Medicare-Medicaid Plan (MMP) Enrollment -- Overview

Sharon Donovan
Medicare-Medicaid Coordination Office (MMCO)

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Agenda

• Overview of final Enrollment Guidance
  – En rollments
    • Passive
    • Voluntary
  – Cancellations, Disenrollments, and “Opting Out”
    • Beneficiary-initiated
    • Involuntary
  – Emphasis on policy/procedures
    • With notes on operations
References in each slide’s header

– “Step ***” refers to step in process flow
  • Process flows will be provided in a separate document
– “§” 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
• 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:

  - State(or MMP)
  - MMP enrollment file submission to Infocrossing’s SFTP server
  - Infocrossing (validates the file format and converts into a MARx format)
  - CMS (processes enrollment and sends DTRR to Infocrossing)
  - Infocrossing (distributes the DTRR to State or MMP)
  - MMP Enrollment (State and MMP send out enrollment notices and materials)
Passive Enrollment
Identify Passive Enrollees
(Step 1; §§ 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 (Step 1; §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
(Steps 1a-b; §§ 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)
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
(Step 2; §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
(Steps 2-2a; §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
(Steps 3&15; §30.3)

• 60 days before passive enrollment effective date, State
  – [Step 3] 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

• [Step 15] Submits 834 Benefit Enrollment and Maintenance file to MMP, with address
Infocrossing Batch Transaction Processing (Steps 4-7)

- Infocrossing performs:
  - File format check and data validation
    - Sends back rejected records to States that have errors or mismatches 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 (Step 10)

- CMS returns a DTRR to Infocrossing
  - Infocrossing sends to State and MMP simultaneously
- DTRR 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
(Steps 10-14; §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
• 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
(Step 18; §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
(Steps 1-3; §§ 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
(Step 2; §§ 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  
(Steps 11-11a; § 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)
• 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
(Step 3; §§ 20.1, 30, 30.1.1, 30.2 l., 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 (Steps 4-14)

• 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
(Step 15; §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
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)
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

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<thead>
<tr>
<th>TRC</th>
<th>Definition</th>
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<tbody>
<tr>
<td>011 A</td>
<td>ENROLLMENT ACCEPTED AS SUBMITTED</td>
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<tr>
<td>015 A</td>
<td>ENROLLMENT CANCELLED</td>
</tr>
<tr>
<td>016 I</td>
<td>ENROLLMENT ACCEPTED, OUT OF AREA</td>
</tr>
<tr>
<td>022 A</td>
<td>TRANSACTION ACCEPTED, CLAIM NUMBER CHANGE</td>
</tr>
<tr>
<td>023 A</td>
<td>TRANSACTION ACCEPTED, NAME CHANGE</td>
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## Enrollment TRCs - Continued

<table>
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<th>ENROLLMENT TRCs</th>
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<tr>
<td>307 A</td>
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<td>308 R</td>
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<td>313 R</td>
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The following TRCs are the most common disenrollment TRCs to be received by States and MMPs

<table>
<thead>
<tr>
<th>DISENROLLMENT TRCs</th>
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<tbody>
<tr>
<td>013 A</td>
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<td>014 A</td>
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<td>018 A</td>
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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
Additional Resources

• PCUG Main Guide:

• PCUG Appendices:
Questions?

• Send enrollment policy and procedure questions to CMS
  MMCOCapsmodel@cms.hhs.gov

• Send questions related to Infocrossing
  MCareSupport@wipro.com
  (877) 833-3499