ICRC | Integrated Care Resource Center

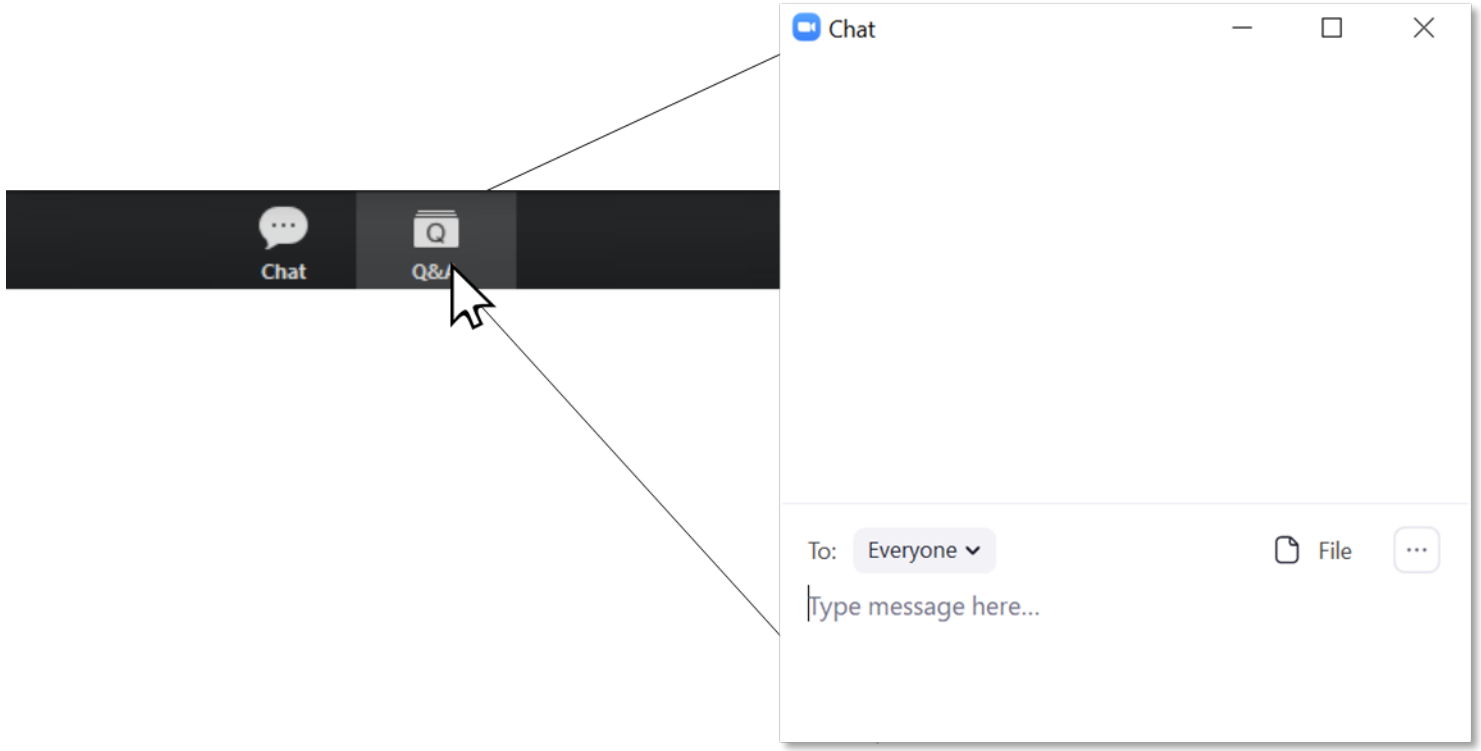
Working with Medicare: State Contracting with D-SNPs

Part 3: Using State Contracts with D-SNPs to Advance State Goals and Improve Coordination and Quality of Care for D-SNP Enrollees

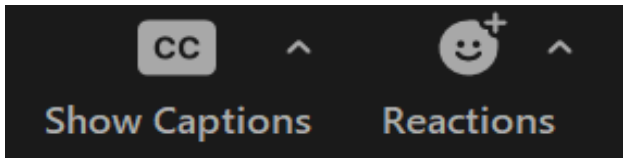
January 14, 2026
3:00 – 4:00 pm ET

Logistics

To ask a question or share a comment, use the Q&A icon at the bottom of your screen.



To enable closed captioning, click on the “Show Captions” icon in the Zoom toolbar at the bottom of your screen.



ICRC's "Working with Medicare" series

- Designed for all states interested in improving coordination of Medicare and Medicaid benefits for dually eligible individuals.
- Webinars in the current Working with Medicare series:
  - Medicare 101
  - Introduction to dual eligibility
  - State contracting with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs):
    - Part 1: Introduction to D-SNPs and D-SNP contracting basics
    - Part 2: Contracting strategies and considerations for states with integrated D-SNPs
    - Part 3: Using state contracts with D-SNPs to advance state goals and improve coordination and quality of care for D-SNP enrollees
- Supplemented by:
  - ICRC technical assistance briefs and other written tools on Medicare topics
  - ICRC updates/e-alerts on Medicare policies and programs affecting dually eligible individuals and states. Sign up to receive e-alerts and view past e-alerts: https://www.integratedcareresourcecenter.com/about-us/e-alerts

Why contract with D-SNPs?

- D-SNPs only enroll people who are dually eligible for Medicare and Medicaid and offer certain benefits that regular Medicare Advantage plans do not, such as:
  - Models of care and care coordination services;
  - Plan benefit packages (PBP), including supplemental benefits, that are designed specifically for dually eligible individuals; and
  - Enrollee advisory committees that solicit enrollee input on improving care.
- D-SNPs must also always coordinate (and sometimes cover) Medicaid benefits, in addition to covering Medicare benefits.
- 45% of dually eligible individuals were enrolled in D-SNPs in 2024, up from 17% in 2015.

Sources: Centers for Medicare & Medicaid Services (CMS). "SNP Comprehensive Reports." Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/special-needs-plan-snp-data; CMS. "MMCO Enrollment Snapshots, Quarterly Release." Available at: https://www.cms.gov/data-research/research/statistical-resources-dually-eligible-beneficiaries/mmco-statistical-analytic-reports; ATI Advisory. "Dual Eligible Enrollment Dashboard, 2024 Q4: All States + DC + PR." Available at: https://atiadvisory.com/state-resource-center.

State roles in advancing Medicare-Medicaid integration in D-SNPs

- D-SNPs must hold contracts with both CMS and the state(s) where they operate.
- Medicaid agencies can use their contracts with D-SNPs to:
  - Influence the level of Medicare-Medicaid integration and coordination that D-SNPs provide for their enrollees; and
  - Advance state goals aimed at improving quality of care for dually eligible individuals.

Agenda

- Welcome and introductions
- Key takeaways from Parts 1 and 2 of this webinar series
- Using state Medicaid agency contract (SMAC) requirements to promote D-SNP integration and enrollment into integrated D-SNPs
- Using SMACs to advance other state goals
- State monitoring and oversight of D-SNPs
- Questions and answers

Presenters

Fariha Mujeebuddin
Managing Consultant, Mathematica

Emily Costello
Advisory Services Analyst, Mathematica

Diane Beaver
Managing Consultant, Mathematica

Nida Joseph
Program Officer, CHCS

Key Takeaways from Parts 1 and 2 – State Contracting with D-SNPs

Basic D-SNP contracting principles

- D-SNPs are Medicare Advantage (MA) plans that only enroll dually eligible individuals.
- All D-SNPs must hold contracts with state Medicaid agencies (known as state Medicaid agency contracts, or "SMACs").
  - Those contracts must contain at least the minimum elements described at 42 CFR § 422.107(c)-(d).
  - States can add elements to their SMACs to support their integration goals.
  - Take note of key MA dates when developing and issuing SMACs.

States can learn about key Medicare Advantage dates in this ICRC resource:

https://www.integratedcareresourcecenter.com/resource/key-2025-medicare-advantage-dates

Levels of D-SNP integration

Coordination-Only (CO) D-SNPs

- Must meet minimum CMS requirements for D-SNPs.
- Must notify the state Medicaid agency or its designee of hospital and skilled nursing facility admissions for at least one designated group of "high-risk," full-benefit dually eligible (FBDE) enrollees.

Highly Integrated Dual Eligible (HIDE) SNPs

- Must cover either Medicaid behavioral health benefits, long-term services and supports (LTSS), or both.
- Contract for coverage of Medicaid benefits may be with the D-SNP, the D-SNP's parent company, or another entity owned and controlled by the D-SNP's parent company.
- A HIDE SNP's capitated contract with the state Medicaid agency must cover the entire service area of the D-SNP.

Fully Integrated Dual Eligible (FIDE) SNPs

- Must operate with exclusively aligned enrollment and use a unified plan-level appeal and grievance process.
- Must cover Medicaid primary and acute care services; Medicare cost sharing; home health; durable medical equipment, supplies and appliances; behavioral health and LTSS, including at least 180 days of nursing facility coverage.
- Must use specialized care management and network methods to coordinate care for high-risk beneficiaries.
- Entity contracted to cover Medicaid benefits must be the same legal entity that holds the D-SNP contract with CMS.
- Capitated contracts with the state Medicaid agency must cover the entire service area of the D-SNP.
- Must use an integrated Health Risk Assessment (HRA) and an integrated member ID card starting in 2027.

For more information, see Weir Lakhmani, E. "Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025." Integrated Care Resource Center. December 2022. Available at: https://www.integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023.

Applicable Integrated Plans (AIPs)

To qualify as an AIP, a D-SNP must be:

1. A FIDE SNP; or
2. A HIDE SNP that operates with EAE; or
3. A CO D-SNP that operates with EAE and covers Medicaid primary and acute care benefits, Medicare cost sharing, and at least one of the following additional Medicaid benefits:
   - Nursing facility services;
   - Home health services; and/or
   - Medical supplies, equipment, and appliances.

Exclusively aligned enrollment (EAE) 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.

[1] 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.

Source: 42 CFR § 422.561

Part 1: Introduction to D-SNPs and D-SNP contracting basics

- Introduction to dually eligible individuals
- Introduction to D-SNPs:
  - How D-SNPs differ from other Medicare Advantage plans
  - Minimum federal rules for all D-SNPs
- Basic D-SNP contracting principles:
  - Minimum requirements for all state Medicaid agency contracts (SMACs)
  - Additional requirements for integrated D-SNPs
- New rules for certain D-SNPs in 2026, 2027 and 2030

Webinar slide deck and recording are available at:

https://www.integratedcareresourcecenter.com/webinar/working-medicare-state-contracting-d-snps-introduction-d-snps-and-d-snp-contracting-basics

Part 2: Contracting strategies and considerations for states with integrated D-SNPs

- Contracting strategies for states with integrated D-SNPs:
  - Direct capitation of D-SNPs
  - Aligning D-SNPs with affiliated Medicaid managed care plans offered by the same parent organization
- Medicaid managed care regulations and D-SNP contracting:
  - Rules at 42 CFR Part 438 apply to D-SNPs that cover Medicaid benefits
- Medicaid procurement considerations for states with integrated D-SNPs:
  - Key Medicare Advantage dates to keep in mind
  - Leveraging Medicare resources in Medicaid procurements
  - Unexpected events and contingency planning

Webinar slide deck and recording are available at:

https://www.integratedcareresourcecenter.com/webinar/working-medicare-state-contracting-d-snps-part-2-contracting-strategies-and-considerations

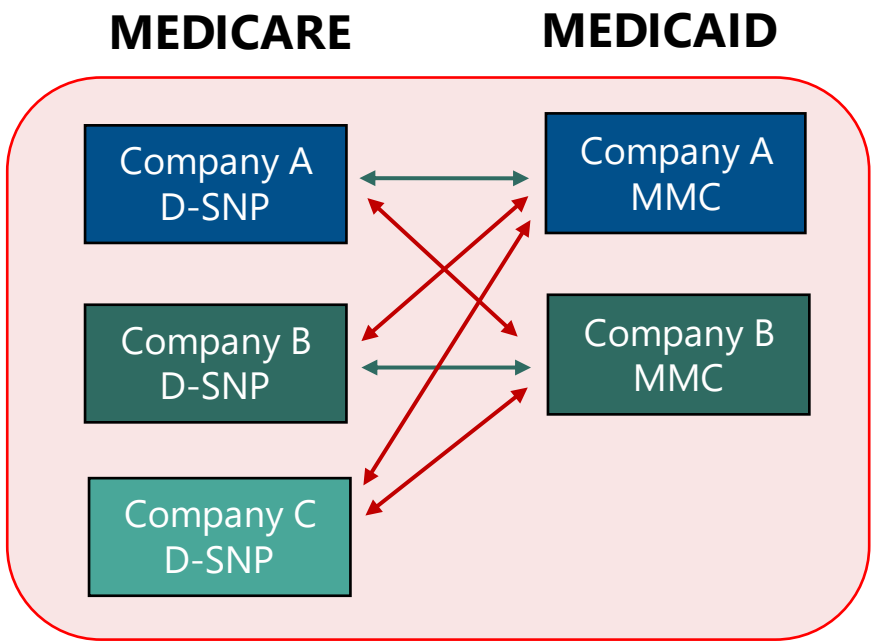
Using SMAC Requirements to Promote D-SNP Integration and Enrollment into Integrated D-SNPs

State policies that support D-SNP integration and enrollment into integrated plans

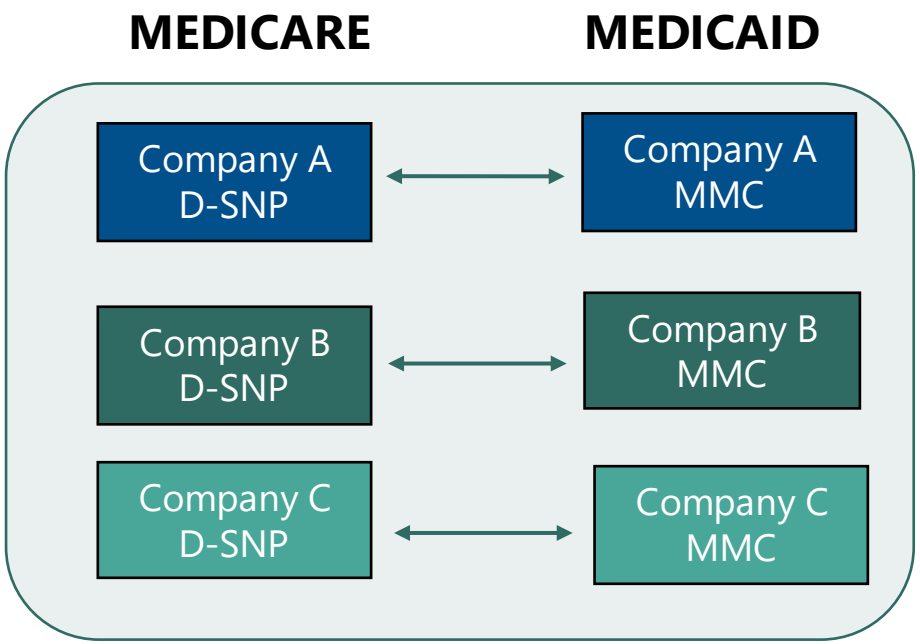
- Require D-SNPs to operate with EAE.
- Allow or require D-SNPs to use default enrollment.
- Require D-SNPs to use separate PBPs within D-SNPs to serve different groups of dually eligible individuals.

Understanding aligned enrollment

Aligned enrollment occurs when a dually eligible individual is enrolled in a D-SNP and a Medicaid managed care (MMC) plan offered by the **same parent company** in the same geographic area.



Aligned and Unaligned Enrollees



All Aligned Enrollees

Requiring D-SNPs to operate with EAE

- EAE occurs when the state contract limits enrollment in the D-SNP to **FBDE 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.
- EAE facilitates use of several strategies to integrate coverage and navigation of Medicare and Medicaid benefits, such as fully integrated enrollee materials, single ID cards, and unified appeal and grievance processes.

For more information on **EAE**, see ICRC's resource page at: https://www.integratedcareresourcecenter.com/resources-by-topic/exclusively-aligned-enrollment

Use default enrollment to facilitate enrollment into integrated D-SNPs

- States can promote the use of default enrollment to increase enrollment into integrated D-SNPs.
- Default enrollment enables qualifying D-SNPs to enroll people who are currently enrolled in the D-SNP's affiliated Medicaid MCO and become newly eligible for Medicare.
- To qualify for default enrollment, a D-SNP must
  - Obtain approval from the state and CMS;
  - Provide CMS with documentation of the process that the state will use to inform the D-SNP of MCO enrollees attaining Medicare eligibility;
  - Have a minimum overall quality rating of at least three stars;
  - Not have a CMS prohibition on new enrollments;
  - Have an affiliated MCO in the same service area as the D-SNP; and
  - Be able to continue offering – through the D-SNP or an affiliated Medicaid managed care plan – a substantial range of Medicaid benefits to D-SNP enrollees.

For more information on **default enrollment**, see ICRC's tip sheet at: https://www.integratedcareresourcecenter.com/resource/using-default-enrollment-align-coverage-dually-eligible-medicare-medicaid-beneficiaries

Use separate D-SNP PBPs to enroll different groups of dually eligible individuals

- States can require D-SNPs to offer separate PBPs that enroll different groups of dually eligible individuals, such as:
  - Full-benefit vs. partial-benefit dually eligible individuals;
  - Dually eligible individuals who are eligible for the state's integrated care program vs. those who are not eligible (for example, due to age, dual eligibility status, nursing facility level of care needs, or other criteria); and/or
  - Dually eligible individuals with coverage for Medicare cost sharing vs. those who do not qualify for such coverage (to promote clarity in benefits and materials about enrollees' cost-sharing responsibilities).
- Use of separate PBPs for different groups of D-SNP enrollees can help advance other state strategies that promote aligned enrollment, such as EAE and default enrollment.

States interested in requiring D-SNPs to use separate PBPs should consider the Medicare Advantage bid process timeline.

See ICRC's calendar of key Medicare Advantage dates at: https://integratedcareresourcecenter.com/resource/key-2025-medicare-advantage-dates

Simplifying D-SNP materials through use of separate PBPs

PBP with **$0 cost sharing**

		In-Network
Inpatient Hospital Care		$0 copay per stay
Outpatient Hospital	Ambulatory Surgical Center (ASC)	$0 copay
	Outpatient Hospital, including surgery	$0 copay
	Outpatient Hospital Observation Services	$0 copay
Doctor Visits	Primary Care Provider	$0 copay
	Specialists	$0 copay
Preventative services	Medicare-covered	$0 copay

PBP without **$0 cost sharing**

		In-Network
Inpatient Hospital Care		$0 - $1,500 copay per stay
Outpatient Hospital	Ambulatory Surgical Center (ASC)	$0 copay for a diagnostic colonoscopy $0 copay – 20% coinsurance otherwise
	Outpatient Hospital, including surgery	$0 copay for a diagnostic colonoscopy $0 copay – 20% coinsurance otherwise
	Outpatient Hospital Observation Services	$0 copay – 20% coinsurance
Doctor Visits	Primary Care Provider	$0 copay – 20% coinsurance
	Specialists	$0 copay – 20% coinsurance
Preventative services	Medicare-covered	$0 copay – 20% coinsurance

Key takeaways: Using state requirements to promote integration

- For FBDEs, EAE facilitates the use of strategies to integrate coverage and navigation of Medicare and Medicaid benefits, including fully integrated enrollee materials, single ID cards, and unified appeal and grievance processes.
- Qualified plans can use default enrollment to increase integrated D-SNP enrollment among individuals newly eligible for Medicare.
- Use of separate PBPs for different groups of D-SNP enrollees can help advance EAE and default enrollment strategies, while also helping to clarify enrollee cost-sharing responsibilities.

Using SMACs to Advance Other State Goals

Using SMACs to advance state goals

- Beyond minimum federal requirements, states can use SMACs to establish additional requirements that advance state goals in key areas, such as:
  - Care coordination;
  - Coverage of Medicaid benefits;
  - Eligibility and enrollment;
  - Enrollee communications and marketing; and
  - Data reporting.

States can reference examples of (1) required language that must be in all states' SMACs and (2) optional language that states can add to SMACs to achieve state goals with the following ICRC tools: https://integratedcareresourcecenter.com/resources-by-topic/sample-smac-language

Enhanced SMAC requirements: Care coordination

- States who wish to improve care coordination experiences for D-SNP enrollees could use SMACs to require D-SNPs to:
  - Meet state model of care (MOC) expectations;
  - Establish processes to improve discharge planning and support transitions in care;
  - Include state-specific elements in HRAs or impose additional requirements regarding HRA timing;
  - Provide specific training to D-SNP care coordinators, or require that they have certain backgrounds or education levels;
  - Collaborate on care planning with specific entities (e.g., HCBS waiver case manager when D-SNP enrollee has a distinct care coordinator).

Timing considerations for Models of Care (MOC):

- May be approved for up to 3 years at a time
- States may review MOCs to confirm state elements have been addressed
- Due to CMS the Friday before the first Monday in June in a review year
- "Off cycle" reviews are possible, but states may find it easier to work new MOC requirements into a D-SNP's existing MOC review schedule

ICRC hosted a webinar in April 2023 which discussed other ways to leverage D-SNP Models of Care to enhance enrollee care coordination: https://integratedcareresourcecenter.com/webinar/leveraging-dual-eligible-special-needs-plan-d-snp-models-care-enhance-enrollee-care

Enhanced SMAC requirements: Coverage of Medicaid benefits

- States who wish to influence how D-SNPs cover certain benefits could require D-SNPs to:
  - Cover Medicaid benefits for members (through the D-SNP or an affiliated Medicaid managed care plan offered by the same parent company as the D-SNP), including coverage of Medicare cost sharing.
  - Coordinate MA supplemental benefits with Medicaid benefits by:
    - Sending the state a list of the MA supplemental benefits offered by the D-SNP;
    - Requiring use of supplemental benefits before an overlapping Medicaid benefit is used (for example, dental);
    - Covering certain items or services as MA supplemental benefits (for example, eyeglasses) instead of using Medicaid benefits.

Timing considerations for supplemental benefits:

- MA plans submit bids to CMS in June, but planning for bids begins several months earlier.
- If a state wants to require a D-SNP to cover a certain benefit in 2027, they state should alert the D-SNP at least six months before bid submission.

Enhanced SMAC requirements: Eligibility and enrollment

- Requiring D-SNPs to assist enrollees with Medicaid eligibility redetermination processes.
- Requiring D-SNPs to use eligibility deeming periods of at least a certain length.
- Requiring or allowing D-SNPs to use default enrollment.
- Limiting D-SNP enrollment to full-benefit dually eligible individuals or requiring use of separate PBPs to serve different groups of dually eligible individuals (such as full- and partial-benefit dually eligible individuals).

States can learn more about redetermination and deeming period requirements in the following ICRC tool: https://integratedcareresourcecenter.com/resource/preventing-and-addressing-unnecessary-medicaid-eligibility-churn-among-dually-eligible

States can learn more about default enrollment in the following ICRC tool: https://integratedcareresourcecenter.com/resource/using-default-enrollment-align-coverage-dually-eligible-medicare-medicaid-beneficiaries

Enhanced SMAC requirements: Enrollee communication and marketing

- States can require D-SNPs to submit materials for state review and/or require D-SNPs to use specific language in certain materials to ensure that the materials are clear and accurately reflect state-specific information.
- States with AIPs can require AIPs to use integrated versions of certain materials that the states develops with CMS, such as:
  - Summary of Benefits,
  - Evidence of Coverage (Member Handbook),
  - Annual Notice of Change,
  - Provider and Pharmacy Directory, and
  - List of Covered Drugs (Formulary).
- Note that all AIPs will be required to use integrated member ID cards starting in 2027.

States can learn more about developing integrated materials with the following ICRC tool:

https://www.integratedcareresourcecenter.com/resource/integrating-dual-eligible-special-needs-plan-materials-promote-enrollee-understanding-and

Enhanced SMAC requirements: Data reporting

- To support state monitoring and oversight of D-SNP performance and quality improvement, states can require D-SNPs to share data with the state, such as:
  - Medicare Advantage encounter data (including Part D prescription drug event (PDE) files),
  - Quality measure data,
  - Appeal and grievance data,
  - MA bid information,
  - Medicare audit findings, notices of non-compliance, and corrective action plans,
  - Care management data,
  - Enrollment data, and
  - Provider network information.

ICRC has developed a suite of resources that can help states improve oversight and monitoring of D-SNPs:

https://integratedcareresourcecenter.com/resources-by-topic/oversight-and-monitoring-dual-eligible-special-needs-plans

Key takeaways: Using SMACs to improve coordination

- To operate in a state, a D-SNP must hold a contract with the state Medicaid agency.
- States can include provisions in their SMACs to advance state goals in key areas, ranging from state specific care coordination requirements and streamlining enrollment to using D-SNPs to deliver a comprehensive set of Medicaid and Medicare benefits.
- ICRC has developed SMAC language tools that review: (1) required language that must be in all states' SMACs and (2) optional language that states can add to SMACs to achieve state goals.
  - These tools are available at: https://integratedcareresourcecenter.com/resources-by-topic/sample-smac-language.

State Monitoring and Oversight of D-SNPs

State roles in monitoring and overseeing D-SNPs

Level one: Oversight of CO D-SNPs, which cover Medicare benefits and coordinate the delivery of Medicare and Medicaid benefits.

Level two: Oversight of D-SNPs that cover both Medicare benefits and at least some Medicaid benefits beyond Medicare cost sharing, such as LTSS, behavioral health, and/or dental.

CMS and states **share responsibility** for D-SNP oversight, especially when D-SNPs cover Medicaid benefits.

For more information, see Stringer, R., E. Weir Lakhmani, and E. Costello. "Tips for States on Incorporating D-SNPs into Medicaid Quality Improvement Activities." Integrated Care Resource Center tip sheet. October 2023. Available at: https://www.integratedcareresourcecenter.com/resource/tips-states-incorporating-d-snps-medicaid-quality-improvement-activities.

Step 1: Identify performance improvement opportunities

- Use data to identify opportunities for improvement. Example sources include:
  - Quality measure data (see ICRC's Improving Quality and Performance in D-SNPs webinar for example quality measure sources, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures and member experience survey data sources);
  - Encounter data and/or reports about use of particular services;
  - Appeals and grievance data.
- Consider requiring D-SNPs to report data in a way that enables identification of discrepancies in enrollees' access to or use of services, and/or experiences with care.

Step 2: Set measurable goals and objectives

- Develop measurable goals and objectives with performance targets and communicate them in the state's SMAC.
- Consult D-SNP enrollees for input and feedback to inform goals.
  - Consider leveraging D-SNP-enrollee advisory committees, state-level Medicaid Advisory Councils and/or outreach events.
- Use measures and monitoring strategies included in the goals and objectives to monitor progress.
- Consider incorporating D-SNPs into state Medicaid managed care quality strategies and aligning goals for D-SNPs with those established for Medicaid managed care plans in the state.

Goals are high-level managed care performance aims that provide direction for the state.

Objectives are measurable steps toward meeting the state's goals and typically include quality measures.

More information about state Medicaid quality strategies and developing goals and objectives is available in the CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies.

Step 3a: Use performance improvement tools

- States can use Medicaid and Medicare tools to drive performance improvement. These include:
  - Quality Assessment and Performance Improvement (QAPI) programs, including Performance Improvement Projects (PIPs);
  - MA Quality Improvement programs;
  - MA Chronic Care Improvement Programs (CCIPs); and
  - D-SNP MOCs.
- States can:
  - Collaborate with D-SNPs to design and implement these tools; and
  - Include the measures and monitoring strategies that the state chooses to monitor progress in these tools.

Step 3b: Use incentives and penalties

- States can also use incentives and/or penalties to drive D-SNP performance improvement. Examples include:

Incentives	Penalties
• Quality/performance withholds • Bonus payments • Publicly posting performance "report cards" • Allowing only high-performing D-SNPs to use default enrollment or conduct certain types of marketing	• Corrective action plans (CAPs) • Fines • Suspension of marketing activities • Suspension of new enrollment and/or default enrollment (if default enrollment is used) • Contract termination

Step 4: Monitor progress

- Collect data and monitor state-level and D-SNP-level performance on the measures and monitoring strategies that the state selected for its goals and objectives.
- Collect feedback from enrollees, D-SNPs, providers, and other interested groups to understand and address facilitators and barriers to goal progress.

Requiring D-SNP-only contracts to ease state oversight of D-SNPs

- Some Medicare resources (such as MA HEDIS measures and Star Ratings) are only available at the MA contract level. Because MA contracts can include multiple plans operating across states, this dilutes states' ability to leverage these resources for monitoring individual D-SNPs.
- States can require D-SNPs that operate with EAE to establish (and operate within) contracts with CMS that only include one or more D-SNPs within a state. These are referred to as **D-SNP-only contracts.**
  - This flexibility enables **reporting of contract-level resources specific to the D-SNPs within a particular state** rather than for all MA plans included in a contract.

For more information about D-SNP only contracts, see: Beaver, D.,H. Gallo Sutherland, N. Joseph. "D-SNP-Only Contracts: Benefits and Key Steps for States." Integrated Care Resource Center webinar. March 2024. Available at: https://integratedcareresourcecenter.com/resource/d-snp-only-contracts-benefits-and-key-steps-states and Centers for Medicare & Medicaid Services (CMS). "Guidance for States Seeking to Leverage New Opportunities for Integrated Care Programs." August 2025. Available at: https://www.cms.gov/files/document/stateoppsintegratedcareprogs.pdf.

Benefits of D-SNP-only contracts for states

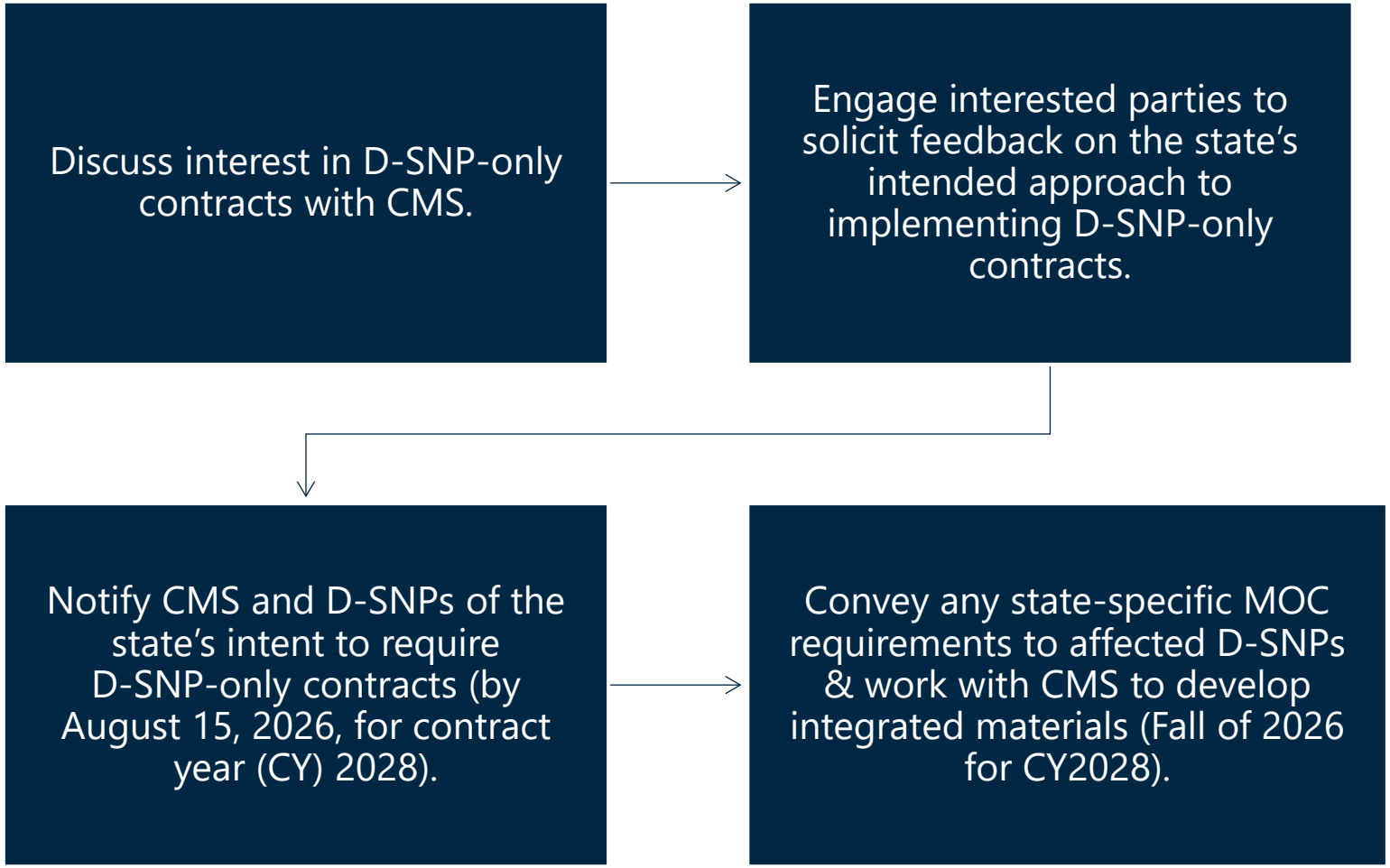
D-SNP-specific quality measures and MA Star Ratings

State access to the CMS Health Plan Management System (HPMS)

Customized MOCs

Health care spending transparency

Key steps for states interested in requiring D-SNP-only contracts



For more information on D-SNP only contracting, see ICRC's webinar on D-SNP only contracting at https://integratedcareresourcecenter.com/resource/d-snp-only-contracts-benefits-and-key-steps-states.

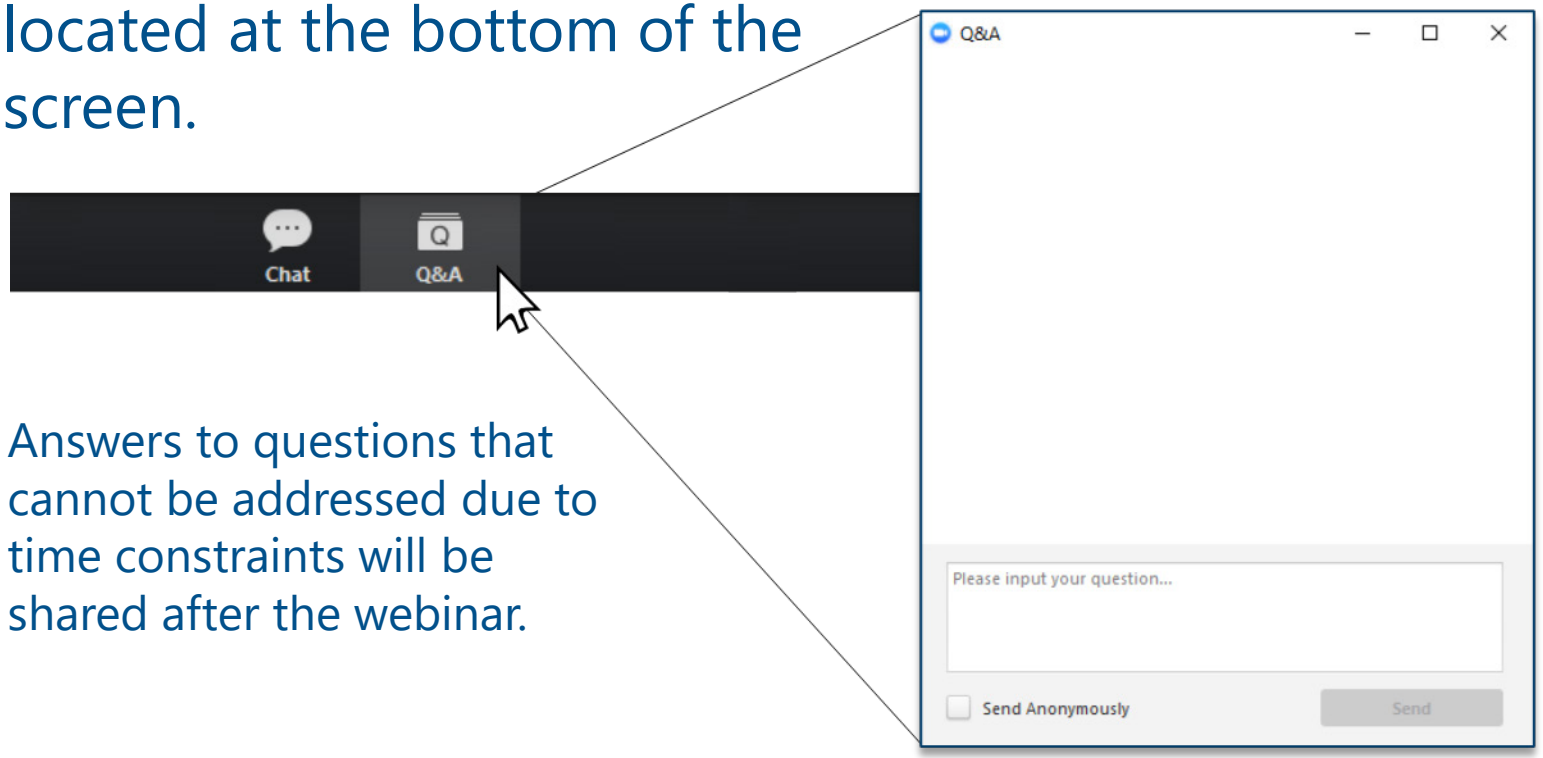
Key takeaways: State monitoring and oversight

- CMS and states share responsibility for D-SNP oversight, especially when D-SNPs cover Medicaid benefits.
- States can improve D-SNP performance by identifying performance improvement opportunities, setting goals and objectives, applying performance improvement tools, incentives, and penalties, and monitoring performance.
- States can use D-SNP-only contracts to gather contract-level Medicare resources specific to the D-SNPs in their states.

Questions?

Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.



Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.

About ICRC

- Established by CMS to advance integrated care models for dually eligible individuals.
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica and the Center for Health Care Strategies.
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges.
- Send other ICRC questions to: integratedcareresourcecenter@mathematica-mpr.com.