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 12 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 12 states can provide guidance and examples for states that have varying opportunities and resources for D-SNP contracting, including states that 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 the minimum required contracts with D-SNPs 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. 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. 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, nursing facility services, personal care assistance, and related services – through Medicaid. Medicare-Medicaid enrollees who receive LTSS are the most costly for Medicaid and among the most costly for Medicare,[3] 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. Over a dozen states are now developing and implementing programs to integrate care for Medicare-Medicaid enrollees through the Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative.[4]

Several 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 now 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.[5]) Prior to 2013, federal law and regulations encouraged D-SNPs to contract with states, but did not require it.
- **States that are not participating in the CMS Financial Alignment Initiative are looking for alternative ways of integrating care for Medicare-Medicaid enrollees.** The capitated model allows integrated Medicare-Medicaid Plans (MMPs) 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 January 2015, 28 states offered or planned to offer at least one MLTSS program,[6] 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 MIPPA Contracting Requirements

D-SNP and MIPPA Contracting Overview

Medicare Advantage D-SNPs are one of three types of SNP that were authorized in the Medicare Modernization Act of 2003 and began operating in January 2006.[7] D-SNPs were 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.

For the first time in 2008, MIPPA required 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.[8] This technical assistance

tool refers interchangeably to "D-SNP contracts" and "MIPPA contracts," since all D-SNP contracts with states must now meet the minimum MIPPA requirements.

Minimum MIPPA Contract Requirements

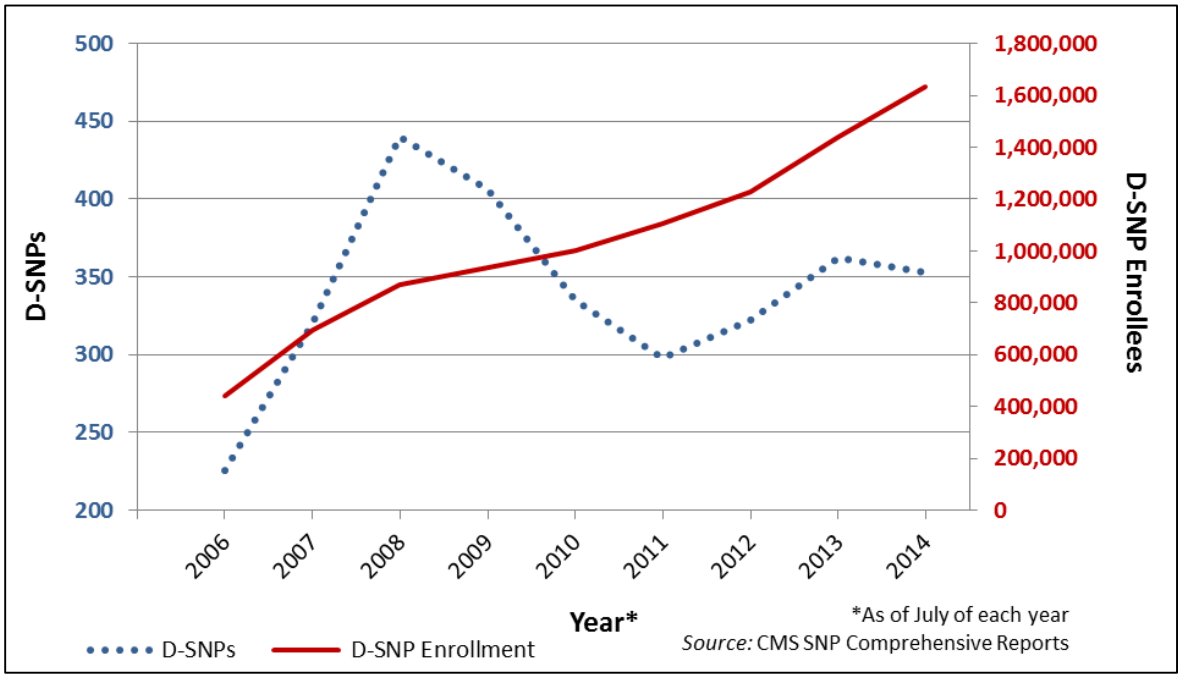
D-SNPs must submit MIPPA contracts with states to CMS for review by July 1 of the year before the D-SNP federal contract year begins (by July 1, 2015 for calendar year 2016, for example). At a minimum D-SNP MIPPA contracts with states must document:[9]

1. The D-SNP's responsibility, including financial obligations, to provide or arrange for Medicaid benefits;
2. The categories of eligibility for dually-eligible beneficiaries to be enrolled under the SNP (full benefit, Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), etc.);[10]
3. The Medicaid benefits covered under the SNP;
4. The cost-sharing protections covered under the SNP;
5. The identification and sharing of information on Medicaid provider participation;
6. The verification of enrollees' eligibility for both Medicare and Medicaid;
7. The service area covered by the SNP; and
8. The contract period for the SNP.

D-SNP Enrollment Trends

D-SNP enrollment has grown steadily since 2006, while the number of D-SNPs has fluctuated. 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. There were 353 D-SNPs operating in July of 2014, with a total enrollment 1,645,457.[11] The number of D-SNPs dropped in January 2015 to 336, while enrollment continued to grow.

Exhibit 1: Trends in D-SNP Numbers and Enrollment, 2006 – 2014



D-SNPs are operating in 38 states, the District of Columbia, and Puerto Rico in 2015, down from 42 states, the District of Columbia, and Puerto Rico in 2008, the first year CMS reported SNP enrollment by state. While D-SNPs are operating in a wide range of states in 2015, D-SNP enrollment is concentrated in a relatively limited number of states, as shown in Exhibit 2. In January 2015, 64 percent of D-SNP enrollment was in 10 states, and 59 percent of all D-SNPs were in those states. Seventeen percent of total enrollment was in Puerto Rico.

Exhibit 2: D-SNPs and Enrollment by State, January 2015

State	Number of D-SNPs	Total D-SNP Enrollment
Puerto Rico	12	272,248
Florida	45	198,063
California	30	181,055
New York	41	175,141
Texas	21	132,121
Pennsylvania	10	103,407
Arizona	22	74,606
Tennessee	6	67,398
Alabama	4	47,879
Georgia	10	42,061
Minnesota	9	36,537
Massachusetts	6	33,568
Louisiana	10	25,812
South Carolina	3	24,563
Washington	5	22,710
Oregon	7	21,782
Hawaii	4	18,944
Wisconsin	15	18,476
Michigan	7	16,977
North Carolina	6	15,705
Arkansas	5	12,054
Mississippi	6	11,287
Ohio	11	10,960
Missouri	4	10,847
Colorado	4	10,140
New Mexico	4	9,484
Illinois	6	9,461
Connecticut	2	9,241
Utah	2	8,281
New Jersey	2	7,824
Washington DC	3	4,574
Kentucky	6	3,331
Maryland	2	2,206
Delaware	1	2,004
Maine	3	1,455
Idaho	1	1,340
Virginia	2	1,258
Indiana	3	721
Iowa	1	201
West Virginia	1	74
TOTAL	**342**	**1,645,793**

Source: CMS SNP Comprehensive Report, January 2015. 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 January 2015, 55 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 have the flexibility to offer additional supplemental benefits not typically covered by Medicare.[12] To obtain FIDE SNP status, D-SNPs must request CMS review and approval when they submit their MIPPA contracts on or before July 1 for the upcoming contract year.

As of January 2015, 37 FIDE SNPs are operating in seven states (Arizona, California, Idaho, Massachusetts, Minnesota, New York, and Wisconsin), with a total national enrollment of 107,837. Sixty-five 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 MIPPA D-SNP Contracts in 12 States

Selection of States

This review of D-SNP contracts includes states that illustrate the 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 considering how D-SNP contracts can be used to link to those programs more effectively to Medicare. 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 include only the minimum MIPPA requirements. Neither state has a Medicaid MLTSS program with which to coordinate.

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 coordination and information-sharing 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 12 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 12 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 that contain 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

States have the option of contracting with all, some, or none of the D-SNPs operating in the state.[13] The minimum MIPPA contract requirements give states the flexibility to determine the scope of service and financial responsibility

that D-SNPs must assume. States also have the authority to target subsets of the state's dually eligible population for integrated D-SNP enrollment. States may specify the geographic area for D-SNP operations and may 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

Ten of the 12 states reviewed have Medicaid MLTSS programs, although the MLTSS programs in Florida and New Jersey are just now being implemented. Oregon and Pennsylvania do not have Medicaid MLTSS programs. States with new or existing MLTSS programs can align their Medicaid MLTSS plans with D-SNPs operating in their state by requiring the entities offering MLTSS plans to offer companion D-SNPs covering the same geographic area. States with MLTSS programs can also choose to contract only with D-SNPs that have companion MLTSS plans. This creates a platform for integration to occur with one health plan delivering both Medicare and Medicaid covered services.

While states can mandate enrollment in Medicaid MLTSS programs – as Arizona, Florida, Hawaii, Minnesota, New Mexico, Tennessee, and Texas have done[14] – enrollment in D-SNPs is voluntary. States can therefore encourage Medicare-Medicaid enrollees in MLTSS to obtain their Medicare benefits from a companion D-SNP, but they cannot require it. Similarly, health plans that operate companion MLTSS and D-SNP plans can encourage their Medicare-Medicaid enrollees to get all their benefits from the companion plans, but beneficiaries are free to get their Medicare benefits from fee-for-service or another Medicare Advantage plan. 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.

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 MIPPA 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.

As shown in Exhibit 3 and in more detail in Appendix 1, five of the states included in this analysis (Arizona, Hawaii, Massachusetts, Minnesota, and Wisconsin) currently align their D-SNP and MLTSS plans, at least to some extent. Hawaii and Tennessee are planning to align D-SNP and MLTSS contractors beginning in 2015, and Florida and New Jersey are also taking steps toward alignment.

- **Arizona** requires contractors in its Arizona Long Term Care System (ALTCS) MLTSS program to have companion D-SNPs to cover Medicare services.
- **Florida** does not require D-SNPs and Medicaid MLTSS contractors to be aligned, but is making capitated payments to aligned and unaligned D-SNPs for Medicaid services.
- **Hawaii** requires that D-SNP plans also have Medicaid QUEST Integration (QI) contracts in contract year 2015, and that all QI contractors must offer a D-SNP in contract year 2016. Two of the five current QI contractors did not offer D-SNPs in the state in 2014.
- **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 Medicaid managed care organizations (MCOs). D-SNPs must cover Medicaid nursing facility services by 2015 and home- and community-based services (HCBS) by 2016.
- **New Mexico** requires MLTSS plans 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** D-SNPs are not currently required to have a companion MLTSS plan, although Medicaid MCOs (which also provide MLTSS) must have a companion D-SNP under the 2015 contract.
- **Texas** requires MLTSS plans to offer a D-SNP plan in the most populous counties in the 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 Partnership program to have a companion D-SNP.

Exhibit 3: Overview of Major Features of D-SNP Contracts in 12 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 Medicaid services offered by companion MLTSS and 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	• Encounter data • Grievance and appeals • Marketing materials • Quality reports • Financial reports	• Low star ratings, corrective action plans, and warning letters • Plan 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	Not currently, but will be a requirement in 2016	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
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

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 • 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	Not in 2015, but they must be an approved contractor for Medicaid managed care services	No	All Medicaid services offered by companion MLTSS plans, except home- and community-based services	Pending	• Encounter data • Grievance and appeals • Marketing materials • Quality reports • Financial reports	• Plan 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	• None	• None
Pennsylvania	No	N/A	N/A	None	Minimum	• None	• None
Tennessee	Yes	No	Not currently, but will be a requirement in 2015	None	Follow up after observation days and emergency department visits to address member needs and coordinate Medicaid benefits	• Encounter data • Marketing materials • Medicare Advantage 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 • CMS approval of D-SNP application and amendments to the agreement, including the addition, deletion, or modification of a service area
Wisconsin	Yes	Yes	No	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

State Payments to D-SNPs for Medicaid Services

As shown in Exhibit 3 and in more detail in Appendix 1, nine of the states reviewed (Arizona, Florida, Hawaii, 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 go to the Medicaid plan. 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.
- **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. 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. New Jersey does not currently make payments to D-SNPs' companion Medicaid MLTSS plans for Medicaid HCBS, but does make payments for other Medicaid services.
- **Degree of alignment.** When D-SNPs receive capitated payments from Medicare for Medicare services, and have companion Medicaid MLTSS plans that receive capitated payments for Medicaid services from the state, there are substantial opportunities to achieve greater financial and service integration. The extent to which this actually occurs, however, cannot be ascertained without a detailed examination of how each such entity operates, which we did not undertake for this report. Since these entities are contracting with separate Medicare and Medicaid payers that have separate requirements, the integration is not as complete as in the CMS capitated model financial alignment initiative.

4. MIPPA Contract Features That Go Beyond Minimum MIPPA Requirements

In addition to addressing the minimum MIPPA required provisions in D-SNP contracts, 10 of the 12 states (all but Oregon and 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 12 contracts, while Appendix 2b describes more tools for coordination that some of the 12 states are using. The 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 that have aligned MLTSS and D-SNP plans have additional service coordination requirements that go beyond the basic requirement that the two plans be aligned. Following are some examples of these service coordination requirements. There are similarities in the requirements in each state, although the specific requirements reflect the context and history of each state's program. There is more detail in Appendix 2a.

- **Arizona** requires the aligned plans to coordinate all aspects of members' health, including disease management and care management. The state requires an established contact at each plan that will be responsible for sharing 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, 2015, D-SNP contract, Sec. 2.1)

- **Hawaii** requires that D-SNP enrollees have a service coordinator responsible for coordination of Medicaid acute and primary care and LTSS and coordination of Medicare services. D-SNPs must provide continuity of care when members are discharged from the hospital with prescribed medications that are normally prior-authorized or not on the plan's formulary, facilitate access to services including community services, provide assistance resolving concerns about service delivery or providers, and assist enrollees to maintain continuous Medicaid benefits. (HI, QI RFP, 2013, Sec. 40.900)
- **Massachusetts** requires the aligned Senior Care Options (SCO) Medicaid and D-SNP plans to ensure effective linkages of clinical management systems across all providers, including written protocols for referrals, information sharing, and tracking transfers. The SCO plan is also required to ensure all relevant providers are informed about utilization of services, and must demonstrate its capacity to provide coordination of care and care management. Massachusetts SCO enrollees are assigned to a primary care provider with at least two years of experience caring for persons over age 65. (MA, SCO contract, 2013, Sec. 2.4.a.6-7, Sec. 2.4.c, and Sec 2.5.b.2.a.4)
- **Minnesota** fully integrates D-SNP and Medicaid MLTSS and other services in its MSHO program. All MSHO plans are FIDE SNPs in 2015, 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 standard D-SNP Model of Care requirements, for example, include additional Medicaid MLTSS requirements in MSHO plans. (MN, MSHO/Minnesota Senior Care Plus (MSC+) contract, 2014, Sec. 3.7 and Sec. 6.1) Minnesota has been able to achieve increased administrative integration in the MSHO program as a result of a September 2013 Memorandum of Understanding (MOU) with CMS.[15]
- **Tennessee** has a number of additional requirements for D-SNP contractors, including notifying the member'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 developing person-centered plans of care for MLTSS members, coordinating nursing facility services across programs, and training staff on coordinating benefits for dually eligible beneficiaries. (TN, D-SNP contract, 2014, 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 member is admitted to a nursing facility. (TX, D-SNP contract, 2013, Sec. 3.06a and 9.08)
- **Wisconsin** has detailed requirements for care planning, inter-disciplinary team composition, and assessment. Wisconsin requires the D-SNP 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 member within 90 days of enrollment. (WI, Family Care/Partnership contract, 2014, Art. V.D and VII.C)

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. Seven of the 12 reviewed states require D-SNPs to submit CMS-required Medicare quality reports and data. This includes Medicare HEDIS data and other Medicare quality-related information, including information on Medicare-required quality improvement projects (QIPs) and chronic care improvement projects (CCIPs). Understanding D-SNP performance and the Medicare quality requirements that

plans are measured against can support states in developing state-specific strategies for quality improvement related to their integrated programs. Following are specific examples of state requirements:

- **Massachusetts** requires D-SNPs to report on Medicare HEDIS measures to the extent that they are relevant to the age 65 or older SCO population. (MA, SCO contract, 2013, 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. (MN, MSHO/MSC+ contract, 2014, 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, DSNP contract, 2014, 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, 2014, Sec. 12.B)

Financial Reports. Six of the 12 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. 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 their contracts with aligned MLTSS plans/D-SNPs. (MA, SCO contract, 2013, 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, 2014, Sec. 3.7 and FL 2015, D-SNP contract, Attachment I, Sec. D.5)

Medicare bid information can be used by states to establish payment rates for Medicaid cost-sharing and services covered under the state's D-SNP contract:

- **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, 2014, Sec. 3.7 and 3.9 and WI, Family Care/Partnership contract, 2014, Art. XVII.B)

Submission of CMS-Required Notices of Plan Changes to State

Medicare Advantage contracts between CMS and 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.[16] Five of the states reviewed (Arizona, Massachusetts, Minnesota, New Jersey and Texas) have developed requirements for D-SNPs to notify the state of any mid-year terminations, non-renewals, or service area changes at the same time the D-SNP notifies CMS (See Appendix 2a).

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 specific examples of state requirements:

- **Arizona** requires plans (starting in 2015) 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, 2015, D-SNP contract, 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 contract, 2013, Section 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, 2014, 3.9)
- **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, 2013, Sec. 3.01b)

Sample Contract Language: State Notification of Medicare Advantage Plan Changes

Minnesota (MSHO/MSC+ contract, 2014, Sec. 3.9.1(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 Eligibles, 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."

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

Four of the states reviewed (Arizona, Massachusetts, Minnesota, and Tennessee) have developed 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 four of these states also require alignment between D-SNP and MLTSS contractors, which facilitates this type of information sharing.

States that receive such notifications directly from D-SNPs are better able to anticipate potential CMS actions that may impact D-SNP ability to enroll new members, maintain current contracts with CMS, or extend contracts in subsequent years, which could potentially have an impact on quality or continuity of care for Medicare-Medicaid enrollees in these D-SNPs. Following are examples of specific state requirements:

- **Arizona** requires D-SNPs (starting in 2015) 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, 2015, D-SNP contract, Sec. 2.10 and 2.11)
- **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 contract, 2013, Sec. 5.1.a)
- **Minnesota** requires D-SNPs to inform the state of any significant changes 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, 2014, Sec. 3.9.1)
- **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, DSNP Contract, 2014, Sec. A.2.b.10)

Submission of Marketing Materials to the State

Seven of the D-SNP contracts reviewed (Arizona, Hawaii 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.[17]

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 is the only state that outlines requirements for accessible formats and languages and cultural sensitivity that the D-SNP has to adhere to for all member 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 contract, 2013, 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, 2014, 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 members for enrollment in its D-SNP. (TN, DSNP contract, 2014, 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 member and marketing/outreach materials. (WI, Family Care/Partnership contract, 2014. Art. IX. A, B, and E)

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

Wisconsin (Family Care/Partnership contract, 2014, 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 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.[18] Of the 12 states reviewed, four (Hawaii, Massachusetts, Minnesota, and Wisconsin) have contract provisions that require D-SNPs to coordinate Medicare Advantage grievance and appeals processes with Medicaid processes (See Appendix 2b).

Some states, including Arizona and New Jersey, require submission of quarterly summary reports of Medicare Advantage grievances and appeals and the outcomes of those appeals; however they do not explicitly require coordination of Medicare and Medicaid grievance and appeals processes in D-SNP contracts. 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 member appeals received and the outcome of those appeals as well as summaries of Independent Review Entity (IRE)

decisions received during the reporting period. Service-level detail on the appeals that were upheld and overturned is also required. (AZ, D-SNP contract, 2015, Sec. 2.9)

- **Hawaii** requires D-SNPs to use state-developed templates for communication to members regarding the grievance system process, and submit grievance policies and procedures to the state for review and approval as part of the readiness review process (HI, QI RFP, 2013, Section 51.105)
- **Massachusetts** requires D-SNPs to submit detailed monthly reports on enrollee complaints and appeals, specifying the quantity, types, solutions, and timeframes they were resolved. D-SNPs are also required to cooperate with the state to implement improvements based on the findings of these reports. (MA, SCO contract, 2013, Sec 2.14.d)
- **Minnesota** has one integrated appeals process that incorporates both Medicare and Medicaid requirements and is used for all MSHO members, a feature of its September 2013 MOU with CMS.[19] D-SNPs must submit Medicare grievance and appeals and service denial information to the state including Part D denials. (MN, MSHO/MSC+ contract, 2014, Sec. 8.1)
- **New Jersey** has D-SNP contract provisions that give the state the right to submit comments to the contractor regarding the merits or suggested resolution of any grievance and appeal. (NJ, D-SNP contract, 2014, Sec. 4.5)

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

Of the states reviewed, eight (Arizona, Hawaii, Massachusetts, Minnesota, New Jersey, New Mexico, 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 are not currently requiring plans to do so (See Appendix 2b). This analysis did not consider how states used Medicare data or any difficulties they may have had in obtaining and analyzing the data.

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

Minnesota (MSHO/MSC+ contract, 2014, Sec. 3.7.1 (B) (1))

"Individual Enrollee-specific, claim-level encounter data for services provided by (1) 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, 2014, Sec. A.2.c.1.b and Amendment #1, Sec. A.2.c.1(b))

"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 have aligned Medicare and Medicaid quality improvement project topics and reporting formats. (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, 2014, Sec. 7.2)

- **New Jersey** has contract provisions related to state and CMS coordination on topics for D-SNP program performance improvement projects. D-SNPs must conduct both a Medicare chronic condition improvement program and a Medicaid quality improvement program, with both being overseen by the state's external quality review organization. (NJ, D-SNP contract, 2014, Sec. 4.4)
- **Wisconsin** allows D-SNPs to use Medicare quality improvement project templates for submission of Medicaid performance improvement projects with prior state approval. (WI, Family Care/Partnership contract, 2014, Art. XII.C.8.c.)

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

Minnesota (MSHO/MSC+ contract, 2014, 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."

Other State Requirements that Go Beyond MIPPA Requirements

States may use D-SNP contracts to hold plans accountable for targeted state initiatives and various D-SNP program and administrative responsibilities (See Appendix 2b). Examples include:

- **Arizona** encourages D-SNPs that also operate a Medicaid health plan to direct market only to individuals enrolled in the D-SNP organization's Medicaid product to increase alignment. (AZ, D-SNP contract, 2015, Sec. 2.8)
- **Florida** requires D-SNPs to facilitate Medicaid eligibility redeterminations for enrollees, including assisting with applications for medical assistance and conducting member 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 MIPPA requirements.[20]
- **Massachusetts** allows D-SNPs to submit integrated enrollment and disenrollment forms to the state and CMS on behalf of D-SNP members. (MA, SCO Contract, 2013, Sec 2.11.b)
- **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[21] 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.[22] (MN, MSHO/MSC+ contract, 2014, Sec. 3.7, 3.9, and 4.9)

Conclusion

In this analysis, the states with the most detailed and extensive D-SNP contracts are 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 capacities needed 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, states with few or no D-SNPs operating in the state may not want to devote limited 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 Managed LTSS 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 with a medical need for long term care services	ALTCS: Acute (including primary), behavioral health, prescription drugs, LTSS (nursing facility [NF], ICF/MR, HCBS)	None for MLTSS plan members	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, acute, prescription drugs)	D-SNPs are required to have a companion Medicaid plan that covers all Medicaid services and state- defined counties and population(s) (AZ, D-SNP contract, 2015, no section)
Florida Long-Term Care Program (2013)	Mandatory population: Adults 18+ with long-term care (LTC) needs in nursing facilities (NF) or select home- and community-based services (HCBS) waivers including dually eligible recipients Voluntary population: Adults 18+ with LTC needs in Program of All-Inclusive Care for the Elderly and select HCBS waivers	Managed Medical Assistance Program: primary, acute, prescription drugs LTC Program: behavioral health, prescription drugs, long-term services and supports (LTSS) (i.e., NF, HCBS waiver including occupational, physical and speech therapies)	None for MLTSS plan members	FBDE, SLMB, SLMB+, QDWI, QI, 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, including LTSS 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) Preceded by QUEST Expanded Access (QExA) (2009)	ABD individuals, children, adults < 65 with physical disabilities, adults < 65 with intellectual or developmental disabilities, adults 65+ Full benefit dual eligibles	QI Program: primary and acute care, behavioral health, prescription drugs, long-term services and supports (nursing facility, home health, hospice, home- and community-based services, personal care, self-directed options)	Additional behavioral health services for adults with serious and persistent mental illness and children with serious emotional disturbance, dental, home- and community based waiver services for people with intellectual or developmental disabilities, and institutional care for intellectual or developmental disabilities	FBDE	All Medicaid services provided by the QI Program	D-SNP contractors must be QI contractors in CY2015 State will require that QI contractors offer a D-SNP in CY2016[b]

[a] Based on review of Florida's standard D-SNP contract for 2014. For 2014 Florida also maintained a Coordination of Benefits (COB)-only D-SNP contract that covers all dually eligible beneficiaries. In 2015, the COB-only D-SNP contract will not be used and all applicable D-SNP eligibility categories will be enrolled under Florida's standard D-SNP contract.
[b] State correspondence.

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 or older with MassHealth Standard coverage	SCO Program: All Medicaid, including primary and acute care, behavioral health, prescription drugs, long-term services and supports (nursing facility, 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 or older 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 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, long-term services and supports (nursing facility-up to 180 days), State plan personal care and home care, and all home and community based services Elderly Waiver services)	Nursing facility 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 Dual Eligible Special Needs Plan (SNP) (MN, MSHO/MSC+ contract, 2014, Sec. 3.9.1)
New Jersey FamilyCare Managed Long-Term Services and Supports (2014)	All Medicaid eligible individuals, including children, meeting financial and nursing facility level of care requirements	FamilyCare MLTSS: All Medicaid, including primary and acute care, behavioral health, prescription drugs, long-term services and supports benefits of personal care attendant and medical day care); nursing facility (up to 30 days); home and community based services; mental health and substance abuse services	Grandfathered Special Care Nursing Facility and Nursing Facility residents	FBDE, QMB+	All Medicaid services provided by FamilyCare MLTSS excluding HCBS	D-SNPs are required to be approved by state as standard Medicaid managed care contractor. D-SNPs must offer NF MLTSS by 2015 and HCBS MLTSS by 2016
New Mexico Centennial Care (2012) Preceded by Coordination of Long Term Services (COLTS) (2008)	All Medicaid eligible individuals with exception of dual eligible recipients 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, prescription drugs, long-term services and supports (HCBS waiver, state plan personal care, nursing facility)	HCBS services for medically fragile and developmentally disabled individuals; 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 long-term services and supports	Varies by D-SNP (most include FBDE, QMB+, SLMB+, and one All-Dual D-SNP)	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**
Pennsylvania (No State Medicaid MLTSS Program)	NA	None: no MLTSS program	All long-term services and supports	FBDE, QMB Only, QMB+,SLMB Only, SLMB+, QDWI, QI	None	None
Tennessee TennCare CHOICES (2010)	NF residents (all ages), Adults >65 and adults >21 with PD who meet NF LOC or are at risk for NF LOC	TennCare CHOICES: primary and acute care, behavioral health, long-term services and supports: nursing facility, home- and community-based waiver-like services	Prescription drugs[c]	QMB only, QMB+, SLMB+, FBDE	None	Medicaid MCOs must have companion D-SNP under 2015 contract D-SNPs are not required to have a companion MLTSS plan
Texas STAR+PLUS (1998)	SSI or SS exclusion children <21, Adults 21+ w SSI, Adults 21+ in community-based alternatives, HCBS waiver adults 65+, Full-benefit duals	STAR+PLUS: primary and acute care, behavioral health, long-term services and supports: HCBS waiver services Behavioral health provided through separate NorthSTAR BH managed care program in Dallas, Ellis, Collin, Hunt, Rockwell and Kaufman counties	Nursing Facility (will be included beginning March 1, 2015)	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[d]
Wisconsin Family Care (1999) 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: State plan, long-term services and supports (nursing facility, 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 Partnership: All Family Care services except includes all state plan services	Family Care: Acute and primary care, prescription drugs Partnership: None	FBDE (18+ with NF LOC who reside in areas where the Family Care benefit package is available, ESRD duals 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

[c] 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).
[d] 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

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 members' health care including, but not limited to, discharge planning, disease management, and care management (AZ, 2015, D-SNP contract, Sec. 2.1.2) D-SNP must establish and provide the name of a contact person at each Arizona Health Care Cost Containment System acute or ALTCS Medicaid plan who will be responsible to share, at minimum, timely inpatient hospital, emergency room, and chronic illness information to coordinate care when benefit coverage switches from Medicare to Medicaid (AZ, D-SNP contract, 2015, Sec. 2.1.7 (a))	Quality reporting is due annually (AZ, D-SNP contract, 2015, Appendix 1)	Financial reporting is due quarterly. (AZ, D-SNP contract, 2015, 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, 2015, 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, 2015, Sec. 2.10 and 2.11)
Florida (New statewide Medicaid managed long-term care program implemented in 2013 and 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, Attch I, Sec. B.2.k.)	D-SNP provides duplicate copies of quality reports, measures, and findings generated from SNP(s) quality management programs as required by and submitted to CMS CMS requires the health plan to submit copies of quality reports, measures and findings from the health plan's SNP(s) quality management programs (FL, D-SNP Contract, 2015, Sec. III.E.iii)	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, Attch I, Sec. D.5.)	Not required in MIPPA contract	Not required in MIPPA 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
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 long-term services and supports, including coordination with Medicare services; (2) providing continuity of care when members 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 members and ensuring continuity of care (HI, QI RFP, 2013, Sec. 40.900)	Not required in MIPPA contract	Not required in MIPPA contract	Not required in MIPPA contract	Not required in MIPPA 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 and coordination enrollee transfers from one setting to another. (MA, SCO Contract, 2013, Sec. 2.4.a.6) MCO must also keep all parties informed about utilization of services for emergency conditions and urgent care (MA, SCO Contract, 2013, Sec 2.4.a.7) MCO must demonstrate the capacity to provide coordination of care and expert care management through the PCT (MA, SCO Contract, 2013, Sec., 2.4.c.1) Enrollees' care will be managed by a primary care physician or a primary care team who must have at least two years' experience in the care of persons over the age of 65 (MA, SCO Contract, 2013, Sec. 2.5.B.2.a.4)	MCO must report MA-SNP HEDIS measures if it is relevant to the SCO population (MA, SCO Contract, 2013, 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 Contract, 2013, 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 ratios as detailed in the contract. All reports must contain subsections for: (1) the contractor's activity only; and (2) combined data for the contractor and all subcontractors. (MA, SCO Contract, 2013, 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 Contract, 2013, Sec 5.1.a).	Not required in MIPPA 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 managed care organizations (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 long term care 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, 2014, 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 frailty and risk assessment scores and most recent SNP Model of Care to state as well as Medication Therapy Management program. (MN, MSHO/MSC+ contract, 2014, Sec. 3.7.2) D-SNP required to participate in state Health Care Home initiative and integrated care program partnerships to establish provider level integration projects intended to improve coordination of care (MN, MSHO/MSC+ contract, 2014, Sec. 3.7.2)	State had 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, 2014, 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, 2014, 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, 2014, 2.9 and 3.9)	The MCO shall inform the state regarding significant changes including notices of Corrective Action Requests within 30 days (MN, MSHO/MSC+ contract, 2014, 2.9)

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 Jersey FamilyCare Managed Long-Term Services and Supports (2014)	Managed care organization (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, D-SNP contract, 2014, Sec. 4.6)	MCO must annually provide HEDIS data and reports to the state (NJ, D-SNP contract, 2014, Sec. 4.4)	MCO shall semi-annually submit to the state copies of the CMS required financial reports (NJ, D-SNP contract, 2014, Sec. 7.24.2)	When MCO terminates or fails to renew its contract with CMS to offer the Medicare Advantage Product, the MCO shall notify the state immediately upon knowledge of the impending termination or failure to renew (NJ, D-SNP contract, 2014, Sec. 7.12) Terminating and successor MCOs shall notify enrollees of the pending transition, with all notices to be submitted to the state for review and approval before mail out (NJ, D-SNP contract, 2014, Sec. 7.13)	Not required in MIPPA 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
New Mexico Centennial Care (2012) Preceded by Coordination of Long Term Services (COLTS) (2008)	Managed care organization (MCO) will identify Medicaid benefits the member 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) Developed care plan must also include 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 long-term care services with the member's Medicare primary care provider (NM, Centennial Care contract, 2013, Sec. 4.8.4.1)	Not required in MIPPA contract	Not required in MIPPA contract	Not required in MIPPA contract	Not required in MIPPA 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
Oregon (No State Medicaid MLTSS Program)	In the event the D-SNP does not have an active contract with a Medicaid managed care organization (MCO) or Coordinated Care Organization (CCO) (or the Medicaid MCO contract ends before the end of the D-SNP contract period), the D-SNP agrees to honor all coordination of benefits requirements in the existing agreement with any MCO or CCO that enrolls an existing member for the duration of the contract (OR, DSNP contract, 2015, Sec. 9.1) "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, DSNP contract, 2015, Sec. 9.2) "[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, DSNP contract, 2015, Sec. 1.2) "…shall demonstrate that Contractor's Provider network is adequate to provide both the Medicaid and Medicaid Covered Services to its dual eligible populations." (OR, DSNP contract, 2015, Sec. 1.1)	Not required in MIPPA contract	Not required in MIPPA contract	Not required in MIPPA contract	Not required in MIPPA 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
Pennsylvania (No State Medicaid MLTSS Program)	The managed care organization (MCO) shall assist in the coordination and access to needed Medicaid services and arrange for the provision of such services to dual eligible members. Coordination of care will include the following: identification 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, 2014, Sec. 4.2.2)	Not required in MIPPA contract	Not required in MIPPA contract	Not required in MIPPA contract	Not required in MIPPA 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
Tennessee TennCare CHOICES (2010)	The contractor is responsible for coordinating Medicare and Medicaid services for all full benefit dual eligible (FBDE) members including benefits the contractor does not cover for its members (TN, D-SNP contract, 2014, Sec. A.2.b.6) Contractor must: (1) notify TennCare managed care organization (MCO) within two business days of inpatient admissions (hospital, skilled nursing facility, and others); (2) coordinate inpatient discharge planning with FBDE member's TennCare MCO when Medicaid long-term services and supports (LTSS), home health or private duty nursing services may be needed; and follow up with member and the member's TennCare MCO to address member needs and coordinate Medicaid benefits; (3) coordinate with TennCare MCO regarding CHOICES LTSS that may be needed by the member; (4) participate upon request in needs assessments and/or development of person-centered plan of care for CHOICES members; and (5) coordinate with TennCare MCO any needed CHOICES LTSS services processes for coordination, benefits under TennCare, including CHOICES (TN, D-SNP contract, 2014, Amendment #1, 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, 2014,Sec. A.2.b.9)	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, 2014, Sec. A.2.b.10.)	Not required in MIPPA contract	Not required in MIPPA 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, 2014, 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 will provide coordination of care for dual eligible members and other D-SNP members who are eligible for long-term services and supports (LTSS), make reasonable efforts to coordinate Medicare Advantage benefits with LTSS Texas Department of Aging and Disability Services and the STAR+PLUS HMOs. Coordination of Care must include: (1) identify providers of covered Medicaid LTSS; (2) help members access and coordinate delivery of 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 Members 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 member admission to a nursing facility. (TX, D-SNP contract, 2013, Sec. 3.0) Contract identifies contact person at the D-SNP and at the Medicaid agency that should be sent "all notices, consents, requests, instructions, approvals, or other communications (TX, D-SNP contract, 2013, Sec. 9.08) State will provide SNP with links to online LTSS provider information for fee-for-service and STAR+PLUS programs. SNP must post info on their site within 30 days, and notify members that info is available on the SNP and State website, and that they may request /copies of provider directories (TX, D-SNP contract, 2013, Sec. 3.08c)	Requires DSNP to report HEDIS measures to the state within 45 days after submission to CMS (TX, D-SNP contract, 2013, Sec. 3.08d)	Not required in MIPPA contract	D-SNP must notify state when CMS approves their D-SNP application, and if the D-SNP makes any amendments to the agreement. This includes the addition, deletion, or modification of a service area D-SNP required to notify state within 15 days of CMS decision regarding if the plan may provide an MA Product in a Texas service area Additionally, the D-SNP must notify the state contact of all amendments to the Medicare Advantage agreement's Texas service areas. This includes but is not limited to, the addition, deletion, or modification to a Texas service area, CMS contract code, plan identification, or plan name. The D-SNP has 15 business days after the effective date to notify the State of any amendments to the MA Agreement. (TX, D-SNP contract, 2013, Sec. 3.01b)	Not required in MIPPA 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
Wisconsin Family Care (1999) Family Care Partnership (1996)	The managed care organizations (MCO) shall promptly provide or arrange for the provision of all health and long-term care services in the benefit package, consistent with the member-centered plan (WI, Family Care/Partnership contract, 2014, Art. VII.C) MCOs are required to complete comprehensive assessments within 30 calendar days of enrollment and fully developed member care plan within 60 calendar days of the enrollment date ((WI, Family Care/Partnership contract, 2014, 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, 2014, 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 ten (10) business days of being reported to the other entities (WI, Family Care/Partnership contract, 2014, Art.VII.B)	The MCO is required to submit financial reports within forty-five (45) calendar days of the close of each of the first three (3) 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, 2014, 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

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 Beyond MIPPA Minimums
Arizona Arizona Long-Term Care System (ALTCS) (1989)	D-SNP 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 does not include a reference to state benefits and/or service information (AZ, AHCCCS Contractor Operations Manual, Marketing, 2014, Sec. III.D.1.a)	D-SNP required to submit quarterly summary of Part C and D pre-service 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, 2015, Sec. 2.9)	D-SNP required to submit Medicare encounter data as requested by the state (AZ, D-SNP contract, 2015, Sec. 2.6)	Not required in MIPPA contract	State encourages D-SNPs that operate a Medicaid health plan to direct market only to individuals enrolled in the D-SNPs Medicaid managed care plan (AZ, D-SNP contract, 2015, Sec. 2.8)
Florida (New statewide Medicaid managed long-term care program implemented in 2013 and 2014)	Not required in MIPPA contract	Not required in MIPPA contract	No Note: There are provisions in the contract for the submission of encounter data, but Florida is not requiring this information to be submitted at this time	Not required in MIPPA 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, Sec. B.1.d)
Hawaii QUEST Integration (QI) RFP (2013) Preceded by QUEST Expanded Access (QExA) (2009)	All marketing materials must be reviewed and approved before they are distributed by health plans (HI, QI RFP, 2013, Sec. 50.630)	D-SNPs must use state-developed templates for communication to members regarding the grievance system process, and must submit grievance policies and procedures to Department of Human Services for review and approval as part of the readiness review process (HI, QI RFP, 2013, Section 51.105)	The health plan shall submit encounter data to the state at least once per month The health plan may be required to submit encounter data to an all-payer claims database (APCD). (HI, QI RFP, 2013, Section 51.580).	Not required in MIPPA contract	Not required in MIPPA 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 Beyond MIPPA Minimums
Massachusetts Massachusetts Senior Care Options (2004)	Managed care organization (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 Contract, 2013, Sec 2.11.b.1, 3, 4)	The MCO must submit monthly reports on the number and types of enrollee complaints and appeals. 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 contract, 2013, Sec. 2.14.d) The form and content of notices regarding appeals must be approved by CMS and the state (MA, SCO contract, 2013, Sec 2.9.a.2) Whenever the MCO sends notification to an Enrollee of its service decision, the MCO must include information on filing a Board of Health Appeal. The form and content of the notification must be approved in advance by the state and CMS (MA, SCO contract, 2013, Sec. 2.9.c.2.a)	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 contract, 2013, 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 contract, 2013, 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 contract 2013, 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 contract, 2013, Sec. 2.15.c.1)	Not required in MIPPA contract	Massachusetts allows D-SNP submission of integrated enrollment and disenrollment forms to the state and CMS on behalf of D-SNP members (MA, SCO contract, 2013, Sec 2.11.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 Beyond MIPPA Minimums
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 managed care organization (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, 2014, Sec. 3.6.4)	The system must include a Medicare process for Medicare covered services and a Medicaid process, and 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, 2014, 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, 2014, 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 fifteen (15) days of submission. (MN, MSHO/MSC+ contract, 2014, Sec. 7.2)	D-SNPs 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 contract, 2014, Sec. 3.7 and 3.9) D-SNPs are required to waive the Medicare 3-day hospital stay requirement for Medicare skilled nursing facility coverage (MSHO contract, 2014, Sec 4.9.2.4) D-SNPs are required to participate in an administrative alignment demonstration based on a memorandum of understanding between the state and CMS (MN, MSHO contract, 2014, Sec. 3.9) DSNP 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 contract, 2014, Sec 3.9.1.D) D-SNP required to independently contract with state as enrollment TPA for all but one MSHO contractors (MN, MSHO contract, 2014, 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 Beyond MIPPA Minimums
New Jersey 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, D-SNP contract, 2014, Sec. 5.4)	Managed care organization (MCO) must submit quarterly reports of all grievance/appeal requests and resolutions to the state State shall have the right to submit comments to the contractor regarding the merits or suggested resolution of any grievance/appeal The MCO shall electronically submit quarterly reports of all Medicaid UM and non-UM enrollee grievance/appeal requests and dispositions directly to the state on the database format provided by the state (NJ, D-SNP contract, 2014, Sec. 4.5)	MCO must submit data on enrollee and provider characteristics as specified by the state and services furnished to enrollees through an encounter data system (NJ, D-SNP contract, 2014, Sec. 7.23) For purposes of premium risk development, the MCO must submit to the state complete Medicaid and Medicare encounter data (NJ, D-SNP contract, 2014, App. A.2)	MCO must conduct both a chronic condition improvement program (CCIP) and quality improvement program (QIP). MCO shall be subject to annual, external, independent reviews of its quality improvement activities by the state external review organization. (NJ, D-SNP contract, 2014, Sec. 4.4)	Not required in MIPPA contract
New Mexico Centennial Care (2012) Preceded by Coordination of Long Term Services (COLTS) (2008)	Not required in MIPPA contract	Not required in MIPPA contract	D-SNPs must submit Medicare encounters to the state (NM, Centennial Care contract, 2013, Sec. 4.19.2)	Not required in MIPPA contract	Not required in MIPPA contract
Oregon (No State Medicaid MLTSS Program)	Not required in MIPPA contract	Not required in MIPPA 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, 2015, Sec. 8.1)	Not required in MIPPA contract	"Health Plan shall assign staff to coordinate payment between Medicaid and DSNP programs (OR, D-SNP contract, 2015, Sec. 1.2)

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 Beyond MIPPA Minimums
Pennsylvania (No State Medicaid MLTSS Program)	Not required in MIPPA contract	Not required in MIPPA contract	Not required in MIPPA contract.	Not required in MIPPA contract	Not required in MIPPA contract
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, 2014, Sec. A.2.g)	Not required in MIPPA contract	Contractor must submit encounter data, including Part D claims "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, 2011, Amendment #1, Sec. A.2.c.1.(b))	Not required in MIPPA contract	Not required in MIPPA contract
Texas STAR+PLUS (1998)	Not required in MIPPA contract	The Medicare Advantage D-SNP must provide the State contact with a copy of the CMS complaint tracking module ("CTM") report. This report must be given for all members within 30 business days of MA Dual SNP's receipt of this report from CMS (TX, D-SNP contract, 2013, Sec. 3.08e)	Planned The contract states that the MA SNP must provide monthly encounter data to the state. However, encounter data are not yet being submitted by D-SNPs. (TX, D-SNP contract, 2013, Sec. 3.04a)	Not required in MIPPA contract	"The MA Dual SNP must have written procedures for ensuring that Dual Eligible Members and Other Dual SNP Members have access to the services identified in the MA Product. These procedures include policies regarding network adequacy consistent with the MA Agreement requirements. The MA Dual SNP must provide the State with a copy of these policies no later than 5 business days after a request." (TX, D-SNP contract, 2013, Sec. 3.08c)

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 Beyond MIPPA Minimums
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, 2014, Art. IX.A) The managed care organization (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, 2014, 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, 2014, 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, 2014, Art. XI.I)	Not required in MIPPA 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, 2014, Art. XII.C.8.c.)	Not required in MIPPA contract

Appendix 3: Contracts Reviewed

Arizona:

- Arizona Health Care Cost Containment System (AHCCCS), Division of Business and Finance, Contract Amendment, Effective Date April 1, 2014. http://www.azahcccs.gov/commercial/Downloads/ContractAmendments/ALTCS/ALTCSCYE2014/NF4114QuarterAmend13final.pdf
- Medicare Advantage D-SNP Health Plan Agreement between AHCCS and ___, 2015. http://www.chcs.org/media/AZ-D-SNP-Contract-2015.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.chcs.org/media/2015-Attachment-I-Scope-of-Services.pdf; http://www.chcs.org/media/2015-D-SNP-Exhibit-A.pdf; http://www.chcs.org/media/2015-Exhibit-B.pdf ; and http://www.chcs.org/media/2015-Exhibit-C.pdf

Hawaii:

- Hawaii Contract for Health and Human Services Competitive Purchase of Services, between Department of Human Services and Med-QUEST Division, Signed February 4, 2008. http://www.chcs.org/media/HI_QUEXA_Contract.pdf
- 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. http://hawaii.gov/spo2/health/rfp103f/attachments/rfp10091375755966.pdf

Massachusetts:

- MassHealth Senior Care Options Contract for Senior Care Organizations by and Between the Executive Office of Health and Human Services and ___, 2013. http://www.chcs.org/media/MA-SCO-Contract-Template-and-Appendices-2013.pdf

Minnesota:

- Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, 2014 MSHO/MSC+ Contract (MCO), http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_174195

New Jersey:

- Contract Between State of New Jersey Department of Human Services Division of Medical Assistant and Health Services and ___, Contractor, Accepted January 2014, http://www.nj.gov/humanservices/dmahs/info/resources/care/hmo-contract.pdf
- Dual Eligible Special Needs Plan Contract between State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and ___ Contractor, 2014, http://www.state.nj.us/humanservices/dmahs/info/d-snp_contract.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.
  - 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.chcs.org/media/NM-D-SNP-Contract-2013.pdf

Oregon:

- Oregon Health Authority Coordination of Benefits Agreement, ___, 2015. http://www.chcs.org/media/2015-OR-DSNP-Contract-Template-FINAL-clean.pdf

Pennsylvania:

- Cooperative Agreement between Pennsylvania Dept. of Public Welfare and Medicare Advantage Health Plan, Effective January 1, 2014. http://www.chcs.org/media/H4279_Dual_PA_State_Contract.pdf

Tennessee:

- Contactor Risk Agreement Between The State of Tennessee d.b.a. TennCare and ___, Effective January 1, 2014, http://www.tn.gov/tenncare/forms/eastwestmcocontract.pdf
- Contract Between the State of Tennessee, Department of Finance and Administration Bureau of TennCare and ___, Contract Begin Date January 1, 2011, Contract End Date December 31, 2014. http://www.chcs.org/media/TN-SNP-Blended-Document.pdf

Texas:

- Star+Plus Medicaid Rural Area MCO RFP, Star+Plus Covered Services, 2012, http://www.hhsc.state.tx.us/contract/529130042/docs/Attachment-B-1.pdf

- Texas Health & Human Services Commission, General Contract Terms & Conditions, Revised 2012.http://www.chcs.org/media/TX-STARPLUS-Expansion-Contract.pdf
- Agreement Between Texas Health and Human Services Commission and Medicare Advantage Dual Eligible Special Needs Plan, Signed May 28, 2013 and March 27, 2013. http://www.chcs.org/media/H4522_Dual_TX_Contract.pdf

Wisconsin:

- Partnership Contract Between Department of Health Services Division of Long Term Care and CARE Wisconsin Health Plan, Inc. January 1, 2014 – December 31, 2014. http://www.chcs.org/media/WI-Partnership-Contract-2014.pdf

Endnotes

[1] MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book." Exhibit 4, p.28. January 2015.
[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: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidity_2014.pdf.
[3] MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid Data Book." Exhibit18, p. 54.
[4] For details, see the CMS Medicare-Medicaid Coordination Office website: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.
[5] 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).
[6] National Association of States United for Aging and Disabilities. "State Medicaid Integration Tracker," p. 3. January 1, 2015. Available at: http://www.nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker.
[7] 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.119, 11-28-15). Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf.
[8] Public Law 110-275, Section 164(c)(4).
[9] 42 CFR §422.107.
[10] 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, March 2013. Available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf.
[11] CMS SNP Comprehensive Report, July 2014. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html.
[12] For more details on FIDE SNPs, see CMS Medicare Managed Care Manual, Chapter 16b (Special Needs Plans), Sections 40.4.3, 30.2, and 40.4.4 (Rev.119, 11-28-14).
[13] As previously noted, Medicare Advantage plans that want to operate in a state that is not willing or able to enter into a D-SNP contract may choose to operate a non-SNP Medicare Advantage plan or a chronic condition or institutional SNP in the state if they are federally qualified to do so.
[14] ICRC analysis of state MLTSS contracts. See also MaryBeth Musumeci, "Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers," Issue Brief, Kaiser Commission on Medicaid and the Uninsured, November 2014, Table 2, pp. 9-10.
[15]For the text of this MOU, see: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Minnesota.html.
[16] 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.
[17] For a discussion of differences between 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.
[18] State Medicaid programs must require that 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 MA plans set out in 42 CFR 422 et seq. CMS has proposed a model for integrating the Medicare and Medicaid appeals processes for D-SNPs that is available on the ICRC website: http://wayback.archive-it.org/2744/20110805030355/ http:/www.cms.gov/IntegratedCareInt/Downloads/Integrated_Appeals_Process.pdf.
[19] The administrative alignment MOU entered into between Minnesota and CMS on September 13, 2013 is available at: http://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.
[20] CMS, Medicare Managed Care Manual, Chapter 16b: Special Needs Plans, Sec. 40.5.1, Rev. 119, 11-28-14,
[21] 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. 183, 04-04-14). Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf.
[22] The September 2013 MOU outlining details of the demonstration is available on the MMCO website: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOU.pdf.