

# Expanding Auto-Enrollment Opportunities for Dually Eligible Individuals

## Introduction

Roughly 13 million Americans are dually eligible for both Medicare and Medicaid.<sup>1</sup> This population – often referred to as “duals” or “dually eligible individuals” – faces persistently fragmented care as they navigate programs that are financed and administered separately. The resulting misalignment leads to poor care coordination, avoidable hospitalizations, higher costs for states and the federal government, and diminished health outcomes. For this population characterized by complex medical needs, multiple chronic conditions, functional limitations, and disproportionate social risk, integrated care is essential.

In general, dually eligible individuals receive Medicare coverage for most preventive, primary, and acute health care services and prescription drugs, while Medicaid covers their long-term services and supports (LTSS), certain behavioral health services, and Medicare premiums and cost-sharing.<sup>2</sup> Although they make up only about 19 percent of Medicare enrollees and 13 percent of Medicaid enrollees, they account for roughly one-third of total spending in both programs.<sup>3</sup> The disproportionate cost of covering dually eligible individuals underscores the urgency of advancing integration to improve outcomes and reduce system-wide inefficiencies.

Today, dually eligible individuals navigate a patchwork of enrollment options, ranging from fee-for-service in both programs to Medicare Advantage (MA) and Medicaid managed care, often in uncoordinated combinations. A small subset also accesses integrated programs such as the Program of All-Inclusive Care for the Elderly (PACE) or the soon-to-be-sunset Financial Alignment Initiative (FAI). However, the most widely available vehicle for integrated care is the Dual Eligible Special Needs Plan (D-SNP). D-SNPs are MA plans specifically designed to meet the needs of dually eligible individuals through enhanced care coordination, comprehensive supplemental benefits, and wraparound services, including LTSS and Behavioral Health. D-SNPs are instrumental to streamlining care delivery for dually eligible individuals while minimizing administrative burden and costs to state and federal governments.

The vast majority of dually eligible individuals (73 percent) are eligible for full Medicaid benefits, meaning they can receive the full range of state-covered services in addition to what Medicare covers and would benefit from the care coordination that D-SNPs offer. However, despite D-SNP’s ability to meet the specific needs of dually eligible individuals, enrollment has remained low, with less than half of all dually eligible individuals enrolled in a D-SNP.<sup>4</sup> Historically, in response to low participation in integrated Medicare–Medicaid models, CMS has leveraged different forms of auto-enrollment coupled with beneficiary protections to improve enrollment. This was demonstrated most clearly in the Financial Alignment Initiative where passive enrollment was used to sustain enrollment numbers in Medicare-

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<sup>1</sup> [https://www.macpac.gov/wp-content/uploads/2024/01/Jan24\\_MedPAC\\_MACPAC\\_DualsDataBook-508.pdf](https://www.macpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508.pdf)

<sup>2</sup> <https://www.cms.gov/files/document/mmco-report-congress.pdf-0>

<sup>3</sup> [https://www.macpac.gov/wp-content/uploads/2024/01/Jan24\\_MedPAC\\_MACPAC\\_DualsDataBook-508.pdf](https://www.macpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508.pdf)

<sup>4</sup> <https://www.kff.org/medicare/10-things-to-know-about-medicare-advantage-dual-eligible-special-needs-plans-d-snps>

Medicaid plans (MMPs).

In this document, we advocate for expanded auto-enrollment options for dually eligible individuals as a solution for low enrollment in integrated plans. We also propose several beneficiary protections and reasonable guardrails to ensure that beneficiary choice, relevant beneficiary education, and continuity of care are preserved.

## History of Auto-enrollment

Auto-enrollment describes the process by which dually eligible individuals are automatically enrolled into a health plan without a requirement to take enrollment action themselves. Auto-enrollment is designed to simplify enrollment into health plans, but prospective enrollees always have the option to decline participation by opting out before their enrollment is active.<sup>5</sup> CMS currently permits auto-enrollment for dually eligible individuals through two primary mechanisms: default enrollment and passive enrollment.

### ***Medicare Default Enrollment***

Default enrollment (previously referred to as “seamless conversion” allows an MA organization to enroll a member of an affiliated Medicaid managed care organization (MCO) into its D-SNP when that member **first** becomes eligible for Medicare.<sup>6</sup> This form of auto-enrollment is only available during the Initial Coverage Election Period (ICEP), and both the state and CMS must approve its use. Prospective enrollees must be notified of their default enrollment at least 60 calendar days before they become Medicare-eligible (i.e. their enrollment effective date) and may decline the default enrollment prior to the effective date. MA plans must have a minimum 3-star rating in order to participate in default enrollment. Currently, default enrollment is actively used in 15 states to auto-enroll dually eligible individuals from Medicaid MCOs into D-SNPs.<sup>7</sup>

### ***Medicare Passive Enrollment***

Passive enrollment, unlike default enrollment is permitted under limited circumstances for MA organizations and is initiated by CMS. It is generally used when necessary to prevent loss of coverage or harm to enrollees but also to promote continuity of care and integrated care for dually eligible individuals. Through passive enrollment, CMS automatically enrolls individuals already enrolled in an MA plan into a different plan that meets CMS requirements. The circumstances under which passive enrollment is permitted are:

1. The plan in which the individual is enrolled is immediately terminated.
2. CMS determines that remaining enrolled in a plan poses potential harm to the members.
3. **Other instances in which CMS determines that passive enrollment is necessary to promote**

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<sup>5</sup> [Passive Enrollment Of Dual-Eligible Beneficiaries Into Medicare And Medicaid Managed Care Has Not Met Expectations - PMC](#)

<sup>6</sup> [42 CFR 422.66](#)

<sup>7</sup> <https://www.cms.gov/files/document/chart-approved-ma-organizations-default-enrollment-q1-2025.pdf>

**integrated care and continuity of care for full-benefit dual eligible individuals.<sup>8</sup>**

For purposes of this paper, we will focus primarily on the third circumstance. Under this circumstance, CMS requires the plan receiving passive enrollees to meet **all** of the following criteria:

- Operate as a fully integrated dual eligible special needs plan (FIDE-SNP) or highly integrated dual eligible special needs plan (HIDE-SNP).<sup>9,10</sup>
- Have substantially similar provider and facility networks and Medicare- and Medicaid-covered benefits as the plan (or plans) from which the beneficiaries are passively enrolled.
- Have an overall quality rating from the most recently issued ratings of at least 3 stars **OR** be a low enrollment contract or new MA plan.
- Not have any prohibition on new enrollment imposed by CMS.
- Have limits on premiums and cost-sharing appropriate to full-benefit dual eligible beneficiaries.
- Have the operational capacity to passively enroll beneficiaries and agree to receive the enrollments.

As is the case for Default Enrollment, enrollees must receive prior notice of their passive enrollment and retain the ability to opt out and choose a different plan or move into fee-for-service Medicare. CMS requires the first notice of passive enrollment to be issued no less than 60 days prior to the enrollment effective date and a second notice must be sent no less than 30 days prior. Also, unlike Default Enrollment, which occurs during the ICEP, once CMS initiates passive enrollment, a special enrollment period will be triggered for impacted enrollees.<sup>11</sup> It is important to note that currently, Passive Enrollment authority does not apply when dually eligible individuals are in Medicaid and/or Medicare fee-for service. It is only applicable when moving enrollees from one MA plan to another.

***Lessons Learned from the Financial Alignment Initiative***

While Passive Enrollment has historically been used under limited circumstances for enrollment into MA plans, it was essential to sustain enrollment into Medicare-Medicaid Plans participating in the Financial Alignment Initiative (FAI). The FAI is a CMMI demonstration announced in 2011, which aimed to integrate primary, acute, behavioral health and long-term services and supports for dually eligible individuals and better align the financing of the Medicare and Medicaid programs through two

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<sup>8</sup> [42 CFR 422.60\(g\)](#)

<sup>9</sup> A FIDE-SNP is a D-SNP that provides dually eligible individuals access to Medicare and Medicaid benefits – including long-term services and supports (LTSS), behavioral health services, home health services and medical supplies, equipment and appliances - under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract with the applicable state. A HIDE-SNP similarly provides access to Medicare and Medicaid benefits but may provide **either** LTSS **or** behavioral health services. A HIDE-SNP's parent organization may also contract with the applicable state, while the HIDE-SNP holds the MA contract with CMS unlike the single contract holder requirement for FIDE-SNPs.

<sup>10</sup> [42 CFR 422.2](#)

<sup>11</sup> [42 CFR 422.60\(g\)\(5\)](#)

contracting models: a capitated model and a managed fee-for-service model.<sup>12</sup><sup>13</sup> 13 states participated in the demonstration, 9 of which participated under the capitated model, which leveraged 3-way contracts between CMS, the state and the health plan to integrate care. In capitation states, there was an “opt-in” period during which eligible dually eligible individuals could choose to participate in the program. Following this period, the state would initiate a passive enrollment period (in all capitation states except New York and California) to auto-assign individuals who had yet to make a decision, but enrollees could still opt out of the demonstration program at any time.<sup>14</sup> According to the Medicaid and CHIP Payment and Access Commission (MACPAC), passive enrollment was a key factor to higher enrollment rates in the demonstration because enrollees who were passively enrolled were generally less likely to opt out, with some state exceptions.<sup>15</sup>

When individuals did decide to opt-out of the demonstration, the primary reported reasons were to continue seeing an existing provider, concerns about coverage of specific services or benefits, satisfaction with current coverage, and difficulty understanding the new program. Some states, including New York and Rhode Island, also reported challenges related to beneficiary confusion, with beneficiaries either being fearful of change, or opting out of MMPs due to unfamiliarity or a lack of understanding.<sup>16</sup> Providers’ unfamiliarity with the program was also a major driver of enrollee opt-outs. Institutional providers, particularly nursing facilities, reported confusion about coverage for long-term care services among some MMPs and discouraged beneficiaries from participating in the demonstration.<sup>17</sup> California, Illinois, Virginia and Michigan all reported instances of provider steering, where eligible patients were encouraged to opt out of the program due to a general lack of understanding of the demonstration and the features that could support these individuals.<sup>18</sup><sup>19</sup>

These documented challenges with enrollee opt-outs underscore the need for auto-enrollment mechanisms to be accompanied by adequate education to both enrollees and providers to ensure successful enrollment and retention. As an example, to combat provider hesitation, California conducted strategic outreach to providers linked to higher opt-out decisions, refined enrollee and provider outreach and training materials, and reengineered enrollment methods, all of which helped to stabilize enrollment numbers.<sup>20</sup> California’s focus on creating an active stakeholder community minimized

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<sup>12</sup> Capitated Model: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care. Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

<sup>13</sup> <https://www.cms.gov/priorities/innovation/innovation-models/financial-alignment>

<sup>14</sup> <https://www.macpac.gov/wp-content/uploads/2022/05/Financial-Alignment-Initiative-2022-Update-5.pdf>

<sup>15</sup> <https://www.macpac.gov/wp-content/uploads/2022/05/Financial-Alignment-Initiative-2022-Update-5.pdf>

<sup>16</sup> [Financial Alignment Initiative New York Fully Integrated Duals Advantage \(FIDA\) Program First Evaluation Report](#)  
[Rhode Island Integrated Care Initiative: Third Evaluation Report](#)

<sup>17</sup> [Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare](#)

<sup>18</sup> [Financial Alignment Initiative California Cal MediConnect: First Evaluation Report](#)

<sup>19</sup> [Financial Alignment Initiative, Illinois Medicare-Medicaid Alignment Initiative, First Evaluation Report](#)

[Financial Alignment Initiative Michigan MI Health Link First Evaluation Report](#)

<sup>20</sup> [Financial Alignment Initiative California Cal MediConnect: First Evaluation Report](#)

participation discouragement and allowed stakeholders to become meaningful partners with the state.<sup>21</sup>

Tailoring auto-enrollment policies with these insights in mind could help enrollees make more informed decisions, while improving enrollment and retention in integrated coordinated care plans, leading to better overall health outcomes.

### ***Autoenrollment in Medicaid***

Unlike auto-enrollment authority under Medicare, Medicaid auto-enrollment authority is far less restrictive. Medicaid managed care enrollment regulations at 42 CFR 338.54 allow states to implement auto-enrollment in either voluntary or mandatory managed care programs. In a voluntary program, beneficiaries are allowed to choose between enrolling in managed care or remaining in fee-for-service (FFS). States may use passive enrollment only after beneficiaries are first given an opportunity to make an active choice; if no choice is made within the required timeframe, the state may assign them to a managed care plan in accordance with regulatory guidelines, including appropriate notice and beneficiary protections.<sup>22</sup> In a mandatory program, beneficiaries are required to receive services through managed care, but they must still be given the opportunity to select a plan. If no selection is made, the state can proceed with passive assignment, in accordance with federal safeguards.

Federal regulation requires that all passive enrollment assignments be made only into “qualified” managed care plans—meaning plans not under sanction and able to accept new members. States must prioritize continuity of care by assigning beneficiaries to plans that align with existing provider relationships or with providers that have historically served Medicaid populations. When such continuity cannot be ensured, states must distribute enrollees equitably across available plans and may consider additional non-discriminatory factors such as family preferences, quality ratings, or prior plan history. States must also provide timely notices informing beneficiaries of their enrollment rights, including the ability to disenroll without cause within 90 days of enrollment, and must clearly explain how enrollees may access beneficiary support systems.

States most commonly use this authority to transition beneficiaries from FFS into managed care or to assign individuals to state-selected MCOs. However, it may also be leveraged to align Medicaid and Medicare enrollment for dually eligible individuals. Specifically, states can auto-enroll beneficiaries into Medicaid MCOs affiliated with their selected D-SNPs, thereby advancing integrated care.

### **Proposals to Expand Auto-Enrollment**

Auto-enrollment for dually eligible individuals serves not only as a useful mechanism for enrolling and retaining members in integrated products broadly, but also as a means for achieving what is known as “aligned enrollment.” Aligned enrollment refers to the enrollment of full-benefit dually eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization into an affiliated D-SNP (e.g. a single organization owns both the Medicaid MCO and the D-SNP or the D-SNP

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<sup>21</sup> [Financial Alignment Initiative California Cal MediConnect: First Evaluation Report](#)

<sup>22</sup> [42 CFR 438.54](#)

itself also holds a Medicaid MCO contract with the state). When State policy limits a D-SNP's membership to individuals with aligned enrollment, this condition is referred to as “exclusively aligned enrollment.”<sup>23</sup> Currently, states have the ability to leverage default enrollment (described above) to achieve aligned enrollment; however this form of autoenrollment is only available during the individual’s Initial Coverage Election Period (ICEP) and the alignment is based on the individual’s pre-existing Medicaid MCO enrollment i.e. the individual is enrolled into a D-SNP that is affiliated with their Medicaid MCO).

The MLTSS Association supports broader use of autoenrollment mechanisms to achieve aligned enrollment for dually eligible individuals when paired with appropriate beneficiary education and protections. We recommend that CMS issue additional guidance to states and health plans on the full scope of existing autoenrollment authority, expand federal autoenrollment authority to facilitate alignment efforts, and grant states the flexibility to choose whether alignment should be based on Medicaid or Medicare enrollment as detailed below.

Promote and expand auto-enrollment flexibilities for dually eligible individuals in the following ways:

**Expand auto-enrollment authority to facilitate aligned enrollment based on an individual’s Medicaid MCO enrollment choice/assignment:**

For full benefit dually eligible individuals enrolled in a Medicaid MCO, who are also enrolled in Medicare FFS, **grant states additional auto-enrollment authority to automatically align dually eligible individuals to an affiliated integrated D-SNPs** in accordance with federal guidelines for beneficiary notice and protections.

**Promote the use of existing authority to facilitate aligned enrollment based on an individual’s Medicare D-SNP enrollment choice:**

For full benefit dually eligible individuals who elect to receive Medicare coverage through a D-SNP, **encourage states to leverage state Medicaid manage care enrollment authority at 42 CFR 438.54 to auto-enroll these individuals into an affiliated Medicaid MCO when available.**

**Specific Mechanism of Change**

**When Medicaid Leads:** States currently have flexibility to auto-enroll full-benefit dually eligible individuals into an affiliated D-SNP during the Initial Coverage Election Period (ICEP). Expand auto-enrollment authority to permit auto-enrollment of dually eligible individuals currently enrolled in traditional (FFS) Medicare into the Medicaid MCO's parent company's D-SNP.

**When Medicare Leads:** States already have the flexibility to allow auto-enrollment of full-benefit dually eligible individuals into a Medicaid MCO affiliated with their D-SNP election. Encourage this process through targeted education, outreach, and technical assistance to ensure states can operationalize

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<sup>23</sup> 42 CFR 422.2 “Aligned enrollment”

these flexibilities effectively to achieve aligned enrollment, while incorporating required notice, opt-out rights, and continuity-of-care protections.

For both auto-enrollment mechanisms, provide guidance to states and health plans highlighting best practices for the use of enrollment authorities, **including adequate education for members and health plans** and timely notifications. Emphasize the need for education and technical assistance to states about the alignment of Medicaid enrollment periods and effective dates with those in Medicare to facilitate a seamless transition and prevent delays in covered services.

The MLTSS Association **supports aligned enrollment into integrated care plans and does not support one auto-enrollment pathway over another**. To achieve aligned enrollment, the MLTSS Association supports giving states the flexibility to implement the auto-enrollment policies that work best for them. We believe that advancing integrated care will look different across states and do not wish to be prescriptive in our approach.

## Proposed Beneficiary Protections and Guardrails

This auto-enrollment proposal includes robust guardrails to ensure individuals are protected, including:

### Under both scenarios:

- Enrollees would have a 60-90 day opt-out period.
- If an enrollee has actively chosen a product (i.e., standalone D-SNP, HIDE, or FIDE), they should not be moved to another option through passive enrollment to preserve enrollee choice.
- The consumer protection floor should follow [MMP guidelines](#)<sup>24</sup>.

### When Medicaid leads:

- HIDE-SNPs/FIDE-SNPs must notify enrollees 60 days prior to effective enrollment date and follow continuity of care provisions for 6 months. Notices must include information on other D-SNP plan options available to them and provide a direct link to the Medicare Plan Finder for their county, filtered to show D-SNPs they are eligible for.
- Plans must have 3+ Stars in order to be eligible for passive enrollment; or have no Star Rating if the plan is new and/or has low enrollment.
- There must be at least two D-SNPs in a service area to have auto-enrollment.
- Automatic enrollment into HIDE and FIDE SNPs would apply to any HIDE SNP and FIDE SNP entities that have a Medicaid contract which covers, at minimum, a comprehensive set of long-term services and supports as well as home and community-based services with reasonable state-specified service

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<sup>24</sup> Each state participating in the Financial Alignment Initiative was required to develop a Memorandum of Understanding (MOU) with CMS to establish the parameters of the demonstration, including beneficiary protections.

exclusions and carve-outs.

- New D-SNP enrollees should receive a transition/temporary supply of eligible Part D drugs (generally at least a one-month supply where applicable) so beneficiaries do not have a gap in therapy on their effective date. Plans should send the CMS-approved written transition notice to the enrollee (and prescriber when applicable) within 3 business days
- For beneficiaries who are mid-course of treatment at the time they switch plans, D-SNPs must honor existing prior authorizations and provide a minimum 90-day transition period during which the new plan generally may not impose a new prior authorization or interrupt the active course of treatment. This is an existing regulatory requirement.

**When Medicare leads:**

- States with Medicaid plan selection lock-in policies should evaluate their impact on beneficiary choice in the context of this authority and the monthly special enrollment periods.
- For beneficiaries who are mid-course of treatment at the time they switch plans, Medicaid managed care plans must honor existing prior authorizations and provide a minimum 90-day transition period during which the new plan generally may not impose a new prior authorization or interrupt the active course of treatment.