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 Certain 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 levels of integration for 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). FIDE SNPs must operate with exclusively aligned enrollment[1] and cover Medicare cost sharing; Medicaid behavioral health

ABOUT THIS TOOL

This technical assistance tool is the second 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 *required* SMAC sample language applicable to certain types of D-SNPs, such as applicable integrated plans (AIPs). All four of the technical assistance tools in this series are available on the ICRC website. Use of the 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.

services; home health services and medical supplies, equipment, and appliances; in addition to covering Medicaid primary and acute care services and LTSS.[2]

- **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. 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 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 FIDE SNP, (2) a HIDE SNP that operates with exclusively aligned enrollment, or (3) 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). D-SNPs with the AIP designation 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.

This technical assistance tool contains four tables with sample state Medicaid agency contract (SMAC) language designed to comply with the federal requirements applicable to: (1) CO D-SNPs that enroll full-benefit dually eligible individuals; (2) FIDE SNPs; HIDE SNPs; and (4) AIPs. The sample contract language has generally been derived or adapted from existing state D-SNP contracts, with ICRC editing for clarity and conciseness. applicable to all types of D-SNPs. States can consider using this sample language in their SMACs to advance their care coordination, eligibility and enrollment, data reporting, and communication and marketing goals:

- **Table 1, which begins on page 4,** provides language that can be used to meet the information sharing requirements for CO D-SNPs.
- **Table 2**, **which begins on page 7**, provides language that can be used in SMACs with D-SNPs that seek to qualify as FIDE SNPs.
- **Table 3**, **which begins on page 16**, provides language that can be used in SMACs with D-SNPs that seek to qualify as HIDE SNPs.
- **Table 4**, **which begins on page 20**, provides language that can be used in SMACs with any D-SNPs that seek to qualify as AIPs.

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 1: Required Language Applicable to All 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 the Additional Contract Element Required to Qualify As a CO D-SNP

D-SNPs that do not qualify as FIDE SNPs or HIDE SNPs (that is, CO D-SNPs) and enroll full-benefit dually eligible individuals need to have at least one additional contract element in their SMACs beyond the elements described in the first TA tool in this series on minimum required elements for all D-SNP SMACs. Specifically, CO D-SNPs will need to have language in their SMACs that specifies the process(es) those D-SNPs will use to share information about hospital and skilled nursing facility (SNF) admissions with the state (or the state's designee) for a designated group of high risk, full-benefit dually eligible individuals. States that contract with FIDE SNPs, HIDE SNPs, and AIPs can also use this language in their SMACs to support information-sharing and care coordination goals. Table 1 provides more detailed information about this requirement and sample contract language that states can use to address it in their SMACs with CO D-SNPs.

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.**

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
Requiring D-SNPs to share information about hospital and SNF admissions with the state or the state's designee *(Required for D-SNPs that enroll full-benefit dually eligible individuals and do not qualify for designation as a FIDE SNP or a HIDE SNP)*	"(d) *Additional minimum contract requirement*. For any dual eligible special needs plan that is not a fully integrated or highly integrated dual eligible special needs plan, except as specified in paragraph (d)(2) of this section, the contract must also stipulate that, for the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the SNP notifies, or arranges for another entity or entities to notify, the State Medicaid agency, individuals or entities designated by the State Medicaid agency, or both, of hospital and skilled nursing facility admissions for at	The SMAC must describe the process whereby the Medicare Advantage organization offering the D-SNP notifies, or arranges for another entity or entities to notify, the state Medicaid agency, individuals or entities designated by the state Medicaid agency, or both, of hospital and SNF admissions for at least one group of high-risk, full-benefit dually eligible individuals, identified by the state Medicaid agency. The SMAC must describe the timeframe and methods by which such notice is provided, and the criteria for identifying the high-risk full-benefit dually eligible individuals for whom the notice is provided. The SMAC must describe the specific information-sharing process as described	For all *[D-SNP]* enrollees *[in specified Medicaid health home/HCBS waiver/behavioral health MCO/MLTSS plan, with specified diagnosis(es), etc.—use state-specific terms, include all that apply]*, the Contractor shall provide timely notification of all admissions to a hospital and skilled nursing facility (SNF) to *[specify whether notification should be sent to the state Medicaid agency or to a designee, such as the enrollee's Medicaid health home/HCBS waiver case manager/behavioral health MCO/MLTSS plan, etc.—use state-specific terms, include all that apply]*. Timely notification is defined as *[insert specifications for timeliness; see examples below]*. Notification shall be sent by *[specify method(s) to be used for delivery of notifications, including references to any policy manuals or other documents wherein the state may provide detailed guidance for the variables and values to be used within files shared; see examples of sample language for notification methods below]*. **Sample language regarding specification of method to identify the population of high-risk, full-benefit dually eligible individuals for whom notification is required:** To ensure proper and timely identification of all plan enrollees meeting the criteria specified in *[reference to section of contract designating population for*

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
	least one group of high-risk full-benefit dual eligible individuals, identified by the State Medicaid agency. The State Medicaid agency must establish the timeframe(s) and method(s) by which notice is provided. In the event that a SNP authorizes another entity or entities to perform this notification, the SNP must retain responsibility for complying with the requirement in this paragraph(d)(1)." (42 CFR §422.107[d][1]) "(2) For a dual eligible special needs plan that, under the terms of its contract with the State Medicaid agency, only enrolls beneficiaries who are not entitled to full medical assistance under a State plan under title XIX of the Act, paragraph (d)(1) of this section does not apply if the SNP operates under the same parent organization and in the same service area as a dual eligible special needs plan limited to beneficiaries with full medical assistance under a State plan under title XIX of the Act that meets the requirements at paragraph (d)(1) of this section." (42 CFR §422.107[d][2])	above. The SMAC may not defer to a "to-be-determined" or other non-specific process. This requirement does not apply to CO D-SNPs that: (1) only enroll partial-benefit dually eligible individuals; and (2) operate under the same parent organization and in the same service area as a D-SNP that meets this requirement and only enrolls full-benefit dually eligible individuals.	*notifications]*, the Contractor will *[specify method for identifying enrollees meeting the state's specified criteria, such as a review a file shared by the state, or extract data from a state Medicaid enrollment database]* on a *[specify frequency]* basis, in accordance with *[specify any instructions or guidance provided elsewhere]*. **Sample language regarding timeliness and notification method for states/D-SNPs using Health Information Exchange technology:** "Timely notification" is defined as any real-time notification provided by the Contractor or its contracted hospitals and skilled nursing facilities via Health Information Technology (HIT) or Health Information Exchange (HIE) or, where notification via HIT or HIE is not provided, via direct communication from the Contractor within *[specify x hours/days]* of the Contractor becoming aware of such admission. **Sample language regarding timeliness and notification method for states/D-SNPs using file sharing methods:** "Timely notification" is defined as daily, automated file exchange. Every day, seven days a week, prior to *[specify time of day/close of business/other specification]*, the Contractor will upload a *[specify file type]* file to *[specify server]*. The file shall be organized and populated in accordance with the template provided by *[specify state Medicaid agency]* and designate which of the Contractor's plan enrollees who meet the criteria specified in *[specify section of contract designating population for notifications]* have experienced a hospital or SNF admission in the prior 24-hour period. **Sample language regarding timeliness and notification method for states/D-SNPs using manual, direct communication methods:** "Timely notification" is defined as *[fax/email/telephone/other form of manual communication]* communication initiated within *[specify timeframe, such as 24 hours, 48 hours]* of the time upon which the D-SNP becomes aware that an enrollee who meets the criteria specified in *[reference to section of contract designating population for notifications]* has experienced a hospital or SNF admission. To facilitate this communication, on a *[specify frequency]* basis, *[specify state Medicaid agency]* will provide an updated list of contacts at *[specify receiving entity(ies) – HCBS care management providers, Medicaid*

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
			managed care plans, etc.] to whom the Contractor should send these notifications. **Sample language for when a D-SNP delegates responsibility for notification to its contracted hospitals and SNFs:** The Contractor shall require its contracted hospitals and SNFs to meet the notification requirements on admissions as specified in this Contract. The Contractor retains responsibility for compliance with the notification requirements in this Contract.

Table 2: Sample Language for Additional Contract Elements Required for FIDE SNPs

FIDE SNPs need to have additional contract elements in their SMACs (beyond the elements described in the first TA tool in this series on minimum required elements for all D-SNP SMACs) to demonstrate that they meet the qualifications for a FIDE SNP designation from CMS. For example, to qualify as a FIDE SNP, D-SNPs must have language in their SMACs that shows that they cover certain Medicaid benefits and meet additional requirements for administrative alignment. Table 2 provides more detail on these requirements and sample contract language that states can use to address them.

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.**

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
FIDE SNP Identification and Ownership Sample Language			
Requiring D-SNPs to identify the single entity that holds the Medicare Advantage contract with CMS and the Medicaid managed care contract with the state for purposes of FIDE SNP designation	*"Fully integrated dual eligible special needs plan* means a dual eligible special needs plan— (1) That provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Act with the applicable State…" (42 CFR §422.2)	If a D-SNP seeks FIDE SNP designation by CMS, the SMAC will need to clearly state that a single legal entity holds both: (1) the Medicare Advantage contract with CMS; and (2) the contract with the state Medicaid agency for coverage of required Medicaid services, including: (a) Medicaid primary and acute care and (b) LTSS, including coverage of nursing facilities for a period of at least 180 days during the plan year. Starting in 2025, the contract will also need to clearly show that the legal entity is also responsible for coverage of Medicare cost-sharing and Medicaid behavioral health services, home health services, and medical supplies, equipment, and appliances.	**Sample language for states that contract directly with FIDE SNPs to cover Medicaid benefits for FIDE SNP enrollees:** The legal entity holding a Medicare Advantage contract with CMS for the D-SNP(s) named within this Contract receives direct capitation from *[specify state Medicaid agency]* to provide coverage of the Medicaid benefits described in *[specify section of contract that lists Medicaid benefits covered by the D-SNP]* for enrollees in the D-SNP(s) covered under this contract. The legal name of that entity is *[specify name of entity]*. **Sample language for states that contract with Medicaid managed care plans affiliated with FIDE SNPs to cover Medicaid benefits for FIDE SNP enrollees:** The legal name of the entity that holds a contract with *[specify state Medicaid agency]* for coverage of the Medicaid benefits described in *[specify section of the contract that lists Medicaid benefits covered by the D-SNP]* is: *[specify name of entity - have D-SNP contractors specify the exact legal name of the entity responsible for coverage of Medicaid benefits]*. This entity is: ☐ The same legal entity as the entity that holds the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this Contract. *(This box must be selected for FIDE SNP designation; it may be selected for*

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
		As part of the Medicare Advantage contracting process, CMS asks the Medicare Advantage organization to provide the exact legal name of the Medicaid managed care plan for purposes of FIDE SNP designation.	*HIDE SNP designation.)* The Contractor shall provide documentation to the State and to CMS that demonstrates that the entity responsible for coverage of the Medicaid benefits described within this Contract is the same legal entity as the entity holding the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this Contract. ☐ A separate legal entity owned and controlled by the same parent organization as the entity that holds the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this Contract. *(This box may be selected for HIDE SNP designation.)* The Contractor shall provide documentation to the State and to CMS that demonstrates that the entity responsible for coverage of the Medicaid benefits described within this Contract is owned and controlled by the same parent organization as the entity holding the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this Contract.
FIDE SNP Coverage of Medicaid Benefits and Medicare Cost Sharing Sample Language			
Requiring FIDE SNPs to cover Medicaid primary care and acute care services	"Fully integrated dual eligible special needs plan means a dual eligible special needs plan—... (2) Whose capitated contract with the State Medicaid agency requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a fully integrated dual eligible special needs plan (FIDE SNP) in the State, except as approved by CMS under §422.107(g) and (h): (i) **Primary care and acute care**, and for plan year 2025 and subsequent years including	If a D-SNP seeks FIDE SNP designation by CMS, the SMAC will need to clearly show that the legal entity holding the Medicare Advantage contract with CMS covers Medicaid primary and acute care services.	The Contractor shall provide the following *[specify state Medicaid program]* Medicaid primary and acute care services when medically necessary and appropriate: *[State must provide a list of all Medicaid primary and acute care services to be covered by the contractor]*. These benefits will be covered *[insert one of the following: (1) directly by the D-SNP or (2) by the D-SNP's affiliated Medicaid managed care plan, which is part of the same legal entity as the D-SNP]*. **Sample language for contracts in which the Medicare Advantage organization offering the FIDE SNP receives direct capitation from the state for coverage of Medicaid primary care and acute care services:** Except as noted in *[specify section describing exceptions to payment schedule]*, on *[specify day of month or other identification of periodicity for payments]*, *[specify state Medicaid agency]* agrees to pay the Contractor capitated monthly rates calculated as specified in *[specify contract appendix or other source where state describes rates and rate-setting methodology]*, per Enrollee enrolled with the Contractor as full compensation for *[specify state Medicaid program]* Medicaid primary care and acute care services provided hereunder in that month, under this Contract. The *[specify name of Medicaid primary care and acute care services rate*

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
	Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries;…" (42 CFR §422.2)		*cell]* includes the following components, which are adjusted for *[specify demographic characteristics used for risk adjustment]*: *[specify components included in rate]*. Enrollees who meet the following conditions will be assigned to the *[specify name of Medicaid primary care and acute care services rate cell]*: *[specify conditions]*. Assignment of rate cells *[specify "may" or "shall"]* be based on *[specify data sources to be used to assign enrollees to rate cells]*. Rate cell categories shall be assigned prospectively for the next available month. *[Repeat/customize language for all capitated rate rates associated with the contract]*.[4]
Requiring FIDE SNPs to cover Medicare cost sharing *(Required for FIDE SNPs starting in 2025)*	"Fully integrated dual eligible special needs plan means a dual eligible special needs plan—… (2) Whose capitated contract with the State Medicaid agency requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a fully integrated dual eligible special needs plan (FIDE SNP) in the State, except as approved by CMS under §422.107(g) and (h): (i) Primary care and acute care, and for plan year 2025 and subsequent years including **Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries;…**" (42 CFR §422.2)	If a D-SNP seeks FIDE SNP designation by CMS, the SMAC will need to clearly show that the legal entity holding the Medicare Advantage contract with CMS covers Medicare cost sharing. More information and sample language on cost sharing is available in ICRC's TA tool: Sample Language for State Medicaid Agency Contracts with D-SNPs: Required Language for All D-SNPs.	The Contractor is responsible for covering all Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) for all D-SNP enrollees. These cost-sharing benefits will be covered *[insert one of the following: (1) directly by the D-SNP or (2) by the D-SNP's affiliated Medicaid managed care plan, which is part of the same legal entity as the D-SNP]*. **Sample language for contracts in which the Medicare Advantage organization offering the FIDE SNP receives direct capitation from the state for coverage of Medicare cost sharing:** Except as noted in *[specify section describing exceptions to payment schedule]*, on *[specify day of month or other identification of periodicity for payments]*, *[specify state Medicaid agency]* agrees to pay the Contractor capitated monthly rates calculated as specified in *[specify contract appendix or other source where state describes rates and rate-setting methodology]*, per Enrollee enrolled with the Contractor as full compensation for *[specify state Medicaid program]* Medicare cost sharing provided hereunder in that month, under this Contract. The *[specify name of the Medicare cost-sharing rate cell]* includes the following components, which are adjusted for *[specify demographic characteristics used for risk adjustment]*: *[specify components included in rate]*. Enrollees in the following categories will be assigned to the *[specify name of the Medicare cost-sharing rate cell]*: *[specify categories such as enrollees residing in specific geographic areas, or categories of dual eligibility]*. Assignment of rate cells *[specify "may" or "shall"]* be based on *[specify data sources to be used to assign enrollees to rate cells]*. Rate cell categories shall be assigned prospectively for the next available month.

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
			[Repeat/customize language for all capitated rate rates associated with the contract].[5]
Requiring FIDE SNPs to cover Medicaid LTSS	*"Fully integrated dual eligible special needs plan* means a dual eligible special needs plan—… (2) Whose capitated contract with the State Medicaid agency requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a fully integrated dual eligible special needs plan (FIDE SNP) in the State, except as approved by CMS under §422.107(g) and (h): (ii) **Long-term services and supports, including coverage of nursing facility services for a period of at least 180 days…**" (42 CFR §422.2)	If a D-SNP seeks FIDE SNP designation by CMS, the SMAC will need to clearly show that the legal entity holding the Medicare Advantage contract with CMS covers Medicaid LTSS, including coverage of nursing facilities for a period of at least 180 days during the plan year. Per 42 CFR §422.107(g), a D-SNP can receive CMS approval to qualify as a FIDE SNP even if its contract with the state Medicaid agency has carve-outs of certain LTSS, as long as those carve-outs: "(1) Apply primarily to a minority of the beneficiaries eligible to enroll in the dual eligible special needs plan who use long-term services and supports; or (2) Constitute a small part of the total scope of long-term services and supports provided to the majority of beneficiaries eligible to enroll in the dual eligible special needs plan."	The Contractor shall provide the following *[specify state Medicaid program]* Medicaid LTSS when medically necessary and appropriate: *[State must provide a list of all Medicaid LTSS (including coverage of nursing facilities for a period of at least 180 days during the plan year) to be covered by the contractor]*. These benefits will be covered *[insert one of the following: (1) directly by the D-SNP or (2) by the D-SNP's affiliated Medicaid managed care plan, which is part of the same legal entity as the D-SNP]*. **Sample language for Medicaid LTSS that are not covered by the contract:** Medicaid LTSS that are not covered by this Contract include *[list any Medicaid LTSS that are carved out of the D-SNP contract as allowed under 42 CFR §422.107(g) but covered in fee-for-service Medicaid]. [If applicable, include language describing the entity(ies) responsible for covering the Medicaid LTSS 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 in which the Medicare Advantage organization offering the FIDE SNP receives direct capitation from the state for coverage of Medicaid LTSS:** Except as noted in *[specify section describing exceptions to payment schedule]*, on *[specify day of month or other identification of periodicity for payments]*, *[specify state Medicaid agency]* agrees to pay the Contractor capitated monthly rates calculated as specified in *[specify contract appendix or other source where state describes rates and rate-setting methodology]*, per Enrollee enrolled with the Contractor as full compensation for *[specify state Medicaid program]* Medicaid LTSS provided hereunder in that month, under this Contract. The *[specify name of the Medicaid LTSS rate cell]* rate cell includes the following components, which are adjusted for *[specify demographic characteristics used for risk adjustment]*: *[specify components included in rate]*. Enrollees who meet the

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
			following conditions will be assigned to the *[specify name of the Medicare cost sharing rate cell]*: *[specify conditions]*. Assignment of rate cells *[specify "may" or "shall"]* be based on *[specify data sources to be used to assign enrollees to rate cells]*. Rate cell categories shall be assigned prospectively for the next available month. *[Repeat/customize language for all capitated rate rates associated with the contract]*.[6]
Requiring FIDE SNPs to cover Medicaid behavioral health services *(Required for FIDE SNPs starting in 2025)*	*"Fully integrated dual eligible special needs plan* means a dual eligible special needs plan—… (2) Whose capitated contract with the State Medicaid agency requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a fully integrated dual eligible special needs plan (FIDE SNP) in the State, except as approved by CMS under §422.107(g) and (h): (iii) **For plan year 2025 and subsequent years, behavioral health services;…**" (42 CFR §422.2)	If a D-SNP seeks FIDE SNP designation by CMS, the SMAC will need to clearly show that the legal entity holding the Medicare Advantage contract with CMS covers Medicaid behavioral health services. Per 42 CFR §422.107(h), a D-SNP can receive CMS approval to qualify as a FIDE SNP even if its contract with the state Medicaid agency has carve-outs of certain behavioral health services, as long as those carve-outs: "(1) Apply primarily to a minority of the beneficiaries eligible to enroll in the dual eligible special needs plan who use behavioral health services; or (2) Constitute a small part of the total scope of behavioral health services provided to the majority of beneficiaries eligible to enroll in the dual eligible special needs plan."	The Contractor shall provide the following *[specify state Medicaid program]* Medicaid behavioral health services when medically necessary and appropriate: *[State must provide a list of all Medicaid behavioral health services to be covered by the contractor]*. These benefits will be covered *[insert one of the following: (1) directly by the D-SNP or (2) by the D-SNP's affiliated Medicaid managed care plan, which is part of the same legal entity as the D-SNP]*. **Sample language for Medicaid behavioral health services that are not covered by the contract:** Medicaid behavioral health services that are not covered by this Contract include *[list any Medicaid behavioral health services that are carved out of the D-SNP contract as allowed under 42 CFR §422.107(h) but covered in fee-for-service Medicaid]*. *[If applicable, include language describing the entity(ies) responsible for covering the Medicaid behavioral health 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 in which the Medicare Advantage organization offering the FIDE SNP receives direct capitation from the state for coverage of Medicaid behavioral health services:** Except as noted in *[specify section describing exceptions to payment schedule]*, on *[specify day of month or other identification of periodicity for payments]*, *[specify state Medicaid agency]* agrees to pay the Contractor capitated monthly rates calculated as specified in *[specify contract appendix or other source where state describes rates and rate-setting methodology]*, per Enrollee enrolled with the Contractor as full compensation for *[specify state Medicaid program]* Medicaid

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
			behavioral health services provided hereunder in that month, under this Contract. The *[specify name of the Medicaid behavioral health rate cell]* includes the following components, which are adjusted for *[specify demographic characteristics used for risk adjustment]*: *[specify components included in rate]*. Enrollees who meet the following conditions will be assigned to the *[specify name of the Medicaid behavioral health rate cell]*: *[specify conditions]*. Assignment of rate cells *[specify "may" or "shall"]* be based on *[specify data sources to be used to assign enrollees to rate cells]*. Rate cell categories shall be assigned prospectively for the next available month. *[Repeat/customize language for all capitated rate rates associated with the contract]*.[7]
Requiring FIDE SNPs to cover Medicaid home health services *(Required for FIDE SNPs starting in 2025)*	*"Fully integrated dual eligible special needs plan* means a dual eligible special needs plan—… (2) Whose capitated contract with the State Medicaid agency requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a fully integrated dual eligible special needs plan (FIDE SNP) in the State, except as approved by CMS under §422.107(g) and (h): (iv) **For plan year 2025 and subsequent years, home health services…"** (42 CFR §422.2)	If a D-SNP seeks FIDE SNP designation by CMS, the SMAC will need to clearly show that the legal entity holding the Medicare Advantage contract with CMS covers Medicaid home health services.	The Contractor shall provide the following *[specify state Medicaid program]* Medicaid home health services when medically necessary and appropriate: *[State must provide a list of all Medicaid home health services to be covered by the contractor]*. These benefits will be covered *[insert one of the following: (1) directly by the D-SNP or (2) by the D-SNP's affiliated Medicaid managed care plan, which is part of the same legal entity as the D-SNP]*. **Sample language for contracts in which the Medicare Advantage organization offering the FIDE SNP receives direct capitation from the state for coverage of Medicaid home health services:** Except as noted in *[specify section describing exceptions to payment schedule]*, on *[specify day of month or other identification of periodicity for payments]*, *[specify state Medicaid agency]* agrees to pay the Contractor capitated monthly rates calculated as specified in *[specify contract appendix or other source where state describes rates and rate-setting methodology]*, per Enrollee enrolled with the Contractor as full compensation for *[specify state Medicaid program]* Medicaid home health services provided hereunder in that month, under this Contract. The *[specify name of the Medicaid home health rate cell]* includes the following components, which are adjusted for *[specify demographic characteristics used for risk adjustment]*: *[specify components included in rate]*. Enrollees who meet the following conditions will be assigned to the *[specify name of the Medicaid home health rate cell]*: *[specify conditions]*. Assignment of rate cells *[specify "may" or "shall"]* be based on *[specify data sources to be used to assign enrollees to rate cells]*. Rate cell categories shall be assigned prospectively for the next available

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
			month. *[Repeat/customize language for all capitated rate rates associated with the contract]*.[8]
Requiring FIDE SNPs to cover Medicaid medical supplies, equipment, and appliances *(Required for FIDE SNPs starting in 2025)*	*"Fully integrated dual eligible special needs plan* means a dual eligible special needs plan—… (2) Whose capitated contract with the State Medicaid agency requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a fully integrated dual eligible special needs plan (FIDE SNP) in the State, except as approved by CMS under §422.107(g) and (h): (v) **For plan year 2025 and subsequent years, medical supplies, equipment, and appliances…**" (42 CFR §422.2)	If a D-SNP seeks FIDE SNP designation by CMS, the SMAC will need to clearly show that the legal entity holding the Medicare Advantage contract with CMS covers Medicaid medical supplies, equipment, and appliances.	The Contractor shall provide the following *[specify state Medicaid program]* Medicaid medical supplies, equipment, and appliances when medically necessary and appropriate: *[State must provide a list of all Medicaid medical supplies, equipment, and appliances to be covered by the contractor]*. These benefits will be covered *[insert one of the following: (1) directly by the D-SNP or (2) by the D-SNP's affiliated Medicaid managed care plan, which is part of the same legal entity as the D-SNP]*. **Sample language for contracts in which the Medicare Advantage organization offering the FIDE SNP receives direct capitation from the state for coverage of Medicaid medical supplies, equipment, and appliances:** Except as noted in *[specify section describing exceptions to payment schedule]*, on *[specify day of month or other identification of periodicity for payments]*, *[specify state Medicaid agency]* agrees to pay the Contractor capitated monthly rates calculated as specified in *[specify contract appendix or other source where state describes rates and rate-setting methodology]*, per Enrollee enrolled with the Contractor as full compensation for *[specify state Medicaid program]* Medicaid medical supplies, equipment, and appliances provided hereunder in that month, under this Contract. The *[specify name of the Medicaid medical supplies, equipment, and appliances rate cell]* includes the following components, which are adjusted for *[specify demographic characteristics used for risk adjustment]*: *[specify components included in rate]*. Enrollees who meet the following conditions will be assigned to the *[specify name of the Medicaid medical supplies, equipment, and appliances rate cell]*: *[specify conditions]*. Assignment of rate cells *[specify "may" or "shall"]* be based on *[specify data sources to be used to assign enrollees to rate cells]*. Rate cell categories shall be assigned prospectively for the next available month. *[Repeat/customize language for all capitated rate rates associated with the contract]*.[9]

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
FIDE SNP Care Coordination, Network Management, Beneficiary Experience, and Service Area Sample Language			
Requiring FIDE SNPs to integrate care coordination, network management, and other aspects of the beneficiary experience with the plan	*"Fully integrated dual eligible special needs plan* means a dual eligible special needs plan—… (3) That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and (4) That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement;…." (42 CFR §422.2)	If a D-SNP seeks FIDE SNP designation from CMS, the D-SNP will need to show that it meets the FIDE SNP requirements to use aligned care management and specialty network methods for high-risk beneficiaries. In addition, it will need to employ policies and procedures that coordinate or integrate enrollee communication materials, enrollment, communications, appeals and grievances, and quality improvement. More information on integrated enrollee communication and marketing materials is available in ICRC's TA tool: Sample Language for State Medicaid Agency Contracts with D-SNPs: Optional Language Applicable to All D-SNPs. More information on integrated enrollment is available in ICRC's TA tool: Sample Language for State Medicaid Agency Contracts with D-SNPs: Optional Language Applicable to Certain D-SNPs. More information on unified appeal and grievance language is available in Table 4 of this TA tool. More information on integrated quality improvement for D-SNPs is available in ICRC's TA tool: Tips for States on	**Sample language for coordinating the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries:** The Contractor shall coordinate the delivery of covered Medicare and Medicaid services specified in *[specify section of the contract that lists the Medicare and Medicaid benefits covered by the D-SNP]*, including Medicaid services not covered under this contract specified in *[specify section of the contract describes Medicaid services not covered by the D-SNP, including any services that are carved out of the D-SNP contract as allowed under 42 CFR §422.107(g)-(h) but covered in fee-for-service Medicaid]* using aligned care management and specialty care network methods for high-risk enrollees. High-risk enrollees are defined as *[specify definition of high-risk enrollees as determined by the state, such as enrollees with institutional LTSS needs, multiple chronic conditions, and/or substance use disorder]*. In addition to the care coordination requirements specified in *[specify section(s) of the contract that contain the D-SNP's care coordination requirements]*, aligned care management and specialty care network methods that the Contractor shall implement for high-risk enrollees include, but are not limited to: *[specify methods that D-SNPs must use, such as operating integrated clinic models and creating integrated care teams consisting of nurse practitioners, social workers, registered nurses and/or licensed practical nurses, and licensed behavioral health clinicians who coordinate care across enrollees' Medicare and Medicaid benefits]*.[10] **Sample language for coordinating and/or integrating beneficiary communication materials, enrollment, communications, grievances and appeals, and quality improvement:** The Contractor shall employ policies and procedures to coordinate or integrate the following: • Enrollee communication and marketing materials, including *[specify coordinated/integrated enrollee communication materials and marketing materials requirements, such as integrated provider directories and summary of benefits documents, or specify the section of the contract that contains these requirements]*.

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
		Incorporating D-SNPs into Medicaid Quality Improvement Activities.	• Enrollment, including *[specify coordinated/integrated enrollment requirements, such as processes to effectuate exclusively aligned enrollment and default enrollment, or specify the section of the contract that contains these requirements]*. • Appeals and grievances, including *[specify unified plan-level appeal and grievance requirements as detailed at 42 CFR §422.107(c)(9), or specify the section of the contract that contains these requirements]*. • Quality improvement, including *[specify coordinated/integrated quality improvement requirements, such as integrated Medicaid performance improvement projects (PIP) and Medicare chronic care improvement programs (CCIP), or specify the section of the contract that contains these requirements]*.[11]

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
Requiring FIDE SNPs' capitated contracts with the state Medicaid agency to cover the entire service area of the D-SNP *(Required for FIDE SNPs starting in 2025)*	"*Fully integrated dual eligible special needs plan* means a dual eligible special needs plan—… (6) For plan year 2025 and subsequent years, whose capitated contract with the State Medicaid agency covers the entire service area for the dual eligible special needs plan." (42 CFR §422.2).	Starting in 2025, a FIDE SNP's capitated contract with the state Medicaid agency (for coverage of required Medicaid benefits) must cover the entire service area of the D-SNP. (Note: this means the Medicaid service area can be larger than the FIDE SNP service area).	The legal entity that holds the contract with CMS for the D-SNP(s) offered under this Contract also holds a capitated contract with the State to cover *[specify Medicaid benefits covered]*, and that Medicaid contract covers the entire service area detailed in *[specify section of the SMAC that details the service area covered by the D-SNP(s) covered under the SMAC]*. The Medicaid contract covers *[specify contract appendix or other source that includes the service area that the Medicaid contract covers or specify the counties that the Medicaid contract covers]*. **Additional sample language for states that align D-SNPs with affiliated Medicaid managed care plans that operate within a separate Medicaid managed care program within the state:** Each Medicare Advantage organization offering a D-SNP product(s) must also operate a *[specify Medicaid managed care program]* plan in all Service Areas in which it holds a D-SNP contract. The State shall execute an Agreement only when a Medicare Advantage organization holds a *[specify companion or affiliated; use state-specific terms] [Medicaid managed care program]* contract that covers the entire service area(s) as the D-SNP under this Contract. Each contracted Medicare Advantage organization plan shall have, and assure *[specify state]* it does have, the legal and actual authority to direct, manage, and control the operations of both the corporation operating its D-SNP contract and its *[specify "companion" or "affiliated"] [specify Medicaid managed care program]* contract to the extent necessary to ensure integration of Medicare and Medicaid services for individuals enrolled for both programs.

Table 3: Sample Language for Additional Contract Elements Required for HIDE SNPs

HIDE SNPs also need to have additional contract elements in their SMACs (beyond the elements described in the first TA tool in this series on minimum required elements for all D-SNP SMACs) to demonstrate that they meet the qualifications for a HIDE SNP designation from CMS. For example, to qualify as a HIDE SNP, D-SNPs must have language in their SMACs that shows that they cover LTSS and/or behavioral health services. Table 3 provides more detail on these requirements and sample contract language that states can use to address them.

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.**

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
HIDE SNP identification and ownership sample language			
Requiring D-SNPs to identify their ownership of and/or affiliation with a Medicaid managed care plan for purposes of HIDE SNP designation	*"Highly integrated dual eligible special needs plan* means a dual eligible special needs plan offered by an MA organization that provides coverage of Medicaid benefits under a capitated contract that meets the following requirements— (1) The capitated contract is between the State Medicaid agency and— (i) The MA organization; or (2) The MA organization's parent organization, or another entity that is owned and controlled by its parent organization;…" (42 CFR §422.2)	If a D-SNP seeks HIDE SNP designation by CMS, the SMAC will need to clearly identify the entity that holds a contract with the state to cover Medicaid LTSS, behavioral health benefits, or both for D-SNP enrollees, as well as the relationship between the D-SNP and the organization that holds that Medicaid contract—whether the Medicaid contract is held by the D-SNP, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization. As part of the Medicare Advantage contracting process, CMS asks the Medicare Advantage organization to provide the exact legal name of the Medicaid managed care plan for purposes of HIDE SNP designation.	**Sample language for states that contract directly with HIDE SNPs to cover Medicaid benefits for HIDE SNP enrollees:** The legal entity holding a Medicare Advantage contract with CMS for the D-SNP(s) named within this Contract receives direct capitation from *[specify state Medicaid agency]* to provide coverage of the Medicaid benefits described in *[specify section of contract that lists Medicaid benefits covered by the D-SNP]* for enrollees in the D-SNP(s) covered under this contract. The legal name of that entity is *[specify name of entity]*. **Sample language for states that contract with Medicaid managed care plans affiliated with HIDE SNPs to cover Medicaid benefits for HIDE SNP enrollees:** The legal name of the entity that holds a contract with *[specify state Medicaid agency]* for coverage of the Medicaid benefits described in *[specify section of contract that lists Medicaid benefits covered by the D-SNP]* is: *[specify name of entity - have D-SNP contractors specify the exact legal name of the entity responsible for coverage of Medicaid benefits].* This entity is: ☐ The same legal entity as the entity that holds the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this contract. *(This box must be selected for FIDE SNP designation; it may be selected for HIDE SNP designation.)* The Contractor shall provide documentation to

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
			the State and to CMS that demonstrates that the entity responsible for coverage of the Medicaid benefits described within this contract is the same legal entity as the entity holding the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this Contract. ☐ A separate legal entity owned and controlled by the same parent organization as the entity that holds the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this contract. *(This box may be selected for HIDE SNP designation.)* The Contractor shall provide documentation to the State and to CMS that demonstrates that the entity responsible for coverage of the Medicaid benefits described within this contract is owned and controlled by the same parent organization as the entity holding the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this Contract.
HIDE SNP Coverage of Medicaid LTSS and/or Behavioral Health Sample Language			
Requiring HIDE SNPs to cover Medicaid LTSS	*"Highly integrated dual eligible special needs plan* means a dual eligible special needs plan offered by an MA organization that provides coverage of Medicaid benefits under a capitated contract that meets the following requirements—… (2) The capitated contract requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a highly integrated dual eligible special needs plan (HIDE SNP) in the State, except as approved by CMS under §422.107(g) or (h): (i) **Long-term services and**	If a D-SNP seeks HIDE SNP designation by CMS, the D-SNP contract will need to clearly show that it provides coverage of Medicaid LTSS and/or Medicaid behavioral health services under a capitated contract with the state Medicaid agency. The capitated contract with the state Medicaid agency may be executed directly with the D-SNP, with the D-SNP's parent organization, or with another entity that is owned and controlled by the D-SNP's parent organization. As a reminder, HIDE SNPs are required to cover Medicaid LTSS or behavioral health services, but are not required to cover both.	The Contractor shall provide the following *[specify state Medicaid program]* Medicaid LTSS services when medically necessary and appropriate: *[State must provide a list of all Medicaid LTSS, including community-based long-term services and supports and some days of coverage of nursing facility services during the plan year, to be covered by the Contractor, the Contractor's parent organization, or another entity that is owned and controlled by the Contractor's parent organization]*. These benefits will be covered *[insert one of the following: (1) directly by the D-SNP or (2) by the D-SNP's affiliated Medicaid managed care plan]*. **Sample language for Medicaid LTSS that are not covered by the contract:** Medicaid LTSS that are not covered by this Contract include *[list any Medicaid LTSS that are carved out of the D-SNP contract as allowed under 42 CFR §422.107(g) but covered in fee-for-service Medicaid]*. *[If applicable, include language describing the entity(ies) responsible for covering the Medicaid LTSS 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).

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
	supports, including community-based long-term services and supports and some days of coverage of nursing facility services during the plan year; or (ii) Behavioral health services;…" (42 CFR §422.2)	Per 42 CFR §422.107(g), a D-SNP can receive CMS approval to qualify as a HIDE SNP even if its contract with the state Medicaid agency has carve-outs of certain LTSS, as long as those carve-outs: "(1) Apply primarily to a minority of the beneficiaries eligible to enroll in the dual eligible special needs plan who use long-term services and supports; or (2) Constitute a small part of the total scope of long-term services and supports provided to the majority of beneficiaries eligible to enroll in the dual eligible special needs plan."	**Sample language for contracts in which the Medicare Advantage organization offering the HIDE SNP receives direct capitation from the state for coverage of Medicaid LTSS:** Except as noted in *[specify section describing exceptions to payment schedule]*, on *[specify day of month or other identification of periodicity for payments]*, *[specify state Medicaid agency]* agrees to pay the Contractor capitated monthly rates calculated as specified in *[specify contract appendix or other source where state describes rates and rate-setting methodology]*, per Enrollee enrolled with the Contractor as full compensation for *[specify state Medicaid program]* Medicaid LTSS provided hereunder in that month, under this Contract. The *[specify name of the Medicaid LTSS rate cell]* rate cell includes the following components, which are adjusted for *[specify demographic characteristics used for risk adjustment]*: *[specify components included in rate]*. Enrollees who meet the following conditions will be assigned to the *[specify name of the Medicaid LTSS rate cell]*: *[specify conditions]*. Assignment of rate cells *[specify "may" or "shall"]* be based on *[specify data sources to be used to assign enrollees to rate cells]*. Rate cell categories shall be assigned prospectively for the next available month. *[Repeat/customize language for all capitated rate rates associated with the contract]*.[12]
Requiring HIDE SNPs to cover Medicaid behavioral health services	*"Highly integrated dual eligible special needs plan* means a dual eligible special needs plan offered by an MA organization that provides coverage of Medicaid benefits under a capitated contract that meets the following requirements—… (2) The capitated contract requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a	If a D-SNP seeks HIDE SNP designation by CMS, the D-SNP contract will need to clearly show that it provides coverage of Medicaid LTSS and/or Medicaid behavioral health services under a capitated contract with the state Medicaid agency. The capitated contract with the state Medicaid agency may be executed directly with the D-SNP, with the D-SNP's parent organization, or with another entity that is owned and controlled by the D-SNP's parent organization.	The Contractor shall provide the following *[specify state Medicaid program]* Medicaid behavioral health services when medically necessary and appropriate: *[State must provide a list of all Medicaid behavioral health services to be covered by the Contractor, the Contractor's parent organization, or another entity that is owned and controlled by the Contractor's parent organization].* These benefits will be covered *[insert one of the following: (1) directly by the D-SNP or (2) by the D-SNP's affiliated Medicaid managed care plan]*. **Sample language for Medicaid behavioral health services that are not covered by the contract:** Medicaid behavioral health services that are not covered by this Contract include *[list any Medicaid behavioral health services that are carved out of the D-SNP contract as allowed under 42 CFR §422.107(h) but covered in fee-for-service Medicaid]. [If applicable, include language describing the entity(ies) responsible for*

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
	highly integrated dual eligible special needs plan (HIDE SNP) in the State, except as approved by CMS under §422.107(g) or (h): (i) Long-term services and supports, including community-based long-term services and supports and some days of coverage of nursing facility services during the plan year; or (ii) **Behavioral health services**…" (42 CFR §422.2)	As a reminder, HIDE SNPs are required to cover Medicaid LTSS or behavioral health services, but are not required to cover both. Per 42 CFR §422.107(h), a D-SNP can receive CMS approval to qualify as a HIDE SNP even if its contract with the state Medicaid agency has carve-outs of certain behavioral health services, as long as those carve-outs: "(1) Apply primarily to a minority of the beneficiaries eligible to enroll in the dual eligible special needs plan who use behavioral health services; or (2) Constitute a small part of the total scope of behavioral health services provided to the majority of beneficiaries eligible to enroll in the dual eligible special needs plan."	*covering the Medicaid behavioral health 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 in which the Medicare Advantage organization offering the HIDE SNP receives direct capitation from the state for coverage of Medicaid behavioral health services:** Except as noted in *[specify section describing exceptions to payment schedule]*, on *[specify day of month or other identification of periodicity for payments]*, *[specify state Medicaid agency]* agrees to pay the Contractor capitated monthly rates calculated as specified in *[specify contract appendix or other source where state describes rates and rate-setting methodology]*, per Enrollee enrolled with the Contractor as full compensation for *[specify state Medicaid program]* Medicaid behavioral health services provided hereunder in that month, under this Contract. The *[specify name of the Medicaid behavioral health rate cell]* includes the following components, which are adjusted for *[specify demographic characteristics used for risk adjustment]*: *[specify components included in rate]*. Enrollees who meet the following conditions will be assigned to the *[specify name of the Medicaid behavioral health rate cell]*: *[specify conditions]*. Assignment of rate cells *[specify "may" or "shall"]* be based on *[specify data sources to be used to assign enrollees to rate cells]*. Rate cell categories shall be assigned prospectively for the next available month. *[Repeat/customize language for all capitated rate rates associated with the contract]*.[13]

Table 4: Sample Language for Additional Contract Elements Required for AIP D-SNPs

FIDE SNPs, HIDE SNPs, and CO D-SNPs designated as AIPs also need to have additional elements in their SMACs (beyond the elements described in the first TA tool in this series on minimum required elements for all D-SNP SMACs) to demonstrate that they meet the qualifications for AIP designation from CMS. For example, to qualify as an AIP, D-SNPs must have language in their SMACs that shows that the D-SNP must maintain exclusively aligned enrollment and implement unified grievance and appeal procedures in compliance with 42 CFR §§422.629 – 422.634. Table 4 provides more detail on these requirements and sample contract language that states can use to address them.

In the sample contract language provided, **italicized text in brackets [ ] is used to convey instructions and situations in which the state will need to insert state-specific information.**

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
Requiring D-SNPs to maintain exclusively aligned enrollment *(Required for D-SNPs designated as AIPs; will also be required of FIDE SNPs starting in 2025)*	"*Applicable integrated plan* means… (2) On or after January 1, 2023. (i)(A) A fully integrated dual eligible special needs plan or highly integrated dual eligible special needs plan with **exclusively aligned enrollment**; and (B) The Medicaid managed care organization, as defined in section 1903(m) of the Act, through which such dual eligible special needs plan, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such dual eligible special needs plan and such Medicaid managed care organization; or (ii) A dual eligible special needs plan and affiliated Medicaid managed care plan where—(A) The dual special needs plan, by State policy, **has enrollment limited to those beneficiaries enrolled in a Medicaid**	Exclusively aligned enrollment is required for: (1) AIPs and (2) FIDE SNPs starting in 2025. Exclusively aligned enrollment occurs when the state contract limits enrollment in the D-SNP to full-benefit dually eligible individuals who receive their Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the same parent company as the D-SNP. More information on exclusively aligned enrollment is available on ICRC's website.	**Sample language for contracts with D-SNPs required to operate with exclusively aligned enrollment**: The Contractor agrees to conduct enrollment of Eligible Persons in accordance with the policies and procedures set forth in this Contract and maintain exclusively aligned enrollment for the duration of the contract period. **Sample language for contracts in which D-SNPs cover Medicaid benefits, and Medicaid enrollment is automatic as a result of D-SNP enrollment:** An Eligible Person's decision to enroll in the Contractor's D-SNP shall be voluntary. However, selection of the D-SNP for Medicare benefits initiates enrollment into the D-SNP for Medicaid benefits, as well. To complete enrollment in the D-SNP, *[specify state Medicaid agency]* shall auto-assign the Enrollee to the Contractor's D-SNP for the purpose of receiving Medicaid benefits and services. An Enrollee's effective date of enrollment shall be the first day of the month in which the Enrollee's name appears on the *[specify name of enrollment file]* and is enrolled in the Contractor's D-SNP product for that month.

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
	managed care organization as described in paragraph (2)(ii)(B) of this definition; (B) There is a capitated contract between the MA organization, the MA organization's parent organization, or another entity that is owned and controlled by its parent organization; and (1) A Medicaid agency; or (2) A Medicaid managed care organization as defined in section 1903(m) of the Act that contracts with the Medicaid agency; and (C) Through the capitated contract described in paragraph (2)(ii)(B) of this definition, Medicaid benefits including primary care and acute care, including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries, and at a minimum, one of the following: Home health services as defined in § 440.70 of this chapter, medical supplies, equipment, and appliances as described in § 440.70(b)(3) of this chapter, or nursing facility services are covered for the enrollees." (42 CFR §422.561) "*Fully integrated dual eligible special needs plan* means a dual eligible special needs plan—… (5) For plan year 2025 and subsequent years, that has exclusively aligned enrollment;…" (42 CFR §422.2).		To notify the state of new D-SNP enrollment and initiate D-SNP enrollment for Medicaid benefits, the Contractor shall submit *[specify mechanism, format, and frequency for sharing enrollment files with state]*.[14] **Sample language for contracts in which Medicaid benefits are provided by an entity operated by the same parent organization as the D-SNP and the state initiates Medicaid auto-assignment based on D-SNP enrollment:** An Eligible Person's decision to enroll in the Contractor's D-SNP shall be voluntary. However, as a condition of eligibility for the D-SNP, individuals may only enroll in the Contractor's D-SNP if they also simultaneously agree to enroll in the Contractor's *[specify Medicaid managed care program name] [plan/organization/entity/product]* as defined in this Contract. An Enrollee's effective date of enrollment shall be the first day of the month in which the Enrollee's name appears on the *[specify name of enrollment file]* and is enrolled in the Contractor's D-SNP for that month. To notify the state of new D-SNP enrollment, the Contractor shall submit *[specify mechanism, format, and frequency for sharing enrollment files with state]*.[15] Upon verification of appropriate eligibility for and enrollment in the D-SNP, *[specify state Medicaid agency]* shall enroll D-SNP enrollees into the D-SNP's affiliated *[specify Medicaid managed care program name][plan/organization/entity/product]*.

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
Requiring CO D-SNPs to cover certain Medicaid benefits through the D-SNP, the D-SNP's parent organization, or another entity owned and controlled by the D-SNP's parent organization (*Required for CO D-SNPs designated as AIPs)*	See definition of AIP in the first row of Table 4 above.	In addition to maintaining exclusively aligned enrollment, CO D-SNPs seeking designation as an AIP must cover (through the D-SNP or an affiliated Medicaid managed care plan) Medicaid primary and acute care, Medicare cost sharing, and at least one of the following additional Medicaid benefits: home health services, medical supplies, equipment, and appliances, or nursing facility services. If one entity covers some Medicaid benefits and another entity or entities covers others, the contract language should specify which entity covers which Medicaid benefits.	The Contractor is responsible for covering the following *[specify state Medicaid program]* services for D-SNP enrollees when medically necessary: *[Specify a list of all Medicaid services to be covered by the Contractor or an affiliated Medicaid managed care plan. The list of covered services must include Medicaid primary and acute care, Medicare cost sharing, and at least one of the following additional Medicaid benefits: home health services, medical supplies, equipment, and appliances, or nursing facilities]*. **Sample language for states that contract directly with AIPs to cover Medicaid benefits for AIP enrollees:** The legal entity holding a Medicare Advantage contract with CMS for the D-SNP(s) named within this Contract receives direct capitation from *[specify state Medicaid agency]* to provide coverage of the Medicaid benefits described in *[specify section of contract that lists Medicaid benefits covered by the D-SNP]* for enrollees in the D-SNP(s) covered under this contract. The legal name of that entity is *[specify name of entity]*. **Sample language for states that contract with Medicaid managed care plans affiliated with AIPs to cover Medicaid benefits for AIP enrollees:** The legal name of the entity that holds a contract with *[specify state Medicaid agency]* for coverage of the Medicaid benefits described in *[specify section of contract that lists Medicaid benefits covered by the D-SNP]* is: *[specify name of entity - have D-SNP contractors specify the exact legal name of the entity responsible for coverage of Medicaid benefits]*. This entity is: ☐ The same legal entity as the entity that holds the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this contract. The Contractor shall provide documentation to the State and to CMS that demonstrates that the entity responsible for coverage of the Medicaid benefits described within this contract is the same legal entity as the entity holding the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this Contract. ☐ A separate legal entity owned and controlled by the same parent organization as the entity that holds the Medicare

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
			Advantage contract(s) with CMS for the D-SNP(s) covered under this contract. The Contractor shall provide documentation to the State and to CMS that demonstrates that the entity responsible for coverage of the Medicaid benefits described within this contract is owned and controlled by the same parent organization as the entity holding the Medicare Advantage contract(s) with CMS for the D-SNP(s) covered under this Contract.
Requiring AIPs to integrate appeals and grievance processes *(Required for D-SNPs designated as AIPs)*	"(9) For each dual eligible special needs plan that is an applicable integrated plan as defined in §422.561, a requirement for the use of the unified appeals and grievance procedures under §§422.629 through 422.634, 438.210, 438.400, and 438.402." (42 CFR §422.107[c][9])	In SMACs for AIPs, states should include a requirement that the AIPs use the unified appeals and grievance procedures described at 42 CFR §§422.629 through 422.634, 438.210, 438.400, and 438.402. Per 42 CFR §422.629(c), states can require D-SNPs to use shorter timeframes or different notice requirements that are more protective to enrollees than the requirements under 42 CFR §§422.629 – 422.631 and 42 CFR §§422.633 – 422.634, so long as those state-specific requirements are consistent with federal Medicaid rules at 42 CFR §438, Subpart F. If states choose to implement different timeframes than those described in the federal regulations, the variant timeframes must be clearly delineated in the D-SNP's SMAC. Any state-specific provisions should explicitly describe the state-specific standard and cite the federal standard it is replacing. For example, if a state	Consistent with state policy, the Contractor shall implement a grievance and appeal system and process grievances and appeals in compliance with the terms of 42 CFR §§422.629 – 422.634, 438.210, 438.400, and 438.402. This includes: • Grievances and appeals systems that meet the standards described in §422.629; • An integrated grievance process that complies with §422.630; • A process for making integrated organization determinations consistent with §422.631; • Continuation of benefits while an integrated reconsideration is pending consistent with §422.632; • A process for making integrated reconsiderations consistent with §422.633; and • A process for effectuation of decisions consistent with §422.634.

Contract Element and D-SNPs for Which Element Is Required	Requirement	Description	Sample Contract Language
		wished to require a 15-day timeframe for resolution of a standard integrated reconsideration (appeal) rather than the 30 days allowed under §422.633(f)(1), it should include the following: "The plan must resolve standard integrated reconsiderations within 15 calendar days from the date of receipt in lieu of the 30 calendar days permitted under 42 CFR §422.631(f)(1)."	

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] This language was adapted from the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services (not available online).

[5] This language was adapted from the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services (not available online).

[6] This language was adapted from the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services (not available online).

[7] This language was adapted from the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services (not available online).

[8] This language was adapted from the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services (not available online).

[9] This language was adapted from the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services (not available online).

[10] This language was adapted from the 2019 Tennessee Department of Finance and Administration, Division of TennCare and UnitedHealthcare Plan of the River Valley SNP Contract (not available online).

[11] This language was adapted from the 2019 Tennessee Department of Finance and Administration, Division of TennCare and UnitedHealthcare Plan of the River Valley SNP Contract (not available online).

[12] This language was adapted from the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services (not available online).

[13] This language was adapted from the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services (not available online).

[14] 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).

[15] 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).

Appendix A: FIDE/HIDE Checklist

To help states confirm that D-SNPs meet the criteria to be classified as a FIDE SNP or a HIDE SNP, states can add a checklist to their SMACs that requires D-SNPs to confirm whether they meet the requirements necessary to meet either classification. This appendix provides an example of how states could structure such a checklist. For each PBP that is included in the contract, the Contractor would be asked to provide responses to each of the following indicators. The state would add or remove columns based on the number of PBPs covered under the SMAC.

Indicator	PBP #1	PBP #2
For each PBP, indicate the CMS contract number, contract name, PBP number, and D-SNP name(s).	CMS contract number (H#): _____ Contract name: _____ D-SNP PBP number(s): _____ D-SNP name(s): _____	CMS contract number (H#): _____ Contract name: _____ D-SNP PBP number(s): _____ D-SNP name(s): _____
For each PBP, indicate whether the Contractor is seeking FIDE SNP designation as defined in 42 CFR §422.2.	___ Yes ___ No	___ Yes ___ No
For each PBP, indicate whether the Contractor is seeking HIDE SNP designation as defined in 42 CFR §422.2.	___ Yes ___ No	___ Yes ___ No
For each PBP for which the Contractor is seeking FIDE SNP designation, enter the name of the legal entity that: (1) holds (or will hold, if the Medicare Advantage organization is in the process of submitting its SMAC as part of the Medicare Advantage bid process) the Medicare Advantage contract with CMS and (2) holds the contract with the state Medicaid agency for coverage of required Medicaid services, including: (a) Medicaid primary and acute care and (b) LTSS, including coverage of nursing facilities for a period of at least 180 days during the plan year. Starting in 2025, the entity will also be responsible for coverage of Medicare cost-sharing and Medicaid behavioral health services, home health services, and medical supplies, equipment, and appliances.	*[specify name of entity]* ___ Not applicable	*[specify name of entity]* ___ Not applicable
For each PBP for which the Contractor is seeking HIDE SNP designation, enter the name of the entity (the D-SNP, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization) that holds a contract with the state to cover Medicaid LTSS, behavioral health benefits, or both for the D-SNP's enrollees.	*[specify name of entity]* ___ Not applicable	*[specify name of entity]* ___ Not applicable
For each PBP, indicate whether the Contractor has a fully executed Medicaid managed care contract with the state. If "no", indicate the expected date upon which the contract is expected to be in place.	___ Yes ___ No, *[insert expected date]*	___ Yes ___ No, *[insert expected date]*
For each PBP, indicate whether the following Medicaid benefits are covered under the aforementioned Medicaid managed care contract.	___ Medicare cost-sharing ___ Medicaid primary care benefits ___ Medicaid acute care benefits	___ Medicare cost-sharing ___ Medicaid primary care benefits ___ Medicaid acute care benefits

Indicator	PBP #1	PBP #2
(*Starting in 2025, D-SNPs seeking FIDE SNP designation will be required to cover Medicare cost-sharing, Medicaid behavioral health services, home health services, and medical supplies, equipment, and appliances, in addition to continuing to cover Medicaid primary and acute care services and LTSS*).	___ Home health services ___ Medical supplies ___ Equipment and appliances ___ Behavioral health services ___ Check if all behavioral health services are covered, without carve outs of certain behavioral health services into the state's fee-for-service program ___ Check if some behavioral health services are carved out ___ LTSS ___ Check if all LTSS are covered, without carve outs of certain LTSS into the state's fee-for-service program ___ Check if some LTSS are carved out ___ Nursing facility services ___ Check if fewer than 180 days of nursing facility services are covered during the plan year ___ Check if at least 180 days of nursing facility services are covered during the plan year	___ Home health services ___ Medical supplies ___ Equipment and appliances ___ Behavioral health services ___ Check if all behavioral health services are covered, without carve outs of certain behavioral health services into the state's fee-for-service program ___ Check if some behavioral health services are carved out ___ LTSS ___ Check if all LTSS are covered, without carve outs of certain LTSS into the state's fee-for-service program ___ Check if some LTSS are carved out ___ Nursing facility services ___ Check if fewer than 180 days of nursing facility services are covered during the plan year ___ Check if at least 180 days of nursing facility services are covered during the plan year
For each PBP for which any behavioral health services are carved out, indicate which of the following statements apply.	__ Behavioral health services that are carved out apply primarily to a minority of the dually eligible individuals who are eligible to enroll in the D-SNP and who use behavioral health services ___ Behavioral health services that are carved out constitute a small part of the total scope of behavioral health services provided to the majority of dually eligible individuals who are eligible to enroll in the D-SNP ___ Not applicable	__ Behavioral health services that are carved out apply primarily to a minority of the dually eligible individuals who are eligible to enroll in the D-SNP and who use behavioral health services ___ Behavioral health services that are carved out constitute a small part of the total scope of behavioral health services provided to the majority of dually eligible individuals who are eligible to enroll in the D-SNP ___ Not applicable
For each PBP for which any LTSS are carved out, indicate which of the following statements apply.	___ LTSS that are carved out apply primarily to a minority of the dually eligible individuals who are eligible to enroll in the D-SNP and who use LTSS	___ LTSS that are carved out apply primarily to a minority of the dually eligible individuals who are eligible to enroll in the D-SNP and who use LTSS

Indicator	PBP #1	PBP #2
	___ LTSS that are carved out constitute a small part of the total scope of LTSS provided to the majority of dually eligible individuals who are eligible to enroll in the D-SNP ___ Not applicable	___ LTSS that are carved out constitute a small part of the total scope of LTSS provided to the majority of dually eligible individuals who are eligible to enroll in the D-SNP ___ Not applicable
For each PBP, indicate which categories of dual-eligible beneficiaries can enroll.	___ 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	___ 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
Indicate whether each PBP operates with exclusively aligned enrollment. *(Required for FIDE SNPs starting in 2025).*	___ Yes ___ No	___ Yes ___ No
Indicate whether each PBP qualifies as an applicable integrated plan as defined in 42 CFR §422.561. *(D-SNPs, including FIDE SNPs and HIDE SNPs, designated as applicable integrated plans 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.)*	___ Yes ___ No	___ Yes ___ No
For each PBP for which the Contractor seeks FIDE SNP designation, the Contractor verifies that it will coordinate the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries (42 CFR §422.2).	___ Yes ___ Not Applicable	___ Yes ___ Not Applicable
For each PBP for which the Contractor seeks FIDE SNP designation, the Contractor verifies that it will employ policies and procedures approved by CMS and the state to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement (42 CFR §422.2).	___ Yes ___ Not Applicable	___ Yes ___ Not Applicable
Specify all counties in which each PBP will operate in the state. *(Starting in 2025, FIDE SNP and HIDE SNP contracts with the state Medicaid agency for coverage of the required Medicaid benefits must cover the entire service area of the D-SNP).*	*[Specify counties]*	*[Specify counties]*