ICRC | Integrated Care Resource Center

TECHNICAL ASSISTANCE TOOL

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Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans (D-SNPs): Required Language Applicable to All Types of D-SNPs

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Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage plan that only enrolls dually eligible individuals. D-SNPs differ from other Medicare Advantage plan types in important ways and vary in the level of Medicaid and Medicare integration they offer for dually eligible individuals. All D-SNPs are required to hold contracts with the state Medicaid agency in each state where they operate, and those contracts must contain at least certain minimum elements. There are three types of D-SNPs:

- **Fully Integrated D-SNPs (FIDE SNPs)** are D-SNPs that provide coverage of Medicare and Medicaid benefits under a single legal entity that holds both: (1) a Medicare Advantage contract with the Centers for Medicare & Medicaid Services (CMS); and (2) a contract with the state Medicaid agency. FIDE SNPs must cover at least Medicaid primary and acute care services and long-term services and supports (LTSS), including at least 180 days of nursing facility coverage during the plan year. FIDE SNPs must also coordinate Medicare and Medicaid benefits "using aligned care management and specialty care network methods for high-risk beneficiaries" and employ "policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievances and appeals, and quality improvement" (42 CFR §422.2). Starting in 2025, FIDE SNPs must operate with exclusively aligned enrollment[1] and cover Medicare cost sharing; Medicaid behavioral health services; home health services and medical supplies, equipment, and appliances; in addition to covering Medicaid primary and acute care services and LTSS.[2]

ABOUT THIS TOOL

This technical assistance tool is the first in a series of four tools that provide sample State Medicaid Agency Contract (SMAC) language that states can use in contracts with D-SNPs to meet federal requirements and advance state goals regarding care coordination, eligibility and enrollment, data reporting, marketing and enrollee communications, or other requirements regarding D-SNP activities.

This tool provides sample language designed to comply with the minimum federal requirements applicable to all types of D-SNPs. All four of the technical the technical assistance tools in this series are available on the ICRC website. Use of sample language contained in this tool does not guarantee that CMS will approve a D-SNP's bid to operate in a particular state or geographic area.

- **Highly Integrated D-SNPs (HIDE SNPs)** are D-SNPs that provide coverage of Medicaid benefits (through the D-SNP or an affiliated Medicaid managed care plan), including LTSS, behavioral health, or both, under a capitated contract with the state Medicaid agency. Starting in 2025, a HIDE SNP's capitated contract with the state Medicaid agency (for coverage of the required Medicaid benefits) must cover the entire service area of the D-SNP. [3]
- **Coordination-Only (CO) D-SNPs** meet minimum CMS requirements but do not quality as a HIDE SNP or a FIDE SNP. CO D-SNPs must coordinate the delivery of Medicare and Medicaid services for their enrollees and meet the information-sharing requirements described at 42 CFR §422.107(d).

A FIDE SNP, HIDE SNP, or CO D-SNP may be designated as an **applicable integrated plan (AIP)**, as well. To qualify as an AIP, a D-SNP must be: (1) a HIDE SNP or FIDE SNP that operates with exclusively aligned enrollment; or (2) a CO D-SNP that operates with exclusively aligned enrollment and covers Medicaid primary and acute care benefits, Medicare cost sharing, and at least one of the following additional Medicaid benefits: (1) home health services; (2) medical supplies, equipment, and appliances; and/or (3) nursing facility services (42 CFR §422.561). AIPs must implement unified plan-level appeal and grievance processes in accordance with the requirements at 42 CFR §422.107(c)(9), §422.629 through §422.634, §438.210, §438.400, and §438.402.

For more information on each type of D-SNP, see the Integrated Care Resource Center (ICRC)'s tip sheet on D-SNP definitions at https://integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023.

In addition to including language to meet one of the levels of integration described above, per 42 CFR §422.107(c), all D-SNPs must also have eight minimum elements documented in their state Medicaid agency contracts (SMACs). **Table 1** provides a brief description of each of these minimum federal requirements and sample contract language that states can use to address each requirement. In the sample contract language provided, ***blue italicized*** **text in brackets [ ] is used to convey instructions and highlight areas in which states will need to insert state-specific information.** Some rows in Table 1 also contain links to additional sample contract language that may be useful in specific circumstances. The sample contract language has generally been derived or adapted from existing state D-SNP contracts, with ICRC editing for clarity and conciseness.

For more sample language regarding **required** D-SNP contractual elements as well as sample **optional** contract language that states can use to advance their Medicare-Medicaid integration goals, see the additional tools in this series:

- Part 2: Required Language Applicable to Certain D-SNPs
- Part 3: Optional Language Applicable to All D-SNPs
- Part 4: Optional Language Applicable to Certain D-SNPs

Table 1: Sample Language for State Medicaid Agency Contract Elements Required for All D-SNPs

Contract Element	CMS Requirement	Description	Sample Contract Language
Coordinating the delivery of Medicare and Medicaid benefits and services	"(1) The [Medicare Advantage] organization's responsibility to — (i) Coordinate the delivery of Medicaid benefits for individuals who are eligible for such services; and (ii) If applicable, provide coverage of Medicaid services, including long-term services and supports and behavioral health services, for individuals eligible for such services." (42 CFR §422.107[c][1])	This contractual element requires the Medicare Advantage organization offering the D-SNP to clearly describe its responsibility to coordinate delivery of Medicaid benefits in the contract between the state Medicaid agency and the Medicare Advantage organization. The Medicare Advantage organization should describe mechanisms for coordinating Medicaid services covered under Medicaid fee-for-service, by the Medicare Advantage organization itself (or by a Medicaid plan offered by the Medicare Advantage organization's parent organization or another entity owned and controlled by its parent organization), or by other Medicaid plans available in the state.	**Sample language for coordinating the delivery of benefits:** The Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medicaid, including when Medicaid benefits are delivered via fee-for-service *[specify if applicable: and/or managed care providers]*. The Contractor is responsible for coordinating the enrollee's Medicare and Medicaid benefits, including, but not limited to discharge planning, disease management, and care management. **Additional sample language is available in Appendix A** for the topics listed below: • Contract language requiring coordination with unaffiliated Medicaid managed care plans, the state Medicaid agency, and/or specialized Medicaid benefit contractors • Contract language describing coordination in D-SNPs with integrated benefits and exclusively aligned enrollment

Required Language for All D-SNPs

Contract Element	CMS Requirement	Description	Sample Contract Language
Category(ies) of dually eligible individuals eligible to enroll in the D-SNP	"(2) The category(ies) and criteria for eligibility for dual eligible individuals to be enrolled under the [Special Needs Plan (SNP)], including as described in sections 1902(a), 1902(f), 1902(p), and 1905 of the Act." (42 CFR §422.107[c][2])	This contractual element requires the contract to clearly identify the dually eligible population that is eligible to enroll in the D-SNP. A D-SNP may only enroll dually eligible individuals as specified in the SMAC. For example, if a state Medicaid agency specifies in the SMAC that D-SNP enrollment is limited to certain sub-sets of dually eligible individuals (for example, only full-benefit dually eligible individuals, only full-benefit dually eligible individuals who are age 65 and above or only full-benefit dually eligible individuals who require a nursing facility level of care), the D-SNP must limit enrollment to the specified population(s) of dually eligible individuals. This contractual element may also include provisions that limit D-SNP enrollment to full-benefit dually eligible individuals who are also enrolled in a Medicaid plan offered by the Medicare Advantage organization, its parent organization, or another entity owned and controlled by its parent organization—that is, D-SNPs with exclusively aligned enrollment under 42 CFR §422.2. Note that the Specified Low-Income Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled and Working Individual (QDWI) programs only provide coverage for Medicare Part A or B premiums. SLMB, QI, and QDWI enrollees will therefore be subject to higher cost-sharing than other dually eligible individuals and will not be eligible for coverage of any Medicaid benefits coordinated or covered by the D-SNP.	The Contractor may enroll only those categories of dual eligible individuals[4] indicated below *[Check or list all that apply]*: ☐ Only full-benefit dually eligible beneficiaries (QMB+, SLMB+ and Other Full Benefit Dually Eligible Beneficiaries only) ☐ QMB ☐ QMB+ ☐ SLMB ☐ SLMB+ ☐ QI ☐ QDWI ☐ Other Full Benefit Dually Eligible Beneficiaries ☐ Full-benefit dually eligible beneficiaries (QMB+, SLMB+ and Other Full Benefit Dually Eligible Beneficiaries) who are also enrolled in the Medicaid plan affiliated with the Contractor's D-SNP (for D-SNPs with exclusively aligned enrollment) *[Some states may also choose to incorporate other eligibility restrictions, such as restrictions based on age, special program status, or receipt of certain Medicaid waiver services, for example.]* **Appendix B** provides an example table that states can use in their SMACs to identify eligible categories of dually eligible individuals and service areas covered by each plan benefit package (PBP) included in the SMAC.
Medicaid benefits covered by the D-SNP	"(3) The Medicaid benefits covered under a capitated contract between the State Medicaid agency and the MA organization offering the SNP, the SNP's parent organization, or	This contractual element requires that information be included on plan benefit design, capitated payment methodology, benefit administration, and assignment of responsibility for providing the covered benefits. The SMAC must list all Medicaid benefits covered by the D-SNP—or by a Medicaid managed care plan offered by the same parent organization (or another entity owned and controlled by the same parent organization) as the D-SNP—for the specified contract year.	**Sample language regarding who is responsible for covering Medicare cost sharing for D-SNP enrollees:** The following entity(ies) will be responsible for covering Medicare cost sharing incurred on behalf of dually eligible individuals enrolled in the Contractor's D-SNP (select all that apply): ☐ The state Medicaid agency ☐ The D-SNP

Contract Element	CMS Requirement	Description	Sample Contract Language
	another entity that is owned and controlled by the SNP's parent organization." (42 CFR §422.107[c][3])	The SMAC may include the list of Medicaid benefits in an attachment to the contract but must incorporate by reference the attachment in the body of the contract. Medicare Advantage organizations and states have flexibility on how to reflect the Medicaid benefits in the SMAC; however, the SMAC must list the Medicaid benefits that will be covered for the specified contract year. The SMAC should also describe the entity responsible for Medicaid coverage of Medicare cost sharing.	☐ A Medicaid managed care plan that is affiliated with (offered by the same parent company as) the D-SNP ☐ One or more Medicaid managed care plans offered by parent companies that are not affiliated with the D-SNP **Sample language for contracts with D-SNPs that cover at least some Medicaid benefits:** Services covered by this Contract. The Contractor shall provide the following *[specify state Medicaid program]* services when medically necessary and appropriate: *[State must provide a list of all Medicaid covered services to be covered by the D-SNP, using a cross-reference to the list within the contract or a cross-reference to the appendix within the contract].* Services not covered by this Contract. Services that are not covered by this Contract include: *[List Medicaid services carved out of the D-SNP contract but covered in fee-for-service Medicaid]. [If applicable, include language describing the entity(ies) responsible for covering the services carved out of the D-SNP contract].* These services are not included in the capitated rate paid to the Contractor by *[specify state Medicaid agency].* The Contractor is not required to provide these services, but is responsible for ensuring coordination of these services, per the federal regulations described at 42 CFR §422.107(c)(1). **Sample language for contracts with D-SNPs that do not cover any Medicaid benefits:** The Contractor is not responsible for providing or reimbursing any Medicaid benefits. The Contractor shall maintain current knowledge and familiarity of *[specify state Medicaid program]* benefits through ongoing reviews of *[specify state]* laws, rules, policies, and further guidance as posted on the *[specify state Medicaid program]* website. The Contractor shall timely coordinate *[specify state Medicaid program]* benefits for its enrolled Dual Eligible Members as

Contract Element	CMS Requirement	Description	Sample Contract Language
			described in *[specify attachment or section that lists and describes Medicaid benefits]* of this Agreement. *[Specify section/attachment that describes care coordination requirements]* details the Contractor's specific Medicare-Medicaid care coordination requirements. *[State]* Medicaid covered services are described in Title XIX of the Social Security Act, 42 CFR §§440 and 441; *[Specify state statutory reference(s), state policy manual reference(s), contractual references, etc. as applicable, including references to other sections of the contract that list state Medicaid benefits];* the *[specify state Medicaid program]* website; and other relevant materials.[5] **Additional optional contract language is available in Appendix A** for the topic listed below. • Contract language for D-SNPs that provide comprehensive and fully integrated coverage of Medicare and Medicaid benefits
Cost-sharing protections	"(4) The cost-sharing protections covered under the SNP." (42 CFR §422.107[c][4])	This contractual element requires that Medicare Advantage organizations offering D-SNPs and their network providers do not impose cost sharing on specified dually eligible individuals (individuals who receive full Medicaid benefits, Qualified Medicare Beneficiaries (QMBs), and any other dually eligible population designated by the state) that exceed the amounts permitted under the Medicaid State Plan if the individuals were not enrolled in the D-SNP. In addition, the D-SNP must meet all Medicare Advantage maximum out-of-pocket (MOOP) requirements.	For sample cost sharing protections language, see ICRC's resource: Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans (D-SNPs): Cost-Sharing Protections for D-SNP Enrollees. **Sample language regarding tracking of Maximum Out of Pocket (MOOP) Amounts:** The Contractor must track each enrollee's accrued out-of-pocket spending and alert enrollees and providers when the maximum out-of-pocket (MOOP) amount is reached, in accordance with federal regulations at 42 CFR §422.100(f)(4) and (f)(5)(iii) and 42 CFR §422.101(d). *[If desired, the state can also add language here specifying that the D-SNP must also notify the state using a state-specified or agreed-upon mechanism, such as a monthly file, to alert the state to D-SNP enrollees for whom the MOOP amount has been reached].*

Contract Element	CMS Requirement	Description	Sample Contract Language
State identification and sharing of information on Medicaid provider participation	"(5) The identification and sharing of information on Medicaid provider participation." (42 CFR §422.107[c][5])	This contractual element requires that a process be specified regarding how the state will identify and share information on providers contracted with the state Medicaid agency for inclusion in the D-SNP provider directory. Although CMS does not require all D-SNP network providers to accept both Medicare and Medicaid, the D-SNP's network must meet the needs of the dually eligible population served.	*[Specify state Medicaid agency]* will provide the Contractor with an electronic data file containing Medicaid participating providers in a mutually agreed upon format on a *[specify timeframe, such as daily/weekly/monthly/periodically]* basis. *[specify if applicable: any D-SNPs affiliated with a companion Medicaid managed care plan can obtain the file from the affiliated [Medicaid managed care program] plan.]* Once *[specify State Medicaid agency]* provides an electronic data file list of enrolled Medicaid providers, the Contractor will identify in its provider directory those providers that accept both Medicare and Medicaid (providers that are currently registered providers under *[specify Medicaid program name]* and are also within the Contractor's network).[6]
D-SNP verification of enrollee eligibility for Medicaid	"(6) The verification of an enrollee's Medicaid eligibility." (42 CFR §422.107[c][6])	This contractual element requires that the state Medicaid agency provide the Medicare Advantage organization offering the D-SNP with access to real-time information that the Medicare Advantage organization will use to verify the Medicaid eligibility of dually eligible individuals who wish to enroll in the D-SNP. The contract must describe in detail the agreed-upon eligibility verification process between the Medicare Advantage organization and the state.	To verify the Medicaid eligibility of an individual requesting enrollment in Contractor's D-SNP, *[specify state Medicaid agency]* agrees to provide the Contractor with real-time access to *[specify state Medicaid program]*'s eligibility information via *[specify files/methods to be used to verify Medicaid eligibility at point of enrollment]*. To verify the Medicaid eligibility of all current members of Contractor's D-SNP on a *[specify timeframe, such as daily/weekly/monthly/periodically]* basis, *[specify state Medicaid agency]* and the Contractor will exchange eligibility verification data files pursuant to a method agreed upon by both parties. *[List available verification methods (for example, individual, batch, electronic, non-electronic) that the D-SNP will use to verify the Medicaid eligibility of its members on an ongoing basis and describe methods for accessing each option. In states where D-SNPs have affiliated Medicaid managed care plans, the state may wish to include language here explaining that the D-SNP will verify ongoing Medicaid eligibility through the enrollment and disenrollment processes established for its affiliated Medicaid managed care program health plan].*[7]

Required Language for All D-SNPs

Contract Element	CMS Requirement	Description	Sample Contract Language
D-SNP service area	"(7) The service area covered by the SNP." (42 CFR §422.107[c][7])	This contractual element requires that the covered service area(s), in which the state has agreed the Medicare Advantage organization offering the D-SNP may market and enroll, be clearly identified in the contract. The D-SNP service area(s) in the SMAC must be consistent with the service area(s) that the D-SNP specifies in the CMS Health Plan Management System (HPMS) when submitting its bid to CMS.	The service area is the geographic area in which enrollees or potential enrollees reside and for whom the Contractor is approved to provide services. The Contractor's service area must be approved by both CMS and the State. The service area covered by this Contractor is *[List counties served]. [If contract covers more than one D-SNP plan benefit package, and the different benefit packages cover different service areas, the state may wish to incorporate a table that lists each Medicare Advantage contract number and plan ID covered by the contract, along with the counties served by each plan].* **Appendix B** provides an example table that states can include in their SMACs to identify eligible categories of dually eligible individuals and service areas covered by each PBP included in the SMAC.
Contract period	"(8) The contract period for the SNP." (42 CFR §422.107[c][8])	This contractual element requires a period of performance between the state Medicaid agency and the Medicare Advantage organization offering the D-SNP of at least January 1 through December 31 of the year following the due date of the contract.	This contract is effective January 1, *[specify year]* through December 31, *[specify year]*. Additional optional contract language is available in **Appendix A** for the topic listed below: • Contract language for states that wish to use "evergreen" contracts with D-SNPs beginning January 1, 2021[8]

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] More information on exclusively aligned enrollment is available in ICRC's webinar and written tools on the topic at: https://integratedcareresourcecenter.com/resources-by-topic/exclusively-aligned-enrollment.

[2] CMS. "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs." Federal Register, May 9, 2022. Available at: https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-andtechnical-changes-to-the-medicare-advantage-and.

[3] CMS. "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs." Federal Register, May 9, 2022. Available at: https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-andtechnical-changes-to-the-medicare-advantage-and.

[4] Full- and partial-benefit categories of dual eligibility are explained in detail in a CMS document entitled, "Dual Eligible Individuals – Categories," available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

[5] This language was adapted from the 2020 Arizona Health Care Cost Containment System (AHCCCS) Medicare Advantage Organization Agreement, available at: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/medicareagreements.html.

[6] This language was adapted from three state contracts: the 2020 Pennsylvania Department of Human Services Medicare Improvements for Patients and Providers Act Contract (not available online); the 2020 Delaware Health and Social Services Division of Medicaid and Medical Assistance D-SNP Contract (not available online); and the 2020 Kansas Department of Health and Environment Division of Health Care Financing D-SNP Contract (not available online).

[7] This language was adapted from the 2020 Pennsylvania Department of Human Services Medicare Improvements for Patients and Providers Act Contract (not available online).

[8] An "evergreen" contract is a contract that remains in effect continuously, rather than solely for a single year. States that use evergreen contracts typically incorporate contract amendments on an annual or more frequent basis to revise or update contract elements, to ensure the contract provisions remain relevant over time. States that currently use evergreen contracts with D-SNPs must initiate a new contract, effective January 1, 2021, that includes language to meet the new D-SNP integration requirements described in the final rule entitled "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021," released April 16, 2019, available at: https://www.federalregister.gov/documents/2019/04/16/2019-06822/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare. After January 1, 2021, states may again utilize evergreen contracts with D-SNPs moving forward.

Appendix A: Optional Contract Language from Table 1

This appendix contains additional sample contract language referenced in Table 1, which describes minimum contract elements that must be in all D-SNP SMACs. In the sample contract language provided, ***blue italicized*** **text in brackets [ ] is used to convey instructions and situations in which the state will need to insert state-specific information.**

Coordination of the Delivery of Medicare and Medicaid Benefits and Services

Contract language requiring coordination with unaffiliated Medicaid managed care plans, the state Medicaid agency, and/or specialized Medicaid benefit contractors[1]

The Medicare Advantage organization is responsible for the coordination of both Medicare and Medicaid benefits, regardless of whether an individual is enrolled with the Medicare Advantage Organization's *[specify "companion" or "affiliated;" use state-specific terms] [Medicaid managed care program]* plan for Medicaid benefits.

- If a D-SNP enrollee is enrolled with the Medicare Advantage organization for both Medicare and Medicaid benefits, the Medicare Advantage organization is responsible for coordinating all benefits covered by both Medicare and *[specify Medicaid program]*.
- If a D-SNP enrollee is enrolled with the Medicare Advantage organization for both Medicare and Medicaid benefits, the Medicare Advantage organization shall utilize Medicare Parts A, B and D data, and Medicaid health care and other data received from *[specify State Medicaid Agency]*, to coordinate all aspects of the enrollee's integrated benefits, including, but not limited to discharge planning, disease management, and care management.
- If a D-SNP enrollee is not enrolled with the Medicare Advantage organization's *[specify "companion" or "affiliated;" use state-specific terms] [Medicaid managed care program]* plan for Medicaid benefits, the Medicare Advantage organization shall coordinate *[specify Medicaid program]* benefits with the enrollee's assigned *[specify Medicaid managed care program]* plan. Coordination of Medicaid benefits is not the enrollee's responsibility.
- If any D-SNP enrollees are enrolled under fee-for-service *[specify Medicaid program]* with *[specify State Medicaid Agency]*, the Medicare Advantage organization shall coordinate benefits directly with *[specify State Medicaid Agency]*, its program representatives or contractors or providers.
- The Medicare Advantage organization shall coordinate *[specify Medicaid program]* benefits with *[specify Medicaid program]* payers responsible for specialized *[specify Medicaid program]* benefit provision to enrollees, including *[specify state-specific dental health plans, non-emergency medical transportation contractors, behavioral health organizations, etc.]*. Coordination of *[indicate specific Medicaid benefits to be coordinated]* shall occur when *[specify necessary and appropriate or indicate state-specific criteria for coordination]*. Coordination of Medicaid benefits is not the enrollee's responsibility.

[1] This language was adapted from the 2020 Arizona Health Care Cost Containment System (AHCCCS) Medicare Advantage Organization Agreement, available at: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/medicareagreements.html.

Contract language describing coordination in D-SNPs with integrated benefits and exclusively aligned enrollment [2]

The Medicare Advantage organization is responsible for the coordination of both Medicare and Medicaid integrated benefits within a single managed care organization. The Medicare Advantage organization shall be responsible for coordinating all services required by the enrollee, including any Medicaid benefits that are carved out of the capitated contract but provided under the *[specify Medicaid program]* State Plan, Waiver Programs, Medicare Part C, Medicare Part D, or other medically or socially necessary community services, as identified in the enrollee's Plan of Care. The Medicare Advantage organization shall use Medicare Parts A, B and D data, and *[specify Medicaid program]* health care and other data received from *[specify State Medicaid Agency]*, to coordinate all aspects of the enrollee's integrated benefits, including, but not limited to discharge planning, disease management, and care management.

- The Medicare Advantage organization shall assign a D-SNP care coordinator who is responsible for ensuring integrated Medicare-Medicaid benefits are coordinated. Coordination of Medicare and/or Medicaid benefits is not the enrollee's responsibility.
- The Medicare Advantage organization shall have a process to share Health Risk Assessment or other key data with the enrollee's primary care or specialty providers and with relevant *[specify Medicaid program]* case managers, contractors, or providers where information can inform shared care plan development.
- The Medicare Advantage organization shall ensure care coordination works to support seamless care transitions, integrated care planning, and strategies to reduce unnecessary hospitalizations.

Medicaid Benefits Covered by the D-SNP

Contract language for D-SNPs that provide comprehensive and fully integrated coverage of Medicare and Medicaid benefits [3]

For all eligible enrollees, the Contractor shall provide or arrange to have provided comprehensive, preventive, and diagnostic and therapeutic, health, behavioral health and LTSS services to enrollees that include all services that beneficiaries are entitled to receive under *[specify Medicaid program]*, subject to any limitations and/or excluded services as specified in *[specify relevant contract section(s) describing benefit limitations/exclusions]*.

Provision of these services shall be equal in amount, duration, and scope as established by *[specify Medicaid program]*, in accordance with medical necessity and without any predetermined limits, unless specifically stated, and shall be provided as set forth in 42 C.F.R. Parts 440; 434, and 438; the Medicaid State Plan; *[specify references to state statutes/regulations, policy manuals, and other documents describing Medicaid policy within the state]*; and all applicable federal and State statutes, rules, and regulations, including *[specify references to relevant statutory and/or regulatory guidance]*.

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[2] This language was adapted from the 2020 New Jersey Department of Human Services Division of Medical Assistance and Health Services FIDE SNP contract (not available online) and the 2019 Oregon D-SNP Coordination of Benefits contract (not available online).

[3] This language was adapted from the 2020 New Jersey Department of Human Services Division of Medical Assistance and Health Services FIDE SNP contract (not available online) and the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services.

All covered benefits, except for *[specify exceptions]* and services mandated by state or federal law, are subject to determination of medical necessity by the Contractor, as defined in *[specify appropriate statutory and/or regulatory reference(s)]*.

Consistent with 42 CFR §438.206(b)(4), if the Contractor's provider network is unable to provide necessary medical services covered under the Contract to a particular enrollee, the Contractor must adequately and timely cover these services out of network for the enrollee.

Except as otherwise provided under this Contract, or otherwise mandated by state or federal law, all health care services prescribed or recommended by a network physician, dentist, care manager, or other practitioner, or approved by the Contractor, are limited to services covered under Medicare or *[specify State Medicaid program]*.

Contract Period

Contract language for states that wish to use "evergreen" contracts with D-SNPs beginning January 1, 2021 [4]

The performance, duties, and obligations of the parties hereto shall commence on the effective date, provided that at the effective date the *[specify state Medicaid agency]* and the Contractor agree that all procedures necessary to implement this contract are ready and shall continue for a period of twelve (12) months thereafter unless suspended or terminated in accordance with the provisions of this contract. The initial twelve (12) month period shall be known as the "original term" of the contract. The effective date of the contract shall be [*January 1, 2021 or other future effective date, as applicable*].

The contract may be amended, extended, or modified by written contract duly executed by *[specify state Medicaid agency]* and the Contractor. Any such amendment, extension or modification shall be in writing and executed by the parties hereto. It is mutually understood and agreed that no amendment of the terms of the contract shall be valid unless reduced to writing and executed by the parties hereto, and that no oral understandings, representations or contracts not incorporated herein nor any oral alteration or variations of the terms hereof, shall be binding on the parties hereto. Every such amendment, extension, or modification shall specify the date its provisions shall be effective as agreed to by the Department and the Contractor. Any amendment, extension, or modification is not effective or binding unless approved, in writing, by duly authorized officials of *[specify state Medicaid agency]*, CMS, and any other entity, as required by law or regulation. *[Specify state Medicaid agency]* shall provide the Contractor with advanced notice of changes or amendments unless the changes are due to a change in law, including budget appropriation, or regulation, and it is not possible to provide such notice.

This contract may be extended for successive twelve (12) month periods beyond the original term of the contract whenever *[specify state Medicaid agency]* supplies the Contractor with at least *[specify appropriate time period]* advance notice of such intent and if a written amendment to extend the contract is obtained from both parties. This successive twelve (12) month period shall be known as an "extension period" of the contract. In addition,

[4] This language was adapted from the 2020 New Jersey Department of Human Services Division of Medical Assistance and Health Services FIDE SNP contract (not available online).

[specify appropriate time period] prior to the contract expiration, *[specify state Medicaid agency]* shall provide the Contractor with the proposed capitation rates for the extension period.

In the event that the capitation rates for the extension period are not provided *[specify time period]* prior to the contract expiration, the contract will be extended at the existing rate which shall be an interim rate. After the execution of the succeeding rate amendment, a retroactive rate adjustment will be made to bring the interim rate to the level established by that amendment.

Nothing in this Article shall be construed to prevent *[specify state Medicaid agency]* by amendment to the contract from extending the contract on a month-to-month basis under the existing rates until such a time that *[specify state Medicaid agency]* provides revised capitation rates.

Appendix B: Categories of Dually Eligible Individuals and Service Areas Covered Under Each PBP

To help states identify and document which categories of dually eligible individuals and service areas are covered under each PBP included in the SMAC, states can add a table to their SMACs with this information. This appendix provides an example of how states could structure such a table. For each PBP that is included in the contract, the state and contractor would provide information on each of the following elements. The state would add or remove rows based on the number of PBPs covered under the SMAC.

PBP #	Please select which categories of dually eligible individuals will be allowed to enroll in each PBP.	Please specify which counties in the state each PBP will serve.
PBP 001	___ Qualified Medicare beneficiaries (QMB) ___ QMB-Plus ___ Specified Low-Income Medicare beneficiaries (SLMB) ___ SLMB-Plus ___ Qualifying individuals ___ Qualified disabled and working individuals (QDWI) ___ Other full benefit dually eligible individuals	*[List all counties in state for the D-SNP to select or have the D-SNP list counties to be served].*
PBP 002	___ Qualified Medicare beneficiaries (QMB) ___ QMB-Plus ___ Specified Low-Income Medicare beneficiaries (SLMB) ___ SLMB-Plus ___ Qualifying individuals ___ Qualified disabled and working individuals (QDWI) ___ Other full benefit dually eligible individuals	*[List all counties in state for the D-SNP to select or have the D-SNP list counties to be served].*