Tips for States with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs):

Using Default Enrollment to Align Medicare and Medicaid Coverage for Dually Eligible Individuals

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States are increasingly promoting coordinated service delivery for individuals dually eligible for Medicare and Medicaid by aligning their enrollment in Medicaid managed care organizations (MCOs) and affiliated Medicare Advantage (MA) dual eligible special needs plans (D-SNPs) offered by the same organization. In certain circumstances, states can promote the use of "default enrollment" to increase aligned enrollment into certain D-SNPs when existing Medicaid MCO enrollees become newly eligible for Medicare Parts A and B by virtue of age or disability. Under default enrollment, D-SNPs that receive approval from the state and Centers for Medicare & Medicaid Services (CMS) may offer automatic enrollment to individuals who are newly Medicare-eligible individuals (due to age or disability) if those individuals (1) are enrolled in a Medicaid MCO that has an affiliated D-SNP and (2) will continue to receive Medicaid benefits from the same parent organization upon becoming Medicare-eligible.

This technical assistance brief summarizes enrollee eligibility standards, state roles in the default enrollment approval and implementation process, steps that D-SNPs must take to obtain CMS approval for default enrollment, and enrollee rights during the default enrollment process. It also provides references to additional resources for more detail and context that can inform states interested in working with D-SNPs and CMS to establish this process.

ABOUT THIS TOOL

States can allow or require D-SNPs that meet certain requirements to use default enrollment to align Medicare and Medicaid coverage for dually eligible individuals. Under default enrollment, D-SNPs may automatically enroll individuals who are enrolled in a comprehensive Medicaid MCO offered by the same parent organization as the D-SNP when those individuals first become eligible for Medicare Parts A and B (at the same time) due to age or disability. This technical assistance brief summarizes enrollee eligibility standards for default enrollment, state roles in the default enrollment approval and implementation process, steps that D-SNPs must take to obtain CMS approval for default enrollment, enrollee rights, and additional resources on this topic.

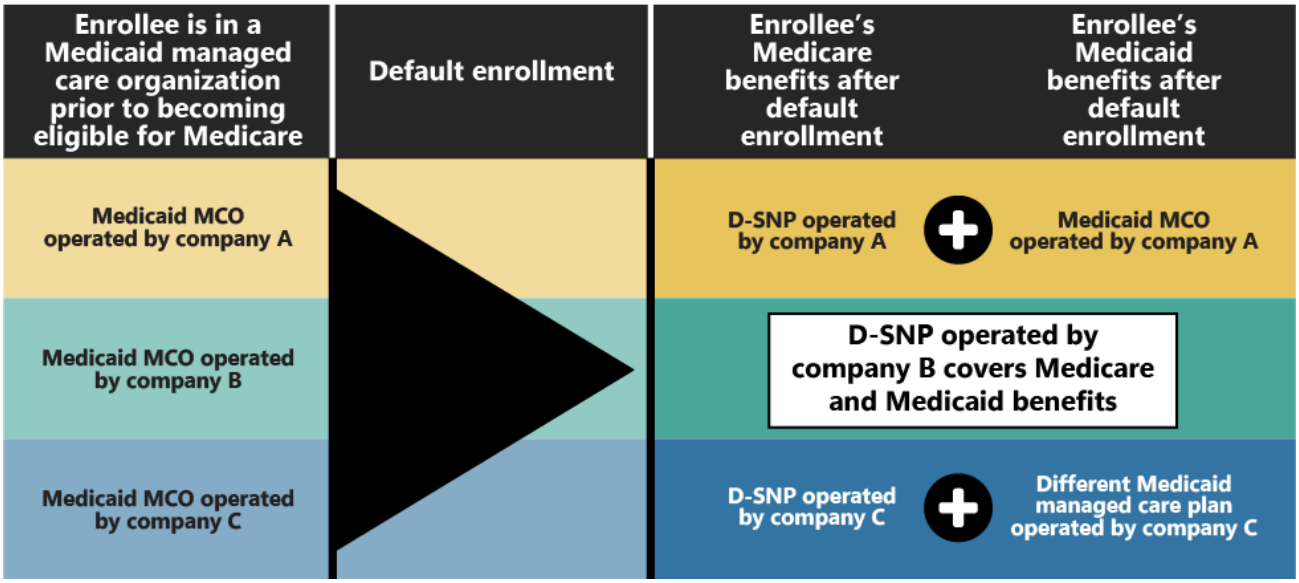
Enrollees eligible for default enrollment into a D-SNP

To be eligible for default enrollment into a D-SNP, an individual must be enrolled in comprehensive Medicaid MCO that is operated by the Medicare Advantage organization (MAO) offering the D-SNP or by a legal entity under the same parent organization as the D-SNP that operates in the same service area as the MCO (D-SNPs and MCOs that operate in the same service area are often referred to as "affiliated" plans).[1] Additionally, the individual must:

- Be becoming eligible for Medicare Parts A and B for the first time due to age or disability (default enrollment must be effective the month the individual is first eligible for Medicare Parts A and B);
- Reside within the D-SNP's service area;
- Retain eligibility for full Medicaid benefits after becoming Medicare eligible;[2] and
- Remain enrolled in a Medicaid managed care plan upon conversion to Medicare. This Medicaid managed care plan may be the original MCO, the D-SNP, or a different Medicaid managed care plan offered by the same parent company and affiliated with the D-SNP.[3]

Exhibit 1 illustrates three different coverage arrangements that can follow default enrollment. Regardless of the arrangement used, the individual who is default enrolled must receive (1) a substantial range of Medicaid benefits from the plan(s) to which they are default enrolled and (2) a high level of integration between Medicare and Medicaid coverage.

Exhibit 1. Possible coverage arrangements before and after default enrollment



State roles in default enrollment

D-SNPs interested in using default enrollment must first obtain (1) approval from the applicable state Medicaid agency and (2) an agreement from that state Medicaid agency to provide data identifying MCO enrollees who are eligible for default enrollment.

While states are not obligated to approve any D-SNP for default enrollment, a state interested in allowing D-SNPs to use default enrollment may choose to approve all qualified D-SNPs, only certain D-SNPs, or no D-SNPs at all, depending on the state's goals for Medicare-Medicaid integration. States may also impose their own requirements for D-SNPs—in addition to the federal requirements—to receive state approval for default enrollment. For example, Washington only approves D-SNPs for default enrollment if 95% of the Medicaid MCO's network providers are also in the D-SNP's network.[4] States that would like D-SNPs to implement default enrollment must (1) approve the use of default

enrollment in their state Medicaid agency contract (SMAC) with the MAO and (2) provide a description of their data sharing process and agreement to provision prospective Medicare eligibility data to the MAO in a state policy document that can be shared with the D-SNP. Examples of acceptable state policy documents include but are not limited to a SMAC, state letter, and/or a copy of the state's completed/signed default enrollment plan application, if applicable.

To enable default enrollment, states must provide D-SNPs with timely information about MCO enrollees who (1) are becoming eligible for Medicare Parts A and B for the first time due to age or disability and (2) will retain full Medicaid benefits after becoming Medicare-eligible.

Identifying MCO enrollees with prospective Medicare eligibility

States can use data files that they are already exchanging with CMS to identify Medicaid MCO enrollees who are becoming eligible for Medicare in the near future. In particular, states can use Medicare Modernization Act (MMA) files, Territory Batch Query (TBQ) files, or the Prospective Dual File (PDF) – all described in **Appendix A** of this tool – to identify Medicaid MCO enrollees with prospective Medicare eligibility.[5] After determining which CMS data source to use, the state should review the selected file(s) at least once a month (but ideally more frequently) to identify Medicaid MCO enrollees with prospective Medicare Part A and B eligibility dates. States must identify these individuals for D-SNPs far enough in advance to enable the D-SNPs to issue default enrollment notices at least 60 days prior to the MCO enrollee's first day of Medicare eligibility.[6]

Determine ongoing Medicaid eligibility

Medicaid MCO enrollees may only be default enrolled into a D-SNP if they will remain eligible for full Medicaid benefits after becoming eligible for Medicare. Eligibility redeterminations must be completed far enough in advance of the prospective enrollee's Medicare eligibility date for the D-SNP to meet the noticing requirement mentioned above. (See **Box 1**.)

Box 1. Medicaid redeterminations before D-SNP default enrollment

If a Medicaid MCO enrollee will become eligible for Medicare on October 1, the state will need to complete a redetermination of that individual's Medicaid eligibility by July 1 to ensure that the D-SNP has time to confirm the individual's eligibility for default enrollment, submit the default enrollment transaction to CMS and provide the prospective enrollee with appropriate notice by August 1.

In addition to redetermining Medicaid eligibility, determinations of any other state-specific D-SNP eligibility criteria, such as assessments for nursing home level of care, must also be completed in time for the D-SNP to submit the enrollment transaction and send the required notice at least 60 days before the MCO enrollee's first day of Medicare eligibility.

Sharing relevant data with D-SNPs

After identifying Medicaid MCO enrollees with upcoming Medicare eligibility and determining their ongoing Medicaid eligibility, the state should use a Health Insurance Portability and Accountability Act (HIPAA)-compliant mechanism (such as an Accredited Standards Committee (ASC) X12 834 enrollment file or a proprietary file format) to share data with the relevant D-SNP(s) about MCO enrollees who are

eligible for default enrollment. The state should share the data with the D-SNP on at least a monthly basis to meet CMS requirements and allow for monthly default enrollment. More frequent data sharing allows for more complete identification of MCO enrollees who are eligible for default enrollment. Additionally, as noted previously, the state must share the information with the D-SNP timely enough to support the D-SNP's issuance of a default enrollment notice at least 60 days prior to the MCO enrollee's first day of Medicare eligibility.

Within the files shared with the D-SNP(s), the state must provide all information needed to support the D-SNP's default enrollment transactions to CMS, including each prospective enrollee's full name, Medicare Beneficiary Identifier (MBI), date of birth, gender, and Medicare Part A and B start dates.[7]

Document the data sharing process

Once a state has determined the process it will use to identify individuals eligible for default enrollment and share the necessary information with the applicable D-SNP(s), the state must share key details about that process with the applicable D-SNPs to support CMS review and approval of the D-SNPs' default enrollment applications. Examples of documents that states can use to share this information include (but are not limited to) the SMAC, a state letter, and/or a copy of the state's completed and signed default enrollment plan application, if applicable. In its default enrollment application to CMS, a D-SNP must provide state-issued documentation indicating the following:

- The CMS data source(s) the state will use to identify MCO enrollees who are in their Medicare initial coverage election period (including individuals becoming eligible for Medicare based on age and those becoming eligible for Medicare based on disability);
- The frequency with which the state will check the CMS data source(s);
- The method the state will use to transmit CMS eligibility data to the D-SNP (for example, an 834 enrollment file or other proprietary file);
- The data elements the state will share that are necessary for the D-SNP to submit enrollment transactions to CMS, per 42 CFR 422.66(d)(6) and 42 CFR 422.60(e)(5); and
- The frequency with which the state will transmit the prospective Medicare eligibility data to the D-SNP and information about who will be included in the files (for example, beneficiaries who are within 120 days, 100 days, or 90 days of becoming eligible for Medicare Parts A and B).

The sample SMAC language provided in **Box 2** describes each of these key points.

Box 2. Sample SMAC language describing the state's process for identifying individuals eligible for default enrollment

The sample language below was adapted from Indiana's 2026 SMAC.

"The Contractor must obtain approval from the Centers for Medicare & Medicaid Services (CMS) to conduct default enrollment of eligible individuals into the Contractor's D-SNP. In accordance with 42 CFR 422.66(c), 422.68(a) and other CMS-published sub-regulatory guidance, as applicable, the Contractor shall conduct default enrollment of eligible individuals enrolled in [the D-SNP's affiliated Medicaid managed care organization] who are newly eligible for Medicare Parts A and B for the first time due to age or disability.

If the Contractor receives a returned mail from an individual being default enrolled into the Contractor's D-SNP, the Contractor must make a minimum of three (3) call attempts to the individual regarding their default enrollment eligibility.

The Contractor must maintain a minimum Medicare Advantage Star Rating of three (3) stars and may not have any prohibition on new enrollment imposed by CMS, as outlined at 42 CFR 422.66(c), in order to participate in default enrollment.

The State shall identify for the Contractor individuals who are in or approaching their Medicare initial coverage election period during the term of this Contract. At least [specify frequency, such as once a month], the State will use [specify file(s) to be used, such as the CMS Territorial Beneficiary Query (TBQ) files, Medicare Modernization Act (MMA) files, and/or Prospective Dual File (PDF)] to identify individuals who are enrolled in [the D-SNP's affiliated Medicaid managed care organization] with prospective Medicare Parts A and B eligibility due to age or disability. For the eligible individuals identified by the State, the State will provide the following information to the Contractor in a [specify frequency, such as monthly] [specify file format, such as 834 file or proprietary state file format] transmitted through [specify method of transmission, such as secure file transfer protocol (SFTP)]:

1. *First and last name*
2. *Medicare Part A and B entitlement dates*
3. *Date of birth*
4. *Medicare Beneficiary Identifier (MBI)*
5. *Gender*

The State will provide this information to the Contractor no less than [specify timing, such as 70 days] before an eligible individual becomes eligible for Medicare Parts A and B due to age or disability.

The Contractor must establish an internal process to validate information shared by the State. In order to enroll, to the greatest extent possible, all members included in the [state file exchange], the Contractor shall supplement information provided by the State where appropriate.

The Contractor must also take the necessary steps to renew any existing default enrollment process approval(s) with CMS, as per the requirement of 42 CFR 422.66(c)(2)(ii), so that such subsequent CMS approval(s)/renewal(s) of an existing approved default enrollment process shall be effective no later than 120 days prior to the expiration of the existing CMS approval requested to be renewed. To achieve this, the Contractor shall submit its full default enrollment renewal application to CMS no later than 150 days prior to that expiration date.

The Contractor must submit renewal default enrollment applications to the State for review and approval at least [specify time period for state review, such as 30 days] prior to CMS submission.

Obtaining CMS approval for default enrollment

After receiving state approval and obtaining a data provisioning agreement from the state, a D-SNP must obtain CMS approval before implementing default enrollment. D-SNPs can earn approval for default approval from CMS for up to five years. To earn CMS approval, D-SNPs must:

- Demonstrate state approval to conduct default enrollment via language in the D-SNP's SMAC and provide a state letter and/or a copy of the state's completed/signed default enrollment plan application, if applicable, that describes the state's agreement to provide the D-SNP with information about prospective Medicare eligibility for MCO enrollees who are attaining Medicare eligibility based on age or disability;
- Have a minimum overall quality rating of least three stars (or be a low enrollment contract or new Medicare Advantage plan as defined in 42 CFR 422.252);
- Not have a CMS prohibition on new enrollments;
- Be operated by a legal entity or parent organization that also operates an MCO in the same service area as the D-SNP (from which enrollees will be default enrolled into the D-SNP); and
- Be able to continue offering – through the D-SNP or an affiliated Medicaid managed care plan – a substantial range of Medicaid benefits to full-benefit dually eligible individuals who are default enrolled into the D-SNP. (See Exhibit 1 for three possible pathways to delivering these benefits.)

Default enrollment application

D-SNPs must submit default enrollment applications for CMS review through the CMS Health Plan Management System (HPMS).[8] D-SNPs should assume that CMS review of these applications will take 30 days and allow additional time for communication with CMS and application revisions as needed.

As part of the default enrollment application, the D-SNP must provide:

- Documentation of the state's approval (in the SMAC) of the D-SNP's use of default enrollment;
- The state letter and/or completed/signed default enrollment plan application, if applicable, that describes the CMS data source(s) and process(es) the state will use to identify and notify the D-SNP of enrollees in the D-SNP's affiliated Medicaid MCO who are approaching their initial Medicare coverage election period, including the frequency with which the state will check those data sources, the methods and frequency of the state's data exchange with the D-SNP, and the data elements to be shared;
- A copy of the notice that will be used to notify eligible MCO enrollees of their default enrollment into the D-SNP; and
- All other written, telephonic, or electronic outreach materials that will be sent to perspective enrollees and used to support default enrollment activities, along with a description of the D-SNP's intended outreach activities.

States approving D-SNPs for default enrollment can work with those D-SNPs to develop a common application template that the D-SNPs could include in their default enrollment applications to CMS. Use of a common template promotes uniformity in the content of the D-SNPs' default enrollment applications, which makes the applications easier for CMS to review and approve. Before developing a common application, states should contact the CMS Medicare-Medicaid Coordination Office for technical assistance at MMCO_DSNPOperations@cms.hhs.gov.

Default enrollment notice

In addition to providing the initial enrollment materials required at 42 CFR §422.111 (such as an Evidence of Coverage and Summary of Benefits document), D-SNPs approved for default enrollment must notify eligible MCO enrollees in writing about the default enrollment process and their options for accepting or opting out of default enrollment into the D-SNP. CMS recommends that D-SNPs use a CMS-developed default enrollment model notice for this purpose.[9] The notice must be issued at least 60 calendar days before the individual's date of initial Medicare eligibility and include all of the following information:

- Whether the prospective enrollee's primary care physician is in the D-SNP's provider network;
- The process an enrollee needs to take for accessing care through the D-SNP;
- How the enrollee can opt out of (decline) the enrollment prior to their enrollment effective date to enroll in Original Medicare or choose a different Medicare Advantage plan. This must include the opportunity to contact the D-SNP in writing or through a toll-free telephone number);
- Differences in premiums and cost-sharing amounts between the individual's current Medicaid MCO and the D-SNP;
- Differences in benefits covered by the individual's current Medicaid MCO and the D-SNP; and
- A general description of alternative Medicare health and drug coverage options available to the individual during their initial coverage election period.[10]

The D-SNP must send the default enrollment transaction to CMS at the same time it sends this notice.

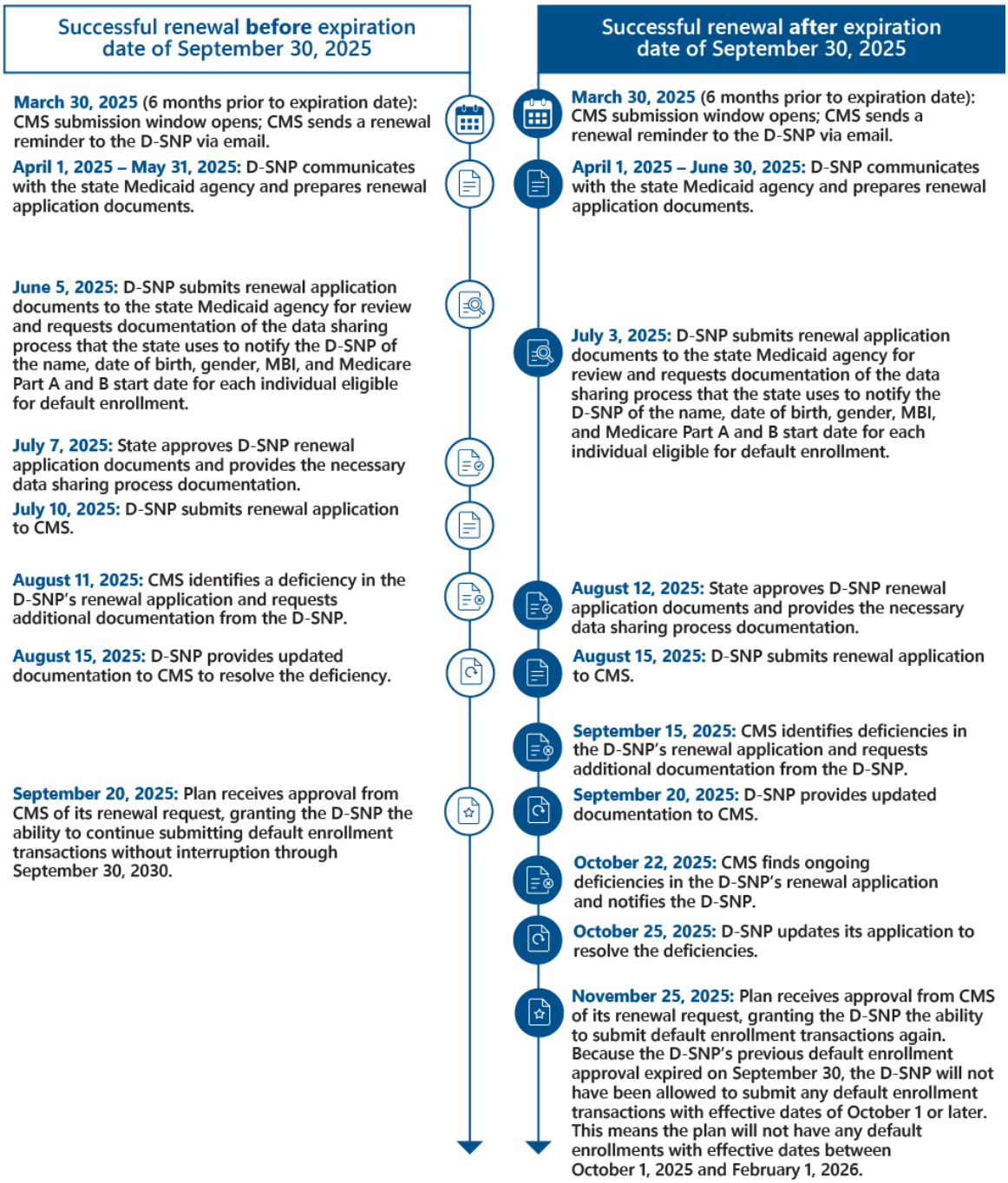
Renewal of CMS approval for D-SNP default enrollment

D-SNPs can earn approval for default approval from CMS for up to five years. CMS may suspend or rescind approval prior to the expiration of this period if CMS determines that the D-SNP is not in compliance with federal requirements. As a D-SNP's default enrollment approval expiration date approaches, the D-SNP will need to submit a renewal application to CMS that includes all of the same documentation needed for the initial default enrollment application.

Renewals of CMS approval for default enrollment are not automatic. If a D-SNP does not submit its default enrollment renewal application well in advance of its five-year approval end date, the D-SNP will face a gap in its ability to submit default enrollments and must submit a new initial application to CMS to begin default enrollment again.

To minimize the risk of disruption in default enrollment processing, D-SNPs should submit renewal applications to CMS well in advance of their five-year approval end dates. CMS will notify the MAO six months before the expiration of default enrollment approval and recommends that D-SNPs submit renewal applications quickly after receiving that notification. CMS will then send an additional reminder notice three months prior to the expiration date. As with the initial application, D-SNPs should assume that CMS will need at least 30 days to review the renewal application and leave additional time for communication and resubmission of documentation if CMS identifies a deficiency in the application. **Exhibit 2** provides sample renewal timelines.

Exhibit 2. Sample default enrollment renewal timelines



Enrollee rights during the default enrollment process

D-SNPs approved for default enrollment must submit enrollment transactions no later than 60 days prior to the enrollment effective date, which is the first day of the month the individual is eligible for Medicare Parts A and B. During that 60-day period, the individual has the right to opt out of default enrollment, choose Original Medicare, or another Medicare health or drug plan. If an individual does not opt out of default enrollment, is ultimately default enrolled into a D-SNP, and wants to change their coverage after the default enrollment occurs, they can use a Medicare open enrollment or special enrollment period to disenroll from the D-SNP or enroll into a different plan.[11]

Additionally, beneficiaries who will receive Medicaid benefits from a new managed care plan under the same legal entity after default enrollment have the right to receive information about other Medicaid managed care choices prior to default enrollment, as well as the right to switch Medicaid managed care plans during the default enrollment process.[12] These individuals must also be allowed to disenroll or change Medicaid managed care plans without cause for at least 90 days after the enrollment is effectuated (or 90 days after the enrollment notice is received, whichever is later), and with cause at any time.[13] If an individual is default enrolled into a highly or fully integrated D-SNP with exclusively aligned enrollment, disenrollment from the Medicaid plan will require disenrollment from the D-SNP, as well.

As of January 1, 2024, all Medicare Advantage coordinated care plans—including D-SNPs—must offer enrollees a continuity of care transition period of at least 90 days. During that period, the plan must cover any active course of treatment that the enrollee had already begun prior to enrolling in the plan, even if the service or prescription drug is furnished by a provider who is not in the plan's network.[14] This continuity of care period applies to individuals who are default enrolled into a D-SNP.

States can establish within their SMACs additional enrollee protections that D-SNPs must provide during the default enrollment process. For example, states can require D-SNPs to provide default enrollees with continuity of care periods longer than 90 days or require D-SNPs to engage default enrollees within a certain period of time after default enrollment to answer questions and address any challenges that those enrollees may experience.

States may also wish to collect data from D-SNPs on beneficiaries who are default enrolled, who opt out of default enrollment, and who disenroll within a certain time period (for example, three months) of default enrollment; the reasons enrollees have given when opting out or disenrolling; and/or appeals or grievances filed by default enrollees within a certain period of time of default enrollment or grievances filed in relation to default enrollment. Additionally or alternatively, states can contact enrollees who have been default enrolled into a D-SNP to obtain feedback about their experiences with the process. This information can be used to understand the extent to which beneficiaries are satisfied with default enrollment and improve enrollee experiences with default enrollment.

See **Box 3** for an example of D-SNP reporting requirements from Arizona.

Box 3. Arizona Default Enrollment Reporting Requirements

The following language is from Attachment 5 of Arizona's 2025 SMAC.

"[D-SNP] shall report quarterly (by month) each of the following five (5) default enrollment data elements to [state Medicaid agency], as per the requirements of Attachment 1: Chart of Deliverables.

a. *Number of… Full Benefit Dual Eligible Members, separated by eligibility based on age or disability, that were identified and noticed by [D-SNP] at least sixty (60) calendar days prior to the effective date of default enrollment.*

b. *Number of beneficiaries (Full Benefit Dual Eligible Members) who opt out of (decline) default enrollment prior to their effective date. Differentiate between those who opt out by telephone or in writing, as well as eligibility based on age or disability.*

c. *At the end of the first month of enrollment, specify the number of rapid disenrollments (the number of Full Benefit Dual Eligible Members who disenroll within their first month of default enrollment). Continue to track for rapid disenrollments within the first three (3) months of a Full Benefit Dual Eligible Member's default enrollment effective date.*

d. *Provide information regarding any complaints received internally, including grievances relating to default enrollment. For complaints with a Medicare Advantage Complaint Tracking Module (CTM) identification number, please also list the CTM number with the complaint. Provide this information in an Excel spreadsheet.*

e. *Indicate if MAO has identified any individuals Full Benefit Dual Eligible Members) for which it was unable to identify for default enrolment in the required timeframe (minimum 60 calendar days prior) for notification of default enrollment, and an explanation of why they were excluded from the default enrollment process."*

Source: Arizona Health Care Cost Containment System (AHCCCS) Medicare Advantage Organization Agreement, 2024 version. (All of Arizona's current D-SNP SMACs are available at https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/medicareagreements.html.)

Engagement with dually eligible individuals and other interested groups

Finally, states and D-SNPs should engage with dually eligible individuals and other interested groups (such as health care providers and beneficiary advocacy organizations) before and during default enrollment. Engagement with these groups can enable smoother default enrollment transitions and highlight potential challenges or concerns that states and D-SNPs can address.

States can also inform organizations that provide enrollee education and/or advocacy (for example, State Health Insurance Assistance Programs, or SHIPs, Medicaid customer service hotlines, county offices, enrollment brokers, consumer groups, and key provider groups) about the state's default enrollment strategy, which Medicaid managed care plans and D-SNPs are involved, the materials and communications that will be disseminated to beneficiaries before and after default enrollment, and key dates in the process. If these organizations are properly educated, they can better assist beneficiaries with questions and concerns.

Resources

Federal requirements for the default enrollment process are described at 42 CFR 422.66(c). CMS also provides guidance for D-SNPs on default enrollment in the Medicare Advantage Enrollment and Disenrollment Guidance provided at https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment.

A list of states and plans approved to conduct default enrollment can be found at https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment.

For technical assistance with implementing default enrollment, states may contact the CMS Medicare-Medicaid Coordination Office at MMCO_DSNPOperations@cms.hhs.gov or the Integrated Care Resource Center at ICRC@mathematica-mpr.com.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the Integrated Care Resource Center are coordinated by Mathematica and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

Endnotes

[1] Enrollees in limited-benefit Medicaid managed care plans, such as prepaid inpatient health plans (PIHP) and prepaid ambulatory health plans (PAHP) are not eligible for default enrollment, nor are Medicaid beneficiaries involved in managed fee-for-service models, such as primary case management, health homes, or accountable care organizations.

[2] Individuals who become eligible for Medicaid benefits through a "medically needy" pathway are not eligible for default enrollment, as these individuals may gain or lose Medicaid coverage on a monthly basis.

[3] After default enrollment, eligible Medicaid MCO enrollees may (1) remain enrolled in the same Medicaid MCO for Medicaid benefits and begin receiving Medicare benefits from the D-SNP operated by the same legal entity or parent organization as the MCO; (2) receive Medicare and Medicaid benefits from the D-SNP operated by the same legal entity or parent organization as their original MCO; or (3) receive Medicare benefits from a D-SNP and Medicaid benefits from another Medicaid managed care plan, as long as both the D-SNP and the new Medicaid managed care plan are operated by the same legal entity or parent organization as the original Medicaid MCO and the new Medicaid managed care plan covers a substantial range of Medicaid benefits. For example, if a D-SNP only covers Medicare cost sharing (and does not cover any other Medicaid benefits), that D-SNP will not be eligible to conduct default enrollment because Medicare cost sharing alone does not constitute a substantial range of Medicaid benefits.

[4] For more details about Washington's provider network alignment requirements, see ICRC's technical assistance tool on working with D-SNPs to coordinate physical and behavioral health services at https://www.integratedcareresourcecenter.com/resource/tips-states-working-dual-eligible-special-needs-plans-improve-coordination-physical-and.

[5] For information about MMA and TBQ files, see the CMS Medicare Advantage and Prescription Drug (MAPD) State User Guide at https://www.cms.gov/data-research/cms-information-technology/access-cms-data-application/mapd-state-user-guide.

[6] 42 CFR 422.66(c)(iv)

[7] For a list of all of the data elements a D-SNP must include on an enrollment transaction to CMS, see Appendix 2 on page 162 of the CY2024 version of Chapter 2 of the CMS Medicare Managed Care Manual at https://www.cms.gov/files/document/cy-2024-ma-enrollment- and-disenrollment-guidance.pdf.

[8] The HPMS default enrollment module allows D-SNPs to upload application documents, retrieve documents with CMS feedback, and view status and email history reports.

[9] Starting with contract year 2026, the CMS model default enrollment notice will be available at https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment. States interested in adding state-specific information to this model notice can reach out to the CMS Medicare-Medicaid Coordination Office at MMCO_DSNPOperations@cms.hhs.gov for options.

[10] See 42 CFR §422.66(c)(2)(iv) for default enrollment notice requirements.

[11] Individuals who are default enrolled into a D-SNP (or who voluntarily enroll in a Medicare Advantage plan when they first become eligible for Medicare Parts A and B) may use the Medicare Advantage Open Enrollment Period described at 42 CFR §422.62(a)(3)(ii) to make a new plan election in the three months after their enrollment effective date (which is their date of initial entitlement for Medicare). They may also use Medicare Special Election Periods (SEPs) for which they qualify, which are described at 42 CFR §422.63(b). Details about Medicare enrollment and special enrollment periods are also provided in the Medicare Advantage enrollment and disenrollment guidance available at https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment.

[12] As described at 42 CFR §438.54, states must allow active plan choice in all Medicaid managed care programs (regardless of whether the program uses voluntary or mandatory enrollment). Medicaid managed care enrollment notices must follow the requirements described at 42 CFR §438.10.

[13] 42 CFR §438.56(c)

[14] 42 CFR 422.112(b)(8)(B)

Appendix A. CMS files that states can use to find people eligible for default enrollment

D-SNPs may only apply to CMS to conduct default enrollment when their State Medicaid Agency Contract (SMAC) indicates that 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. Table A.1 summarizes three CMS file exchanges that states can use for this purpose. All of these files provide advance notice of Medicare eligibility, so states can use any of these files (or a combination of them) to identify people in Medicaid MCOs who will soon become eligible for Medicare.

Table A.1. CMS files that can be used to identify prospective Medicare eligibility

File	Description	Frequency of file exchange
Medicare Modernization Act (MMA)	The MMA file is a data file that states submit to CMS on a regular basis to identify current and prospective dually eligible individuals. In addition to identifying in these files people who are currently dually eligible, states can submit records for Medicaid-only beneficiaries who could become eligible for Medicare in the future. For each MMA request file sent by the state, CMS returns a response file with Medicare eligibility and enrollment information for the beneficiaries included in the state's request file.	States submit monthly full files and daily updates, all of which result in CMS response files
Territory Beneficiary Query (TBQ)	The TBQ is an ad hoc query that CMS offers to states. The TBQ returns the same robust range of Medicare data as the CMS MMA response file, but on an ad hoc basis. States and territories may query CMS as frequently as daily for Medicare beneficiary eligibility and enrollment information using the TBQ.	Ad hoc; states may submit requests as often as daily
Prospective Dual Eligible File (PDF)	The PDF is generated by CMS using the same file format and elements as the TBQ response file. States can elect to receive the PDF from CMS twice a month without needing to send a request file to initiate the data exchange.	Twice a month

MMA response files, TBQ response files, and PDF files all provide the following information (when applicable) from the Medicare Beneficiary Database (MBD):

- The beneficiaries first and last name (as well as middle initial or middle name when applicable);
- The beneficiary's date of birth and gender;
- The beneficiary's Social Security Number, Medicare Beneficiary Identifier (MBI), and Social Security or Railroad Retirement claim account number and beneficiary identification code;
- The beneficiary's residence and mailing addresses;
- The beneficiary's Part A and B entitlement start date, end date, reason code, and status code;
- The beneficiary's eligibility, subsidy and copayment levels, and start and end dates for the Part D low-income subsidy (LIS) program;
- Current and past Medicare Advantage and Part D plan enrollment information; and
- Information regarding whether the beneficiary is ineligible to enroll in a Medicare plan due to incarceration or unlawful presence.

For more information about the Medicare Modernization Act (MMA) and Territory Beneficiary Query (TBQ) files, see the MAPD State User Guide. For more information about the Prospective Dual File (PDF), please contact MMCOEnrollment@cms.hhs.gov.