Appendix 5: California Specific MMP Enrollment and Disenrollment Guidance

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This document defines California specific Enrollment/Disenrollment Requirements where there are differences from the national MMP Enrollment and Disenrollment Guidance as published by CMS on August 2, 2018.

California Enrollment Specific Assumptions[1]:

Passive Enrollment Transactions can be initiated by the State or the County Organized Health System (COHS) Medicare-Medicaid Plans (MMP).

1. Voluntary Enrollment Requests from beneficiaries can be accepted and processed by the State (for non-COHS MMPs), or the MMPs for beneficiaries in COHS counties. Non-COHS MMPs are also permitted to outreach to eligible beneficiaries in their corresponding Medicaid (Medi-Cal) managed care plans and may enroll them through a voluntary enrollment process called "Streamlined Enrollment." Non-COHS MMPs may collect enrollment information from the beneficiary and transmit it directly to the State for processing.
2. Opt-outs, Cancellations, or Voluntary Disenrollment Requests can be accepted and processed by the State (for beneficiaries in non-COHS counties) or the MMP for beneficiaries in COHS counties. If beneficiary contacts the MMP in a non-COHS county to opt-out or disenroll, the MMP will refer beneficiary to the State. If beneficiary contacts the State in a COHS county to opt-out or disenroll, the State will refer beneficiary to the MMP. Per the national guidance, the beneficiary may also request disenrollment from the MMP and opt out from any future passive enrollment into MMP by contacting 1-800-MEDICARE.
3. Involuntary Disenrollment requests can be initiated by the State or CMS.
4. COHS MMPs must comply with all enrollment and disenrollment processing requirements, including timeliness requirements outlined in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance including State-specific requirements that are applicable to COHS MMPs. The following sections describe the specific California variances to each section of the MMP Enrollment and Disenrollment Guidance.

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- COHS MMPs refer to MMPs in San Mateo and Orange County.
- Non-COHS MMPs refer to MMPs in Los Angeles, San Bernardino, San Diego, Santa Clara, and Riverside.

1. **Eligibility for Enrollment in Medicare-Medicaid Plans** – *This section supplements and clarifies the requirements of **§10** of the MMP Enrollment and Disenrollment Guidance*

   Individuals covered under an employee benefit plan may not enroll in an MMP. The State, and delegated MMPs, must deny a request for voluntary enrollment to otherwise eligible individuals covered under an employer/union or spouse's group health benefits plan.

2. **Completion of Enrollment Request -** *This section supplements and clarifies the requirements of **§10.3** of the MMP Enrollment and Disenrollment Guidance.*

   Individuals living in Los Angeles, San Bernardino, San Diego, Santa Clara, and Riverside may request enrollment in an MMP by contacting the state enrollment broker (Health Care Options/Maximus) or by contacting their MMP directly.

   Individuals living in Orange or San Mateo County may request enrollment in an MMP by contacting the MMP plan directly.

3. **Medicaid Eligibility and Additional State-Specific Eligibility Requirements for Enrollment in Medicare-Medicaid Plans** - *This section supplements and clarifies the requirements of **§10.5** of the MMP Enrollment and Disenrollment Guidance.*

   A. In addition to the eligibility criteria listed in §10, an individual must meet the following criteria in order to be eligible to enroll:
      - Age 21 and older at the time of enrollment;
      - Entitled to or enrolled in Medicare Part A, enrolled in Medicare Parts B, eligible to enroll in Medicare Part D, and receiving full Medicaid benefits;
      - Eligible for full Medicaid (Medi-Cal), including
        - o Individuals enrolled in the Multipurpose Senior Services Program (MSSP).
        - o Effective January 1, 2022, individuals who meet the share of cost provisions described below:
          - Nursing facility residents with a share of cost,

- Reside in one of the following Demonstration counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
    - Up to 200,000 individuals in Los Angeles County may be enrolled in Participating Plans for the Demonstration. CMS and the State will monitor the enrollment and will close the MMPs to new enrollments when this enrollment cap is met.
- Individuals in San Mateo County receiving services through California's regional centers or state developmental centers or intermediate care facilities for the developmentally disabled.
- Individuals residing in San Mateo or Orange County with a diagnosis of end stage renal disease (ESRD) at the time of enrollment may enroll in an MMP.

B. The following populations will be excluded from enrollment:

- Individuals under age 21;
- Individuals covered under an employee benefit plan;
- Individuals with other private or public health insurance;
- Individuals receiving services through California's regional centers or state developmental centers or intermediate care facilities for the developmentally disabled in the following Demonstration counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego and Santa Clara;
- Effective January 1, 2022, individuals with a share of cost that do not meet the requirements outlined above;
- Individuals residing in one of the Veterans' Homes of California;
- Individuals living in the following rural zip codes:
    - San Bernardino County – 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 93592, and 93558
    - Los Angeles County - 90704
    - Riverside County - 92225, 92226, 92239;
- Individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment and residing in Los Angeles, San Bernardino, San Diego, Santa Clara, and

Riverside, unless they are already enrolled in a separate Medicare line of business operated by the MMP on the first day of eligibility. Individuals enrolled in the Demonstration who are subsequently diagnosed with ESRD, as with all enrollees, may choose to disenroll from the Demonstration or may choose to stay enrolled.

C. Individuals that may enroll but may not be passively enrolled include:

- Individuals residing in the following rural zip codes in San Bernardino County in which only one MMP operates: 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92326, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, and 92398;
- Individuals enrolled in a Home and Community Based Services (HCBS) waiver (except MSSP);
- Individuals who have developmental disabilities;
- Individuals enrolled in Medicare Advantage organizations.
- Individuals may not be concurrently enrolled in an MMP and one of the following programs:
  - The following 1915(c) waivers: Nursing Facility/Acute Hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In-Home Operations Waiver;
  - Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation

4. Elections and Effective Dates - *This section supplements and clarifies the requirements of* ***§20*** *of the MMP Enrollment and Disenrollment Guidance.*

Elections include both enrollment and disenrollment requests.

On an ongoing (i.e., month to month) basis, individuals who meet the criteria for enrollment in MMPs may:

- Switch from Original Medicare to an MMP
- Switch from an MMP to Original Medicare (beneficiary will be required to enroll in a Medi-Cal Managed Care Plan for their Medi-Cal benefits)

- Switch from a Medicare health or drug plan to an MMP
- Switch from an MMP to a Medicare health or drug plan (beneficiary will be required to enroll in a Medi-Cal Managed Care Plan for their Medi-Cal benefits)
- Switch from one MMP to another MMP
- Switch from an MMP to a PACE organization
- Switch from a PACE organization to an MMP
- Switch from an MMP to a Medi-Cal Managed Care Plan
- Switch from a Medi-Cal Managed Care Plan to an MMP
- Switch from Medi-Cal FFS to an MMP

The State, or delegated MMP, will determine whether the individual is eligible for enrolling in an MMP using State specific eligibility criteria specified in Section 3 of this Appendix 5. All enrollment requests are processed by the State or designated MMPs, as follows:

In Santa Clara, Los Angeles, San Bernardino, Riverside, and San Diego counties, the State will determine whether the individual is eligible for enrolling in an MMP. The State or CMS may disenroll an individual if it is subsequently determined that the individual is not eligible for the program.

In Orange and San Mateo counties, the MMP will determine whether the individual is eligible for enrolling in an MMP using the state-specific eligibility criteria in Section 3 of this Appendix. The State or CMS may disenroll an individual if it is subsequently determined that the individual is not eligible for the program.

This includes enrollment requests completed or approved by CMS or the State, including passive enrollments.

5. Effective Date of Voluntary Disenrollment - *This section supplements and clarifies the requirements of* ***§20.2*** *of the MMP Enrollment and Disenrollment Guidance.*

When a member voluntarily disenrolls from an MMP, the member will return to Original Medicare and be enrolled in the MMP's Medi-Cal managed care plan (unless the individual

elects a different Medi-Cal managed care plan) effective on the first day of the following month; and will remain in the MMP until the last day of the month the disenrollment request was received.

Note: If the beneficiary disenrolls from the MMP by enrolling in a different Medicare Advantage plan or Medicare prescription drug plan, the beneficiary will be enrolled in the MMP's Medi-Cal managed care plan (unless the individual elects a different Medi-Cal managed care plan) effective on the first day of the following month.

If eligible for the Medicare Part D Low Income Subsidy, CMS will auto-enroll the beneficiary into a Medicare Prescription Drug Plan. The individual will have access to the LI NET prescription drug plan during any coverage gap. When an individual enrolls in a Medicare health or drug plan while currently enrolled in an MMP, they will automatically be disenrolled from the MMP effective the last day of the month.

Individuals have until the last calendar day of the month to request disenrollment. All voluntary disenrollments are effective on the first day of the month following receipt of the request by the State.

6. **Enrollment Procedures** - *This section supplements and clarifies the requirements of* ***§30*** *of the MMP Enrollment and Disenrollment Guidance.*

MMPs in Santa Clara, Los Angeles, San Bernardino, Riverside, and San Diego counties may not accept disenrollment, transfer, and opt-out requests directly from individuals. These requests must be referred to the State enrollment broker (Health Care Options – Maximus).

The State will defer enrollment activities to the MMPs in Orange and San Mateo counties.

The State will send the 834 Benefit Enrollment and Maintenance file (which includes member address) to MMPs according to existing delivery schedules.

The state does not do passive enrollment into Medicare-Medicaid Plans.

7. **4Rx Data** (Supplement to **§30.1.4 J.** of the MMP Enrollment and Disenrollment Guidance)

   The state will omit "4Rx data" from the enrollment transactions (TC 61) sent to CMS, and instead direct MMPs to submit this data to CMS directly after receiving a Daily Transaction Reply Report that confirms enrollment.

8. **ESRD and Enrollment** *This section supplements and clarifies the requirements of* ***§30.2.5*** *of the MMP Enrollment and Disenrollment Guidance.*

Individuals with ESRD living in Orange or San Mateo County may enroll in an MMP.

Individuals with ESRD living in Los Angeles, San Bernardino, San Diego, Santa Clara, and Riverside may not be enrolled in an MMP, unless they are already enrolled in a separate Medicare line of business operated by the MMP's parent organization on the first day of eligibility. Individuals enrolled in the MMP who are subsequently diagnosed with ESRD, as with all enrollees, may choose to disenroll from the Demonstration or may choose to stay enrolled.

9. **Enrollment of Individuals with Medicare Employer Group Health Plan Coverage or Individuals Being Claimed for the Retiree Drug Subsidy (RDS) –** *This section supplements and clarifies the requirements of* ***§30.2.5*** *of the MMP Enrollment and Disenrollment Guidance.*

Individuals with Medicare Employer Group Health Plan Coverage or claimed for Retiree Drug Subsidy are excluded from enrollment in an MMP. Requests for enrollment will be denied.

10. **Individuals with Employer/Union Coverage – Other Sources –** *This section supplements and clarifies the requirements of* ***§30.2.6*** *of the MMP Enrollment and Disenrollment Guidance.*

Individuals with Employer/Union Coverage are excluded from enrollment in an MMP. Requests for enrollment will be denied.

11. Prior to the Effective Date of Coverage -- *This section supplements and clarifies the requirements of **§30.4.1** of the MMP Enrollment and Disenrollment Guidance.*

With prior approval from CMS and the State, MMPs may perform Health Risk Assessments (HRAs) for Passive Enrollees up to 20 days prior to the MMP coverage effective date. This provision does not waive the requirement that MMPs send a welcome letter 30 days prior to a beneficiary's effective date. If the MMP chooses to conduct HRAs prior to the coverage effective date then later changes to conducting HRAs on or after the coverage effective date, the MMP must notify CMS and the State before implementing this change. This policy is effective for January 1, 2015 enrollment.

12. Disenrollment Procedures - *This section supplements and clarifies the requirements of **§40** of the MMP Enrollment and Disenrollment Guidance.*

MMPs in the COHS counties (Orange and San Mateo) may accept disenrollment (opt-out) requests directly from individuals and process such requests themselves according to procedures described in ***§40*** of the MMP Enrollment and Disenrollment Guidance.

Voluntary disenrollment requests to MMPs in non-COHS counties must direct requests to the State.

13. Voluntary Disenrollment by Member - *This section supplements and clarifies the requirements of **§40.1** of the MMP Enrollment and Disenrollment Guidance.*

A member may request disenrollment from an MMP in any month but must enroll in one of the Medi-Cal managed care plan. The member may do so for any reason. The member may disenroll by:

Contacting the MMP or the State enrollment broker for beneficiaries living in Los Angeles, San Bernardino, San Diego, Santa Clara, and Riverside counties.

- Contacting the MMP directly for beneficiaries in Orange or San Mateo counties.
- Enrolling in a Medicare Advantage plan or Medicare prescription drug plan by calling 1-800-MEDICARE or using CMS' online enrollment center.

14. Optional Period of Deemed Continued Eligibility Due to Loss of Medicaid Eligibility. *This section supplements and clarifies the requirements of* ***§40.2.3.2*** *of the MMP Enrollment and Disenrollment Guidance*

Through August 31, 2022, an MMP shall provide a two--month period of deemed continued eligibility for individuals who lose MMP eligibility for one of the following reasons: 1) loss of Medicaid eligibility, 2) Medicaid eligibility status has changed, or 3) beneficiary has moved out of the service area; as long as the individual can reasonably be expected to regain Medicaid eligibility within the (1) or (2) months. If the MMP decides to offer this "grace period," it must apply the criteria consistently to all members of the plan and fully inform the State and its members of this policy. The optional period of deemed continued eligibility starts on the first of the month following the month in which the State notifies the MMP of the loss of eligibility by the State.

If the MMP enrollee does not re-qualify within the plan's period of deemed continued eligibility, they must be involuntarily disenrolled from the plan, with proper notice as outlined below, at the end of this period. Individuals will be put in Original Medicare and auto-enrolled into a Medicare Prescription Drug Plan by CMS.

Any plan that elects to provide this grace period must continue to offer the full continuum of MMP benefits (including all those traditionally considered Medi-Cal) as outlined in its Plan Benefit Package (PBP), even if the State is not providing the Medicaid capitation payment to the MMP.

Notice Requirements -

For individuals enrolled in MMPs which offer the period of deemed continued eligibility, the State must provide each affected individual a written notice regarding the loss of Medicaid eligibility (the standard series of three state notices to those losing Medicaid suffice for this purpose; a separate notice is not required). In addition, the State delegates to the MMP the requirement to provide the member a written notice within 10 calendar days of the MMP learning of the loss of eligibility. This notice must provide the member an opportunity to prove that they are still eligible to be in the plan. In addition, the notice must include information regarding the period of deemed continued eligibility, including its duration, a complete description of the Medicare SEP for which individuals are eligible (see §30.4.4, item #5 of Chapter 2 of the Medicare Managed Care Manual), the consequences of not regaining eligibility within the period of deemed continued eligibility and the effective disenrollment date (see Exhibit 22 or Exhibit 30a, whichever applicable). Organizations are encouraged to work with the individual and the State to assist the individual with regaining Medicaid eligibility during the period of deemed continued eligibility.

Should the individual not regain eligibility within the period of deemed continued eligibility, the State must provide the member a written notice regarding the involuntary disenrollment from the MMP/demonstration due to loss of eligibility. The disenrollment notice to the individual and the transaction to CMS must be sent within three (3) business days following the last day of the period of deemed continued eligibility. The notice must include information regarding the disenrollment effective date and the Medicare SEP for which such individuals are eligible (see Exhibit 21).

Special Period of Deemed Continued Eligibility for Demonstration Transition to D-SNPs

Beginning September 1, 2022, an MMP shall provide four months of deemed continued eligibility for individuals who lose MMP eligibility for one of the following reasons: 1) loss of Medicaid eligibility, 2) Medicaid eligibility status has changed, or 3) beneficiary has moved out of the service area. The MMP must apply this grace period consistently to all members of the plan. The special period of deemed continued eligibility will start effective September 1, 2022 and continue through December 31, 2022.

If the MMP enrollee does not re-qualify within the plan's period of deemed continued eligibility, they will be subject to a CMS Rollover into the Dual Special Needs Plan (D-SNP) that is operated by the same parent organization of the MMP. Upon enrollment into the D-SNP, the member is subject to that D-SNP's individual deeming policy as described in Section 50.2.5 of the CY2021 Medicare Managed Care Manual Chapter 2, Medicare Advantage Enrollment and Disenrollment[2].

MMPs must provide the full continuum of MMP benefits (including all those traditionally considered Medi-Cal) as outlined in its Plan Benefit Package (PBP), even if the State is not providing the Medicaid capitation payment to the MMP.

Notice Requirements -

For individuals enrolled in MMPs which offer the period of deemed continued eligibility, the State must provide each affected individual a written notice regarding the loss of Medicaid eligibility (the standard series of three state notices to those losing Medicaid suffice for this purpose; a separate notice is not required). In addition, the State delegates to the MMP the requirement to provide the member a written notice within 10 calendar days of the MMP learning of the loss of eligibility. This notice must provide the member an opportunity to prove that they are still eligible to be in the plan. This notice must also include information regarding the period of deemed continued eligibility, including its duration, as well as a description of the transition from the MMP to the D-SNP, and references to the transition notice the MMPs are sending to all members beginning October 1, 2022. The applicable notice must articulate the consequences of not regaining eligibility within the MMP period of deemed continued eligibility, or after the transition to the D-SNP. Should the individual not regain eligibility following transition to the D-SNP, the individual is subject to involuntary disenrollment noticing requirements articulated in Section 50.2.5 of the CY2021 Medicare Managed Care Manual Chapter 2, Medicare Advantage Enrollment and Disenrollment

[2] https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

MMP and D-SNP organizations are encouraged to work with the individual and the State to assist the individual with regaining Medicaid eligibility during the period of deemed continued eligibility.