Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans

Pursuant to the Bipartisan Budget Act of 2018, the Centers for Medicare & Medicaid Services (CMS) released a final rule on April 16, 2019 that requires Dual Eligible Special Needs Plans (D-SNPs) to do one of the following by January 1, 2021:[1]

- Obtain designation from CMS as a fully integrated D-SNP (FIDE SNP) or a highly integrated D-SNP (HIDE SNP), through coverage of Medicaid long-term services and supports (LTSS) and/or behavioral health (BH); **OR**
- Share information about hospital and SNF admissions with the state (or the state's designee) for a designated group of high-risk, full benefit dually eligible beneficiaries.

Additionally, HIDE SNPs and FIDE SNPs that operate with exclusively aligned enrollment (referred to in the final rule as "applicable integrated plans") must use new, integrated processes to respond to enrollee grievances and appeals.

For 2021, in addition to the minimum contract elements required by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008,[2] D-SNPs' state Medicaid agency contracts (SMACs) must include language detailing the new requirements described in the April 2019 final rule. This technical assistance tool provides **sample contract language that states can use in their D-SNP SMACs to comply with D-SNP SMAC requirements**. Use of this language in the contract does not guarantee that CMS will approve the D-SNP to operate.

- **Table 1, which begins on page 2,** provides sample language designed to comply with the requirements applicable to all D-SNP SMACs. States may use this "foundational" language in their D-SNP SMACs or use other language that meets the minimum regulatory requirements. Table 1 also includes links to additional optional language that goes beyond the minimum requirements and may be of interest to states seeking greater integration of Medicare and Medicaid benefits.

- **Table 2, which begins on page 8,** provides language for those contract elements that apply to D-SNP SMACs in specific circumstances: (1) the D-SNP does not qualify as a FIDE SNP or HIDE SNP and must implement an information-sharing process; (2) the D-SNP wishes to be designated as a FIDE SNP or HIDE SNP and must meet certain requirements to achieve that designation; and (3) the D-SNP qualifies as an applicable integrated plan and must implement integrated appeal and grievance procedures in 2021. States may use this "foundational" language in their D-SNP SMACs or use other language that meets the minimum regulatory requirements. In particular, any language used for D-SNPs seeking FIDE SNP or HIDE SNP designation by CMS must make clear the coverage provided for Medicaid benefits is through capitated payments. States that use the D-SNP SMAC as the contract vehicle for delivery of Medicaid managed care benefits will also need to meet Medicaid contracting requirements. Those Medicaid managed care requirements are not addressed in this technical assistance tool. Table 2 also includes links to additional optional contract language for states seeking additional refinements of these requirements.

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

Per 42 CFR 422.107(c), all D-SNPs must document eight minimum elements in their contracts with states. Table 1 provides a brief description of each of these required elements and sample contract language that states can use to address each requirement. Links to additional optional contract language are also provided to give states examples of language that may be used in specific circumstances or to require D-SNPs to go beyond the minimum requirements. In the sample contract language provided, **italicized text in brackets [ ] is used to convey instructions and situations in which state-specific information will need to be inserted.**

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

Contract Element	CMS Requirement	Description	Foundational Contract Language	Additional Contract Language Options
Category(ies) of Dually Eligible Beneficiaries Eligible to Enroll in the D-SNP	"(2) The category(ies) and criteria for eligibility for dual eligible individuals to be enrolled under the [Special Needs Plan (SNP)], including as described in sections 1902(a), 1902(f), 1902(p), and 1905 of the Act." (42 CFR §422.107[c][2])	This contractual element requires the contract to clearly identify the dually eligible population that is eligible to enroll in the D-SNP. A D-SNP may only enroll dually eligible individuals as specified in the SMAC. For example, if a state Medicaid agency limits D-SNP enrollment to full benefit dually eligible individuals (e.g., those aged 65 and above, or individuals assessed as requiring a nursing home level of care) in the SMAC, the D-SNP must limit enrollment to that population of dually eligible individuals. This contractual element may also include provisions that limit D-SNP enrollment to full benefit dually eligible individuals who are also enrolled in a Medicaid plan offered by the MAO, its parent organization, or another entity owned and controlled by its parent organization—that is, D-SNPs with exclusively aligned enrollment under 42 CFR §422.2. Note that the SLMB, QI and QDWI programs only provide coverage for Medicare Part A or B premiums. SLMB, QI and QDWI members will be subject to higher cost-sharing than other dually eligible individuals, and will not be eligible for coverage of any Medicaid benefits coordinated or covered by the D-SNP.	The Contractor may enroll only those categories of dual eligible individuals[3] indicated below *[Check or list all that apply]*: ☐ Only full-benefit dually eligible beneficiaries (QMB+, SLMB+ and Other Full Benefit Dually Eligible Beneficiaries only) ☐ QMB ☐ QMB+ ☐ SLMB ☐ SLMB+ ☐ QI ☐ QDWI ☐ Other Full Benefit Dually Eligible Beneficiaries ☐ Full-benefit dually eligible beneficiaries (QMB+, SLMB+ and Other Full Benefit Dually Eligible Beneficiaries) who are also enrolled in the Medicaid plan affiliated with the Contractor's D-SNP (*for D-SNPs with exclusively aligned enrollment*)	*[D-SNP SMACs should also identify any applicable eligibility restrictions imposed by the state (for example, restrictions based on age, special program status, or receipt of certain Medicaid waiver services).]*

Contract Element	CMS Requirement	Description	Foundational Contract Language	Additional Contract Language Options
Medicaid Benefits Covered by the D-SNP	"(3) The Medicaid benefits covered under a capitated contract between the State Medicaid agency and the MA organization offering the SNP, the SNP's parent organization, or another entity that is owned and controlled by the SNP's parent organization." (42 CFR §422.107[c][3])	This contractual element requires that information be included on plan benefit design, capitated payment methodology, benefit administration, and assignment of responsibility for providing the covered benefits. D-SNPs must include in the SMAC all Medicaid benefits covered by the D-SNP or by a Medicaid MCO offered by its parent organization or another entity owned and controlled by its parent organization for the specified contract year. The SMAC may include the list of Medicaid benefits in an attachment to the contract but must reference the attachment in the body of the contract. MAOs and states have flexibility on how to reflect the Medicaid benefits in the SMAC; however, the SMAC must list the Medicaid benefits for the specified contract year. The SMAC should describe the entity responsible for Medicaid coverage of Medicare cost sharing.	**Language for contracts with D-SNPs that cover at least some Medicaid benefits:** Services covered by this Contract. The Contractor shall provide the following *[State Medicaid program]* services when medically necessary and appropriate: *[State must provide a list of all Medicaid covered services to be covered by the D-SNP, using a cross-reference to the list within the contract or a cross-reference to the appendix within the contract.]* Services not covered by this Contract. Services that are not covered by this Contract include: *[list Medicaid services carved out of D-SNP contract, but covered in fee-for-service Medicaid]. [If applicable, include language describing the entity(ies) responsible for covering the services carved out of the D-SNP contract.]* These services are not included in the capitated rate paid to the Contractor by *[State Medicaid agency].* The Contractor is not required to provide these services, but is responsible for ensuring coordination of these services, per the federal regulations described at 42 CFR §422.107(c)(1). **Language for contracts with D-SNPs that cover Medicare cost-sharing:** The Contractor shall track and pay all eligible providers the cost-sharing obligations incurred on behalf of enrolled dually eligible beneficiaries with applicable Medicaid eligibility categories covered under this Contract.[4] **Language for contracts with D-SNPs that do not cover any Medicaid benefits:** The Contractor is not responsible for providing or reimbursing any Medicaid benefits. The Contractor shall maintain current knowledge and familiarity of *[State Medicaid program]* benefits through ongoing reviews of *[State]* laws, rules, policies, and further guidance as	Additional optional contract language is available in Appendix A for the topics listed below. Click on the links below to see the relevant contract language: • **Contract language for D-SNPs that provide comprehensive and fully integrated coverage of Medicare and Medicaid benefits**

Contract Element	CMS Requirement	Description	Foundational Contract Language	Additional Contract Language Options
			posted on the *[State Medicaid program]* website. The Contractor shall timely coordinate *[State Medicaid program]* benefits for its enrolled Dual Eligible Members as described in *[reference attachment or section that lists and describes Medicaid benefits]* of this Agreement. *[Reference section/attachment that describes care coordination requirements]* details the Contractor's specific Medicare-Medicaid care coordination requirements. *[State]* Medicaid covered services are described in Title XIX of the Social Security Act, 42 CFR §§440 and 441; *[add state statutory reference(s), state policy manual reference(s), contractual references, etc. as applicable, including references to other sections of the contract that list state Medicaid benefits];* the *[state Medicaid program]* website; and other relevant materials.[5]	

Contract Element	CMS Requirement	Description	Foundational Contract Language	Additional Contract Language Options
Cost-Sharing Protections	"(4) The cost-sharing protections covered under the SNP." (42 CFR §422.107[c][4])	This contractual element requires that MAOs offering D-SNPs not impose cost sharing on specified dually eligible individuals (i.e., full Medicaid individuals, Qualified Medicare Beneficiaries (QMBs), or any other population designated by the state) that exceed the amounts permitted under the Medicaid State Plan if the individual were not enrolled in the D-SNP. In addition, the D-SNP must meet all MA maximum out-of-pocket (MOOP) requirements.	The Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Dual Eligible Members that would exceed the amounts permitted under the *[State]* State Plan for Medical Assistance, per section 1852(a)(7) of the Act and 42 CFR §422.504(g)(1)(iii).[6] Section 1902(n)(3)(B) of the Social Security Act prohibits a Medicare provider from billing a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments.[7] A Dual Eligible Member with QMB benefits has no legal obligation to make further payment to a provider or to the Contractor for Medicare Part A or Part B cost sharing amounts. The Contractor's provider agreements shall specify that a contracted Medicare provider agrees to accept the Contractor's Medicare reimbursement as payments in full for services rendered to Dual Eligible Members, or to bill *[State or State Medicaid program health plan]* as applicable for any additional Medicare payments that may be reimbursed by Medicaid. Dual Eligible Members shall be responsible for any applicable Medicaid copayments.[8]	Additional optional contract language is available in Appendix A for the topic listed below. Click on the link below to see the relevant contract language: • **Contract language for D-SNPs that offer zero dollar cost-sharing to some or all enrollees**
State Identification and Sharing of Information on Medicaid Provider Participation	"(5) The identification and sharing of information on Medicaid provider participation." (42 CFR §422.107[c][5])	This contractual element requires that a process be specified regarding how the state will identify and share information on providers contracted with the state Medicaid agency for inclusion in the D-SNP provider directory. Although CMS does not require all providers to accept both Medicare and Medicaid, the D-SNP's network must meet the needs of the dually eligible population served.	*[State Medicaid agency]* will provide the Contractor with an electronic data file containing Medicaid participating providers in a mutually-agreed upon format on a *[insert periodicity]* basis. [*Insert if applicable: any D-SNPs affiliated with a companion Medicaid managed care plan can obtain the file from the affiliated [Medicaid managed care program] plan.*] Once *[State Medicaid agency]* provides an electronic data file list of enrolled Medicaid providers, the Contractor will identify in its provider directory those providers that accept both Medicare and Medicaid (providers that are currently registered providers under *[Medicaid program name]* and are also within the Contractor's network).[9]	*N/A*

Contract Element	CMS Requirement	Description	Foundational Contract Language	Additional Contract Language Options
D-SNP Verification of Enrollee Eligibility for Medicare and Medicaid	"(6) The verification of enrollee's eligibility for both Medicare and Medicaid." (42 CFR §422.107[c][6])	This contractual element requires that the state Medicaid agency provide the MAO offering the D-SNP with access to real-time information verifying eligibility of dually eligible enrollees. The contract must describe in detail the agreed-upon eligibility verification process between the MAO and the state.	To verify Medicaid eligibility of an individual member, *[State Medicaid Agency]* agrees to provide the Contractor with real-time access to the *[State Medicaid program]*'s eligibility verification system. To verify eligibility of all members in a D-SNP on a *[enter periodicity (for example, daily/weekly/monthly/periodically)]* basis, *[State Medicaid Agency]* and the Contractor will exchange eligibility verification data files pursuant to a method agreed upon by both parties. *[List available verification methods (for example, individual, batch, electronic, non-electronic) and describe methods for accessing each option. In states where D-SNPs have affiliated Medicaid managed care plans, the state may wish to include language here explaining that the D-SNP will verify ongoing Medicaid eligibility through the enrollment and disenrollment processes established for its affiliated Medicaid managed care program health plan.]* [10] The Contractor shall verify Medicare eligibility of individual members when requested by *[State Medicaid Agency]*.	Additional optional contract language is available in Appendix A for the topics listed below. Click on the links below to see the relevant contract language: • **Contract language requiring D-SNP to inform providers of verified enrollee eligibility and plan enrollment** • **Contract language requiring D-SNPs to report changes in enrollee status that may impact enrollee eligibility**[11] • **Contract language for D-SNPs with exclusively aligned enrollment that requires the D-SNP to use a state-approved enrollment file as its final enrollment list** • **Contract language requiring D-SNP to verify eligibility for institutional level of care, in addition to Medicare and Medicaid eligibility, for purposes of calculating cost-sharing**

Contract Element	CMS Requirement	Description	Foundational Contract Language	Additional Contract Language Options
D-SNP Service Area	"(7) The service area covered by the SNP." (42 CFR §422.107[c][7])	This contractual element requires that the covered service area(s), in which the state has agreed the MAO offering the D-SNP may market and enroll, be clearly identified in the contract. The D-SNP service area(s) in the SMAC must be consistent with the service area(s) for the D-SNP in HPMS.	The service area is the geographic area in which enrollees or potential enrollees reside and for whom the Contractor is approved to provide services by CMS. The service area covered by this Contractor is *[List counties served]. [If contract covers more than one D-SNP plan benefit package, and the different benefit packages cover different service areas, the state may wish to incorporate a table that lists each Medicare Advantage contract number and plan ID covered by the contract, along with the counties served by each plan.]*	*N/A*
Contract Period	"(8) The contract period for the SNP." (42 CFR §422.107[c][8])	This contractual element requires a period of performance between the state Medicaid agency and the MAO offering the D-SNP of at least January 1 through December 31 of the year following the due date of the contract.	This contract is effective January 1, *[year]* through December 31, *[year].*	Additional optional contract language is available in Appendix A for the topic listed below. Click on the link below to see the relevant contract language: • **Contract language for states that wish to use "evergreen" contracts with D-SNPs beginning January 1, 2021**[12]

Table 2: Sample Language for Additional Contract Elements Required for Certain D-SNPs

Certain D-SNPs need to have additional contract elements in their contracts with state Medicaid agencies, beyond the minimum required elements described in Table 1. For example, starting in 2021, D-SNPs that do not qualify as Fully Integrated D-SNPs (FIDE SNPs) or Highly Integrated D-SNPs (HIDE SNPs) will need to have language in their state Medicaid agency contracts that specifies the process the D-SNPs will use to share information about hospital and SNF admissions with the state (or the state's designee) for a designated group of high risk, full benefit dually eligible beneficiaries. To qualify as a FIDE SNP or HIDE SNP, D-SNPs must be able to identify language in their contracts with state Medicaid agencies that shows that the D-SNP covers Medicaid BH and/or LTSS benefits, and FIDE SNPs must show that they meet additional requirements for administrative alignment. Finally, FIDE SNPs and HIDE SNPs that have exclusively aligned enrollment ("applicable integrated plans") will need to implement new integrated grievance and appeal procedures, in compliance with 42 CFR 422.629 – 422.634. Table 2 describes these and other required contract elements that are only applicable to certain D-SNPs.

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

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
Requiring D-SNPs to Share Information about Hospital and SNF Admissions with the State or the State's Designee *(Required for D-SNPs that do not qualify for designation as a FIDE SNP or a HIDE SNP)*	"(d) *Additional minimum contract requirement*. For any dual eligible special needs plan that is not a fully integrated or highly integrated dual eligible special needs plan, the contract must also stipulate that, for the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the SNP notifies, or arranges for another entity or entities to notify, the State Medicaid agency, individuals or entities designated by the State Medicaid agency, or both, of hospital and skilled nursing facility admissions for at least	This contractual element applies to D-SNPs that are not FIDE SNPs or HIDE SNPs, as defined in 42 CFR §422.2, beginning for CY 2021. The SMAC must describe the process whereby the MAO offering the D-SNP notifies, or arranges for another entity or entities to notify, the state Medicaid agency, individuals or entities designated by the state Medicaid agency, or both, of hospital and SNF admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the state Medicaid agency. The SMAC must describe the timeframe and methods by which such notice is provided, and the criteria for identifying the high-risk full-benefit dually eligible individuals for whom the notice is provided.	For all plan enrollees enrolled in *[Medicaid health home/HCBS waiver/behavioral health MCO/MLTSS plan—Use state specific terms, include all that apply]*, the Contractor shall provide timely notification of all admissions to a hospital and skilled nursing facility (SNF) to the enrollee's *[Medicaid health home/HCBS waiver case manager/behavioral health MCO/MLTSS plan—Use state-specific terms, include all that apply]* as applicable to the member. Timely notification is defined as [*insert specifications for timeliness and method(s) to be used for delivery of notifications]*. **Sample language regarding specification of method to identify the population of high-risk full-benefit dually eligible individuals for whom notification is required:** To ensure proper and timely identification of all plan members meeting the criteria specified in	Additional optional contract language is available in Appendix B for the topic listed below. Click on the link below to see the relevant contract language: • **Contract language requiring enhanced D-SNP coordination and discharge planning**

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
	one group of high-risk full-benefit dual eligible individuals, identified by the State Medicaid agency. The State Medicaid agency must establish the timeframe(s) and method(s) by which notice is provided. In the event that a SNP authorizes another entity or entities to perform this notification, the SNP must retain responsibility for complying with this requirement." (42 CFR §422.107[d])		*[reference to section of contract designating population for notifications],* the Contractor will *[specify method for identifying members meeting the state's specified criteria – for example, review a file shared by the state, or extract data from a state Medicaid enrollment database]* on a *[frequency]* basis, in accordance with *[reference to any instructions or guidance provided elsewhere]*. **Sample language regarding timeliness and notification method for states/D-SNPs using Health Information Exchange technology:** "Timely notification" is defined as any real-time notification provided by the Contractor or its contracted hospitals and skilled nursing facilities via Health Information Technology (HIT) or Health Insurance Exchange (HIE) or, where notification via HIT or HIE is not provided, via direct communication from the Contractor within *[x hours/days]* of the Contractor becoming aware of such admission. **Sample language regarding timeliness and notification method for states/D-SNPs using file sharing methods:** "Timely notification" is defined as daily, automated file exchange. Every day, seven days a week, prior to *[time of day/close of business/other specification]*, the Contractor will upload a *[specify file type]* file to *[specify server]*. The file shall be organized and populated in accordance with the template provided by *[state Medicaid agency]* and designate which of the Contractor's plan members who meet the criteria specified in *[reference to section of contract designating population for*	

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
			notifications] have experienced a hospital or SNF admission in the prior 24 hour period. **Sample language regarding timeliness and notification method for states/D-SNPs using manual, direct communication methods:** "Timely notification" is defined as *[fax/email/telephone/other form of manual communication]* communication initiated within *[time frame – for example, 24 hours, 48 hours]* of the time upon which the D-SNP becomes aware that a member who meets the criteria specified in *[reference to section of contract designating population for notifications]* has experienced a hospital or SNF admission. To facilitate this communication, on a *[frequency]* basis, *[state Medicaid agency]* will provide an updated list of contacts at *[receiving entity(ies) – HCBS care management providers, Medicaid managed care plans, etc.]* to whom the Contractor should send these notifications. **Sample language for when a D-SNP delegates responsibility for notification to its contracted hospitals and SNFs:** Contractor will require its contracted hospitals and SNFs to meet the notification requirements on admissions as specified in this contract. Contractor retains responsibility for compliance with the notification requirements in this contract.	

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
Requiring D-SNPs to Identify Their Ownership and /or Affiliation with a Medicaid Managed Care Plan (for purposes of FIDE SNP or HIDE SNP designation) *(Required for FIDE SNPs and HIDE SNPs)*	*"Fully integrated dual eligible special needs plan* means a dual eligible special needs plan— (1) That provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Act with the applicable State… *Highly integrated dual eligible special needs plan* means a dual eligible special needs plan offered by an MA organization that provides coverage, consistent with State policy, of long-term services and supports, behavioral health services, or both, under a capitated contract that meets one of the following arrangements— (1) The capitated contract is between the MA organization and the Medicaid agency; or (2) The capitated contract is between the MA organization's parent organization (or another entity that is owned and controlled by its parent organization) and the Medicaid agency." (42 CFR §422.2)	If a D-SNP seeks FIDE SNP or HIDE SNP designation by CMS, the D-SNP will need to clearly identify the entity that holds a capitated contract with the State Medicaid Agency for coverage of any Medicaid benefits covered under the contract, in order to demonstrate that either LTSS or behavioral health benefits, or both, are covered by "the Medicare Advantage organization offering the SNP, the SNP's parent organization, or another entity that is owned and controlled by the SNP's parent organization." (42 CFR §422.107[c][3]) To obtain a FIDE SNP designation, the D-SNP must demonstrate that the entity holding the capitated contract with the state Medicaid agency is the same legal entity as the entity holding the Medicare Advantage contract with CMS.	Please specify which of the following applies to the D-SNP(s) covered under this contract: ☐ The legal entity holding a contract with CMS for the D-SNP(s) covered under this Contract receives direct capitation from *[State Medicaid agency]* to provide coverage of the Medicaid benefits described in *[reference to section of contract that lists Medicaid benefits covered by the D-SNP]*. ***[Note: This language can result in either HIDE SNP or FIDE SNP designation.]*** ☐ The legal entity holding a contract with CMS for the D-SNP(s) covered under this Contract is under the ownership and control of the same parent organization, *[name of parent organization],* as a [*Medicaid Managed Care Program Name*] plan operating in the same region as the D-SNP(s) covered under this Contract. The *[Medicaid Managed Care Program Name]* plan is responsible for covering the Medicaid benefits described in *[reference to section of contract that lists Medicaid benefits covered by the Medicaid managed care plan]*. ***[Note: This language can only result in HIDE SNP designation.]***	Additional optional contract language is available in Appendix B for the topic listed below. Click on the link below to see the relevant contract language: • **Contract language requiring D-SNPs to operate an affiliated Medicaid managed care plan in the same service area(s) as their D-SNPs** • **Contract language requiring Medicaid managed care organizations to operate affiliated D-SNPs in the same service area(s) as their Medicaid managed care plan(s)**

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
Requiring FIDE SNPs to Cover Medicaid Benefits, including LTSS *(Required for FIDE SNPs)*	*"Fully integrated dual eligible special needs plan* means a dual eligible special needs plan—… (2) Whose capitated contract with the State Medicaid agency provides coverage, consistent with State policy, of specified primary care, acute care, behavioral health, and long-term services and supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year…" (42 CFR §422.2)	If a D-SNP seeks FIDE SNP designation by CMS, the D-SNP contract will need to clearly show that it provides the scope of coverage for Medicaid primary care, acute care, behavioral health and LTSS services through the D-SNP or through a Medicaid MCO contract with the legal entity offering the D-SNP. The Medicaid LTSS coverage must include coverage of LTSS in the community and coverage of nursing facility services for a period of at least 180 days during the plan year. Minimal LTSS service carve-outs consistent with state policy are allowed. Behavioral health can be carved out, consistent with state policy.	**Language for FIDE SNP coverage of Medicaid benefits, including LTSS:** Services covered by this Contract. The Contractor shall provide the following *[State Medicaid program]* services when medically necessary and appropriate: *[State must provide a list of all Medicaid community-based and institutional LTSS services to be covered by the D-SNP or the Medicaid MCO offered by the legal entity that offers the D-SNP, either within the text of the contract, or in an appendix that is referenced within the text of the contract. Any limitation on coverage of Nursing Facility days must be specified.]* Services not covered by this Contract. Services that are not covered by this Contract include *[list any LTSS not covered, including HCBS waiver services carved out of D-SNP contract, but covered in fee-for-service Medicaid]. [If applicable, include language describing the entity(ies) responsible for covering the services carved out of the D-SNP contract.]* These services are not included in the capitated rate paid to the Contractor by *[State Medicaid agency]*. The Contractor is not required to provide these services, but is responsible for ensuring coordination of these services, per the federal regulations described at 42 CFR §422.107(c)(1). **Language for contracts in which the MA organization offering the D-SNP receives direct capitation from the state for coverage of Medicaid services:** Except as noted in [*reference to section describing exceptions to payment schedule*], on *[day of month or other identification of periodicity for payments]*,	*N/A*

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
			[State Medicaid agency] agrees to pay the Contractor capitated monthly rates calculated as specified in *[contract appendix or other source where state describes rates and rate-setting methodology]*, per Enrollee enrolled with the Contractor as full compensation for *[state Medicaid program]* goods and services provided hereunder in that month, under this Contract. The *[identify rate cell type – for example, institutional, community-based waiver recipient, non-LTSS, etc.]* rate cell includes the following components, which are adjusted for *[insert demographic characteristics used for risk adjustment]*: *[insert components included in rate].* Enrollees who meet the following conditions will be assigned to the *[identify rate cell type]* rate cell: *[list conditions]. [Repeat language for all capitated rate rates associated with the contract.]* Assignment of rate cells *[may/shall]* be based on *[insert data sources to be used to assign enrollees to rate cells]*. Rate cell categories shall be assigned prospectively for the next available month.[13]	
Requiring HIDE SNPs to Cover Medicaid BH and/or LTSS Benefits *(Required for HIDE SNPs)*	*"Highly integrated dual eligible special needs plan* means a dual eligible special needs plan offered by an MA organization that provides coverage, consistent with State policy, of long-term services and supports, behavioral health services, or both, under a capitated contract that meets one of the following arrangements—	If a D-SNP seeks HIDE SNP designation by CMS, the D-SNP contract will need to clearly show that it provides coverage of Medicaid LTSS and/or Medicaid behavioral health (BH) services through the D-SNP or through a Medicaid MCO contract with the legal entity offering the D-SNP. Minimal LTSS or BH service carve-outs, consistent with state policy, are allowed.	**Contract language for HIDE SNP coverage of Medicaid LTSS or BH benefits:** <u>Services covered by this Contract.</u> The Contractor shall provide the following *[State Medicaid program]* services when medically necessary: *[State must provide a list of all Medicaid community-based and institutional LTSS services and/or institutional and community based BH to be covered by the Contractor or through a Medicaid contract with another organization that is controlled by the same parent organization as the Contractor, and include the cross-reference to that list in this provision.]*	*N/A*

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
	(1) The capitated contract is between the MA organization and the Medicaid agency; or (2) The capitated contract is between the MA organization's parent organization (or another entity that is owned and controlled by its parent organization) and the Medicaid agency. (42 CFR §422.2)		Services not covered by this Contract. Services that are not covered by this Contract include: *[list LTSS, including HCBS waiver services, carved out of the contract and BH services carved out of the contract but covered under the Medicaid state plan. If applicable, include language describing the entity(ies) responsible for covering the services carved out of the D-SNP contract.]* These services are not included in the capitated rate paid to the Contractor by *[State Medicaid agency]*. The Contractor is not required to provide these services, but is responsible for ensuring coordination of these services, per the federal regulations described at 42 CFR §422.107(c)(1). **Language for contracts in which the MA organization offering the D-SNP receives direct capitation from the state for coverage of Medicaid services:** Except as noted in *[reference to section describing exceptions to payment schedule]*, on *[day of month or other identification of periodicity for payments]*, *[State Medicaid agency]* agrees to pay the Contractor capitated monthly rates calculated as specified in *[contract appendix or other source where state describes rates and rate-setting methodology]*, per Enrollee enrolled with the Contractor as full compensation for *[state Medicaid program]* goods and services provided hereunder in that month, under this Contract. The *[identify rate cell type – for example, institutional, community-based waiver recipient, non-LTSS, etc.]* rate cell includes the following components, which are adjusted for *[insert*	

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
			demographic characteristics used for risk adjustment]: *[insert components included in rate].* Enrollees who meet the following conditions will be assigned to the *[identify rate cell type]* rate cell: *[list conditions]. [Repeat language for all capitated rate rates associated with the contract.]* Assignment of rate cells *[may/shall]* be based on *[insert data sources to be used to assign enrollees to rate cells]*. Rate cell categories shall be assigned prospectively for the next available month.[14]	
Requiring FIDE SNPs to Integrate Care Coordination, Network Management, and Other Aspects of the Beneficiary Experience with the Plan *(Required for FIDE SNPs)*	*"Fully integrated dual eligible special needs plan* means a dual eligible special needs plan—… (3) That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and (4) That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement." (42 CFR §422.2)	If a D-SNP seeks FIDE SNP designation from CMS, the D-SNP will need to show that it meets the FIDE SNP requirements to use aligned care management and specialty network methods for high-risk beneficiaries and policies and procedures that coordinate or integrate beneficiary communication materials, enrollment, communications, grievances and appeals, and quality improvement.	Through the D-SNP product described in this Contract, the Contractor agrees to cover all costs incurred for benefits by its enrolled dually eligible members, as listed in this contract. The Contractor agrees to coordinate the delivery of covered Medicare and Medicaid health and long- term care services, using aligned care management and specialty care network methods for high-risk beneficiaries, including but not limited to: a. The coordination of care provisions described in *[reference to relevant section]*. b. Providing a long-term care case manager who will manage care transitions and assist members accessing the full range of medically necessary services across their Medicare and Medicaid benefits. The Contractor agrees to employ policies and procedures to coordinate or integrate member materials, including enrollment communications, grievance and appeals, and quality assurance, including but not limited to: a. Facilitating Medicaid eligibility redeterminations, including assisting with applications for medical assistance and	Additional optional contract language is available in Appendix B for the topics listed below. Click on the links below to see the relevant contract language: • **Contract language requiring integrated approach to beneficiary marketing materials and inclusion of State Medicaid agency in review of marketing materials with Medicaid information** • **Contract language requiring use of a single enrollee ID card for Medicare**

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
			conducting member education regarding Medicaid eligibility, as described in *[reference to contract section]*; b. Performing integrated Medicare and Medicaid Health Risk Assessments upon enrollment and annually thereafter; and c. Integrating member facing materials wherever possible, including integrated enrollment communications and a single member identification card for Medicare and Medicaid.[15]	**and Medicaid benefits**
Requiring D-SNPs to Maintain Exclusively Aligned Enrollment *(Required for "applicable integrated plans" - FIDE SNPs and HIDE SNPs with exclusively aligned enrollment)*	"*Applicable integrated plan* means: (1) A fully integrated dual eligible special needs plan with exclusively aligned enrollment or a highly integrated dual eligible special needs plan with exclusively aligned enrollment, and (2) The Medicaid managed care organization, as defined in section 1903(m) of the Act, through which such dual eligible special needs plan, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such dual eligible special needs plan and such Medicaid managed	States may choose to require D-SNPs to maintain exclusively aligned enrollment to promote integration of care for the D-SNPs' dually eligible enrollees. "Exclusively aligned enrollment" occurs when everyone enrolled in a D-SNP for coverage of Medicare benefits receives coverage of Medicaid benefits from that D-SNP or another entity controlled by the same entity as the D-SNP's parent organization. When a state contracts directly with the D-SNP for provision of Medicaid services for all the full benefit dually eligible individuals who are enrolled in the D-SNP and only full benefit dually eligible individuals can enroll in the D-SNP, then that D-SNP has exclusively aligned enrollment. When a FIDE SNP or a HIDE SNP has exclusively aligned enrollment, that plan meets the definition of an "applicable integrated plan," at 42 CFR	The Contractor agrees to conduct enrollment of Eligible Persons in accordance with the policies and procedures set forth in this contract and maintain exclusively aligned enrollment for the duration of the contract period. **Language for contracts in which a D-SNP covers Medicaid benefits through the same, single product as the D-SNP and Medicaid enrollment is automatic as a result of D-SNP enrollment:** An Eligible Person's decision to enroll in the Contractor's D-SNP product shall be voluntary. However, as a condition of eligibility for the D-SNP product, individuals may only enroll in the Contractor's D-SNP product if they also simultaneously enroll in the Contractor's *[Medicaid managed care program name]* product as defined in this agreement. An Enrollee's effective date of enrollment shall be the first day of the month in which the Enrollee's name appears on the *[name of enrollment file]* and is enrolled in the Contractor's D-SNP product for that month.	*N/A*

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
	care organization." (42 CFR §422.561) *Aligned enrollment* refers to the enrollment in a dual eligible special needs plan of full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and: the dual eligible special needs plan's (D-SNP's) MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization. When State policy limits a D-SNP's membership to individuals with aligned enrollment, this condition is referred to as exclusively aligned enrollment.	§422.561 and must use the integrated appeal and grievance processes described at 42 CFR §§422.629 through 422.634, 438.210, 438.400, and 438.402.	**Language for contracts in which Medicaid benefits are provided by an entity operated by the same parent organization as the D-SNP and the state initiate Medicaid auto-assignment based on D-SNP enrollment:** An Eligible Person's decision to enroll in the Contractor's D-SNP Product shall be voluntary. However, selection of the D-SNP initiates enrollment in the Medicare Advantage D-SNP product. To complete enrollment in the D-SNP, *[State Medicaid agency]* shall auto-assign the Enrollee to the Contractor's product for the purpose of receiving Medicaid Managed Care benefits and services. To notify the state of new D-SNP enrollees, the Contractor shall submit *[specify mechanism, format, and frequency for sharing enrollment files with state]*.[16]	
Requiring Applicable Integrated Plans (FIDE SNPs and HIDE SNPs with exclusively aligned enrollment) to Integrate Appeals and	"(9) For each dual eligible special needs plan that is an applicable integrated plan as defined in §422.561, a requirement for the use of the unified appeals and grievance procedures under §§422.629 through 422.634, 438.210, 438.400, and 438.402." (42 CFR 422.107[c][9])	This contractual element applies to applicable integrated plans, as defined in 42 CFR §422.561, beginning for CY 2021. In the SMACs for applicable integrated plans, state Medicaid agencies should include a requirement that they use the unified appeals and grievance procedures under 42 CFR §§422.629 through 422.634, 438.210, 438.400, and 438.402. States that	Consistent with state policy, the Contractor shall implement a grievance and appeal system and process grievances and appeals in compliance with the terms of 42 CFR §§ 422.629 – 422.634, 438.210, 438.400, and 438.402. This includes: • Grievances and appeals systems that meet the standards described in §422.629; • An integrated grievance process that complies with §422.630;	*[Per 42 CFR §422.629(c), state agencies can choose to require D-SNPs to utilize shorter timeframes or different notice requirements that are more protective to enrollees than the requirements*

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
Grievance Processes *(Required for "applicable integrated plans" - FIDE SNPs and HIDE SNPs with exclusively aligned enrollment)*		require shorter timelines or different notice requirements that are more protective for enrollees than the requirements under §§422.629 through 422.634 for applicable integrated plans to adjudicate appeals or grievances must include such requirements in the SMAC.	• A process for making integrated organization determinations consistent with §422.631; • Continuation of benefits while an integrated reconsideration is pending consistent with §422.632; • A process for making integrated reconsiderations consistent with §422.633; and • A process for effectuation of decisions consistent with §422.634.	*under 42 CFR §§422.629 –422.631 and 42 CFR §§422.633 – 422.634, so long as those state-specific requirements are consistent with federal Medicaid rules at 42 CFR §438, Subpart F. If states choose to implement different timeframes than those described in the federal regulations, the variant timeframes must be clearly delineated in the D-SNP's SMAC.* *Any state-specific provisions should explicitly describe the state-specific standard and cite the federal standard it is replacing. For example, if a state wished to require a 15-day timeframe for resolution of a standard integrated reconsideration (appeal) rather than the 30 days allowed under §422.633(f)(1), it should include the following: "The plan*

Contract Element and D-SNPs for which Element is Required	Requirement	Description	Foundational Contract Language	Additional Contract Language Options
				must resolve standard integrated reconsiderations within 15 calendar days from the date of receipt in lieu of the 30 calendar days permitted under 42 CFR §422.631(f)(1).”] Additional optional contract language is available in Appendix B for the topic listed below. Click on the link below to see the relevant contract language: • **Contract language requiring D-SNP reporting of integrated grievances and appeals**

Appendix A: Optional Contract Language from Table 1

This appendix contains sample additional optional contract language referenced in Table 1, which describes eight minimum contract elements that must be in all D-SNP SMACs. The language in this appendix may be used or adapted in a variety of situations in which states choose to go beyond the minimum requirements to further enhance integration. In the sample contract language provided, **italicized text in brackets [ ] is used to convey instructions and situations in which state-specific information will need to be inserted.**

Coordination of the Delivery of Medicare and Medicaid Benefits and Services

Contract language requiring coordination with unaffiliated Medicaid managed care plans, the state Medicaid agency, and/or specialized Medicaid benefit contractors[17]

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

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

Contract language describing coordination in D-SNPs with integrated benefits and exclusively aligned enrollment[18]

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

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

Medicaid Benefits Covered by the D-SNP

Contract language for D-SNPs that provide comprehensive and fully integrated coverage of Medicare and Medicaid benefits[19]

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

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

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

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

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

Cost-Sharing Protections

Contract language for D-SNPs that offer zero dollar cost-sharing to some or all enrollees[20]

The Contractor's system shall provide for coordinating benefits for enrollees that are also covered by Medicare. The Contractor shall communicate fully integrated Medicare-Medicaid coverage to all members, providers, Contractor staff, and other stakeholders, including guarantee of complete member protection from financial liability – meaning all deductibles, premiums, coinsurance, copayments, and cost sharing of any kind, with exception for *[list exceptions, if applicable]*.

As a general rule, if a participating or non-participating Provider renders a covered service to a managed care enrollee, the Provider's sole recourse for payment, other than collection of any authorized cost-sharing and /or third party liability, is the Contractor, not the enrollee.

Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for *[list exceptions, if applicable]*.

D-SNP Verification of Enrollee Eligibility for Medicare and Medicaid

Contract language requiring D-SNP to inform providers of verified enrollee eligibility and plan enrollment[21]

The Contractor shall be responsible for keeping its network of Providers, Vendors, and Subcontractors that administer benefits described in *[reference to portion of contract where benefits are described]* of this contract informed of the enrollment status of each enrollee. The Contractor shall be able to report and ensure enrollment to network Providers through electronic means.

Contract language requiring D-SNPs to report changes in enrollee status that may impact enrollee eligibility[22]

The Contractor must report to [*State Medicaid agency*] any change in status of its Enrollees, which may impact the Enrollee's eligibility for Medicaid or the D-SNP, within *[insert state specified timeframe]* of such information becoming known to the Contractor. This information includes, but is not limited to: births; change of address; incarceration; 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 Medicare Advantage Product, as defined in this contract.

Contract language for D-SNPs with exclusively aligned enrollment that requires the D-SNP to use a state-approved enrollment file as its final enrollment list[23]

The Contractor shall accept new enrollments, make enrollments effective, and limit involuntary disenrollments, as provided in subpart B of 42 CFR 422.

The Contractor shall submit to the State a full enrollment file every *[enter frequency of file exchange, for example, daily, weekly, or monthly]* and shall use the state-supplied HIPAA-compliant file format, which is hereby made a part of this contract as if set forth fully herein.

Upon State approval of enrollments submitted in the Contractor's file, the final enrollment file generated by *[State Medicaid Agency]* shall serve as the official Contractor enrollment list. The Contractor shall be responsible for the provision and cost of care for an enrollee during the months on which the enrollee's name appears on the enrollment file, except as indicated in [*list contract article/section that describes exceptions*]. The *[State Medicaid Agency]*'s enrollment file shall include data on eligibility determinations or other errors so that the Contractor can resolve discrepancies that may arise between the *[State Medicaid Agency]* enrollment file and Contractor's or Medicare's enrollment files. If *[State Medicaid Agency]* notifies the Contractor in writing of changes in the enrollment file, the Contractor shall rely upon that written notification in the same manner as the enrollment file.

Contract language requiring D-SNP to verify eligibility for institutional level of care, in addition to Medicare and Medicaid eligibility, for purposes of calculating cost-sharing[24]

Additional eligibility verification steps may be necessary for individuals with an institutional level of care for the purpose of receiving $0 cost sharing, including $0 copayment for prescription drugs. *[State Medicaid Agency]* shall make all reasonable efforts to supply HCBS eligibility information upon the receipt of the request from the Contractor using the access methods described below.

[Insert access method(s) and any relevant terms of access, such as subscription payment for electronic data exchange tool(s).]

Contract Period

Contract language for states that wish to use "evergreen" contracts with D-SNPs beginning January 1, 2021[25]

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

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

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

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

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

Appendix B: Optional Contract Language from Table 2

This appendix contains sample additional optional contract language referenced in Table 2, which describes contract elements that must be in D-SNP SMACs for certain D-SNPs (for example, D-SNPs that do not qualify as FIDE SNPs or HIDE SNPs in 2021, D-SNPs that do qualify as FIDE SNPs or HIDE SNPs, and FIDE SNPs or HIDE SNPs that have exclusively aligned enrollment and therefore qualify as "applicable integrated plans"). The language in this appendix may be used or adapted in a variety of situations in which states choose to go beyond the minimum requirements to enhance integration. In the sample contract language provided, **italicized text in brackets [ ] is used to convey instructions and situations in which state-specific information will need to be inserted.**

Requiring D-SNPs to Share Information about Hospital and SNF Admissions with the State or the State's Designee

Contract language requiring enhanced D-SNP coordination and discharge planning[26]

To ensure coordination of inpatient discharge planning, the Contractor shall link clinical management systems across all providers, including written protocols for accountability, referrals, information sharing, and tracking transfers between settings such as from the hospital to the home, from the nursing facility to the home, or from the hospital to the nursing facility. The Contractor must require that its contracted hospitals, nursing facilities, and skilled nursing facilities notify both the Contractor and a member's service coordinator within 24 hours of visits and admissions of that member. The service coordinator must follow-up to address any care needs including skilled services covered by Medicare and LTSS services covered by *[Medicaid program]*. To the extent possible, *[State Medicaid Agency]* would like these processes to be electronic and automated but they may include fax, email, telephone and other forms of manual communication and coordination.

Requiring D-SNPs to Identify Their Ownership and /or Affiliation with a Medicaid Managed Care Plan (for purposes of FIDE SNP or HIDE SNP designation)

Contract language requiring D-SNPs to operate affiliated Medicaid managed care plans in the same service area(s) as their D-SNPs[27]

Each MAO offering a D-SNP product(s) must also operate a *[Medicaid managed care program]* plan in all Service Areas in which it holds a Medicaid contract. *[State]* shall execute an Agreement only when an MAO holds a *[companion or affiliated, use state specific terms] [Medicaid managed care program]* contract that covers the same service area(s) as the *[Medicaid managed care program]* plan.

Each contracted MAO plan shall have, and assure *[State]* it does have, the legal and actual authority to direct, manage, and control the operations of both the corporation operating its D-SNP contract and its *[companion/affiliated] [Medicaid managed care program]* contract to the extent necessary to ensure integration of Medicare and Medicaid services for individuals enrolled for both programs.

Contract language requiring Medicaid managed care organizations to operate affiliated D-SNPs in the same service area(s) as their Medicaid managed care plan(s)[28]

As required in its *[Medicaid managed care program]* contract, each *[Medicaid managed care program]* plan is required to also operate a MAO offering a D-SNP product(s) in all Service Areas in which it holds a Medicaid contract. *[State]* shall execute an Agreement only when an MAO holds a *[companion or affiliated, use state specific terms] [Medicaid managed care program]* contract that covers the same service area(s) as the *[Medicaid managed care program]* plan.

Each contracted *[Medicaid managed care program]* plan shall have, and assure *[State]* it does have, the legal and actual authority to direct, manage, and control the operations of both the corporation operating its *[Medicaid managed care program]* contract and its *[companion/affiliated]* MAO to the extent necessary to ensure integration of Medicare and Medicaid services for individuals enrolled for both programs.

Requiring FIDE SNPs to Integrate Care Coordination, Network Management, and Other Aspects of the Beneficiary Experience with the Plan

Contract language requiring integrated approach to beneficiary marketing materials and inclusion of State Medicaid Agency in review of marketing materials with Medicaid information[29]

In developing marketing materials and conducting marketing activities pertinent to *[Medicaid program]* services, the Contractor shall:

- Comply with the information requirements of 42 CFR 438.104 and 42 CFR 438.10 to ensure that, before enrolling, the individual receives from the Contractor the accurate oral and written information he or she needs to make an informed decision on whether or not to enroll;
- Ensure that marketing materials are accurate and not misleading, and do not defraud enrollees, potential enrollees or *[State Medicaid agency]*;
- Ensure that marketing materials do not contain any assertion or statement that the *[Medicaid program]* beneficiary must enroll in the Contractor's D-SNP product in order to obtain benefits or in order to avoid the loss of benefits; or that the D-SNP is endorsed by CMS, the Federal or State government or similar entity;
- Use *[State Medicaid agency]*-issued *[templates/template language]* in the development of member handbooks, descriptions of transition of care policies and notices, including the Annual Notice of Changes (ANOC), Evidence of Coverage (EOC), which serves as the Medicare-Medicaid compliant FIDE SNP member handbook, and Summary of Benefits (SB), as per 42 CFR §438.10(c)(4)(ii), 42 CFR 438.10(g), and 42 CFR 438.62(b)(3);
- Obtain prior approval from the State before distributing any marketing materials, in accordance with the requirements and procedures set forth in [*list contract section or appendix*]; and
- Submit integrated marketing materials to CMS for prior approval by the CMS Regional Office.

The Contractor shall abide by integrated materials review policies for all member communications and marketing materials to beneficiaries or potential enrollees mentioning *[Medicaid program name]* and the Contractor's D-SNP product information. "Marketing materials" and "member communications" shall, for the purpose of this article, include [*List materials to be included – for example: all marketing materials in all media, including but not limited to: print ads in general publications (such as newspapers, magazines, or advertising inserts for same), flyers, posters, direct mail (such as billboards or bus ads), television commercials (via terrestrial, satellite, or internet broadcast), sponsored ads associated with search engine inquiries and results, online banner and interstitial ads (including those specific to social media), and ads appearing in mobile apps (applications of ruse on mobile devices such as phones or tablets).]* These review policies shall apply also to *[include as applicable: broker training materials, staff training materials, benefit build tables, call center training materials (and any associated desk reference or similar resource documents), policies and procedures, ANOC/EOC, Summary of Benefit, Member Notices, Integrated Denial Notices, Notices of Action and any other material provided to Members or Providers]* regarding the *[D-SNP and/or Medicaid managed care program]* in *[State],* as directed by *[State Medicaid agency*].

Contract language requiring use of a single enrollee ID card for Medicare and Medicaid benefits[30]

The Contractor must issue a single ID card, for use in obtaining all managed Medicare, Medicaid, and prescription drug benefits. Except as set forth in *[reference to contract section stipulating exceptions]*, the Contractor shall deliver to each new enrollee prior to the effective enrollment date, but no later than *[time frame]* after the enrollee's effective date of enrollment, a Contractor Identification Card for those enrollees who have selected a PCP. The Identification Card shall have at least the following information:

- Name of enrollee
- Issue Date for use in automated card replacement process
- Primary Care Provider Name or "your Medicare PCP" (may be affixed by sticker)
- Primary Care Provider Phone Number (may be affixed by sticker)
- What to do in case of an emergency and that no prior authorization is required in emergencies
- Applicable copayment information
- Contractor 800 number – emergency message

Any additional information shall be approved by *[State Medicaid Agency]* prior to use on the ID card.

Requiring Applicable Integrated Plans (D-SNPs with exclusively aligned enrollment) to Integrate Appeals and Grievance Processes

Contract language requiring D-SNP reporting of integrated grievances and appeals

The Contractor shall submit grievance and appeal reports in accordance with *[insert deliverable schedule and/or any other state requirements]*. The reports shall include the following information and any additional information specified by *[State Medicaid Agency]*:

- A quarterly summary of integrated grievances received and the outcomes of those grievances;
- A quarterly summary of integrated organization determination requests and the outcomes of those requests. This includes service level detail on approved and denied requests.
- A quarterly summary of integrated reconsideration requests and the outcomes of those integrated reconsiderations. This includes service level detail on reconsiderations upheld and overturned, including a description of the action that was appealed.
- A quarterly summary of Medicare Independent Review Entity decisions received.

Quarterly summary reports should include all data elements as specified in *[reference to appendix, manual, or other document that specifies the fields to be included in each report and acceptable data codes/submissions for each field]*.

[Examples of data elements that states may wish to include in reports of integrated grievances and appeals include: member name, ID number, date of birth and/or demographic information; type/topic of appeal or grievance; date of service for the service in question; type of service in question; provider name; provider type; service county. For appeals only: date the initial denial notice was issued; denial type; effective date of service termination, reduction, or suspension; units denied; whether the service is partially covered by Medicare and/or Medicaid; rationale for plan action/decision; state or federal law cited in decision; highest stage of appeal sought prior to final disposition; appeal outcomes at each stage; date and type of resolution.]

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by **Mathematica** and the **Center for Health Care Strategies**. For more information, visit **www.integratedcareresourcecenter.com**

ENDNOTES

[1] The final rule is entitled "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" and is available at: https://www.federalregister.gov/documents/2019/04/16/2019-06822/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare. On October 7, 2019, CMS also released a guidance memo explaining the new D-SNP integration requirements. That memo is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DSNPsIntegrationUnifiedAppealsGrievancesMemorandumCY202110072019.pdf.

[2] 9 Public Law 110-275, Section 164(c)(4).

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

[4] This language was adapted from the State of Florida Agency for Healthcare Administration Standard Contract for D-SNPs, revised July 2013 and amended to remain applicable through 2019 (not available online).

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

[6] This language was adapted from the Commonwealth of Virginia Department of Medical Assistance Services 2020 D-SNP Contract, available at: https://www.dmas.virginia.gov/files/links/3624/FINAL%20CY2020%20DSNP%20Contract.pdf.

[7] In addition to QMBs, full dual eligible beneficiaries who qualify for long-term services and supports, in an institution or through home and community based services, are not responsible for any cost sharing or copayments, including low-income subsidy pharmacy copayments (See Chapter 13 of the Medicare Prescription Drug Policy Manual, Sections 60.2 – 60.2.2, available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter-13-Premium-and-Cost-Sharing-Subsidies-for-Low-Income-Individuals-v09-14-2018.pdf).

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

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

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

[11] If a state wishes to require D-SNPs to report changes in enrollee status that may impact enrollee eligibility (for example, birth, change of address, incarceration, death, etc.), language describing the notification requirement must be included in the state's D-SNP contract.

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

[13] This language was adapted from the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services.

[14] This language was adapted from the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services.

[15] This language was adapted from a 2020 Florida FIDE SNP contract (Agency for Healthcare Administration Contract Number FP041, Attachment I, Exhibit D) (not available online).

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

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

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

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

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

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

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

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

[24] This language was adapted from the 2019 Tennessee Department of TennCare D-SNP contract, available at: https://www.integratedcareresourcecenter.com/resource/tennessee-2019-d-snp-contract.

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

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

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

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

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

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