CMS Establishes Enrollment Rules for the Dual Eligible Financial Alignment Demonstrations


How the Guidance Functions

The guidance sets uniform minimum requirements across states but is designed so that state-specific requirements can be added as an appendix. Further, model forms can be modified to reflect state procedures, but any modification requires CMS concurrence. Thus it appears that ultimately, there will be a complete enrollment guidance package for each of the financial alignment demonstration states consisting of:

1. The main guidance text without alteration;
2. State specific forms which will be modified versions of the model forms currently attached to the guidance; and,
3. A state-specific appendix that details:
   a. state variations and Medicaid-specific requirements, and
   b. the enrollment functions that will be delegated to Medicare-Medicaid Plans (MMPs) in the state.

Modifications in the appendix should be consistent with the MOU and the three-way contract.

In states that intend to mandate Medicaid managed care enrollment (even for individuals opting out of the demonstration), the state has the choice to either include guidance about handling those situations in the appendix or put that guidance into a separate document.

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CMS did not state whether it expects that the process of creating a state appendix to the guidance will be simultaneous with or subsequent to the negotiation of a three-way contract.

**Importance for Advocates**

Advocates working with their states on enrollment issues should familiarize themselves with the enrollment guidance, so that they may understand the flexibilities that CMS provides to states on designing and operating an enrollment system. It will be important to ensure that the state-specific appendix lays out all the consumer protections that advocates have worked for in the enrollment process. Advocates should review the model application form and notices to determine what changes are needed to reflect their state’s proposal. Further, they should consider what changes could be made to improve the clarity of the notices and whether the notices need to be revised to meet state requirements for grade-level readability.

**Context for the Guidance**

This guidance, geared primarily to plans, builds on previous policy statements by CMS that permit states to passively enroll individuals into the demonstrations but require that individuals be able to opt out before passive enrollment is effectuated. Further, even after enrollment, individuals can disenroll at any time from managed care for Medicare services—states may not impose any lock-in period. CMS encourages states to have an initial voluntary enrollment period, but does not require it.

Several states are asking CMS for permission to mandatorily enroll dual eligibles into Medicaid managed care, even if those individuals opt out of the demonstration. Mandatory Medicaid enrollment must be approved separately as part of a Medicaid waiver and is not part of this guidance. Further, although the guidance is more detailed than what we have seen previously, it still leaves many details, such as how enrollment brokers will function, unanswered.

Aspects of the guidance that are of particular interest to advocates include:

**Eligible populations**

The guidance permits states, if they choose, to include individuals with ESRD in the demonstration population and to subject them to passive enrollment in a Medicare-Medicaid Plan (MMP). (Sec. 30.2.4) States may also decide to passively enroll hospice
enrollees. PACE members may not be passively enrolled, though they may disenroll from PACE and voluntarily join the demonstration. (30.1.4.A)

**Enrollment timing**

**Opting in:** Generally, a voluntary decision to enrollment in the demonstration is effective the first day of the month following the month of enrollment. States may set an earlier cut-off for accepting enrollment applications, but that cut-off may not be more than five calendar days before the end of the month. (Sec. 20)

**Switching from one MMP to another:** The state option to set an earlier cut-off date for accepting enrollment requests applies to requests to change enrollment from one MMP to another. (Sec. 20)

**Disenrolling:** All disenrollments are effective the month following the disenrollment request. Disenrollment requests must be accepted through the last day of the month—states may not set an earlier cut-off date. Dual eligibles who disenroll from an MMP and do not choose their own plan or opt out of future enrollment will be auto-enrolled in a Part D plan and receive their other Medicare benefits through fee-for-service Medicare. (Sec. 20.2)

**Passive Enrollment**

**Passive Enrollment Notices and Opting Out:** States must provide at least 60 days notice of passive enrollment, with a 30-day follow-up. Individuals can opt out through the state or 1-800-Medicare. Plans must refer individuals to these entities. Individuals must be allowed to opt out of passive enrollment verbally as well as in writing. (Sec. 30.1.4.E)

**Passive Enrollment Only Once:** An individual may not be offered passive enrollment into any plan offering Medicare benefits (MA, Part D, MMP) more than once per benefit year. The only circumstance when an individual can be passively enrolled into an MMP more than once in a benefit year would be in case of MMP terminations or if CMS and the state determine that remaining in the MMP poses potential harm to members. (Sec. 30.1.4) If individuals opt out of passive enrollment, the state cannot passively enroll them into another plan for the life of the demonstration. (Sec. 30.1.4)

**Coordination with Part D Reassignment.** In September of each year, CMS will provide states with the identities of dual eligibles who are scheduled to be reassigned to a new Part D plan because their current plan has lost benchmark status. States have two options: a) accelerate passive enrollment into the demonstration for those individuals
so that their enrollment date is January 1 (CMS will then cancel the Part D reassignment), or b) postpone enrollment for those individuals until at least January 1 of the next plan year (this protects these individuals from experiencing passive enrollment more than once in any year). (Sec. 30.1.4.H).

Plan Assignment: Passive enrollment cannot be random. It must be based on the individual’s providers over the past 12 months and/or membership in a Medicare or Medicaid managed care plan by the same sponsor. (Sec. 30.1.4.B)

Method and coordination

Method of Enrollment: States must have paper enrollment procedures. They may, but are not required to offer internet (Sec. 30.1.2) and/or telephone enrollment (Sec. 30.1.3). Enrollments must be handled by the state (or its agents). States may, with CMS approval, defer some enrollment activities to plans, but not passive enrollment (p. 1).

Data Transmission Deadlines: States must transmit enrollment data to CMS within 7 calendar days of receipt. States are encouraged to make more frequent transmissions. (Sec. 30.3)

Plan eligibility for passive enrollment

The state may not passively enroll individuals into a plan sponsored by an organization that is an “outlier” or has a consistently low performing icon (LPI) unless the individual already belongs to a Medicare or Medicaid managed care plan by the same organization. (Sec. 30.1.4.B) Past performance outlier status is based on a plan’s performance in 11 categories. LPI designation is given to plans with poor or below average Medicare plan ratings, or less than three stars for three or more consecutive years.² Though they may not participate in passive enrollment, these plans may continue to accept voluntary enrollment. Further, their participation in passive enrollment may be reinstated if, in a subsequent year, they lose outlier or LPI status.

Disenrollment When Medicaid Eligibility Is Lost

An individual who loses Medicaid eligibility may not remain in the demonstration. The general rule is that the plan must disenroll the individual on the first day of the month following notification to the plan that the individual is no longer eligible for Medicaid.

Plans, however, have the option of allowing the individual to remain in the plan for a two month grace period if the individual can reasonably be expected to regain Medicaid eligibility within two months. (Sec. 40.2.3.2)

**Notices**

The guidance includes a model application form and model notices related to enrollment and disenrollment. Mailing deadlines for notices are also included. (p. 76) Model notices may be modified to reflect state-specific provisions and to meet reading level and translation requirements in the state if those requirements are more beneficiary-friendly than federal standards. States also may require additional notices. States may delegate to plans the mailing of some notices. (p. 75)

**Conclusion**

The CMS enrollment guidance provides additional clarity on federal requirements for enrollment in the demonstrations. It also provides an opportunity for advocacy to ensure that the state-specific elements that will be added to the guidance offer adequate protections and ensure a beneficiary-friendly process.

For more information on the dual eligible demonstrations, go to [www.dualsdemoadvocacy.org](http://www.dualsdemoadvocacy.org) or subscribe to the National Senior Citizens Law Center’s health policy alerts at [www.nsclc.org/index.php/store/subscriptions/](http://www.nsclc.org/index.php/store/subscriptions/). Questions about the Enrollment Guidance can be directed to Georgia Burke, [gburke@nsclc.org](mailto:gburke@nsclc.org).