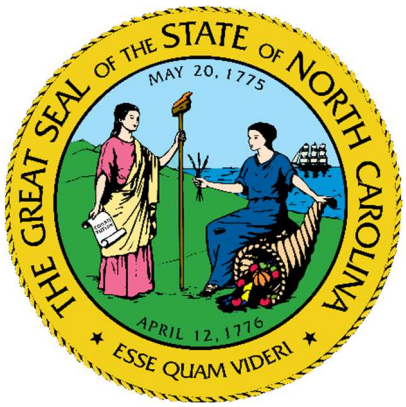

NC Department of Health and Human Services

Transition of Care Protocols

Beneficiaries Disenrolling from Standard Plan or Tailored Plan Due to Dual Eligibility

NC Medicaid Standard Plan Transition of Care Disenrollment Protocols

Transition Due to Dual Eligibility

Change Log		
Version	**Posting Date**	**Updates/Change Made**
1.0	8/20/2021	Initial Posting, effective date 7/1/2021
1.1	12/16/2022	Updated regarding Tailored Plan launch

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General References

Transition Disenrollment Scenario covered by this Protocol: Member Disenrolls Due to Medicare Enrollment

Related Disenrollment Protocols:

The *LTSS Managed Care Disenrollment Form Template* is maintained on the PCDU at the paths below.

File Name:
LTSS Disenrollment Form Template.pdf

Standard Plan Path:

/ Library Documents / Standard Plan / Guidance Documents / C_Benefits_and_Care_Management

Tailored Plan Path:

/ Library Documents / Tailored Plan / Guidance Documents / B.2- Medicaid - Benefits

Protocol Limitations:

- The Protocol does not guide Health Plans on payment or reimbursement dynamics related to these transitions.
  - While the Protocol references eligibility dynamics, NC Medicaid eligibility policy serves as "source of truth" for Medicaid eligibility process and requirements.
- Transition of Care Requirements related to data file transfer are established in Transition of Care Data Specification Guidance.

General Description of Eligibility Redetermination Process Due to Medicare Eligibility

- A Member who becomes dually eligible for both Medicaid and Medicare services will be disenrolled from the Health Plan.

- A Member is disenrolled from the Health Plan on the first of the month following the DSS entry of Medicare evidence into NC FAST, regardless of the day it was entered. Retroactive eligibility for Medicare may be a factor, especially for Members who are newly eligible for Medicaid and those members who become dually eligible due to end stage renal disease (ESRD).
- Once Medicare evidence is entered into NC FAST, the Member's disenrollment will appear on the eligibility segment on the 834 the following day.
- A Member's Medicare goes into effect on the first of the month of Medicare eligibility.

Overview of Medicare Eligibility Activation

Summary Medicare Eligibility Triggers

- The first day of the month in which the member turns 65.
- Automatically, in the twenty-fifth month after receiving SSDI and SSI.
- A Member who is diagnosed with End-Stage Renal Disease (coverage timelines may vary).
- A Member who receives SSDI because of Lou Gehrig's disease, automatically upon the first month of receiving SSDI.
- Other circumstances specified by the Social Security Administration and the Centers for Medicare and Medicaid Services.

Pathways through Which DSS Identifies Medicare Eligibility

DSS identifies a Member's Medicare eligibility in one of three ways:

1. **When SSI member becomes eligible for Medicare:**
    - Evidence comes over automatically on the nightly batch feed to DSS from Social Security.
    - DSS caseworker does not have to manually enter any evidence. NC FAST creates evidence automatically.
    - Nightly feed will notify NC FAST that on the first of the following month, the Medicare eligibility will take effect.
    - Example: Nightly feed on May 17 indicates that member's Medicare eligibility will be effective on June 1. As a result, the Member's disenrollment from the Health Plan will also go into effect June 1. NC FAST will be updated and Health Plan's 834 on May 18 should reflect this future eligibility span, indicating the Members disenrollment on June 1.
2. **Social Security sends report to DSS ("Bendex Report") to notify of any member change (in income, Medicare eligibility) via a task in NCFAST. DSS Case worker then enters Medicare evidence.**
    - Typically, Bendex Report provides advance notification of upcoming Medicare eligibility.
    - NOTE: Medicare evidence received on the Bendex Report is not automatically updated in the Member's record. DSS worker must key the evidence.
    - *Medicare* evidence will activate the first of the Member's first month of Medicare eligibility.
    - Example [steps apply to all scenarios related to Bendex Report]:
        - Member turns 65 on April 7

- Bendex report potentially alerts DSS around February of anticipated Medicare eligibility.
- The DSS worker enters evidence on February 15, with a Medicare effective date of April 1.
- February 16's 834 file reflects this change on future eligibility segment, with disenrollment date of March 31, at 11:59, with FFS enrollment effective on April 1.
  - NOTE: Future eligibility segments will appear so long as eligibility has been determined for the future date span (e.g. if the member was due for a redetermination in March, the April segment would not appear until the redetermination was made).
- April 1: Member disenrolls back to FFS [because this is the first month of Medicare eligibility].

3. **Member notifies DSS worker (rare)**

   Bendex Reports serves as reliable notification source of upcoming Medicare eligibility. However, in cases of newly enrolled Medicaid beneficiary and Bendex report has not caught up yet or DSS worker has lagged in entering Bendex report evidence, the upcoming Medicare eligibility evidence may first be self-reported.

- It is the Department's intent for Health Plans to work proactively with Members, DSS staffers, applicable options counseling entities and NC Medicaid Direct Receiving entity to ensure a safe a seamless transition back into NC Medicaid Direct.

Protocol-Specific Guidance on Transition of Care Requirements

Transition of Care timelines are established in the NC DHHS Transition of Care Policy and related technical requirements.

Guidance on Identifying Anticipated Dually Eligible Members

In order to assist Member's through the disenrollment experience, Health Plans are advised to establish protocols that identify members likely to become Dually Eligible and not rely solely on notification of member's anticipated Medicare eligibility through the 834. Factors to consider:

- Age;
- Medicaid for Disabled (MAD) status;
- Clinical record;
- Other criteria identified by the Health Plans;
- Coordination with member and member's eligibility worker at DSS.

Warm Handoff

- Warm Handoff timelines are established in the DHHS Transition of Care Policy.
- The Transition Summary, which the Health Plan will develop for every disenrolling Member requiring a warm handoff, outlines key topics for any warm handoff.

Transition File:

- The Health Plan will transfer the transition file through CCNC sFTP site.

Guidance on Preparing Member

- Consistent with NC DHHS Transition of Care Policy, Health Plans shall initiate live, real -time dialogue with Members prior to anticipated disenrollment to prepare member for the disenrollment.
- In alignment with the significant increase in Medicare-related materials the Member will begin receiving, Health Plans are advised to align the Member's preparation Medicare Open Enrollment Period which begins three months prior to Medicare eligibility. Health Plans are advised to accomplish all recommended steps no later than 30 days prior to Medicare enrollment.
- Planning dialogue should include:
  a. Confirming pending Medicare status with Member (reviewing communication received from Social Security) and anticipated disenrollment date.
  b. Providing an overview of the Medicare program;
  Note: Tutorial resources are available on the NC DOI website.
  c. Initiating and coordinating linkage to an unbiased, qualified counselors to advise Members on options available under the Medicare program.

  Note: Members may already be receiving solicitations for various Medicare plans. information to provide member about SHIIP role:
  - *You will be enrolling in Medicare soon.*
  - *If you are confused about Medicare and how it will work with Medicaid, the Seniors' Health Insurance Information Program (SHIIP) can help if you have questions.*
  - *Call toll-free 855-408-1212 to talk to a specialist or visit www.ncshiip.com.*
  - *Providing free, unbiased help in all 100 North Carolina counties.*

  d. Coordinate communication with Member, DSS and applicable providers to confirm how disenrollment will impact current services and follow care planning protocols to ensure Member continuity of care. Member should be notified in writing:
  - When PAs will expire;
  - If any services will end because of disenrollment.

  e. As applicable, a Health Plan must adhere to *Medicare Managed Care Marketing Guidelines* at all times when preparing the Member for disenrollment.
- Follow all applicable transitional care management protocols and TOC protocols for disenrolling members.

Guidance on Preparing Provider(s)

Consistent with current the Transition of Care Policy, the Health Plan will notify the provider of the anticipated disenrollment and provide the following:

- Guidance on anticipated disenrollment and current Prior Authorization status;
- If applicable (i.e. the member receives LTSS services), point of contact for FFS assessing entity (i.e. the CIAE, as described below);
- Information about coordination of benefits with Medicare;

- Instructions to submit claims to both Medicare and Medicaid Direct (or LME-MCO as applicable) for members following disenrollment from a Health Plan due to becoming dually eligible for Medicare and Medicaid.

Designated Receiving Entity:

- Prepaid Inpatient Health Plans (PIHPs) provides care management for Medicaid Direct members receiving Tailored Care Management (TCM)
- Tribal Option provides care management for Medicaid Direct members enrolled in Tribal Option
- Community Care of North Carolina (CCNC) provides care management for Medicaid Direct members who are not managed by the PIHPs or Tribal Option

Coordination with Applicable Entities

- CCNC Point of Entry for Transition of Care Activity: Each Health Plan should contact their designated CCNC Care Management Director (CMD)**Disinterested, qualified options counselor:** Department of Insurance, SHIIP Program
  - Recommended timeline for notification: No later than 30 days prior to the member's disenrollment of Medicare eligibility date.
  - Call the Department of Insurance, SHIIP program toll-free at 1-855-408-1212
  - Hours of Operation: Monday through Friday from 8am to 5pm, excluding state holidays.
- **To activate fee-for-service assessment processes related to LTSS services:**
  - The NC Medicaid Comprehensive Independent Assessment Entity (CIAE) will serve as the referral, assessment, and options counseling point of entry for all Medicaid Long-Term Services and Supports not managed by the Health Plan.
  - The Department will establish an interim CIAE process that will be place on July 1, 2021 and will communicate intake instructions.
  - The Health Plan should coordinate with the interim CIAE for any disenrolling member who is utilizing LTSS services by submitting the LTSS Disenrollment Form (see Reference Materials).
  - The Health Plan submits the LTSS Disenrollment Form to the interim CIAE (Medicaid.LTSS.TCC@dhhs.nc.gov) 30 days in advance of Member's anticipated disenrollment or one(1) business day of 834 Notice Date, or upon request if Member's disenrollment date was not identifiable prior.