ICRC | Integrated Care Resource Center

TECHNICAL ASSISTANCE TOOL

Updated January 2025

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

ABOUT THIS TOOL

This technical assistance tool is the third 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 *optional* SMAC sample language applicable to all types of D-SNPs. All four of the technical assistance tools in this series are available on the ICRC website.

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 five tables with optional sample state Medicaid agency contract (SMAC) language 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 optional sample language that states can use to advance their care coordination goals. For example, states can require D-SNPs to include state-specific elements in their model of care (MOC) and health risk assessments (HRA) to facilitate coordination between Medicaid and Medicare covered services.
- **Table 2, which begins on page 10**, provides optional sample language that states can use to advance their eligibility and enrollment goals. For example, states can require D-SNPs to use deeming periods to reduce unnecessary enrollment churn among dually eligible individuals and to assist dually eligible individuals with Medicaid eligibility redetermination processes.
- **Table 3, which begins on page 12**, provides optional sample language that states can use to advance their D-SNP reporting and information-sharing goals. For example, states can require D-SNPs to submit Medicare encounter data and quality measurement data to the state to facilitate state oversight activities.
- **Table 4, which begins on page 18**, provides optional sample language that states can use to advance their communication and marketing materials goals. For example, states can require D-SNPs to submit communication and marketing materials to the state for review and identify providers who accept Medicaid in their provider directories.

- **Table 5, which begins on page 21**, provides optional sample language that states can use to advance their enrollee advisory committee goals. For example, states can require D-SNPs to address particular access and care coordination topics in their enrollee advisory committees.

The sample contract language has generally been derived or adapted from existing state D-SNP contracts, with ICRC editing for clarity and conciseness. In considering whether to include these optional contract requirements in their SMACs, states should determine whether they have or will be able to obtain the resources needed to analyze and use the information they will acquire.

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

Table 1: Optional Sample Care Coordination Contract Language

This table provides optional sample contract language that states can use with any D-SNP type – FIDE SNP, HIDE SNP, or CO D-SNP – to advance state care coordination goals. The first column in the table lists each optional contract element. The second column describes how states can incorporate each element into their SMACs, and the third column provides sample language. For example, for 'Requiring D-SNPs to meet state MOC expectations' in the first column, the table contains two rows in the second and third columns: one row for requiring D-SNPs to include state-specific care coordination elements in their MOCs, and a second row for requiring D-SNPs to submit their MOCs to the state. States can use these sample contract language options to build SMAC language that furthers their goals.

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

Element	Description	Optional Sample Contract Language
Requiring D-SNPs to meet state MOC expectations	All D-SNPs must develop and implement a MOC that describes enrollees' unique characteristics and needs, the plan's care coordination and management processes, and other topics.[4] D-SNPs must submit their MOCs to CMS and obtain approval of their MOCs from the National Committee for Quality Assurance (NCQA). States can require D-SNPs to include state-specific care coordination information in their MOCs to ensure that dually eligible D-SNP enrollees' Medicare and Medicaid services are coordinated in line with state goals. For example, states can require D-SNPs to include activities like the following in their MOCs: • Assessing enrollees for LTSS and behavioral health needs during HRAs (and potentially incorporating a state-specified BH or LTSS assessment tool into the HRA, as well) • Assessing enrollee needs for services that are covered by D-SNP supplemental benefits and/or Medicaid, such as dental and/or transportation services • Explaining in the MOC how they will educate enrollees on how to access supplemental benefits and/or how the D-SNP will arrange access to those benefits for enrollees • Training care coordination staff about state Medicaid benefits and systems, such as information about the programs and providers that deliver behavioral health, LTSS and/or other types of community-based services and supports	The Contractor shall implement a Special Needs Plan Model of Care (MOC). In addition to meeting requirements detailed at 42 CFR §422.101(f) and earning approval from the National Committee for Quality Assurance (NCQA), the Contractor shall include all of the following in its MOC: *[Specify in a bulleted list or paragraphs the state-specific content that the D-SNP's parent organization must include in the MOC – see the list in the column to the left for examples]*.[5]

Element	Description	Optional Sample Contract Language
	• Incorporating Medicaid services and supports into enrollee individualized care plans (ICP), such as LTSS • Involving family members and key LTSS, behavioral health, and other Medicaid providers in enrollee interdisciplinary care teams (ICT) • Collaborating with Medicaid and/or community-based entities, such as Medicaid home- and community-based services (HCBS) waiver coordinators, for portions of their care management responsibilities • Coordinating with enrollees, caregivers, Medicaid providers, Medicaid managed care plans, and/or other designated entities as part of the care transition and discharge planning processes More information on D-SNP MOCs is available in ICRC's webinar at: https://www.integratedcareresourcecenter.com/webinar/leveraging-dual-eligible-special-needs-plan-d-snp-models-care-enhance-enrollee-care.	
	States can require D-SNPs to submit MOCs to the state for informational purposes and/or state review to verify that the D-SNP has included information required by the state in its MOC. Reviewing D-SNPs' MOCs can help states understand how D-SNPs operationalize care coordination and whether there are any inconsistencies between the processes described in the D-SNPs' MOCs and the state's contractual requirements for the D-SNPs. When requiring D-SNPs to submit their MOCs to the state for review, states should include process and timeline expectations. For example, states interested in only reviewing MOCs for informational purpose may wish to require D-SNPs to submit final MOCs that have already been approved by NCQA. On the other hand, states interested in reviewing and approving D-SNPs' MOC content (to ensure its compliance with the state's SMAC requirements) should require D-SNPs to submit MOCs to the state in advance of or concurrent with submission of the MOC to NCQA for review.	**Sample contract language for requiring D-SNPs to submit finalized MOCs to the state:** The Contractor shall submit to the state via *[specify submission method]* its final, approved MOC with its MOC score to the State within *[specify timeframe]* after receiving approval of the MOC from NCQA.[6] If the Contractor makes any changes to its MOC, the Contractor shall resubmit its MOC to the State within thirty (30) days of submission to CMS.[7] **Sample contract language for requiring D-SNPs to submit draft MOCs to the state in a timeframe that aligns with submitting their MOCs to NCQA:** The Contractor shall submit its MOC to the State on the same or the following business day after submitting the draft MOC to NCQA for review.[8] **Add the following sentence and any submission requirements if the state plans to review the MOC:** The State will review the MOC within *[specify timeframe]* after the Contractor submits its MOC to the State. The State will review the MOC to ensure compliance with the requirements described at *[specify SMAC section where MOC requirements and MOC submission requirements are located]*. The State may provide feedback on

Element	Description	Optional Sample Contract Language
		the MOC. If the State requests updates to the MOC, the Contractor shall provide a revised MOC to the State for review, with the requested updates inserted and highlighted, within *[specify timeframe]* of receipt of State feedback.
Requiring D-SNPs to coordinate discharge planning	Although NCQA reviews D-SNP care transition protocols when reviewing D-SNP MOCs,[9] states can add state-specific discharge planning requirements to D-SNP SMACs to ensure that enrollees are connected to the Medicaid services and supports (such as HCBS) that may be needed for successful transitions. In addition, states can specify in the SMAC that particular transition protocols must be used with D-SNP enrollees who have specific diagnoses or conditions, such as dementia, or enrollees who are entering or leaving particular settings, such enrollees transitioning into or out of skilled nursing facilities. For example, states can require D-SNPs to: • Connect enrollees to appropriate Medicaid provider(s) during and after discharge • Connect enrollees to particular types of community resources to meet health-related social needs during and after discharge • Ensure that follow-up services and appointments for Medicaid-covered services are scheduled within appropriate timeframes after discharge • Ensure continuity of care across all necessary Medicare and Medicaid services after discharge • Ensure that ICPs are updated as needed and transferred to relevant Medicare and Medicaid providers after discharge • Share discharge planning materials with the enrollee and relevant caregivers and Medicare and Medicaid providers, including LTSS, behavioral health, primary care, and other providers who are involved in the enrollee's care.	The Contractor shall develop and implement a discharge planning policy for enrollees who are discharged from inpatient or other institutional settings. The Contractor's discharge planning policy must include the following elements: *[specify discharge planning policy elements, such as connecting enrollees to appropriate Medicaid providers after discharge, ensuring that follow-up services and appointments for Medicaid-covered services are scheduled, and ensuring care plans and/or discharge materials are shared with appropriate parties]*.[10]
	States can require D-SNPs to coordinate with specific Medicaid providers such as Medicaid HCBS waiver service coordinators and/or Medicaid managed care plans to arrange for specific Medicaid services post-discharge, including medically necessary home health services, durable medical equipment (DME), personal care services, and any additional HCBS services.	The Contractor shall coordinate with *[specify Medicaid providers and other Medicaid entities, such as Medicaid HCBS waiver service coordinators]* regarding planning for and facilitating enrollees' discharge from inpatient and other institutional settings. The Contractor must arrange for enrollees to receive all medically necessary benefits following discharge, including the following Medicaid benefits: *[indicate specific Medicaid services, such as home health services and other HCBS services]*.[11]

Element	Description	Optional Sample Contract Language
	States can require D-SNPs to collaborate with Medicaid providers/entities to conduct specific assessments during the discharge process. For example, states can require D-SNPs to verify that Medicaid LTSS assessments are completed prior to discharge. States should align their standards for completion of LTSS assessments for individuals who are in an inpatient setting with any D-SNP requirements.	The Contractor shall coordinate with *[indicate appropriate providers, such as hospitals, HCBS waiver assessment agencies, and/or other care coordination entities]* to verify that a/an *[indicate type of needs assessment, such as a Medicaid LTSS assessment]* is completed prior to enrollee discharge from inpatient and other institutional settings.[12]
	States can require D-SNPs to require their contracted hospitals and nursing facilities to notify the D-SNP and an enrollee's care coordinator(s) of emergency department visits and hospital and/or nursing facility admissions within a specific timeframe to facilitate the discharge planning process. States can also specify what modality the D-SNP and its contracted providers use to share this information. To the extent that a state has an admission, discharge, and transfer (ADT) system that facilitates desired notifications, states and D-SNPs should consider how such systems may be used in this process.	The Contractor shall require that its contracted hospitals, nursing facilities, and skilled nursing facilities notify both the Contractor and the enrollee's care coordinator(s) within *[specify timeframe]* of all emergency department, inpatient, and institutional visits and admissions of the Contractor's enrollees. The enrollee's designated care coordinator must follow up with the enrollee to identify and address any care and/or care coordination needs, including skilled services covered by Medicare and LTSS services covered by *[specify Medicaid program]* within *[specify time period]* of the Contractor's receipt of these notifications. To the extent possible, these processes should be electronic and automated but may include fax, email, telephone, and other forms of manual communication and coordination.[13]
	CMS requires D-SNPs to describe care transition protocols in their MOCs.[14] States that wish to ensure that D-SNPs are communicating particular information to enrollees during discharge can use SMAC requirements to require D-SNPs to communicate particular information to enrollees and caregivers during the discharge process. For example, states can require D-SNPs to communicate information about: • The enrollee's diagnosis and treatment plan • The enrollee's needs, such as DME, nutrition, physical or occupational therapy needs, and medication review and reconciliation • HCBS or institutional LTSS plans • Accessible transportation for follow-up appointments as well as picking up medications and groceries • Follow-up appointments with providers that are set before prior to discharge • Specific contacts in case of questions or what actions to take regarding health deterioration after discharge	The Contractor shall ensure the following information has been communicated *[specify modality, such as through a written form]* to the enrollee, caregiver(s)/family support, and provider(s) prior to discharge: *[indicate types of information that must be communicated prior to discharge, such as the enrollee's treatment plan and follow-up appointments with providers set prior to discharge]*.[15]

Element	Description	Optional Sample Contract Language
Requiring D-SNPs to incorporate state-specific elements in their HRAs	D-SNPs must assess enrollee physical, psychosocial, and functional needs through initial and annual HRAs.[16] CMS also requires the HRA to include questions on housing stability, food security, and access to transportation. To comply with the CMS requirements for these social needs screening questions described at 42 CFR §422.101(f)(1)(i) and in sections 90.2 and 90.3 of Chapter 16-B of the Medicare Managed Care Manual,[17] D-SNPs must use either: (1) a validated, widely used screening instrument; or (2) an instrument required by the state. To facilitate coordination of Medicare and Medicaid services, states can require D-SNPs to screen for state-specific elements in their HRAs, such as: • Information on enrollees' Medicaid service utilization/receipt • Need for additional Medicaid-covered services, such LTSS, behavioral health, and transportation services • Social risks and needs, such as social isolation, loneliness, and employment supports • Personal goals • Enrollee and caregiver care preferences • Need for services covered by Medicaid and/or D-SNP supplemental benefits, such as dental, hearing, and/or vision services • Availability and use of informal support networks • Need for additional screenings or services for at-risk populations, including people diagnosed with Alzheimer's disease and dementia[18] If developing requirements in this area, states should ensure that their requirements do not conflict with Medicare HRA requirements.[19]	The Contractor shall use a standardized, person-centered health risk assessment (HRA) instrument to assess enrollees' physical, psychosocial, and functional needs. In addition to collecting information about housing stability, food security, and access to transportation in accordance with the requirements specified at 42 CFR §422.101(f)(1)(i) and in sections 90.2 and 90.3 of Chapter 16.B of the Medicare Managed Care Manual, the Contractor's HRA instrument shall at minimum collect the following information: *[Indicate state-specific elements that the HRA instrument must collect, such as information on the Medicaid services the enrollee receives, personal goals, and enrollee and caregiver care preferences].*[20] To the extent that Medicaid and Medicare requirements for health risk assessment conflict or overlap, the Contractor shall determine how to follow Medicare requirements.[21] *[Note: If a state wishes to require its D-SNPs to use a state-specified screening tool to collect information about housing stability, food security, and access to transportation from the D-SNP enrollees, the state can also add information about using that state-specified screening tool for the collection of that information to its SMAC requirements.]*
	States can also specify <u>when</u> D-SNPs must conduct HRAs. At a minimum, CMS requires D-SNPs to conduct initial assessments within 90 days before or after an enrollee's effective enrollment date, and D-SNPs must also conduct annual reassessments with each enrollee.[22] States can require more stringent timelines for initial HRAs depending on enrollee health status, care needs, and Medicaid assessments. For example, for enrollees eligible for Medicaid LTSS services, states can require D-SNPs to conduct initial HRAs at the same time that Medicaid comprehensive assessments occur.	The Contractor shall conduct an initial health risk assessment for each new enrollee *[specify timeframe, such as within 60 days of enrollment or at the same time that that the enrollee receives a comprehensive Medicaid assessment].*[23]

Element	Description	Optional Sample Contract Language
	States can specify whether the D-SNP must conduct HRAs in person, or if D-SNPs can conduct HRAs over the phone or by video conferencing. States may choose to vary the allowable assessment modalities based on an enrollee's risk stratification (for example, if an enrollee has LTSS needs) and whether the enrollee is receiving an initial assessment or annual reassessment.	**Sample contract language for requiring D-SNPs to conduct initial assessments using specific modalities:** The Contractor shall conduct initial health risk assessments *[specify assessment modality, such as in person]* for enrollees assigned to *[specify risk stratification level(s), for example if an enrollee has LTSS needs]*.[24] **Sample contract language for requiring D-SNPs to conduct annual assessments using specific modalities:** The Contractor shall conduct annual health risk reassessments *[specify assessment modality, such as in person]* for enrollees assigned to *[specify risk stratification level(s), for example if an enrollee has LTSS needs]*.[25]
	States can specify the minimum qualifications of D-SNP staff who conduct HRAs to ensure that the staff conducting HRAs are best suited to capture the information needed to provide appropriate care and support to D-SNP enrollees. Examples of professionals that states may consider for this role include registered nurses, licensed practical nurses, social workers, qualified intellectual disabilities professionals, or mental health counselors. States can also specify degree(s), certifications, training, and/or length of relevant experience that these individuals must have. For example, a state might specify that individuals conducting HRAs must have a two-year degree and at minimum two years' experience in health care or a health care-related industry.	The Contractor shall use qualified health professionals, including individuals who possess an appropriate professional scope of practice, licensure, and/or credentials, to conduct HRAs. Examples of health professionals who may complete portions or all of the HRA include *[specify health professionals who can conduct HRAs, such as registered nurses and social workers]*.[26]
	States can require D-SNPs to use specific assessment tools within the HRA process to ensure that D-SNPs capture enrollee information that will facilitate the identification of enrollee needs and support care coordination. If a state requires its D-SNPs to use a particular screening tool as the entirety of the D-SNPs' HRA, the state should ensure that the designated HRA tool includes questions on housing stability, food security, and access to transportation, since CMS requires plans to include questions on these areas per 42 CFR §422.101(f)(1)(i).	The Contractor shall *[include/incorporate]* the *[specify specific screening tool]* into its health risk assessment to *[describe goal(s) to be supported by incorporating specified tool into the HRA process]*.[27] The Contractor shall use the *[specify specific screening tool]* as its health risk assessment tool for all D-SNP enrollees. The *[screening tool]* contains appropriate questions about housing stability, food security, and access to transportation to comply with the federal requirements described at 42 CFR §422.101(f)(1)(i).

Table 2: Optional Sample Eligibility and Enrollment Contract Language

This table provides optional sample contract language that states can use with any D-SNP type – FIDE SNP, HIDE SNP, or CO D-SNP – to advance state goals for eligibility and enrollment. The first column in the table lists each optional contract element. The second column describes how states can incorporate each element into their SMACs, and the third column provides sample language. For example, for 'Requiring D-SNPs to Use Eligibility Deeming Periods' in the second row of the first column, the table contains two rows in the second and third columns: one row for requiring D-SNPs to use specific deeming periods, and a second row for requiring D-SNPs to inform the state of the specific deeming period that the D-SNP uses if the state sets a minimum deeming period. States can use these sample contract language options to build SMAC language that furthers their goals.

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

Element	Description	Optional Sample Contract Language
Requiring D-SNPs to restrict the sub-groups of dually eligible individuals allowed to enroll	States can require D-SNPs to limit the sub-groups of dually eligible individuals who are allowed to enroll in the D-SNP. For example, states can restrict D-SNP enrollment to only full-benefit dually eligible individuals, to those who are age 65 and above, those who live in a specified service area, or those who are enrolled in (or willing to enroll in) the D-SNP's affiliated Medicaid managed care plan. When including this requirement in their SMACs, states can define who is eligible to enroll in the D-SNP, define who is not eligible to enroll in the D-SNP, or use a combination of both approaches. Appendix A 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.	The Contractor is excluded from enrolling the following categories of individuals in the D-SNP(s) offered under this Contract: *[specify the categories of individuals who are or are not allowed to enroll in the D-SNP, such as full-benefit or partial-benefit dually eligible individuals, those age 65 and older, those age 64 and younger, or those who reside in a particular geographic area]*.[28]
Requiring D-SNPs to use eligibility deeming periods	States can require D-SNPs to use deeming periods to help to maintain continuity of coverage when dually eligible individuals lose Medicaid eligibility for a temporary period of time. Specifically, a deeming period refers to a limited period of continued enrollment in the D-SNP following a loss of Medicaid eligibility for individuals who lose Medicaid eligibility but are expected to regain Medicaid coverage within six months. The D-SNP may choose any length of time from one month to six months for deeming continued eligibility. States that choose to require D-SNPs to implement a deeming period should specify the length of the time for the deeming	The Contractor shall use an eligibility deeming period of *[specify a deeming period of a particular time period OR a deeming period of a minimum time period]* following notification of the enrollee having lost eligibility for *[specify Medicaid program name(s)]*.[29]

Element	Description	Optional Sample Contract Language
	period. More information on deeming periods is available in ICRC's tip sheet at: https://www.integratedcareresourcecenter.com/resource/preventing-and-addressing-unnecessary-medicaid-eligibility-churn-among-dually-eligible.	
	If a state requires its D-SNPs to use a deeming period but does not specify a minimum length for the deeming period, the state can require its D-SNPs to inform the state of the length of the deeming period that the D-SNP uses.	The Contractor shall inform the State of the deeming period that the Contractor uses by *[specify date]* each year.[30]
Requiring D-SNPs to assist enrollees with Medicaid eligibility redetermination processes	States can require D-SNPs to help enrollees respond to Medicaid eligibility redetermination notices to prevent unnecessary Medicaid eligibility churn and/or help D-SNP enrollees re-establish Medicaid eligibility after a loss of Medicaid eligibility. For example, activities that states can require D-SNPs to complete include: • Helping enrollees complete Medicaid redetermination materials • Monitoring Medicaid financial eligibility termination dates to identify enrollees who may soon need assistance with Medicaid redetermination processes and conducting outreach to those enrollees • Educating enrollees on maintaining their Medicaid eligibility	The Contractor shall assist enrollees with Medicaid eligibility redetermination processes. The Contractor shall *[specify a list or bullet points of activities that the D-SNP must complete, such as assisting enrollees complete their Medicaid redetermination renewals]*.[31]
	States that require D-SNPs to assist enrollees with Medicaid eligibility redetermination processes can provide D-SNPs with Medicaid eligibility data to facilitate this assistance. These data can be shared, for example, through monthly 834 enrollment files or by providing plans access to state Medicaid eligibility portals that contain this information.	The State shall provide the Contractor with access to information about upcoming Medicaid eligibility redetermination dates for enrollees in the Contractor's D-SNP via *[specify how the state will share this information, such as through monthly 834 files]* on a/an *[specify frequency]* basis to support the Contractor in assisting D-SNP enrollees with responding to Medicaid eligibility redetermination requests.

Element	Description	Optional Sample Contract Language
Requiring D-SNPs to report changes in enrollee status that may impact enrollee eligibility	States can require D-SNPs to report enrollee status changes that may impact eligibility to the state to help ensure that services covered by the D-SNP are provided to eligible individuals. This can include, for example, changes of address, death, and disenrollment from the D-SNP.	The Contractor shall report to the State any change in status of its enrollees which may impact the enrollee's eligibility for Medicaid or the D-SNP, within *[specify timeframe]* of such information becoming known to the Contractor. This information includes, but is not limited to: births; changes of address; incarceration; enrollees who the D-SNP has been unable to contact; permanent placement in a State-operated psychiatric or developmental institution or other program rendering the individual ineligible for enrollment in D-SNP; death; and disenrollment from the Contractor's D-SNP, as defined in this Contract. [32]

Table 3: Optional Sample D-SNP Reporting and Information Sharing Contract Language

This table provides optional sample contract language that states can use with any D-SNP SNP type – FIDE SNP, HIDE SNP, or CO D-SNP – to advance state goals around D-SNP reporting and information sharing. The first column in the table lists each optional contract element. The second column describes how states can incorporate each element into their SMACs, and the third column provides sample language. For example, for 'Requiring D-SNPs to submit Medicare bid information' in the first column, the table contains two rows in the second and third columns: one row for requiring D-SNPs to submit their Medicare bid information to the state, a second row for requiring D-SNPs to submit their Medicare bid information to the state's Medicaid managed care actuarial firm. States can use these sample contract language options to build SMAC language that furthers their goals. For some of the reporting and information sharing rows below, states provide detailed data specifications through an appendix, manual, or other document and indicate this within the SMAC.

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

Element	Description	Optional Contract Language
Requiring D-SNPs to submit Medicare bid information	States can require D-SNPs to submit Medicare bid information to the state to help the state understand annual changes to D-SNPs and to assure that the state does not duplicate payments to the D-SNP or affiliated Medicaid plan for services covered by Medicare under D-SNP contracts with CMS.	Within *[specify timeframe]* of notice of award from CMS, the Contractor shall submit to the State a copy of the final bid submitted to CMS for the Medicare Advantage contract containing the PBPs covered by this Contract.[33]
	States that require D-SNPs to submit Medicare bid information to the state can also require D-SNPs to send bid information directly to the state's actuarial firm to facilitate Medicaid rate setting and to assure that the state does not duplicate payments for services (including supplemental benefits) covered by Medicare.	Within *[specify timeframe]* of notice of award from CMS, the Contractor shall submit to the State's actuarial firm a copy of the final bid submitted to CMS for the Medicare Advantage contract containing the PBPs covered by this Contract.[34]
Requiring D-SNPs to submit Medicare Advantage encounter data to the state	All Medicare Advantage plans (including D-SNPs) are required to submit Medicare Advantage encounter data to CMS.[35] States can require D-SNPs to submit these data to the state to facilitate program oversight activities in areas such as financing, access, quality, and care coordination. When requiring D-SNPs to submit encounter data, states should specify how often D-SNPs must submit the data.	The Contractor shall electronically submit to the State all Medicare Advantage encounter data submitted to CMS for the enrollees covered under this Contract in accordance with *[insert deliverable schedule]*.

Element	Description	Optional Contract Language
Requiring D-SNPs to submit supplemental benefit utilization data	States can require D-SNPs to submit data on D-SNP enrollees' utilization of D-SNP supplemental benefits to help the state assess enrollee awareness of access to those supplemental benefits. Because D-SNPs do not currently have to submit supplemental benefit utilization data to CMS in a standardized format, states interested in collecting this data should determine: (1) which supplemental benefits are of most interest to the state; and (2) a format and method for data submission that will be amenable to the state. The state should also communicate with the D-SNPs to determine appropriate specifications for data submission that will align with the kinds of information that D-SNPs will have available for the specific benefits of interest to the state.	The Contractor shall submit supplemental benefit utilization data to the State in accordance with *[insert deliverable schedule]*. The supplemental benefit data shall include the following information: *[Specify supplemental benefit data to be submitted, such as dental and vision utilization data]*. The supplemental benefit data shall adhere to the data specification and format requirements included in *[specify reference to appendix, manual, or other document that specifies data requirements]*.
Requiring D-SNPs to submit Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), or other quality measure reports and/or data to the state	States can require D-SNPs to submit HEDIS and other quality measure reports and/or data to the state to facilitate state quality oversight activities. Note that CAHPS data are reported at the contract level rather than at the plan level, and that contracts may cover more than one state and/or Medicare Advantage plan type. When requiring D-SNPs to submit quality measure reports and data, states should specify how often D-SNPs must submit those reports and/or data. States should specify what quality measure reports and/or data that D-SNPs are required to submit. Examples include: • Summary-level and patient-level HEDIS data the D-SNP is required to submit to NCQA and CMS • The final NCQA HEDIS compliance audit report provided to the D-SNP • Medicare Health Outcomes Survey (HOS) reports • CAHPS survey reports • Data for state-specific quality measures or enrollee satisfaction surveys More information on CMS resources that states can use to facilitate quality oversight is available in ICRC's TA tool at: https://www.integratedcareresourcecenter.com/resource/how-states-can-monitor-dual-eligible-special-needs-plan-performance-guide-using-cms-data.	The Contractor shall electronically submit *[quality measurement reports and/or data]* to the State in accordance with *[insert deliverable schedule]*. The *[quality measurement reports and/or data]* shall include the following information and any additional information specified by the State: *[Specify the quality measurement reports and/or data that the D-SNP must submit to the state, such as HEDIS data, CAHPS survey reports, and/or data on state-specific quality measures]*.[36] **If the state requires the D-SNP to submit quality measurement data, insert the following sentence:** The quality measurement data shall adhere to the data specification and format requirements specified in *[specify reference to appendix, manual, or other document that specifies data requirements]*.

Element	Description	Optional Contract Language
Requiring D-SNPs to submit data on the D-SNP's organization (benefit) determinations, appeals, and/or grievances to the state	All Medicare Advantage plans, including D-SNPs, are required to submit summary grievance and organization determination/reconsideration reports to CMS annually.[37] States can require D-SNPs to submit copies of these reports to the state to facilitate state oversight of D-SNP operations. These reports include, for example: • The total number of grievances, organization determinations, and reconsiderations • The number of withdrawn or dismissed organization determinations • The number of fully favorable and partially favorable organization determinations and reconsiderations to the enrollee States should specify timing requirements for submission of these reports (for example, within 30 days of submission to CMS).	The Contractor shall submit copies of the annual grievance and organization determination/reconsideration reports submitted to CMS as defined by the 'Medicare Part C Reporting Requirements' document *[specify the effective date of the most recent document, such as January 1, 2023]* and 'Medicare Part C Technical Specifications Document' document within *[specify reporting time period]* of submission to CMS.

Element	Description	Optional Contract Language
	States can require D-SNPs to submit custom grievance and organization determination/reconsideration data to the state. For example, these could include: • Grievances received and the outcomes of those grievances • Organization determination requests and the outcomes of those requests. This includes a service level detail on approved and denied requests • Reconsideration requests and the outcomes of those reconsiderations (this can include service level detail on reconsiderations upheld and overturned, including a description of the action that was appealed) • Medicare Independent Review Entity decisions received Examples of data elements that states may wish D-SNPs to include in grievance and organization determination/reconsideration data include: enrollee name, ID number, date of birth and/or demographic information; type/topic of organization determination/reconsideration or grievance; date of service for the service in question; type of service in question; provider name; provider type; and service county. Examples of data elements that states may wish D-SNPs to include only in organization determinations/reconsiderations data include: date the initial denial notice was issued; denial type; effective date of service termination, reduction, or suspension; units denied; rationale for plan action/decision; state or federal law cited in decision; highest stage of appeal sought prior to final disposition; outcomes at each stage; date and type of resolution.	The Contractor shall electronically submit grievance and organization determination/reconsideration data to the State in accordance with *[insert deliverable schedule]*. The data shall include the following information and any additional information specified by the State: *[Specify required data, such as grievances received and the outcomes of those grievances]*. The grievance and organization determination/reconsideration data shall adhere to the data specification and format requirements included in *[specify reference to appendix, manual, or other document that specifies data requirements]*.[38]

Element	Description	Optional Contract Language
Requiring D-SNPs to send copies of CMS program audits, notices of non-compliance, warning letters, corrective action plans, or enforcement actions to the state	States can require D-SNPs to send copies of CMS program audit results and other compliance/enforcement documents to the state to support state oversight of D-SNP operations. States should specify: (1) the timeframe in which the D-SNP is required to submit copies of these documents to the state; and (2) which documents D-SNPs are required to submit. Example documents that states can require D-SNPs to submit include: • CMS program audit notices and findings • CMS-issued compliance actions, including notices of non-compliance from CMS, warning letters, and sanctions • CMS notices of Medicare star ratings less than 3.0 • Notices of significant changes to the terms of the D-SNP's contract with CMS, including D-SNP non-renewals and terminations More information on CMS program audits is available in ICRC's tip sheet at: https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-using-medicare-program-audit.	The Contractor shall submit copies of the following documents within *[specify timeframe]* after receipt from CMS: *[Specify documents that D-SNPs are required to submit to the state, such as CMS audit notices and findings and CMS-issued compliance actions]*.[39]
	If the state requires D-SNPs to send copies of CMS program audit results and other non-compliance/enforcement documents to the state, the state can also require D-SNPs to submit copies of any documents created by D-SNPs or their sponsors in response to those CMS oversight activities.	Within *[specify timeframe]* of submission to CMS, the Contractor shall submit to the State copies of any documents submitted to CMS in response to the CMS notices specified in *[specify the contract section that lists the CMS notices]*.[40]
Requiring D-SNPs to submit enrollment and/or disenrollment data to the state	D-SNPs are required to submit enrollment and disenrollment data to CMS twice annually.[41] States can require D-SNPs to submit these data to the state to support state oversight of enrollment/disenrollment trends. These data include, for example: • The total number of enrollment requests by medium (paper, telephonic, and electronic) • The total number of voluntary disenrollment requests States should specify timing requirements for submission of these data.	The Contractor shall submit a copy of the enrollment and disenrollment data submitted to CMS as defined by the 'Medicare Part C Reporting Requirements' document *[specify the effective date of the most recent version of the reporting requirements document, such as January 1, 2023]* and 'Medicare Part C Technical Specifications Document' document *[specify the effective date of the most recent version of the technical specifications document, such as January 1, 2023]* within *[specify reporting time period]* of submission to CMS.[42]

Element	Description	Optional Contract Language
	States can require D-SNPs to submit more specific enrollment and/or disenrollment data or submit data to the state more frequently. Example elements states can require D-SNPs to submit for enrollments and/or disenrollments include: • Identifying information for each enrollee (such as enrollee name, date of birth, social security number, etc.) • Medicaid eligibility category and Medicaid waiver information • Transaction type (enrollment or disenrollment) • Date of transaction request • Effective date of transaction • Reason for disenrollment (if applicable)	The Contractor shall submit *[enrollment and/or disenrollment]* data to the State in accordance with *[insert deliverable schedule]*. The *[enrollment and/or disenrollment]* data shall include the following information and any additional information specified by the State: *[specify required enrollment and disenrollment data elements, such as enrollee identifying information, Medicaid eligibility category, and transaction type]*.[43] The *[enrollment and/or disenrollment]* data shall adhere to the data specification and format requirements included in *[specify reference to appendix, manual, or other document that specifies data requirements]*.
Requiring D-SNPs to submit HRA or other care management data to the state	D-SNPs are required to submit care management data to CMS annually.[44] States can require D-SNPs to submit copies of these data to the state to understand the dually eligible population enrolled in D-SNPs, monitor the population's care coordination needs over time, and support their oversight of plans' care coordination activities. For example, these data include the following elements: • Number of new enrollees due for an initial HRA • Number of enrollees eligible for annual reassessment • Number of HRAs performed (initial and annual reassessments) • Number of HRA refusals (initial and annual reassessments) • Number of HRAs (initial and annual reassessments) not performed because the D-SNP was unable to reach enrollees • Number of enrollees who need assistance with activities of daily living (ADL)[45] States should specify timing requirements for submission of these data (e.g., within 30 business days after submitting data to CMS).	The Contractor shall submit a copy of the annual Special Needs Plan Care Management data submitted to CMS as defined by the 'Medicare Part C Reporting Requirements' document *[specify the effective date of the most recent version of the reporting requirements document, such as January 1, 2023]* and 'Medicare Part C Technical Specifications Document' document *[specify the effective date of the most recent version of the technical specifications document, such as January 1, 2023]* within *[specify reporting time period]* of submission to CMS.

Element	Description	Optional Contract Language
	States can also require D-SNPs to submit enrollee-level care management data to the state. States should specify what data D-SNPs must submit, the reporting period, and timing requirements (e.g., within 30 business days of the close of each quarter). Example care management data or reports that states can require D-SNPs to submit include: • Enrollees due for an annual assessment within the prior 90 calendar days • Enrollees due for a service plan, the date the plan was due, and the completion date of the service plan • A roster of enrollees with the date of last contact by their care coordinators and the type of contact (face-to-face or other) • A roster of enrollees with all care coordination engagement over a reporting period, as well as the type of engagement[46]	The Contractor shall submit care management data to the State in accordance with *[insert deliverable schedule]*. The care management data shall include the following information: *[Specify required care management data, such as enrollees due for an annual assessment within the prior 90 days and care coordinator caseload data]*.[47] The care management data shall adhere to the data specification and format requirements included in *[specify reference to appendix, manual, or other document that specifies data requirements]*.
Requiring D-SNPs to submit data at the Plan Benefit Package (PBP) level	To the extent feasible, states can require D-SNPs to submit certain data at the PBP level for the specific D-SNP PBPs operated by the contracting organization within the state. Before implementing this kind of requirement, states should consider the extent to which D-SNPs are able to report data at the PBP level. For example, some D-SNPs may have insufficient enrollment to report HEDIS data at the PBP level because CMS only collects HEDIS data from D-SNPs with 30 or more enrollees.	As agreed upon by the Contractor and the State, the Contractor shall submit all data specified in *[specify contract section(s) which contain data submission requirements]* at the PBP level for the PBP(s) included in this Contract.[48]

Table 4: Optional Sample D-SNP Communication and Marketing Materials Contract Language

This table provides optional sample contract language that states can use with any D-SNP type – FIDE SNP, HIDE SNP, or CO D-SNP – to advance state goals around communication and marketing materials. The first column in the table lists each optional contract element. The second column describes how states can incorporate each element into their SMACs, and the third column provides sample language. For example, for 'Requiring D-SNPs to submit communication and/or marketing materials to the state' in the first column, the table contains rows in the second and third columns for topics such as state review and approval of those materials.

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

Element	Description	Optional Contract Language
Requiring D-SNPs to submit communication and/or marketing materials to the state	D-SNPs are required to submit marketing materials, election forms, and certain communication materials to CMS for review.[49] States can require D-SNPs to submit their communication and/or marketing materials to the state, either for informational purposes or to obtain state approval prior to using the materials. States should include timing information for their review and approval/disapproval of the materials, taking into consideration the timing of CMS's review of the materials. If CMS review of the materials is required under 42 CFR §422.2261, the state should also clearly indicate whether the D-SNP must submit the materials to the state before or after CMS review. Starting in 2024, states that require D-SNPs to establish D-SNP only contracts with CMS[50] will be granted access to the marketing module within the CMS Health Plan Management System (HPMS),[51] so the state can jointly review D-SNPs' integrated communication and marketing materials alongside CMS.	**Sample language for states requesting submission of materials for informational purposes only:** The Contractor shall submit all new and substantively revised communication materials and marketing materials to the State for informational purposes. The State will not provide any feedback or approval of materials submitted for State review; the Contractor should continue to use CMS approval and file-and-use processes to obtain approval for use of materials. When submitting materials to the State, the Contractor shall include information on the purpose of the materials, the intended audience, and the timeline for the use of the materials.[52] When the Contractor is not required to submit a material to CMS as required under 42 CFR §422.2261, the Contractor shall submit the material to the State within *[specify timeframe]*. When the Contractor is required to submit a material to CMS as required under 42 CFR §422.2261, the Contractor shall submit these materials to the State *[specify timeframe, such as "(specify timeframe) prior to submission to CMS," "concurrent with submission to CMS," or "(specify timeframe) after submission to CMS"]*. **Sample language for states requesting submission of materials for state review and approval:**

Element	Description	Optional Contract Language
		Sample language for states who choose to review all communications materials and marketing materials: The Contractor must obtain written or electronic approval from the State before making communication materials and marketing materials available to enrollees or prospective enrollees. The State will review and provide approval or disapproval of the communication and marketing materials within *[specify timeframe]* after the Contractor submits the materials to the State for review.[53] ***Sample language for states who choose to review a subset of D-SNP communication and marketing materials:*** Contractor materials which require State review include: *[Specify D-SNP communication and marketing materials that the state will review, such as the Annual Notice of Change and Evidence of Coverage documents, provider and pharmacy directories, formulary documents, plan orientation and enrollment materials, marketing outreach presentations, radio or television advertisements, etc.]*.[54] The State will review and provide approval or disapproval of the communication materials and marketing materials submitted within *[specify timeframe]* after the Contractor submits the materials to the State for review.[55]
	States that require D-SNPs to obtain state approval before making communication materials and/or marketing materials available to dually eligible individuals can add language to indicate default approval by the state for scenarios in which the state does not have the capacity needed to review and approve those materials.	If the State does not approve or disapprove the materials specified in *[insert cross reference to the SMAC section detailing which materials D-SNPs must obtain state approval for]* within *[specify timeframe]*, the submission is deemed approved by the State by default.[56]
	To reduce administrative burden, states can also clarify what materials do not require submission and/or approval, such as: • Internet web sites that merely link to the state's web site for information • Materials previously approved by the state with changes that are non-substantive. Non-substantive changes include, but are not limited to: web addresses, contact information, formatting, technical corrections, etc.	Communication materials and marketing materials that the Contractor is not required to submit to the State include: *[indicate specific materials D-SNPs are not required to submit or obtain approval for, such as internet websites that only link to the state's website, or materials previously approved by the state with non-substantive changes]*.[57]

Element	Description	Optional Contract Language
Requiring D-SNPs to identify providers who accept Medicaid in plan provider directories	States can require D-SNPs to include particular Medicaid providers in their provider directories, such as LTSS and dental providers.[58]	The provider directory shall include *[specify provider types the D-SNP must include in the directory, such as particular specialists, dental, and LTSS providers]*.
	CMS requires Medicare Advantage plans (including D-SNPs) to update their provider directories any time the plan becomes aware of changes. Plans must update online and hardcopy directories within 30 days.[59] States may establish a more restrictive timeline.	The Contractor shall update and publish its provider directory *[specify the frequency by which the D-SNP must update its provider directory]*.[60]

Table 5: Optional Sample D-SNP Enrollee Advisory Committee Contract Language

This table provides optional sample contract language that states can use with any D-SNP type – FIDE SNP, HIDE SNP, or CO D-SNP – to advance state enrollee advisory committee goals.

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

Element	Description	Optional Contract Language
Requiring D-SNPs to meet state enrollee advisory committee standards	All Medicare Advantage organizations offering D-SNPs must establish and maintain at least one enrollee advisory committee. States can require D-SNPs to meet additional state enrollee advisory committee standards, such as: • Inviting state Medicaid staff to enrollee advisory committee meetings • Submitting enrollee advisory committee meeting notes to the state • Addressing particular access topics during enrollee advisory committee meetings, such as access to Medicaid covered services including LTSS and behavioral health • Addressing particular care coordination topics during enrollee advisory committee meetings, such coordination between inpatient and LTSS covered services during enrollee care transitions • Reporting to the state on how the D-SNP acted upon the feedback provided by the enrollee advisory committee • Reporting to the state on the enroll advisory committee's composition, stratified by race, ethnicity, or other demographic characteristics of the dually eligible enrollees of the plan	The Medicare Advantage organization offering the D-SNP(s) under this Contract shall establish and maintain at least one enrollee advisory committee in the state that meets the requirements under 42 CFR §422.107(f). The enrollee advisory committee(s) operating in *[insert state]* shall *[specify requirements, such as submitting meeting notes to the state and addressing particular topics during meetings]*.[61]

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] More information on D-SNP MOC requirements is available at: 42 CFR §422.101(f) and https://snpmoc.ncqa.org/.

[5] This language was adapted from the 2023 Idaho Department of Health and Welfare Medicare Medicaid Coordinated Plan Medicaid Provider Agreement (not available online).

[6] This language was adapted from the 2023 Florida Agency for Health Care Administration Standard Contract (not available online).

[7] This language was adapted from the 2024 Washington State Health Care Authority State Medicaid Agency Contract (not available online).

[8] This language was adapted from the 2023 Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning D-SNP contract, available at: https://www.in.gov/medicaid/partners/medicaid-partners/dual-eligible-special-needs-plans/.

[9] More information on NCQA MOC scoring guidelines is available at: https://snpmoc.ncqa.org/scoring-guidelines-2023.

[10] This language was adapted from the 2023 Oregon Health Authority Coordination of Benefits Agreement (not available online).

[11] This language was adapted from the 2023 Indiana Family & Social Services Administration Professional Services Contract, available at: https://www.in.gov/medicaid/partners/medicaid-partners/dual-eligible-special-needs-plans/.

[12] This language was adapted from the 2023 Oregon Health Authority Coordination of Benefits Agreement (not available online).

[13] This language was adapted from the 2021 Pennsylvania Department of Human Services Medicare Improvements for Patients and Providers Act Contract, available at: https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-MIPPA-Documents.aspx.

[14] More information on NCQA MOC scoring guidelines is available at: https://snpmoc.ncqa.org/scoring-guidelines-2023.

[15] This language was adapted from the 2023 Oregon Health Authority Coordination of Benefits Agreement (not available online).

[16] More information on D-SNP HRA requirements is available at 42 CFR §422.101(f)(1)(i).

[17] Chapter 16-B of the Medicare Managed Care Manual may be accessed at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c16b.pdf.

[18] These elements were adapted from the 2023 Idaho Department of Health and Welfare Medicare Medicaid Coordinated Plan Medicaid Provider Agreement (not available online) and the 2023 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide, available at: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

[19] More information on D-SNP HRA requirements is available at 42 CFR §422.101(f)(1)(i).

[20] This language was adapted from the 2023 Idaho Department of Health and Welfare Medicare Medicaid Coordinated Plan Medicaid Provider Agreement (not available online).

[21] This language was adapted from the 2023 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide, available at: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

[22] CMS. 2023. Medicare Part C Technical Specifications Document, Contract Year 2023. Available at: https://www.cms.gov/files/document/cy2023-part-c-technical-specifications-222023.pdf.

[23] This language was adapted from the 2023 Idaho Department of Health and Welfare Medicare Medicaid Coordinated Plan Medicaid Provider Agreement (not available online).

[24] This language was adapted from the 2023 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp.

[25] This language was adapted from the 2023 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp.

[26] This language was adapted from the 2023 Idaho Department of Health and Welfare Medicare Medicaid Coordinated Plan Medicaid Provider Agreement (not available online).

[27] This language was adapted from Massachusetts' Second Amended and Restated Contract for Senior Care Organizations, available at: https://www.mass.gov/lists/senior-care-organization-sco-contracts#second-(2nd)-amended-and-restated-(a&r)-sco-contract-.

[28] This language was adapted from the 2023 Commonwealth of Virginia Department of Medical Assistance Services D-SNP Contract (not available online).

[29] This language was adapted from the 2023 California Department of Health Care Services exclusively aligned enrollment D-SNP contract, available at: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-(D-SNP)-Contract-and-Program-Guide.aspx.

[30] This language was adapted from the 2023 California Department of Health Care Services exclusively aligned enrollment D-SNP contract, available at: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-(D-SNP)-Contract-and-Program-Guide.aspx.

[31] This language was adapted from the 2021 Pennsylvania Department of Human Services Medicare Improvements for Patients and Providers Act Contract, available at: https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-MIPPA-Documents.aspx, and the 2023 Commonwealth of Virginia Department of Medical Assistance Services D-SNP Contract (not available online).

[32] This language was adapted from the 2023 New Jersey Department of Human Services Division of Medical Assistance and Health Services FIDE SNP contract (not available online).

[33] This language was adapted from the 2023 California Department of Health Care Services exclusively aligned enrollment D-SNP contract, available at: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-(D-SNP)-Contract-and-Program-Guide.aspx and the 2023 Hawaii Department of Human Services Med-QUEST Division HIDE SNP contract (not available online).

[34] This language was adapted from the 2023 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp.

[35] See 42 CFR §422.310 for this requirement.

[36] This language was adapted from the 2023 Indiana Family & Social Services Administration Professional Services Contract, available at: https://www.in.gov/medicaid/partners/medicaid-partners/dual-eligible-special-needs-plans/.

[37] More information on Medicare Advantage reporting requirements is available at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.

[38] This language was adapted from the 2023 State of Tennessee, Department of Finance and Administration, Division of TennCare D-SNP contracts, available at: https://www.tn.gov/tenncare/information-statistics/tenncare-contracts.html.

[39] This language was adapted from the 2023 Commonwealth of Virginia Department of Medical Assistance Services D-SNP Contract (not available online).

[40] This language was adapted from the 2023 Commonwealth of Virginia Department of Medical Assistance Services D-SNP Contract (not available online) and the 2023 Louisiana Department of Health CO SNP contract (not available online).

[41] More information on Medicare Advantage reporting requirements is available at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.

[42] This language was adapted from the 2023 Pennsylvania Department of Human Services Medicare Improvements for Patients and Providers Act Contract, available at: https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-MIPPA-Documents.aspx.

[43] This language was adapted from the 2023 State of Tennessee, Department of Finance and Administration, Division of TennCare D-SNP contracts, available at: https://www.tn.gov/tenncare/information-statistics/tenncare-contracts.html.

[44] More information on Medicare Advantage reporting requirements is available at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.

[45] These elements were adapted from the 2023 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide, available at: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

[46] This language was adapted from the 2023 Idaho Department of Health and Welfare Medicare Medicaid Coordinated Plan Medicaid Provider Agreement (not available online).

[47] This language was adapted from the 2023 Idaho Department of Health and Welfare Medicare Medicaid Coordinated Plan Medicaid Provider Agreement (not available online).

[48] This language was adapted from the 2023 California Department of Health Care Services exclusively aligned enrollment D-SNP contract, available at: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-(D-SNP)-Contract-and-Program-Guide.aspx and the 2023 Pennsylvania Department of Human Services Medicare Improvements for Patients and Providers Act Contract, available at: https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-MIPPA-Documents.aspx.

[49] For more information on materials D-SNPs are required to submit to CMS, see 42 CFR §422.2261.

[50] In federal regulations described at 42 CFR §422.107€, CMS has provided states with the flexibility to require their contracted D-SNPs to operate within state-specific, D-SNP only contracts with CMS if the Medicare Advantage Organizations offering the D-SNPs offer one or more D-SNPs in the state that operate with exclusively aligned enrollment. In states that choose to use this flexibility, D-SNPs operating with exclusively aligned enrollment must use integrated versions of certain materials, including the Summary of Benefits, Formulary, and Combined Provider and Pharmacy Directory documents. Additionally, the states will be granted access to HPMS for the purpose of conducting joint review (along with CMS) of those integrated materials.

[51] HPMS is a web-enabled system that CMS uses to support the Medicare Advantage and Part D programs, including collecting and reviewing a variety of forms of data, documents and other information from Medicare Advantage and Part D plans. Information about HPMS is available at: https://www.cms.gov/about-cms/information-systems/hpms, and authorized users can access the system at https://hpms.cms.gov/app/ng/home/.

[52] This language was adapted from the 2023 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp.

[53] This language was adapted from the 2023 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp.

[54] This language was adapted from the 2023 Agreement between the Rhode Island Executive Office of Health and Human Services CO SNP contract, available at: https://eohhs.ri.gov/providers-partners/medicaid-managed-care.

[55] This language was adapted from the 2023 Commonwealth of Virginia Department of Medical Assistance Services D-SNP Contract (not available online).

[56] This language was adapted from the 2023 Memorandum of Understanding between the Maine Department of Health and Human Services and Care Improvement Plus South Central Insurance Company CO SNP contract (not available online).

[57] This language was adapted from the 2023 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp.

[58] These elements were adapted from the 2023 State of Tennessee, Department of Finance and Administration, Division of TennCare D-SNP contracts, available at: https://www.tn.gov/tenncare/information-statistics/tenncare-contracts.html.

[59] See 42 CFR §422.2267(e)(11)(iv) for this requirement.

[60] This language was adapted from the 2023 State of Tennessee, Department of Finance and Administration, Division of TennCare D-SNP contracts, available at: https://www.tn.gov/tenncare/information-statistics/tenncare-contracts.html.

[61] This language was adapted from the 2023 Oregon Health Authority Coordination of Benefits Agreement (not available online).

Appendix A: 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].*