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TOOLKIT

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

REPORTING AND TRANSPARENCY REQUIREMENTS FOR STATE MEDICAID AGENCY CONTRACTS (SMACS)

October 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 VII of the toolkit provides an overview of the reporting and transparency requirements related to encounter data more broadly, and specifically, to data related to supplemental benefits and care coordination. All other sections of the toolkit are summarized below.

- Part I: Eligibility, Enrollment and Supplemental Benefits
- Part II: Marketing and Communications
- Part III: Care Coordination
- Parts IV: Member Engagement and Support (e.g., Enrollee Advisory Committees and Ombuds Programs)
- Part V: Member Rights (e.g., Maintaining Coverage and Appeals and Grievances)
- Part VI: Provider Network Adequacy

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.

REPORTING & TRANSPARENCY REQUIREMENTS

For many Medicare enrollees and their families, understanding the coverage rules and restrictions (e.g., provider networks, prior authorization, etc.) to access benefits under their Medicare Advantage (MA) plan is challenging enough. For dually eligible individuals navigating coverage rules and restrictions for both their Dual Eligible Special Needs Plan (D-SNP) and Medicaid coverage compounds the complexity.

To ensure transparency and accountability, states and the public need access to more information about how well D-SNPs administer and coordinate Medicare and Medicaid covered benefits. For example, there is limited publicly accessible information about plan-specific services related data, and the administration of plan supplemental benefits (e.g., dental, vision, hearing, transportation, etc.). In turn, there is a lack of information about plan performance presented in a way that dually eligible individuals and their families can evaluate performance when choosing a plan. To ensure dually eligible enrollees have enough information to make informed plan choices, and to support state oversight of D-SNP performance, required D-SNP data reporting is key.

GUIDING PRINCIPLE

Integrated models are held accountable through robust oversight.

SUPPORTING PRINCIPLE

State and federal governments commit adequate resources and personnel to program oversight and management to enable thorough oversight commensurate with the model's scope.

Encounter Data

Federal Requirements

According to 42 CFR 422.310, MA plans must submit to Centers for Medicare and Medicaid Services (CMS) all data related to the items and services provided to enrollees per provider type. This data is also known as risk adjustment data or MA encounter data.[1] CMS uses encounter data for specific purposes, including quality review and improvement, to determine the risk adjustment factors used to adjust payments, and to support Medicare and Medicaid program administration.[2] Additionally, the regulation describes the circumstances under which CMS will consider releasing this data.[3] For example, at its discretion, CMS may share encounter data with state Medicaid agencies for the purposes of coordinating care for dually eligible individuals.[4]

D-SNP-ONLY CONTRACTS AND QUALITY MEASURES

Many D-SNPs combine quality metrics with the data of other Medicare Advantage plans, making it difficult to evaluate individual plan performance. States can require EAE D-SNPs[5] to enter into "D-SNP-only" contracts.[6] D-SNP-only contracts ensure that quality measures and Medicare Star Ratings are evaluated solely on the D-SNP's performance and not combined with other non-D-SNP data.[7] This provides a much more accurate analysis of how well the D-SNP is performing specifically for its dual eligible members. Additionally, CMS grants access to its reporting system called the Health Plan Management System (HPMS), to states that operate D-SNP-only contracts. Access to HPMS metrics specific to each plan operating in the state facilitates better state oversight.[8]

SMAC Recommendations

To understand the full picture of how dually eligible individuals are utilizing services and accessing benefits, states should leverage their authority in 42 CFR 422.107 and require all D-SNPs, including minimally integrated Coordination Only D-SNPs (CO D-SNPs), to report MA encounter data to the state.[9] States should also provide D-SNPs with guidance on meeting encounter data accuracy standards and specify the consequences for noncompliance.

Template Language

Washington

Washington requires all D-SNPs to submit encounter data for all medical and pharmacy encounters without alterations on a monthly basis.[10]

Specific terms in Washington's SMAC include:

- Encounter data must be submitted to the state monthly, at a minimum, and no later than 30 calendar days from the end of the month in which the contractor submitted encounter data to CMS.
- The contractor will submit and maintain encounter data. Encounter data submitted should include medical and pharmacy encounters.[11]

Michigan

Michigan requires D-SNPs to submit all encounter data for which the plan incurred a financial liability and for the services eligible for processing where a financial liability was not incurred. This includes data on plan supplemental benefits. In addition, the state also requires D-SNPs to have in place an administrative staff position that ensures the plan collects enrollee demographic and geographic data to identify and address health disparities.

Encounter Data Quality Standards includes and is not limited to the following:

- Contractor must submit encounter data for enrollee health services where the contractor incurred a financial liability and must include encounters for services provided that were eligible to be processed but where no financial liability was incurred by contractor.
- Contractor must collect and maintain one hundred percent (100%) encounter data for each covered service and supplemental benefit services provided to enrollees, including encounter data from any sub-capitated sources.[12]

Quality Improvement and Utilization Director responsibilities include and are not limited to the following:

- Provide leadership in the design and implementation of contractor's strategies and programs to ensure health equity is prioritized and addressed, including but not limited to:
    - » Ensure the contractor collects and meaningfully uses demographic and geographic data (e.g., age, race, ethnicity, language, disability, sexual orientation, gender identity) to identify disparities.
    - » Develop targeted interventions designed to reduce health disparities and address health inequities.
    - » Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to reduce health disparities and address health inequities.[13]

Massachusetts

In addition to requiring D-SNPs to periodically report on all encounter data including all Medicare covered services, denials and Medicare supplemental benefits, Massachusetts requires plans to ensure a high level of data accuracy. The SMAC requires plans to cooperate with quarterly assessments of data submissions. Plans must also report data errors or other issues that impact encounter data compliance and submit to the state a remediation plan within a specified period. The SMAC also lays out consequences for plans that fail to satisfy data remediation plan requirements.

- Submit encounter data that is at a minimum of ninety-nine (99%) percent complete and ninety-five (95%) percent accurate. To meet the completeness standard, all critical fields in the data must contain valid values. To meet the accuracy standard, the contractor shall have systems in place to monitor and audit claims. The contractor shall also correct and resubmit denied encounters as necessary.
- Participate in, and be responsive to requests for information during, the states' quarterly assessment of the contractor's encounter data submissions.
- Notify the state, prior to encounter data submission, that the data is not complete or accurate.
- Submit for state approval, within a time frame established by the state which shall not exceed 30 days from the day the contractor identifies or is notified that it is not in compliance with the encounter data requirements, a data remediation action plan and timeline for resolution to bring the accuracy and completeness to an acceptable level.
- If the contractor fails to satisfy the data remediation plan requirements, the state may apply a capitation payment deduction.[14]

Supplemental Benefits Data

Federal Requirements

In recent years, CMS implemented a series of measures to improve collection of supplemental benefits encounter data. For example, CMS incorporated a requirement for MA plans to report expenditures for various categories of supplemental benefits through the Medical Loss Ratio (MLR) reports, added a new collection of data elements related to supplemental benefits cost and utilization among plan enrollees, and improved plan benefit package (PBP) categorization of supplemental dental services.[15] In the CY 2025 Medicare Advantage and Part D final rule, CMS created new guardrails for certain types of supplemental benefits only available to enrollees who are chronically ill.[16]

MA SUPPLEMENTAL BENEFITS DEFINED

MA supplemental benefits must meet CMS requirements including the requirement that the benefits are not covered by Medicare Parts A, B or D.[17] The categories of MA plan supplemental benefits can encompass a range of benefits including reduced cost sharing for Part A and B services, reduced Part B premiums, enhanced Part D benefits, and coverage of services not covered by Original Medicare (e.g., dental, vision and hearing services, etc.).[18] Fully Integrated (FIDE) and Highly Integrated (HIDE) SNPs that meet certain requirements may provide additional supplemental benefits if those benefits demonstrate better integration of care for enrollees.[19] However, FIDE and HIDE SNPs that offer additional supplemental benefits must offer these benefits without cost sharing or premium increases to enrollees.[20]

SMAC Recommendations

States can provide effective oversight of D-SNP performance by addressing the gaps in CMS encounter data regulations. For example, states should require D-SNPs to report to the state or designee supplemental benefits utilization data for all benefits offered including dental, vision, hearing, long-term services and supports, and for all services provided directly by the plan and any contracted vendors. Supplemental benefits utilization data should include disaggregated demographic data on enrollees who use the supplemental benefits (e.g., by age, race, ethnicity, language, type of disability, sexual orientation, gender identity, and geographic area).[21] For each supplemental benefit offered, states should also require plans to report data on actual out-of-pocket costs [22] among users per contract ID and by Medicare ID number.[23]

To better assess D-SNP supplemental benefits expenditures, states should require plans to report to the state or designee spending data for all supplemental benefits offered at the plan level. Expenditure reports should include detailed spending data for the different types of transactions that enrollees utilize within all supplemental benefit categories (e.g., within the dental benefit category, report on dental exams, cleanings, x-rays, etc.).[24] Additionally, state reporting requirements should mandate that D-SNP data distinguish between basic Medicare covered services or supplemental services and optional or mandatory supplemental benefits.[25]

While states must safeguard enrollee confidentiality, states can and should promote transparency by making some D-SNP data on supplemental benefits publicly available on a timely basis and in an accessible format. For example, states should consider creating a D-SNP data dashboard on the state website that shows a breakdown of each supplemental benefit offered by each D-SNP plan operating in the state, data on the supplemental benefits utilization rates per benefit category along with some demographic information on enrollee users of the benefits (e.g., by age, race, ethnicity, language, type of disability, sexual orientation, gender identity, and geographic area) and without personally identifying information such as Medicare ID numbers.[26]

Template Language

Ohio

Ohio requires D-SNPs to report encounter data for Medicare and Medicaid services for dually eligible enrollees. For value-added services such as plan supplemental benefits, the state requires plans to report these services using a distinct reporting template. Additionally, the SMAC requires data for services provided by subcontractors and providers or vendors that have "sub-capitated payment arrangements" with the D-SNPs. The state also requires D-SNPs to ensure a proper infrastructure with sufficient staffing to address data issues and errors.

- The contractor must collect data on services furnished to members through a claims system and must report encounter data to the state. For dual benefit members, the data must include Medicare and Medicaid services.
- All data on any services provided to members that are not reflected as claims or encounters will be submitted through the Value- Added Services Reporting Template. This includes but is not limited to care coordination, non-emergency transportation, Medicare supplemental benefits, and other value-added or additional services.
- For subcontracted payment arrangements in which the subcontractor directly pays particular claims (i.e., delegated arrangements in which the delegate is responsible for paying claims on behalf of the D-SNP to providers), the contractor must submit encounters that include the amounts paid by the subcontractor to the provider and include claim-level detailed information.
- For sub-capitated payment arrangements (i.e., the vendor/provider is paid a fixed amount regardless of whether or what services are rendered), the contractor must shadow price the encounter and submit encounters that include the amount that would have been paid if the vendor/provider was not capitated and include claim-level detailed information.
- The contractor must submit encounters no later than seven calendar days from completion of the claim (i.e., remittance advice generated). The D-SNP must submit encounters for capitated providers within seven calendar days of receipt of the encounter.
- The contractor must have processes and staffing to ensure that if the state discovers errors or a conflict with a previously adjudicated encounter or claim, the contractor is able to adjust or void the encounter within a specific number of days as directed by the state.[27]

Washington

Washington requires D-SNPs to develop a summary of value-added items and services in a format determined by the state. Plans are also required to share this information with the State Health Insurance Assistance Program (SHIP) for the purposes of educating Medicare enrollees during Medicare Open Enrollment. The state also requires plans to report any changes to their supplemental benefits or value-added items and services for the next contract year and provide a transition plan for impacted enrollees.[28]

Specific terms in Washington's SMAC include:

- The contractor will develop and provide a state-specific summary of supplemental benefits, and value-added items and services to assist with helping potential members make plan choices to the SHIP. This will be provided to the state via email annually in advance of open enrollment using the template provided by the state.
- If a plan is ending a supplemental benefit or value-added items and services in the next contract year, the contractor will provide notice to the state of the benefit that is ending, the number of individuals impacted by ending the benefit, and a clear explanation of how they will work with the beneficiary to transition.[29]

Additional SMAC Language

The contractor supplemental benefits encounter data reporting should clearly differentiate between basic Medicare covered services and plan supplemental services, optional and mandatory supplemental benefits.[30] Supplemental benefits encounter data reporting should also include disaggregated demographic data on enrollees who use the benefits.[31] The contractor shall report supplemental benefits encounter data that includes and is not limited to the following:

- Utilization data for all supplemental benefits offered (e.g., dental, vision, hearing, etc.) by the plan and by any subcontracted vendors.[32]
- Utilization data should be reported in the specific format requested by the state and should include enrollee user disaggregated demographic data (e.g., age, race, ethnicity, language, disability, sexual orientation, gender identity, and geographic area).[33]
- Data on out-of-pocket costs among enrollee users per plan contract ID and by enrollee Medicare ID number for each supplemental benefit offered.[34]
- Data on total out-of-pocket spending for all supplemental benefits offered at the plan level. This should include detailed spending data for the different types of transactions that enrollees utilize within all supplemental benefit categories. For example, within the dental supplemental benefit category, data should include dental exams, cleanings, x-rays, etc.[35]

Care Coordination Data

Federal Requirements

CMS requires D-SNPs to submit care management data, including on the health risk assessment (HRA) on an annual basis.[36]

SMAC Recommendations

Through SMACs, states can require D-SNPs to report on quality and care coordination measures beyond what is federally required. States can also include quality measures to evaluate additional care coordination responsibilities implemented in the SMAC.

States should utilize their contracting authority at 42 CFR 422.107 to require all D-SNPs including those with minimal levels of integration to submit care coordination data. To ensure states are able to monitor and assess how well plans are meeting the needs of the dually eligible population and supporting state integration goals, D-SNP care coordination reporting should include data on health risk assessment (HRA) responses stratified by age, race, ethnicity, language, disability, sexual orientation, gender identity, and geographic area; individualized care plan completion rates; and data on care transitions and discharge planning.[37] To promote transparency, states should develop a D-SNP data dashboard on the state website that incorporates care coordination data. The care coordination data dashboard should include the enrollee demographic information listed previously without personally identifying information such as Medicare ID numbers. The state should make the D-SNP care coordination data dashboard public on a timely basis and in an accessible format to facilitate its use by independent researchers, advocates, enrollees and their families, and other interested parties.[38]

Template Language

Minnesota

Minnesota requires D-SNPs to submit audit reports within specific time frames determined by the state on care plans, care coordination and case management services including those provided by subcontractors. These audits must follow appropriate sampling methodology and incorporate populations of enrollees receiving long-term services and supports waiver services and those not receiving waiver services.

- The D-SNP shall audit a sample of care plans for the various programs including those that provide waiver services to enrollees. The D-SNP may include non-waiver enrollees in the audit sample if a care plan is required for these enrollees by the plan. The sample must follow the appropriate sampling methodology. The D-SNP must use a protocol submitted to and approved by the state that follows the care planning audit data protocols. The D-SNP must collaborate with the state to ensure the protocol is compatible with the state system for long-term care services and supports (LTSS) assessments and can be used to conduct effective audits after LTSS implementation. This protocol incorporates requirements for waiver services and case management as appropriate for the enrollee.
- The D-SNP shall conduct reviews of care coordination/case management for enrollees covered under this contract. This review includes care coordination/case management provided through contracts with local agencies, tribal nations, clinic or primary care systems, community organizations, case management organizations, health plan staff or any other entity or individual that meets the requirements to provide care coordination/case management.
- Written audit reports of each reviewed contractor must be submitted by a date determined by the state during the contract year using the template developed jointly by the state and D-SNPs. The written reports must include a description of the organizational, service delivery, and case management structures, and the risk sharing arrangement between the D-SNP and each contractor that is reviewed. In addition, the written reports must include the process used by the MCO to conduct the review, any deficiencies and/or concerns raised during the review, and any corrective actions taken by either the D-SNP or by the contractor to address deficiencies and/or concerns raised during the review.[39]

California

California requires D-SNPs to report on a series of quality measures including and not limited to care coordinator to member ratio, members with a care plan completed within 90 days of enrollment, and the state-specific integrated care coordination system.

- Care Coordinator to Member Ratio
    - » Total number of full time equivalent (FTE) care coordinators working at the D-SNP as of the last day of the reporting period.

- Members with a Care Plan Completed within 90 Days of Enrollment
  - » Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period;
  - » Of the total reported, the number of members with a care plan completed within 90 days of enrollment.
- Integrated Care Management
  - » Total number of unique members who were currently enrolled in the D-SNP at the end of the reporting period and were identified as eligible for ICM services during the reporting period;
  - » Of the total reported as enrolled and identified eligible, the number of unique members who received ICM services during the reporting period;
  - » Of the total reported of members receiving ICM, the number of unique members who received an in-person care management interaction for ICM services during the reporting period;
  - » Please describe your plan's assumptions and process around reporting members eligible for and receiving ICM services.[40]

The state requires race and ethnicity stratification for select measures including those related to care coordination. Additionally, the state provides a publicly accessible dashboard showing a number of D-SNP data including enrollment demographics, health risk assessment percentages per plan, and care plan completion percentages per plan.[41]

- The state requires D-SNPs to report race/ethnicity stratifications for select quality measures as described in this contract. D-SNPs may use their data source of choice for reporting race/ethnicity. When submitting data files, plans are required to identify the source used for race/ethnicity stratifications in the correct tabs described per instructions in this contract. For select measures, D-SNPs must submit summary data stratified by the race and ethnicity categories identified by the state, and that align with NCQA standards.
- All D-SNPs must prepare and submit internally validated state-specific measures directly to the state, with EAE D-SNP results separate from non-EAE D-SNP results if the organization has both. MA results should be excluded if the plan has both MA and D-SNP PBPs.[42]

Additional SMAC Language

D-SNP contractors are required to submit to the state data stratified by age, race, ethnicity, language, disability, sexual orientation, gender identity, and geographic area for health risk assessment responses, individualized care plan completion rates, data on care transitions, and discharge planning during the designated reporting time frames specified in this contract.[43] The state will continue to engage with stakeholders via focus groups, surveys, and community engagement forums to identify other meaningful metrics to measure quality in Care Coordination.

ENDNOTES

1 For more information on the definition of encounter data, see CMS Customer Service and Support Center (CSSC), "Encounter Data Submission and Processing Guide," § 2.1 (May 2025) (Accessed April 2026).

2 See the full list at 42 CFR 422.310(f)(1).

3 42 CFR 422.310(f)(2).

4 42 CFR 422.310(f)(3)(v).

5 Per 42 CFR 422.2, D-SNPs with exclusively aligned enrollment (EAE) are those that limit enrollment to full-benefit dually eligible individuals who receive their Medicaid benefits from the plan or an affiliated Medicaid managed care plan offered by the same parent company as the D-SNP; see also Shea, Kathleen, et al., "Introduction to Exclusively Aligned Enrollment," Integrated Care Resource Center (June 2023) (Accessed April 8, 2026).

6 42 CFR 422.107(e).

7 Integrated Care Resource Center, "D-SNP-Only Contracts," slide 15 webinar PowerPoint (Mar. 19, 2024) (Accessed Apr. 8, 2026).

8 *Id.*, see also Medicare Advantage and Part D 2027 final rule at 91 FR 17542.

9 For a robust discussion on how states can leverage MA encounter data for oversight and quality improvement, see Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 2: Optimizing State Medicaid Agency Contracts," pp. 52 – 53 (June 2024) (Accessed April 17, 2026).

10 Language adapted from the Washington State Health Care Authority, "Amended and Restated State Medicaid Agency Contract," §1.15, pp. 52-53 (Rev. Mar. 13, 2026) (Accessed Apr. 21, 2026).

11 *Id.*

12 Language adapted from Michigan Department of Health & Human Services, "Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) State of Work Contract Activities Ver. 2.0," p. 220 (2026) (Accessed Apr. 27, 2026).

13 *Id.* at 232.

14 This language was adapted from the Massachusetts Executive Office of Health and Human Services (EOHHS), "Amended and Restated One Care Contract CCA," §2.15.2, pp. 281-285 (Jan. 2026) (Accessed Jun. 15, 2026).

15 CMS, "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records—Reminders, Other Supplemental Service Updates, and Frequently Asked Questions (FAQs)," (Nov. 12, 2024) (Accessed Apr. 23, 2026); see also MedPAC, "Chapter 2: Supplemental Benefits in Medicare Advantage," p.72-74 (June 2025) (Apr. 22, 2026).

16 Medicare Advantage and Part D 2025 final rule at 89 FR 30451.

17 42 CFR 422.100(c)(2)(ii); 42 CFR 422.102.

18 MedPAC, "Chapter 2: Supplemental Benefits in Medicare Advantage," p.63 (June 2025) (Apr. 22, 2026).

19 42 CFR 422.102(e)

20 *Id.*

21 This is based on the robust discussion on the limitations of the CMS encounter data regulations at MedPAC, "Chapter 2: Supplemental Benefits in Medicare Advantage," p.72-74 (June 2025) (Apr. 22, 2026).

22 For more information on the enrollee cost-sharing for mandatory and optional supplemental benefits, see CMS, "Medicare Managed Care Manual Chapter 4," § 10.3 (Issued Apr. 22, 2016) (Accessed Jun. 15, 2026); see also 42 CFR 422.102(e) for more information on the supplemental benefits for certain D-SNPs that must be offered without cost-sharing.

23 See The Commonwealth Fund, "CMS–4207–NC; Request for Information: Medicare Advantage Data," p. 3 (May 16, 2024) (Accessed Apr. 24, 2026).

24 This is based on the robust discussion on the limitations of the CMS encounter data regulations at Fuglesten Biniek, Jeannie, et al., "Gaps in Medicare Adantage Data Remain Despite CMS Actions to Increase Transparency," (Apr. 10, 2024) (Accessed Apr. 24, 2026).

25 This is based on the robust discussion on the limitations of the CMS encounter data regulations at MedPAC, "Chapter 2: Supplemental Benefits in Medicare Advantage," p.63 (June 2025) (Apr. 22, 2026); see also 42 CFR 422.102 for a definition of optional and mandatory supplemental benefits.

26 California provides a publicly accessible D-SNP dashboard that provides an overview of plan enrollment data along with some enrollee demographic information. California's dashboard can serve as a model for presenting D-SNP supplemental benefits data. See California DHCS, "Dual-Eligible Special Needs Plan Dashboard," 2024 Q4 (Accessed May 29, 2026).

27 Language adapted from Ohio Department of Medicaid, "Next Generation MyCare Ohio Provider Agreement for MyCare Ohio Plan," Attachment A, pp. 296-298, (Accessed Apr. 21, 2026).

28 Language adapted from the Washington State Health Care Authority, "Amended and Restated State Medicaid Agency Contract," §1.15, pp. 52-53 (Rev. Mar. 13, 2026) (Accessed Apr. 21, 2026).

29 *Id.*

30 This is based on the robust discussion on the limitations of the CMS encounter data regulations at MedPAC, "Chapter 2: Supplemental Benefits in Medicare Advantage," p.63 (June 2025) (Apr. 22, 2026); see also 42 CFR 422.102 for a definition of optional and mandatory supplemental benefits.

31 This is based on the robust discussion on the limitations of the CMS encounter data regulations at MedPAC, "Chapter 2: Supplemental Benefits in Medicare Advantage," p.72-74 (June 2025) (Apr. 22, 2026).

32 *Id.*

33 *Id.*

34 See The Commonwealth Fund, "CMS–4207–NC; Request for Information: Medicare Advantage Data," p. 3 (May 16, 2024) (Accessed Apr. 24, 2026).

35 This is based on the robust discussion on the limitations of the CMS encounter data regulations at Fuglesten Biniek, Jeannie, et al., "Gaps in Medicare Adantage Data Remain Despite CMS Actions to Increase Transparency," (Apr. 10, 2024) (Accessed Apr. 24, 2026).

36 CMS, "Medicare Part C Reporting Requirements: Technical Specifications Document Contract Year 2026," §4 (Updated Dec. 2025) (Accessed Apr. 29, 2026); see also Stringer, Ryan, et al., "Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans (D-SNPs): Optional Language Applicable to All D-SNPs," pp. 18-19 Integrated Care Resource Center (Updated Jan. 2025) (Accessed Apr. 29, 2026).

37 Based on the robust discussion of how states can utilize care coordination data to monitor D-SNP performance in Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 2: Optimizing State Medicaid Agency Contracts," p. 45 (June 2024) (Accessed May 8, 2026).

38 *Id.*

39 Language adapted from Minnesota Department of Human Services, "BluePlus MSHO/MSC+ contract," § 7.8 (Jan. 1, 2026) (Accessed Jun. 15, 2026).

40 Language adapted from California DHCS, "CALAIM Dual Eligible Special Needs Plan Policy Guide—Contract Year 2026," pp. 53 - 55, (Feb. 2026) (Accessed May 29, 2026).

41 California DHCS, "Dual-Eligible Special Needs Plan Dashboard," 2024 Q4 (Accessed May 29, 2026).

42 Language adapted from California DHCS, "CALAIM Dual Eligible Special Needs Plan Policy Guide—Contract Year 2026," pp. 50 - 51, (Feb. 2026) (Accessed May 29, 2026).

43 For a robust discussion on how states can leverage care coordination data for oversight and quality improvement, see Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 2: Optimizing State Medicaid Agency Contracts," pp. 45 – 51 (June 2024) (Accessed April 17, 2026).