%20-%20Default_Enrollment_FAQs_2-25-19.pdf
- **Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program** (CMS, April 2018). Pages 16495 to 16502 of this *Federal Register* notice describe comments CMS received on the proposed rule regarding default enrollment, CMS' responses, and CMS' final decisions. https://www.gpo.gov/fdsys/pkg/FR-2018-04-16/pdf/2018-07179.pdf
- **42 CFR §422.66(c)(2): Coordination of Enrollment and Disenrollment through MA Organizations.** Section 422.66(c)(2) contains default enrollment regulations. https://www.ecfr.gov/cgi-bin/text-idx?SID=3b6dff4d4e210a63417d833560de42a8&mc=true&node=se42.3.422_166&rgn=div8
- **Medicaid Managed Care Manual: Chapter 2 - Medicare Advantage Enrollment and Disenrollment** (CMS, July 2018). Section 40.1.4 of this manual provides an overview of the default enrollment process. https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollm ent_Guidance.pdf
- **Default Enrollment Option for Newly Medicare Advantage Eligible Medicaid Managed Care Plan Enrollees (formerly known as "Seamless Conversion Enrollment")** (CMS, August 2018). This document provides guidance to MA organizations on the default enrollment process. https://www.integratedcareresourcecenter.com/resource/default-enrollment-option-newlymedicare-advantage-eligible-medicaid-managed-care-plan
- **Aligning Coverage for Dually Eligible Beneficiaries Using Default and Passive Enrollment** (Integrated Care Resource Center, July 2018). This webinar describes the default enrollment process, and, in particular, state roles in this process, including the need to identify beneficiaries newly eligible for Medicare. https://www.integratedcareresourcecenter.com/webinar/aligningcoverage-dually-eligible-beneficiaries-using-default-and-passive-enrollment
- **CMS Files That Provide Data to States on Upcoming Medicare Eligibility** (CMS, July 2018). This resource provides states with a description of CMS data sources that states can use to support default enrollment. https://www.integratedcareresourcecenter.com/PDFs/File_Comparison_Chart_7-26-18.pdf

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by **Mathematica Policy Research** and the **Center for Health Care Strategies**. For more information, visit **www.integratedcareresourcecenter.com**.

[1] See 42 CFR §422.66(c)(2) for detailed default enrollment requirements. States interested in default enrollment can review the February 2019 FAQs document prepared by CMS and cited at the end of this fact sheet. For more detail on the background and rationale for this new default enrollment option, see pp. 16495-16502 of the final rule published in the April 16, 2018 Federal Register, and cited at the end of this fact sheet.

[2] Centers for Medicare & Medicaid Services. "CMS Files That Provide Data to States on Upcoming Medicare Eligibility." July 2018. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/File_Comparison_Chart_7-26-18.pdf.

[3] Technically, it is the Medicare Advantage organization that owns the D-SNP that must apply for default enrollment and must meet these default enrollment requirements.