NEW YORK STATE | Department of Health

Integrated Benefits for Dually Eligible Enrollees (IB-Dual) Enrollment Guide

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I. Purpose

The purpose of this guide is to provide instructions for Mainstream Medicaid Managed Care (MMC) Plans and Health and Recovery Plans (HARPs), herein after referred to as 'MMCPs', that offer or are seeking to offer the Integrated Benefits for Dually Eligible Enrollees (IB-Dual) program in New York. The State anticipates releasing additional guides related to the IB-Dual program in 2026.

II. Background

In November 2020, the 1115 Medicaid Waiver Authority was updated to allow certain Dual Eligible enrollees to remain voluntarily enrolled in their MMCP (HIV SNP enrollees were not included) upon becoming eligible for Medicare. These dual eligible enrollees are defined as MMC/HARP enrollees who have enrolled in their MMCP's aligned Medicare Dual Special Needs Plan (D-SNP). These dual eligible enrollees may enroll in the IB-Dual program within a MMC plan or HARP.

In April 2021, the Department of Health (Department) coordinated with New York Medicaid Choice (NYMC), the State's enrollment broker, to implement the Default Enrollment process. This process transitions newly eligible Medicare individuals currently enrolled in an MMCP into a D-SNP that is aligned with that MMCP. The process also transitions individuals identified as mandatory for Managed Long Term Care (MLTC) into an aligned Medicaid Advantage Plus (MAP) plan and their MMCP's MAP aligned D-SNP.

In 2022, the Department began to explore alternative enrollment pathways into IB-Dual. For dual eligible individuals in Fee-for-service (FFS) Medicaid and enrolled in the aligned D-SNP, a pilot program was created to allow these members to move from FFS Medicaid to IB-Dual. MMCPs were required to submit a proposal/outreach plan and any member materials to the Department for approval to utilize this enrollment pathway. The FFS transition process is now an established option that requires Department approval.

The Department resumed the revised Medicare transition (M-File) process, which disenrolls or transfers newly dual eligibles to FFS Medicaid or Managed Long Term Care (MLTC), on August 1, 2025. Simultaneously, the Department updated the Default Enrollment process, which seamlessly enrolls new dual eligibles into an aligned D-SNP and companion Medicaid product depending upon eligibility.

III. IB-Dual Overview

The IB-Dual program is a premium rate group within Mainstream MMC and HARP plans for individuals not requiring more than 120 days of Community Based Long Term Services and Supports (CBLTSS), and who are eligible for Medicare and have elected to enroll in the MMCP's aligned D-SNP. Individuals in receipt of only Personal Care Level 1 services may remain or enroll in the program.

IB-Dual is a voluntary program and does not contain a lock in provision, meaning individuals are not required to remain in their plan or program for a set amount of time before making changes. Individuals must meet the eligibility criteria to enroll and cannot be excluded from enrollment as outlined in the Medicaid Managed Care Exclusion Exemption Chart. There are three (3) pathways for a member to join IB-Dual:

- Default Enrollment Process
- FFS Medicaid Transition Process
- Aligned Population

IV. IB-Dual Enrollment Pathways

A. Default Enrollment Process

The Default Enrollment process is a Centers for Medicare and Medicaid Services (CMS) approved enrollment procedure that allows MMCP enrolled individuals to be automatically enrolled into the aligned D-SNP of their current plan as they become Medicare (Parts A & B) eligible for the first time. The Default Enrollment process allows eligible MMCP enrollees who are not otherwise excluded and meet the MLTC mandatory criteria, to transition to a MAP plan and the affiliated D-SNP, where available, unless they opt-out. For the plan to participate in the Default Enrollment process, the MMCP must receive approval from both CMS and the Department.

The 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. If the individual decides to enroll in Original Medicare (Parts A & B) or a Medicare D-SNP that does not align with their MMCP, they would not be eligible to transition into the IB-Dual or MAP program and would be considered unaligned.

The Default Enrollment process is coordinated between NYMC and the MMCPs. NYMC identifies MMCP individuals who will become Medicare eligible approximately 90 to 110 days before the Medicare start date. MMCPs that have been approved by CMS and the Department receive a monthly report (DF-File) from NYMC around the 28th day of every month, listing their enrollees who are potentially eligible for Default Enrollment based on current eligibility rules.

The MMCPs return the completed monthly report (DFF-File) to NYMC by the 15th of the following month and are responsible for confirming Default Enrollment eligibility and identifying if the individual is eligible to remain enrolled in their MMCP or enroll in a MAP plan. The Medicare Advantage Health Plans are responsible for issuing a 60-day notification informing the individual that they will be default enrolled into the Medicare D-SNP of their MMCP.

NYMC reviews the response files from the MMCPs and either takes no action on MMCP individuals that are eligible for the IB-Dual Program or transitions the MMCP individuals that are MLTC mandatory into an available MAP plan.

- **IB-Dual Example**: An individual who is currently enrolled in an MMCP is becoming Medicare eligible. The MMCP identifies that the individual is not receiving CBLTSS and is eligible for Default Enrollment and indicates this on a file to NYMC. Upon the individual's Medicare start date, the individual remains in MMC (or HARP) while the IB-Dual aligned D-SNP enrolls them for their Medicare coverage.

- **MAP Example**: An individual who is currently enrolled in an MMCP is becoming Medicare eligible. The MMCP identifies that the individual is in need of CBLTSS for more than 120 days and indicates this on a file to NYMC. NYMC confirms the MMCP has a MAP approved for Default Enrollment. Upon the individual's Medicare start date, NYMC enrolls the individual into MAP, while the MAP aligned D-SNP enrolls them for their Medicare coverage.

B. FFS Medicaid Transition Process

The FFS Medicaid Transition Process allows for individuals who are in FFS Medicaid and in an IB-Dual plan's aligned Medicare D-SNP to transition from FFS Medicaid into IB-Dual. This pathway is open to enrollees who are in the process of joining an MMCP's aligned Medicare D-SNP; in this instance, the member should not be enrolled in IB-Dual (MMC or HARP) prior to enrolling in the aligned D-SNP. However, according to current CMS rules, the member may be enrolled in the aligned D-SNP prior to and without being enrolled in IB-Dual.

The FFS Medicaid Transition Process differs slightly for WMS (Welfare Management System) and New York State Of Health (NYSOH) and Medicaid Eligibility and Client Management (MECM) systems. Most members meeting the eligibility criteria for this process are in WMS.

A. WMS: Beginning 1/1/2026, Health Plans may either perform a 3-way phone call with the enrollment broker and the enrollee or submit a U-File to enroll the member into IB-Dual. Beginning 4/1/2026, Health Plans should only be using the U-File submission process unless extenuating circumstances require a phone call.

B. NYSOH and MECM**:** Individuals in NYSOH and MECM can select to join the aligned MMCP IB-Dual plan of their current D-SNP in their member portals (NYSOH Accounts). For NYSOH/MECM consumers who voluntarily join IB-Dual via selection in the portal, plans do not need to submit any files for enrollment. However, the Department will release guidance separately on how plans should monitor all FFS transitions for eligibility criteria, such as the usage of CBLTSS that would make a member ineligible.

C. Aligned Population:

New dual eligible individuals who, prior to being disenrolled from their MMCP, join their Health Plan's aligned D-SNP are automatically enrolled in IB-Dual. This pathway was used during the COVID-19 Public Health Emergency when individuals were not being

disenrolled for unaligned Medicare. With the restart of the M-file and the phases of the duals unwind, this pathway will now become very rare.

V. IB-Dual Application Processes

MMCPs that want to operate an IB-Dual program must apply through the Department. An MMCP must submit a mini-application to the Department for review and approval. For questions or to request the mini-application, MMCPs can email their Mainstream Plan Manager or contact the Department at bmccsmail@health.ny.gov.

An existing or new plan applying to operate the MMC line of business that is also seeking to offer IB-Dual must be approved to operate the MMC line of business and have at least three (3) months of successful MMC enrollment before applying to offer IB-Dual or any enrollment pathways into IB-Dual. Plans must follow established timelines found on the Department's webpage at: https://www.health.ny.gov/health_care/managed_care/plans/ for submission of applications, service area expansions, and any other communications required for Department review. Any application not meeting the above criteria will not be reviewed. The Department reserves the right to deny or delay the approval of such applications for IB-Dual if plans are unable to operate their new MMC line of business to the Department's performance standards.

The mini-application submission must include the template document as well as a network congruency report demonstrating alignment of the Medicaid and Medicare provider network and enrollment and financial projections for the proposed IB-Dual service area. When the IB-Dual program has been approved by the Department, the Health Plan may apply to CMS for use of the Default Enrollment process or to the Department for the FFS Transition Process. Health Plans that choose to expand their IB-Dual service area must submit a new mini-application to the Department for approval as well as communicate any service area expansion to CMS prior to including additional counties for Default Enrollment.

A. Application for Default Enrollment

Health Plans offering IB-Dual or MAP must complete the Default Enrollment Application for submission to CMS for approval with a copy to dualintegration@health.ny.gov. Health Plans must forward to the Department a copy of CMS' Default Enrollment process approval notification or correspondence to Health Plan within 10 calendar days of receipt.

The Department will coordinate with NYMC to add the Health Plan to the prospective Default Enrollment file process. As a reminder to plans, approval of Default Enrollment results in the Health Plan receiving future prospective files, meaning that Health Plans will not receive new enrollments via default until approximately four (4) to six (6) months after approval.

B. Default Enrollment Renewal Requirements

Health Plans are approved for Default Enrollment for a period of five (5) years. CMS will contact Health Plans at least six (6) months prior to the expiration of the Default Enrollment approval to begin the process for coordinating those activities necessary to

renew any existing Default Enrollment process approval(s) with CMS, as per the requirements of 42 CFR § 422.66(c)(2)(ii), so that any such subsequent CMS approval(s)/renewal(s) of an existing approved Default Enrollment process shall be effective no later than 120 calendar days prior to the expiration of the existing CMS approval.

Health Plans will coordinate with the Department regarding activities necessary to obtain such CMS renewal approval(s) of an existing IB-Dual and/or MAP Default Enrollment process. Health Plans shall forward to the Department copies of their Default Enrollment process renewal notification and materials, and CMS' renewal approval(s) notification or correspondence, within 10 calendar days of receipt.

C. IB-Dual Plan Benefit Package (PBP) Changes

Health Plans that make changes to their IB-Dual D-SNP plan benefit package (PBP) identifier will be required to file an updated Default Enrollment application with CMS in order to participate in Default Enrollment with the new PBP. Therefore, if the Health Plan's approved IB-Dual H# contract and PBP is changed to a new PBP or another PBP is added to the IB-Dual D-SNP, the Health Plan must ensure approval of the PBP change by CMS and the Department to continue Default Enrollment without interruption.

D. Application for Fee for Service (FFS) Transition Pathway

Both new applicants and existing plans must complete Attachment A of this document in 2026. Existing plans are required to submit by April 1st, 2026, and new plans will submit on a rolling basis. Approved plans may resubmit their already approved written proposal. New plans are encouraged to meet with the Department by emailing dualintegration@health.ny.gov prior to submission. After Department approval of the FFS Transition written proposal and attestation and testing with NYMC for file submissions, plans may begin outreach and enrollment through this pathway.

VI. Reporting and Plan Inquires

Health Plans submit reports as described in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract for individuals enrolled in a Mainstream MMC plan or a HARP, as well as any reports outlined in the State Medicaid Agency Contract (SMAC) and/or reports required by CMS for dual eligibles enrolled in the Medicare Advantage D-SNP.

In addition, to assist the Department in monitoring of integrated products, Health Plans shall submit a yearly IB-Dual enrollment summary no later than April 1, 2026, and every April 1st thereafter. The first report shall encompass enrollments from January 1, 2025, through December 31, 2025, in excel format, submitted to dualintegration@health.ny.gov.

- FFS Transition Process:
    - The number of individuals to which the Health Plan performed outreach by each modality used (Mailings, Phone calls, etc.); if multiple modalities were used, please indicate
    - The number of individuals who joined via the FFS Transition pathway

    - The total size of their Medicaid FFS population in the aligned D-SNP as of December 31, 2025
    - The number of individuals who attempted to join via the FFS Transition pathway but could not, broken down by the reason they were unable to join (CBLTSS, lost contact, etc.)

- Default Enrollment:
    - The Department currently monitors Default Enrollment via the enrollment broker and does not require reporting from Plans. The Department reserves the right to request similar details from plans as needed.

Health Plans that have questions regarding member alignment, 834s, or other data inquiries must submit them to mcsys@health.ny.gov with dualintegration@health.ny.gov cc'd. Health Plans that have general integration or IB-Dual questions must submit them to dualintegration@health.ny.gov.

Appendix A

NEW YORK STATE DEPARTMENT OF HEALTH

MEDICAID FEE FOR SERVICE (FFS) TRANSITION TO IB-DUAL APPLICATION & ATTESTATION

FFS Transition Enrollment Attestation Instructions:

The New York State Department of Health (Department) requires this Attestation to be completed by the Mainstream Medicaid Managed Care Plan or Health and Recovery Plan in order to be approved for Fee-for-Service (FFS) Medicaid transition to the Integrated Benefit for Dually Eligible Enrollees (IB-Dual) program.

Health Plans should include a written outreach proposal and any member materials or scripts and submit to the Duals Integration email address at: dualintegration@health.ny.gov.

Approved plans should also sign and submit this attestation with their final approved written proposal and any companion materials. As a reminder, any updates to a plan's proposal or materials must be approved by the Department.

PLAN'S INDENTFYING INFORMATION
Plan Name: _____
Plan's Representative's Name: _____
Telephone # (__ __ __) __ __ __ - __ __ __ __

As part of this approval, (insert Health Plan Name) _____ attests to the following:

1. The Plan attests that they will only perform outreach to individuals in FFS Medicaid and in their IB-Dual aligned Dual Special Needs plan (D-SNP).
2. The Plan attests that they will not enroll individuals who are ineligible for the IB-Dual program, either due to services or exclusions, and will verify eligibility before submitting for enrollment.
   Note: The enrollment broker will also confirm individual eligibility.
3. The Plan attests that they will keep a record, whether via a recorded call or a written statement, that the individual or authorized representative has agreed to join the IB-Dual program. The Plan must retain these records in accordance with State and/or Federal retention requirements and are not required to submit them to the Department unless requested by the Department.

4. The Plan agrees that improper enrollments, outreach, or practices may result in suspension of the Plan's approval to perform FFS Medicaid transitions to the IB-Dual Program by the Department.
5. The Plan agrees that any changes to processes, additions/deletions to service area, or changes in outreach methodology must have the Department's approval prior to being implemented.
6. The Plan agrees to submit any member materials, scripts, notices or other related documents to the Department for approval prior to their use.
7. The Plan shall track outreach attempts and enrollments conducted by the plan and submit them yearly on April 1st, and additionally as requested.

Health Plan Representative Name: _____
Health Plan Representative Signature: _____
Title: _____
Date: _____