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State Medicaid Agency Contracts

Interviews with key stakeholders

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Overview

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- Key themes
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  - SMAC authority
  - Data and reporting
  - Monitoring and oversight
  - Performance improvement and enforcement
- Next steps

Background

Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs)

- Medicare Advantage D-SNPs are a type of special needs plan designed to provide targeted care to dually eligible beneficiaries
- D-SNPs are different from other Medicare Advantage or special needs plans because they are required to contract with state Medicaid agencies
- Levels of Medicaid-Medicare integration in a D-SNP vary
- In 2021, 54 percent of dually eligible beneficiaries enrolled in Medicare managed care were enrolled in a D-SNP
  - The majority are in coordination-only D-SNPs, which typically provide minimal levels of integration

State Medicaid Agency Contracts (SMACs)

- Minimum requirements for coordination of Medicaid benefits were established for D-SNPs by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)
  - Additional requirements, including those defining higher integration plans, were included in the Bipartisan Budget Act of 2018 (P.L. 115-123)
- States can go beyond these requirements to require greater integration or better tailor how D-SNPs serve their population
- The federal government has established minimum requirements, such as information sharing regarding care transitions

Conducting Interviews

Methodology

- Case study states
  - California
  - District of Columbia
  - Idaho
  - Minnesota
  - New Jersey
- Interviewees
  - Federal officials at the Centers for Medicare & Medicaid Services (CMS)
  - State Medicaid officials
  - Health plan representatives

Key Themes

Contracting Considerations

- CMS requires a SMAC for D-SNPs to operate, but states are not required to contract with every plan
- States consider whether contracting with a D-SNP would strengthen Medicaid and Medicare alignment
  - All case study states require exclusively aligned enrollment
- States also said they prioritize limiting disruptions for beneficiaries in regard to plan enrollment
- Input from health plans
  - State staff meet regularly with D-SNPs to solicit feedback on planned changes to SMAC requirements
  - Health plan representatives noted that SMAC approval timelines can be difficult to reconcile with Medicare deadlines

SMAC Authority

- CMS officials said states are free to include any requirements as long as they do not conflict with federal law
- However, state officials were mixed on their perceptions of the level of flexibility
- States also said certain factors imposed operational limits on what they could feasibly require in their SMAC
  - Staff capacity
  - Lack of Medicare knowledge

Data and Reporting

- All case study states require data and reports related to:
  - appeals and grievances,
  - provider networks,
  - care coordination, and
  - enrollment and disenrollment.
- States noted that strong relationships with the D-SNPs allowed them to request other data not required in the SMAC
- Health plan representatives noted challenges in meeting data reporting requirements due to delays in guidance from states, as well as the potential for administrative burden from state-specific operational requirements and unaligned enrollment

Data and Reporting, continued

- States and CMS said that care coordination data were useful in assessing program health and plan performance
  - Includes information related to health risk assessments, individualized care plan completion rates, care transitions, and discharge planning
- CMS requires D-SNPs to submit a variety of data and reports for purposes of Medicare oversight
  - Such data may be useful to states in evaluating D-SNP performance and for care coordination, but states must require these data in their SMAC to receive it
- Several states require Medicare Advantage encounter data
  - State capacity to use these data is limited, but officials expressed interest in building capacity to do so

Monitoring and Oversight

- CMS oversees compliance with Medicare requirements while states primarily oversee delivery of Medicaid services, particularly long-term services and supports
- States use data and reports to monitor and oversee D-SNPs. However, due to limited staff capacity, reports are frequently checked only for timeliness, completion, and accuracy.
- Staff capacity limits what data can be used for oversight and states are reluctant to include additional requirements without sufficient capacity to oversee them
  - Small core teams lead oversight efforts with support from other teams across departments and agencies
- Data on appeals and grievances and care coordination are commonly used to identify problems with plan performance

Performance Improvement and Enforcement

- States described a number of enforcement mechanisms available to ensure plan compliance with SMAC requirements
- Penalties
  - Corrective action plans
  - Fines and monetary damages
  - Public data dashboards of plan performance
- Few states include financial incentives for D-SNPs in their SMACs
  - Officials cited a lack of resources and clear quality benchmarks
- CMS said that enforcement tools should be included in the SMAC in order to be most effective

Next Steps

- Items for discussion:
  - What are the considerations for states in terms of monitoring and enforcing their SMAC authority? What burden do additional requirements place on states?
  - How should states build upon care coordination requirements included in the D-SNP Model of Care?
  - Do Medicare Advantage encounter data provide enough value to states given limited state capacity?
- Depending on Commissioner interest, we will return in March with policy options

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