

JUSTICE IN AGING

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TOOLKIT

Dual Eligible Special Needs Plans (D-SNP) State Medicaid Agency Contract Toolkit:

PROVIDER NETWORK PROTECTIONS FOR D-SNP STATE MEDICAID AGENCY CONTRACTS

MARCH 2026

This toolkit provides policymakers, including State Medicaid Agency staff, and advocates, with principles and corresponding template language to develop State Medicaid Agency Contracts (SMACs) that are responsive to the needs of the dually eligible populations they serve. Stakeholders are encouraged to use this tool to advance their priorities by tailoring the components that are most appropriate for their state's integrated environments.

Part VI of the toolkit centers on consumer protections related to provider network adequacy. Parts IV and V of the toolkit provide a robust discussion on consumer protections within D-SNPs, including [Member Engagement and Support](#) (e.g., Enrollee Advisory Committees and Ombuds Programs), and [Member Rights](#) (e.g., Maintaining Coverage and Appeals and Grievances). [Part I of this toolkit covers Eligibility and Enrollment](#) as well as [Supplemental Benefits](#), [Part II of this toolkit focuses on Marketing and Communications](#), and [Part III of this toolkit encompasses Care Coordination](#).

Drawing from Justice in Aging's [D-SNP Issue Brief](#), we center the experiences of dually eligible enrollees and highlight the challenges faced by this population in navigating their health insurance coverage. To guide the discussion, we reference the Justice in Aging [Guiding Principles](#), a core set of values and goals that call for robust consumer protections, health equity, person-centered care, and more oversight and accountability in integration models.

This publication highlights best practices drawn from D-SNP model contracts and Financial Alignment model initiatives. For this tool, in instances where existing SMAC language is not publicly available or has not yet been written, Justice in Aging provides suggested template language to help advance key consumer protections and principles.

PROVIDER NETWORK ADEQUACY

Unlike most Original Medicare enrollees who can see any provider who accepts Medicare, Medicare Advantage (MA) enrollees can face the challenge of finding plans with networks that meet their health care and prescription medication needs. This entails verifying that their providers, suppliers, and pharmacies are in their MA plan's network. For dually eligible enrollees with complex medical needs, this can be a particularly daunting task due to potentially having many providers including multiple specialists to treat chronic conditions, and the lack of reliably accurate information about MA plan provider networks. Many dually eligible individuals with established relationships with their providers may not be able to make changes easily due to provider shortage issues impacting many rural and some urban regions. While CMS recently issued guidance clarifying Medicare cost sharing protections for dually eligible individuals enrolled in Medicare Advantage plans who see out-of-network providers and suppliers, the reality on the ground is often confusion resulting in inappropriate billing.¹ Hence, to avoid billing issues, dually eligible individuals also have the added task of confirming that their plan's in-network providers also accept their Medicaid coverage when Medicaid is primary. D-SNPs provide an opportunity to streamline this complexity and ensure dually eligible enrollees have access to provider networks that meet their needs under Medicare and Medicaid.

Provider Network Adequacy: Access to Care

GUIDING PRINCIPLE

Integrated models improve access to care and member experience across the diverse dually eligible population.

SUPPORTING PRINCIPLE

Members can access their Medicare and Medicaid benefits without delay.

Federal Requirements

Under the federal regulations outlined in [42 CFR 422.116](#),² MA plans must demonstrate an adequate provider network that allows for meaningful access to covered services. Plans must also meet maximum time and distance standards and contract with a specified minimum number of providers and specialty-facility types. MA plans such as D-SNPs that provide prescription drug coverage must also meet the pharmacy network requirements outlined in [42 CFR 423.120](#).³

According to [42 CFR 422.112](#), MA plans must ensure covered services are available and equitably accessible to all enrollees.⁴ Per [42 CFR 422.112\(a\)\(8\)](#), equitable access encompasses the delivery of care in a culturally competent manner taking into account the needs of enrollees in terms of language, ethnic, cultural, racial, and religious identities, gender identity, disabilities, etc.⁵ This requires plans monitor and maintain an adequate network of contracted providers that meet the needs of the population being served. When plan networks are unable to satisfy enrollee need, plans are mandated to provide coverage of medically necessary covered benefits from out-of-network providers at in-network cost sharing.⁶

SMAC Recommendations

The state should exercise more oversight of network adequacy by requiring D-SNPs to report on all network providers including specialty providers, where they serve, and the populations they serve by including disaggregated patient demographic data (e.g., age, zip code, race/ethnicity, sexual orientation and gender identity, primary language, and disability status). To ensure that D-SNPs contract with a diverse pool of providers that can meet the needs of the enrollee population, states should require plans to contract with a minimum number of providers that serve high risk populations.

In situations where the D-SNP provider network is unable to meet the needs of enrollees, states should require plans to assign a Care Manager to support enrollees in accessing care out-of-network.⁷ To ensure enrollees are informed, SMACs should require plans to include information about out-of-network provider support in all enrollee marketing materials that meet health literacy and accessibility standards.⁸ This information should include clear instructions about how enrollees can contact the designated Care Manager to access support. The SMAC should also specify a set timeframe by which the Care Manager must find an out-of-network provider for enrollees who request the support. To ensure states can properly monitor and track the adequacy of plan networks, SMAC reporting requirements should include D-SNP out-of-network encounter data, the average enrollee wait time to access covered benefits out-of-network, and the average wait time to receive Care Manager support with out-of-network requests. States should also make this data publicly available to promote transparency and accountability.

Justice in Aging has heard from advocates working with dually eligible individuals who have experienced barriers accessing care within their D-SNP's provider network due to referral restrictions. For example, when in-network primary care physicians only refer to specialists within their group practice or hospital system, the result for enrollees is often longer waiting times or traveling farther from home to access care. To avoid de facto reductions in plan provider networks when contracted providers impose their own referral restrictions, states should require D-SNPs to better manage contracted providers and support enrollees by allowing the application of referrals to the broader plan network of providers.

Template Language

Washington

State oversight of D-SNP provider networks is included in the Washington SMAC. D-SNPs are required to submit monthly reports on various provider types including specialty providers.

- The contractor will provide documentation of its provider network including provider types necessary for Medicare network adequacy and all specialty provider types. Documentation shall be submitted no later than the 15th of the first month for the current reporting quarter. Reports are due: January 15 (October through December); April 15 (January through March); July 15 (April through June); and October 15 (July through September).⁹

Massachusetts

The Massachusetts SMAC includes a broad range of provider network accessibility requirements. For example, plans are required to be responsive to the unique needs of the enrollee population and ensure access to the full range of covered services. To meet state provider diversity standards, D-SNPs are required to contract with specific state agency providers and are prohibited from discriminating against providers who serve high risk populations.

- The contractor shall maintain and monitor a provider network sufficient to provide all enrollees, including those with limited English proficiency or physical or mental disabilities, with meaningful access to the full range of covered services, including Behavioral Health, Oral Health, LTSS, Additional Community-based Services, other specialty services, and all other services required in 42 C.F.R. §§422.112, 423.120, and 438.206(b)(1) and under this contract.
- The provider network shall be responsive to the linguistic, cultural, and other individual needs of any enrollee, person experiencing homelessness, transgender or gender-diverse persons, or other special populations served by the contractor by, at a minimum, including the capacity to communicate with enrollees in languages other than English, communicate with individuals who are deaf, hard of hearing or deaf blind.
- The contractor shall not establish selection policies and procedures that discriminate against providers that serve high risk populations or specialize in conditions that require costly treatment.

- The contractor shall contract with all inpatient hospitals, outpatient hospitals, and community mental health centers that are operated by the Department of Mental Health (DMH) and the Department of Public Health (DPH).¹⁰

Massachusetts also requires D-SNPs to secure dental provider network access for enrollees with special needs and disabilities. The state provides outreach requirements to ensure the plan dental provider network has the capacity to serve the needs of the enrollee population.

- Contractor shall contact all offices that treated members with disabilities, including IDD, during the previous contract year, determine each of those offices' capacity to treat enrollees with disabilities, including IDD, and encourage each of those offices to treat additional enrollees by providing training on how best to treat enrollees with disabilities, including IDD.
- The contractor shall create and submit to the state for approval a plan to expand network capacity for enrollees with disabilities, including IDD.
- The contractor shall make best efforts to contract with mobile providers. The contractor shall outreach to any non-network mobile providers at least annually to attempt to contract with them.¹¹

Minnesota

In addition to coverage for emergency and urgent care services received out-of-network, Minnesota requires D-SNPs to cover non-emergency medical services out-of-network for as long as the plan is unable to cover the services in-network. Additionally, the state requires D-SNPs to include consumer protections in their agreements with out-of-network providers that guard against the practice of directly billing enrollees for any portion of the approved service.

- If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the Managed Care Organization (MCO) must adequately and timely cover these services out-of-network for the enrollee, for as long as the MCO's network is unable to provide them.
- As a condition of payment where a single case or other similar agreement is arranged, the MCO must require the non-network provider to agree in writing to refrain from billing the enrollee for any portion of the cost of the authorized service.¹²

Additional SMAC Language

- The contractor will maintain a minimum number, as determined by the state, of essential community providers, defined as providers who primarily serve low-income and medically underserved populations. These providers include and are not limited to providers in federally qualified health clinics, community clinics, critical access hospitals and state-operated facilities.¹³
- The contractor will work with network providers and implement a provider referral process to support enrollees' timely access to care. The contractor will appoint a Care Manager designee as the main contact responsible for connecting enrollees who need support with a referral to the broader network of providers.
- The contractor will include information about plan coverage of out-of-network provider services in all enrollee materials that meet health literacy and accessibility standards. This information will include clear instructions about how enrollees can request assistance to access out-of-network provider services. To ensure enrollees receive timely support, the contractor will appoint a Care Manager designee as the main contact responsible for connecting enrollees who need access to services with an out-of-network provider. The Care Manager designee will be required to provide enrollees who request assistance with support within a designated time period.

Provider Network Adequacy: Alignment with Medicaid Networks

GUIDING PRINCIPLE

Integrated models improve access to care and member experience across the diverse dually eligible population.

SUPPORTING PRINCIPLE

Members can access their Medicare and Medicaid benefits without delay.

Federal Requirements

Most Medicare and Medicare Advantage providers should be able to bill Medicaid for cost-sharing amounts if a service or item is covered by Medicare. States are required under federal law to have a mechanism to allow enrollment of all Medicare-enrolled providers and suppliers for the purposes of the state paying cost-sharing amounts. States can choose to use a limited enrollment option, meaning that these providers and suppliers can bill for Medicare cost-sharing without becoming full Medicaid providers.¹⁴

Alignment of D-SNP provider networks – meaning that D-SNP providers also enroll as full Medicaid providers – would significantly reduce disruptions in care. Justice in Aging hears of issues, for example, of disruptions as enrollees are asked to switch dentists, transportation vendors, and other providers mid-treatment in order to access Medicaid coverage after Medicare coverage runs out.

While CMS does not require all D-SNP network providers to enroll in full Medicaid, Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) must utilize aligned care management and specialty care network methods to coordinate the delivery of covered Medicare and Medicaid benefits for high-risk populations.¹⁵ Additionally, plans are required to work with the state to identify and share Medicaid provider participation information.¹⁶

D-SNPs and other MA plans with dually eligible enrollees must also abide by enrollee billing protection regulations. For example, plan provider contracts must require in-network providers to accept the plan's payment and any Medicaid payment of Medicare cost sharing as payment in full and prohibits in-network providers and suppliers from collecting any Medicare cost-sharing from certain dually eligible populations.¹⁷ Lastly, D-SNPs and their contracted network providers are prohibited from imposing cost sharing that exceed amounts permitted by the state Medicaid plan on full benefit dually eligible individuals and QMB enrollees.¹⁸

SMAC Recommendations

To ensure enrollees are able to access Medicaid State plan benefits when there is overlap with Medicare benefits including supplemental benefits (e.g., dental, vision, transportation, durable medical equipment, etc.) and avoid improper billing, states should require all D-SNPs to align their plan provider networks (including supplemental benefit provider / vendor lists) with the state Medicaid provider networks.

Template Language

Washington

Network alignment with Medicaid is a requirement in the Washington SMAC. The state requires Highly Integrated (HIDE) SNPs to align the plan provider network with the affiliated Medicaid Managed Care plan network. Lower integration plans such as Coordination Only D-SNPs without affiliated Medicaid Managed Care plans must work to contract with providers who also accept Medicaid. Additionally, Washington requires plans to provide a list of their provider network alignment percentages per county. For counties that do not meet desired alignment thresholds, the state mandates plans create an action plan with the goal to reach at least 80% alignment in those respective counties. HIDE SNPs that do not reach the state's alignment targets are not allowed to market their product.¹⁹

- In counties where the contractor (or another organization under the same parent company) has a Managed Care Medicaid contract, the contractor will align its Medicare network with its affiliated Integrated Managed Care Medicaid network, with respect to the Medicare required network provider types as defined by the state.
- By November 1 of each calendar year, the contractor will provide: a list of all counties and relative percentages for the next upcoming contract year showing the alignment percentage. In counties where less than 80% percent of their Medicaid providers for CMS critical specialties also contract for and accept Medicare members for the current plan year, the contractor will develop an action plan to reach at least 80% alignment by November 1.
- In counties where the contractor is considered Coordination Only, the contractor will work to contract with providers who also accept Medicaid clients.
- If the contractor is not at 80% in a county where the contractor is considered highly integrated and offers a Medicaid plan, they may not market their D-SNP to dually eligible members or utilize any information provided by the state for outreach purposes.²⁰

California

California requires D-SNPs that operate with exclusively aligned enrollment (EAE) to report the number of contracted Medicaid providers that are aligned with the affiliated Medicaid Managed Care Plan and that are also contracted as Medicare plan providers.²¹ For D-SNPs that offer dental supplemental benefits, the state requires plans to report overlap between the Medicare and Medicaid dental provider networks. Additionally, the state requires D-SNPs operating with EAE to analyze the available linguistic services available to enrollees in their provider networks.²²

- EAE D-SNPs must report to the state the percent and number of contracted Medicaid physicians and facilities for the D-SNPs aligned Medicaid managed care plan (MCP) that are also contracted Medicare physicians and facilities with the EAE D-SNP. The MCP network used for this calculation should just be for the plan aligned with the EAE D-SNP parent company. If the MCP is a prime plan, the calculation should reflect the prime plan's network. If the MCP is a delegate plan, the calculation should only reflect the delegate plan network.
- EAE D-SNPs will be required to analyze their linguistic services, which includes languages offered (American Sign Language inclusive) by the plan or by a skilled medical interpreter at the provider's office. This analysis should be with respect to differences between Medicare network providers and the specified Medicaid network providers. To demonstrate compliance with these requirements, plans must submit the Language Gap Assessment Deliverable including the following:
 - » A description of the gap analysis process;
 - » The languages for the service area;
 - » The specific languages offered by the plan for each service area;
 - » The plan for addressing the gaps in language services, by service area, including target dates for closing the gaps.
- Any D-SNP contractor that offers dental supplemental benefits must report to the state on the level of overlap for their Medicare dental network and the Medicaid dental network.²³

Additional SMAC Language

- D-SNP Contractor must appoint a Care Manager designee to assist enrollees who are improperly billed cost sharing by contracted providers. Assistance includes and is not limited to the Care Manager designee communicating with the contracted provider's billing department to ensure enrollees are reimbursed timely. The Care Manger designee shall be responsible to train and educate network providers to prevent improper billing and ensure enrollees are not discriminated against due to their dual eligibility status.²⁴

Provider Network Adequacy: Accurate Provider Directories

GUIDING PRINCIPLE

Integrated models safeguard consumer choice and enable informed and unbiased decision-making.

SUPPORTING PRINCIPLE

People dually eligible receive clear, accurate materials that enable informed enrollment decisions.

Federal Requirements

Per [42 CFR 422.111\(b\)\(3\)](#), MA plans are required to provide enrollees with access to specific network information including a list of providers and contractors where members can obtain services. Additionally, plans are required to meet the provider directory requirements outlined in [42 CFR 422.2267\(e\)\(11\)](#). This includes time frames to issue current and new enrollees with provider directories, and for updating information.²⁵ D-SNPs and other MA plans that offer prescription drug coverage must also follow the requirements in [42 CFR 423.128](#) and furnish enrollees with timely access to coverage information including the plan's pharmacy network. Per [42 CFR 422.107\(e\)\(1\)\(ii\)](#), D-SNPs that operate with exclusively aligned enrollment are also required to integrate Medicare and Medicaid content including and not limited to provider and pharmacy directories.²⁶

FEDERAL POLICY CHANGES

Recent federal policy changes aim to address some of the challenges with provider directories. For example, in 2025 CMS launched a centralized provider directory on Medicare Plan Finder, and during 2026 there is a temporary special enrollment period (SEP) to change plans if the provider directory is inaccurate.²⁷ Additionally, Congress just passed a law in 2026 that requires heightened standards for Medicare Advantage provider directories and, starting in 2028, will provide more robust cost-sharing protections for enrollees who receive care from a provider who was inaccurately listed on the directory.²⁸ However, given the scope of the issue, implementation of these changes at the federal level may be difficult or delayed.²⁹

SMAC Recommendations

To promote accuracy and transparency, states can go further than the federal requirements and exercise more oversight over D-SNP provider directories. For example, to ensure that enrollees have access to the same information listed on Medicare Plan Finder, states should require D-SNPs to list the plan identification number that matches the information on Medicare Plan Finder clearly on the plan website. States should also require plans to make clear in their directories which providers are accepting new enrollees, whether providers have the accommodations to meet enrollee needs, and delimit any restrictions on access. SMACs can also include a requirement that plans submit provider directory information to the state for approval before the information goes public.

Additionally, states can require D-SNPs to synchronize their plan directories with the state's Medicaid provider directory to ensure enrollees have access to timely information about aligned Medicare and Medicaid providers. States can also utilize SMACs to facilitate enrollee choice and require D-SNPs to include a directory for independent providers (e.g., independent contractor list for Long-Term Services and Support (LTSS)). Lastly, the SMAC should clearly stipulate the verification process that the state will utilize to confirm the validity and adequacy of the D-SNPs provider directory.

Template Language

Minnesota

In addition to requiring D-SNPs to report their network providers' capacity to accommodate enrollees with disabilities, Minnesota mandates plans include a range of important information in their provider directories including, and not limited to, the plan's care coordination system, and any restrictions that impact enrollee's freedom to choose and access providers.

- The directory shall include:
 - » Whether the network provider's office/facility has accommodations for enrollees with physical disabilities, including offices, exam room(s) and equipment.
 - » Whether the provider offers covered services via telehealth.
 - » Whether the provider is accepting new enrollees.
 - » Information that oral interpretation is available for any language and written information will be available in prevalent non-English languages.
 - » Information about how to access mental health, substance use disorder, Elderly Waiver, Home Care, dental, and Medical Emergency and Urgent Care services. The directory must include a statement on how an enrollee can request a listing of home care agencies and Personal Care Assistance Provider Agencies (PCPAs).
 - » A description of the Managed Care Organization's (MCO) D-SNP and the affiliated Medicaid Managed Care Plan Care Systems, Care Coordination systems, Case Management systems, and any other distinguishing information that will assist the enrollee in making a decision to enroll in the D-SNP product. If the MCO limits access to providers by use of a Care System model, the MCO must describe which providers are available to enrollees based on the Care System chosen.
 - » Information concerning the selection process, including a statement that the enrollee must select an MCO in which their primary care provider or specialist participates, if they wish to continue to obtain services from their provider.
 - » Any restrictions on the enrollee's freedom of choice among network providers.
 - » Any language required by the state in order to provide protection and additional information for consumers of health care.³⁰

Ohio

In Ohio, D-SNPs are required to receive prior state approval of their provider directories before publicly launching. Additionally, the state requires plans to guarantee that network providers are the same for both dual benefit and Medicaid only populations, effectively mandating plans contract with Medicaid providers. To ensure information is synchronized to match the state's Medicaid provider directory, plan directories must update information at the same frequency as the state. For long-term services and supports (LTSS), the SMAC requires plans to make available to enrollees a directory of independent providers that provide various LTSS services. Lastly, the SMAC specifies the oversight mechanism that the state will use to verify the validity and adequacy of the D-SNP provider directories.

- General
 - » The D-SNP's provider directory must include all of the D-SNPs network providers, and the Medicaid providers must be the same for both dual benefit and Medicaid only members.
 - » The D-SNP must ensure that the information in the D-SNP provider directory exactly matches the data in the state provider network management system for the D-SNPs network providers.
 - » The D-SNP's provider directory must be in the format specified by or otherwise prior approved by the state.
 - » The D-SNP's provider and pharmacy directory for dual benefit members must be developed based on the model materials provided by the state.
- Long-Term Services and Support Service Providers
 - » When a member expresses a preference for an independent (non-agency) provider for an eligible service identified on the member's person-centered care plan, the D-SNP must make available a directory of all independent providers of the following services:
 - Personal care;
 - Waiver nursing;
 - Home care attendant; and
 - State plan private duty nurse.
 - » The directory must be organized by service and location and clearly identify which providers are accepting new members.
 - » The D-SNP must offer members assistance with the provider enrollment process, incorporating easily understood guidance to facilitate provider enrollment into the state provider network management.
 - » The D-SNP's provider recruitment plan must include the recruitment of independent providers.
- Verification of Provider Network Information
 - » The state contracts with an external quality review organization (EQRO) to conduct telephone surveys of a statistically valid sample of providers' offices to verify information submitted to the state Medicaid system. The state will use these results to evaluate D-SNP performance.³¹

ENDNOTES

- 1 CMS, “[Provider Enrollment and Third Party Liability for Items and Services Rendered to Dually Eligible Individuals](#),” §3, p.7 (January 14, 2025) (Accessed February 10, 2026).
- 2 These requirements apply to network-based Medicare Advantage plans defined in 42 CFR 422.2 and do not include plans that are Medical Savings Accounts (MSA).
- 3 Per 42 CFR 422.2, D-SNPs must provide Part D prescription drug coverage.
- 4 These requirements apply to Medicare Advantage plans that are coordinated care plans (e.g., PPOs, HMOs, PSOs, etc.) as defined in 42 CFR 422.4. D-SNPs fall in this category.
- 5 Note that the upcoming final rule of the “Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program” will likely change this regulation.
- 6 [42 CFR 422.112\(a\)\(1\)\(iii\)](#).
- 7 For a robust discussion on the core responsibilities of a Care Manager, see Justice in Aging, “[Template Toolkit: Care Coordination for D-SNP State Medicaid Agency Contracts](#),” (Aug. 19, 2025).
- 8 For a robust discussion on health literacy and accessibility standards in D-SNP plan marketing materials, see Justice in Aging, “[Template Toolkit: Marketing and Communications for D-SNP State Medicaid Agency Contracts](#),” (May 5, 2025).
- 9 Washington State Health Care Authority, “[Amended and Restated State Medicaid Agency Contract](#),” §1.6.9, p. 44 (Rev. Mar. 13, 2026) (Accessed Jan. 26, 2026).
- 10 This language was adapted Massachusetts Executive Office of Health and Human Services (EOHHS), “[2023 One Care Model Contract](#),” §2.8.1, pp. 141-146 (2025) (Accessed Jan. 26, 2026).
- 11 *Id.* at 184.
- 12 Minnesota Department of Human Services (DHS), “[Model Template for 2026 Contracts with MCOs for Seniors](#),” §6.12 at 185, (January 1, 2026) (Accessed Feb. 4, 2026).
- 13 For a robust discussion on network adequacy and essential community providers, see MedPAC, “[Chapter 2: Provider Networks and Prior Authorization in Medicare Advantage](#),” pp. 72-73, (June 13, 2024) (Accessed Jan. 26, 2026).
- 14 CMS, “[Provider Enrollment and Third Party Liability for Items and Services Rendered to Dually Eligible Individuals](#),” §4 (January 14, 2025).
- 15 [42 CFR 422.2](#) “Fully integrated dual eligible special needs plan.”
- 16 [42 CFR 422.107\(c\)\(5\)](#); see also Ryan Stringer, et al., “[Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans \(D-SNPs\): Required Language Applicable to All Types of D-SNPs](#),” at pp. 6-7, Integrated Care Resource Center (Jan. 2025) (Accessed Jan. 24, 2026).
- 17 [42 CFR 422.107\(c\)\(4\)](#); [42 CFR 422.504\(g\)\(1\)\(iii\)](#); see also CMS, “[Provider Enrollment and Third Party Liability for Items and Services Rendered to Dually Eligible Individuals](#),” §3, p.6 (January 14, 2025) (Accessed February 10, 2026).
- 18 *Id.*
- 19 This language was adapted from the Washington State Health Care Authority, “[Amended and Restated State Medicaid Agency Contract](#),” §1.6, pp. 42-43 (Rev. Mar. 13, 2026) (Accessed Jan. 26, 2026).
- 20 *Id.*
- 21 For more information about exclusively aligned enrollment, see Shea, Kathleen et al., “[Introduction to Exclusively Aligned Enrollment](#),” Integrated Care Resource Center (June 2023) (Accessed Feb. 12, 2026)
- 22 D-SNP requirements to align with Medicaid provider networks can also serve to mitigate default enrollment. For more discussion on default enrollment and Medicaid provider alignment, see Justice in Aging, “[Eligibility, Enrollment, and Supplemental Benefits for D-SNP State Medicaid Agency Contracts](#),” p. 2 (May 2025).

- 23 This language was adapted from the CA Department of Health Care Services (DHCS), [“CALAIM Dual Eligible Special Needs Plan Policy Guide—Contract Year 2026,”](#) pp. 36-37 (Sept. 2025) (Accessed Jan. 28, 2026).
- 24 MA plans must ensure enrollees are not discriminated against due to their “source of payment” such as having cost sharing support from a Medicaid State Plan. For more information, see CMS, [“Medicare Managed Care Manual—Chapter 4,”](#) §10.5.2, pp. 13-14 (Rev. 121, Issued Apr. 16, 2016) (Accessed Feb. 2, 2026).
- 25 According to 42 CFR 422.2267(e)(11), MA plans must update provider directories anytime they have new information. Plans have 30 days after receiving the information to update both printed materials and online information.
- 26 For more information about the requirements for D-SNPs that operate with EAE to integrate materials including provider and pharmacy directories, see Justice in Aging, [“Marketing and Communications for D-SNP State Medicaid Agency Contracts: Integrated Materials and Processes,”](#) (May 5, 2025).
- 27 Medicare Rights Center, [Final Rule and New Special Enrollment Period will aid those misled by Provider Directories](#) (Sept. 2025).
- 28 Section 6220 of the Consolidated Appropriations Act of 2026.
- 29 See AARP, [Medicare Works to Fix Tech Glitches in New Plan Finder Tool](#) (Oct. 2025).
- 30 Language adapted from Minnesota Department of Human Services (DHS), supra note 12, at 56 (January 1, 2026) (Accessed Feb. 4, 2026).
- 31 Language adapted from Ohio Department of Medicaid, [“Next Generation MyCare Ohio Provider Agreement for MyCare Ohio Plan,”](#) Attachment A, pp. 236-239, (Accessed Feb. 04, 2026).