DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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TO: Medicare Advantage Organizations with a Dual Eligible Special Needs Plan

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SUBJECT: Release of the CY 2025 SMAC Submission Instructions and Updates to Medicare Managed Care Manual Chapter 16-B

The purpose of this memorandum is to highlight certain regulatory updates that may affect D-SNPs in 2025 and share updates to Medicare Managed Care Manual Chapter 16-B.

CY 2025 State Medicaid Agency Contract (SMAC) Considerations

In conjunction with the release of the Contract Year (CY) 2025 Medicare Advantage (MA), Prescription Drug Plan (PDP), Employer/Union-Only Group Waiver Plan (EGWP), and Special Needs Plan (SNP) applications, CMS has also released the CY 2025 SMAC Submission Instructions.

CMS reminds those organizations seeking to offer a fully integrated D-SNP (FIDE SNP) or highly integrated D-SNP (HIDE SNP) that we recently codified rules on FIDE SNPs and HIDE SNPs for CY 2025. They include requirements:

- In the FIDE SNP definition (42 CFR 422.2) related to:
  - Medicaid coverage of Medicare cost sharing, Medicaid behavioral health services, and other Medicaid services, and
  - Exclusively aligned enrollment; and
- In the FIDE SNP and HIDE SNP definitions (42 CFR 422.2) related to aligning service areas between Medicare and Medicaid.

As a result of these regulatory changes, some plans currently designated as FIDE SNPs or HIDE SNPs may no longer qualify for those designations for CY 2025. D-SNPs that are no longer FIDE SNPs or HIDE SNPs would need to meet the requirement at 42 CFR 422.107(d) (related to certain minimum Medicaid integration requirements) to have an approvable SMAC. We encourage organizations to carefully consider these issues is preparing bids and SMACs for CY 2025.

Organizations seeking to offer a HIDE or FIDE SNP for CY 2025 should follow the necessary steps for filing the appropriate applications by 8:00 p.m. EST on February 14, 2024.

CY 2025 Medicare Advantage applications, including the CY 2025 SMAC Submission instructions are available at the following link: https://www.cms.gov/medicare/health-drug-plans/medicare-advantage-application.

Updates to Chapter 16-B of the Medicare Managed Care Manual

We are sharing updates to section 20.2.1 and 20.2.5 through 20.2.7 of Chapter 16-B of the Medicare Managed Care Manual on the definitions of dual eligible special needs plans (D-SNPs) and additional requirements for certain D-SNPs under section 1853(a) of the Act, and 42 CFR 422.2, 422.107, and 422.561. As part of the revisions to these sections, we are also redesignating existing 20.2.6 to 20.2.8, following the new text added at sections 20.2.6 and 20.2.7.

The updated sections reflect current regulatory requirements in light of recent rulemaking stemming from the Bipartisan Budget Act of 2018. Where there are differences between statute or regulations and the manual, the statute or regulations control over the manual (and any other guidance). Therefore, interested parties should consult the applicable statutes, regulations, and final rules.

Chapter 16-B, incorporating the updated section, is available at the following link: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c16b.pdf. The updates for this section are also in Attachment A.

Questions regarding CY 2025 SMAC Submission Instructions, HIDE and FIDE SNP requirements, or updates to Chapter 16-B may be directed to MMCO_DSNPOperations@cms.hhs.gov. Please include your CMS Account Manager regarding any questions on Chapter 16-B.

Attachment A: Updates to section 20.2.1 and 20.2.5-7

20.2 – Dual Eligible SNPs

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

20.2.1– General *Definitions*

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

20.2.1.1– Eligibility Definitions

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

D-SNPs enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility. Individuals in the following Medicaid eligibility categories may be eligible to enroll in D-SNPs, to the extent permitted in the state Medicaid agency contract (see section 20.2.2 of this chapter):

- *Full Medicaid (only);*
- *Qualified Medicare Beneficiary without other Medicaid (QMB Only);*
- *QMB Plus;*
- *Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB Only);*
- *SLMB Plus;*
- *Qualifying Individual (QI); and*
- *Qualified Disabled and Working Individual (QDWI).*

States may vary in determining their eligibility categories; therefore, there may be state-specific differences in the eligibility levels in comparison to those listed here. For specific information regarding Medicaid eligibility categories, refer to: https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/medicaremedicaidenrolleecategories.pdf.

20.2.1.2 D-SNP Definitions

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

20.2.1.2.1 Definition of a D-SNP

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

Dual eligible special needs plans (D-SNPs) are SNPs that exclusively serve Medicare beneficiaries who are also entitled to Medicaid.

Per 42 CFR 422.2, a D-SNP:

> *(1) Coordinates the delivery of Medicare and Medicaid services for individuals who are eligible for such services;*

(2) May provide coverage of Medicaid services, including long-term services and supports and behavioral health services for individuals eligible for such services; and

(3) Has a contract with the state Medicaid agency that meets the minimum requirements in paragraph 42 CFR 422.107(c) (further described in section 20.2.2 of this chapter.)

Additionally, each D-SNP must satisfy one or more of the following criteria for the integration of Medicare and Medicaid benefits:

(1) Meet the additional requirement specified in 42 CFR 422.107(d) in its contract with the state Medicaid agency, or in other words, meet the criteria for a coordination-only D-SNP;

(2) Meet the definition of a highly integrated dual eligible special needs plan (HIDE SNP); or

(3) Meet the definition of a fully integrated dual eligible special needs plan (FIDE SNP).

These concepts and definitions are described in more detail below.

20.2.1.2.2 Definition of FIDE SNP
(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

A FIDE SNP is defined in 42 CFR 422.2 as a D-SNP—

- *That provides dually eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Act with the applicable state;*
- *Whose capitated contract with the state Medicaid agency requires coverage of the following elements to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a FIDE SNP in the state, except as approved by CMS under 42 CFR 422.107(g) and (h):*
    - *Primary care and acute care, and for plan year 2025 and subsequent years including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to QMBs;*[1]
    - *Long-term services and supports (LTSS), including coverage of nursing facility services for a period of at least 180 days during the plan year;*
    - *For plan year 2025 and subsequent years, behavioral health services;*
    - *For plan year 2025 and subsequent years, home health services as defined in 42 CFR 440.70; and*
    - *For plan year 2025 and subsequent years, medical supplies, equipment, and appliances, as described in 42 CFR 440.70(b)(3);*
- *That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries;*
- *That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement;*

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[1] *Under 42 CFR 422.107(g) and (h), CMS allows limited carve-outs from the scope of Medicaid LTSS and Medicaid behavioral health services that must be covered by FIDE SNPs and HIDE SNPs. More information on carve-outs can be found in section 20.2.6 of this chapter.*

- *For plan year 2025 and subsequent years, that has exclusively aligned enrollment;[2] and*
- *For plan year 2025 and subsequent years, whose capitated contract with the state Medicaid agency covers the entire service area for the D-SNP.*

Beginning in 2025, all FIDE SNPs also qualify as applicable integrated plans, as defined in 42 CFR 422.561 and section 20.2.1.2.5 of this chapter, but not all applicable integrated plans qualify as FIDE SNPs.

20.2.1.2.3 Definition of HIDE SNP
(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

A HIDE SNP, as defined in 42 CFR 422.2, is a D-SNP that provides coverage of Medicaid benefits under a capitated contract that meets the following requirements:

- *The capitated contract is between the state Medicaid agency and—*
  - *The MA organization; or*
  - *The MA organization's parent organization, or another entity that is owned and controlled by its parent organization.*
- *The Medicaid capitated contract requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a HIDE SNP in the state, except as approved by CMS under 42 CFR 422.107(g) or (h) (see section 20.2.2.4 of this chapter):*
  - *LTSS, including community-based LTSS and some days of coverage of nursing facility services during the plan year; or*
  - *Behavioral health services.*
- *For plan year 2025 and subsequent years, the capitated contract covers the entire service area for the D-SNP.*

HIDE SNPs may also qualify as applicable integrated plans, as defined in 42 CFR 422.561 and section 20.2.1.2.5 of this chapter, but not all applicable integrated plans are HIDE SNPs.

20.2.1.2.4 Coordination-only D-SNPs
(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

If a D-SNP is not a FIDE SNP or a HIDE SNP, it is a coordination-only (CO) D-SNP and is subject to the contracting requirement specified at 42 CFR 422.107(d)(1). CO D-SNPs must have a CMS-approved contract with a state Medicaid agency that stipulates that, for the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the D-SNP notifies, or arranges for another entity or entities to notify, the state Medicaid agency,

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[2] Aligned enrollment, as defined in 42 CFR 422.2, refers to the enrollment in a D-SNP of full-benefit dually eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract (i.e., Medicaid MCO contract under section 1903(m)(2)(A) of the Act) between (A) the applicable state and (B) the D-SNP's MA organization, the D–SNP's parent organization, or another entity that is owned and controlled by the D–SNP's parent organization. When state policy limits a D-SNP's membership to individuals with aligned enrollment, this condition is referred to as exclusively aligned enrollment.

individuals or entities designated by the state Medicaid agency, or both, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the state Medicaid agency. The state Medicaid agency must establish the timeframe(s) and method(s) by which notice is provided. In the event that a D-SNP authorizes another entity or entities to perform this notification, the D-SNP must retain responsibility for complying with this notification requirement.

There are no federal requirements for FIDE SNPs or HIDE SNPs to comply with the requirement at 42 CFR 422.107(d)(1). However, some states choose to apply similar notifications requirements in their state Medicaid agency contracts for FIDE and/or HIDE SNPs.

For a CO D-SNP that, under the terms of its contract with the state Medicaid agency, only enrolls partial-benefit dually eligible individuals, the data notification requirements at 42 CFR 422.107(d)(1) do not apply if the D-SNP operates under the same parent organization and in the same service area as a D-SNP limited to full-benefit dually eligible enrollees that meets the requirements at 42 CFR 422.107(d)(1) and outlined above in this section. Said another way, partial-benefit-only D-SNPs are not required to meet the notification requirement in 42 CFR 422.107(d)(1) when the MA organization also offers a D-SNP with enrollment limited to full-benefit dually eligible individuals that meets the integration criteria at 42 CFR 422.2 and is in the same state and service area and under the same parent organization.

Table 2: Features of D-SNP Types

Plan Type	***Single entity holds both MA and Medicaid contracts***	***State option to carve out certain Medicaid benefits***	***Integrated materials***	***Exclusively aligned enrollment***	***Applicable integrated plan***	***Medicaid plans cover entire service area of the D-SNP***	***Data notification requirements for enrollee use of hospital or SNF admission***
FIDE SNP	*Required*	*No, except as approved by CMS under 42 CFR 422.107(g) or (h)*	*Required*	*Required in plan year 2025 and later*	*For 2025 and later, all FIDE SNPs are AIPs*	*Required in plan year 2025 and later*	*Not federally required*
HIDE SNP	*Not federally required*	*May carve out LTSS **or** behavioral health but not both. Any carve-out of services in the category must be approved by CMS under 42 CFR 422.107(g) or (h)*	*Not federally required*	*Not federally required*	*Can qualify as AIPs, but not AIPs by default*	*Required in plan year 2025 and later*	*Not federally required*
CO D-SNP	*Not federally required*	*No requirements on Medicaid benefits provided*	*Not federally required*	*Not federally required*	*Can qualify as AIPs in certain contexts*	*Not federally required*	*Required, except in specific instances for D-SNPs that only enroll partial-benefit dually eligible individuals*

Note: States may apply requirements beyond the federal minimum requirements shown in the table above.

20.2.1.2.5 Applicable Integrated Plan
(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

Applicable integrated plans (AIPs) are defined in 42 CFR 422.561 as either of the following arrangements:

- *A FIDE SNP or HIDE SNP and a Medicaid managed care organization where—*
  - *The FIDE SNP or HIDE SNP has exclusively aligned enrollment; and*
  - *The Medicaid managed care organization (as defined in section 1903(m) of the Act and which has a contract under section 1903(m)(2)(A) of the Act) through which such D-SNP, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such D-SNP and such Medicaid managed care organization; or*
- *A D-SNP and affiliated Medicaid managed care plan where—*
  - *The D-SNP, by state policy, has enrollment limited to those beneficiaries enrolled in a Medicaid managed care organization;*
  - *There is a capitated contract between the MA organization, the MA organization's parent organization, or another entity that is owned and controlled by its parent organization and*
    - *A Medicaid agency, or*
    - *A Medicaid managed care organization that contracts with the Medicaid agency; and*
  - *Through the capitated contract, Medicaid benefits including primary care and acute care, including Medicare cost-sharing without regard to the limitation of that definition to QMBs, and at a minimum, one of the following: home health services as defined in 42 CFR 440.70, medical supplies, equipment, and appliances as described in 42 CFR 440.70(b)(3), or nursing facility services are covered for the enrollees.*

AIPs must offer integrated appeals and grievances at the plan level in accordance with 42 CFR 422.629 through 422.634. More information on integrated appeals and grievances can be found in the Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans, located here: https://www.cms.gov/files/document/dsnpartscdgrievancesdeterminationsappealsguidanceaddendum.pdf

Beginning in 2025, all FIDE SNPs are AIPs. Currently, most AIPs are FIDE SNPs or HIDE SNPs. CO D-SNPs may qualify as AIPs under certain circumstances. As an example, the following arrangements would be AIPs under current regulations, where both plans include enrollment that is exclusively aligned between the CO D-SNP and the affiliated Medicaid MCO:

- *A CO D-SNP and affiliated Medicaid MCO where the CO D-SNP holds a contract with a separate Medicaid MCO to cover all capitated managed care benefits in the state and the separate Medicaid MCO holds the contract with the state for those benefits; and*
- *A CO D–SNP and affiliated Medicaid MCO where the affiliated Medicaid MCO holds a contract with the state for the capitated Medicaid benefits.*

20.2.5 – *Additional Requirements for Certain D-SNPs*
(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

20.2.5.1 – Application of Frailty Adjustment for FIDE SNPs

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

Section 1853(a)(1)(B)(iv) of the Act gives the Secretary the authority to apply a frailty adjustment payment under the rules for Program of All-Inclusive Care for the Elderly (PACE) payment, for certain FIDE SNPs, to reflect the costs of treating high concentrations of frail individuals. CMS announces its methodology for determining whether a FIDE SNP "has a similar average level of frailty…as the PACE program" in *the annual Announcement of Calendar Year (CY) Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies* located at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. *Policy changes and changes in the assumptions and methodologies for MA payment and the calculation of the frailty adjustment are discussed each year in the Advance Notice of Methodological Changes for Calendar Year (CY) for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, which is issued at least 60 days before the first Monday in April of the year preceding the calendar year for which the rates and frailty adjustment are applicable. Each year*, we also notify each FIDE SNP of its frailty score and of how it compares to PACE organizations.

*CMS calculates f*railty scores *at the PBP level* using the limitation on activities of daily living (ADL) reported by a plan's enrollees, based on the Medicare Health Outcomes Survey (HOS) *or Health Outcomes Survey-Modified (HOS-M)* from the year previous to the payment year. For example, for payment year 20*24*, CMS will use the 20*23* HOS or HOS-M to determine a frailty score for FIDE SNPs. MA o*rganization*s that believe they will be sponsoring a FIDE SNP in 20*24* and want to be considered for a frailty payment must participate in the 20*23* HOS or HOS-M to allow for CMS to calculate their frailty score. For more information, please see the annual HPMS memo, "Participation in HOS*/HOS-M* for MA Organizations Planning to Sponsor FIDE SNPs."

Therefore, in order for a SNP to be eligible to receive frailty payments pursuant to section 1853 of the Act, the SNP must: (1) satisfy the FIDE SNP definition under 42 CFR 422.2; (2) participate in the HOS*/HOS-M*; and (3) have similar average levels of frailty as PACE organizations as described in the Advance Notice for the given year.

20.2.6 – *Medicaid Carve-Outs and FIDE SNP and HIDE SNP Status*

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

CMS determines the integration status for MA organizations offering D-SNPs through our annual SMAC review. As part of the review, CMS assesses the scope of existing or proposed carve-outs against regulatory requirements and determines whether a D-SNP meets the FIDE SNP or HIDE SNP designation. This policy is designed to accommodate differences in state Medicaid policy.

Under 42 CFR 422.107(g) and (h), CMS allows limited carve-outs from the scope of Medicaid LTSS and Medicaid behavioral health services that must be covered by FIDE SNPs and HIDE SNPs.

CMS currently grants FIDE SNP and HIDE SNP status despite limited carve-out of Medicaid LTSS if such carve-outs:

1. *Apply primarily to a minority of the dually eligible LTSS users eligible to enroll in a FIDE SNP or HIDE SNP who use long-term services and supports; or*
2. *Constitute a small part of the total scope of Medicaid LTSS provided to the majority of dually eligible individuals eligible to enroll in a FIDE SNP or HIDE SNP who use Medicaid LTSS.*

CMS did not establish a uniform set of carve-out limits or a numerical limit on carve-outs due to the variation across states.[3]

Examples of permissible LTSS carve-outs for FIDE SNPs and HIDE SNPs that apply to a minority of dually eligible LTSS users may include services specifically limited to individuals with intellectual or developmental disabilities, individuals with traumatic brain injury, or children.

Carve-outs of specific Medicaid LTSS are permissible if the carved-out services would typically only be a small component of the broad array of LTSS provided to the majority of Medicaid LTSS users eligible to enroll in the FIDE SNP or HIDE SNP. CMS would not, however, approve carve-outs for LTSS services for a specific population – for example, individuals with intellectual or developmental disabilities – if enrollment in the FIDE SNP or HIDE SNP was limited to individuals with those disabilities. For example, personal emergency response systems or home modifications may be important supports for participants in a Medicaid home and community-based waiver program, but those specific services would rarely constitute the preponderance of an enrolled dually eligible individual's care plan because most individuals receiving such services also receive other types of in-home supports, such as personal care services. Therefore, approving a carve-out of coverage of personal emergency response systems or home modifications may be permissible under § 422.107(g)(2) where those constitute a small part of the total scope of LTSS provided to the majority of beneficiaries eligible to enroll in the D-SNP. In contrast, CMS would not expect to approve carve-outs of in-home personal care or related

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[3] *For further discussion, see 87 FR 27757*

support services provided to older adults or people with disabilities even if such services were limited to individuals meeting a nursing home level of care.

CMS defines Medicaid behavioral health carve-outs to be of limited scope if such carve-outs:

1. *Apply primarily to a minority of the dually eligible users of behavioral health services eligible to enroll in the D-SNP who use behavioral health services; or*
2. *Constitute a small part of the total scope of behavioral health services provided to the majority of beneficiaries eligible to enroll in the D-SNP.*

Only a small part of the Medicaid behavioral health services may be carved out to ensure the innovative services that many Medicaid programs provide to individuals with severe and moderate mental illness are covered through the affiliated Medicaid managed care plan (or the D-SNP if it holds the Medicaid managed care contract directly).

Examples of permissible carve-outs that apply to primarily a minority of dually eligible users of such services who are eligible to enroll in the FIDE SNP or HIDE SNP include school-based services for individuals under 21 years of age and court-mandated services where the D-SNP is not limited to individuals under 21 years of age.

Examples of permissible carve-outs that constitute a small part of the total scope of Medicaid behavioral health services include inpatient psychiatric facilities and other residential services, specifically payment of Medicare cost-sharing or coverage of days not covered by Medicare; substance abuse treatment, such as payment of Medicare cost-sharing or coverage of services not covered by Medicare; services provided by a Federal Qualified Health Center or Rural Health Clinic; and Medicaid-covered prescription drugs for treatment of behavioral health conditions.[4]

20.2.7 State D-SNP-only Contracts

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

20.2.7.1 Limiting Certain MA Contracts to D-SNPs

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

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[4] As discussed in the CMS-4185-F rule, CMS had historically determined D-SNPs to be FIDE or HIDE SNPs when they meet the necessary requirements but included limited carve-outs of certain services from the Medicaid coverage provided by the Medicaid managed care plan. The CMS HPMS memorandum entitled, "Additional Guidance on CY 2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans," January 17, 2020 (retrieved from: https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf) discussed the policy later finalized at 422 CFR 422.107(g) and (h) and discussed in section 20.2.6 of this chapter. The requirements at 422 CFR 422.107(g) and (h) and discussed in section 20.2.6 of this chapter supersede the January 17, 2020 HPMS memorandum.

Through the SMAC, a state can require MA organizations to (a) apply for and seek CMS approval of MA contracts that only include one or more D-SNPs with exclusively aligned enrollment within a state and (b) require those D-SNPs to utilize certain integrated materials and notices for enrollees. CMS will facilitate such requirements in accordance with the procedures and requirements at 42 CFR 422.107(e). CMS will approve D-SNP-only contracts when a state, through the SMAC, requires exclusively alignment enrollment, requires the D–SNPs to request MA contracts that only include one or more state-specific D–SNPs, and requires the D-SNP to use (and the D-SNP uses) certain minimum integrated member materials. However, implementation of such D-SNP-only contracts requires prior notification and administrative activities to begin well in advance of the applicable contract year.

20.2.7.2 State Notification to CMS

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

Implementation of a D-SNP-only contract and development of integrated plan materials generally requires administrative steps that cannot be completed between reviewing the contract (after bid submission) and the start of the plan year. CMS will begin good faith work following receipt of a letter from the state Medicaid agency indicating intent to include the requirements for a D-SNP-only contract and use of integrated materials in a future contract year and collaborate with CMS on implementation. To begin the process to establish state D-SNP-only contracts under 42 CFR 422.107(e)(2), CMS requests the respective state Medicaid agency submit a letter to CMS regarding its intention to pursue the further integration opportunities available under 42 CFR 422.107(e)(1) by August of two years prior (e.g., August 2023 in anticipation of implementation in plan year 2025) to enable the MA organization and CMS to start the necessary steps. More information on this process can be found in previous guidance at the following link: https://www.cms.gov/files/document/stateoppsintegratedcareprogs.pdf

20.2.7.3 Integrated Materials

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

To meet the requirements of 42 CFR 422.107(e)(1)(ii), the SMAC must require the D-SNP(s) to use required materials that integrate Medicare and Medicaid content, including at a minimum the Summary of Benefits, Formulary, and combined Provider and Pharmacy Directory. The state may require use of additional integrated materials. Integrated materials must meet Medicare and Medicaid managed care requirements consistent with applicable regulations in 42 CFR 422, 423, and 438. CMS coordinates with states that choose to require, through their SMACs, that a

D-SNP with exclusively aligned enrollment integrate its Medicare and Medicaid member materials to ensure these integrated materials comply with regulatory requirements.

20.2.7.4 Joint State/CMS Oversight

(Rev. XXX, Issued: XX-XX-XX, Effective: XX-XX-XX, Implementation: XX-XX-XX)

To enhance coordination between states, D-SNPs, and CMS, states that establish D-SNP-only contracts have the opportunity to collaborate with CMS on oversight activities through access to the Health Plan Management System (HPMS) and coordination on program audits. The state must request access to HPMS and comply with applicable rules and policies related to such access (e.g., agree to protect the proprietary nature of information to which the state Medicaid agency may not otherwise have direct access). More information on these activities can be found at 42 CFR 422.107(e)(3) and in the CY 2023 MA and Part D final rule published on May 9, 2022 (87 FR 27773).