

Tools for States on Exclusively Aligned Enrollment in Dual Eligible Special Needs Plans: Key Steps and Considerations for States Using “Medicare-First” Exclusively Aligned Enrollment Processes with Dual Eligible Special Needs Plans (D-SNPs)

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States seeking to integrate Medicare and Medicaid benefits for dually eligible individuals often do so through contracts with Medicare Advantage (MA) dual eligible special needs plans (D-SNPs), which states require to operate with “exclusively aligned enrollment” (EAE). This means that the D-SNPs may only enroll full-benefit dually eligible individuals who receive Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the same parent organization as the D-SNP.¹

This technical assistance brief outlines key steps and considerations for states implementing EAE using a dually eligible individual’s choice of D-SNP enrollment to drive Medicare-Medicaid alignment – what we refer to as a “Medicare-first” approach. The tips and considerations within this brief are applicable for states in which integrated D-SNPs are “aligned” with “affiliated” Medicaid managed care plans offered by the same parent organization as the D-SNP, as well as for states that choose to directly capitate D-SNPs to cover Medicaid benefits for their enrollees. After a brief background on EAE, this brief provides: 1) an overview of the MA enrollment process; (2) key steps in aligning Medicaid coverage with D-SNP enrollment; 3) key decisions for states interested in using Medicare-first EAE; 4) a summary of common enrollment and disenrollment scenarios for states to consider when designing Medicare-first EAE processes; and 5) descriptions of the files through which states can learn about D-SNP enrollments and disenrollments.

ABOUT THIS BRIEF

This technical assistance brief is part of a suite of resources developed for states by the Integrated Care Resource Center (ICRC) on exclusively aligned enrollment (EAE). These resources, including a foundational tip sheet that provides a more basic introduction to EAE, are available at <https://integratedcareresourcecenter.com/resources-by-topic/exclusively-aligned-enrollment>.

This brief provides: 1) an overview of the Medicare Advantage enrollment process; 2) key steps in aligning Medicaid coverage with D-SNP enrollment; 3) key decisions for states interested in using “Medicare-first” EAE; 4) a summary of common enrollment and disenrollment scenarios for states to consider when designing Medicare-first EAE processes; and 5) descriptions of the files through which states can learn about D-SNP enrollments and disenrollments.

Background on EAE

By limiting enrollment to individuals whose Medicare and Medicaid coverage is housed within the same parent organization, EAE facilitates access to a unified package of benefits and supports several important advantages for enrollees, providers, and states, including providing states with multiple opportunities to strengthen integrated care programs.² For example, EAE enables states to: (1) use financial incentives to encourage health plans to improve and streamline care and reduce costs; (2) access consolidated enrollee utilization and experience of care data (as enrollees receive both Medicare and Medicaid benefits via one parent organization); (3) provide simplified messaging and materials to dually eligible individuals about their benefits; and (4) integrate plan-level Medicare and Medicaid appeal and grievance processes to make these processes easier to navigate.

Beginning in 2030, some D-SNPs will be federally required to operate with EAE. Specifically, federal regulations at 42 CFR §422.514(h) will require D-SNPs to operate with EAE if they: 1) enroll full-benefit dually eligible individuals; and 2) operate in the same service areas as affiliated Medicaid managed care organizations (MCOs) offered by the same parent organizations as the D-SNPs.³

When requiring D-SNPs to operate with EAE, states have two options:

- **A “Medicare-first” approach**, in which the state (or a state contractor) aligns a full-benefit dually eligible individual’s Medicaid managed care plan enrollment with the person’s choice of D-SNP enrollment after the state learns that the individual has enrolled in an integrated D-SNP. This strategy preserves the dually eligible individual’s option to choose from multiple integrated D-SNPs and increases enrollment in integrated programs.
- **A “Medicaid-first” approach**, wherein the state restricts D-SNP enrollment to full-benefit dually eligible individuals who are already enrolled in the D-SNP’s affiliated Medicaid managed care plan. This option limits an eligible individual’s opportunities for enrollment into an integrated Medicare-Medicaid plan arrangement to a single D-SNP. In states that use 12-month “lock-in” policies in their Medicaid managed care programs, use of this option may reduce the number of dually eligible individuals enrolled in an integrated care program.⁴

For sample state Medicaid agency contract (SMAC) language for both approaches to EAE, see **Appendix A**.

In considering which EAE approach to use, a state will likely need to weigh features of its Medicaid enrollment and eligibility processes, current information systems design, and other resource and capacity issues. The Centers for Medicare & Medicaid Services’ Medicare-Medicaid Coordination Office (MMCO) and ICRC are available to help states select the approach that will work best for their circumstances. ICRC created this brief to help states establish Medicare-first EAE processes because this approach to EAE:

- Is the most commonly used among states that have already implemented EAE;
- Maximizes Medicare plan choice for dually eligible individuals; and

- Minimizes the opportunity for plan enrollment errors that may arise when D-SNPs are required to use Medicaid-first EAE but do not adequately abide by that requirement.

Overview of the MA enrollment process

Understanding MA’s enrollment processes is the first step to implementing Medicare-first EAE. MA enrollment processes are independent of state Medicaid enrollment processes, and MA processes cannot be altered to align with state-specific enrollment policies or procedures.

Dually eligible individuals have a choice in how they receive their Medicare benefits. They can choose to receive Medicare Parts A and B benefits from Original Medicare (also known as “fee-for-service” or “Traditional” Medicare) with a standalone Part D prescription drug plan. Alternatively, they can enroll in an MA plan, including a D-SNP, for coverage of Medicare Parts A, B, and D benefits. To enroll in a D-SNP, dually eligible individuals can: 1) contact 1-800-MEDICARE for enrollment assistance (or use the Medicare.gov online enrollment center to submit an enrollment request for a plan that opts to use that enrollment center); 2) contact the D-SNP directly to enroll; or 3) speak with a plan-sponsored or independent agent or broker who is approved by the plan to assist with D-SNP enrollments.

Prior to processing an enrollment request, a D-SNP must verify eligibility for enrollment in the D-SNP. Specifically, the D-SNP must confirm Medicare eligibility via CMS system access, and the D-SNP must also verify the individual’s Medicaid eligibility (along with any other state eligibility requirements) via state eligibility systems before submitting an enrollment transaction to CMS. **Box 1** describes two ways that D-SNPs can verify Medicaid eligibility and provides sample SMAC language that can be used to describe any state-specific eligibility requirements and instruct D-SNPs on how to verify Medicaid eligibility.

After verifying the beneficiary’s eligibility for the D-SNP, the D-SNP submits an enrollment transaction to CMS for review. If CMS rejects a D-SNP enrollment request, the D-SNP must notify the individual that their request for D-SNP enrollment has been denied, along with the reason for denial. If CMS accepts the enrollment transaction, the individual will be enrolled into the D-SNP for Medicare benefits on the first day of the month following the D-SNP’s submission of the enrollment transaction. For a summary of key steps in the MA enrollment process, see **Appendix B**.

The next section of this brief summarizes key steps for states in aligning Medicaid enrollment with D-SNP enrollment.

Box 1. Options for D-SNP verification of Medicaid eligibility

D-SNPs must verify a dually eligible individual’s Medicare and Medicaid eligibility before processing the individual’s request for enrollment in the D-SNP. States commonly instruct D-SNPs to confirm Medicaid eligibility in one of two ways:

- 1) **Accessing a state provider portal that provides Medicaid eligibility information; or**
- 2) **Submitting a 270 file (and receiving a 271 response file from the state).**

In states where certain sub-populations of dually eligible individuals are excluded from D-SNP enrollment (such as individuals above or below a certain age, individuals enrolled in a particular home and community-based services (HCBS) waiver, or individuals who need—or do not need—a nursing facility level of care), D-SNPs may need to access another tool, such as a state provider portal, to verify eligibility because details such as waiver participation or level of care need may not be available in 271 files.

When 271 files can provide sufficient eligibility information, D-SNPs often prefer to use the 270/271 file exchange process for Medicaid eligibility verification because that process allows plans to confirm Medicaid eligibility for multiple beneficiaries at once. In some states, D-SNPs use a combination of these two methods.

States can use the following sample language in SMACs to describe state-specific eligibility requirements and how D-SNPs must verify Medicaid eligibility before processing D-SNP enrollment requests:

“The Contractor will verify that a beneficiary meets all applicable eligibility requirements prior to enrolling the beneficiary into the D-SNP. These eligibility requirements include enrollment in Medicare Parts A and B, full Medicaid benefits, and [insert any other state-specific eligibility requirements, such as age, nursing facility level of care need, etc.]. [In states that exclude particular groups of full-benefit dually eligible individuals from D-SNP eligibility, add the following statement: The Contractor must exclude the following populations from D-SNP enrollment [list applicable populations].]”

To verify [Medicaid eligibility, age, etc.], the Contractor will [describe state system(s) that the Contractor will access/steps they will take to verify Medicaid eligibility and any other state eligibility requirements. D-SNPs use CMS data to verify Medicare eligibility; that step does not need to be described in the SMAC.]”

Key steps in aligning Medicaid enrollment with D-SNP enrollment

To ensure timely alignment of Medicaid managed care enrollment with D-SNP enrollment in states using a Medicare-first EAE process, states (and/or state contractors) typically take four steps: 1) obtaining information about D-SNP enrollment; 2) verifying Medicaid eligibility (and other state eligibility requirements, when applicable) for the D-SNP and providing state approval of the enrollment to the D-SNP (if a state chooses to provide such approval – some states simply accept all D-SNP enrollments without this verification step); 3) enrolling the individual into the applicable Medicaid managed care plan for coverage of Medicaid benefits;⁵ and 4) notifying the applicable Medicaid managed care plan of the individual’s new Medicaid enrollment.⁶ The following sections provide more detail on each of these steps.

1 Obtaining D-SNP enrollment information

After a D-SNP’s Medicare enrollment transaction is accepted by CMS, a state (or a state contractor) can learn of the D-SNP enrollment through one of three file exchange methods, which are described in detail in the next section of this brief. States can select a file type that best aligns with their existing systems and processes (for example, by choosing a file type that the state already uses). Depending on the file exchange selected, a state may be notified of new D-SNP enrollments by the D-SNPs or via files received from CMS.

2 Verifying Medicaid eligibility and approving D-SNP enrollment

Once the state has learned that an individual has been enrolled into a D-SNP, it may want to verify that person’s Medicaid eligibility and approve their D-SNP enrollment. While a D-SNP can verify Medicaid eligibility in one of two ways as described in **Box 1**, a state may opt to verify a D-SNP enrollee’s Medicaid eligibility (as well as other state eligibility criteria, when applicable) and provide the D-SNP with formal acceptance or rejection of the D-SNP enrollment, from the state’s perspective. This verification step allows states to address any inappropriate D-SNP enrollments prior to the enrollment effective date (or at least quickly after D-SNP enrollment). Alternatively, states may choose to accept D-SNP enrollments without verification and adjust Medicaid enrollment accordingly. States that choose this option may want to conduct periodic audits of D-SNP enrollees to ensure that D-SNPs are only enrolling individuals who meet state eligibility requirements.

States should not verify a D-SNP enrollee’s Medicare eligibility, as CMS is the source of truth for that information. D-SNPs will verify Medicare eligibility with CMS as part of the Medicare enrollment process.⁷

3 Aligning Medicaid enrollment with Medicare enrollment

Once a state receives information about D-SNP enrollment (and verifies the individual’s eligibility for the D-SNP, if applicable), the state (or a state contractor) will need to assign the individual in the state’s enrollment system to the applicable Medicaid managed care plan for coverage of Medicaid benefits. The applicable Medicaid managed care plan may be the D-SNP (when the state pays the D-SNP a direct capitation to cover Medicaid benefits) or a separate Medicaid managed care plan that is offered by the same parent organization as the D-SNP (known as an “affiliated” Medicaid managed care plan).⁸ If the individual is already enrolled in another D-SNP or Medicaid managed care plan for coverage of Medicaid benefits, the state (or a state contractor) will also need to disenroll the individual from that plan and notify the plan accordingly. In states with Medicaid managed care enrollment cut-off date policies, the state should consider and communicate to D-SNPs and enrollees the implications of those cut-off dates for alignment of Medicare and Medicaid enrollment effective dates. **Box 2** describes Medicaid managed care enrollment cut-off dates in more detail.

Box 2. Implications of Medicaid managed care enrollment cut-off dates for alignment of Medicaid enrollment with D-SNP enrollment

MA plan enrollments (including D-SNP enrollments) are always effective the first day of the month following the date the enrollment request is submitted. For example, if a dually eligible individual submits a D-SNP enrollment request on March 27 and CMS approves the enrollment, the individual’s D-SNP enrollment will be effective April 1.

When a state has a cut-off date policy for Medicaid managed care plan enrollments, the effective date of a new Medicaid managed care enrollment will be the first day of the second month after the enrollment request if the request is submitted after the state’s cut-off date. For example, if a Medicaid managed care enrollment request is submitted on March 27 and the state’s enrollment cut-off date is the 15th of each month, the Medicaid managed care enrollment will be effective on May 1, rather than April 1.

Several states have opted to establish processes that adjust Medicaid managed care enrollment effective dates to align with D-SNP enrollment effective dates in integrated D-SNP programs. In these states, the Medicare and Medicaid enrollment dates are always the same. For example, if a D-SNP enrollment request is submitted on March 27, the D-SNP enrollment effective date and the Medicaid managed care enrollment effective date will both be April 1.

In states that do not take steps to align Medicaid managed care enrollment effective dates with D-SNP enrollment effective dates, Medicaid managed care enrollment effective dates may lag behind D-SNP enrollment effective dates by one month when an eligible individual enrolls in a D-SNP late in a month (past the state’s cut-off date). In these cases, states and D-SNPs must make sure that enrollees understand this lag and its implications for their Medicaid coverage.

For more information about the implications of Medicaid managed care cut-off dates for integrated D-SNP programs (including a graphic showing two different enrollment timelines), see ICRC’s [tip sheet on key policy decisions and considerations for states preparing for EAE](#).

4 Notifying the D-SNP or the D-SNP’s affiliated Medicaid managed care plan of Medicaid enrollment alignment

Finally, the state (or a state contractor) should notify the D-SNP or the D-SNP’s affiliated Medicaid managed care plan of the new Medicaid managed care enrollment. States typically send these notifications using 834 enrollment files (which are described in the next section of this brief). If the individual was already enrolled in another D-SNP or that D-SNP’s affiliated Medicaid managed care plan, the state (or a state contractor) will need to notify the plan of the disenrollment.

See **Appendix B** for a flow chart showing the full set of steps in D-SNP enrollment and aligning Medicaid enrollment with D-SNP enrollment. For examples of specific states’ approaches to EAE, see **Appendix C** and ICRC’s [webinar on using EAE to integrate Medicare and Medicaid benefits for dually eligible individuals](#).

Key decisions for states in planning for Medicare-first EAE

When planning to initiate Medicare-first EAE using the steps described above, states will need to make several key policy decisions, such as:

- The method(s) the state will use to learn about D-SNP enrollments and disenrollments (see the next section of this brief for details on three file exchange options states can use for this purpose) and the frequency with which files will be exchanged (daily is recommended).
- Whether the state wishes to: 1) verify Medicaid eligibility for individuals who have been enrolled in D-SNPs and notify D-SNPs of state acceptance or rejection of those enrollments; or 2) passively accept all D-SNP enrollments identified. **Once the state (or the state contractor) has accepted an individual’s D-SNP enrollment, it will then align the person’s Medicaid managed care enrollment accordingly.**
- The entity(ies) that will be responsible for: 1) identifying D-SNP enrollments and disenrollments; 2) verifying Medicaid eligibility for D-SNP enrollment, accepting or rejecting the D-SNP enrollment, and notifying the D-SNP of the state’s acceptance or rejection of the enrollment (if the state has chosen not to passively accept all D-SNP enrollments); 3) processing Medicaid managed care enrollment changes to align Medicaid enrollment with D-SNP enrollment and updating state systems accordingly; and 4) notifying the D-SNP or the D-SNP’s affiliated Medicaid managed care plan of the new Medicaid enrollment (and disenrollment, if applicable). For example, states may wish to include enrollment brokers or other contractors in some or all of these steps. (See **Appendix C** for specific state examples.)
- Whether the Medicaid enrollment effective date will align with the D-SNP enrollment effective date or lag behind the D-SNP enrollment effective date by one month if a dually eligible individual enrolls in D-SNP after the state’s Medicaid managed care enrollment cut-off date (see **Box 2**).
- Whether the state wishes to impose specific requirements in contracts with D-SNPs and/or Medicaid managed care plans regarding roles that the plans will be expected to play in the EAE process. For example, a state may require the D-SNP to send enrollment and disenrollment files to the state (or a state contractor) and/or require the Medicaid managed care plan to notify the D-SNP when a D-SNP enrollee is disenrolled from the Medicaid managed care plan (thereby making the person ineligible for the D-SNP).

ICRC recommends that states consider several different enrollment and disenrollment scenarios when making these decisions to ensure that all necessary roles and processes are clearly established prior to EAE implementation. In addition, states should consider how their decisions and strategies may influence beneficiary experience, plan participation, and the broader landscape of integrated care.

To help states think through these considerations, ICRC has developed several enrollment and disenrollment scenarios (see **Box 3**), and sample scenario tables (see **Appendix D**) to help states think

about the processes involved in each scenario and the entities that will play key roles in each process. Not all scenarios will apply to every state, and state approaches to EAE will vary based on state Medicaid contracting strategies, health plan landscapes, eligibility requirements, systems, and use of contractors for key Medicaid processes. When planning for EAE, states should identify enrollment and disenrollment scenarios that will apply to their integrated D-SNP program and the specific actions that will need to be taken by beneficiaries, D-SNPs, CMS, the state, state contractors (when applicable), and Medicaid managed care plans (when applicable).

Box 3. Common scenarios for enrollment into and disenrollment from integrated D-SNPs

The following are examples of common scenarios in which a dually eligible individual may enroll into an integrated D-SNP:

- A Medicaid beneficiary who becomes dually eligible or is a dually eligible individual who is currently enrolled in a state Medicaid managed care plan for Medicaid benefits chooses to enroll in an integrated D-SNP through the same parent organization as their current state Medicaid managed care plan (see Appendix D, Scenario 1.A).
- A dually eligible individual who is currently enrolled in fee-for-service Medicaid chooses to enroll in an integrated D-SNP or a dually eligible individual who is in a state Medicaid managed care plan chooses to enroll in an integrated D-SNP through a different parent organization than their current state Medicaid managed care plan (see Appendix D, Scenario 1.B).
- A dually eligible individual switches from one integrated D-SNP to another or from a Program of All-Inclusive Care for the Elderly (PACE) program to an integrated D-SNP (see Appendix D, Scenario 1.C).
- A Medicare beneficiary becomes newly eligible for Medicaid and chooses to enroll in an integrated D-SNP soon after becoming dually eligible (see Appendix D, Scenario 1.D).

The following are examples of common scenarios in which a dually eligible individual may disenroll from an integrated D-SNP:

- A dually eligible individual voluntarily disenrolls from an integrated D-SNP to enroll in fee-for-service Medicare or a non-integrated Medicare Advantage plan (using a Medicare enrollment period or Special Election Period [SEP]) (see Appendix D, Scenario 2.A).
- A PACE-eligible dually eligible individual elects to enroll in a PACE program, triggering D-SNP disenrollment (see Appendix D, Scenario 2.B).
- A dually eligible individual loses Medicare eligibility, triggering D-SNP disenrollment, but the person is still eligible for and enrolled in Medicaid (see Appendix D, Scenario 2.C).
- A dually eligible individual loses Medicaid eligibility, triggering D-SNP disenrollment (after the deeming period, if applicable) (see Appendix D, Scenario 2.D).
- A dually eligible individual becomes incarcerated (see Appendix D, Scenario 2.E).
- A dually eligible individual permanently moves out of the D-SNP’s service area (see Appendix D, Scenario 2.F).
- A dually eligible individual who is enrolled in an integrated D-SNP with an affiliated Medicaid managed care plan contacts the state or the state’s enrollment broker and requests to change Medicaid managed care plans (see Appendix D, Scenario 2.G).

State file exchange options for identifying D-SNP enrollments and disenrollments

To align Medicaid managed care plan enrollment with D-SNP enrollment, states (or state contractors) need frequent, timely information about new D-SNP enrollments. As of this brief’s publication in 2026, states have three options for obtaining this information: 1) exchange of Territories & States Beneficiary Query (TBQ) files with CMS; 2) receipt of files directly from D-SNPs; or 3) receipt of copies of D-SNPs’ Daily Transaction Reply Report (DTRR) files from CMS. Regardless of the method selected, states should opt to obtain information about D-SNP enrollments frequently to ensure that the state can take timely steps to align Medicaid managed care plan enrollment with D-SNP enrollment. ICRC recommends that states use daily file exchanges for this purpose.

States should not use Medicare Modernization Act (MMA) files to identify D-SNP enrollment for the purpose of aligning Medicaid coverage with D-SNP coverage. While the MMA file contains information about Medicare plan enrollment and MMA files are exchanged daily between states and CMS, daily MMA files are only used to submit changes or adjustments (such as new or lost coverage and address changes) to the full MMA file, which states submit to CMS on a monthly basis. Because states only submit full MMA files once a month, states will not be able to obtain Medicare enrollment information from these files quickly enough for EAE processing. Using MMA files to support EAE can cause major lags between D-SNP and Medicaid managed care enrollment effective dates, especially in states that have Medicaid managed care enrollment cut-off date policies.

States should choose a method for identifying D-SNP enrollment early in the EAE planning process, as subsequent steps to align Medicaid plan enrollment with D-SNP enrollment may depend on the method selected. When making this decision, a state may wish to consider the extent to which the state may already use certain file exchange processes for other purposes, as well as whether the state may be able to leverage or build on existing systems and processes.

The sections below provide details on each of the three recommended file exchange processes.

1 TBQ files exchanged with CMS

The TBQ is a file exchange process that U.S. states and territories can use to obtain from CMS detailed Medicare beneficiary information, including Medicare Parts A, B, and D eligibility and enrollment information. States can send TBQ requests at any time, and each request triggers a response from CMS that provides information about individuals’ Medicare eligibility and enrollment (including D-SNP enrollment).

The TBQ is a nationally standardized file exchange, and many states already use the TBQ file for other purposes, such as enrolling eligible beneficiaries into the Part D low-income subsidy (LIS) program.⁹ If a state is already actively using the TBQ for other purposes, using the TBQ to identify D-SNP enrollment may be relatively easy to implement, as the state will likely already have a process in place to ingest and use the information in TBQ files, and the state would not need to set up a new file exchange process. States with large dually eligible populations and/or many D-SNPs may also find the

TBQ easier to use for processing large volumes of D-SNP enrollments from a wide variety of plans than setting up direct file exchanges with individual D-SNPs. Once a D-SNP enrollment transaction is accepted by CMS, that information will be incorporated into Medicare’s enrollment database, so states will be able to see the new enrollment information in TBQ response files within 24 hours of CMS acceptance of the transaction. (Enrollment transactions that are rejected by CMS will not be visible in TBQ files.)

One challenge with using the TBQ file for identification of D-SNP enrollments is that TBQ response files from CMS are only sent to states in response to a query that is initiated by the state. Therefore, to successfully identify all possible D-SNP enrollments, a state must ensure that anyone who is or who may become dually eligible is included in the state’s TBQ request file to CMS.¹⁰ If a potentially D-SNP-eligible person is left out of the state’s initial query file, the state will not receive information from CMS about that person’s Medicare enrollment in the TBQ response file, and the state could miss a D-SNP enrollment as a result.

For details about the information included in TBQ request and response files, see the [MAPD State User Guide](#).

2 Daily enrollment files from D-SNPs

States that do not regularly use the TBQ file exchange process for other purposes may want to consider requiring D-SNPs to submit daily enrollment files to the state with information about individuals who have enrolled in or disenrolled from the D-SNP. As of 2026, several states (such as Idaho and New Jersey) use this method to identify D-SNP enrollment. Most states that use this method require D-SNPs to use the ASC X12 834 file format for this purpose, as it is a HIPAA-compliant format that the federal government has adopted as the national standard for sharing health plan enrollment and disenrollment information (45 CFR §162.1502). The 834 file format is used frequently—and is therefore well known—by both states and health plans. States can also choose to require D-SNPs to use a state-specified file format, though it is worth noting that states opting for this approach will need to: 1) ensure that the file exchange process established is HIPAA-compliant; and 2) provide D-SNPs with clear guidance on the information to be submitted.

A benefit of this option is the possibility for states to establish state-specific requirements for file submission. If a state wishes to obtain a particular type of information from the D-SNP (for example, the reason for a disenrollment), the state can incorporate that into its requirements for the file exchange. This option can also be useful for states that do not use the TBQ for other purposes and/or smaller states that have fewer dually eligible individuals and fewer D-SNPs with which the state will need to establish a secure data exchange. (In other words, setting up a direct file exchange with a few D-SNPs may be easier for some states than using the TBQ file exchange process if the state is not already using the TBQ).

A potential challenge with this option is that the state will need to establish a direct file exchange process with each D-SNP, through which the D-SNP can submit files to the state and the state can

ingest and use the information. This can be difficult for states with large numbers of D-SNPs and states for which readiness reviews and data exchange testing may be challenging.

States that use this approach should require D-SNPs to submit enrollment information to the state after the D-SNP’s enrollment transaction is accepted by CMS. If D-SNPs notify the state of D-SNP enrollment transactions prior to CMS acceptance of those transactions, the state could receive information about enrollments that will ultimately be rejected by CMS. If the state then initiates Medicaid enrollment alignment for a D-SNP enrollment request that is rejected by CMS, the state will have to reverse that change, which can cause confusion for the beneficiary, the plan, and other key partners in the process. Instead, by requiring D-SNPs to ensure that D-SNP enrollment transactions have been accepted by CMS prior to notifying the state of the enrollments, the state can ensure that it is taking steps to align Medicaid enrollment with a Medicare enrollment that will be fully processed.

3 DTRR files from CMS

CMS sends DTRR files to MA plans (including D-SNPs) to: 1) indicate CMS acceptance or rejection of transactions submitted by plans; 2) provide information about changes (such as involuntary disenrollments) initiated by CMS; and 3) note informational changes such as change in residence address or LIS status updates. MA plans (including D-SNPs) receive these files daily. D-SNPs can request that CMS provide a copy of their DTRR files to a state through a process known as “dual routing.”

Some of the states that transitioned capitated model Financial Alignment Initiative demonstrations to integrated D-SNP models in 2026 have chosen to use copies of D-SNP DTRR files to identify D-SNP enrollments and disenrollments because those states were already familiar with and actively using DTRR files in their demonstrations.

Because DTRR files are complex and contain far more information than a state would need to align Medicaid enrollment with D-SNP enrollment, states that are not already used to using these files for other purposes would likely find the TBQ or a daily file exchange with D-SNPs to be an easier, more straightforward option for implementing Medicare-first EAE.

For details about the DTRR, see the CMS [Plan Communications User Guide for Medicare Advantage and Prescription Drug Plans](#).

Conclusion

The “Medicare-first” EAE approach allows states to align a D-SNP enrollee’s Medicaid enrollment with their D-SNP enrollment. States interested in using Medicare-first EAE can establish processes that reflect their D-SNP contracting approaches, Medicaid landscape and eligibility requirements, and existing systems and processes. States can use the information provided in this technical assistance brief to understand the MA enrollment process and key steps in aligning Medicaid coverage with D-SNP enrollment, support key policy decisions about EAE processes, and consider common enrollment and disenrollment scenarios when designing those processes.

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 Full-benefit dually eligible individuals qualify for full Medicaid benefits in their state, in addition to qualifying for Medicare benefits (and in some cases, for Medicare Savings Program benefits, as well). Partial-benefit dually eligible individuals qualify for Medicare Savings Program benefits, but do not qualify for full Medicaid benefits. For more information about full- and partial-benefit dual eligibility, see ICRC’s introductory webinar on dual eligibility at <https://integratedcareresourcecenter.com/webinar/working-medicare-introduction-dual-eligibility>.

² For more information about the benefits of EAE for D-SNP enrollees, providers, and states, see ICRC’s introductory EAE tip sheet at <https://integratedcareresourcecenter.com/resource/tools-states-exclusively-aligned-enrollment-dual-eligible-special-needs-plans-introduction>.

³ For more information about the EAE requirements encompassed within these rules, see ICRC’s tip sheet on the rules at 42 CFR §422.514(h) at <https://integratedcareresourcecenter.com/resource/514tipsheet>.

⁴ For more information about Medicaid managed care “lock-in” policies, see ICRC’s tip sheet on key EAE policy decisions and considerations for states at <https://integratedcareresourcecenter.com/resource/tools-states-exclusively-aligned-enrollment-dual-eligible-special-needs-plans-key-policy>.

⁵ The applicable Medicaid managed care plan may be the D-SNP (if a D-SNP is directly capitated to serve as a Medicaid managed care plan and cover Medicaid benefits for D-SNP enrollees) or an affiliated Medicaid managed care plan offered by the same parent organization as the D-SNP.

⁶ The applicable Medicaid managed care plan is the D-SNP in cases where D-SNPs are directly capitated to cover Medicaid benefits for D-SNP enrollees.

⁷ When a Medicare Advantage organization accepts an enrollment request, the organization must process that request and determine eligibility for enrollment. CMS guidance for Medicare Advantage organizations on Medicare eligibility verification is available in the Medicare Advantage and Part D Enrollment and Disenrollment Guidance at <https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment>.

⁸ Direct capitation of D-SNPs involves contracting directly with D-SNPs and paying them capitated rates to cover Medicaid benefits for their enrollees. Directly capitated D-SNPs do not have affiliated Medicaid managed care plans because those D-SNPs cover the Medicaid benefits for their enrollees. Directly capitated D-SNPs qualify as Medicaid managed care plans and must comply with the rules for Medicaid managed care plans at 42 CFR Part 438. When a state aligns D-SNPs with affiliated Medicaid managed care plans that are offered by the same parent organizations as the D-SNPs, D-SNP enrollees have two plans – one for Medicare and one for Medicaid, but both plans are offered by the same parent organization and should coordinate with one another. For more information about these two D-SNP contracting strategies, see ICRC’s contracting strategies and considerations for states webinar at <https://www.integratedcareresourcecenter.com/webinar/working-medicare-state-contracting-d-snps-part-2-contracting-strategies-and-considerations>.

Key Steps and Considerations for States Using “Medicare-First” Exclusively Aligned Enrollment Processes with Dual Eligible Special Needs Plans (D-SNPs)

⁹ The Part D LIS program provides assistance with prescription drug premiums and cost sharing for Medicare beneficiaries with limited incomes and resources, including dually eligible individuals. CMS guidance for states on state Medicaid agency responsibilities in determining LIS eligibility is available at <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/Downloads/StateLISGuidance021009.pdf>.

¹⁰ A state can identify prospective dually eligible individuals by: 1) including all Medicaid beneficiaries in the state’s TBQ request to sweep for all beneficiaries with Medicare eligibility and enrollment information (at an ad hoc basis); 2) electing to receive a Prospective Dual Eligible File (PDF) from CMS twice a month (states do not need to send a request file to initiate the data exchange); and/or 3) submitting the full MMA file to CMS on a monthly basis. States can use any of these files (or a combination of them) to identify Medicaid beneficiaries who will soon become eligible for Medicare. For more information about using the MMA file to identify dually eligible individuals, see ICRC’s technical assistance tool at <https://www.integratedcareresourcecenter.com/resource/using-medicare-modernization-act-mma-files-identify-dually-eligible-individuals> and CMS’ MAPD State User Guide at <https://www.cms.gov/data-research/cms-information-technology/access-cms-data-application/mapd-state-user-guide>. For more information about the PDF process, contact MMCO at MMCOEnrollment@cms.hhs.gov.

Appendix A. Sample state Medicaid agency contract language for Medicare-first and Medicaid-first EAE

States that wish to use a Medicare-first approach to EAE may wish to incorporate the following sample language (with any state-specific edits needed) into SMACs with applicable D-SNPs:

"The [D-SNP/Contractor] must operate with exclusively aligned enrollment, meaning the [D-SNP/Contractor] may only enroll in its D-SNP full-benefit dually eligible individuals who also agree to receive Medicaid benefits from [the D-SNP/the D-SNP's affiliated Medicaid managed care plan].

The [D-SNP/Contractor] will verify that a beneficiary meets all applicable eligibility requirements prior to enrolling the beneficiary into the D-SNP. These eligibility requirements include enrollment in Medicare Parts A and B, full Medicaid benefits, and *[insert any other state-specific eligibility requirements, such as age, nursing facility level of care need, etc.]*. *[In states that exclude particular groups of full-benefit dually eligible individuals from D-SNP eligibility, add the following statement: The [D-SNP/Contractor] must exclude the following populations from D-SNP enrollment [list applicable populations].]*

To verify *[Medicaid eligibility, age, etc.]*, the [D-SNP/Contractor] will *[describe state system(s) that the [D-SNP/Contractor] will access/steps they will take to verify Medicaid eligibility and any other state eligibility requirements. D-SNPs use CMS data to verify Medicare eligibility; that step does not need to be described in the SMAC.]*

To facilitate alignment of Medicaid plan enrollment with D-SNP enrollment, the [D-SNP/Contractor] will: *[list/describe specific actions to be taken by the [D-SNP/Contractor]. Those actions could include some of the following – not all of the following bullets will apply in all states:*

- *Submit daily, HIPAA-compliant enrollment and disenrollment files to [the State/the State's designee], in a manner and format to be specified by the State, within one (1) business day of receipt of CMS acceptance of a D-SNP enrollment or disenrollment transaction or notification from CMS of a D-SNP enrollee's disenrollment from the plan [if the state is requiring the D-SNP to submit files to the state identifying D-SNP enrollments and disenrollments].*
- *Submit a dual routing request to CMS to enable the [State/ State's designee] to access the D-SNP's Daily Transaction Reply Report (DTRR) files [if the state intends to use DTRR files to identify D-SNP enrollments].*
- *Ingest [daily/weekly/monthly] files from the State indicating the [State's/State designee's] acceptance or rejection of D-SNP enrollment transactions.*

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- *If the State rejects an enrollment transaction, the D-SNP must submit an enrollment cancellation to CMS immediately and notify the beneficiary of the enrollment cancellation, including the reason for the cancellation.*
- *If the [D-SNP/Contractor] receives the State’s enrollment cancellation after the beneficiary’s D-SNP enrollment effective date, the [D-SNP/Contractor] must disenroll the beneficiary and notify the beneficiary of the disenrollment and reason for the disenrollment, in accordance with CMS requirements.*
- *Ingest [daily/weekly/monthly] [file type] Medicaid enrollment files from the [State/State’s designee] and use those files as the source of truth for Medicaid enrollment [if the state will be providing Medicaid enrollment files directly to the D-SNP, as may be the case for directly capitated D-SNPs].*
- *Respond to State inquiries regarding beneficiary enrollment or disenrollment transactions within [specify time period].*
- *Provide a single, named point of contact for State inquiries regarding beneficiary enrollment and disenrollment transactions.]*

The effective date of a D-SNP enrollee’s Medicaid enrollment with the [D-SNP/Contractor] shall be the date provided on the [file type] file issued by the [State/State’s designee]. Typically, Medicaid enrollment effective dates shall be the first day of the month after the month the [D-SNP/Contractor] submits a D-SNP enrollment transaction to CMS. [Insert if applicable: D-SNP enrollment transactions submitted after the [specify cut-off date] of each month will have a Medicaid enrollment effective date of the first day of the month after the month of the D-SNP enrollment effective date.]”

States that wish to use a Medicaid-first approach to EAE may wish to incorporate the following sample language (with any state-specific edits needed) into SMACs with applicable D-SNPs:

“The [D-SNP/Contractor] must operate with exclusively aligned enrollment, meaning the Contractor may only enroll in its D-SNP full-benefit dually eligible individuals who receive Medicaid benefits from the D-SNP’s affiliated Medicaid managed care plan.

The [D-SNP/Contractor] will verify that a beneficiary meets all applicable eligibility requirements prior to enrolling the beneficiary into the D-SNP. These eligibility requirements include enrollment in Medicare Parts A and B, full Medicaid benefits, and [insert any other state-specific eligibility requirements, such as age, nursing facility level of care need, etc.]. [In states that exclude particular groups of full-benefit dually eligible individuals from D-SNP eligibility, add the following statement: The [D-SNP/Contractor] must exclude the following populations from D-SNP enrollment [list applicable populations].]

To verify [Medicaid eligibility, age, etc.], the [D-SNP/Contractor] will [describe state system(s) that the [D-SNP/Contractor] will access/steps they will take to verify Medicaid eligibility and

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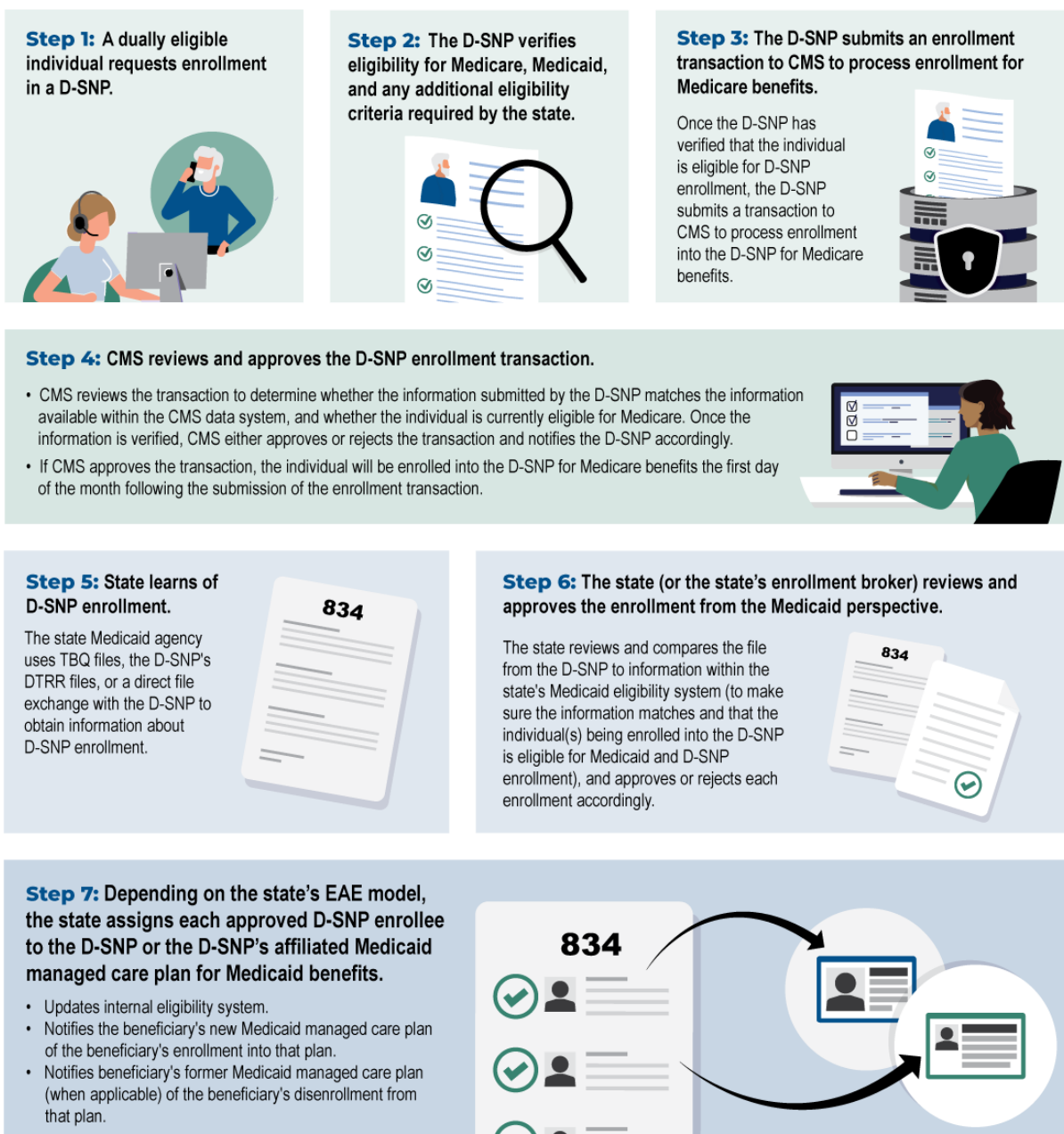
any other state eligibility requirements. D-SNPs use CMS data to verify Medicare eligibility; that step does not need to be described in the SMAC.]

The *[D-SNP/Contractor]* will be responsible for verifying the potential enrollee’s enrollment in the affiliated *[state Medicaid managed care program]* managed care plan prior to submitting an enrollment transaction to CMS. (The “affiliated” *[state Medicaid managed care program]* managed care plan is the managed care plan operated by the *[D-SNP/Contractor]*, the *[D-SNP/Contractor]*’s parent organization, or another entity owned and controlled by the *[D-SNP/Contractor]*’s parent organization.) A potential D-SNP enrollee may be considered “enrolled” in the D-SNP’s affiliated Medicaid managed care plan if the affiliated Medicaid managed care plan has received an *[834 or other applicable file type]* enrollment file from the *[state Medicaid agency or designee]* indicating that the potential D-SNP enrollee is (or will soon be) enrolled in the affiliated Medicaid managed care plan for coverage of Medicaid benefits. The *[D-SNP/Contractor]* may not use the potential enrollee’s verbal confirmation of Medicaid managed care enrollment alone as proof of Medicaid managed care plan enrollment.”

Appendix B. Steps in D-SNP enrollment and aligning Medicaid enrollment with D-SNP enrollment

Figure B.1 provides a flow chart showing the full set of steps in D-SNP enrollment and aligning Medicaid enrollment with D-SNP enrollment for states using a Medicare-first EAE process. This figure illustrates enrollment and eligibility verification steps during the MA enrollment process, and the typical steps taken by states (and/or state contractors) to align Medicaid managed care enrollment with D-SNP enrollment.

Figure B.1. Summary of steps in D-SNP enrollment and aligning Medicaid enrollment with D-SNP enrollment



Appendix C. Examples of Medicare-first EAE state approaches

States can use different approaches to implement the technical processes involved in executing EAE, depending on state Medicaid contracting strategies, health plan landscapes, eligibility requirements, systems, and use of contractors for key Medicaid processes. **Table C.1** compares key elements of seven states' approaches to processing Medicare-first EAE transactions.

Table C.1. Seven states' approaches to processing Medicare-first EAE transactions

	Idaho	Illinois	Michigan	New Jersey	New York	Ohio	Texas
Method that state uses to identify D-SNP enrollment	D-SNP sends daily 834 file to the state	CMS file (DTRR)	CMS file (daily TBQ)	D-SNP sends daily 834 file to the state	CMS files (MMA and daily TBQ)	CMS file (DTRR)	CMS file (daily TBQ)
Entity that processes Medicaid enrollment transactions to align with D-SNP enrollment	State	Enrollment broker	State	State	Enrollment broker (all MAP AIPs and most others); state (select populations in IBD AIPs) ^a	State	State and enrollment broker
State or state contractor sends a response file to the D-SNP to indicate acceptance and/or rejection of D-SNP enrollment^b	Yes	Yes	Yes	Yes	Yes	Yes	Yes ^c
Medicaid enrollment start date will align with Medicare enrollment start date^d	No ^e	Yes	Yes	Yes	No ^e	No ^e	No ^e

Table Notes:

^a "MAP" is the state's Medicaid Advantage Plus program, through which FIDE SNPs are affiliated with MAP Medicaid Managed Care Plans, while "IBD" is the state's "IB Dual" program, through which HIDE SNPs are affiliated with Mainstream Medicaid Managed Care Plans or Health and Recovery Plans.

^b Some states issue a daily response file to D-SNPs indicating whether each D-SNP enrollment has been accepted or rejected by the state (often with reason codes indicating the reasons for enrollment rejections). When a state rejects an enrollment, the D-SNP must: 1) cancel the enrollment (if the rejection notification was received prior to the D-SNP enrollment effective date); or 2) disenroll the beneficiary from the D-SNP after providing the beneficiary with the advance notice required for disenrollment. In other states, D-SNPs (or D-SNPs' affiliated MCOs) simply receive an 834 enrollment file from the state indicating beneficiaries who have been enrolled into the D-SNP or Medicaid MCO for Medicaid benefits. In those cases, the D-SNPs and MCOs may need to interpret the absence of a beneficiary from a Medicaid 834 enrollment file as a rejection of the D-SNP enrollment by the state.

^c Texas indicates "acceptance" of D-SNP enrollment by enrolling the beneficiary in the affiliated STAR+PLUS Medicaid managed care plan and including them in the STAR+PLUS plan's 834 enrollment file. Texas includes D-SNP enrollments that the state does not accept in a monthly reconciliation file that identifies discrepant enrollments.

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^d Medicare Advantage plan enrollments are always effective the first day of the month following the date the enrollment request is submitted, even if the enrollment request is made late in the month. In states with Medicaid enrollment “cut off” dates, if a Medicaid enrollment request is made late in the month, the Medicaid enrollment effective date will be the first day of the month after the month following the date of the enrollment request. For example, if a beneficiary submits a D-SNP enrollment request on March 28, the D-SNP enrollment will be effective April 1, but the Medicaid enrollment may not be effective until May 1. States with a “yes” in this row take steps to ensure that a D-SNP enrollee’s Medicaid enrollment effective date aligns with the D-SNP enrollment effective date (except in rare circumstances, such as retroactive Medicare Advantage enrollment effective dates). In states with a “no” in this row, Medicaid “cut off” dates apply, so the Medicaid effective date may lag one month behind the Medicare effective date when a D-SNP enrollee submits their enrollment request late in a month.

^e In these states, when a beneficiary enrolls in a D-SNP late in a month, the Medicaid enrollment start date may lag behind the Medicare enrollment start date by one month. Texas will align the Medicaid enrollment start date with the D-SNP enrollment start date if the enrollee is not currently enrolled in a STAR+PLUS MCO (and will therefore be joining a STAR+PLUS MCO for the first time as they enroll in the D-SNP). If a STAR+PLUS MCO enrollee chooses to enroll in a D-SNP through a different parent organization than their current STAR+PLUS plan and makes that enrollment request after the state’s MCO enrollment cut off date, the change in STAR+PLUS MCO enrollment will be effective one month later than the D-SNP enrollment effective date.

Appendix D. Sample EAE scenario tables for enrollment to and disenrollment from integrated D-SNPs

When planning for Medicare-first EAE, states should identify the enrollment and disenrollment scenarios that will apply to their state landscape and the processes involved. States can use the sample scenario tables provided in this appendix to document specific actions that will need to be taken by beneficiaries, D-SNPs, CMS, the state, state contractors (when applicable), and Medicaid managed care plans (when applicable) to align Medicaid enrollment with Medicare enrollment. **Table D.1** presents several common scenarios in which a full-benefit dually eligible individual chooses to enroll into an integrated D-SNP and the actions a state and/or other parties may need to take to adjust the individual’s Medicaid enrollment accordingly. **Table D.2** presents several common scenarios in which a full-benefit dually eligible individual voluntarily chooses to disenroll from an integrated D-SNP or is involuntarily disenrolled from an integrated D-SNP due to loss of eligibility for the plan. In these cases, the state and/or other parties may also need to take corresponding action related to the individual’s Medicaid coverage.

While Tables D.1 and D.2 summarize several common enrollment and disenrollment scenarios, not all scenarios or actions will apply to every state, and some states may identify additional scenarios that arise in their particular landscape. State approaches to the steps described in these tables will also vary based on state Medicaid contracting strategies, health plan landscapes, eligibility requirements, systems, and use of contractors for key Medicaid processes. Both tables are designed for states that align D-SNPs with affiliated Medicaid managed care plans for the coverage of Medicaid benefits but can be used by states that plan to directly capitate D-SNPs to cover Medicaid benefits. States that plan to directly capitate D-SNPs for the coverage of Medicaid benefits may need to remove or alter certain scenarios and actions to fit their landscape. States without a Medicaid managed care program for dually eligible individuals (outside of directly capitated D-SNPs) may wish to remove the “Medicaid managed care plan(s)” column and any references to Medicaid managed care plans when populating the sample tables. For states that need assistance determining the applicability of the following scenarios and related actions, the Integrated Care Resource Center is available to provide technical assistance.

Table D.1. Scenarios in which a beneficiary elects to enroll in an integrated D-SNP

Actions Taken By:					
Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
1.A. Medicaid beneficiary who becomes dually eligible or a dually eligible individual who is currently enrolled in a <i>[state Medicaid managed care program]</i> plan for Medicaid benefits chooses to enroll in an integrated D-SNP through the same parent organization as their current <i>[state Medicaid managed care program]</i> plan	Enrolls in D-SNP by (1) contacting the D-SNP; (2) calling 1-800-MEDICARE or submitting an enrollment request via Medicare.gov; or (3) consulting an agent or broker who can assist with submitting an enrollment request	<ul style="list-style-type: none"> • Receives enrollment request from beneficiary or CMS • Determines Medicare eligibility for D-SNP using data exchange with CMS; determines Medicaid eligibility and any other state-specified eligibility criteria via <i>[describe state system(s) that the D-SNP will access/steps they will take to verify Medicaid eligibility and any other state-specified eligibility requirements]</i> • If eligibility established, submits enrollment transaction to CMS • <i>[Insert and edit if applicable: If the state rejects the D-SNP enrollment transaction and/or does not include the individual in the state’s response file, the D-SNP cancels the enrollment (if rejection is received prior to enrollment effective date) or disenrolls the beneficiary (if rejection is received after enrollment effective date)]</i> • Sends beneficiary enrollment notice and enrollment materials (including applicable integrated plan materials/member ID card) 	<ul style="list-style-type: none"> • If beneficiary contacts 1-800-MEDICARE for enrollment assistance, a 1-800-MEDICARE customer service representative assists the beneficiary and submits an application to the plan via the CMS Health Plan Management System (HPMS) for eligibility verification and processing • Receives enrollment transaction from D-SNP, accepts/rejects the transaction, and signals acceptance/rejection in the plan’s Daily Transaction Reply Report (DTRR) 	<p>D-SNP eligibility verification:</p> <ul style="list-style-type: none"> • State enables D-SNPs to verify Medicaid eligibility and other state-specified eligibility requirements prior to D-SNP enrollment using <i>[insert process to verify Medicaid eligibility]</i> <p>Medicaid enrollment alignment:</p> <ul style="list-style-type: none"> • State receives D-SNP enrollment information from <i>[insert the file exchange process (e.g., TBQ file, DTRR, file from the D-SNP)]</i> • <i>[If applicable, describe how the state will notify the D-SNP of acceptance and/or rejection of D-SNP enrollment]</i> • No change to <i>[state Medicaid managed care program]</i> plan needed – the dually eligible individual is already in the <i>[state Medicaid managed care program]</i> plan that is affiliated with the D-SNP 	<ul style="list-style-type: none"> • N/A – No change to <i>[state Medicaid managed care program]</i> plan

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Actions Taken By:

Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
<p>1.B. Dually eligible individual who is currently enrolled in fee-for-service Medicaid chooses to enroll in an integrated D-SNP or a dually eligible individual who is in a <i>[state Medicaid managed care program]</i> plan chooses to enroll in an integrated D-SNP through a different parent organization than their current <i>[state Medicaid managed care program]</i> plan</p>	<p>Beneficiary takes same actions described in scenario 1.A</p>	<p>D-SNP takes same actions described in scenario 1.A</p>	<p>CMS takes same actions described in scenario 1.A</p>	<p>D-SNP eligibility verification:</p> <ul style="list-style-type: none"> State enables D-SNPs to verify Medicaid eligibility and other state-specified eligibility requirements prior to D-SNP enrollment using the <i>[insert process to verify Medicaid eligibility]</i> <p>Medicaid enrollment alignment:</p> <ul style="list-style-type: none"> State receives D-SNP enrollment information from <i>[insert the file exchange process (e.g., TBQ file, DTRR, file from the D-SNP)]</i> <i>[If applicable, describe how the state will notify the D-SNP of acceptance and/or rejection of D-SNP enrollment]</i> <i>[Insert steps that the state and/or state contractor(s) will take to: 1) change the dually eligible individual's Medicaid enrollment to match the D-SNP enrollment; and 2) notify the applicable Medicaid managed care plan(s) of the enrollment change]</i> 	<ul style="list-style-type: none"> Former Medicaid plan (if applicable) learns of the beneficiary's disenrollment via <i>[insert the file exchange process]</i> New Medicaid plan learns of the beneficiary's enrollment into that plan via <i>[insert the file exchange process]</i> New Medicaid plan may need to suppress issuance of enrollment-related materials that will already be issued in integrated form by the D-SNP

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Actions Taken By:

Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
<p>1.C. Dually eligible individual switches from one integrated D-SNP to another or from a Program of All-Inclusive Care for the Elderly (PACE) program to an integrated D-SNP</p>	<p>Beneficiary takes same actions described in scenario 1.A</p>	<p>New D-SNP D-SNP takes same actions described in scenario 1.A</p> <p>Former D-SNP or PACE organization</p> <ul style="list-style-type: none"> • Learns of disenrollment via CMS DTRR • Issues disenrollment notice to beneficiary 	<ul style="list-style-type: none"> • CMS takes same actions described in scenario 1.A • Notifies former D-SNP or PACE organization of disenrollment via DTRR 	<p>D-SNP eligibility verification:</p> <ul style="list-style-type: none"> • State enables D-SNPs to verify Medicaid eligibility and other state-specified eligibility requirements prior to D-SNP enrollment using the <i>[insert process to verify Medicaid eligibility]</i> <p>Medicaid enrollment alignment:</p> <ul style="list-style-type: none"> • State receives D-SNP enrollment information from <i>[insert the file exchange process (e.g., TBQ file, DTRR, file from the D-SNP)]</i> • <i>[If applicable, describe how the state will notify the D-SNP of acceptance and/or rejection of D-SNP enrollment]</i> • <i>[Insert steps that the state and/or state contractor(s) will take to: 1) change the dually eligible individual's Medicaid enrollment to match the D-SNP enrollment; and 2) notify the applicable Medicaid managed care plan(s) of the enrollment change]</i> 	<ul style="list-style-type: none"> • Former Medicaid plan (or PACE organization) learns of the beneficiary's disenrollment via <i>[insert the file exchange process]</i> • New Medicaid plan learns of the beneficiary's enrollment into that plan via <i>[insert the file exchange process]</i> • New Medicaid plan may need to suppress issuance of enrollment-related materials that will already be issued in integrated form by the D-SNP

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Actions Taken By:

Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
<p>1.D. Medicare beneficiary becomes newly eligible for Medicaid and chooses to enroll in an integrated D-SNP soon after becoming dually eligible</p>	<ul style="list-style-type: none"> • Applies for Medicaid and verifies eligibility if needed • <i>[In states with mandatory Medicaid managed care programs for full-benefit dually eligible individuals, insert: Receives enrollment packet explaining Medicaid managed care plan options]</i> • Enrolls in D-SNP by (1) contacting the D-SNP; (2) calling 1-800-MEDICARE or submitting an enrollment request via Medicare.gov; or (3) consulting an agent or broker who can assist with submitting an enrollment request 	<p>D-SNP takes same actions described in scenario 1.A</p>	<p>CMS takes same actions described in scenario 1.A</p>	<p>D-SNP eligibility verification:</p> <ul style="list-style-type: none"> • State enables D-SNPs to verify Medicaid eligibility and other state-specified eligibility requirements prior to D-SNP enrollment using the <i>[insert process to verify Medicaid eligibility]</i> <p>Medicaid enrollment alignment:</p> <ul style="list-style-type: none"> • State receives D-SNP enrollment information from <i>[insert the file exchange process (e.g., TBQ file, DTRR, file from the D-SNP)]</i> • <i>[If applicable, describe how the state will notify the D-SNP of acceptance and/or rejection of D-SNP enrollment]</i> • <i>[Insert steps that the state and/or state contractor(s) will take to: 1) change the dually eligible individual's Medicaid enrollment to match the D-SNP enrollment; and 2) notify the applicable Medicaid managed care plan(s) of the enrollment change]</i> • <i>[Insert actions needed to override Medicaid managed care plan auto-assignment, if needed, with new Medicaid plan enrollment to align with D-SNP]</i> 	<ul style="list-style-type: none"> • If the beneficiary has already chosen (or been assigned to) a Medicaid managed care plan prior to D-SNP enrollment, the “old” managed care plan will learn of disenrollment via <i>[insert the file exchange process]</i> • New Medicaid plan learns of the beneficiary's enrollment into that plan via <i>[insert the file exchange process]</i> • New Medicaid plan may need to suppress issuance of enrollment-related materials that will already be issued in integrated form by the D-SNP

Table D.2. Scenarios in which a beneficiary chooses to disenroll from an integrated D-SNP or is involuntarily disenrolled due to loss of eligibility for the D-SNP

Actions Taken By:					
Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
2.A. Dually eligible individual voluntarily disenrolls from an integrated D-SNP to enroll in fee-for-service Medicare or a non-integrated Medicare Advantage plan (using a Medicare enrollment period or Special Election Period [SEP])	Disenrolls from D-SNP by: (1) calling 1-800-MEDICARE or submitting a new enrollment request via Medicare.gov; (2) consulting an agent or broker who can assist with submitting an enrollment request; (3) contacting the new Medicare Advantage plan (or PACE organization) to enroll; or (4) contacting the current D-SNP to disenroll	<ul style="list-style-type: none"> • Current D-SNP is notified of disenrollment by CMS if the beneficiary disenrolls by contacting 1-800-Medicare, submitting a new plan enrollment request via Medicare.gov, or contacting a new Medicare Advantage plan (or PACE organization) to enroll • If the beneficiary contacts the D-SNP to disenroll, the D-SNP submits a disenrollment transaction to CMS • Regardless of the beneficiary’s method of disenrollment, the D-SNP sends the beneficiary a disenrollment notice indicating the beneficiary’s disenrollment from the D-SNP 	Receives and accepts enrollment transaction from new plan OR receives disenrollment transaction from D-SNP, accepts/rejects transaction, and signals acceptance/rejection of disenrollment transaction in DTRR	<ul style="list-style-type: none"> • <i>[Describe the file exchange process the state will use to learn about the D-SNP disenrollment (e.g., TBQ file, DTRR, file from the D-SNP)]</i> • For states that align D-SNPs with affiliated Medicaid managed care plans, insert: <i>[Describe whether a beneficiary who voluntarily disenrolls from an integrated D-SNP will remain in the state Medicaid managed care program plan that is affiliated with the D-SNP from which they disenroll. If the beneficiary remains enrolled, the state will not need change the beneficiary’s Medicaid managed care plan enrollment.]</i> • For states that directly capitate D-SNPs for coverage of Medicaid benefits, insert: <i>[Steps taken by the state and/or state contractor(s) to disenroll the beneficiary from the D-SNP for coverage of Medicaid benefits]</i> 	The Medicaid managed care plan will need to send new materials to the beneficiary because the integrated materials will no longer apply

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Actions Taken By:					
Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
2.B. PACE-eligible dually eligible individual elects to enroll in a PACE program, triggering D-SNP disenrollment	Enrolls in PACE program by contacting PACE organization (PACE organization determines PACE eligibility and submits enrollment transaction to CMS)	<ul style="list-style-type: none"> Notified of disenrollment by CMS (through DTRR) Does not need to submit a disenrollment transaction to CMS; PACE enrollment transaction will automatically trigger D-SNP disenrollment If beneficiary contacts D-SNP and says they want to disenroll to enroll in PACE, D-SNP should tell the beneficiary to contact the PACE organization Sends beneficiary disenrollment notice 	Receives enrollment transaction from PACE organization and accepts/rejects the transaction; if CMS accepts the PACE enrollment, CMS notifies D-SNP of disenrollment via the DTRR	<ul style="list-style-type: none"> <i>[Describe the file exchange process(es) the state will use to learn about the PACE enrollment and the D-SNP disenrollment (e.g., TBQ file, DTRR, files from the PACE organization and D-SNP)]</i> <i>[Describe process by which the state or state contractor(s) will assign the beneficiary to the PACE organization for coverage of Medicaid benefits]</i> <i>[Describe process by which the state or state contractor(s) will notify the Medicaid managed care plan of disenrollment and the PACE organization of Medicaid enrollment]</i> 	<p>Medicaid managed care plan learns of the beneficiary's disenrollment via <i>[insert the file exchange process]</i></p> <p>PACE organization learns of the beneficiary's enrollment for Medicaid benefits via <i>[insert the file exchange process]</i></p>

Key Steps and Considerations for States Using “Medicare-First” Exclusively Aligned Enrollment Processes with Dual Eligible Special Needs Plans (D-SNPs)

Actions Taken By:					
Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
2.C. Dually eligible individual loses <u>Medicare</u> eligibility, triggering D-SNP disenrollment, but the person is still eligible for and enrolled in Medicaid	No beneficiary action needed, other than to take steps to re-establish Medicare coverage if still eligible	<ul style="list-style-type: none"> Notified by CMS of beneficiary disenrollment due to loss of Medicare (Part A and/or B) eligibility via DTRR D-SNP does not have to submit any disenrollment transactions to CMS CMS recommends that D-SNPs send a disenrollment notice to the beneficiary (see CMS' Medicare Advantage enrollment and disenrollment guidance) 	<ul style="list-style-type: none"> CMS notifies beneficiary of loss of Medicare benefits CMS will send the disenrollment notification to the D-SNP via the DTRR 	<ul style="list-style-type: none"> <i>[Describe the file exchange process the state will use to be made aware of the D-SNP disenrollment (e.g., TBQ file, DTRR, file from the D-SNP)]</i> The state will <i>[describe the process the state will take to update the beneficiary's Medicaid eligibility group/aid code]</i> <i>[If beneficiary will remain in the same Medicaid managed care plan, note that here. If beneficiary will be disenrolled from Medicaid managed care plan/program due to loss of Medicare eligibility, explain the process for disenrollment and notification of beneficiary and applicable managed care plan]</i> <i>[Insert if applicable: If the person is eligible for a different program, the state will send the person an enrollment packet]</i> 	If beneficiary is disenrolled from the Medicaid managed care plan as a result of loss of Medicare eligibility, the Medicaid managed care plan will learn of the beneficiary's disenrollment via <i>[insert the file exchange process]</i>

Key Steps and Considerations for States Using “Medicare-First” Exclusively Aligned Enrollment Processes with Dual Eligible Special Needs Plans (D-SNPs)

Actions Taken By:					
Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
2.D. Dually eligible individual loses <u>Medicaid</u> eligibility, triggering D-SNP disenrollment (after deeming period, if applicable)	No beneficiary action needed, other than to take steps to re-obtain Medicaid coverage if still eligible	<ul style="list-style-type: none"> • Learns of loss of Medicaid eligibility via <i>[insert applicable file exchange process]</i> • Implements eligibility deeming period if applicable, disenrolling beneficiary at end of deeming period if Medicaid eligibility is not re-established (for information about deeming periods in D-SNPs, see information about “loss of special needs status” in the CMS Medicare Advantage enrollment and disenrollment guidance) prior to end of deeming period • Prior to processing disenrollment, sends beneficiary written notification of loss of special needs status • Submits disenrollment transaction to CMS • Sends beneficiary involuntary disenrollment notice 	Receives disenrollment transaction from D-SNP, accepts/rejects transaction, and signals acceptance/rejection of disenrollment to the D-SNP in DTRR	<ul style="list-style-type: none"> • <i>[Describe process by which the state or state contractor(s) determine(s) Medicaid ineligibility and notifies the beneficiary]</i> • <i>[Describe process that the state or state’s contractor(s) will use to disenroll the beneficiary from the Medicaid managed care plan (or the D-SNP for coverage of Medicaid benefits)]</i> 	<ul style="list-style-type: none"> • Medicaid plan learns of the beneficiary’s disenrollment via <i>[insert the file exchange process]</i> • Medicaid plan notifies the D-SNP of the beneficiary’s disenrollment from the Medicaid plan

Key Steps and Considerations for States Using “Medicare-First” Exclusively Aligned Enrollment Processes with Dual Eligible Special Needs Plans (D-SNPs)

Actions Taken By:					
Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
2.E. Dually eligible individual becomes incarcerated	<ul style="list-style-type: none"> No action needed (unless incarceration information is incorrect) If a beneficiary has been released from incarceration, but CMS data still shows them as incarcerated, they can go to their local Social Security Administration (SSA) office to show proof that they are no longer incarcerated (and the state can offer documentation to support this) 	<ul style="list-style-type: none"> Learns of beneficiary disenrollment from Medicare due to incarceration from CMS D-SNP does not have to submit a disenrollment transaction to CMS Sends beneficiary disenrollment notice indicating that beneficiary has been disenrolled from the plan due to incarceration If state learns of incarceration prior to CMS and disenrolls the beneficiary from the Medicaid managed care plan, the D-SNP will disenroll the person based on loss of Medicaid eligibility (as described in scenario 2.D) but without a deeming period 	<p><u>CMS Identifies Incarceration:</u></p> <ul style="list-style-type: none"> CMS will effectuate a disenrollment based on incarceration status data received from SSA and notify D-SNP in DTRR <p><u>State Identifies Incarceration (CMS Does Not):</u></p> <ul style="list-style-type: none"> CMS receives disenrollment transaction from D-SNP, accepts/rejects transaction, and signals acceptance/rejection of disenrollment to the D-SNP in DTRR 	<p><u>CMS Identifies Incarceration:</u></p> <ul style="list-style-type: none"> <i>[Describe the file exchange process the state will use to be made aware of the D-SNP disenrollment (e.g., TBQ file, DTRR, file from D-SNP)]</i> <i>[Insert if applicable: The state will confirm incarceration by [insert process to be used] before disenrolling the beneficiary]</i> For states that align D-SNPs with affiliated Medicaid managed care plans, insert: <i>[The state will disenroll the beneficiary from the Medicaid managed care plan. The state sends [insert file exchange process (e.g., daily 834 file, state propriety file, etc.)] to the Medicaid managed care plan indicating disenrollment due to loss of Medicaid eligibility]</i> For states that directly capitate D-SNPs for coverage of Medicaid benefits, insert: <i>[The state will disenroll the beneficiary from the D-SNP for coverage of Medicaid benefits]</i> <p><u>State Identifies Incarceration (CMS Does Not):</u></p> <ul style="list-style-type: none"> State notifies Medicaid managed care plan of loss of Medicaid eligibility/suspension of Medicaid benefits due to incarceration via <i>[insert the file exchange process]</i> 	<ul style="list-style-type: none"> Medicaid plan learns of the beneficiary's disenrollment via <i>[insert the file exchange process]</i> Notifies the D-SNP of the beneficiary's disenrollment from the Medicaid plan due to incarceration

Key Steps and Considerations for States Using “Medicare-First” Exclusively Aligned Enrollment Processes with Dual Eligible Special Needs Plans (D-SNPs)

Actions Taken By:					
Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
2.F. Dually eligible individual permanently moves out of the D-SNP’s service area	Alerts D-SNP (or state or CMS) that they have moved	<ul style="list-style-type: none"> If the D-SNP learns of the move from a source other than the beneficiary, it must attempt to contact the member to confirm whether the move is permanent and document its efforts (see CMS’ Medicare Advantage enrollment and disenrollment guidance) Submits disenrollment transaction to CMS Sends beneficiary disenrollment notice indicating that beneficiary has been disenrolled from the plan due to the move out of the plan’s service area 	If the D-SNP submits the disenrollment transaction, CMS receives disenrollment transaction from D-SNP, accepts/rejects transaction, and signals acceptance/rejection of disenrollment to the D-SNP in DTRR	<ul style="list-style-type: none"> <i>[Describe the process for when a beneficiary notifies the state of their move]</i> <i>[Describe the file exchange process the state will use to be made aware of the D-SNP disenrollment (e.g., TBQ file, DTRR, file from D-SNP)]</i> <i>[Describe the process that the state or state’s contractor(s) will use to disenroll the beneficiary from the Medicaid managed care plan (or the D-SNP for coverage of Medicaid benefits) if applicable]</i> 	<ul style="list-style-type: none"> If applicable, Medicaid plan learns of the beneficiary’s disenrollment via <i>[insert the file exchange process]</i> If applicable, Medicaid plan notifies the D-SNP of the beneficiary’s disenrollment from the Medicaid plan due to move out of service area

Key Steps and Considerations for States Using “Medicare-First” Exclusively Aligned Enrollment Processes with Dual Eligible Special Needs Plans (D-SNPs)

Actions Taken By:					
Scenario	Beneficiary	D-SNP	CMS	State (or state contractor)	Medicaid managed care plan(s)
2.G. Dually eligible individual who is enrolled in an integrated D-SNP with an affiliated Medicaid managed care plan contacts the state or the state’s enrollment broker and requests to change Medicaid managed care plans	Contacts state/state enrollment broker and requests to switch from current Medicaid managed care plan to a different plan	<ul style="list-style-type: none"> • Learns of Medicaid managed care plan disenrollment from affiliated Medicaid managed care plan • Send disenrollment transaction to CMS to disenroll beneficiary (involuntary disenrollment due to loss of special needs status) • Sends beneficiary disenrollment notice 	Receives disenrollment transaction from D-SNP, accepts/rejects transaction, and signals acceptance/rejection of disenrollment to the D-SNP in DTRR	<ul style="list-style-type: none"> • Educates beneficiary about the implications of changing Medicaid managed care plans (i.e., the beneficiary will be disenrolled from the D-SNP and returned to fee-for-service Medicare; need to select a Part D plan or CMS will choose one for them) • Refers the beneficiary to the State Health Insurance Assistance Program (SHIP) for help understanding and navigating plan options • <i>[Describe steps needed to process the beneficiary’s desired plan change if beneficiary still wishes to change plans after education]</i> • <i>[Describe process by which the state or state contractor(s) will notify the old and new Medicaid managed care plans of enrollment/disenrollment]</i> 	<ul style="list-style-type: none"> • Former Medicaid plan learns of the beneficiary’s disenrollment via <i>[insert the file exchange process]</i> • New Medicaid plan learns of the beneficiary’s enrollment into that plan via <i>[insert the file exchange process]</i>