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The Dual Default Process and Medicare Transition Process

NYSDOH & NYMC

SEPTEMBER 2025 - MLTC

WEBINAR LOGISTICS

- Phone numbers must be associated with an attendee in the participant list.
- Participants will remain muted throughout the presentation.
- Questions can be submitted through the Q&A function **at the end of the presentation** and will be answered as time permits.
- The slides will be shared after the webinar.

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AGENDA

- Background: Medicare Transition
- MLTCP Excluded Population - Long Term Nursing Home Stay
- Integrated Benefits for Dually Eligible Enrollees
- Dual Default and Medicare Transition
- Dual Default
- Opt-Out Process – MAP Default
- Medicare Transition Process
- New York State of Health (NYSOH) Cases
- Appendix

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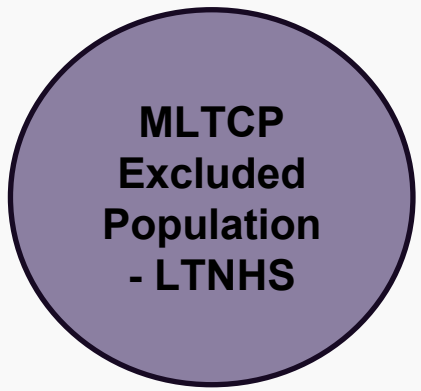
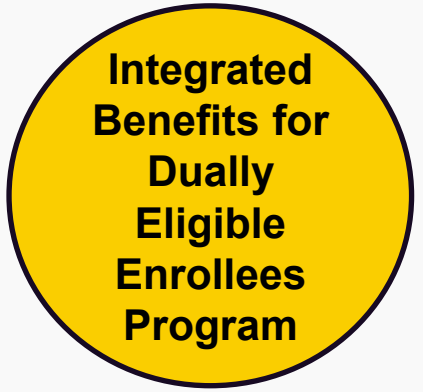
BACKGROUND: MEDICARE TRANSITION

- Prior to March 2020, New York Medicaid Choice (NYMC) generated a monthly **Medicare File (M-File)** that identified existing and prospective dual eligible members of all Medicaid Managed Care, Health and Recovery Program (HARP) and HIV Special Needs Plans (HIV SNP).
- Individuals in receipt of CBLTSS were **auto-transferred** to the sister MLTC Partial Capitated (MLTCP) plan of their MMC/HARP/HIV SNP Plan or auto assigned to a MLTCP serving their area.
- **Non-CBLTSS** and **MLTC Excluded CBLTSS** individuals were disenrolled to Medicaid Fee-For-Service (FFS).

- Due to the Public Health Emergency (PHE), the M-File process was placed on hold in 2020.
- Dual individuals enrolled in MMC/HARP/HIV SNP were **not** disenrolled and were permitted to remain in their Plans.
- New York State Department of Health (Department) is returning to normal rules.
- The below-initiatives will be incorporated within the revised Dual Default and M-File process:





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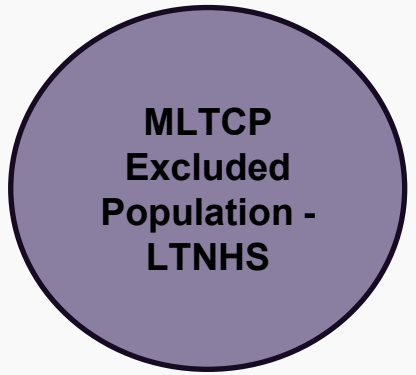
MLTCP EXCLUDED POPULATION - LONG TERM NURSING HOME STAY

- Prior to 2020, Long Term Nursing Home Stay (LTNHS) dual individuals were mandatory for enrollment in an MLTC Plan
- In the prior M-File process, LTNHS individuals were auto-assigned into an MLTCP plan if one was not selected.
- In Jan 2020, LTNHS dual individuals at the time of enrollment became an excluded population for enrollment into an MLTCP.
- This change will impact the resumption of the M-File process and all dual LTNHS individuals will be disenrolled to Medicaid FFS due to being excluded from MLTCP.



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INTEGRATED BENEFITS FOR DUALLY ELIGIBLE ENROLLEES PROGRAM

- In December 2020, the Department introduced the **Integrated Benefits for Dually Eligible Enrollees program**.
- The program is designed to streamline healthcare access for individuals who qualify for **both** Medicare and Medicaid, by aligning their benefits within a single plan, through a **Medicare Dual Special Needs Plan (D-SNP)** with coordinated Medicare and Medicaid Managed Care coverage.
- The enrollment into the D-SNP occurs at the time the individual becomes newly Medicare eligible through CMS default process.

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DUAL DEFAULT AND MEDICARE TRANSITION

Today's presentation will focus on two processes that transition dual eligible MMC/HARP/HIV SNP enrollees from their plan consistent with the 1115 Medicaid Demonstration waiver.

- Dual Default Enrollment
- Medicare Transition Process

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DUAL DEFAULT

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THE DUAL DEFAULT PROCESS

- The purpose of this process is to **default enroll** eligible, prospective dual MMC and HARP members, gaining Medicare 90-110 days in the future, into an aligned Medicare D-SNP of their MMC/HARP Plan.
- The individual's default enrollment effective date is their **Medicare Start Date**.
- Default Enrollment seamlessly enrolls individuals into the D-SNP of either:
  - IB-Dual (MMC/HARP)
  - **MAP**
- Health Plans must be approved by the Department and Centers for Medicare and Medicaid Services (CMS) to participate in Default Enrollment.

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DUAL DEFAULT ENROLLMENT PROCESS

- The Dual Default Enrollment process is voluntary and includes an opt-out provision preserving the dual eligible individual's right to select the Medicare coverage of their choice.
- The Dual Default Enrollment process is coordinated between NYMC and the MMC/HARP plans.
- The Medicare health plans are responsible for issuing a 60-day notification informing the individual that they will be Default enrolled.
- For individuals enrolled into a MAP plan, NYMC sends an enrollment confirmation notice, which informs an individual that they are mandatory and includes FH rights.

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MAP DUAL DEFAULT ENROLLMENT CRITERIA

Individuals MUST:

- Be enrolled in one of the State-approved MMC or HARP Plans that have a sister MAP product
- Have active Medicaid with the appropriate coverage for MAP enrollment
- Be gaining Medicare (Part A and B) within the next 90-110 days
- Meet the MLTC eligibility criteria and not be excluded
- Reside in a MAP Default approved county
- Be enrolled in the aligned Medicare D-SNP product at the time of default enrollment

Note: Eligible individuals are default enrolled into the aligned Medicare D-SNP by the Health plan. NYMC enrolls the individual into the Medicaid Advantage Plus (MAP).

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MAP DUAL DEFAULT PATHWAY

90-110 Days Prior to Medicare Start Date:

- NYMC identifies individuals who are enrolled in a participating MMC/HARP and are also prospectively Medicare eligible.
- NYMC generates the Dual Default File and sends it to the respective MMC/HARP plans.
- MMC/HARP plans identify individuals on the Dual Default File who may be eligible for MAP according to the enrollment criteria.

60 Days Prior to Medicare Start Date:

- Plans are responsible for notifying qualifying individuals that they will be default enrolled into the aligned MAP and Medicare D-SNP.

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MAP DUAL DEFAULT PATHWAY

25 Days Prior to Medicare Start Date:

- MAP Default occurs and NYMC sends out an enrollment confirmation notice to individuals enrolled into a MAP plan, aligning with their Medicare start date.
- The MAP Default Enrollment Confirmation notice has been updated and includes:
  - Language that informs an individual that they must be enrolled in an MLTC plan to continue receiving community based long term services and supports
  - If the individual changes their Medicare plan, they will need to select another MLTC Plan
  - Notices contain a Frequently Asked Questions Section
  - Fair Hearing Rights

In October 2025, MLTCP Plans will begin receiving Enrollment Files (E-Files) due to DF-File auto-transfers for an 11/1/25 effective date.

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OPT-OUT PROCESS MAP DEFAULT

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OPT-OUT PROCESS – MAP DEFAULT

- Prospective Dual Default individuals may opt-out of being defaulted into the Medicare DSNP.
- Individuals who opt-out are no longer eligible for MAP Default.
- MLTC Mandatory individuals who opt-out of Default Enrollment into MAP are auto-assigned to:
  - The Sister MLTCP of the individual's current MMC/HARP or,
  - An MLTCP that serves in the individual's county.

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OPT-OUT PROCESS AND NOTICING

Individuals enrolled in an MMC/HARP plan who opt-out from the D-SNP before NYMC processes the MAP default enrollment receive an outreach notice from NYMC. Outreach notices has been updated and includes:

- Language that informs an individual that they must be enrolled in an MLTC plan to continue receiving community based long term services and supports
- Tailored Language based on “with” or “without a Sister MLTCP plan”
  - **With a Sister MLTCP plan:** The notice informs them that they have 30 days to select an MLTCP plan or they will be auto-assigned into their current Plan’s Sister MLTCP.
  - **Without a Sister MLTCP plan:** The notice informs them that they have **30 days** to select an MLTCP plan or they will be auto-assigned into an MLTCP plan that serves their county.
- Notices contain a Frequently Asked Questions Section
- Fair Hearing Rights

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DUAL DEFAULT ENROLLMENT SCENARIOS

- For individuals who opt-out **by the 25th** of the month prior to the Medicare start date, NYMC conducts an outreach call for Mandatory MLTC Plan selection.
  - Example: Plan reports MAP opt-out on 10/23/25, individual is outreached and selects an MLTCP for effective date 11/1/2025.
  - If outreach attempts are unsuccessful or if individual does not select an MLTC plan, individuals are **auto-transferred** to the Sister MLTCP or an MLTCP that serves their area.
- Individuals who opt-out **after the 25th** of the month prior to the Medicare start date, remain enrolled in the MAP plan for no more than (1) month and will be enrolled into an MLTCP.
  - Example: Plan reports opt-out to NYMC on 10/30/25, individual is outreached and selects an MLTCP. MAP default Plan remains in effect for 11/1/25 and the new MLTC is effective 12/1/2025.

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MEDICARE TRANSITION PROCESS

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MEDICARE TRANSITION PROCESS

- The Medicare (M-File) process transitions MMC/HARP/HIV-SNP enrollees to FFS Medicaid, or into an MLTC plan, as they first become Medicare eligible.
- The M-File process is coordinated between NYMC and the MMC/HARP/HIV SNP plans.
- NYMC identifies individuals gaining Medicare within the next 60 days. MMC/HARP/HIV SNP plans are responsible for identifying individuals that meet the mandatory criteria for MLTC.
- NYMC is responsible for processing all enrollments into MLTC. All other individuals, including individuals that are excluded from enrollment into MLTC, are disenrolled to FFS by NYMC.

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MEDICARE TRANSITION PROCESS

- Effective August 10th, 2025, and on the 10th of every following month, the Medicare transition (M-File) will resume generating for MMC/HARP/HIV SNP Health Plans.

- The purpose of the M-File will be to identify **current or prospective duals** and:
  - Transfer to MLTC
  - Disenroll to FFS Medicaid

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CRITERIA FOR MLTC ENROLLMENT

Individuals MUST:

- Be 18 years and older
- In receipt of or expect to be in receipt of Medicare (Part A and B) within the next 60 days
- Meet the MLTC Mandatory eligibility criteria and are not excluded

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MEDICARE TRANSITION - SISTER PLAN

In **October 2025**, MLTCP Plans will begin receiving Enrollment Files (E-Files) due to M-File auto-transfers for an **11/1/25 effective date.**

60 Days Prior to MLTC Auto-Assignment:

- Individuals who are in an MMC/HARP/HIV SNP with a Sister-Partial Plan MLTCP plan, receive an outreach notice.
- The notice advises them that they have 30 days to select an MLTCP plan or they will be auto-assigned into their current Plan's Sister-Partial Plan.

30 Days Prior to Sister-MLTC Effective Date:

- Individuals who do not select an MLTCP plan within 30 days are auto-assigned into their current Plan's MLTCP plan and receive an enrollment confirmation notice.

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MEDICARE TRANSITION – NON SISTER PLAN

60 Days Prior to MLTC Auto-Assignment:

- Individuals in an MMC/HARP/HIV SNP without a Sister-Partial Plan, receive a notice from NYMC.
- The notice informs them that they have 30 days to select an MLTCP plan or they will be auto-assigned into an MLTC Partial Plan that serves their county.

30 Days Prior to Sister-MLTC Effective Date:

- Individuals who do not select an MLTCP plan within 30 days are auto-assigned into an MLTCP and are sent a confirmation notice.

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MEDICARE TRANSITION - OUTREACH NOTICE

Outreach notices have been updated and includes:

- Language that informs an individual that they must be enrolled in an MLTC plan to continue receiving community based long term services and supports
- Tailored Language based on “with” or “without a Sister MLTCP plan”.
  - **With a Sister MLTCP plan:** The notice informs them that they have 30 days to select an MLTCP plan or they will be auto-assigned into their current Plan’s Sister MLTCP.
  - **Without a Sister MLTC plan:** The notice informs them that they have **30 days** to select an MLTCP plan or they will be auto-assigned into an MLTCP plan that serves their county.
- Notices contain a Frequently Asked Questions Section
- Fair Hearing Rights

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MEDICARE TRANSITION - ENROLLMENT CONFIRMATION NOTICE

- The Enrollment Confirmation notice has been updated and includes:
  - Language that informs an individual that they must be enrolled in an MLTC plan to continue receiving community based long term services and supports
  - Notices contain a Frequently Asked Questions Section
  - Fair Hearing Rights

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MEDICARE TRANSITION - DISENROLLMENTS

Individuals will be **disenrolled** to FFS Medicaid, including:

- Individuals that are excluded
- Individuals that are not eligible for MLTC
- Individuals that are not in receipt of CBLTSS

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NYSOH CASES

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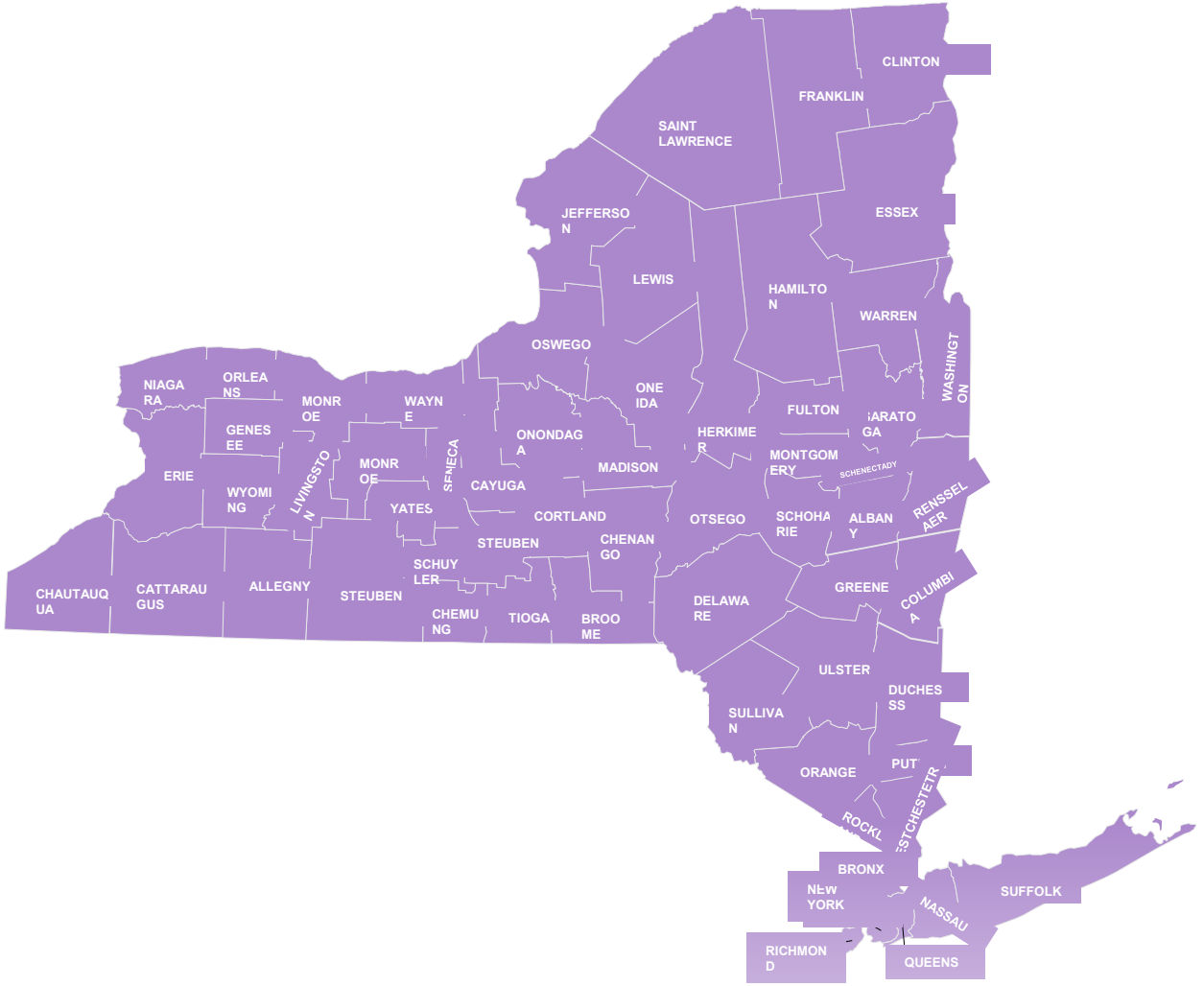
New York State of Health Cases

- Both the DF and M-File processes will **include** New York State of Health (NYSOH) cases.
- NYMC identifies NYSOH cases that will be transitioned to MLTC and coordinates with the Department to have the cases converted prior to MLTC enrollment.
- **NYSOH CBLTSS** cases are converted to WMS at the local district to allow for MLTC Plan processing and for eligible individuals to receive CBLTSS through the district.
- If individuals have NYSOH status at the time of MAP Default or MLTCP plan transfer, the transaction will not be processed.



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ACRONYMS

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ACRONYMS

CBLTSS – Community Based Long Term Services and Supports

CMS – Centers for Medicare and Medicaid Services

Dual Default – A CMS procedure whereby newly Medicare eligible individuals are enrolled into their MMC/HARP plan's aligned Medicare D-SNP for MMC/HARP or MAP depending upon service needs and eligibility; uses the DF file *(officially called Default Enrollment*)

D-SNP – Duals Special Needs Plan: a special Medicare Advantage plan for individuals eligible for both Medicare and Medicaid (dual eligibles)

FFS – Fee for Service Medicaid

HARP – Health and Recovery Plans

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ACRONYMS (CONTINUED)

HIV SNP – HIV Special Needs Plans

IB-Dual – Integrated Benefit for Dually Eligible Enrollees Program

LTNHS – Long Term Nursing Home Stay

M-File – Medicare File for disenrolling new duals from Medicaid Managed Care (**MMC**), Health and Recovery Plans (**HARP**), and HIV SNP

MLTC – Managed Long Term Care

MAP – Medicaid Advantage Plus

MLTCP – Managed Long Term Care Partial

PACE – Program of All-Inclusive Care for the Elderly

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ACRONYMS (CONTINUED)

MMC – Medicaid Managed Care

NYMC – New York Medicaid Choice, the Department's enrollment broker

NYSOH – New York State of Health (eligibility system for MAGI enrollees)

PCS – Personal Care Services

PHE – Public Health Emergency

WMS – Welfare Management System (eligibility system for non-MAGI enrollees)

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APPENDIX

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APPENDIX - NOTICES

MAP Default Enrollment Confirmation Notice Language Updates:

IMPORTANT: You Must Enroll in a Managed Long Term Care Plan

Dear <Consumer Name>: <CIN>

This notice is to let you know that you must enroll in a **Managed Long Term Care plan** by **<choose date>**, to continue receiving community based long term services and supports. You will no longer be enrolled in <Current plan>, starting **<effective date>**.

The **Medicaid program requires that you** enroll in a Managed Long Term Care plan because:

- you will have both Medicaid and Medicare, **and**
- you are receiving **at least one** community based long term service and support for more than 120 days.

What happens next:

- You will be enrolled in **<MAP Plan Name>**, a Medicaid Advantage Plus (MAP) plan that is offered by the same health insurance company as your current plan. **<MAP Plan Name>** will provide your community based long term services and supports starting **<effective date>**.
- Your new plan will send you a welcome letter and a health plan card.
- You will also receive information about your benefits and the services your MAP plan covers.
- You may reach **<MAP Plan Name>** at **<Plan phone number>**. TTY: **<TTY Number>**.
- If you decide to change your Medicare health plan before your enrollment into **<MAP Plan Name>** on **<effective date>**, you will not be eligible to remain enrolled in **<MAP Plan Name>.** Instead, you will be enrolled in a Managed Long Term Care (MLTC) Medicaid plan.

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APPENDIX - NOTICES

Frequently Asked Questions

What is a Medicaid Advantage Plus (MAP) plan?
A MAP plan is a type of Managed Long Term Care plan. The plan will cover your Medicaid home care, long term care, and other health services. When you enroll in a MAP plan, you must be enrolled in the plan's Medicare health plan for your Medicare services. This means you will receive your Medicaid and Medicare services from the same health insurance company.

Can I change my Medicare health plan and remain enrolled in my Medicaid Advantage Plus (MAP) plan?
No, if you change your Medicare health plan, you cannot remain enrolled in **<MAP Plan Name>**. Your Medicaid Advantage Plus (MAP) plan and your Medicare health plan must be aligned, meaning they must be offered through the same health insurance company. If you decide to change your Medicare health plan, you will also need to change your Medicaid Advantage Plus (MAP) plan so that both your Medicaid and Medicare services are covered by one plan.

What happens if I do not want to enroll in <MAP Plan Name>?
If you do not enroll in **<MAP Plan Name>**, you must choose another Managed Long Term Care plan and change your Medicare coverage. To continue receiving community based long term services and supports you must be enrolled in a Managed Long Term Care plan.

Updated FAQ Section for MAP Default Enrollment Confirmation Notice

Who does not have to enroll in a Managed Long Term Care plan?
Some individuals have a special situation that allows them to choose either to enroll in a health plan or to receive fee-for-service Medicaid. Call **New York Medicaid Choice** for more information.

Will the services I get now change?
For the first 90 days, **<MAP Plan Name>** will continue to provide the same community based long term services and supports you receive now from your current plan. After 90 days, the plan may change or reduce your community based long term services and supports. If they do, they will tell you in writing first. You have the right to appeal their decision.

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APPENDIX - NOTICES

Sister MLTC Pathway – What Happens Next Section

What happens next:

- If you do not choose a plan by **<choose date>**, you will be enrolled in **<MLTC Plan Name>**, a Managed Long Term Care (MLTC) Medicaid plan that is offered by the same health insurance company as your current plan.
- You can choose one of the plans on the enclosed list of **Managed Long Term Care Plans**. These plans have different plan eligibility requirements. The plan that you choose will be responsible to determine if you meet their plan eligibility requirements.

CBLTSS Definition :

What are community based long term services and supports?
Community based long term services and supports are medical and non-medical services that are covered by Medicaid to help adults with disabilities or illnesses live safely in their homes and communities. These services and supports include:

- Nursing services in the home
- Home health aide services
- Private duty nursing
- Personal care services in the home
- Adult day health care
- Consumer directed personal assistance services
- Therapies in the home (physical, occupational, respiratory and speech pathology)

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APPENDIX - NOTICES

Sister MLTC Pathway – Auto-Assignment Language

Dear <Consumer Name>: <CIN>

This notice is to let you know that starting on **<effective date>**, you will be enrolled in **<Plan Name>**, a Managed Long Term Care (MLTC) Medicaid plan.

To continue receiving community based long term services and supports you must remain enrolled in a Managed Long Term Care plan. The **Medicaid program requires that you** are enrolled in a Managed Long Term Care plan because:

- you have both Medicaid and Medicare; **and**
- you are receiving **at least one** community based long term service and support for more than 120 days.

What Happens Next

What happens next:

- Your new plan will send you a welcome letter and health plan card.
- You will also receive information about your benefits and the services your plan covers.
- You may reach **<Plan Name>** at **<Plan phone number>**. **TTY: <TTY Number>**.

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APPENDIX - NOTICES

Non-Sister MLTC Pathway – Auto-Assignment Language

This letter is to let you know that you must enroll in a **Managed Long Term Care plan** by <**choose date**>, to continue receiving community based long term services and supports. You will no longer be enrolled in **<Current plan>,** a Medicaid Managed Care plan, starting **<effective date>**.

The **Medicaid program requires that you** enroll in a Managed Long Term Care plan because:

- you will have both Medicaid and Medicare; **and**
- you are receiving **at least one** community based long term service and support for more than 120 days.

What Happens Next

What happens next:

- You can choose one of the plans on the enclosed list of **Managed Long Term Care Plans**. These plans have different plan eligibility requirements. The plan that you choose will be responsible to determine if you meet their plan eligibility requirements.
- To learn about the Managed Long Term Care plans available to you, call **New York Medicaid Choice** at **1-888-401-6582**. A counselor can tell you about your plan options and let you know which plans work with your providers.
- If you do not choose a plan by **<choose date>**, you will be enrolled in a Managed Long Term Care (MLTC) Medicaid plan.

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APPENDIX - NOTICES

Disenrollment Confirmation Notice Language Updates:

Important Notice About Your Plan Disenrollment

Dear <Member Name>: <Full Case ID>

This notice is to let you know that you will no longer be enrolled in <Old Health Plan>, a Medicaid Managed Care plan, starting **<Plan Effective Date>**. You can no longer remain enrolled in <Old Health Plan>, because:

Our records show that you have Medicaid and Medicare. Individuals who have both Medicaid and Medicare cannot be enrolled in a Medicaid Managed Care plan unless they are enrolled in the Integrated Benefits for Dually Eligible Enrollees (IB-Dual) program. For more information, see the "Frequently Asked Questions" section.

What happens next:

- You will be disenrolled to fee-for-service (FFS) Medicaid. You must contact your Local Department of Social Services to discuss your care needs. Call us at 1-800-505-5678 and we will give you their phone number.
- After **<Plan Effective Date>**, the way you receive services will change. You will receive health care by using your NY State Benefit Identification card (Medicaid card). You will no longer use your plan card or receive coverage through <Old Health Plan>.
- Your plan will continue providing your current services until you are disenrolled to FFS Medicaid on **<Plan Effective Date>**.

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