Default Enrollment FAQs

February 2019

Q1. What is default enrollment?

A. Default enrollment is an enrollment process that allows a Medicare Advantage (MA) organization, following approval by the state and CMS, to enroll – unless the member chooses otherwise – a member of an affiliated Medicaid Managed Care Organization (MCO) into its Medicare Dual Eligible Special Needs Plan (D-SNP) when that member becomes newly eligible for Medicare. This process is only permissible in circumstances where the member remains enrolled with the Medicaid MCO upon Medicare eligibility. The only default enrollment effective date possible is the date an individual is initially eligible for Medicare Advantage (i.e., has both Medicare Part A and Part B for the first time).

For more information, please see 42 CFR 422.66 (c)(2) and section 40.1.4 of Chapter 2 of the Medicare Managed Care Manual, which can be found on the CMS MA enrollment webpage.

Q2. What type of plan can apply for default enrollment?

A. MA organizations that have an affiliated Medicaid MCO and also offer a D-SNP in the same service area may apply for default enrollment into their D-SNP. The default enrollment is limited to members who are enrolled in their Medicaid MCO at the time of the member's initial eligibility for Medicare, based on disability as well as age, and who meet the other requirements for enrolling in the D-SNP. This process is only permissible in circumstances where the member continues to receive comprehensive Medicaid coverage from the Medicaid MCO after attainment of Medicare eligibility to meet the regulatory requirements that default enrollment promote integrated Medicare and Medicaid coverage. If Medicare eligibility disqualifies an individual from Medicaid MCO enrollment, the MA organization may not receive approval for default enrollment of these individuals.

MA organizations interested in applying for default enrollment must also have a minimum overall quality rating of at least 3 stars in the most recently published data (or not have a star rating because it is a low enrollment contract or is a new MA plan), and not have any prohibition on new enrollment imposed by CMS. These criteria are codified at 42 CFR 422.66(c).

Q3. What is the state's role in default enrollment?

A. First, MA organizations can apply for default enrollment only where states approve the use of the default enrollment process through the State Medicaid Agency Contract (SMAC) with the D-SNP. Please see Q6 (below), 42 CFR 422.107, and Chapter 16b of the Medicare Managed Care Manual for more information on SMAC contract requirements.

In addition, MA organizations can apply for default enrollment only where the state agrees to provide to the organization prospective Medicare eligibility information on its MCO enrollees on a monthly or more frequent basis. Accurate, timely state-plan information exchange is critical to an organization's ability to properly operationalize the default enrollment process. States will need to take a number of steps to identify and share the needed data with organizations; please see Q7 below for additional information.

Q4. If a state is interested in pursuing default enrollment with D-SNPs in their state, what are its next steps?

A. To begin the process, states should reach out to interested stakeholders (e.g., beneficiary advocates) and the MA organization(s) in their state to communicate the state's interest in participating in default enrollment. We also recommend consulting with CMS' Medicare-Medicaid Coordination Office (MMCO) early, so we can provide technical assistance to states and MA organizations throughout the process.

Q5. When a D-SNP applies to CMS for permission to conduct default enrollment, how can it demonstrate state support for default enrollment?

A. The D-SNP can demonstrate state support for default by submitting any of the following:

- State approval for the use of default enrollment in its State Medicaid Agency Contract (SMAC),
- Documentation that the state has interpreted the SMAC to cover default enrollment and state provision of prospective Medicare eligibility data, or
- Documentation of a legally binding adjunct to the SMAC that includes default enrollment and state provision of prospective Medicare eligibility data.

Q6. How does a state share data on upcoming Medicare eligibility with the Medicaid MCO?

A. CMS makes available to states data on upcoming Medicare eligibility for Medicaid enrollees in a variety of ways. As a result, the state should first determine the CMS data exchange it wants to use to identify MCO enrollees about to become Medicare eligible. The at-least monthly "State MMA" file exchange with CMS has prospective Medicare eligibility; CMS also provides other ad hoc, batch query options, including the Medicare Enrollment Data Base (EDB) file and the Territory Batch Query (TBQ) file. To learn more

about each of these files, please contact MMCOEnrollment@cms.hhs.gov. Please see Appendix: "CMS Files That Provide Data to States On Upcoming Medicare Eligibility" at the end of the FAQs for more information on the above data files.

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 (as both are required for enrollment in a D-SNP).

Finally, the state determines the frequency and mechanism for sharing the data with the D-SNPs. It is important to establish a process in which the state provides the Medicare eligibility data to the MA organization in enough time for plans to send the required default enrollment notice to beneficiaries no fewer than 60 days prior to the start of Medicare eligibility.

Prior to issuing the default enrollment notice, each plan will need sufficient time to review the data it receives from the state and further validate the individuals' eligibility for the D-SNP (e.g., individual is current member of Medicaid MCO, continues to have Medicaid eligibility, and lives in the service area).

Q7. What are the challenges with identifying individuals eligible for default enrollment?

A. The key challenge for states and plans has been to identify upcoming Medicare eligibility of Medicaid plan members via CMS data files in time for the plan to meet the default enrollment notification deadline (i.e., for sending affected beneficiaries notice of pending enrollment 60 days prior to the enrollment effective date, which is the first day of the month the beneficiary is eligible for Medicare Part A and enrolled in Medicare Part B). This has been especially true for those about to become eligible for Medicare based on disability.

In addition, some states complete a re-determination of Medicaid eligibility when an individual turns 65 or otherwise becomes Medicare-eligible. To facilitate default enrollment, such Medicaid redeterminations would need to be completed far enough in advance of Medicare eligibility so that the state can not only notify plans of MCO enrollees with upcoming Medicare eligibility, but also confirm that these individuals' Medicaid eligibility will continue. This would need to be more than 60 days prior to the start of Medicare eligibility so that the D-SNP can meet the regulation's requirement to send a notice no fewer than 60 days prior to the effective date of Medicare eligibility.

For example, if a Medicaid MCO enrollee has Medicare eligibility effective October 1, any state Medicaid redeterminations would need to be completed by July so that the D-SNP could confirm MA eligibility, submit transactions to CMS and send the beneficiary notice no later than August 1.

Q8. When a D-SNP applies for CMS permission to conduct default enrollment, what must it provide to show that it has a process in which the state shares information to identify members of the affiliated Medicaid Managed Care organization who are approaching Medicare eligibility?

A. A D-SNP must provide the following information to demonstrate its ability to identify default-enrollment eligible individuals timely:

- Agreement by the state to provide the information necessary for the D-SNP to identify individuals in their Medicaid MCO who are in their MA initial coverage election period;
- A description of the data process, including:
    - Which CMS data source they use to identify upcoming Medicare eligibility of Medicaid MCO enrollees (will be one of the following: Enrollment Beneficiary Database [EDB], Medicare Modernization Act [MMA] file, Territory Batch Query [TBQ])
        - State will need to supply the following:
            - MBI
            - Medicare A/B start date
    - Method for transmitting data to plan (e.g., 834 enrollment file to Medicaid MCO, separate file)
        - Frequency of transmitting data to plan
            - Should be at least monthly
        - Must be at least 60 days prior to Medicare eligibility date for individuals being reported to MAO
    - How frequently the state checks CMS data source
        - Should be at least monthly

Q9. How can a D-SNP apply for default enrollment?

A. An MA organization with an affiliated Medicaid MCO and offering a D-SNP may submit a proposal for default enrollment to their appropriate CMS Account Manager. All proposals must be submitted via Medicare's Health Plan Management System (HPMS), reviewed by the Account Manager, and approved by CMS. The Default Enrollment module in the HPMS enables users to manage their proposals, upload supporting documents as required, select the type of plan the beneficiaries will be moving from, and view a report.

Q10. What can D-SNPs do to prepare for requesting approval for default enrollment for the first time?

A. The MA organization can begin to develop the template for their beneficiary notice, test data exchanges with the state, and assemble other documents/information required to request default enrollment. In addition, we encourage plans to add additional capacity to support outreach to beneficiaries, such as outbound calls and additional reminder letters.

Q11. What are the new notice requirements for D-SNPs?

A. Medicare Advantage plans are required to send a written notice to identified eligible members no fewer than 60 days prior to the effective date of Medicare eligibility and enrollment in the plan. The beneficiary notice for default enrollment must address the following:

- Information on how to opt out of, or decline, the enrollment, up to and including the day prior to the enrollment effective date, and either enroll in Original Medicare or choose another MA plan. The opt-out or decline process must include the opportunity to contact the MA organization either in writing or by telephone to a toll-free number. Opt-outs are to be processed as enrollment cancellations;
- Information on the differences in premium, benefits, and cost sharing between the individual's current Medicaid managed care plan and the D-SNP;
- Information on the process for accessing care under the D-SNP; and
- A general description of alternative Medicare health and drug coverage options available to an individual in his or her Initial Coverage Election Period.

Please note that CMS must approve the notice prior to its use.

Q12. What is the timeframe within which the D-SNP must submit default enrollment transactions to CMS?

A. The MA organization will send the appropriate enrollment transaction to CMS at that same time that it sends the written notice (i.e., no fewer than 60 days prior to the Medicare effective date—the first day of the month of the beneficiaries' eligibility for Medicare Parts A and B).

Q13. What else can the state do to promote a successful default enrollment process?

A. The state can assess whether it and/or its Medicaid MCO has any standard notices triggered by an individual becoming Medicare eligible, and determine how to coordinate that communication with the D-SNP's default enrollment notice.

In addition, CMS strongly encourages states to engage stakeholders.

Q14. How does CMS interpret the regulatory requirement that, to be eligible for default enrollment, a Medicaid beneficiary must remain in the Medicaid managed care organization upon becoming Medicare-eligible (dually eligible)?

A. This requirement is met under the following scenarios:

- The individual remains enrolled with the same Medicaid managed care organization for Medicaid benefits. Default enrollment results in enrollment in a companion D-SNP offered by the same legal entity or by an entity that shares a parent organization with the Medicaid managed care organization.
- Through default enrollment, the individual, upon becoming dually eligible, transitions into receiving Medicare and Medicaid coverage through a D-SNP that contracts with the state to provide Medicaid benefits and that is offered by the same legal entity or by an entity that shares a parent organization with the Medicaid managed care organization.

Q 15. Does the default-enrolled, dually eligible beneficiary have to remain enrolled in the exact same Medicaid plan in which they were enrolled before attaining Medicare eligibility?

A. No. Through the default enrollment process, a dually eligible beneficiary can transition to a different Medicaid managed care plan offered by the same legal entity, or by an entity that shares a parent organization with the MCO that provided his or her Medicaid coverage prior to becoming Medicare eligible. For example, a beneficiary could, upon becoming Medicare eligible, transition from a Medicaid managed care organization to Medicaid coverage under a FIDESNP in which the beneficiary receives both Medicare and Medicaid benefits through one managed care organization.

Q 16. What types of Medicaid managed care plans can a D-SNP draw from for default enrollment? Are D-SNPs eligible to default enroll beneficiaries enrolled in limited benefit managed care plans or case management arrangements for default enrollment?

A: As stated in the preamble to the final rule, beneficiaries are only eligible for default enrollment if they are enrolled in a comprehensive Medicaid managed care organization affiliated with the D-SNP prior to becoming Medicare-eligible. Default enrollment is not available if an individual is enrolled in a more limited Medicaid prepaid inpatient health plan or prepaid ambulatory health plan; in a plan that only covers Medicare cost-sharing; or in a managed fee-for-service model such as primary care case management, health home, or accountable care organization.

Q 17. What types of Medicaid managed care plans must a default-enrolled individual be enrolled in after becoming Medicare-eligible? Can these Medicaid managed care plans be limited benefit managed care plans?

A. The Medicaid managed care plan post-default enrollment must cover a substantial range of Medicaid benefits that result in a higher level of integrated coverage for the beneficiary. D-SNPs that have coverage of Medicare cost sharing as their only Medicaid benefit would not qualify for default enrollment.

APPENDIX
CMS FILES THAT PROVIDE DATA TO STATES ON UPCOMING MEDICARE ELIGIBILITY

D-SNPs can only apply to CMS to conduct default enrollment when their State Medicaid Agency Contract includes provisions indicating the state approves the use of default enrollment and agrees to provide the plan with advance notice of Medicaid MCO enrollees who have upcoming Medicare eligibility. CMS provides states with several options for obtaining these data. Below is a chart comparing the source and timing of data CMS provides to states via various on-going and ad hoc file exchanges. All provide advance notice of Medicare eligibility, so can be used by the states to identify for their plans those in their Medicaid MCOs who are about to become Medicare eligible. For more information, please contact MMCOEnrollment@cms.hhs.gov.

File Name and Description	File Elements								
	Beneficiary Name	**Beneficiary Address**	**Date of Birth**	**HICN MBI SSN**	**Part A**	**Part B**	**Part D**	**Date of Disability**	**Dual Eligibility Status**
Medicare Modernization Act File – MMA The MMA file is a data file states submit at least monthly (and up to daily) to identify existing dually eligible beneficiaries to CMS. States also submit records on those Medicaid-only beneficiaries they believe are about to become Medicare eligible. CMS returns a responsive file with Medicare eligibility, entitlement, and enrollment information. CMS originally used the MMA file data to support Part D operations; it now uses it to support operations in all four parts of Medicare.	Yes	No	Yes	HICN, SSN	Yes	Yes	Yes	No	QMB, SLMB, QI, and other full duals. Prospective
Medicare Enrollment Database – EDB The EDB provides for ad hoc data queries from states on Medicare A/B entitlement/eligibility.	Yes	Mailing	Yes	HICN, MBI, SSN	Yes	Yes	No	Yes	No

File Name and Description	File Elements								
	Beneficiary Name	**Beneficiary Address**	**Date of Birth**	**HICN MBI SSN**	**Part A**	**Part B**	**Part D**	**Date of Disability**	**Dual Eligibility Status**
Batch Eligibility Query – BEQ The BEQ Request File includes transactions submitted daily by plans to CMS' Medicare Advantage and Drug (MARx) enrollment and payment system to obtain Medicare eligibility information for prospective plan enrollees. Plans use this data received in the CMS response file to conduct initial eligibility checks for prospective enrollees.	Yes	Mailing & Residence	Yes	HICN	Yes	Yes	Yes	No	LIS Deemed
Territory Beneficiary Query – TBQ The TBQ is an ad hoc query CMS offers to states that returns the same robust range of Medicare data as in the CMS MMA response file, but on an ad hoc basis. States and territories may query CMS daily for Medicare beneficiary eligibility determination and Medicare Beneficiary Database (MBD) returns a file with this information.	Yes	Mailing & Residence	Yes	Claim Account Number, SSN, MBI	Yes	Yes	Yes (also includes SNP indicator)	No	LIS Co-pay level

Medicare-Medicaid Coordination Prospective Duals File A CMS contractor provides the Prospective Dual File to states, based on querying the Medicare Beneficiary Database. It contains a list of individuals who have already been identified as having Medicaid (from MMA file submissions). It includes information about an individual's Medicare Part A and B entitlement three to four months (and sometimes five to six months) before their Medicare effective date. The Prospective Dual File is available on the CMS contractor's web portal on the second and sixteenth day of every month. States can download the Prospective Dual File from the contractor's web portal or have the contractor push it to them via a secure server. **Note that default enrollment is available only for the very first time an individual is eligible for Medicare A/B. While this Prospective Duals File does identify individuals who do not currently have Medicare A or B but will have it in the near future, it is possible that the individual had been eligible in the past and then lost eligibility. A state would use this file to identify a beneficiary with an upcoming Part A/B eligibility, but would then need to refer to either the MMA or TBQ file to determine if there was a prior A/B entitlement span.*	Yes	Residence	Yes	Medicare ID (MBI)	Yes	Yes	Yes	No	LIS Deemed Medicaid Status

Resources:

MMA File – MAPD State Plan Users Guide (MAPD SPUG): https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Downloads/MAPD-State-User-Guide-Version-60.pdf

EDB File – EDB Data Dictionary: to receive a copy of the Medicare Enrollment Database Data Dictionary Version, send an email To: EDBOnline@cms.hhs.gov with Subject: EDB Data Dictionary, and the most current version will be sent to you.

BEQ File – Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) Appendices (updated quarterly): https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Downloads/PCUG-Appendices-v113-November-30-2017.pdf

TBQ File – Medicare Beneficiary Database Suite of Systems (MBDSS), Interface Control Document (ICD), For Territory Beneficiary Query (TBQ): https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/TBQICDv55_06212017.pdf

MMCO Prospective Duals File FAQ – Identifying Newly Eligible Medicare-Medicaid Individuals for Enrollment in Capitated Financial Alignment Demonstrations: Frequently Asked Questions (FAQs): http://www.integratedcareresourcecenter.com/PDFs/NewDualsID_FAQ_04-04-17.pdf

Infocrossing's Medicare and Medicaid Plans: A Technical Guide to Eligibility and Enrollment Transaction Processing: http://www.integratedcareresourcecenter.com/PDFs/MMP_EE_Guide.pdf

Questions? Contact MMCO Enrollment at MMCOEnrollment@cms.hhs.gov