SMDL #01-026
August 2, 2001

Dear State Medicaid Director:

This letter clarifies the policy of the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, as it relates to the enrollment of Medicare eligible beneficiaries in Medicaid managed care.

As the population of dual eligibles (beneficiaries who are entitled to Medicare as their primary coverage and Medicaid as their secondary coverage) represents a particularly vulnerable group of individuals, we are very concerned with protecting the rights and privileges due them under both the Medicare and Medicaid programs. To that end, we are communicating the following policy regarding the ability to mandatorily enroll dual eligibles, or to allow dual eligible beneficiaries to choose to voluntarily enroll in a Medicaid Managed Care plan that would withhold Medicare cost-sharing reimbursement in the absence of prior authorization for non-emergency out-of-network services.

Mandatory Enrollment

Dual eligibles may be mandatorily enrolled into Medicaid managed care with CMS approval under Section 1115 demonstration or Section 1915 (b) waiver authority, so long as mandatory managed care enrollment does not effect dual eligibles' free choice of Medicare provider. It has been CMS policy not to permit mandatory enrollment of dual eligibles in a Medicaid managed care product (Managed Care Organization - MCO; Health Insurance Organization - HIO; Prepaid Health Plan - PHP; or Primary Care Case Management - PCCM - model) that limits Medicare choice of provider. This is consistent with the emphasis on freedom of choice contained in the Social Security Act.

Furthermore, it has been CMS policy not to approve requests to mandatorily enroll dual eligibles into a Medicaid managed care plan that conditions reimbursement of Medicare cost-sharing (i.e. Medicare coinsurance, copayments, and deductible) on receiving prior authorization for non-emergency services obtained out-of-network.

Voluntary Enrollment

States are permitted to allow dual eligible beneficiaries to choose to voluntarily enroll in a Medicaid managed care plan that would withhold Medicare cost-sharing reimbursement in the absence of prior authorization for non-emergency out-of-network services, if the following protections are met:

· Beneficiaries are fully informed about the health plan before they choose to enroll. This must include marketing materials that are free of language, literacy, or disability barriers. It particularly applies to any policy on denial of payment of Medicare cost-sharing for out-of-network services that have not been prior authorized. We will not approve any waiver request or renewal that fails to include adequate provisions for informed choice.

· The state is able to demonstrate that the principle of beneficiary informed choice is protected at the point of enrollment in the program; and that this practice results in added value to the beneficiary (i.e., coordination of Medicaid and Medicare services).

· Beneficiaries must be permitted to disenroll from the Medicaid MCO (or HIO, PHP, or PCCM model) at the earliest date that is administratively feasible and that is identified in written policy consistent with Balanced Budget Act (BBA) provisions. Administratively feasible is defined as no later than the end of the month following the month in which the request to disenroll is received by the plan.

Benefits

· Strengthened coordination of the Medicare and Medicaid programs is achieved, as both programs must work together to integrate covered services for which a dual eligible is entitled.

· The level of beneficiary education of how both programs work is increased, enabling individuals to make more informed decisions about their total health care.

· Dual eligible beneficiaries will be informed of any potential cost-sharing imposed for Medicare services in a Medicaid managed care plan, which could create a financial hardship on this population of Medicaid eligibles.

CMS will ensure compliance with this policy through demonstration or waiver approval, ongoing monitoring, and contract approval.

If you have any questions, please do not hesitate to contact Melissa Harris at (410) 786-3397.

Sincerely,

/s/

Dennis G. Smith
Director
Center for Medicaid and State Operations

cc:
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