Integrated Care Resource Center

TECHNICAL ASSISTANCE TOOL

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State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options

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IN BRIEF: Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage plan that serve beneficiaries dually enrolled in Medicare and Medicaid. To operate in a state, D-SNPs must have a contract with the state to facilitate coordination of Medicare and Medicaid services for enrollees, although states are not required to enter into such contracts. This technical assistance tool is based on an analysis of D-SNP contracts in 13 states, including states that have made the most extensive use of D-SNP contracting by linking D-SNPs to Medicaid managed long-term services and supports (MLTSS) programs that include the main services that Medicaid covers for Medicare-Medicaid enrollees. This tool summarizes how these states have developed those linkages and describes the specific care coordination and information-sharing requirements that the states have included in their D-SNP contracts. The D-SNP contracting approaches used by this diverse group of 13 states can provide guidance and examples for states that have varying opportunities and resources for D-SNP contracting, including states that may choose not to contract with D-SNPs.

States with the most detailed and extensive contracts with D-SNPs have: (1) well-established Medicaid MLTSS programs; (2) experienced D-SNPs that are interested in contracting with the state; and (3) Medicaid agency leadership and staff who are knowledgeable about both Medicaid and Medicare managed care. These states developed the capacities needed to use D-SNP contracting as an effective tool for integration incrementally over time. As states consider what to include in their D-SNP contracts beyond the minimum requirements, they should take into account the staff and other resources needed to design and implement meaningful integration requirements, review and analyze the information D-SNPs are required to submit to the state, and work with D- SNPs over time to refine and improve their integration programs.

States should approach contracting with D-SNPs strategically. States implementing new Medicaid MLTSS programs can use D-SNP contracts to link Medicare services to those programs increasingly over time. States that do not yet have a Medicaid MLTSS program but are planning on developing one in the future may want to at least enter into contracts with D-SNPs that include the minimum federal requirements to increase the likelihood that D-SNPs will be available to link with the MLTSS program when needed. States with no plans to develop Medicaid MLTSS programs, or with few or no D-SNPs operating in the state or interested in doing so, may not want to devote limited state resources to exploring this option. For states with the necessary resources and opportunities, however, the D-SNP model of integration can improve the coordination of services for Medicare-Medicaid enrollees beyond what separate Medicare and Medicaid plans can do, and beyond what can be accomplished in the fee-for-service system.

The technical assistance tool is organized as follows:

1. Introduction

Why This Issue Is Important To States

Individuals dually eligible for Medicare and Medicaid (Medicare-Medicaid enrollees) are among the highest-cost enrollees in both programs.[1] Many of them have complex health care needs that require services from both Medicare and Medicaid.[2] The lack of coordination between these two programs can make it difficult for enrollees to navigate the two systems to get the care they need, and can add to the cost of both programs.[3] Most primary and acute care services (physician, hospital, prescription drug, and related services) for Medicare-Medicaid enrollees are covered through Medicare, and (for those eligible) most long-term services and supports (LTSS) – including home-and community-based services (HCBS), nursing facility (NF) services, personal care assistance, and related services – are covered through Medicaid. Medicaid also covers Medicare beneficiary premiums and cost sharing. Medicare-Medicaid enrollees who receive LTSS are the most costly for Medicaid and among the most costly for Medicare,[4] and linkages between primary and acute care services and LTSS are not well developed in either program.

Enabling Medicare-Medicaid enrollees to receive coverage of all of their services through one entity can substantially reduce the complexities they must deal with and provide the opportunity for greater coordination of care and lower costs. Thirteen states are now operating programs to integrate care for Medicare-Medicaid enrollees through the Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative.[5] A number of other states are using Medicaid agency contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) to achieve similar integration goals. As discussed more fully below, D-SNPs are a special type of Medicare Advantage plan that serve only beneficiaries enrolled in both Medicare and Medicaid. D-SNPs are required by federal law and regulations to take a number of steps to improve coordination of Medicare and Medicaid services for these enrollees. States can require additional coordination activities in their contracts with D-SNPs.

Why States Contract with D-SNPs

Following are several reasons why state interest in contracting with D-SNPs has grown in recent years:

- **D-SNPs are required to have contracts with states.** The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, as amended by the Affordable Care Act of 2010, required D-SNPs to have a contract with the state Medicaid agency in each state in which they operate "to provide [Medicaid] benefits, or arrange for benefits to be provided" by calendar year 2013. Without such a contract, D-SNPs cannot continue to operate in a state. (States, however, are not required to contract with D-SNPs.[6]) Prior to 2013, federal law and regulations encouraged D-SNPs to contract with states, but did not require it.
- States that chose not to participate in the CMS Financial Alignment Initiative have sought alternative ways of integrating care for Medicare-Medicaid enrollees. The capitated model in the Financial Alignment Initiative allows integrated Medicare-Medicaid Plans to enter into three-way contracts with the state and CMS to cover services for Medicare-Medicaid enrollees. Contracting with D-SNPs provides an opportunity for states to enter into somewhat less integrated arrangements, and to do so incrementally over time if a state is not yet in a position to implement a more integrated program.
- States that have Medicaid managed long-term services and supports (MLTSS) programs are looking for ways to increase coordination with Medicare services, since a large portion of the enrollees in MLTSS programs are Medicare-Medicaid enrollees who receive their primary and acute care services from Medicare. As of July 2016, 23 states offered at least one MLTSS program,[7] and more states are likely to develop MLTSS programs in the coming years. Contracting with D-SNPs can enable these states to achieve greater coordination of services for their MLTSS enrollees.

2. History of D-SNPs and D-SNP Contracting Requirements

D-SNP Contracting Overview

Medicare Advantage D-SNPs are one of three types of SNP authorized in the Medicare Modernization Act of 2003, and began operating in January 2006.[8] D-SNPs are intended to allow Medicare Advantage plans to specialize in serving beneficiaries who are dually eligible for Medicare and Medicaid, although there was no requirement initially that D-SNPs have any formal relationship with state Medicaid agencies. Prior to the authorization of SNPs, Medicare Advantage plans were not permitted to limit enrollment to specific types of beneficiaries.

In 2008, MIPPA required all D-SNPs to have contracts with states that included eight minimum requirements, but provided explicitly that states are not required to contract with D-SNPs.[9] (State Medicaid agency contracts with D-SNPs are sometimes referred to as "MIPPA contracts," but this tool generally uses the term "D-SNP contracts.")

Minimum MIPPA Requirements for D-SNP Contracts

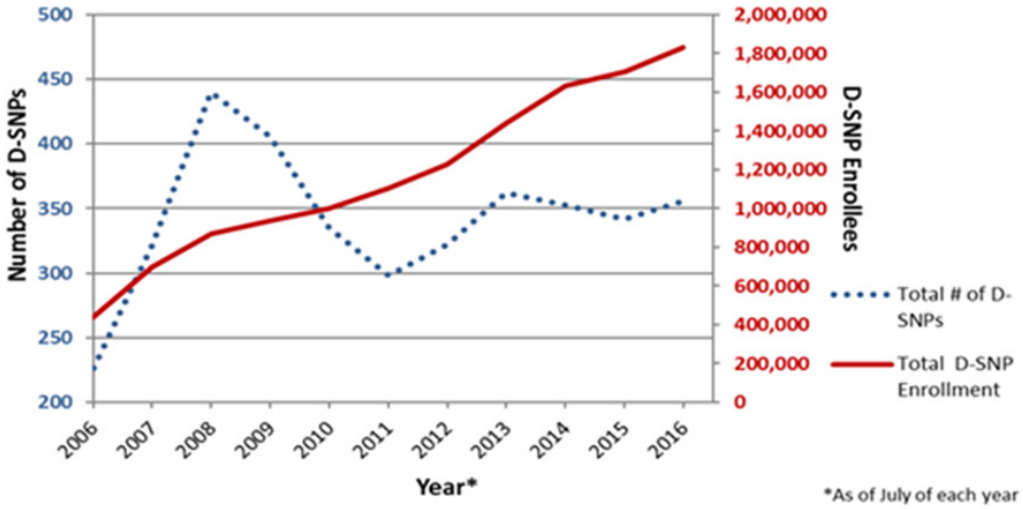
D-SNPs must submit their contracts with states to CMS for review by July 1 of the year before the D-SNP federal contract year begins (by July 1, 2016 for calendar year 2017, for example). At a minimum D-SNP contracts with states must document:[10]

1. The D-SNP's responsibility, including financial obligations, to provide or arrange for Medicaid benefits.
2. The categories of dually eligible beneficiaries eligible to be enrolled under the SNP (e.g., full benefit, Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), etc.).[11]
3. The Medicaid benefits covered under the SNP.
4. The cost sharing protections covered under the SNP.
5. The requirements to identify and share information on Medicaid provider participation.
6. The procedural requirements for the verification of enrollees' eligibility for both Medicare and Medicaid.
7. The service area covered by the SNP.
8. The contract period for the SNP.

D-SNP Enrollment Trends

In 2006, 226 D-SNPs were approved by CMS, and enrollment reached 439,412 in July of that year. Since that time, as shown in Exhibit 1, D-SNP enrollment has grown steadily, while the number of D-SNPs has fluctuated. Many of the new D-SNP entrants in 2006 and 2007 failed to gain significant enrollment, and closed or consolidated with other plans. Increases in federal reporting and other requirements – including the requirement for contracts with states that took effect in 2013 – led to further closings and consolidations. There were 350 D-SNPs operating in October 2016, with a total enrollment 1,867,270.[12]

Exhibit 1: Trends in D-SNP Numbers and Enrollment, 2006 – 2016



Source: CMS SNP Comprehensive Report, October 2016.

D-SNPs currently operate in 38 states, the District of Columbia, and Puerto Rico, down from 42 states, the District of Columbia, and Puerto Rico in 2008, the first year that CMS reported SNP enrollment by state. While D-SNPs are operating in a wide range of states in 2016, D-SNP enrollment is concentrated in a relatively limited number of states, as shown in Exhibit 2. In October 2016, 77 percent of D-SNP enrollment and 61 percent of all D-SNPs were in 10 states, most of which are large states in which managed care in general is well established. Sixteen percent of total enrollment was in Puerto Rico, reflecting some unique features in its Medicare and Medicaid programs that have encouraged D-SNP growth.

Exhibit 2: D-SNPs and Enrollment by State, October 2016

State	Number of D-SNPs	Total D-SNP Enrollment
Puerto Rico	14	282,084
Florida	58	250,544
New York	36	222,594
California	32	142,001
Texas	25	140,415
Pennsylvania	11	116,539
Tennessee	7	86,070
Arizona	21	83,943
Georgia	9	54,578
Alabama	4	50,566
Massachusetts	7	40,456
Minnesota	9	37,984
Louisiana	9	34,004
Washington	6	28,420
South Carolina	3	24,140
Wisconsin	13	23,734
Oregon	7	22,925
North Carolina	7	21,219
Hawaii	6	20,627
Ohio	11	18,406
Connecticut	2	17,158
New Jersey	4	17,060
Mississippi	4	15,886
New Mexico	4	15,715
Arkansas	4	14,928
Illinois	5	12,632
Missouri	3	12,201
Michigan	4	11,902
Colorado	4	9,993
Utah	2	8,408
Kentucky	8	7,593
Washington D.C.	3	6,205
Maryland	3	3,744
Maine	2	3,167
Indiana	3	2,832
Idaho	1	2,496
Virginia	2	1,984
Delaware	1	1,727
West Virginia	1	262
Montana	1	129
TOTAL	**356**	**1,867,270**

Source: CMS SNP Comprehensive Report, October 2016. Five D-SNPs operated in more than one state. For this exhibit, the enrollees in those plans are divided evenly across the states, and the plan is included in each state's total number of D-SNPs. In October 2016, 21 enrollees were in plans with under 11 enrollees and are not included here.

Fully Integrated Dual Eligible Special Needs Plans

Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), a special type of D-SNP, were authorized by the Affordable Care Act (ACA) in 2010 to give additional authority and flexibility to D-SNPs in states that use D-SNP contracts to achieve a high degree of integration of Medicare and Medicaid services. FIDE SNPs must meet several specific requirements, the most important of which is that they must contract with the state for coverage of Medicaid long-term care benefits and services, consistent with state policy, under risk-based financing. They must also coordinate the delivery of Medicare and Medicaid health and long-term care services. Certain FIDE SNPs are eligible for additional Medicare Advantage payments that reflect the frailty of the beneficiaries they enroll, and they have the flexibility to offer additional supplemental benefits not typically covered by Medicare.[13] To obtain FIDE SNP status in a given state, D-SNPs must request this designation when they submit their contract with the state Medicaid agency for CMS review and approval. This submittal and request must be made on or before July 1 for the upcoming contract year.

As of October 2016, 40 FIDE SNPs are operating in nine states (Arizona, California, Idaho, Illinois, Massachusetts, Minnesota, New Jersey, New York, and Wisconsin), with a total national enrollment of 131,571. Sixty percent of total FIDE SNP enrollment in that month was in Massachusetts and Minnesota. FIDE SNPs represent the most fully developed and extensive use of D-SNPs to achieve integration of Medicare and Medicaid services.

3. Overview of D-SNP Contracts in 13 States

Selection of States

This review of D-SNP contracts includes states that represent a range of approaches and options used to contract with D-SNPs. The review was designed to show how states with differing circumstances and opportunities can use D-SNP contracting. It includes states with a long history of D-SNP contracting and contracts that go well beyond the minimum MIPPA requirements in order to link Medicare services to well-established Medicaid MLTSS programs (Arizona, Massachusetts, Minnesota, and Wisconsin). The review also includes three states with Medicaid MLTSS programs that have developed detailed contracts with D-SNPs more recently (Hawaii, Tennessee, and Texas). New Mexico is included because it has used contracts with D-SNPs to enhance its Medicaid MLTSS program in the past, and is currently considering greater use of D-SNP contracts. Florida and New Jersey are included because they have recently implemented Medicaid MLTSS programs and are increasingly focused on using D-SNP contracts to link those programs more effectively to Medicare. Idaho was included because of its unique situation; the state has a single FIDE SNP contract that covers LTSS benefits, but no MLTSS program outside of this single FIDE SNP. Finally, two states (Oregon and Pennsylvania) were chosen that have a number of D-SNPs operating in the state, but whose contracts with D-SNPs have either the minimum MIPPA requirements (Pennsylvania) or only recently added requirements extending beyond the minimums (Oregon). Neither state has a Medicaid MLTSS program with which to coordinate, although Pennsylvania is currently developing an MLTSS program that will be linked to D-SNPs.

Focus of This Technical Assistance Tool

This technical assistance tool focuses on D-SNP contract provisions that go beyond the minimum MIPPA requirements. The analysis notes the presence or absence of a Medicaid MLTSS program in the state, and how D-SNP contracts relate to those programs. The analysis then describes the requirements that states have included in their contracts that go beyond the MIPPA minimums. Exhibit 3 provides a brief overview of these key features in the 13 contracts reviewed. Appendix 1 provides a more detailed overview of state Medicaid MLTSS programs and D-SNPs. Appendices 2a and 2b summarize the contract features in the 13 states that go beyond minimum MIPPA requirements. Appendix 2a describes the most common additional coordination and reporting requirements, and Appendix 2b describes more tools for coordination that states can use.

The remainder of this technical assistance tool summarizes the highlights of those appendices and the features of the D-SNP contracts that are likely to be of most interest to states seeking to enhance their D-SNP contracts. There are

references throughout to where specific contract language can be found, and text boxes with examples of contract language that may be especially useful as models for other states. Appendix 3 contains links to the contracts reviewed.

Minimum MIPPA Requirements and State Flexibility

MIPPA's minimum D-SNP contract requirements give states the flexibility to determine the scope of service and financial responsibility that D-SNPs must assume. States also have the option of adding provisions beyond the minimum MIPPA requirements in their contracts with D-SNPs. States have the authority to specify subsets or categories of their dually eligible populations for D-SNP enrollment if that would facilitate linkages with Medicaid managed care.[14] States must specify the geographic area for D-SNP operations in their MIPPA agreements, and can use this as an opportunity to require that these areas correspond with Medicaid managed care service areas. D-SNPs must tailor their Medicare Advantage applications, plan benefit packages, and bids so they are consistent with these state requirements.

Alignment of D-SNPs with Medicaid MLTSS Programs

States can require D-SNPs to operate "companion"[15] Medicaid MLTSS plans that are in the same geographic area and cover the same dually eligible populations as the D-SNPs. Conversely, states can require Medicaid MLTSS plans to have D-SNPs covering the same geographic areas and populations. This can create a platform for integration with one health plan delivering both Medicare and Medicaid covered services.

States can be as specific about the organizational, financial, and other relationships between these companion Medicare and Medicaid plans as they choose and as the plans will agree to, but the state contracts reviewed for this technical assistance tool generally do not go into detail on these issues.

Ten of the 13 states reviewed have Medicaid MLTSS programs. Pennsylvania is developing an MLTSS program that is slated for implementation in 2017. Neither Idaho nor Oregon have a Medicaid MLTSS program, although Idaho makes capitated payments to its single D-SNP for the provision of all Medicaid LTSS benefits.[16] Six of the states reviewed have at least one FIDE SNP: Arizona, Idaho, Massachusetts, Minnesota, New Jersey, and Wisconsin.

Separate or combined D-SNP and MLTSS contracts. As states consider their options for aligning D-SNP and Medicaid MLTSS programs, they should determine whether this is best done by including the D-SNP requirements in Medicaid MLTSS contracts, as states like Minnesota and Tennessee have done, or whether the requirements applying to D-SNPs should be set out in separate D-SNP contracts, as Arizona and Texas have done. Incorporating the MIPPA requirements into broader MLTSS contracts may make the linkages between Medicare and Medicaid more apparent, while including all the MIPPA requirements in a separate contract may make it easier for contractors, CMS reviewers, and others to identify the specific MIPPA requirements. CMS requires FIDE SNP contracts to combine the MIPPA and Medicaid MLTSS requirements.

As shown in Exhibit 3 and in more detail in Appendix 1, 10 of the states included in this analysis (Arizona, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, New Mexico, Tennessee, Texas, and Wisconsin) currently align their D-SNP and MLTSS plans, at least to some extent.

- **Arizona** requires contractors in its Arizona Long Term Care System (ALTCS) MLTSS program to have companion D-SNPs to cover Medicare services.
- **Hawaii** requires that D-SNPs have Medicaid QUEST Integration (QI) MLTSS contracts and that all QI contractors must offer a D-SNP.
- **Idaho** requires that its one D-SNP contractor in the Medicare-Medicaid Coordinated Plan program provide all Medicare and Medicaid services, including NF and HCBS benefits to enrollees. The state does not have a separate Medicaid MLTSS program.
- **Massachusetts** requires that Senior Care Options (SCO) plans provide Medicaid MLTSS and have a companion D-SNP. The SCO D-SNPs are the only D-SNPs operating in the state.

- **Minnesota** requires Medicaid MLTSS contractors participating in Minnesota Senior Health Options (MSHO) program to offer a D-SNP, and limits enrollment in MSHO to beneficiaries who choose to receive all their Medicare and Medicaid services from the MSHO plan.
- **New Jersey** currently requires D-SNPs to be approved by the state as standard NJ Family Care Medicaid managed care organizations (MCOs) that offer all Medicaid benefits including MLTSS. Only members of the aligned Medicaid MCO can be enrolled in the companion D-SNP.
- **New Mexico** requires MLTSS plans in its Centennial Care program to operate either a D-SNP or a Medicare Advantage plan; however the D-SNP or Medicare Advantage plan service areas do not have to match the statewide Medicaid managed care coverage area.
- **Tennessee** requires Medicaid MCOs that provide MLTSS in its TennCare CHOICES program to offer a companion D-SNP, although D-SNPs contracted with the state prior to January 2014 are currently exempt from this requirement.
- **Texas** requires STAR+PLUS MLTSS plans to offer a D-SNP in the most populous counties in their service area(s), but the state will sign contracts with D-SNPs that do not have a companion MLTSS plan.
- **Wisconsin** requires Medicaid MLTSS contractors participating in the Family Care Partnership program to have a companion D-SNP.

State Payments to D-SNPs for Medicaid Services

As shown in Exhibit 3 and in more detail in Appendix 1, 10 of the states reviewed (Arizona, Florida, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, New Mexico, Texas, and Wisconsin) make capitated payments for Medicaid services to the companion Medicaid MLTSS plans that the state requires D-SNPs to have. The Medicaid services included in the capitation and the degree of alignment between D-SNPs and Medicaid plans vary from state to state.

- **Entity to which payments are made.** When there is a companion Medicaid MLTSS plan, the Medicaid capitated payments generally go to the Medicaid plan, in accordance with the state's Medicaid contract. When there is no companion Medicaid plan, but the state wants the D-SNP to cover some Medicaid benefits, such as beneficiary cost sharing or Medicaid acute care wraparound services, the Medicaid capitated payment may go directly to the D-SNP, in accordance with the state's D-SNP contract. In Idaho, the state makes capitated payments to its single D-SNP for all Medicaid benefits, and there is no companion Medicaid MLTSS plan.
- **Medicaid services included in the capitated payments.** The Medicaid services covered in the capitated payment to companion Medicaid MLTSS plans generally cover all the Medicaid services that are covered by the MLTSS plan for Medicaid-only enrollees, as well as Medicare beneficiary cost sharing. When there is no companion MLTSS plan, as may occur in Texas, the state makes a capitated payment to the D-SNP to cover Medicare beneficiary cost sharing. Similarly, Florida makes capitated payments to D-SNPs for Medicaid wraparound primary and acute care services covered by the state's Managed Medicaid Assistance Program if the D-SNP does not have a companion Medicaid MLTSS plan. If the D-SNP has a companion MLTSS plan, the state also makes capitated payments for Medicaid LTSS to that Medicaid plan.

State Efforts to Facilitate Enrollment in Companion Plans

While states can mandate that Medicaid beneficiaries enroll in Medicaid MLTSS programs – as Arizona, Florida, Hawaii, Minnesota, New Jersey, New Mexico, Tennessee, and Texas have done[17] – Medicare requirements do not allow mandatory enrollment in managed care, including D-SNPs. States can therefore encourage Medicare-Medicaid enrollees in MLTSS plans to obtain their Medicare benefits from a companion D-SNP, but they cannot require it. Similarly, health plans that operate companion D-SNPs and MLTSS plans can encourage their Medicare-Medicaid enrollees to obtain all their benefits from the companion plans, but beneficiaries are free to obtain their Medicare benefits from fee-for-service or another Medicare Advantage plan.[18] If beneficiaries are required to get their Medicaid benefits from an MLTSS plan, however, it generally increases the likelihood that they will choose to obtain their Medicare benefits from a companion D-SNP.

Exhibit 3: Overview of Major Features of D-SNP Contracts in 13 States

State	MLTSS Program	State Contracts Only with D-SNPs That Have a Companion MLTSS Plan	State Requires MLTSS Contractors to Offer D-SNPs	Medicaid Services Provided on a Capitated Basis	Examples of Additional Requirements for Coordination	Required D-SNP Reporting to State	Required D-SNP Notifications to State
Arizona	Yes	Yes	Yes	All services offered by companion MLTSS and separate acute care Medicaid plans	Establish a contact at each Medicaid acute or MLTSS health plan Use of Medicare data (Part A/B, D) for coordination Must apply for seamless conversion	• Encounter data • Grievance and appeals • Marketing materials • Quality reports • Financial reports	• Low star ratings, corrective action plans, deficiencies, and warning letters • Plan changes (i.e., non-renewals, service area changes)
Florida	Yes	No	No	Most D-SNPs must offer all Medicaid services except LTSS; D-SNPs with companion MLTSS plans must offer LTSS	Align eligibility and enrollment	• Quality reports • Financial reports	• None
Hawaii	Yes	Yes	Yes	All Medicaid services offered by companion MLTSS plans	Service coordinator will coordinate all Medicaid and Medicare services	• • Encounter data • • Grievance and appeals • • Marketing materials	• None
Idaho	No, but single D-SNP also provides MLTSS	N/A	N/A	D-SNP offers all Medicaid services including LTSS	Ensure integration of medical, behavioral health, substance use, LTSS, or other social needs Coordinate services with the services received from any other health plan or through fee-for-service	• Enrollee materials • Grievance and appeals	• Plan changes (i.e., non-renewals, service area changes)
Massachusetts	Yes	Yes	Yes	All Medicaid services offered by companion MLTSS plans	Ensure effective linkages of clinical management systems across all providers, including written protocols for referrals, information sharing, and tracking transfers	• Encounter data • Grievance and appeals • Marketing materials • Quality reports • Financial reports	• Plan changes (i.e., non-renewals, service area changes)

State	MLTSS Program	State Contracts Only with D-SNPs That Have a Companion MLTSS Plan	State Requires MLTSS Contractors to Offer D-SNPs	Medicaid Services Provided on a Capitated Basis	Examples of Additional Requirements for Coordination	Required D-SNP Reporting to State	Required D-SNP Notifications to State
Minnesota	Yes	Yes	Yes	All Medicaid services offered by companion MLTSS plans	Provide care coordination/case management services and integrate care delivery	• Encounter data • Grievance and appeals • Marketing materials • Quality reports • Financial reports	• Plan changes (i.e., non-renewals, service area changes) • Proposed additional benefits and premiums and final changes • Corrective action requests within 30 days • Significant changes in Medicare information to beneficiaries, benefits, networks, service delivery, oversight results or policy that are likely to impact the continued integration of Medicare and Medicaid benefits
New Jersey	Yes	Yes	No	All Medicaid services offered by companion MLTSS plans	Integrated care management Enhanced training requirements for outreach and enrollment staff	• Encounter data • Grievance and appeals • Marketing materials • Quality reports • Financial reports	• Plan changes (i.e., non-renewals, service area, benefits, payment changes) • MCO termination or failure to renew contract
New Mexico	Yes	No	Yes	All Medicaid services offered by companion MLTSS plans when D-SNP has a companion Medicaid plan	Minimum	• Encounter data	• None
Oregon	No	N/A	N/A	None	Minimum	• Encounter data	• Plan changes (i.e. non-renewals, service changes) • MCO terminations or non-renewals
Pennsylvania	No	N/A	N/A	None	Minimum	• None	• None
Tennessee	Yes	No, for D-SNPs with a pre-2014 state contract; Yes, for any new D-SNPs	Yes	All Medicaid services offered by companion MLTSS plans	Follow up after inpatient stays, observation days, and emergency department visits to address enrollee needs and coordinate Medicaid benefits	• Encounter data • Marketing materials • Quality/performance reports upon request	• Low performing icons, notices of non-compliance, audit findings and corrective action plans upon request

State	MLTSS Program	State Contracts Only with D-SNPs That Have a Companion MLTSS Plan	State Requires MLTSS Contractors to Offer D-SNPs	Medicaid Services Provided on a Capitated Basis	Examples of Additional Requirements for Coordination	Required D-SNP Reporting to State	Required D-SNP Notifications to State
Texas	Yes	No	Yes, but only in the most populous counties	All Medicaid services offered by companion MLTSS plans when D-SNP has a companion Medicaid plan; only Medicare cost sharing if there is no companion Medicaid plan	Provide training for staff on Medicaid LTSS, and notification of nursing facility admissions	• Encounter data • Medicare Advantage quality/ performance reports	• Plan changes (i.e., non-renewals, service changes) • CMS approval of D-SNP application and amendments to the agreement, including the addition, deletion, or modification of a service area
Wisconsin	Yes	Yes	Yes, for Partnership program Medicaid MCOs	All Medicaid services offered by companion MLTSS plans	Care planning, inter-disciplinary team composition, and assessments	• Grievance and appeals • Marketing materials • Quality reports • Financial reports	• None

Following are some ways in which the states reviewed are encouraging enrollment in companion D-SNPs and Medicaid MLTSS plans:

- **Arizona** assigns dually eligible beneficiaries to companion Medicaid plans, with the option to choose Medicare fee-for-service or another Medicare Advantage plan.
- **Minnesota** and **New Jersey** limit enrollment in D-SNPs to beneficiaries that choose companion Medicaid plans.
- **Arizona**, **Hawaii**, **Massachusetts**, **Minnesota**, **New Jersey**, and **Wisconsin** limit D-SNP enrollment to dually eligible beneficiaries entitled to full Medicaid benefits, since companion Medicaid plans cannot add significant value for dually eligible beneficiaries who are not receiving full Medicaid benefits.
- **Arizona** and **Minnesota** send notices to new and current dually eligible beneficiaries explaining benefits of integrated care, and D-SNP options.
- **Arizona** and **Tennessee** work with D-SNPs and CMS to provide data on Medicaid plan members with pending Medicare eligibility necessary for CMS approval of "seamless conversion" of Medicaid plan enrollees into the D-SNP when they become newly eligible for Medicare.[19]
- **Arizona** works with State Health Insurance Assistance Program and Aging and Disability Resource Center counselors to increase beneficiary understanding of integrated care benefits and options.

4. D-SNP Contract Features That Go Beyond Minimum MIPPA Requirements

In addition to addressing the minimum MIPPA required provisions in D-SNP contracts, 12 of the 13 states reviewed (all but Pennsylvania) have developed additional D-SNP contract requirements that further integration of services and increase administrative alignments between Medicaid and Medicare. Detailed information on the requirements in states that have aligned D-SNP and Medicaid MLTSS contractors can be found in Appendices 2a and 2b. Appendix 2a summarizes the most common additional requirements for coordination and reporting in the 13 contracts, while Appendix 2b describes more tools for coordination that some of the 13 states are using. The basic requirements in Appendix 2a generally do not require extensive D-SNP and state resources to implement, since they primarily involve submission of reports to the state that the D-SNPs must already submit to Medicare. The requirements in Appendix 2b may require more state resources for review, analysis, and follow-up. The remainder of this technical assistance tool summarizes some of the highlights and implications of these additional contract requirements.

Coordination of D-SNP and Medicaid Services

In general, states aligning their MLTSS and D-SNP plans have additional service coordination requirements beyond the basic requirement that the D-SNP provide or arrange for Medicaid benefits. Following are some examples of these service coordination and reporting requirements. There are similarities in the requirements in each state, although the specific requirements reflect the context and history of each state's program. More detail appears in Appendix 2a.

- **Arizona** requires the aligned plans to coordinate all aspects of enrollees' health, including behavioral health, disease management, and care management. This includes use of all Medicare and Medicaid data to coordinate all services. The state requires that there be a contact person at each plan who will be responsible for sharing the information needed to coordinate care when the benefit coverage switches from Medicare to Medicaid, and a point of contact for coordinating care related to cost-sharing protections and balance billing. (AZ, D-SNP contract, 2017, Sec. 2.1)
- **Hawaii** requires that D-SNP enrollees have a service coordinator responsible for coordination of Medicare and Medicaid acute and primary care and LTSS. D-SNPs must: (1) provide continuity of care when enrollees are discharged from the hospital with prescribed medications that are normally prior-authorized or not on the plan's formulary; (2) facilitate access to services including non-medical transportation to community services; (3) provide assistance resolving concerns about service delivery or providers; and (4) assist enrollees to maintain continuous Medicaid benefits. (HI, QI RFP, 2013, Sec. 40.900)

- **Idaho** has extensive D-SNP care coordination requirements, including a requirement that enrollees must have a medical home that forms the foundation of an Integrated Care Team, which ensures the integration of all medical, behavioral, substance abuse, LTSS, and/or social needs. Additional requirements include the D-SNP care coordinator's responsibility to coordinate with other health plans and also with the state to ensure enrollees are linked to any carved-out services. The D-SNP is also required to implement transitional care protocols and processes to ensure hospitals and residential/rehabilitation facilities provide the enrollee's interdisciplinary care team prompt notification of admission or pending discharge. (ID, Medicaid Provider Agreement, 2016, Appendix A, Sec. XXVIII.B and XXIX.A.1)
- **Massachusetts** requires the aligned Medicaid MLTSS plans and D-SNPs in its SCO program to ensure effective linkages of clinical management systems across all providers, including written protocols for referrals, information sharing, and tracking transfers. SCO plans are also required to ensure all relevant providers are informed about utilization of emergency services and urgent care, and must provide coordination of care and expert care management for LTSS users. To support care coordination, SCO plans must maintain a single, centralized, comprehensive record that documents the enrollee's medical, functional, and social status and all services provided, which must be updated in a timely manner by all providers and available to providers at all times. (MA, SCO model contract, 2016, Sec. 2.4.a.6-9 and Sec. 2.4.c)
- **Minnesota** fully integrates D-SNP and Medicaid MLTSS and other services in its MSHO program. All MSHO plans are FIDE SNPs in 2016, and most have had this status for several years. Both Medicare and Medicaid benefits are delivered through MSHO as one plan, with the same care coordination requirements applying to all benefits. The D-SNP Model of Care requirements, for example, include additional Medicaid MLTSS requirements in MSHO plans. (MN, MSHO/Minnesota Senior Care Plus (MSC+) Contract 2016, Sec. 3.7 and Sec. 6.1) Minnesota achieved increased administrative integration in the MSHO program as a result of a September 2013 Memorandum of Understanding (MOU) with CMS.[20]
- **Tennessee** has a number of additional requirements for D-SNP contractors, including notifying the enrollee's Medicaid MCO of any planned or unplanned inpatient admissions, and coordinating with the Medicaid MCO regarding discharge planning, including ensuring that LTSS services are "provided in the most appropriate, cost effective and integrated setting." The requirements also include following up with enrollees and their Medicaid MCO to provide needs assessments or develop person-centered plans of care for MLTSS enrollees, coordinating nursing facility services across programs, and training staff on coordinating benefits for dually eligible beneficiaries. (TN, D-SNP contract, 2016, Sec. A.2.b.6)
- **Texas** requires D-SNP contractors to make "reasonable efforts" to coordinate benefits provided by the D-SNP "with LTSS provided through the Texas Department of Aging and Disability Services and the STAR+PLUS HMOs" including identification of LTSS providers, help accessing LTSS, coordinating the delivery of Medicaid LTSS and Medicare benefits and services, and training D-SNP network providers about LTSS "so they may help members receive needed LTSS that are not covered by Medicare." Coordination may also include reciprocal referral protocols and information sharing. D-SNPs are required to notify the designated LTSS coordinator or caseworker if a D-SNP enrollee is admitted to a nursing facility. (TX, D-SNP contract, 2016, Sec. 3.05)
- **Wisconsin** has detailed requirements for care planning, interdisciplinary team composition, and assessment. Wisconsin requires D-SNPs to promptly arrange for all long-term care services in the benefit package. Building on the CMS SNP model of care requirements, D-SNPs must complete a comprehensive assessment and care plan for each enrollee within 90 days of enrollment. (WI, Family Care/Partnership contract, 2016, Article V.A and VII.D)

A simple way for states to track and monitor the opportunities for coordination between D-SNPs and companion Medicaid MLTSS plans is to require D-SNPs to submit information to the state periodically on the number of D-SNP enrollees who are receiving their Medicaid services from an aligned MLTSS plan, as states like Arizona, Hawaii, Tennessee, and New Jersey do.

Submission of Medicare Advantage Quality/Performance and/or Financial Reports to the State

About half of the D-SNP contracts reviewed include requirements for submission of Medicare Advantage quality/performance and/or financial reports to the state. States are collecting this information to support integrated program design, rate setting, and quality oversight. See Appendix 2a for details.

Quality/Performance Data and Reports. Eight of the 13 reviewed states (Arizona, Florida, Massachusetts, Minnesota, New Jersey, Tennessee, Texas, and Wisconsin) require D-SNPs to submit CMS-required Medicare quality reports and data to the state. This includes Medicare HEDIS data and other Medicare quality-related information, including information on Medicare-required quality improvement projects and chronic care improvement projects. Understanding D-SNP performance and the Medicare quality requirements that plans are measured against can support states in developing state-specific strategies to align quality reporting or quality improvement activities and goals for their integrated programs. Following are examples of state requirements:

- **Massachusetts** requires D-SNPs to report on Medicare HEDIS measures to the extent that they are relevant to the SCO population. (MA, SCO model contract, 2016, Sec. 2.14.a.1)
- **Minnesota** requires D-SNPs to submit Medicare HEDIS and SNP structure and process measure results. Medicare and Medicaid quality and performance improvement projects are conducted jointly, and the state has access to all relevant Medicare performance information including Medicare HEDIS data and CAHPS results. (MN, MSHO/MSC+ contract, 2016, Sec. 7.7)
- **Tennessee** requires plan submission of all D-SNP performance-related information upon request. This includes, but is not limited to, HEDIS, HOS, CAHPS, and Medicare Stars quality rankings. (TN, D-SNP contract, 2016, Sec. A.2.b.10)
- **Wisconsin** requires submission of SNP quality and other reports submitted to CMS pursuant to Medicare regulations including HEDIS, HOS, CAHPS, and SNP measures. (WI, Family Care/Partnership contract, 2016, Sec. 12.B)

Financial Reports. Six of the 13 states (Arizona, Florida, Massachusetts, Minnesota, New Jersey, and Wisconsin) require D-SNPs to submit CMS-required financial reports, including information provided to CMS as part of the Medicare Advantage bid and cost reporting processes, either to the state directly or to the state's contracted actuary (See Appendix 2a). States also require additional financial reporting by D-SNPs, including submission of financial statements and detail on administrative and service costs. This financial reporting data can support state Medicaid rate-setting efforts when the D-SNP is responsible for provision of Medicaid covered benefits and payment of cost sharing. It can also help states assess the financial status of the D-SNPs operating in their state, which can be an indicator of the relative attractiveness of the state to D-SNPs, and to the potential for future D-SNP entries and departures. The contract provisions reviewed vary in terms of the level of specificity of financial reporting that is required:

- **Massachusetts** has detailed financial viability, stability, and reporting requirements in its contracts with aligned MLTSS plans/D-SNPs. (MA, SCO model contract, 2016, Sec. 2.12 and Appendix D)
- **Minnesota and Florida** include broad contract provisions related to the submission of any necessary information specified by the state to meet rate-setting or financial oversight objectives. (MN, MSHO/MSC+ contract, 2016, Sec. 3.7.2 and FL, D-SNP contract, 2015, Attachment I, Sec. D.5)
- **Minnesota and Wisconsin** specifically require D-SNPs to submit both initial Medicare bid submissions and the final approved bid. Notably, Minnesota's MSHO D-SNP contract includes requirements that the D-SNP consult with the state on use of projected Medicare savings and rebates prior to initial bid submission to CMS and notify the state of any changes. MSHO D-SNPs are also required to meet CMS requirements as a low-income benchmark plan so they can offer Part D benefits to enrollees with no premium. (MN, MSHO/MSC+ contract, 2016, Sec. 3.7 and 3.10 and WI, Family Care/Partnership contract, 2016, Article XVII.B)

Submission of CMS-Required Notices of Plan Changes to State

CMS' contracts with D-SNPs require submission of routine notifications to CMS for any anticipated plan or product changes, including entries to new markets, mid-year terminations or contract non-renewals, and service area expansions or reductions that may occur each plan cycle.[21] Seven of the states reviewed (Arizona, Idaho, Massachusetts, Minnesota, New Jersey, Oregon, and Texas) require D-SNPs to notify them of any mid-year terminations, non-renewals, or service area changes when the D-SNP notifies CMS (See Appendix 2a).

Sample Contract Language: State Notification of Medicare Advantage Plan Changes

Minnesota (MSHO/MSC+ contract, 2016, Sec. 3.101(c))

"The MCO will notify the STATE of changes, including but not limited to terminations of SNP plans, changes in type of SNPs approved or applied for, denial of a SNP application, failure to meet the CMS Low Income Subsidy (LIS) requirements, Part D issues that may materially affect the SNP, or a decision to conduct a Federal investigative audit that may lead to termination of the SNP, within thirty (30) days of such actions. For any SNP that may enroll Dual Eligible persons, the MCO also agrees to inform the STATE of any requests to CMS for Service Area changes in its SNP Service Area(s) within Minnesota, and of final approval, denial or withdrawal of such requests to CMS within fifteen (15) days of submission of such requests to CMS or within fifteen (15) days of receipt of notice from CMS, whichever is applicable."

If states have advance notice of these changes, they can work with CMS and plans to better coordinate beneficiary coverage options, including taking into account the availability of plans covering Medicaid benefits for Medicare-Medicaid enrollees. Additionally, for states with established integrated D-SNP programs where a D-SNP is exiting the market, states can use this information to facilitate enrollment into other established D-SNPs in the state in order to maintain integration for Medicare-Medicaid enrollees. Following are examples of state requirements:

- **Arizona** requires plans to notify it of significant changes to the terms of the Medicare contract with CMS, including D-SNP non-renewals, service area changes, terminations, deficiencies, CMS notices of intent to deny, and novation agreements. (AZ, D-SNP contract, 2017, Sec. 2.10)
- **Massachusetts** requires plans to notify the state and CMS of all changes affecting the delivery of care, the administration of its program, or its performance of contract requirements no later than 30 calendar days prior to any significant change. (MA, SCO model contract, 2016, Sec. 5.1.a)
- **Minnesota** has detailed requirements for notifications to the state related to terminations, material changes in its SNP contract with CMS, service area changes, and changes to Medicare premiums or bids. (MN, MSHO/MSC+ contract, 2016, 3.10)
- **Texas** requires D-SNPs to notify the state of CMS approval of D-SNP application and amendments to the contract, including the addition, deletion, or modification of a service area. (TX, D-SNP contract, 2016, Sec. 3.01b)

Submission of CMS Compliance Notices, and/or Notices of Low Star Ratings to the State

CMS has an extensive compliance and audit system for Medicare Advantage plans, including D-SNPs.[22] The Medicare Advantage Star Ratings system also measures and scores Medicare Advantage performance on a wide range of dimensions.[23] States can take advantage of this existing monitoring system to support their own monitoring and oversight of D-SNPs.

Six of the states reviewed (Arizona, Massachusetts, Minnesota, New Jersey, Oregon, and Tennessee) have contract provisions that require D-SNPs to submit Medicare past performance information to the state, including submission of CMS warning letters, corrective action plans, deficiency notices, and/or notices of low Medicare star ratings (See Appendix 2a). All of these states, with the exception of Oregon, also require alignment between D-SNP and MLTSS contractors, which facilitates this type of information sharing and oversight.

States receiving notifications directly and promptly from D-SNPs are better able to anticipate potential CMS actions that may impact D-SNP ability to attract enrollment, maintain current contracts with CMS, or extend contracts in subsequent years, which could potentially have an impact on quality or continuity of care for enrollees. Having knowledge of CMS audit findings and compliance actions can also support state oversight activities for the D-SNP contractor's Medicaid lines of business. Following are examples of state requirements:

- **Arizona** requires D-SNPs to submit any CMS warning letters or corrective actions plans within 10 business days of receipt, and must notify the state of star ratings of less than a 3.0 for either Part C or Part D. (AZ, D-SNP contract, 2017, Sec. 2.10 and 2.11)
- **Minnesota** requires D-SNPs to inform the state of any significant changes to their Medicare program and any significant changes in Medicare oversight results that are likely to have an impact on the continued integration of Medicare and Medicaid benefits. The state also requires submission of CMS corrective action requests to the state within 30 days of receipt. (MN, MSHO/MSC+ contract, 2016, Sec. 3.10)
- **New Jersey** requires D-SNPs to submit all CMS audit findings, reports, corrective actions, adverse actions, and sanctions, as well as final Star Ratings and Past Performance Methodology Scores. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.10.12.)
- **Tennessee** requires D-SNPs to provide all performance-related information upon state request, including information on low performing icons, notices of non-compliance, audit findings and corrective action plans. (TN, D-SNP contract, 2016, Sec. A.2.b.10)

Submission of Marketing Materials to the State

Eight of the D-SNP contracts reviewed (Arizona, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, Tennessee, and Wisconsin) require D-SNPs to submit marketing materials for state review before submission to CMS or distribution (See Appendix 2b). Marketing materials are defined broadly to include materials that reference state benefits or service information, media (e.g., print, video presentation, and advertisements), and outreach and education materials. State review of these materials can identify opportunities to reduce the confusion and inconsistency that may result from differing Medicare and Medicaid requirements.[24]

In Massachusetts and Tennessee, D-SNPs are also required to provide marketing/outreach plans to the state. Tennessee requires submission to the state of documentation of CMS approval while Wisconsin requires that these materials be made available upon state request. Wisconsin's D-SNP contract also specifies that the state will assist D-SNPs when issues arise in obtaining CMS approval. Wisconsin and Minnesota outline requirements for accessible formats and languages and cultural sensitivity that the D-SNP has to adhere to for all enrollee and marketing/outreach materials. Following are examples of provisions related to marketing:

- **Massachusetts** requires submission of all marketing materials for state review. D-SNPs must submit an annual stakeholder outreach plan and all outreach and enrollee materials to the state and CMS for approval. (MA, SCO model contract, 2016, Sec. 2.11.a, c)
- **Minnesota** requires submission of all marketing materials, including scripts and advertising, for state review. Under a long-standing agreement with CMS, the state establishes the parameters for allowable marketing, including formats and language specifications. The state and CMS must review and approve all Medicare-related materials, including Part D materials, and the state must review and approve the Medicaid-only materials. (MN, MSHO/MSC+ contract, 2016, Sec. 3.6.4)
- **Tennessee** requires submission of marketing materials to the state following review and approval by CMS, and the D-SNP must include documentation of CMS approval in its submission. The D-SNP is prohibited from using any eligibility or enrollment information that has been provided by TennCare for any marketing activities or to solicit additional individuals for enrollment in its D-SNP. (TN, D-SNP contract, 2016, Sec. A.2.g)
- **Wisconsin** requires submission of marketing and outreach materials for state and CMS review prior to distribution. The state will assist D-SNPs when issues arise in obtaining CMS approvals. The D-SNP contract also outlines requirements for cultural sensitivity for all enrollee and marketing/outreach materials. (WI, Family Care/Partnership contract, 2016. Article IX. A, B, and E)

Sample Contract Language: Submission of Marketing Materials to CMS and the State

Wisconsin (Family Care/Partnership contract, 2016, Art. IX. E)

"The MCO shall provide member and marketing/outreach materials in formats accessible due to language spoken and various impairments. Materials shared with potential members and members shall be understandable in language and format based on the following: 1. Understandable Language or Interpretation; 2. Materials Easily Understood; 3. Obtaining Accessible Information; 4. Cultural Sensitivity."

Submission of Medicare Advantage Grievance and Appeals Data to State and/or Coordination of Processes

States may require submission of Medicare Advantage grievance and appeals reports as a quality check on D-SNP processes and results. Additionally, states can require that D-SNPs coordinate the Medicare grievance and appeal process with the Medicaid process, to the extent possible given the separate rules and regulations that govern those processes.[25] Of the 13 states reviewed, Arizona, Minnesota, and New Jersey require regular reports of Medicare Advantage grievances and appeals and the appeals' outcomes. Only Minnesota, however, explicitly requires coordination of Medicare and Medicaid grievance and appeals processes, including use of integrated denial notices and aligned timeframes for plan-level appeals, in its D-SNP contract (See Appendix 2b).

While there are no specific federal requirements for coordination of Medicare and Medicaid grievance and appeals processes for D-SNPs in general, CMS requires FIDE SNPs to "employ policies and procedures approved by CMS and the state to coordinate or integrate...grievance and appeals..."[26]

Following are examples of grievance and appeals provisions in D-SNP contracts:

- **Arizona** requires D-SNP to submit quarterly summaries of Part C and D pre-service enrollee appeals received and the outcome of those appeals. Pre-service appeals occur when a D-SNP enrollee appeals a denial of a health service or item before it is received. Arizona also requires D-SNP to submit summaries of Medicare Independent Review Entity (IRE) decisions received and service-level detail on the appeals that were upheld and overturned during the reporting period. (AZ, D-SNP contract, 2017, Sec. 2.9)
- **Minnesota** has one integrated appeals process that incorporates both Medicare and Medicaid requirements and is used for all MSHO enrollees, a feature of its September 2013 MOU with CMS.[27] D-SNPs must submit Medicare grievance and appeals and service denial information to the state including Part D denials. (MN, MSHO/MSC+ contract, 2016, Sec. 8.1)
- **New Jersey** requires D-SNPs to submit an Integrated Denial Notice report that provides the state with a tool to monitor the history of appeals within the integrated program. The report is used to identify trends in Medicare-Medicaid benefit provision and utilization management that may affect enrollee quality of care or quality of life. (NJ, NJ FamilyCare contract, 2016, Article 10, Appendix 10.H.2)

Submission of Medicare Advantage Encounter Data and/or Part D Drug Event Data to the State

Of the states reviewed, nine (Arizona, Hawaii, Massachusetts, Minnesota, New Jersey, New Mexico, Oregon, Tennessee, and Texas) require D-SNPs to submit Medicare Advantage encounter data to the state. Minnesota and Tennessee specify that Part D data must also be submitted. Florida and Texas have authority in the D-SNP contract to require plans to submit Medicare Advantage encounter data, but the states do not currently require plans to do so (See Appendix 2b). This analysis did not examine how states used Medicare data or any difficulties they may have had in obtaining and analyzing the data. In general, however states with significant experience obtaining and using Medicaid encounter data from plans are in a better position to use linked Medicare encounter data to develop a comprehensive picture of service utilization patterns for enrollees in fully integrated programs. States like Arizona and Tennessee that have combined Medicaid and Medicare encounter data in this way have obtained the necessary Medicare encounter data directly from the D-SNPs with which they contract.[28]

Sample Contract Language: Submission of Medicare Advantage Encounter Data and Part D Data to the State

Minnesota (MSHO/MSC+ contract, 2016, Sec. 3.7.1 (B) (1))

"Individual Enrollee-specific, claim-level encounter data for services provided by the MCO to Enrollees detailing all Medicare and Medicaid medical and dental diagnostic and treatment encounters, all pharmaceuticals (including Medicare Part D items), supplies and medical equipment dispensed to Enrollees, Home and Community-Based Services, Nursing Facility services, and Home Care Services for which the MCO is financially responsible."

Tennessee (D-SNP contract, 2016, Sec. A.2.c.1.b and Sec. A.2.c.1.b.12)

"The Contractor shall submit to TennCare, in a mutually agreed upon electronic format, . . . Encounter data for any and all claims, including Part D claims to the extent the Contractor has access to such information and including claims with no patient liability..." "The Contractor shall be able to receive, maintain and utilize data extracts from TennCare and its contractors, e.g., pharmacy data from TennCare or its pharmacy benefit manager (PBM)."

Coordination of Quality Improvement and External Quality Review Activities

A few states use contract requirements to align Medicare and Medicaid quality improvement project topics and reporting formats, which can streamline quality improvement activities for D-SNPs and further state quality improvement goals (See Appendix 2b). Following are examples of state approaches:

- **Minnesota** has detailed requirements and a clear process for D-SNPs to coordinate quality assurance and performance improvement projects across Medicare and Medicaid. D-SNPs must participate in joint Medicare-Medicaid performance and quality improvement projects. (MN, MSHO/MSC+ contract, 2016, Sec. 7.2)
- **New Jersey** has contract provisions related to D-SNP participation in quality improvement projects defined by the state with input from the D-SNP and the state's external quality review organization. New Jersey includes a requirement in its state quality strategy for its external quality review organization to conduct annual SNP audits of operations, performance, and ad hoc special studies. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.4.6.2Q)
- **Wisconsin** allows D-SNPs to use Medicare quality improvement project or chronic care improvement project templates for submission of its performance improvement projects with prior state approval. (WI, Family Care/Partnership contract, 2016, Article XII.C.7.b.)

Sample Contract Language: Alignment of Medicaid and Medicare Quality Improvement Projects

Minnesota (MSHO/MSC+ contract, 2016, Sec. 7.2)

"The MCO may use its Medicare Quality Improvement Project (QIP) to meet the Medicaid Performance Improvement Project (PIP) requirements for both MSHO and MSC+. This includes using Medicare's measurement standards and reporting timelines and templates. The MCO will provide the STATE with copies of the final QIP proposal and reports submitted to CMS within fifteen (15) days of submission."

Beneficiary Cost Sharing Protections

D-SNP contracts are required to describe the beneficiary cost sharing protections covered by the D-SNP. D-SNPs must not impose cost sharing requirements on Medicare-Medicaid enrollees that would exceed the amounts

permitted under the Medicaid state plan, and must enforce limits on beneficiaries' out-of-pocket costs.[29] All Medicare Advantage organizations – not just D-SNPs – must educate providers about the federal statutory prohibition against balance billing of those enrolled in the Qualified Medicare Beneficiaries (QMB) program and specify in their contracts with providers that they must accept the Medicare Advantage payment as payment in full or bill the state for the applicable Medicare cost sharing.[30]

All of the D-SNP contracts reviewed include the minimum MIPPA-required provision that D-SNPs must not impose cost sharing that would exceed the amounts permitted under the state plan. In addition, with the exception of Oregon's, all of the D-SNP contracts reviewed include provisions stating, with varying degrees of specificity, that D-SNPs must assure that providers do not balance bill D-SNP enrollees for Medicare cost sharing. Arizona's D-SNP contract has the most direct and clear language on beneficiary cost sharing and provider balance billing among the contracts reviewed.

Sample Contract Language: Beneficiary Cost Sharing Protections

Arizona (D-SNP Contract, 2017, Sec. 2.3)

"MA [Medicare Advantage] D SNP Health Plan providers shall not impose Medicare cost sharing on dual eligible members for services covered by both Medicare and Medicaid. MA D SNP Health Plan providers agree to accept MA D SNP Health Plan payment as payment in full for services covered by both Medicare and Medicaid, or bill the appropriate AHCCCS or ALTCS Contractor for additional payments that may be reimbursed under Medicaid. Dual eligible members shall be responsible for any applicable AHCCCS copayment. The State cost sharing policy is located in ACOM Policy 201.

Section 1902(n)(3)(B) of the Social Security Act prohibits Medicare providers from balance billing QMB's for Medicare cost-sharing, including deductibles, coinsurance, and copayments. QMB's have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. MA D SNP Health Plan shall include a provision in all provider agreements specifying that the provider agrees to accept MA D SNP payment as payment in full, or bills the appropriate AHCCCS or ALTCS Contractor for additional payments that may be reimbursed under Medicaid."

Other State Requirements that Go Beyond MIPPA Requirements

States may use D-SNP contracts to specify other requirements that promote enrollment into aligned Medicare-Medicaid products, facilitate continuity of care or more seamless coordination of Medicare and Medicaid services, or other state program goals (See Appendix 2b). Examples include:

- **Arizona** encourages D-SNPs that also operate a Medicaid health plan to directly market only to individuals enrolled in the D-SNP contractor's Medicaid product, as a way of increasing alignment. The D-SNP contract also provides for seamless conversion enrollment of newly Medicare-eligible individuals who are currently enrolled in a company's Medicaid plan into the company's companion D-SNP in order to increase the number of individuals in aligned plans, if CMS approves the D-SNP's application. This includes individuals who are aging in to Medicare, as well as those qualifying for Medicare upon the completion of the 24-month waiting period due to a disability. Individuals notified of a pending seamless enrollment under this process can choose another Medicare option before the enrollment takes effect. They can also choose another Medicare option after enrollment if they wish, as can all other D-SNP enrollees (AZ, D-SNP contract, 2017, Sec. 2.8 and 2.1.12)
- Florida requires D-SNPs to facilitate Medicaid eligibility redeterminations for enrollees, including assisting with applications for medical assistance and conducting enrollee education regarding maintenance of Medicaid eligibility. (FL, D-SNP contract, 2015, Sec. B.1.d) This D-SNP activity is facilitated by real-time access to state eligibility information, which is one of the minimum requirements for MIPPA contracts.[31]
- Idaho requires its D-SNP contractor to staff provider and enrollee call centers with representatives who are knowledgeable about Medicare and Medicaid benefits and contract terms and who are capable of conducting "warm transfers" when a caller has Medicaid behavioral health or LTSS benefit questions that require additional assistance. (ID, Medicaid Provider Agreement 2016, Appendix A, Attachment 11.II.A)

- Massachusetts allows D-SNPs to submit integrated enrollment and disenrollment forms to the state and CMS on behalf of D-SNP enrollees. (MA, SCO Model Contract, 2016, Sec 2.3.a.2)
- Minnesota requires D-SNPs, in addition to other D-SNP data or reporting submission requirements, to:
  - Submit to the state D-SNP frailty and risk assessment scores, the CMS-approved Model of Care, and Medicare Part D medication therapy management programs information. The state works with D-SNPs to tailor the D-SNP Model of Care and health risk assessment tool to align with state objectives and requirements.
  - Waive the Medicare three-day hospital stay requirement[32] for Medicare skilled nursing facility coverage.
  - Participate in the state's administrative alignment demonstration based on a memorandum of understanding between the state and CMS.[33] (MN, MSHO/MSC+ contract, 2016, Sec. 3.7, 3.10, and 4.10)
- **Oregon** requires D-SNPs to examine opportunities to enhance Medicare to Medicaid alignment with the state Medicaid agency, define barriers, and report recommendations for achieving greater alignment and coordination for enrollees. (OR, D-SNP contract, 2016, Sec. 1.4, 6.1, 6.4 and 6.5)

5. Conclusion

In this analysis, the states with the most detailed and extensive D-SNP contracts were those that have: (1) well-established Medicaid MLTSS programs; (2) experienced D-SNPs that are interested in contracting with the state; and (3) state Medicaid agency leadership and staff who are knowledgeable about both Medicaid and Medicare managed care. These leading states developed the capacity to use D-SNP contracting as an effective tool for integrating Medicare and Medicaid over time. They strengthened and enhanced their D-SNP contracts incrementally, as state and D-SNP capabilities and opportunities developed.

This technical assistance tool enables states at varying stages of D-SNP contracting to identify opportunities to use these contracts to advance integration. As states consider what to require in their D-SNP contracts, they should take into account the staff and other resources they have to design and implement meaningful integration requirements, review and analyze the information they require D-SNPs to submit, and work with D-SNPs over time to refine and improve D-SNP integration with their Medicaid program.

States should approach contracting with D-SNPs strategically, as many of the states reviewed in this tool have done. States implementing new MLTSS programs can use D-SNP contracts to increase integration of Medicaid services with Medicare services incrementally over time. States that may not yet have a Medicaid MLTSS program but are planning on developing one in the future may want to at least enter into the minimum required contracts with D-SNPs to increase the likelihood that D-SNP options will be available to link with the Medicaid MLTSS program when needed. If a state has no plans to develop a Medicaid MLTSS program, however, or has not identified ways in which contracting with D-SNPs could improve coordination of Medicare and Medicaid services in the state, using scarce state resources to develop such contracts may not be warranted. Similarly, if a state has no or few D-SNPs, it may not want to devote limited state resources to exploring this option. For states with the necessary resources and opportunities, however, the D-SNP model of integration can improve the coordination of services for Medicare-Medicaid enrollees beyond what separate Medicare and Medicaid plans can do, and beyond what can be accomplished in the fee-for-service system.

Appendix 1: Overview of State Medicaid MLTSS Programs and D-SNPs

MLTSS Program Information				D-SNP Information		
State, Medicaid MLTSS Program, and Date Started	**Population Covered**	**Medicaid Services Provided on a Capitated Basis (MLTSS and Other Medicaid Services)**	**Medicaid Services Provided Through Fee for Service**	**Population Covered**	**Medicaid Services Provided on a Capitated Basis through Companion Medicaid Plans or Direct State Payments to D-SNPs**	**Requirements for Alignment of D-SNPs and Medicaid MCOs**
Arizona Arizona Long-Term Care System (ALTCS) (1989)	All elderly, physically disabled or developmentally disabled individuals with a medical need for long term care (LTC) services	ALTCS: Primary and acute care, behavioral health services, prescription drugs, LTSS (nursing facility [NF], ICF/MR, HCBS)	None for MLTSS plan enrollees	FBDE, QMB+, SLMB+ (Arizona Health Care Cost Containment System (AHCCCS) Acute Program and ALTCS Program)	All Medicaid services provided by ALTCS and AHCCCS Acute plans (including primary and acute care, prescription drugs)	D-SNPs are required to have a companion Medicaid plan that covers all Medicaid services and state-defined counties and population(s)
Florida Long-Term Care Program (2013)	Mandatory population: Adults 18+ with LTC needs in nursing facilities (NF) or aged, blind, and disabled individuals 18+ who meet NF level of care including dually eligible individuals Voluntary population: Aged, blind, and disabled adults 18+ with LTC needs in Program of All-Inclusive Care for the Elderly and select HCBS waivers	Managed Medical Assistance Program: Primary and acute care, prescription drugs LTC Program: NF, home health, hospice, HCBS, behavior management, personal care, therapies, medical equipment and supplies, and self-direction option	None for MLTSS plan enrollees	FBDE, SLMB+, QMB and QMB+ enrolled full dual eligibles excluding Institutional Care Program (ICP) eligible recipients during the enrollment month[a]	All services provided by Managed Medical Assistance Program; LTSS also provided if there is a companion Medicaid MLTSS plan	None; however, D-SNPs with companion MLTSS plans provide all LTC program services including NF and HCBS waiver services through the companion MLTSS plan D-SNPs without companion MLTSS plans receive capitated payments from the state to provide the same covered benefits provided under the Managed Medical Assistance Program for the applicable eligibility categories, but do not provide LTSS
Hawaii QUEST Integration (QI) RFP (2013, with revised Section 50.100) Preceded by QUEST Expanded Access (QExA) (2009)	Aged, blind, and disabled (ABD) individuals, children, adults < 65 with physical disabilities, adults < 65 with intellectual or developmental disabilities, adults 65+ Full benefit dual eligibles in above populations covered, but not those receiving only Medicare Special Savings Program benefits	QI Program: Primary and acute care, behavioral health services, prescription drugs, LTSS (NF, home health, hospice, HCBS, personal care, self-directed options)	Additional behavioral health services for adults with serious and persistent mental illness and children with serious emotional disturbance, dental, HCBS waiver services for people with intellectual or developmental disabilities, and institutional care for people with intellectual or developmental disabilities	FBDE	All Medicaid services provided by the QI Program	D-SNP contractors must be QI contractors Since January 2016, QI contractors must offer a D-SNP
Idaho (No State Medicaid MLTSS Program)	MLTSS provided by the single D-SNP operating in the state, which enrolls FBDEs	All Medicaid state plan services	Non-emergency medical transportation (NEMT), development disabilities waiver services, and community crisis supports and developmental therapy provided through 1915(i) state plan	FBDE	All Medicaid state plan services and 1915(c) elderly and disabled waiver services	The single FIDE SNP operating in the state provides both Medicare and Medicaid benefits, including LTSS

MLTSS Program Information				D-SNP Information		
State, Medicaid MLTSS Program, and Date Started	**Population Covered**	**Medicaid Services Provided on a Capitated Basis (MLTSS and Other Medicaid Services)**	**Medicaid Services Provided Through Fee for Service**	**Population Covered**	**Medicaid Services Provided on a Capitated Basis through Companion Medicaid Plans or Direct State Payments to D-SNPs**	**Requirements for Alignment of D-SNPs and Medicaid MCOs**
Massachusetts Senior Care Options (2004)	QMB+ or SLMB+ age 65+ with MassHealth Standard coverage	SCO Program: All Medicaid state plan services, including primary and acute care, behavioral health services, prescription drugs, LTSS (NF, adult foster care, adult day health, personal care, respite, and other services), transportation, dental, durable medical equipment, and institutional care	None	QMB+ or SLMB+ age 65+ with MassHealth Standard coverage	All Medicaid services provided by the SCO Program	D-SNP contractor must also be a Medicaid contractor, and thus holds separate contracts with CMS and the state for the same service area and populations
Minnesota Minnesota Senior Health Options (MSHO) (1997)	Adults age 65+ eligible for both Medicaid and Medicare Parts A & B excluding QMB and SLMB eligibles who are otherwise not eligible for state Medical Assistance	MSHO Program: All Medicaid services (including behavioral health and substance abuse, durable medical equipment, preventive, diagnostic, therapeutic, rehabilitative services, LTSS (NF up to 180 days), State plan personal care and HCBS Elderly Waiver services)	NF after 180 days	FBDE excluding QMB and SLMB eligibles who are otherwise not eligible for state Medical Assistance	All Medicaid services provided by the MSHO Program	The Medicaid MCO agrees to participate in Medicare Advantage as a D-SNP (MN, MSHO/MSC+ contract, 2016, Sec. 3.109.1)
New Jersey NJ FamilyCare Managed Long-Term Services and Supports (2014)	All Medicaid eligible individuals, including children, meeting financial and NF level of care requirements	NJ FamilyCare MLTSS: All Medicaid state plan services, including primary and acute care, behavioral health services (mental health and substance abuse services, prescription drugs, LTSS) benefits of personal care attendant and medical day care); NF; HCBS	Grandfathered Special Care NF and NF residents	FBDE, QMB+	D-SNPs are all designated as FIDE SNPs and provide all Medicaid services provided by NJ FamilyCare MLTSS as one integrated D-SNP/MLTSS benefit package	D-SNPs are required to be approved by state as standard Medicaid managed care contractor As a condition of eligibility, individuals may only enroll in the Medicaid contractor's D-SNP product if they are enrolled in the same health plan for both Medicare and Medicaid service delivery (NJ, NJ FamilyCare contract, 2016, Sec. 10.5.4.C)
New Mexico Centennial Care (2012) Preceded by Coordination of Long Term Services (COLTS) (2008)	All Medicaid eligible individuals with the exception of dually eligible individuals receiving cost sharing and premium assistance only, refugees and undocumented aliens, and out-of-state adoption placements	Centennial Care: Primary and acute care, behavioral health services, prescription drugs, LTSS (HCBS waiver, state plan personal care, NF)	HCBS services for medically fragile individuals and individuals with developmental disabilities; ICF/MR services	FBDE, QDWI, QI, QMB Only, QMB+, SLMB+, SLMB Only	For Centennial Care contractors with a companion D-SNP, all Medicaid services are provided through capitated payments to Centennial Care contractors	Centennial Care contractors are required to be a D-SNP or offer Medicare products in all counties agreed to by the parties (NM, Centennial Care contract, 2013, Sec. 1.12)
Oregon (No State Medicaid MLTSS Program)	NA	None: no MLTSS program	All LTSS	FBDE, QDWI, QI, QMB Only, QMP+, SLMB+, SLMB Only	None	None, however D-SNPs are required to comply with additional information-sharing requirements to improve care coordination with CCOs, LTSS, and fee-for-service for D-SNP enrollees (OR, D-SNP contract, 2016, Sec. 6.1-6.3, 6.5-6.6)
Pennsylvania (No State Medicaid MLTSS Program)	NA	None: no MLTSS program	All LTSS	FBDE, QMB Only, QMB+, SLMB Only, SLMB+, QDWI, QI	None	None

MLTSS Program Information				D-SNP Information		
State, Medicaid MLTSS Program, and Date Started	**Population Covered**	**Medicaid Services Provided on a Capitated Basis (MLTSS and Other Medicaid Services)**	**Medicaid Services Provided Through Fee for Service**	**Population Covered**	**Medicaid Services Provided on a Capitated Basis through Companion Medicaid Plans or Direct State Payments to D-SNPs**	**Requirements for Alignment of D-SNPs and Medicaid MCOs**
Tennessee TennCare CHOICES (2010)	NF residents (all ages), adults age 65+ and adults >21 with physical disabilities who meet NF level of care criteria or are at risk for needing a NF level of care	TennCare CHOICES: primary and acute care, behavioral health services, LTSS (NF, waiver-like HCBS)	Prescription drugs[b]	QMB Only (6 plans) QMB+ (6 plans) SLMB+ (5 plans) FBDE (6 plans) QI (1 plan) QDWI (1 plan)	None	Medicaid MCOs must have companion D-SNP; D-SNPs contracted by January 2014 are not currently required to have a companion MLTSS plan
Texas STAR+PLUS (1998)	SSI or SS exclusion children age <21, adults age 21+ with SSI, adults age 21+ in community-based alternatives, HCBS waiver adults age 65+, FBDE	STAR+PLUS: Primary and acute care, behavioral health services, LTSS (HCBS waiver services) Behavioral health provided through separate NorthSTAR BH managed care program in Dallas, Ellis, Collin, Hunt, Rockwell and Kaufman counties; as of December 2016, all behavioral health will be offered through STAR+PLUS MCOs or other managed care programs in these counties	None	QMB Only, QMB Plus, SLMB+	For D-SNPs that operate STAR+PLUS plans, all Medicaid services are provided through capitated payments to the STAR+PLUS plan For D-SNPs that do not have a Medicaid contract, Medicaid services are limited to Medicare beneficiary cost sharing only	STAR+PLUS contractors must offer D-SNPs in most populous counties in the service area State does not require D-SNPs to have a companion MLTSS plan[c]
Wisconsin Family Care (1999) Family Care Partnership (1996)	Adults with physical disabilities, including persons with Alzheimer's disease or terminal illness; adults with developmental or intellectual disabilities; and frail elders, including persons with Alzheimer's disease or terminal illness Family Care Partnership: must meet NF level of care criteria	Family Care: State plan, LTSS (NF, ICF/I/ID, home health, personal care, durable medical equipment and supplies, behavioral health not provided inpatient or by a physician), HCBS waiver, cost-effective MCO supplemental services Family Care Partnership: All Family Care services as well as primary and acute care, and prescription drug Medicare and Medicaid services.	Family Care: Acute and primary care, prescription drugs Partnership: None	FBDE (18+ with NF level of care) who reside in areas where the Family Care benefit package is available, dually eligible individuals with end-stage renal disease are eligible if plan has CMS waiver	All Medicaid services provided by Family Care	Medicaid MCOs participating in the Partnership program must have a companion D-SNP

FBDE = Full Benefit Dual Eligible; QDWI = Qualified Disabled and Working Individual; QI = Qualifying Individuals; QMB Only = Qualified Medicare Beneficiaries without other Medicaid; QMB+ = Qualified Medicare Beneficiaries with Full Medicaid; SLMB Only = Specified Low-Income Medicare Beneficiaries without Other Medicaid; SLNB+ = Specified Low-Income Beneficiaries with Full Medicaid

[a] Qualified Medicare Beneficiary (QMB) entitles low-income individuals to have Florida Medicaid pay for their Medicare premiums; and deductibles and coinsurance for Medicaid covered services, up to the Florida Medicaid rate. An individual can have QMB only coverage, or QMB coverage and a full Medicaid coverage program.

[b] TennCare pharmacy is operated as a carve out to a single pharmacy benefit manager (PBM) that has tools and incentives to encourage cost-effective use of prescriptions drugs (state correspondence).

[c] MLTSS contractors must also offer D-SNPs in most populous counties in the service area, however Texas will sign contracts with D-SNPs that do not have a companion MLTSS plan (state interview).

Appendix 2a: Contract Features That Go Beyond Minimum MIPPA Requirements: Additional Coordination and Reporting[a]

State/MLTSS Program/Start Date	Requirements for Coordination of D-SNP and Medicaid Services	D-SNP Required to Submit Medicare Advantage (MA) Reports to State			
		Medicare Advantage Quality/Performance Reports	Medicare Advantage Financial Reports	CMS-Required Notices of Plan Changes to State	Warning Letters, Corrective Action Plans, Deficiency Notices and/or Low Star Ratings
Arizona Arizona Long-Term Care System (ALTCS) (1989)	D-SNP must coordinate all aspects of enrollees' health care including, but not limited to, behavioral health, discharge planning, disease management, and care management. (AZ, D-SNP contract, 2017, Sec. 2.1.2 and 2.1.4) D-SNP must establish a contact person at each Arizona Health Care Cost Containment System acute or ALTCS Medicaid plan. This contact will be responsible to share with the D-SNP, at minimum, timely inpatient hospital, emergency room, and chronic illness information to coordinate care when benefit coverage switches from Medicare to Medicaid. D-SNP must provide to the state the name of the contact person at the D-SNP who will be responsible for coordination of care. (AZ, D-SNP contract, 2017, Sec. 2.1.7-2.1.8)	Quality reporting is due annually. (AZ, D-SNP contract, 2017, Appendix 1)	Financial reporting is due quarterly. (AZ, D-SNP contract, 2017, Appendix 1)	D-SNP required to notify state of any significant changes to the terms of the Medicare contract with CMS. (AZ, D-SNP contract, 2017, Sec. 2.10)	D-SNP required to notify state of CMS warning letters, corrective action plans, and star ratings of less than a 3.0 for either Part C or Part D. (AZ, D-SNP contract, 2017, Sec. 2.10 and 2.11)
Florida (Statewide Medicaid managed long-term care program implemented in 2014)	The D-SNP shall coordinate care for enrollees, including but not limited to: (1) assistance in obtaining required services; (2) coordinating benefits and services; (3) informing network providers of benefits and services which are to be provided to enrollees; and (4) training network providers on available benefits and services. (FL, D-SNP contract, 2015, Attachment I, Sec. B.2.k.)	Not required in D-SNP contract.	D-SNP provides all necessary and pertinent information, so the Agency may consult with actuaries to establish payment rates for Medicaid services. The Agency decides what information is necessary and pertinent for the Vendor to provide to the Agency. The Agency consults with actuaries to establish the payment rates for services provided to eligible enrollees under Title XIX of the Federal Social Security Act. (FL, D-SNP contract, 2015, Attachment I, Sec. D.5.)	Not required in D-SNP contract.	Not required in D-SNP contract.

[a] The additional coordination and reporting requirements in Appendix 2a are located in either a stand-alone D-SNP contract or a companion/integrated Medicaid MCO contract, depending on state contracting and integrated program design. The use of the terms D-SNP, MCO, or contractor in this table corresponds to the terminology and structure used in the individual state contracts.

State/MLTSS Program/Start Date	Requirements for Coordination of D-SNP and Medicaid Services	D-SNP Required to Submit Medicare Advantage (MA) Reports to State			
		Medicare Advantage Quality/Performance Reports	Medicare Advantage Financial Reports	CMS-Required Notices of Plan Changes to State	Warning Letters, Corrective Action Plans, Deficiency Notices and/or Low Star Ratings
Hawaii QUEST Integration (QI) RFP (2013) Preceded by QUEST Expanded Access (QExA) (2009)	Enrollees will have a service coordinator responsible for: (1) coordination of acute and primary care, and LTSS, including coordination with Medicare services; (2) providing continuity of care when enrollees are discharged from the hospital with prescribed medications that are normally prior authorized or not on the plan's formulary; (3) facilitating access to services including community services; (4) providing assistance resolving concerns about service delivery or providers; and (5) assisting enrollees to maintain continuous Medicaid benefits, including identifying at risk enrollees and ensuring continuity of care. (HI, QI RFP, 2013, Sec. 40.900)	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.
Idaho (No State Medicaid MLTSS Program)	D-SNP coordination requirements include: (1) all enrollees must have an integrated care team, comprised of a medical home, led by a primary care physician and care coordinator, and any other relevant providers, which "ensures the integration of the enrollee's medical, behavioral health, substance use, LTSS, an/or social needs"; (2) the care coordinator must coordinate services "with the services the enrollee receives from any other health plan"; (3) the D-SNP must "coordinate with the Idaho Department of Health and Welfare (IDHW) to ensure Enrollees are linked to carved out services. Including but are not limited to transferring calls from the Call Center/Help Desk information line to IDHW and providing information on how to access these services in Enrollee education"; and (4) the D-SNP must implement transitional care protocols and processes to ensure hospitals and residential/rehabilitation facilities provide the enrollee's ICT prompt notification of admission or pending discharge. (ID, Medicaid Provider Agreement, 2016, Appendix A, Sec XVIII).	Not required in D-SNP contract.	Not required in D-SNP contract.	Detailed requirements for the transition of the D-SNP to a successor at contract end or if the D-SNP cannot complete its responsibilities for some other reason, the D-SNP must notify the state 180 days prior to the pending transition.	Not required in D-SNP contract.

State/MLTSS Program/Start Date	Requirements for Coordination of D-SNP and Medicaid Services	D-SNP Required to Submit Medicare Advantage (MA) Reports to State			
		Medicare Advantage Quality/Performance Reports	Medicare Advantage Financial Reports	CMS-Required Notices of Plan Changes to State	Warning Letters, Corrective Action Plans, Deficiency Notices and/or Low Star Ratings
Massachusetts Massachusetts Senior Care Options (SCO) (2004)	(Note: SCO D-SNP managed care organizations (MCOs) are at risk for all Medicaid and Medicare services for enrollees) MCO must ensure effective linkages of clinical and management systems across all providers. This includes written protocols for generating or receiving referrals in order to share clinical and plan of care information, and to track and coordinate. Enrollee transfers from one setting to another. (MA, SCO Model Contract, 2016, Sec. 2.4.a.6) MCO must keep all parties informed about utilization of services for emergency conditions and urgent care. (MA, SCO Model Contract, 2016, Sec. 2.4.a.7) The MCO must maintain a single, centralized, comprehensive record that documents the enrollee's medical, functional, and social status and all services provided, which must be updated in a timely manner by all providers, and available to all providers 24 hours per day, 7 days per week. (MA, SCO Model Contract, 2016, Sec. 2.4.a.8). MCO must demonstrate the capacity to provide coordination of care and expert care management through the Primary Care Team (PCT) and must maintain a systematic process for coordinating care with providers of non-covered services including but not limited to state agencies, social services agencies, federal agencies such as the Department of Veterans Affairs and Housing and Urban Development. (MA, SCO Model Contract, 2016, Sec., 2.4.c.1 and 2.4.a.12)	MCO must report Medicare Advantage SNP HEDIS measures relevant to the SCO population on the same time schedule required by CMS. (MA, SCO Model Contract, 2016, Sec. 2.14.a.1) MCO shall cooperate with the state to develop and implement a process for ensuring non-payment for services that constitute or result from so-called serious reportable events, as defined by the National Quality Forum. (MA, SCO Model Contract, 2016, Sec 2.10,I)	On a quarterly or monthly basis, the MCO must report performance to the state and CMS. The reports include financial statements and plan specific enrollment and financial projections. All reports must contain subsections for: (1) the contractor's activity only; and (2) combined data for the contractor and all subcontractors. (MA, SCO Model Contract, 2016, Appendix D)	MCO must notify the state and CMS in writing of all changes affecting the delivery of care, the administration of its program, or its performance of contract requirements. The timeframe for notification is no later than 30 calendar days prior to any significant change to how services are rendered to enrollees, and no later than five business days for all other changes. (MA, SCO Model Contract, 2016, Sec. 5.1.a).	Not required in D-SNP contract.

State/MLTSS Program/Start Date	Requirements for Coordination of D-SNP and Medicaid Services	D-SNP Required to Submit Medicare Advantage (MA) Reports to State			
		Medicare Advantage Quality/Performance Reports	Medicare Advantage Financial Reports	CMS-Required Notices of Plan Changes to State	Warning Letters, Corrective Action Plans, Deficiency Notices and/or Low Star Ratings
Minnesota Minnesota Senior Health Options (MSHO) (1997)	The MCO must provide care coordination/case management services that are designed to ensure access and integrate the delivery of all Medicare and Medicaid preventive, primary, acute, post-acute, rehabilitation, and LTC services, including state plan home care services and elderly waiver services. The MCO shall also coordinate the services it furnishes to its enrollees with the services an enrollee receives from any other MCO. (MN, MSHO/MSC+ contract, 2016, Sec. 6.1.4) D-SNPs are required to provide an annual description of the care coordination system for MSHO. D-SNPs are also required to submit the most recent SNP Model of Care to state as well as Medication Therapy Management program. (MN, MSHO/MSC+ contract, 2016, Sec. 3.7.2 and 3.10.6)	State requires access to all MCO performance information. MCO must annually provide HEDIS report, Structure and Process measures, extensive care plan and care system audit reports, and summarized results. (MN, MSHO/MSC+ contract, 2016, Sec. 7.7)	Financial statements and other information as specified by the state to determine the MCO's financial and risk capability, and for MSHO, all financial information necessary for the administration or evaluation of the Medicare program. This includes per member per month detail on administrative and service costs. The MCO shall provide on a quarterly basis information on revenues and expenditures by product. (MN, MSHO/MSC+ contract, 2016, Sec. 3.7.2)	The MCO must inform the state of notices of requests to CMS for service area changes, proposed and final Medicare benefits and premium information. The MCO must also notify the state of significant changes in Medicare information to beneficiaries, benefits, networks, service delivery, oversight results or policy that are likely to impact the continued integration of Medicare and Medicaid benefits. (MN, MSHO/MSC+ contract, 2016, Sec. 3.10)	The MCO shall inform the state regarding significant changes including notices of Corrective Action Requests within 30 days. (MN, MSHO/MSC+ contract, 2016, Sec. 3.10)
New Jersey NJ FamilyCare Managed Long-Term Services and Supports (2014)	MCO is required to implement care management in accordance with standards for D-SNPs and evidence based model of care; the MCO is responsible for arranging the provision of non-covered Medicaid benefits as a result of this requirement. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.4.5.1.A; Sec. 10.2.B-C; and Sec. 10.4.1.1.A) MCO is required to implement integrated care management requirements that align the full continuum of services available to maximize each enrollee's health and personal independence. (For specific requirements see NJ, NJ FamilyCare contract, 2016, Article 10, Sec 10.10.5.A-D)	MCO must annually, and at the time of filing with CMS, provide HEDIS, CAHPS, and HOS scores to the state. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.10.12) MCO must submit at least annually the results of the DSNP quality improvement project evaluation to Division of Medicaid Assistance and Health Services including the quality indicators. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.10.1.A)	MCO shall submit to the state complete Medicaid and Medicare financial reports in the formats described in the state's Financial Reporting Manual and at Appendix H, Reporting Requirements. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.A.2) MCO shall provide in a manner as advised by the state the Part C and Part D bid filings and all revisions, annually, and at the time of filing with CMS. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.10.12.)	When MCO terminates or fails to renew its contract with CMS to offer the Medicare Advantage product, the MCO shall notify the state the same business day upon knowledge of the impending termination or failure to renew. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.10.13.B) The MCO shall report all significant changes including changes to services, benefits, geographic service area or payment, or enrollment of a new population that may affect the contractor's performance under this contract. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.10.10.B))	MCOs shall provide as advised by the state, annually, and at the time of filing with CMS, all Medicare Advantage audit findings, reports, corrective actions, adverse actions taken by the CMS or sanctions, and final Star Ratings and Past Performance Methodology Scores. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.10.12.)

State/MLTSS Program/Start Date	Requirements for Coordination of D-SNP and Medicaid Services	D-SNP Required to Submit Medicare Advantage (MA) Reports to State			
		Medicare Advantage Quality/Performance Reports	Medicare Advantage Financial Reports	CMS-Required Notices of Plan Changes to State	Warning Letters, Corrective Action Plans, Deficiency Notices and/or Low Star Ratings
New Mexico Centennial Care (2012) Preceded by Coordination of Long Term Services (COLTS) (2008)	MCO will identify Medicaid benefits the enrollee may be eligible for that are not covered under the D-SNP and will provide information to beneficiaries to access Medicaid benefits (as requested). This includes identifying Medicaid participating providers and making Medicaid information available to network providers about coordination of Medicaid and Medicare benefits. (NM, D-SNP contract, 2013, Sec. 2.4 and 2.5) Medicaid health plan required comprehensive needs assessment must consider Medicare services. (NM, Centennial Care contract, 2013, Sec. 4.4.5.5.5) Develop a care plan, which includes information about services provided by Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate services. (NM, Centennial Care contract, 2013, Sec. 4.4.9.6.12) D-SNPs are responsible for coordinating the primary, acute, behavioral health and LTC care services with the enrollee's Medicare primary care provider. (NM, Centennial Care contract, 2013, Sec. 4.8.4.1)	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.
Oregon (No State Medicaid MLTSS Program)	"In the event the Health Plan does not have an active Coordinated Care Organization (CCO) or MCO contract or a contractual relationship with an active CCO or MCO during the Agreement period, including if the CCO or MCO contract is terminated prior to the end of this Agreement term, the Health Plan agrees to honor all coordination of benefits requirements in this Agreement with any CCO or MCO that shall enroll a dually-eligible individual for whom the D-SNP is serving prior to the termination of its affiliated CCO or MCO contract for the duration of this Agreement." (OR, D-SNP contract, 2016, Sec. 10.1) "If the dually eligible individual is enrolled in Oregon Health Plan fee-for-service, D-SNP shall agree to coordinate benefits directly with the Oregon Health Authority. If the Health Plan has an enrollee in its D-SNP that is not also enrolled in its affiliated Medicaid MCO or CCO, the Health Plan also agrees to coordinate benefits with the enrollees' Medicaid payer (MCO, CCO or OHA)." (OR, D-SNP contract, 2016, Sec. 10.2) "[Health Plan]…shall assign Providers as Medically Appropriate to coordinate the care and benefits of Members who are eligible for both Medicaid and Medicare." (OR, D-SNP contract, 2016, Sec. 1.3) "…shall demonstrate that Contractor's Provider network is adequate to provide both the Medicaid and Medicaid Covered Services to its dual eligible populations." (OR, D-SNP contract, 2016, Sec. 1.1)	D-SNP required to submit an annual report to the state on overall outcomes, including an overview of services provided, care coordination and care transitions, development of new policies and agreements to promote information sharing for care coordination, and members served. (OR, D-SNP contract, 2016, Sec. 12.2) D-SNPs follow a state guidance document with mutually agreed upon reporting requirements.	Not required in D-SNP contract, but reported to state insurance division for licensing and solvency review purposes.	Not required in D-SNP contract.	"Within 60 days of CMS notification, Health Plans are required to notify State Medicaid Agency of significant changes to the terms of the Medicare contract with CMS, including D-SNP non-renewals, service are changes, terminations, and deficiencies. Health Plans shall notify the State Medicaid Agency of any novation agreements with CMS within 60 days of CMS approval." (OR, D-SNP contract, 2016, Sec. 10.3)

State/MLTSS Program/Start Date	Requirements for Coordination of D-SNP and Medicaid Services	D-SNP Required to Submit Medicare Advantage (MA) Reports to State			
		Medicare Advantage Quality/Performance Reports	Medicare Advantage Financial Reports	CMS-Required Notices of Plan Changes to State	Warning Letters, Corrective Action Plans, Deficiency Notices and/or Low Star Ratings
Pennsylvania (No State Medicaid MLTSS Program)	The MCO shall assist in the coordination and access to needed Medicaid services and arrange for the provision of such services to dual eligible enrollees. Coordination of care will include the following: identification of participating Medicaid providers and of Medicaid covered services; help with access to needed Medicaid covered services; assistance with the coordination of care for Medicaid covered services; and coverage and financial responsibility for all acute care services as well as pharmaceuticals excluded from Medicare Part D. (PA, D-SNP contract, 2015, Sec. 4.2.2)	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.
Tennessee TennCare CHOICES (2010)	The contractor is responsible for coordinating Medicare and Medicaid services for all full benefit dual eligible (FBDE) enrollees including benefits the contractor does not cover for its enrollees. (TN, D-SNP contract, 2015, Sec. A.2.b.6) Contractor must: (1) notify TennCare MCO within two business days of inpatient admissions (hospital, skilled nursing facility, and others), hospital observation days, and emergency department visits; (2) coordinate inpatient discharge planning with FBDE enrollee's TennCare MCO when Medicaid LTSS, home health or private duty nursing services may be needed; and follow up with enrollee and the enrollee's TennCare MCO to address enrollee needs and coordinate Medicaid benefits after inpatient discharge, observation stays, and emergency department visits; (3) coordinate with TennCare MCO regarding CHOICES LTSS that may be needed by the enrollee; (4) participate upon request in needs assessments and/or development of person-centered plan of care for CHOICES enrollees; and (5) coordinate with TennCare MCO any needed CHOICES LTSS services processes for coordination, and benefits under TennCare, including CHOICES. (TN, D-SNP contract, 2015, Sec. A.2.b.6) Contractor must develop policies for Medicare/Medicaid coordination and submit such policies to TennCare for review and approval. (TN, D-SNP contract, 2015, Sec. A.2.b.9) Discharge planning shall meet minimum requirements as specified by the state. (TN, D-SNP contract, 2015, Sec. A.2.b.6.b)	Contractor shall submit to TennCare HEDIS, CAHPS, and HOS data. Contractor shall make all D-SNP performance info available to TennCare upon request. This includes, but is not limited to, HEDIS, CAHPS, HOS, Star quality rankings. (TN, D-SNP contract, 2015, Sec. A.2.b.10.)	Not required in D-SNP contract.	Not required in D-SNP contract.	D-SNP performance must be available upon request. Including Star quality rankings, poor performing icons, notices of non-compliance, audit findings and corrective action plans. (TN, D-SNP contract, 2015, Sec. A.2.b.10.)

State/MLTSS Program/Start Date	Requirements for Coordination of D-SNP and Medicaid Services	D-SNP Required to Submit Medicare Advantage (MA) Reports to State			
		Medicare Advantage Quality/Performance Reports	Medicare Advantage Financial Reports	CMS-Required Notices of Plan Changes to State	Warning Letters, Corrective Action Plans, Deficiency Notices and/or Low Star Ratings
Texas STAR+PLUS (1998)	The D-SNP must provide coordination of care for D-SNP enrollees who are eligible for LTSS and make reasonable efforts to coordinate Medicare Advantage benefits with LTSS Texas Department of Aging and Disability Services (DADS) and the STAR+PLUS HMOs. Coordination of Care must include: (1) identify providers of covered Medicaid LTSS; (2) help access needed Medicaid LTSS, to the extent they are available to the enrollee; (3) help coordinate the delivery of Medicaid LTSS and Medicare benefits and services; and (4) provide training to providers on Medicaid LTSS (b) the MA Dual SNP's Coordination of Care efforts for LTSS may include protocols for working with STAR+PLUS service coordinators or DADS caseworkers, including protocols for reciprocal referral, communication of enrollee's data and clinical information. (c) D-SNP must notify STAR+PLUS service coordinator or DADS caseworker, as applicable, no later than 5 business days after receiving notice of enrollee admission to a nursing facility. (TX, D-SNP contract, 2016, Sec. 3.05 (a) and (c)) The D-SNP must encourage Network Provider skilled nursing facilities to electronically submit a resident transaction notice to the state within 72 hours after D-SNP enrollee admission or discharge from a nursing facility, (TX, D-SNP contract, 2016, Sec. 3.05 (f))	The D-SNP must submit the MA SNP HEDIS report to the state within 45 calendar days of submission to CMS. Reports should be in the same format submitted to CMS. (TX, D-SNP contract, 2016, Sec. 3.07(d))	Not required in D-SNP contract.	Texas requires D-SNPs to notify the state of CMS approval of D-SNP application and amendments to the contract, including the addition, deletion, or modification of a service area. (TX, D-SNP contract, 2016, Sec. 3.01(b))	
Wisconsin Family Care (1999) Family Care Partnership (1996)	The MCO shall promptly provide or arrange for the provision of all health and LTC services in the benefit package, consistent with the member-centered plan. (WI, Family Care/Partnership contract, 2016, Art. VII.B) Starting on the first day of enrollment, MCOs are required to provide needed or existing services, have direct member contact within three days of enrollment, and complete a face to face initial assessment home visit within ten days of enrollment, The full comprehensive assessment is completed within 30 calendar days of enrollment and the fully developed member care plan within 60 calendar days of the enrollment date. (WI, Family Care/Partnership contract, 2016, Art. V.D)	MCO shall submit to the state any quality reports that it submits to the CMS pursuant to Medicare regulations for SNPs. (WI, Family Care/Partnership contract, 2016, Art. XII.B) Quality indicators will include any available measures of members' outcomes (clinical, functional and personal experience outcomes). Reports must be submitted to the Department within 10 business days of being reported to the other entities. (WI, Family Care/Partnership contract, 2016, Art. VI.B)	The MCO is required to submit financial reports within 45 calendar days of the close of each of the first three calendar quarters. Preliminary financial reporting for the fourth quarter of the contract year is due by March 15 of the following year. MCO required to submit Medicare bid information (both initial and final approved bid). (WI, Family Care/Partnership contract, 2016, Art. XVII.B)	Not required in MIPPA contract.	Not required in MIPPA contract.

Appendix 2b: Contract Features That Go Beyond Minimum MIPPA Requirements: More Tools for Coordination[b]

State/MLTSS Program Name/Start Date	D-SNP Required to Submit Marketing Materials to State	D-SNP Required to Submit MA Grievance and Appeals Data to State and/or Coordinate Processes	D-SNP Required to Submit MA Encounter Data and/or Part D Drug Event Data to State	Coordination of Medicare and Medicaid Quality Improvement and External Quality Review Activities	Other State D-SNP Requirements
Arizona Arizona Long-Term Care System (ALTCS) (1989)	D-SNPs required to submit all marketing materials to the state, including both marketing materials that reference state benefits and/or service information and marketing materials that have not been approved by CMS and/or that do not include a reference to state benefits and/or service information. (AZ, AHCCCS Contractor Operations Manual, Marketing, 2014, Sec. III.D.1.a)	D-SNPs required to submit quarterly summary of Part C and D pre-service (prior authorization) member appeals received and the outcome of those appeals, summary of Independent Review Entity decisions received, and service level detail on the appeals that were upheld and overturned. (AZ, D-SNP contract, 2017, Sec. 2.9)	D-SNPs required to submit Medicare encounter data as requested by the state. (AZ, D-SNP contract, 2017, Sec. 2.6)	Not required in D-SNP contract.	State encourages D-SNPs that operate a Medicaid health plan to directly market only to individuals enrolled in the D-SNP's Medicaid managed care plan. (AZ, D-SNP contract, 2017, Sec. 2.8) State works with D-SNPs to establish seamless conversion enrollment of newly Medicare eligible individuals who are currently in the plan for Medicaid only into the plan's companion D-SNP. (AZ, D-SNP contract, 2017, Sec. 2.1.12)
Florida (New statewide Medicaid managed long-term care program implemented in 2013 and 2014)	Not required in D-SNP contract.	Not required in D-SNP contract.	No Note: There are provisions in the contract for the submission of encounter data, but Florida currently does not require this information to be submitted.	Not required in D-SNP contract.	D-SNPs required to facilitate Medicaid eligibility redeterminations for enrollees, including assisting with applications for medical assistance and conducting member education regarding maintenance of Medicaid eligibility. The agency provides access to information verifying dual eligible eligibility to the health plan using the Medicaid Fiscal Agent's Provider Secured Web Portal to ensure that SNP enrollees are eligible for both Medicare and Medicaid. (FL, D-SNP contract, 2015, Attachment I, Sec. B.1.d)
Hawaii QUEST Integration (QI) RFP (2013, with revised Section 50.100) Preceded by QUEST Expanded Access (QExA) (2009)	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.

[b] State requirements for the additional tools for coordination in Appendix 2b are located in either a stand-alone D-SNP contract or a companion/integrated Medicaid MCO contract, depending on state contracting and integrated program design. The use of the terms D-SNP, MCO, or contractor in this table corresponds to the terminology and structure used in the individual state contracts.

State/MLTSS Program Name/Start Date	D-SNP Required to Submit Marketing Materials to State	D-SNP Required to Submit MA Grievance and Appeals Data to State and/or Coordinate Processes	D-SNP Required to Submit MA Encounter Data and/or Part D Drug Event Data to State	Coordination of Medicare and Medicaid Quality Improvement and External Quality Review Activities	Other State D-SNP Requirements
Idaho (No state Medicaid MLTSS program)	All "enrollee materials" must be submitted to the state in the format specified by the state, and must be accompanied by a description of the D-SNP's intent and procedure for the use of the materials. The D-SNP must submit detailed descriptions of any proposed modification of the materials and the state "reserves the right to notify the Health Plan to discontinue or modify" enrollee materials after approval. (ID, Medicaid Provider Agreement, 2016, Appendix A, Sec VII.B).	D-SNP required to coordinate Medicare and Medicaid grievance and appeals processes.	Not required in D-SNP contract.	Not required in D-SNP contract.	D-SNP must maintain a call center for providers and enrollees, staffed by representatives who are "knowledgeable about Idaho Medicaid, Medicare, and all terms of the contract, including the Covered Services." D-SNP does not "require an enrollee to call a separate number regarding behavioral health and/or long-term care services" but instead may conduct a "warm transfer" to another entity. (ID, Medicaid Provider Agreement, 2016, Appendix A, Attachment 11.II.A).
Massachusetts Massachusetts Senior Care Options (2004)	MCO must submit an annual outreach plan as well as all outreach and enrollee materials to the state and CMS for approval. It must make the current schedule of all activities available to the state and CMS upon request in order to provide information or encourage enrollment. It must also ensure that all pre-enrollment and disenrollment materials include a statement that the contractor's plan is a voluntary MassHealth benefit in association with the state and CMS. (MA, SCO Model Contract, 2016, Sec 2.11.b.1, 3, 4)	The MCO must submit monthly reports on the number and types of enrollee complaints and appeals related to both Medicare and Medicaid covered services. The MCO must specify how and in what time frames they were resolved. The MCO must cooperate with the state to implement improvements based on the findings of these reports. (MA, SCO Model Contract, 2016, Sec. 2.14.d) The form and content of notices regarding appeals must be approved by CMS and the state. (MA, SCO Model Contract, 2016, Sec 2.9.a.2) State clinical staff review Medicare and Medicaid appeals and grievance reports to identify trends and issues.	MCO must meet any diagnosis or encounter data requirements determined necessary by the state (i.e., MCOs have submitted encounter data to the state since January 2013. (MA, SCO Model Contract, 2016, Sec. 2.14.b) MCO must maintain information systems that interface with the state's legacy Medicaid Management Information System (MMIS) and new MMIS and the state Virtual Gateway. (MA, SCO Model Contract, 2016, Sec. 2.15.b.2) MCO also must demonstrate the capability to successfully send and receive interface files such as the provider directory and the 834 daily file. (MA, SCO Model Contract 2016, Sec. 2.15.b.3) MCO must make all systems and system information available to authorized state and other agency staff to evaluate the quality and effectiveness of the contractor's data and systems. (MA, SCO Model Contract, 2016, Sec. 2.15.c.1)	Not required in D-SNP contract.	Massachusetts allows MCO submission of integrated enrollment and disenrollment forms to the state and CMS on behalf of D-SNP members. (MA, SCO Model Contract, 2016, Sec 2..3.a.2)

State/MLTSS Program Name/Start Date	D-SNP Required to Submit Marketing Materials to State	D-SNP Required to Submit MA Grievance and Appeals Data to State and/or Coordinate Processes	D-SNP Required to Submit MA Encounter Data and/or Part D Drug Event Data to State	Coordination of Medicare and Medicaid Quality Improvement and External Quality Review Activities	Other State D-SNP Requirements
Minnesota Minnesota Senior Health Options (MSHO) (1997)	All client education and marketing materials for MSHO regarding the benefit package, and provider network-related materials, must be prior approved by the state and CMS. The state defines the parameters for allowable marking, including formats, language specifications, and call scripts. The MCO must submit all materials including Medicare and Part D materials. The state and CMS shall review all Medicare related materials. The state shall review Medicaid only materials. (MN, MSHO/MSC+ contract, 2016, Sec. 3.6.4)	The system must include a Medicare process for Medicare covered services and a Medicaid process. When an appeal could be filed under either Medicare of Medicaid MSHO enrollees shall have the right to choose which or both processes to pursue. The MCO must submit Medicare grievance and appeals and service denial information to the state including Part D denials. (MN, MSHO/MSC+ contract, 2016, Sec. 8.1)	MCO required to submit encounter data records and Part D data to the state in the format and time frame indicated by the state. (MN, MSHO/MSC+ contract, 2016, Sec. 3.7)	MCO may use its Medicare Quality Improvement Project (QIP) to meet the Medicaid Performance Improvement Project (PIP) requirements, including using Medicare's measurement standards and reporting timelines and templates. The MCO will provide the state with copies of the final QIP proposal and reports submitted to CMS within 15 days of submission. (MN, MSHO/MSC+ contract, 2016, Sec. 7.2)	MCOs are required to submit Medicare frailty and risk assessment scores, the CMS-approved model of care, and Medicare medication therapy management programs information. The state works with D-SNPs to tailor the D-SNP model of care and health risk assessment tool to align with state objectives and requirement. (MN, MSHO/MSC+ contract, 2016, Sec. 3.7 and 3.9) MCOs are required to waive the Medicare 3-day hospital stay requirement for Medicare skilled nursing facility coverage. (MSHO/MSC+ contract, 2016, Sec. 4.9.2.4) MCOs are required to participate in an administrative alignment demonstration based on a memorandum of understanding between the state and CMS. (MN, MSHO/MSC+ contract, 2016, Sec. 3.9) MCOs are required to consult with the state on use of Medicare savings prior to initial bid submission to CMS and to notify of changes and to meet CMS requirements as a low income benchmark plan. (MN, MSHO/MSC+ contract, 2016, Sec. 3.9.1.D) MCOs are required to independently contract with state as enrollment Third Party Administrator (TPA) for all but one MSHO contractors. (MN, MSHO/MSC+ contract, 2016, Sec. 3.1.4)

State/MLTSS Program Name/Start Date	D-SNP Required to Submit Marketing Materials to State	D-SNP Required to Submit MA Grievance and Appeals Data to State and/or Coordinate Processes	D-SNP Required to Submit MA Encounter Data and/or Part D Drug Event Data to State	Coordination of Medicare and Medicaid Quality Improvement and External Quality Review Activities	Other State D-SNP Requirements
New Jersey NJ FamilyCare Managed Long-Term Services and Supports (2014)	Two paths for state review exist when materials contain state-specific Medicaid information. For file and use materials, state submission is required 15 days prior to CMS submission; for full review materials state receives them 45 days prior to use (at the same time as CMS), and the plan must notify CMS that the state is also reviewing. State will review materials (outside of the Health Plan Management System) but will copy CMS on communications to plans. Materials cannot be used until both CMS and DMAHS approval is received by the plan. (NJ, NJ FamilyCare contract, 2016, Article 10,Appendix I)	The MCO must submit an Integrated Denial Notice report that provides the state with a tool for timely monitoring of appeals within the integrated program to identify trends in Medicare-Medicaid benefit provision and utilization management that may affect enrollee quality of care or quality of life. (NJ, NJ FamilyCare contract, 2016, Article 10, Appendix 10.H.2)	MCO must submit Medicare and Medicaid encounter records, including encounters for zero dollar Medicare claims, at least monthly. The encounter records shall be enrollee and provider specific, listing all required data elements for each service provided. The state will use the encounter records to create a database that can be used in a manner similar to fee-for-service history files to analyze service utilization, reimburse the contractor for supplemental payments, and calculate capitation premiums. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.3.9.1)	MCO must participate in quality improvement program(s) defined by the state with input from the MCO and the external quality review organization. Each MCO will, with input from the state and possibly other contractors, define measurable improvement goals and QIP-specific measures which shall serve as the focus for each QIP. The MCO must conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.4.6.2Q)	MCOs are required to issue a single identification card, for use in obtaining all managed Medicare, Medicaid, and prescription drug benefits. (NJ, NJ FamilyCare, 2016, Article 10, Sec. 10.5.8.5) MCOs are required to have a system that provides for coordinating benefits that are also covered by Medicare. D-SNPs must also produce integrated evidence of payment and evidence of benefit documents to support integrated benefit determinations. (NJ, NJ FamilyCare, 2016, Article 10, Sec. 10.3.4.2.E and Sec. 10.10.1.C) In addition to other submission requirements, MCOs shall provide as advised by the state, annually, and at the time of filing with CMS, the November Notice of Intent to Apply, the February State Medicaid Agency Contract (SMAC) attestation and the final SMAC upload matrix, the D-SNP model of care, the NCQA Model of Care score, and the supplemental benefit package as filed with CMS. (NJ, NJ FamilyCare contract, 2016, Article 10, Sec. 10.10.12.)
New Mexico Centennial Care (2012) Preceded by Coordination of Long Term Services (COLTS) (2008)	Not required in D-SNP contract.	Not required in D-SNP contract.	D-SNPs must submit Medicare encounters to the state. (NM, Centennial Care contract, 2013, Sec. 4.19.2)	Not required in D-SNP contract.	Not required in D-SNP contract.

State/MLTSS Program Name/Start Date	D-SNP Required to Submit Marketing Materials to State	D-SNP Required to Submit MA Grievance and Appeals Data to State and/or Coordinate Processes	D-SNP Required to Submit MA Encounter Data and/or Part D Drug Event Data to State	Coordination of Medicare and Medicaid Quality Improvement and External Quality Review Activities	Other State D-SNP Requirements
Oregon (No State Medicaid MLTSS Program)	Not required in D-SNP contract.	Not required in D-SNP contract.	Contractor must submit claims data files, including Part D claims. "[Health Plan]...shall submit healthcare claims data files for all required lines of business under the Oregon All-Payer Healthcare Claims Data Reporting program, in compliance with requirements for mandatory reporters under OAR-409-025-0100 to 409-025-0170, including claims data file layout, format, and coding requirements in OAR 409-025-0120 and healthcare claims data submission requirements in OAR 409-025-0130." (OR, D-SNP contract, 2016, Sec. 9.1)	Not required in D-SNP contract.	"Health Plan shall assign staff to coordinate payment between Medicaid and D-SNP programs" (OR, D-SNP contract, 2016, Sec. 1.2) D-SNPs required to work to ensure information sharing for Medicaid and Medicare benefits coordination and requires D-SNPs to publish a contact phone number at each plan that will be available for member's questions around care coordination, provider access and billing questions, and for providers to inquire about Medicaid or Medicare benefit coordination or billing. (OR, D-SNP contract, 2016, Sec. 6.1 and 6.4) D-SNPs are required to develop written policies to ensure timely notification to relevant care coordinator staff, from the Medicaid CCO, MCO, State Medicaid Agency, or other relevant contractors, of the beneficiary's relevant: (1) planned or unplanned inpatient admissions; (2) high priority health concerns identified through member health assessments; and (3) sharing of key provisions of discharge planning documents. (OR, D-SNP contract, 2016, Sec. 6.5)
Pennsylvania (No State Medicaid MLTSS Program)	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.	Not required in D-SNP contract.

State/MLTSS Program Name/Start Date	D-SNP Required to Submit Marketing Materials to State	D-SNP Required to Submit MA Grievance and Appeals Data to State and/or Coordinate Processes	D-SNP Required to Submit MA Encounter Data and/or Part D Drug Event Data to State	Coordination of Medicare and Medicaid Quality Improvement and External Quality Review Activities	Other State D-SNP Requirements
Tennessee TennCare CHOICES (2010)	"The Contractor shall, upon prior review and approval by the Centers for Medicare and Medicaid Services, submit to TennCare for review and prior written approval, all marketing materials, items, layouts, plans, etc. that will be distributed directly or indirectly to full benefit dual eligible members, including documentation of CMS approval of such materials. The Contractor shall be strictly prohibited from using any eligibility or enrollment information that has been provided by TennCare for purposes of care coordination for marketing activities." (TN, D-SNP contract, 2015, Sec. A.2.g)	Not required in D-SNP contract.	Contractor must submit electronic encounter data, including Part D claims and cross-over claims for Medicare deductibles and co-insurance. "Contractor shall submit encounter data that meets established TennCare data quality standards..." [contract includes very detailed requirements – see section for details]. (TN, D-SNP contract, 2015, Sec. A.2.c.1.b)	Not required in D-SNP contract.	Not required in D-SNP contract.
Texas STAR+PLUS (1998)	Not required in D-SNP contract.	No requirement for submission of MA grievance and appeals data, but D-SNP must provide the state contact with a copy of the CMS complaint tracking module report. This report must be given for all members within 30 business days of D-SNP's receipt of this report from CMS. (TX, D-SNP contract, 2016, Sec. 3.07(e))	Not required in D-SNP contract.	Not required in D-SNP contract.	The D-SNP must have written procedures for ensuring that D-SNP enrollees have access to the services identified in the MA Product. These procedures include policies regarding network adequacy consistent with the MA Agreement requirements and the D0SNP must provide the State with a copy of these policies no later than 5 business days after a request." (TX, D-SNP contract, 2016, Sec. 3.07(c)) The D-SNP must include the Texas Medicaid Summary of Benefits in its Member Handbook for the MA Product. (TX, D-SNP contract, 2016, Sec. 3.07(b))

State/MLTSS Program Name/Start Date	D-SNP Required to Submit Marketing Materials to State	D-SNP Required to Submit MA Grievance and Appeals Data to State and/or Coordinate Processes	D-SNP Required to Submit MA Encounter Data and/or Part D Drug Event Data to State	Coordination of Medicare and Medicaid Quality Improvement and External Quality Review Activities	Other State D-SNP Requirements
Wisconsin Family Care (1999) Family Care Partnership (1996)	Requires that all marketing/ outreach materials must be approved by the Department and CMS prior to distribution. (WI, Family Care/Partnership contract, 2016, Art. IX.A) The MCO is not required to submit model materials required by CMS to the state for review and approval, but must provide a copy of such materials upon request. The state will assist the MCO when issues arise in obtaining CMS approvals. (WI, Family Care/Partnership contract, 2016, Art. IX.B) State outlines requirements for accessible formats and languages and cultural sensitivity that SNP has to adhere to for all member and marketing/outreach materials. (WI, Family Care/Partnership contract, 2016, Art. IX.E)	MCO must submit a quarterly grievance and appeal report, consisting of a summary and log, to the state. MCO must submit any entirely or partially adverse decision and all supporting documentation to the state no later than 20 business days after the MCO mails or hand-delivers the written decision. (WI, Family Care/Partnership contract, 2016, Art. XI.I)	Not required in D-SNP contract.	MCO may use the Medicare quality improvement project template for submission of Medicaid required projects with prior state approval. (WI, Family Care/Partnership contract, 2016, Art. XII.C.8.c.)	Not required in D-SNP contract.

Appendix 3: Contracts Reviewed

Arizona:

- Arizona Health Care Cost Containment System (AHCCCS), Division of Business and Finance, Contract Amendment, Effective Date October 1, 2015. https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ALTCS/ALTCSCYE2015/ALTCSEPD10-1RenewalFinal.pdf
- Medicare Advantage D-SNP Health Plan Agreement between AHCCS and ____, 2017. http://www.integratedcareresourcecenter.net/PDFs/Arizona_D-SNP_2017.pdf
- AHCCCS Contractor Operations Manual, Chapter 101 Marketing Outreach and Incentives, Revised June 30, 2014. http://www.azahcccs.gov/shared/Downloads/ACOM/ACOM.pdf

Florida:

- Florida Agency for Health Care Administration, 2013 – 2018 Long-Term Care Health Plan Model Contract, Revised February 2013. http://ahca.myflorida.com/Medicaid/statewide_mc/plans.shtml
- Florida Agency for Health Care Administration, 2015 Standard D-SNP Contract Template, Attachment I and Appendices. http://www.integratedcareresourcecenter.net/PDFs/Florida_D-SNP_2015.pdf

Hawaii:

- Hawaii Department of Human Services, Med-QUEST Division, Health Care Services Branch. Request for Proposal. QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals, August 5, 2013, with revised Section 50.100. http://hawaii.gov/spo2/health/rfp103f/attachments/rfp10091375755966.pdf

Idaho:

- Idaho Medicare-Medicaid Coordinated Plan. Appendix A – To Idaho Medicaid Provider Agreement. 2016. http://www.integratedcareresourcecenter.net/PDFs/Idaho_D-SNP_2016.pdf

Massachusetts:

- MassHealth Senior Care Options Contract for Senior Care Organizations by and Between the Executive Office of Health and Human Services and __, 2015. http://www.integratedcareresourcecenter.net/PDFs/Massachusetts_D-SNP_contract_and_app_2015.pdf

Minnesota:

- Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, 2016 MSHO/MSC+ Contract (MCO), http://www.integratedcareresourcecenter.net/PDFs/Minnesota_D-SNP_2016.pdf

New Jersey:

- Contract Between State of New Jersey Department of Human Services Division of Medical Assistant and Health Services and __, Contractor (See Article 10 for D-SNP specific provisions), Accepted January 2014, http://www.integratedcareresourcecenter.net/PDFs/NewJersey_D-SNP_2016.pdf

New Mexico:

- New Mexico Human Services Department, Amended and Restated Medicaid Managed Care Services Agreement among New Mexico Human Services Department, New Mexico Behavioral Health Purchasing Collaborative and ___, November 26, 2013. http://www.integratedcareresourcecenter.net/PDFs/NM_MLTSS_Contract_2013.pdf

- Agreement Between The State of New Mexico Human Services Department and Molina Healthcare of New Mexico, Inc. Pursuant to the Medicare Improvement for Patients and Providers Act of 2008, June 26, 2013. http://www.integratedcareresourcecenter.net/PDFs/NewMexico_D-SNP_Contract_2013.pdf

Oregon:

- Oregon Health Authority Coordination of Benefits Agreement, __, 2016. http://www.integratedcareresourcecenter.net/PDFs/Oregon_D-SNP_2016.pdf

Pennsylvania:

- Cooperative Agreement between Pennsylvania Dept. of Public Welfare and Medicare Advantage Health Plan, Effective January 1, 2014. http://www.integratedcareresourcecenter.net/PDFs/Pennsylvania_H4279_Dual_PA_State.pdf

Tennessee:

- MCO Statewide Contract with Amendment 4, Contract Between the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare and _____, Effective January 1, 2014, Contract End Date December 31, 2016. https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf
- SNP Contract Between the State of Tennessee, Department of Finance and Administration Bureau of TennCare Division of Health Care Finance and Administration, Bureau of TennCare and _____, Contract Begin Date January 1, 2011, Contract End Date December 31, 2016. http://www.integratedcareresourcecenter.net/PDFs/SNP_Blended_12-17-15.pdf

Texas:

- Texas Health & Human Services Commission, General Contract Terms & Conditions, Revised 2012. http://www.integratedcareresourcecenter.net/PDFs/TX-STARPLUS-Expansion-Contract.pdf
- Agreement Between Texas Health and Human Services Commission and Medicare Advantage Dual Eligible Special Needs Plan, 2016. http://www.integratedcareresourcecenter.net/PDFs/Texas_2016-SNP-FINAL-2.pdf

Wisconsin:

- Partnership Contract Between Department of Health Services Division of Long Term Care and CARE Wisconsin Health Plan, Inc. January 1, 2016 – December 31, 2016. http://www.integratedcareresourcecenter.net/PDFs/Wisconsin_D-SNP_2016.pdf

ENDNOTES

[1] MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book." Exhibit 4, p.28. January 2016.

[2] Centers for Medicare & Medicaid Services. "Physical and Mental Health Condition Prevalence and Comorbidity among Fee-for-Service Medicare-Medicaid Enrollees," September 2014. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidity_2014.pdf.

[3] D. Grabowski. "Special Needs Plans and the Coordination of Benefits and Services for Dual Eligibles." *Health Affairs*, Vol. 28, No. 1, pp. 136-146, January/February 2009. Available at: http://content.healthaffairs.org/content/28/1/136.full.pdf+html.

[4] MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid Data Book." Exhibit 18, p. 54 January 2016.

[5] For details, see the CMS Medicare-Medicaid Coordination Office website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

[6] Medicare Advantage plans that want to operate in states that are not willing or able to enter into D-SNP contracts may choose to operate a non-SNP Medicare Advantage plan, or another type of SNP (chronic condition or institutional).

[7] V. Smith, K. Gifford, E. Ellis, et al. "Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017." Kaiser Family Foundation and NAMD, October 2016. Available at: http://kff.org/medicaid/report/implementing-coverage-and-payment-initiatives-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2016-and-2017/.

[8] The other SNP types are chronic condition SNPs (C-SNPs) and institutional SNPs (I-SNPs). For details on SNPs and the CMS rules governing all three SNP types, see the CMS Medicare Managed Care Manual, Chapter 16b (Rev.123, Issued 8-19-16). Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf.

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

[10] 42 CFR §422.107.

[11] For a description of the different types of dually eligible beneficiaries, including Full Benefit Dual Eligibles who are eligible for all Medicaid benefits, Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and other categories, see CMS, "Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance." Medicare Learning Network, February 2016. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.

[12] CMS SNP Comprehensive Report, October 2016. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html.

[13] For more details on FIDE SNPs, see CMS Medicare Managed Care Manual, Chapter 16b (Special Needs Plans), Section 20.2.5, Rev. 123, 8-19-16.

[14] CMS Medicare Managed Care Manual, Chapter 16b, Section 20.2.2, Rev. 123, 8-19-16.

[15] "Companion" is not a legal term of art and does not have a specific legal meaning, except to the extent that states give it a specific meaning by defining it in their D-SNP and Medicaid MLTSS contracts.

[16] Idaho's one D-SNP is at risk for all Medicaid covered LTSS benefits. The state does not operate an MLTSS program outside of this arrangement.

[17] ICRC analysis of state MLTSS contracts. See also M. Musumeci, "Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers." Kaiser Commission on Medicaid and the Uninsured, November 2014, Table 2, pp. 9-10.

[18] For a discussion of the type of marketing that is permitted for health plans and states by Medicare and Medicaid marketing rules, see M. Soper and R. Weiser. "Moving Toward Integrated Marketing Rules and Practices for Medicare and Medicaid Managed Care Plans." Integrated Care Resource Center, July 2014. Available at: http://www.integratedcareresourcecenter.net/PDFs/ICRC%20Moving%20Toward%20Integrated%20Marketing.pdf.

[19] For more information on seamless conversion, see the CMS guidance available at: http://www.integratedcareresourcecenter.net/pdfs/ICRC%20Seamless%20Conversion.pdf.

[20] For the text of this MOU, see: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOU.pdf.

[21] For details on these requirements, see the ICRC summary of a March 2014 call with CMS Medicare Advantage experts and states: http://www.chcs.org/media/ICRC-D-SNP-Entries-and-Expansions.pdf. CMS is planning to work with states and D-SNPs to develop procedures to provide early notification to states from CMS of these planned changes. See CMS Final Call Letter for CY 2017, p. 185, at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf.

[22] For details, see: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/index.html.

[23] For details, see: https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata.html.

[24] For a discussion of differences between Medicare and Medicaid marketing rules, see: M. Soper and R. Weiser. Op. cit.

[25] State Medicaid programs must require that Medicaid MCOs, including those that operate companion D-SNPs, meet the Medicaid grievance and appeal rules found in 42 CFR 438 et seq. In addition, CMS requires that D-SNPs also meet the rules for Medicare Advantage plans set out in 42 CFR 422 et seq. For a discussion of how some states have worked to integrate Medicaid and Medicare appeals and grievance processes, see: A. Kruse and A. Philip. "Integrated Appeals Processes for Medicare-Medicaid Enrollees: Lessons from States," Center for Health Care Strategies, January 2015. Available at: http://www.chcs.org/media/Integrated_Appeals_Brief_1_8_15.pdf.

[26] CMS Medicare Managed Care Manual, Chapter 16b (Special Needs Plans), Section 20.2.5, Rev. 123, 8-19-16.

[27] The administrative alignment MOU entered into between Minnesota and CMS on September 13, 2013 is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOU.pdf. See pp. 7-8 for details on the integrated appeals process.

[28] For details, see: Integrated Care Resource Center. "State Use of Medicare Advantage Encounter Data: Perspectives from Two States." May 19, 2015 Study Hall Call. Available at: http://www.chcs.org/media/ICRC-State-Use-of-MA-Encounter-Data-Slides-Final-508.pdf.

[29] CMS, Medicare Managed Care Manual, Chapter 16b: Special Needs Plans, Sec.20.2.2, Rev. 123, 8-19-16.

[30] 42 CFR §422.504(g)(1)(iii). For additional detail on the prohibition against balance billing of Medicare-Medicaid enrollees, see the April 14, 2016 Medicare Advantage Final Call Letter, pp. 181-183 at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf.

[31] CMS, Medicare Managed Care Manual, Chapter 16b: Special Needs Plans, Sec.20.2.2, Rev. 123, 8-19-16.

[32] For details on how the three-day hospital stay requirement works in the Medicare fee-for-service system, see: Centers for Medicare & Medicaid Services. "Medicare Benefit Policy Manual, Chapter 8 – Coverage of Extended Care (SNF) Services under Hospital Insurance." (Rev.211, 10-16-15). Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf.

[33] The September 2013 MOU outlining details of the Minnesota demonstration is on the MMCO web site at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Minnesota.html.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national technical assistance 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 within the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit **www.integratedcareresourcecenter.com.**