Chapter 2:

Optimizing State Medicaid Agency Contracts

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Recommendations

2.1 State Medicaid agencies should use their contracting authority at 42 CFR 422.107 to require that Medicare Advantage dual eligible special needs plans (D-SNPs) operating in their state regularly submit data on care coordination and Medicare Advantage encounters to the state for purposes of monitoring, oversight, and assurance that plans are coordinating care according to state requirements. If states were required by Congress (as previously recommended by the Commission) to develop a strategy to integrate Medicaid and Medicare coverage for their dually eligible beneficiaries, states that include D-SNPs in their integration approach should describe how they will incorporate care coordination and utilization data and how these elements can advance state goals.

2.2 The Centers for Medicare & Medicaid Services should update guidance that supports states in their development of a strategy to integrate care that is tailored to each state's health coverage landscape. The guidance should also emphasize how states that contract with Medicare Advantage dual eligible special needs plans can use their state Medicaid agency contracts to advance state policy goals.

Key Points

- People who are dually eligible for Medicaid and Medicare may experience fragmented care and poor health outcomes when their benefits are not coordinated. Integrated care is an approach meant to align the delivery, payment, and administration of Medicaid and Medicare services for individuals eligible for both programs.
- Medicare Advantage (MA) dual eligible special needs plans (D-SNPs) are the primary source of integrated coverage for dually eligible beneficiaries. D-SNPs are available in 45 states and the District of Columbia, enrolling more than 40 percent of the 12.8 million people who are dually eligible. The level of integration offered in these plans can vary greatly.
- Federal law sets minimum requirements that define how D-SNPs coordinate and cover Medicaid benefits, yet states may impose additional requirements to further integration through the state Medicaid agency contract (SMAC). D-SNPs are required to sign a SMAC to operate within a state, which means that state Medicaid agencies can greatly affect the care a D-SNP delivers.
- Although more states are leveraging their contracting authority, state adoption of SMAC provisions is uneven.
- States may require D-SNPs to submit a variety of data reports, including Medicare data. These reports are typically reviewed for timeliness, completeness, and accuracy rather than used to measure health plan performance or shape policymaking. State officials shared that limited staff capacity and a lack of Medicare expertise hinder their ability to monitor and oversee D-SNP performance. These challenges constrain how the state imposes additional requirements through their SMACs.
- Care coordination is central to the D-SNP model. State and federal officials described data on care coordination as key for evaluating D-SNP performance as well as the value of MA encounter utilization data for informing care coordination efforts. Currently, states struggle with these data, particularly ingesting and analyzing MA encounter data. However, in the Commission's view, these data are necessary for states to improve integrated care. States should prioritize these data in directing resources to their monitoring and oversight efforts and consider them if states were required to develop an integration strategy.
- The Commission also recommends that the Centers for Medicare & Medicaid Services update guidance to inform states about available integrated care models and how states can use SMACs to advance state goals.

CHAPTER 2: Optimizing State Medicaid Agency Contracts

Dually eligible beneficiaries are people eligible for both Medicaid and Medicare. They may experience fragmented care and poor health outcomes when their benefits are not coordinated (CMS 2023a). The most widely available vehicles for integrating Medicaid and Medicare benefits are Medicare Advantage (MA) dual eligible special needs plans (D-SNPs), which operated in 45 states and the District of Columbia in 2023 (CMS 2023b). To operate, D-SNPs must sign a state Medicaid agency contract (SMAC) that details the federal minimum requirements describing how the D-SNP must coordinate Medicaid services for beneficiaries, as well as additional requirements the state chooses to include. This authority affords state Medicaid programs great influence on the care a D-SNP delivers in their state.

Although efforts to enroll dually eligible beneficiaries in integrated care models have spread, the share of individuals enrolled in integrated care remains about 21 percent of the country's full-benefit dually eligible population, or 1.75 million full-benefit dually eligible beneficiaries in 2022 (CMS 2023a).[1] For those who are enrolled in integrated care, most are enrolled in a D-SNP. In 2021, of full-benefit dually eligible beneficiaries receiving their Medicare benefits exclusively from managed care, 60 percent were enrolled in a D-SNP (MACPAC and MedPAC 2024). Notably, not all individuals enrolled in a D-SNP receive fully integrated care, as the majority of these plans meet only minimum federal requirements on coordinating a beneficiary's Medicaid benefits.

In the Commission's previous reports to Congress, we highlighted the benefits of integrated care, several barriers that states face in developing these models, and the strategies available to states to integrate care through their contracts with D-SNPs. Through interviews with states and federal officials, we found that many contracting strategies were not widely used across states (MACPAC 2021). Building on that work, we set out to better understand the degree to which states use their contracting authority to promote care coordination and integrate care for their dually eligible beneficiaries, as well as to understand how states consider, oversee, and enforce their contracts.

Over the past year, we have reviewed SMACs and interviewed stakeholders about the tools and requirements that state Medicaid agencies have for overseeing their contracts with D-SNPs. Interviewees in selected states shared how they choose whether to contract with a D-SNP, the types of requirements they include in their contracts, and how they oversee and enforce those requirements. Although the states we studied, which all require moderate to high levels of integration for D-SNPs, include a broad array of requirements in their contracts, interviewees identified two key elements for overseeing plan performance and developing a fuller understanding of the health of D-SNP enrollees: data on care coordination and MA encounters.

Through these interviews, states also raised a lack of state capacity as the primary barrier for setting and overseeing additional requirements in their contracts with D-SNPs as well as the importance of securing buy-in from state leadership before implementing new requirements. These barriers mirror the overarching challenges that states face in integrating care for their dually eligible populations, which the Commission has raised repeatedly since 2020. In its June 2020 report to Congress, the Commission recommended that Congress provide additional funds to enhance state capacity to develop Medicare expertise and to implement integrated care models. In its June 2022 report to Congress, recognizing that states are at different stages of integrating care for their dually eligible populations, the Commission recommended that Congress require all states to develop a strategy to integrate Medicaid and Medicare coverage with additional federal funding to support that effort.

With these recommendations, we seek to provide states with a starting point for optimizing and overseeing their D-SNP contracts and to understand how integrated care may best fit their circumstances. We recommend that states use their contracting authority to require that D-SNPs submit data on care coordination and MA encounters given the

identified usefulness of these two types of data and their applicability to D-SNPs of all integration levels. Additionally, we recommend that the Centers for Medicare & Medicaid Services (CMS) provide guidance to support states in developing a strategy to integrate care that fits each state's health coverage landscape, including how states can leverage their SMACs to advance state policy goals.

In this chapter, the Commission recommends the following:

2.1 State Medicaid agencies should use their contracting authority at 42 CFR 422.107 to require that Medicare Advantage dual eligible special needs plans (D-SNPs) operating in their state regularly submit data on care coordination and Medicare Advantage encounters to the state for purposes of monitoring, oversight, and assurance that plans are coordinating care according to state requirements. If states were required by Congress (as previously recommended by the Commission) to develop a strategy to integrate Medicaid and Medicare coverage for their dually eligible beneficiaries, states that include D-SNPs in their integration approach should describe how they will incorporate care coordination and utilization data and how these elements can advance state goals.

2.2 The Centers for Medicare & Medicaid Services should update guidance that supports states in their development of a strategy to integrate care that is tailored to each state's health coverage landscape. The guidance should also emphasize how states that contract with Medicare Advantage dual eligible special needs plans can use their state Medicaid agency contracts to advance state policy goals.

Background

In 2021, 12.8 million individuals were dually eligible for Medicaid and Medicare (MACPAC and MedPAC 2024). Most were full-benefit dually eligible beneficiaries (73 percent), who qualify for full Medicaid benefits, in addition to Medicare benefits. Partial-benefit dually eligible beneficiaries—whose only form of Medicaid coverage is assistance with paying Medicare premiums (and in many cases cost sharing through the Medicare Savings Programs)—made up the other 27 percent (MACPAC and MedPAC 2024). Medicaid and Medicare offer dually eligible beneficiaries different benefits. Medicare serves as the primary payer for services that overlap with those offered by Medicaid, providing coverage for services such as inpatient hospital care and physician services, while Medicaid covers long-term services and supports (LTSS) and other services that Medicare does not such as certain behavioral health services.

Even as the dually eligible population has grown, the number of beneficiaries enrolled in integrated care products remains relatively small. In 2022, about 21 percent of full-benefit dually eligible beneficiaries, or 1.75 million individuals, were enrolled in integrated products under managed care arrangements (CMS 2023a). Although partial-benefit dually eligible beneficiaries may also be enrolled in some integrated care products, efforts tend to focus on full-benefit dually eligible beneficiaries because they have full Medicaid coverage to coordinate with Medicare coverage (MACPAC 2022).

Although use of managed care by dually eligible beneficiaries is growing, most still receive coverage of their Medicaid services through fee for service (FFS). About half of states do not enroll their dually eligible population in Medicaid managed care, and a number of states that enroll dually eligible beneficiaries in Medicaid managed care do so at the beneficiary's election. In 2021, 40 percent of dually eligible beneficiaries were enrolled exclusively in Medicaid FFS, and 17 percent were enrolled in Medicaid FFS with a limited-benefit Medicaid managed care plan (MACPAC and MedPAC 2024). In 2021, only 30 percent of full-benefit dually eligible individuals had at least one month of simultaneous enrollment in Medicare managed care (i.e., MA) and comprehensive Medicaid managed care (Table 2-1).[2] Enrollment in a managed care product for a dually eligible individual's Medicaid or Medicare benefits does not necessarily equate to integrated care because the enrollee's benefits may still not be coordinated between health plans and across Medicaid and Medicare.

TABLE 2-1. Overlap between Medicare and Medicaid Managed Care Enrollment for Dually Eligible Beneficiaries, 2021

Enrollment status	Dually eligible beneficiaries				
	Total	Under age 65	Age 65 and older	Full benefit	Partial benefit
At least one month of simultaneous enrollment in Medicare managed care and comprehensive Medicaid managed care	**25%**	22%	26%	30%	10%
Some enrollment in Medicare managed care and/or comprehensive Medicaid managed care, but never in the same month	**48**	44	49	44	58
No months of enrollment in either Medicare managed care or comprehensive Medicaid managed care	**28**	33	25	27	31

Notes: Exhibit includes all dually eligible beneficiaries (fee for service, managed care, and end-stage renal disease). Medicare managed care includes Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative, Programs of All-Inclusive Care for the Elderly (PACE), and Medicare Advantage plans. Percentages may not sum to 100 due to rounding.

Source: Medicare Payment Advisory Commission (MedPAC) and MACPAC, 2024, Exhibit 13: Overlap between Medicare and Medicaid managed care enrollment for dual-eligible beneficiaries, CY 2021, In *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*.

D-SNPs are the primary source of integrated coverage for dually eligible beneficiaries. Some states have other integrated products such as Medicare-Medicaid plans (MMPs) under the Financial Alignment Initiative (FAI) or Programs of All-Inclusive Care for the Elderly (PACE). The MMPs cover nearly all Medicaid and Medicare benefits under a single health plan. PACE also covers both sets of benefits and provides adult day services for people who are age 55 and older and qualify for a nursing facility level of care but can live safely in the community. Although these programs both offer fully integrated coverage, they enroll fewer people than D-SNPs. In 2023, about 300,000 dually eligible beneficiaries were enrolled in MMPs, and 71,000 were enrolled in PACE (ICRC 2023, NPA 2023).[3]

D-SNPs

D-SNPs are one of three types of MA special needs plans (SNPs) that are designed to provide coverage tailored to a specific population.[4] People enrolled in D-SNPs are dually eligible for both Medicaid and Medicare. In 2023, D-SNPs were available in 45 states and the District of Columbia.[5]

In 2019, CMS finalized regulations for D-SNPs that updated classifications of plans depending on their level of integration (CMS 2019a). Today, three types of D-SNPs contract with states and offer varying levels of integration: coordination-only dual eligible special needs plans (CO D-SNPs), highly integrated dual eligible special needs plans (HIDE SNPs), and

fully integrated dual eligible special needs plans (FIDE SNPs). CO D-SNPs are the most common type of D-SNP. They coordinate Medicaid services but typically do not cover Medicaid benefits. Each of these D-SNP types may also be designated as an applicable integrated plan (AIP) if they operate with exclusively aligned enrollment (EAE). If a state requires EAE, D-SNPs may enroll only full-benefit dually eligible beneficiaries who are enrolled in a Medicaid managed care plan under the same parent organization as the D-SNP or who receive their Medicaid benefits directly from the D-SNP itself. AIPs must create a unified appeals and grievance process for their enrollees.

Beginning in 2021, D-SNPs are designated as HIDE SNPs if they have a contract with the state Medicaid agency to cover either LTSS or behavioral health services or both.[6] HIDE SNPs provide moderate levels of integration for beneficiaries. As of December 2023, HIDE SNPs are available in 15 states and the District of Columbia, enrolling more than 1.8 million beneficiaries, or about 35 percent of all dually eligible beneficiaries enrolled in D-SNP products (CMS 2023b).

D-SNPs are designated as FIDE SNPs if they cover both LTSS and behavioral health services, in addition to other Medicaid benefits under their SMACs, unless the state carves behavioral health services out of the capitation rate.[7] FIDE SNPs provide the highest level of integration in a D-SNP. Enrolling about 421,000 beneficiaries in 12 states or about 8 percent of dually eligible beneficiaries in D-SNP products, these plans must cover nearly all Medicaid and Medicare benefits (CMS 2023b, MACPAC 2020a).[8]

In 2021, 46 percent of individuals dually eligible for Medicaid and Medicare services were enrolled in managed care for their Medicare benefits for the entire year, and of that group, most received coverage through D-SNPs (MACPAC and MedPAC 2024). Among dually eligible individuals who were enrolled only in Medicare managed care, about half were enrolled in D-SNPs (54 percent) (Table 2-2). Full-benefit dually eligible beneficiaries were more likely to enroll in D-SNPs (60 percent), while those with partial-benefit dual eligibility were more likely to enroll in other types of plans (57 percent).

TABLE 2-2. Medicare Managed Care Enrollment Among Dually Eligible Beneficiaries, 2021

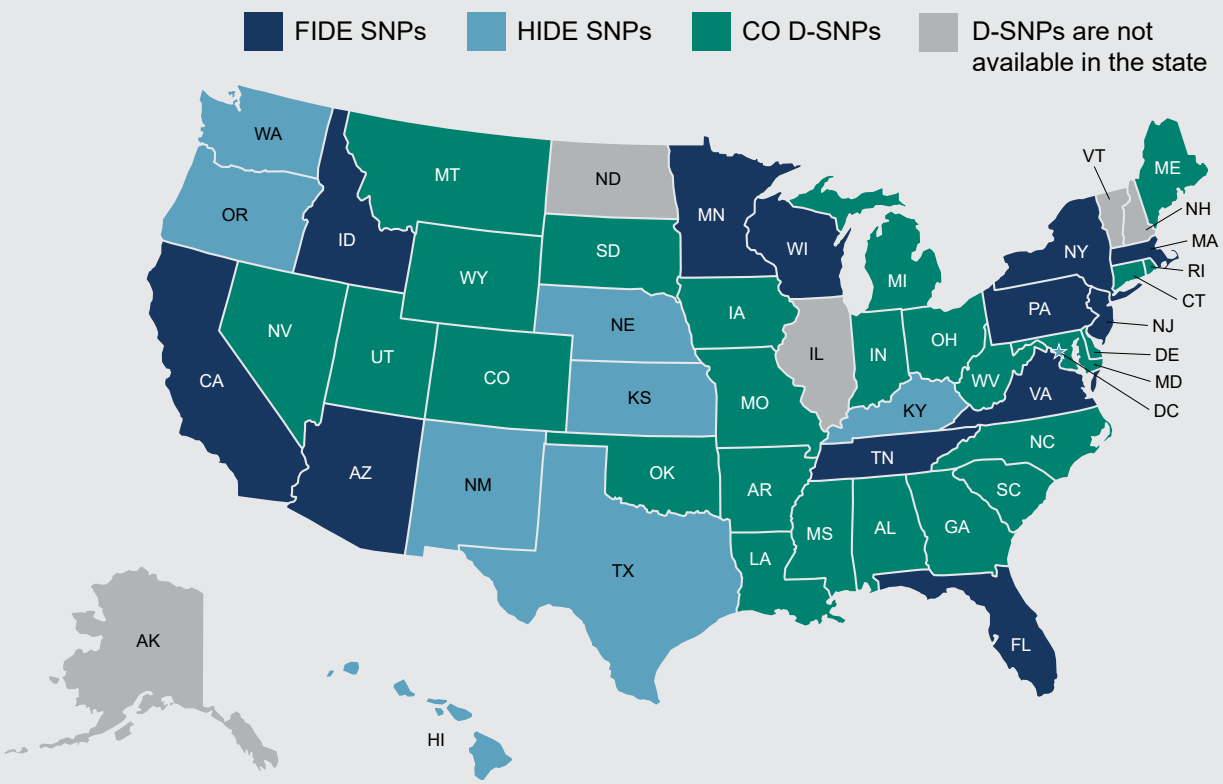
Type of Medicare enrollment among individuals enrolled in managed care only	Dually eligible beneficiaries					Non-dual Medicare beneficiaries
	Total	Under age 65	Age 65 and older	Full benefit	Partial benefit	
D-SNP	**54%**	59%	52%	60%	43%	<1%
Other Medicare managed care	**46**	41	48	40	57	100
Total	**100**	**100**	**100**	**100**	**100**	**100**

Notes: D-SNP is dual eligible special needs plan. All numbers are percentages. D-SNPs include coordination-only dual eligible special needs plans (CO D-SNPs), highly integrated dual eligible special needs plans (HIDE SNPs), and fully integrated dual eligible special needs plans (FIDE SNPs). Other Medicare managed care plan types include: Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative; Programs of All-Inclusive Care for the Elderly (PACE); and other Medicare Advantage plans, including other types of special needs plans and non-D-SNP Medicare Advantage plans.

Source: Medicare Payment Advisory Commission (MedPAC) and MACPAC, 2024. *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*.

Enrollment in D-SNPs has increased steadily since they first began operating in 2006 (Archibald et al. 2019).[9] As of December 2023, more than 40 percent of the 12.8 million people who are dually eligible were enrolled in D-SNPs (CMS 2023b).[10] The majority of D-SNP enrollees, 54 percent, were enrolled in minimally integrated CO D-SNPs and the remainder were enrolled in HIDE SNPs or FIDE SNPs (CMS 2023b). See Figure 2-1 and Figure 2-2 for the availability of integrated plan types by state and state-level requirements for EAE.

FIGURE 2-1. Most Integrated Dual Eligible Special Needs Plan Available by State, 2023

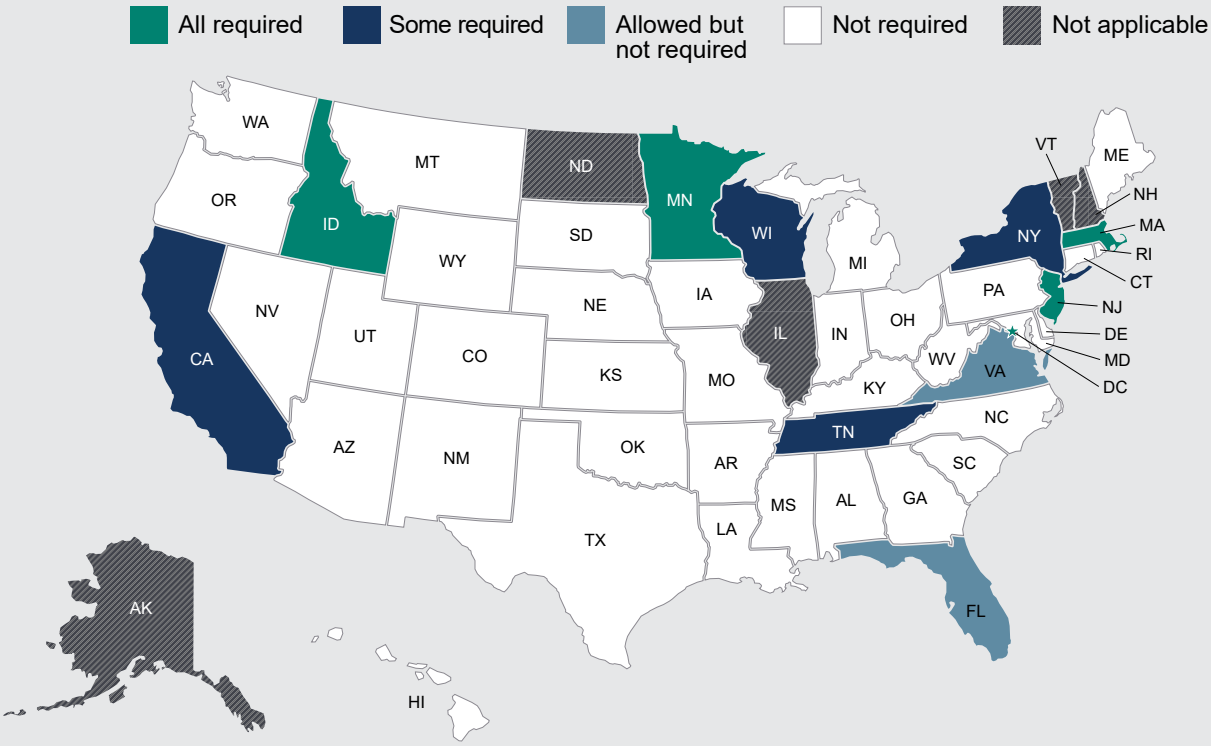


Notes: FIDE SNP is fully integrated dual eligible special needs plan. HIDE SNP is highly integrated dual eligible special needs plan. CO D-SNP is coordination-only dual eligible special needs plan. This figure shows the most integrated type of D-SNP available in the state or District of Columbia as of February 2023. Puerto Rico is excluded from this figure. States may contract with more than one type of D-SNP, but plans are not always available statewide. HIDE SNPs were first available starting in 2021.

Washington does not have comprehensive Medicaid managed care for dually eligible beneficiaries, but it does have HIDE SNPs formed by aligning D-SNPs with organizations that cover behavioral health services.

Source: CMS 2023b.

FIGURE 2-2. Exclusively Aligned Enrollment Requirements for Dual Eligible Special Needs Plans by State, 2023



Notes: States are categorized by whether they require exclusively aligned enrollment (EAE) for all dual eligible special needs plans (D-SNPs) operating in the state, for only some plans, or for those without requirements. Not applicable indicates states that do not have D-SNPs. Florida and Virginia do not require D-SNPs to use EAE, but both states allow plans to use this tool, and there are plans in each state that have EAE. In Virginia, plans may establish separate plan benefit packages for different populations that would allow for EAE. In Florida, highly integrated dual eligible special needs plans (HIDE SNPs) that limit enrollment to full-benefit individuals have EAE because the state Medicaid agency directly contracts with those plans to cover Medicaid benefits. However, HIDE SNPs in the state are not required to limit enrollment. Puerto Rico is excluded from this figure.

Source: MACPAC analysis of contract year 2023 state Medicaid agency contracts, CMS 2023c.

Model of care. To operate, D-SNPs must have an approved model of care (MOC), which federal law requires all SNPs to have and which describes the basic framework for how the plan will meet the needs of its enrollees (§1859(f)(7) of the Social Security Act).[11] The requirement for an approved MOC differentiates SNPs from other MA plans, which do not develop models of care (42 CFR 422.101(f)). The MOC is a tool that ensures that the plan has identified the needs of its enrollees and is addressing them through its care management practices (CMS 2023d). The MOC must be approved by the National Committee for Quality Assurance (NCQA). The Secretary of the U.S. Department of Health and Human Services (HHS) sets the standards for how the MOC is scored by NCQA, including clinical and non-clinical elements. The MOC is scored in four areas: description of the population served, care coordination, provider network, and MOC quality measurement and performance improvement. Each of the four areas contain detailed scoring guidelines on how the requirements will be assessed by NCQA. SNPs are required to develop MOCs based on the specific populations they serve and their own organizational structure and operations. For example,

for the description of the population standard, SNPs are required to include specific characteristics of their populations, such as age, gender and ethnicity profiles, incidence and prevalence of major diseases, and other barriers that their target population faces (NCQA 2024). The care coordination standard requires plans to describe in detail their processes for conducting health risk assessments (HRAs), developing individualized care plans, and operating interdisciplinary care teams (NCQA 2024). States can build on these federal requirements by including additional care coordination requirements in their SMACs. This could include requirements for how a D-SNP conducts HRAs for beneficiaries or the composition of the beneficiary's individualized care plan and interdisciplinary care team.

Comparison with other MA plans. D-SNPs also differ from other MA plans due to certain flexibilities and requirements imposed on D-SNPs that are intended to ensure that the plans can address the needs of dually eligible individuals. Unlike traditional MA plans, organizations that offer D-SNPs are required to establish and maintain enrollee advisory committees that include at least a reasonably representative sample of the enrolled population and solicit input on ways to improve access, care coordination, and health equity (42 CFR 422.107(f)). Additionally, as of the start of 2024, D-SNPs, like all SNPs, are required to screen for health-related social needs during an enrollee's initial HRA by using one or more questions from screening instruments specified by CMS on housing stability, food security, and access to transportation (42 CFR 422.101(f)(1)(i)). D-SNPs may also have greater flexibility to provide supplemental benefits—which are benefits that MA organizations can provide to enrollees that go beyond the services offered in traditional Medicare, such as dental or vision—in cases in which CMS finds that such benefits could further integrate care (42 CFR 422.102(e)).[12]

D-SNPs face competition from other traditional MA plans in the market and dually eligible individuals often have a large number of plan options from which to pick. Some traditional MA plans may seek to enroll a substantial number of dually eligible individuals with benefits targeted to that population because the plans find that enrolling these beneficiaries may be profitable (MedPAC 2019a). These plans are known as "D-SNP look-alikes" because they are designed to attract dually eligible individuals despite not being subject to D-SNP requirements. The Commission has previously voiced concern that such plans draw beneficiaries away from integrated models (MACPAC 2020b). Through rulemaking in 2019, 2022, and 2024, CMS implemented contracting requirements for MA organizations intended to prevent MA plans other than D-SNPs from operating if dually eligible individuals make up more than 80 percent of their enrollees (CMS 2024a, 2022, 2019a). This threshold will gradually be reduced to 60 percent for plan year 2026 (CMS 2024a).

State Medicaid Agency Contracts

All SMACs must include certain minimum elements set by the federal government, and they also serve as important tools for states to establish additional requirements for D-SNPs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) established minimum requirements for SMACs, including requirements on coordination of Medicaid benefits, and gave states the authority to add requirements (42 CFR 422.107(c) and (d)) (see Box 2-1). For example, the contracts must document the Medicaid benefits that are covered under a capitated contract and the service area covered by the D-SNP. Although MIPPA's implementing regulations include coordination between the D-SNP and the state, they do not result in fully integrated coverage (MedPAC 2019a). Subsequent legislation permanently authorized D-SNPs and added new minimum SMAC requirements. The Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) required D-SNPs to take additional steps to promote integration, beyond what was originally required in MIPPA. Specifically, it required D-SNPs to meet one of three criteria to improve integration or coordination of care: (1) meet the requirements to be designated as a FIDE SNP, (2) meet the requirements to be designated as a HIDE SNP, or (3) notify the state of hospital or skilled nursing facility admissions for at least one group of high-risk enrollees (CMS 2019a). For D-SNPs to comply with the third requirement, the state must specify, within its SMAC, the group of high-risk, full-benefit dually eligible individuals for whom a notification must be sent and the time frame and process for sending notifications to either the state or a designee of the state's choosing. The BBA 2018 also required the HHS Secretary to unify plan-level appeals and grievance processes across Medicaid and Medicare for some D-SNPs (42 CFR 422.107(c)(9)).[13]

BOX 2-1. State Medicaid Agency Contract Statutory Language at 42 CFR 422.107

(c) ***Minimum contract requirements.*** At a minimum, the contract must document—

(1) The MA [Medicare Advantage] organization's responsibility to—

(i) Coordinate the delivery of Medicaid benefits for individuals who are eligible for such services; and

(ii) If applicable, provide coverage of Medicaid services, including long-term services and supports and behavioral health services, for individuals eligible for such services.

(2) The category(ies) and criteria for eligibility for dual eligible individuals to be enrolled under the SNP [special needs plan], including as described in sections 1902(a), 1902(f), 1902(p), and 1905 of the Act [Social Security Act].

(3) The Medicaid benefits covered under a capitated contract between the State Medicaid agency and the MA organization offering the SNP, the SNP's parent organization, or another entity that is owned and controlled by the SNP's parent organization.

(4) The cost-sharing protections covered under the SNP.

(5) The identification and sharing of information on Medicaid provider participation.

(6) The verification of enrollee's eligibility for both Medicare and Medicaid.

(7) The service area covered by the SNP.

(8) The contract period for the SNP.

(9) For each dual eligible special needs plan that is an applicable integrated plan as defined in § 422.561, a requirement for the use of the unified appeals and grievance procedures under §§ 422.629 through 422.634, 438.210, 438.400, and 438.402.

(d) ***Additional minimum contract requirement.***

(1) For any dual eligible special needs plan that is not a fully integrated or highly integrated dual eligible special needs plan, except as specified in paragraph (d)(2) of this section, the contract must also stipulate that, for the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the SNP notifies, or arranges for another entity or entities to notify, the State Medicaid agency, 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 SNP authorizes another entity or entities to perform this notification, the SNP must retain responsibility for complying with the requirement in this paragraph (d)(1).

(2) For a dual eligible special needs plan that, under the terms of its contract with the State Medicaid agency, only enrolls beneficiaries who are not entitled to full medical assistance under a State plan under title XIX of the Act, paragraph (d)(1) of this section does not apply if the SNP operates under the same parent organization and in the same service area as a dual eligible special needs plan limited to beneficiaries with full medical assistance under a State plan under title XIX of the Act that meets the requirements at paragraph (d)(1) of this section.

Leveraging SMACs

D-SNPs are widely available across the country and enroll a large swath of dually eligible people. Therefore, they have become an area of focus for policymakers interested in integrating Medicaid and Medicare coverage. Under federal law, states have authority that they can use to increase integration in the D-SNPs in their states and better tailor D-SNP coverage to serve the needs of their dually eligible populations and meet state goals. Over the last several years, MACPAC has developed a body of work in this area. In our June 2021 report to Congress, we described the contracting strategies available to states to promote greater integration through D-SNPs. We identified strategies that could be used in all states and strategies that are easiest to use in states that enroll full-benefit dually eligible beneficiaries in Medicaid managed care. Through interviews with states and federal officials, we found that many strategies were not widely used across states (MACPAC 2021). Building on that work, MACPAC contracted with Mathematica to review all SMACs for contract year 2023 to establish a baseline of how states are leveraging their contracting authority to achieve greater integration, as well as to determine which provisions were most and least commonly used.

Review of contract year 2023 SMACs

To better understand how states currently leverage their SMACs, MACPAC conducted a review of SMAC language for plans operating in contract year 2023 as well as a scan of federal regulatory and subregulatory guidance pertaining to D-SNPs. We reviewed SMACs across all states with D-SNPs and observed state use of particular strategies. As part of this review, we examined contracts with provisions that went beyond minimum federal requirements (Boxes 2-1 and 2-2) and reflected the ways in which states use their SMAC authority to increase integration for dually eligible beneficiaries across benefit design, administration, and beneficiary experience. We also noted where states included provisions intended to enable state Medicaid agencies to oversee the performance and quality of D-SNPs operating in their state, particularly through data sharing.

BOX 2-2. Key Federal Requirements for D-SNPs

- ***Eligibility:*** The state Medicaid agency contract must identify the categories of dually eligible individuals who may enroll in the dual eligible special needs plan (D-SNP) (e.g., only full-benefit dually eligible individuals) and the processes used by D-SNPs to verify these individuals' eligibility for the plan before enrolling them (42 CFR 422.52(f)).
- ***Care coordination:*** D-SNPs must create an evidence-based model of care that guides their care management and care coordination; conduct an initial health risk assessment (HRA) within 90 days of enrollment and an annual reassessment of each enrollee's physical, psychosocial, and functional needs; develop an individualized care plan for each enrollee based on the HRA findings that address each member's needs and goals; and use interdisciplinary care teams to manage care.
- ***Member materials:*** D-SNPs must develop materials and content that meet the requirements at 42 CFR 422.2267 and abide by the Centers for Medicare & Medicaid Services communication and marketing guidelines, which require D-SNPs to send certain Medicare-related materials to enrollees, including the evidence of coverage, explanation of benefits, annual notice of change, summary of benefits, provider directory, and member identification card (42 CFR 422.2267(e)).
- ***Enrollee advisory committee:*** As of 2023, all D-SNPs must establish and maintain an enrollee advisory committee that includes a "reasonably representative sample" of the population enrolled in the D-SNP (42 CFR 422.107(f)).

Based on our review of the contracts, additional state requirements for D-SNPs largely fell under five domains: coverage of Medicaid benefits, care coordination, integrating member materials and experience, data sharing, and improving quality and reducing health disparities (Appendix 3A).

Coverage alignment. Many states address coverage of Medicaid benefits in their SMACs, as well as the alignment of those benefits with Medicare benefits. To meet the federal designation of a HIDE SNP or FIDE SNP, the D-SNP must cover Medicaid services for full-benefit dually eligible beneficiaries with the minimum standards for coverage determined by the specific designation, ranging from some to nearly all of a beneficiary's Medicaid benefits. States can also include additional requirements intended to better align coverage of Medicaid and Medicare benefits.

One way that states may seek to improve alignment of Medicaid and Medicare benefits is by limiting D-SNP enrollment to only full-benefit dually eligible beneficiaries. Since full-benefit dually eligible beneficiaries receive both Medicaid and Medicare benefits, they can benefit from care coordination in a way that partial-benefit dually eligible beneficiaries cannot because they are eligible only for Medicaid assistance with Medicare premiums and cost sharing. This strategy allows uniformity for plan enrollees, including a single set of benefits and rules for care coordination. Another way states may require greater coverage alignment is through EAE. EAE occurs when the state's contract with the D-SNP limits enrollment to full-benefit dually eligible beneficiaries who receive Medicaid benefits from the D-SNP or an aligned Medicaid managed care plan owned by the D-SNP's parent organization. By receiving coverage of both Medicaid and Medicare benefits from the same parent organization, dually eligible beneficiaries may experience more integrated and streamlined member materials and care coordination (MACPAC 2021).[14]

Care coordination. For many policymakers, care coordination is a primary focus of integrating care for dually eligible beneficiaries and an area in which several states have included additional requirements in their SMACs. States may include care coordination requirements, such as stipulating that certain Medicaid services be considered in developing an individualized care plan, in their SMACs for CO D-SNPs, HIDE SNPs, and FIDE SNPs (Appendix 3A). At a minimum, federal law requires that D-SNPs coordinate the delivery of Medicaid benefits for dually eligible beneficiaries, which might entail assisting beneficiaries in obtaining Medicaid-covered services or helping beneficiaries file a Medicaid appeal. These minimum requirements can also be applicable to a CO D-SNP that neither covers a beneficiary's Medicaid services nor aligns with the beneficiary's Medicaid plan. However, states may be more likely to add care coordination requirements into SMACs for D-SNPs that cover Medicaid benefits or have affiliated Medicaid managed care plans because they pay capitation payments to those plans for Medicaid services. For CO D-SNPs, which typically do not cover Medicaid benefits, the D-SNP would be expected to meet state requirements above what federal law requires without payment from the state.

Integrated member materials and member experience. Beneficiaries who receive Medicaid and Medicare notices can experience confusion. Navigating two separate summaries of plan benefits to understand one's combined Medicaid and Medicare benefits can be challenging. Unless a D-SNP is required to use EAE, beneficiaries may also have to navigate different appeals and grievance processes for Medicaid and Medicare, which may be difficult for beneficiaries who need to understand which of their services are covered by which program or plan before filing an appeal or grievance.

States may use their SMACs to set requirements for member materials and communications. Some communications requirements are relevant to all states with D-SNPs, while others are applicable only to D-SNPs with affiliated Medicaid managed care plans or to integrated plans with EAE. For example, all states can require their review of the Medicaid information included in a D-SNP's marketing materials or communications to beneficiaries (19 states). Meanwhile, for D-SNPs with EAE, states could require the D-SNP to issue fully integrated plan materials, such as issuing plan enrollees a single ID card to use for their Medicaid and Medicare coverage (nine states). In Minnesota, FIDE SNPs are required to provide beneficiaries with a single ID card, a single member handbook, and an integrated customer service phone line to address Medicaid and Medicare concerns (Minnesota DHS 2023).

Data sharing. Data sharing requirements are some of the most common ways that states currently leverage their SMACs with D-SNPs (Appendix 3A). These requirements are designed to help states monitor and assess D-SNP performance. MA plans are required to report certain data, such as encounter data or Medicare quality measures to CMS, but for the most part states lack access to Medicare data unless the states include reporting requirements in their SMACs. A number of states use their SMACs to require D-SNPs to submit data to the state, such as information about CMS warnings, sanctions or other actions related to a D-SNP; plan enrollment (18 states) and provider network information (13 states); data on plan determinations and appeals and grievances (13 states); quality measure reports (19 states); and HRA scores (11 states).

SMAC requirements can also facilitate data sharing from the state to the D-SNP. In states in which dually eligible beneficiaries receive their Medicaid services under FFS or Medicaid services are provided through a Medicaid managed care plan that is not aligned with the D-SNP, the D-SNP would lack access to Medicaid data that could assist in care management unless the state provides it. Additionally, states that choose to use default enrollment, which automatically assigns Medicaid beneficiaries who become eligible for Medicare to the D-SNP affiliated with their Medicaid managed care plan, must share enrollment and eligibility information with the D-SNP to facilitate the process (MACPAC 2022).

Improving quality and reducing health disparities. States have a vested interest in improving quality outcomes for their dually eligible beneficiaries, and in recent years, many states have developed a specific focus on addressing health disparities. Several states seek to improve quality of care and the experience of receiving care by including requirements in their SMACs that the D-SNP participate in state Medicaid quality improvement initiatives (7 states) or provide certain supplemental benefits (13 states) (Appendix 3A).

Supplemental benefits are additional Medicare benefits that a D-SNP may provide that go beyond what traditional Medicare offers, such as vision or dental benefits. D-SNPs may also provide "extra benefits," which refer to supplemental benefits that enhance traditional Medicare benefits. These benefits are funded through rebates MA plans receive, which represent the difference between the plan's annual bid and the benchmark rate CMS sets for the county (GAO 2023). In their SMACs, states can require that D-SNPs offer specific supplemental benefits that are primarily health related and overlap with Medicaid benefits, such as adult day care, or they may require plans to offer special supplemental benefits for those with chronic conditions which can be non-medical, such as transportation for nonmedical needs (GAO 2023, CMS 2019b).

In a small number of states, SMACs include requirements that D-SNPs collect data on and work to reduce health disparities among their enrollees (Appendix 2A). One such state, California, requires in its SMAC that D-SNPs identify potential health disparities in its enrollee population as part of its MOC (California DHCS 2023).

Variation in SMAC provisions

State adoption of SMAC provisions is uneven without identifiable, consistent patterns. States are incorporating contract language in their SMACs intended to improve alignment and integration for dually eligible beneficiaries to varying degrees. For example, about a third of states with D-SNPs use their SMACs to limit D-SNP enrollment to full-benefit dually eligible individuals, which allows the D-SNP MOC to be tailored more precisely to their Medicaid services and needs. Some of these states allow partial-benefit dually eligible individuals to enroll in a D-SNP under a separate plan benefit package, which acknowledges that partial-benefit dually eligible individuals are still likely to benefit from a MOC even if they do not receive Medicaid services and would allow them to receive the supplemental benefits a D-SNP may offer. Data sharing provisions were also commonly included in SMACs, for both states with more integrated D-SNP types and those with only CO D-SNPs (Appendix 2A). However, it is unclear how states use the data they require D-SNPs to report.

Other contract provisions have had relatively limited use in SMACs so far. Certain areas, such as identifying health disparities, may reflect new

priorities for states. Others, such as specific training requirements for D-SNP care coordinators, reflect basic tools to improve integration or beneficiary experience yet were included by only a small number of states.

Optimizing and Overseeing SMACs

Few states have taken steps to optimize use of their SMACs, and we needed further information to understand the barriers states face in doing so. Through a series of interviews, MACPAC sought to learn how states consider which provisions to include in their contracts, what types of relationships states have with D-SNPs, how states operationalize their requirements and to what purpose, and, importantly, how states oversee and enforce the requirements they set in their SMACs.

Methodology

We contracted with Mathematica to conduct interviews with state officials in five case study states, federal officials at the CMS Medicare-Medicaid Coordination Office, and health plan representatives for two plans operating across our case study states. We selected case study states that require greater levels of integration in their SMACs, such as a HIDE SNP or FIDE SNP designation, go beyond federal minimum requirements, and conduct monitoring and oversight activities of those requirements. Selected states included California, the District of Columbia, Idaho, Minnesota, and New Jersey.

States that contract with HIDE SNPs or FIDE SNPs represent a minority of those contracting with D-SNPs. However, MACPAC determined that interviews with states that have experience contracting with and overseeing integrated D-SNPs could underscore the level of optimization that leveraging a SMAC can achieve while spotlighting implementation challenges and considerations for states at any stage of experience with D-SNPs or integrated care. More information about our case study states and their dually eligible populations can be found in Appendix 2B.

Key themes

Our interviews with SMAC stakeholders highlighted key themes within four domains: contracting considerations, data and reporting requirements, monitoring and oversight processes, and performance improvement and enforcement. When considering whether to contract with a D-SNP, state officials said that they set priorities for state goals, such as increasing alignment between Medicare and Medicaid plans under the same parent organization, as well as limiting disruptions for beneficiaries. They also emphasized the importance of regularly engaging with the D-SNPs operating in the state to solicit feedback on proposed policy changes ahead of releasing the annual SMAC. Although all states we spoke with require D-SNPs to submit a range of data in the form of reports, officials said that many of those reports are assessed only for timeliness, completeness, and accuracy and are not used for oversight. Instead, officials said that appeals and grievance data and complaints to the ombudsman office typically help to spotlight issues. To ensure compliance with their SMAC requirements, states rely on a number of enforcement tools and penalties, but few states currently include performance incentives in their SMACs. Some of these states have chosen to incorporate enforcement tools within the Medicaid managed care contract rather than the SMAC, which CMS said could influence how and when states choose to use them.

Contracting considerations. States told us that they consider several factors when deciding which D-SNPs to contract with, including opportunities for Medicaid and Medicare alignment and limiting disruptions for existing enrollees. MIPPA requires D-SNPs to have contracts with the state in which they operate, but states are not required to contract with D-SNPs, allowing states to choose whether to contract with D-SNPs at all, and if so, contract with organizations that meet state goals.[15,16] Officials told us that they see value in their authority to be selective about which plans to contract with. Officials in one state shared that a competitive procurement process allows them to negotiate with plans and hold them accountable more than they would be able to if plans felt "entitled" to contract with the state. A state's level of experience

with managed care contracting and marketplace factors may also influence how states decide to contract with D-SNPs. Health plans also have the choice not to operate in a state with requirements they find too burdensome. Some state officials described the need to strike a balance between additional requirements and ensuring beneficiaries have access to a D-SNP.

Additionally, all case study states require the use of EAE. Officials said they see EAE as a benefit to care coordination. For states to use EAE, there must be alignment of D-SNPs and Medicaid managed care plans, so state officials said their Medicaid agencies consider whether a D-SNP has an affiliated Medicaid managed care plan when awarding SMACs. By contracting only with D-SNPs with affiliated Medicaid plans, states can ensure plan alignment that may improve care coordination and limit the number of D-SNPs operating.[17] States may also consider the existing health care landscape for dually eligible individuals to avoid disrupting care for beneficiaries. When the District of Columbia began the process of developing its HIDE SNPs in 2018, officials told MACPAC that one plan already enrolled the majority of beneficiaries in the local CO D-SNP marketplace. Although that organization was ultimately the only plan to submit a bid to operate a D-SNP in the District of Columbia, officials noted they saw value in selecting that plan as choosing a different operator could have disrupted provider networks and care.[18]

During the SMAC development process, stakeholders said that input from health plans plays a substantial role even if plan suggestions do not ultimately alter the contract provisions the state chooses to include. Both states and health plans told us that states meet regularly and often with D-SNPs, as they do with Medicaid managed care plans, to solicit input on SMAC requirements and incorporate suggestions when appropriate. Interviewees described good working relationships between state Medicaid officials and health plan representatives that keep the health plans informed about relevant program changes. Health plans said their feedback is heard, even if states do not always accept plan requests. State officials told MACPAC that a cornerstone of these relationships is regular meetings that they said engender familiarity and allow the state and health plans to engage with one another about proposed SMAC requirements and program operations.[19]

Health plans told MACPAC that they find value in these feedback sessions and that they recognize that state officials make efforts to use plans' operational knowledge to improve SMAC design, even as health plan representatives refrained from describing the conversations as a contract negotiation. During its annual SMAC negotiations, health plan representatives said Minnesota sometimes incorporates plans' ideas into the SMAC. In New Jersey, officials give health plans a few weeks to provide comments on draft SMAC language, especially when a requirement may pose a technical lift for plans. However, health plans also identified several challenges in the SMAC contracting process.

Data and reporting requirements. CMS requires D-SNPs to submit a wide variety of data and reports. For example, as with all MA plans, MA contracts that include D-SNPs must submit Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures related to quality and experience of care. D-SNPs are also required to submit an additional set of plan-level quality measures specific to SNPs, including data related to the SNP quality improvement program (42 CFR 422.152(g)). Although states can leverage data and reports that D-SNPs share with CMS, states must require D-SNPs to share this information with the state if they want guaranteed data access. States, which receive Medicaid reports from the D-SNP or the D-SNP's affiliated Medicaid managed care plan under its Medicaid managed care contract, do not automatically receive any D-SNP data directly from CMS. However, recent rulemaking allowed for states to request MA encounter data from CMS (CMS 2024a). Additionally, with the codification of D-SNP-only contracts in 2022, states that choose to require D-SNP-only contracts can receive reporting of quality measures and calculations of Medicare Star Ratings specific to dually eligible individuals in the state (CMS 2022).

All five case study states require D-SNPs to submit data and reports related to appeals and grievances, provider networks, care coordination, and enrollment and disenrollment. States indicated that encounter

data and care coordination data were the most important for monitoring D-SNP compliance and quality; however, the states we interviewed are limited in their current use of MA encounter data. California officials said the state is working on internal systems changes to receive and use MA encounter data for oversight of D-SNP compliance, quality improvement, care coordination, and utilization in key areas, such as understanding the impact of social determinants of health and to inform policy development for care coordination and transitions of care. Although the state can currently review Medicaid data and FFS Medicare claims, officials said that MA encounter data are crucial for understanding the MA component of its integrated D-SNPs. The District of Columbia, which uses MA encounter data in developing capitation rates to pay D-SNPs to cover Medicare cost sharing, said that any data that inform program operations are critical to effective oversight. For example, officials noted that enrollment data have been especially important during the unwinding of the COVID-19 public health emergency, and that they use other finance reports for Medicaid rate setting.

Each case study state also requires plans to submit care coordination data, such as information related to HRA and individualized care plan completion rates, care transitions, and discharge planning. For example, Minnesota officials said that care coordination data, quality assurance assessments, and appeals and grievance data help to demonstrate compliance and identify gaps in a service area. The state requires its D-SNPs to submit an annual care coordination report in which the D-SNP audits a sample of their care plans and the delegates they contract with for case management. Although Minnesota does not require plans to resubmit their MOCs during this process, the plans' annual care coordination audits can surface changes that need to be made and officials described them as useful in assessing the health of the program. CMS officials agreed that measures focused on HRA completion are a good indicator to states of plan performance. Other types of required data reports include financial reports and information on marketing activities. One national health plan shared that the D-SNP reporting requirements in its SMACs are largely consistent with the Medicaid managed care reporting requirements in those states. Increasingly, CMS said states are using their SMACs to ask plans to submit MA data that the plans report to CMS. For example, among our case study states, California, Minnesota, and New Jersey ask D-SNPs to report Medicare Part C and Part D data, CMS Star Ratings, and CMS audit findings.

Health plan representatives said that state data reporting requirements can sometimes pose technical challenges, particularly when the requirements are inconsistent with other requirements in the SMAC or there are delays on the part of the state in communicating the requirements. A health plan that operates a D-SNP in California shared that the reporting requirements in its SMAC are based on the requirements used in the state's FAI demonstration; however, these requirements do not always align with the language in each D-SNP's MOC. For example, California requires D-SNPs to submit information about how many HRAs the plan completed within 90 days of enrollment, but the plan's MOC indicates that the plan may conduct the HRA within 90 days before enrollment. The health plan said it believes that this misalignment between reporting requirements and the MOC creates an inaccurate understanding of the plan's performance on care coordination measures. For the state to be able to compare plans directly as California does, the health plan said that California should determine whether each plan meets the reporting requirements according to the definitions used in the MOC approved by CMS.[20] A national health plan shared that state-specific quirks can also pose challenges to data reporting. For example, in Minnesota the health plan experienced additional burden reporting on benefit denials, service terminations, and service reductions because the state has its own coding system that does not align with universal billing codes.

In addition to reporting data to the state, plans may be required to share data with other plans to coordinate care for those with unaligned enrollment. Although all of our case study states require EAE, California currently allows unaligned CO D-SNPs to continue operating in several counties.[21] A D-SNP operating in California said it can be difficult to implement requirements to use Medicaid and Medicare data for members who are enrolled in a Medicaid plan offered by a different organization. The D-SNP identified that unaligned enrollees are a particular challenge for care coordination because without active data sharing

between the Medicaid plan and the D-SNP, the plan cannot monitor the enrollee's Medicaid utilization to facilitate care coordination. In an attempt to address this challenge, state officials in California said they instituted an IT solution to help plans meet information sharing requirements and streamline coordination between unaligned Medicaid plans and D-SNPs, including communication with one another about admission and discharge information to hospitals and skilled nursing facilities.

Monitoring and oversight. States use data and reports to monitor and oversee D-SNPs to ensure they meet the contract requirements and performance targets included within their SMACs, with oversight often a collaboration across several Medicaid agency departments and other state agencies. In particular, state officials cited appeals and grievance data and care coordination data as primary sources for identifying issues. However, states also noted that limited staff capacity means that frequently data reports are checked only for timeliness, completion, and accuracy rather than undergoing deeper analysis.

CMS explained that it is responsible for overseeing D-SNPs' compliance with Medicare requirements and quality in covering Medicare benefits, but the state is primarily responsible for oversight and delivery of Medicaid services, especially LTSS. CMS said that states are beginning to enforce SMAC provisions and improving their oversight by collecting their own data or using CMS data. For example, states are starting to collect MA encounter data, but a lack of staff capacity makes it difficult for states to use the data to assess D-SNP compliance or performance. CMS noted that state D-SNP compliance efforts are often driven by a certain state goal. For example, CMS officials said that if a state is using information sharing to coordinate the delivery of services for LTSS recipients, the state may be more interested in ensuring that the D-SNP is compliant on that measure.

All of the case study states require at least some D-SNPs to be AIPs, which are required to use unified appeals and grievance procedures (42 CFR 422.107(c)(9)). States said they use appeals and grievance data to identify trends and track areas that need improvement.[22] Officials in New Jersey said the state uses appeals and grievance data to identify the most frequent problems and inform adjustments to SMAC language. For example, the state said it noticed a disproportionate number of denials for durable medical equipment. After investigating the problem, New Jersey identified a misunderstanding with the language around powered wheelchairs, which caused incorrect denials. Through this monitoring and oversight, New Jersey said it was able to ultimately implement clarified SMAC language to resolve the issue.

Meanwhile, officials in Minnesota noted the importance of care coordination data, such as HRA completion rates.[23] Officials at CMS agreed that measures focused on HRA completion act as a good indicator to states of plan performance. However, officials in Idaho said they do not have enough data to hold D-SNPs accountable for care coordination and case management, but they are exploring additional data reporting requirements that they could then tie to quality withholds. A quality withhold is an arrangement in which a portion of the state's capitation payment to the plan is withheld and repaid to plans according to their performance on certain quality measures.

Case study states also rely on a range of other health plan data and reports to monitor performance, such as reporting of quality measures like HEDIS, CAHPS, and Health Outcomes Survey measures. In California, officials said the state requires D-SNPs to submit HEDIS measures and plans to report them on a publicly available dashboard, which they are developing using data from a variety of sources to provide timely information about key performance metrics.[24] Although Idaho collects HEDIS and CAHPS measures, officials said they do not use them to monitor plan performance due to a lack of staff capacity.

Several state agencies and departments are involved in different aspects of D-SNP oversight, according to officials in case study states. The District of Columbia and Minnesota said they both have core groups that are responsible for D-SNP oversight and collaborate with other teams within the Medicaid agency. For example, in the District of Columbia, these divisions include: the Office of the General Counsel for review of the SMAC and legal advice; a policy team that ensures they have the authority to operate the program; a program integrity unit that assures compliance; and an office of rates, reimbursement, and financial analysis

that does the financial planning, projects enrollment for budgeting purposes, and reviews the financial reporting. In addition, officials said that other staff manage appeals and grievances. Often, policy staff overseeing D-SNPs in case study states and the staff conducting analyses of data reports are separate. Several states, including the District of Columbia, Idaho, and Minnesota, said they rely on a data team within their department to assess encounter data accuracy and completeness, analyze utilization trends, and then share the results with policy staff.[25]

Although some states focused on Medicaid compliance, other states indicated that it was important to also use Medicare data to have a more complete understanding of dually eligible individuals' care. As California collects more data from D-SNPs, including MA encounter data, officials said they are identifying what data are most relevant for informing Medicaid operations. However, officials in New Jersey said they focus on oversight of Medicaid benefits because staff do not have sufficient Medicare knowledge to oversee D-SNP compliance or performance with Medicare data. Nevertheless, New Jersey indicated that it would like to improve its ability to conduct such oversight.

Performance improvement and enforcement. Although states have the flexibility to include a spectrum of additional SMAC requirements, requirements are not meaningful without enforcement. In our interviews, state officials described a number of enforcement mechanisms to ensure plan compliance with contract requirements, including penalties and, to a lesser degree, incentives for good performance. Federal officials also emphasized that although states may rely on enforcement tools included in their Medicaid managed care contract or other policy documents, the SMAC should include language defining enforcement tools that a state wishes to use with D-SNPs for compliance purposes.

States said that they tend to implement penalties in an escalating fashion, using intermediate penalties, such as corrective action plans (CAPs), withholds for non-compliance, and sanctions that are intended to remedy poor performance before contract termination. CAPs and letters of noncompliance are the most common penalties, though states can also levy financial penalties. The District of Columbia's SMAC contains language outlining the CAP process, which begins with a verbal notification of non-compliance, followed by the Office of Contract Procurement requesting a CAP. Several states apply financial penalties or enrollment freezes for non-compliance with SMAC requirements. If Minnesota and Idaho state staff identify an area of non-compliance, officials said that they issue a CAP, notify the D-SNP that it is in breach of contract, and fine it for each day that it is out of compliance. The District of Columbia and New Jersey also said they use financial penalties for non-compliance, while the District of Columbia may also implement enrollment freezes.[26]

Though states said they saw financial penalties as effective in ensuring plan compliance with the SMAC, officials said it is not a tool they use lightly. Idaho officials described a previous experience when the threat of a financial penalty, when large enough, encouraged a plan to agree to a CAP and quickly resolve the identified issue. Officials in New Jersey view liquidated damages, a contractually determined financial penalty for breach of contract, as an effective enforcement mechanism because there is a well-established financial penalty for lack of performance or compliance. However, New Jersey said it often relies on CAPs rather than a notice of deficiency with a direct financial impact. Several states said they also hope that publicly sharing plan performance in a data dashboard may facilitate compliance when financial penalties are ineffective.

Few states included incentives for D-SNPs in their SMACs, noting a lack of resources or clear quality benchmarks. Minnesota said it allows plans to earn back payment withholds if they meet certain quality performance thresholds, such as HRA completion. Officials said the state started out by requiring 50 percent of the HRAs to be completed within 30 days for its Minnesota Senior Health Options program—increasing the percentage of HRA's submitted by 5 percent each year over the course of a few years (Minnesota DHS 2021). Currently, officials said plans are required to submit 95 percent of the HRAs within 30 days, and that all the plans are compliant.[27]

Several states, including California and the District of Columbia, use Medicaid managed care contracts and policy guidance documents to detail requirements

outside of the SMAC. Officials said they appreciate these documents as they allow for regular updates and refinements outside the contract amendment process. Given their responsibility for overseeing Medicaid benefits, officials in California, the District of Columbia, and New Jersey described a greater degree of ownership and enforcement mechanisms in their Medicaid managed care contracts than their SMACs, which some described as one of several legally binding documents. The District of Columbia noted that its Medicaid managed care contract with the D-SNP provides an enforcement lever for the state because the state pays the plan for services through that contract. As there are no payments associated with the SMAC, states said the Medicaid managed care contract was a more effective oversight tool. However, CMS told us that states should include D-SNP requirements directly in the SMAC, including penalties and incentives, as it may be more difficult to implement enforcement tools that do not sit within the contract. Officials in New Jersey confirmed this point of view, saying that they would be hesitant to apply penalties not described within their SMAC.

Considerations for States

States looking to integrate care for their dually eligible beneficiaries face a range of complex considerations. Even states with a wealth of experience in integrating care like our case study states encounter challenges in leveraging and overseeing their SMACs. Although the Commission is cognizant of these challenges and has made several prior recommendations to Congress that seek to address them, we believe that states can still leverage certain data to effectively monitor and oversee their SMACs and to develop an integration strategy in the absence of a congressional requirement.

States at any stage along the path to integrating care for dually eligible beneficiaries should understand their contracting authority and ensure they are collecting data necessary to effectively oversee D-SNPs. Through our interviews, we have identified data on care coordination and MA encounters as meaningful data elements that could represent a starting point for states that are beginning to leverage their SMACs and lay the groundwork for future data analysis. As states continue to struggle with state capacity issues, they should consider how they will support oversight of these data—and how these data can support state goals—if Congress acts to take up MACPAC's June 2022 recommendation on state integration strategies.

Even without congressional action, federal guidance from CMS could support states in developing an integration strategy by outlining various options for integrating care. These options could include a range of currently available integrated care models, which states could leverage as best suits their health coverage landscape. Our review of SMACs for contract year 2023 found wide variation in which provisions states included in addition to federal minimum requirements, and only a small share of states in which D-SNPs operate currently use these contracting strategies. Federal guidance from CMS can provide clarity to states with minimal experience in integrating care for their dually eligible populations on how they can optimize their SMACs under existing federal authority, as well as explain the value that states may gain from leveraging these contracts.

Barriers to optimizing SMACs

Through interviews with state and federal officials, we heard that the barriers states face in leveraging and overseeing their SMACs with D-SNPs are reflective of the challenges that states have previously described in pursuing integrated care models for dually eligible beneficiaries. State officials said that a lack of staff capacity and Medicare knowledge place operational limits on what they believe they can require in their SMACs, and several officials highlighted the importance of connecting SMAC requirements to state goals to garner buy-in from state leadership.

Officials in several states said that they were reluctant to add a requirement to their SMAC without the staff available to oversee health plan compliance with it, emphasizing that additional requirements equate to additional oversight work for state staff. MACPAC's prior work echoes this sentiment as other state officials have described their lack of dedicated staff for the resource-intensive work of launching and overseeing integrated care models, noting that staff working on policies affecting dually eligible beneficiaries juggle a range of other responsibilities (MACPAC 2022,

2020b). With few full-time equivalent staff tasked with overseeing SMACs, several states said in our recent interviews that they seek to only include requirements or collect data for which the state has a clear use. Although states we interviewed acknowledged the broad flexibilities allowed by 42 CFR 422.107, citing capacity issues as the main factor limiting how they leverage their SMACs, CMS said that other states are still learning that they can include additional contract requirements in their SMACs and how to do so.

State officials admitted that staff capacity also poses challenges to overseeing existing requirements. For example, Idaho officials said that due to the limited number of staff, the state has not yet been able to use data they collect from D-SNPs to inform decision making on revising requirements in future SMACs. Instead, Idaho officials said the state currently monitors submitted data to make sure it is on time, complete, and accurate, which was an approach used at least occasionally by several case study states. Additionally, states said they encounter difficulties in building and retaining staff expertise needed to oversee the D-SNP program, highlighting Medicare expertise in particular. For example, Medicaid officials in the District of Columbia said that staff lack detailed Medicare knowledge that could help to avoid duplicative requirements, such as determining whether the D-SNP, in meeting its Medicare obligations, has already met the Medicaid requirements. There are some ongoing efforts to build state expertise in Medicare. For example, in California the state Medicaid agency has joined a Medicare Academy training program operated by the Center for Health Care Strategies to introduce staff to Medicare basics (CHCS 2024). In an interview, California officials said they saw the training program as an opportunity to help staff understand where state requirements may best complement Medicare requirements and to be able to spot issues, particularly as California prepares to receive MA encounter data.

Efforts to integrate care for dually eligible beneficiaries are also competing with other state priorities for limited resources. In a 2021 MACPAC roundtable, state officials talked about how other agency priorities, which change frequently, can affect integration efforts. Those officials said that securing state leadership support for integrated care may be difficult given that the models do not necessarily lead to timely or direct reductions in spending. With competing priorities, roundtable participants said leadership commitment to integrated care is crucial to progress (MACPAC 2022). In our recent interviews, California officials described leadership, including the governor's office, as fully invested in the recent launch of its integrated D-SNPs in 2023. Officials said this progress is in part due to the inclusion of integration efforts in the state's larger Medi-Cal reform project, known as CalAIM (California DHCS 2019).

At its December 2023 public meeting, MACPAC convened a panel of experts, including representatives from CMS, a health plan, and a non-profit providing technical assistance to states, to discuss the transition away from MMPs to integrated D-SNPs (CMS 2022). During a moderated conversation, experts agreed that state capacity issues, including a lack of familiarity with Medicare and how MA plan bids are developed, are preventing many states from integrating care for their dually eligible populations. However, panelists pointed to states that participated in the FAI, and have agreed to transition to integrated D-SNPs by the demonstration's conclusion at the end of 2025 as possible examples for other states. Additionally, citing MACPAC's prior recommendations as discussed below, one panelist argued that without additional federal funding to support the development of an integration strategy, many states will be forced to continue treating integrated care as a side-of-the-desk activity subject to other state priorities (MACPAC 2023).

Prior recommendations

The Commission made recommendations in its June 2020 and June 2022 reports that directed Congress to provide states with additional federal funding to build staff capacity to implement integrated care models and to require that states develop a state integration strategy, respectively (Box 2-3). As of early 2024, Congress has not enacted these recommendations, but several bills have been introduced that would do so.

BOX 2-3. Prior MACPAC Recommendations

June 2022

- Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within two years with a plan to review and update the strategy as needed, to be determined by the Secretary. The strategy should include the following components—integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, and quality measurement—and be structured to promote health equity. To support states in developing the strategy, Congress should provide additional federal funding to states to assist with these efforts toward integrating Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries.

June 2020

- Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

It is the Commission's position that these recommendations remain the best approach to resolving the barriers that states face in developing integrated care options for dually eligible individuals, including those related to contracting with and overseeing D-SNPs.

Examining strategies for effective SMAC oversight

The case study states we examined include an array of requirements in their SMACs that address differing populations, state goals, and priorities. However, interviewees indicated data on care coordination and MA encounters are necessary to monitor D-SNP compliance and assess quality. Although we spoke with officials in states that require greater levels of integration, requirements for plans to submit data on care coordination and MA encounters are applicable to any D-SNP, even those with minimal levels of integration.

Care coordination. States may use their SMAC to require that D-SNPs incorporate certain care coordination practices into their MOC, so long as state requirements do not contradict federal requirements and the MOC is approved by NCQA and CMS. States can add care coordination requirements, including: additional specifications for federally required HRAs, such as requiring D-SNP HRAs to be completed in fewer than 90 days; requirements that Medicaid services or providers be incorporated into beneficiaries' individualized care plans; or specific training requirements for care coordinators. Each case study state requires health plans to submit care coordination data, such as information related to HRA and individualized care plan completion rates, care transitions, and discharge planning to support state goals. For example, a state might request that D-SNPs submit HRA responses stratified by a variable of interest, such as race and ethnicity, if the state has a focus on health equity across its Medicaid program.

Both state and federal officials noted the importance of care coordination data, such as HRA completion rates, in assessing plan performance and the overall health of the integrated care program. Officials said that using data ensures they are setting attainable targets for their plans and establishes a precedent of monitoring and goal setting.

MA encounter data. Currently, D-SNPs submit MA encounter data to CMS but states did not receive these data in 2023 unless they included a requirement in their SMAC. Without MA encounter data, state officials lack a full picture of service utilization among dually eligible beneficiaries because Medicare acts as the primary payer for a wide range of services. Unless Medicaid receives a claim to cover Medicare cost-sharing, Medicaid officials will not receive data on the use of Medicare-covered services.

In April 2024, CMS finalized a rule for contract year 2025 that opened an avenue for states to request to receive MA encounter data from CMS for purposes of improving the Medicaid program (CMS 2024a). Previously, CMS was allowed to release MA encounter data to states to support evaluations and administration of a Medicare-Medicaid demonstration after risk adjustment reconciliation for the applicable payment year had been completed, which created a time lag for states to use such data for care coordination purposes. To allow states to receive and use MA encounter data in support of the state's Medicaid program, CMS revised 42 CFR 422.310(f) to permit the release of MA encounter data to states for Medicaid program activities and evaluations before final reconciliation of the data (CMS 2024a). Though these data would be subject to change after reconciliation, CMS indicated in the final rule that states have experience addressing potential data concerns from using Medicare FFS claims for care coordination, quality improvement, and program integrity. Concerns remain regarding the accuracy and completeness of MA encounter data. The Medicare Payment Advisory Commission made recommendations to improve the collection of MA encounter data in 2019, and CMS recently issued a request for information soliciting feedback on improving MA data collection, including for dually eligible populations (CMS 2024b, MedPAC 2019b).

Analysis of MA encounter data quality is an ongoing effort. States can leverage MA encounter data for a number of analyses, such as: comparing service use among D-SNP enrollees to those not enrolled in a D-SNP, identifying disparities among the dually eligible population, or developing quality improvement goals for future SMACs. In our interviews, several state officials said that it is important to use Medicare data to have a more complete understanding of dually eligible individuals' care. Additionally, states may be able to leverage enhanced federal administrative matching funds for state expenditures for operation of a Medicaid Enterprise System module or component approved by CMS (CMS 2023e). An enhanced match could support states in making information technology (IT) system improvements necessary to ingest and use MA encounters in their state Medicaid Management Information System.

Commission Recommendations

The Commission recommends that states require D-SNPs to submit data to the state on care coordination and MA encounters to bolster monitoring and oversight efforts. The Commission also recommends that CMS update guidance to support states in pursuing integrated care models and leveraging their SMACs.

Recommendation 2.1

State Medicaid agencies should use their contracting authority at 42 CFR 422.107 to require that Medicare Advantage dual eligible special needs plans (D-SNPs) operating in their state regularly submit data on care coordination and Medicare Advantage encounters to the state for purposes of monitoring, oversight, and assurance that plans are coordinating care according to state requirements. If states were required by Congress (as previously recommended by the Commission) to develop a strategy to integrate Medicaid and Medicare coverage for their dually eligible beneficiaries, states that include D-SNPs in their integration approach should describe how they will incorporate care coordination and utilization data and how these elements can advance state goals.

Rationale

Care coordination is central to integrating Medicaid and Medicare services and serves as a key feature of the D-SNP model. Both CMS and state officials identified care coordination data as a useful measure of D-SNP performance and the overall health of the

integrated program. As more states take steps toward requiring greater integration from D-SNPs, states should use their SMACs to require that D-SNPs submit care coordination data so that states may ensure that dually eligible beneficiaries in these products are receiving the levels of care coordination the state expects. Although few states currently collect and use MA encounter data to oversee D-SNPs, state officials said these data are necessary to understand the health of the dually eligible population and inform quality improvement efforts. Importantly, these data elements are applicable to more integrated plans as well as minimally integrated CO D-SNPs, which means that states at any level of integration can begin requiring these data as a first step.

State staff identify a lack of Medicare expertise as an impediment to more fully optimizing and overseeing D-SNPs operating in their state. In some states, limited resources and experience handling managed care data also complicate states' ability to push for higher levels of integration through SMACs. It is unclear how many states may require IT systems upgrades to receive and process health plan data, and some states currently have negligible or no state requirements regarding care coordination beyond the minimum requirements set by federal law. However, should states set priorities tied to their monitoring and oversight efforts, the potential value of these data in improving integrated care would presumably increase. States should consider how data on care coordination and utilization could support quality improvement for dually eligible beneficiaries enrolled in D-SNPs and how analyses of such data might inform policy developments aimed at achieving greater integration for the dually eligible population.

Although the changes in the final rule create new opportunities for states to access MA encounter data, the Commission recommends going a step further by encouraging states to require that the plans submit the data directly to the states. This approach puts the onus on the health plan to provide the data without states having to request it from CMS. It has the potential to allow states to engage with the D-SNP to specify how they want the data presented or reported and may support a stronger working relationship between the state and the D-SNP.

Implications

Federal spending. The Congressional Budget Office (CBO) does not estimate any changes in federal direct spending as a result of this change.

States. Given limits on state capacity, this recommendation may pose a substantial upfront administrative burden for states to implement, particularly with regard to IT systems that may require upgrades to automatically ingest MA encounter data. However, states have an obligation to monitor and oversee SMAC requirements, and this recommendation offers states with any level of experience with D-SNPs a place to begin effective oversight, as well as data elements that could support program improvements. Additionally, states may be eligible for enhanced federal matching funds to support such upgrades.

Enrollees. Although there is no direct effect of this recommendation on enrollees, dually eligible beneficiaries enrolled in D-SNPs may experience more integrated care if states begin receiving and using care coordination and MA encounter data to ensure that plans are meeting state expectations for coordinating or covering Medicaid benefits. Enrollees may potentially see even greater benefit should states use these data for quality improvement and to inform the development of future SMAC requirements in addition to monitoring for compliance with existing requirements.

Plans. D-SNPs may experience some added administrative burden if states require the submission of data on care coordination and MA encounters as plans will likely need to format and package data according to state requirements, which can differ across the states in which the D-SNP or its parent organization operate. However, plans effectively agree to accept these terms if they opt to sign a SMAC with a state.

Providers. There is no direct effect on providers.

Recommendation 2.2

The Centers for Medicare & Medicaid Services should update guidance that supports states in their development of a strategy to integrate care that is tailored to each state's health coverage landscape.

The guidance should also emphasize how states that contract with Medicare Advantage dual eligible special needs plans can use their state Medicaid agency contracts to advance state policy goals.

Rationale

CMS guidance could prompt states to begin developing a strategy by outlining the tools available, even in the absence of congressional action requiring such strategies. States are increasingly adding requirements to their SMACs to tailor those contracts to serve their dually eligible populations and align with state priorities. However, federal officials said that a lack of awareness of state contracting authority and its limitations, as well as the value of leveraging the SMAC, continues to hinder states in optimizing these contracts to further integration. Although the Integrated Care Resource Center (ICRC), which provides technical assistance to states integrating Medicaid and Medicare, has published a number of resources, federal guidance could provide states with clarity on the boundaries of their contracting authority and emphasize for states how leveraging their SMACs can add value to their Medicaid program.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of this change, although it does anticipate this recommendation would increase federal discretionary spending to cover the development of guidance. Issuing guidance does pose some administrative burden on CMS, but the agency can draw on prior guidance and existing educational materials produced by the federally funded ICRC. Technical assistance channels, such as ICRC, already handle questions and requests from state Medicaid agencies, and so we anticipate little additional burden even if many states engage CMS for assistance in developing state integration strategies after publication of this guidance.

States. State Medicaid agencies may benefit from greater clarity on the types of integrated care models available and how each model might function according to the state's own health care landscape for dually eligible beneficiaries. For states that have yet to invest in integrated care for their dually eligible populations, federal guidance that explains the value that states may gain from integration could catalyze these agencies and their leadership to discuss how their programs could benefit from integrated care models.

Enrollees. If federal guidance encourages states to develop an integrated care strategy for dually eligible individuals, enrollees may gain greater access to integrated care options and, with a less fragmented health care landscape, enjoy a more streamlined beneficiary experience.

Plans. There is no direct effect for plans.

Providers. There is no direct effect for providers. However, some providers may benefit from greater clarity on available integrated care models in which they could participate within their state, and such guidance may enable certain providers to better engage with their state Medicaid agency in any stakeholder processes.

Looking Ahead

We plan to continue investigating how integrated care models can achieve greater administrative and financial alignment as well as how dually eligible beneficiaries might receive a more streamlined integrated experience and improved outcomes. In addition, we will monitor ongoing legislative efforts and agency rulemaking related to integrating care for dually eligible beneficiaries.

Endnotes

[1] Integrated care is an approach that is intended to align the delivery, payment, and administration of Medicaid and Medicare services with the goals of improving care, eliminating incentives for cost shifting, and reducing spending that may arise from duplication of services or poor care coordination. In its report, CMS calculates integrated care enrollment to include only full-benefit dually eligible individuals with aligned Medicaid and Medicare enrollment (CMS 2023a).

[2] Without exclusively aligned enrollment, which requires that beneficiaries be enrolled only in the D-SNP affiliated with their Medicaid managed care plan, simultaneous enrollment in managed care for both Medicaid and Medicare benefits does not mean that all individuals in this category are enrolled in aligned plans under the same parent organization.

[3] CMS finalized rulemaking that sunsets the MMPs as of calendar year 2025 (CMS 2022). States are in the process of transitioning their MMPs to integrated D-SNPs.

[4] Other types of special needs plans (SNPs) include chronic condition SNPs (C-SNPs) and institutional SNPs (I-SNPs).

[5] D-SNPs are also available in Puerto Rico but enrollment in the territories is excluded from this analysis.

[6] D-SNPs are designated as HIDE SNPs if their parent organizations have a contract with the state to cover either LTSS or behavioral services or both. In the case in which Medicaid benefits are covered by an aligned Medicaid managed care plan, this would be a managed care contract. In the case in which D-SNPs directly contract to cover Medicaid benefits, this requirement could be conveyed within the SMAC between the D-SNP and the state or a separate Medicaid managed care contract with the D-SNP.

[7] D-SNPs are designated as FIDE SNPs when LTSS and behavioral health services are covered by the same legal entity as the D-SNP. FIDE SNPs are not required to cover behavioral health services if the state carves them out of the capitation rate. FIDE SNPs must also use aligned care management and specialty care network methods to meet the needs of high-risk enrollees and "coordinate or integrate beneficiary communication materials, enrollment, communications, grievance[s] and appeals, and quality improvement" (42 CFR 422.2). More details on these models can be found in Chapter 1 of MACPAC's June 2020 report to Congress (MACPAC 2020a).

[8] Beginning in 2025, plans must cover LTSS, behavioral health, Medicare cost sharing, home health, and medical equipment, supplies, and appliances to qualify as a FIDE SNP (CMS 2022).

[9] The Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) permanently authorized D-SNPs to operate as part of the MA program.

[10] These figures include D-SNP enrollees in Puerto Rico, where, unlike in the states, almost all dually eligible beneficiaries, about 301,000 individuals, are enrolled in a D-SNP (Freed et al. 2024, CMS 2023b).

[11] In April 2024, CMS codified previous guidance regarding MOC scoring and submission procedures in a final rule (CMS 2024a).

[12] Flexibility to offer certain supplemental benefits is available only to HIDE SNPs and FIDE SNPs that meet minimum performance and quality-based standards. All MA plans may offer supplemental benefits that are primarily health-related or that reduce cost sharing for enrollees. Additionally, MA plans may offer special supplemental benefits for the chronically ill to enrollees with complex chronic conditions and high needs, including benefits that are not primarily health related but are reasonably expected to maintain or improve the health or overall function of an enrollee (42 CFR 422.102(f)).

[13] D-SNPs that use EAE and cover at least some Medicaid benefits qualify as AIPs, which must unify certain appeals and grievance processes.

[14] In April 2024, CMS issued a final rule that would increase the number of beneficiaries with EAE, requiring D-SNPs whose parent organizations also contract as a Medicaid managed care plan enrolling full-benefit dually eligible individuals in the same service area to operate with EAE by 2030 (CMS 2024a).

[15] Of the five case study states, four use a competitive procurement process to select the D-SNP or Medicaid managed care plans with which they will contract. Idaho currently contracts with all qualified vendors that wish to operate (Idaho DHW 2022). However, state officials said they are drafting procurement requirements and selection criteria to transition to a competitive procurement process.

[16] CMS is responsible for approving a MA organization's application to contract to cover Medicare services. A MA organization may not operate without this contract.

Application requirements and evaluation procedures are described at 42 CFR 422.501-3.

[17] The District of Columbia, Idaho, and New Jersey directly capitate coverage of Medicaid services to the D-SNP, which means that the D-SNP also holds the Medicaid managed care contract for provision of services to D-SNP enrollees.

[18] Enrollment in managed care through a D-SNP for dually eligible beneficiaries in the District of Columbia is voluntary (DC DHCF 2021).

[19] In California, interviewees said the state also informs plans about proposed policies in its D-SNP policy guide, a separate document referenced in the SMAC that provides plans with operational and technical details for requirements such as data reporting.

[20] Since reporting requirements are listed in the D-SNP policy guide in California, rather than the SMAC, health plan representatives said delays between the SMAC execution date and the policy guide release can complicate efforts to submit reports as contractually required. A health plan said that it frequently does not receive reporting requirements from the state early enough to undergo necessary IT systems changes, and on occasion has had to resubmit data reports because guidelines on data reporting were released after reports were due. Health plan representatives also described an experience where it said that materials it printed to meet CMS deadlines needed to be reprinted due to the state's timing in providing guidance for required language, creating administrative burden and expenses for the plan.

[21] When California replaced the Financial Alignment Initiative demonstration with D-SNPs in seven counties in 2023, it limited D-SNP contracts to plans that operate affiliated Medicaid plans in those counties and will require all Medicaid plans to have a D-SNP by 2026 (California DHCS 2022). California restricts new enrollment in non-AIP D-SNPs in counties in which AIP CO D-SNPs operate.

[22] Minnesota said it tracks complaints from providers, which it uses as a flag to investigate further and determine how plans are performing. For example, state officials said one plan received complaints related to transportation and Minnesota spoke directly to the plan to address the issue. When the District of Columbia identifies spikes in appeals and grievances for certain types of services, officials said they escalate these issues with the plan as necessary.

[23] Minnesota uses data, including HRA completion and quality measures to set quality performance targets for its withholds and ensure plans are meeting those targets. Officials said that using data ensures they are setting attainable targets for their plans and establishes a precedent of monitoring and goal setting.

[24] Similarly, the District of Columbia said it receives HEDIS data and compiles it with measures reported by other health plans in the District. However, officials said these measures are not yet being used to inform operations, such as in the District's initiative focused on health equity.

[25] Departments may also divide oversight duties by plan contract. Minnesota said it has a team of contract managers who are responsible for compliance and oversight, with a team responsible for contract compliance assigned to each health plan. In Idaho, officials said a core D-SNP team oversees the state's four contracts and works with other groups on an ad hoc basis.

[26] Officials in several states said that other monetary tools, such as invoice reductions, are most effective in ensuring plan compliance. Idaho's SMAC has a detailed list of invoice reductions for plans that fail to report data or that do not meet specific metrics.

[27] In New Jersey, officials said FIDE SNP quality incentives are focused on Medicaid program goals that may apply to dually eligible beneficiaries, such as blood pressure, home and community-based service delivery, and nursing facility transition measures. For example, the state said it uses claims data to evaluate if services delivered match what the plan is authorized to provide. If the percentage match is high enough, plans can receive performance incentives.

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APPENDIX 2A: State Use of Selected Contracting Strategies in State Medicaid Agency Contracts

To better understand how states use their state Medicaid agency contracts (SMACs) to further integrated care for dually eligible beneficiaries enrolled in Medicare Advantage dual eligible special needs plans (D-SNPs), MACPAC enlisted Mathematica to conduct a review of all SMACs for contract year 2023. Our review found most contract provisions that go beyond federal minimum requirements fell under five categories: coverage alignment, care coordination, integrated materials and member experience, data sharing, and reducing health disparities and improving quality.

In Table 2A-1, column A includes all 45 states and the District of Columbia that contracted with D-SNPs in contract year 2023 and displays how many of these states use selected contracting strategies in their SMACs. Column B features the subset of these states that contract with highly integrated dual eligible special needs plans or fully integrated special needs plans, although these states may also contract with coordination-only dual eligible special needs plans.

TABLE 2A-1. State Use of Selected Contracting Strategies in State Medicaid Agency Contracts, May 2023

Contract provision category	Count of states with any D-SNP type that use selected contracting strategies (A)	Count of states with HIDE SNPs or FIDE SNPs that use selected contracting strategies (B)
Total number of states with plan type	**46**	**21**[1]
Coverage alignment		
Limits enrollment to FBDE or requires separate PBPs[2]	15	14
Requires EAE	9	9
Requires default enrollment	10	9
Care coordination		
Requirements regarding health risk assessments	11	10
Requirements regarding individualized care plans	9	8
Requirements regarding interdisciplinary care teams	7	6
Requirements for care coordinators	11	9
Requirements for aligned Medicare and Medicaid provider networks	6	6
Integrated materials and member experience		
State review of Medicaid information in D-SNP marketing or communication materials	19	14
State provides template language on Medicaid benefits for marketing or communication materials	6	4

TABLE 2A-1. (continued)

Contract provision category	Count of states with any D-SNP type that use selected contracting strategies (A)	Count of states with HIDE SNPs or FIDE SNPs that use selected contracting strategies (B)
Requires provider directory to indicate providers that accept both Medicaid and Medicare	17	10
Requires single ID card	9	9
Provides integrated customer service line	3	3
Requires integrated communication materials	9	9
Provides translation of enrollee materials	6	6
Data sharing		
Send MA encounter data	15	12
Send quality measure data	19	11
Data on plan determinations, appeals, grievances	13	11
HRA scores	11	9
Enrollment and disenrollment data	18	11
Medicare provider network data	13	10
Reducing health disparities and improving quality		
Requirements related to enrollee advisory committees	5	4
Requirements related to supplemental benefits	13	9
D-SNPs must identify and reduce health disparities among their members or share data on disparities	6	6
D-SNPs must participate in state Medicaid quality improvement initiatives	7	6

Notes: D-SNP is dual eligible special needs plan. HIDE SNP is highly integrated dual eligible special needs plan. FIDE SNP is fully integrated dual eligible special needs plan. FBDE is full-benefit dual eligible. PBP is plan benefit package. EAE is exclusively aligned enrollment. MA is Medicare Advantage. HRA is health risk assessment.

[1] The total number of states with HIDE SNPs or FIDE SNPs includes all states and the District of Columbia in which at least one plan with either designation operates.

[2] This category includes states that limit D-SNP enrollment to full-benefit dually eligible individuals for all or some of their D-SNPs, as well as states that require a separate PBP for partial-benefit dually eligible beneficiaries.

Source: MACPAC analysis of contract year 2023 state Medicaid agency contracts.

APPENDIX 2B: Case Study State Profiles

With Mathematica, MACPAC interviewed five case study states: California, the District of Columbia, Idaho, Minnesota, and New Jersey. Below, we provide brief summaries of the Medicare Advantage (MA) dual eligible special needs plan (D-SNP) coverage landscape for dually eligible individuals in each state.

Summaries describe the state's dually eligible population, how Medicaid benefits—including medical services, behavioral health services, home- and community-based services, nursing facility services, and Medicare cost sharing—are covered, and the D-SNP parent organizations that operate within the state. Although both the full-benefit dually eligible population, comprising those that receive full Medicaid benefits, and partial-benefit dually eligible population, which includes those eligible only for Medicare cost sharing and premium assistance, are described, summaries describe only how Medicaid services are covered for the full-benefit dually eligible population.

Each summary details the number of D-SNP parent organizations operating in the state as of contract year 2023 as well as the range of experiences that D-SNPs have operating in that state.

D-SNPs operate at varying levels of integration and have additional requirements depending on the types of Medicaid services that the D-SNP covers. Integration types include coordination-only dual eligible special needs plans (CO D-SNPs), highly integrated dual eligible special needs plans (HIDE SNPs), and fully integrated dual eligible special needs plans (FIDE SNPs), which are described in this chapter. Each of these plan types may qualify as an applicable integrated plan (AIP) if states require that they use exclusively aligned enrollment, which allows D-SNPs to enroll only beneficiaries who are enrolled in an affiliated Medicaid managed care plan under the same parent organization.

TABLE 2B-1. Characteristics of Case Study States and their Dually Eligible Populations

State	Description
California	Population Dually eligible individuals, 2022: • Full benefit: 1,644,120 (98 percent) • Partial benefit: 28,773 (2 percent) As of September 2023, full-benefit dually eligible individuals received their Medicare coverage through: • Traditional Medicare fee-for-service or traditional MA: 1,213,455 (74 percent) • CO D-SNP: 164,300 (10 percent) • AIP CO D-SNP: 245,331 (15 percent) • AIP FIDE SNP: 21,034 (1 percent) Services • Medi-Cal managed care plans provide most services, excluding some behavioral health benefits that are delivered through county behavioral health agencies. Home- and community-based services are mostly fee for service, except through an affiliated Medi-Cal managed care plan for AIP FIDE SNPs D-SNP parent companies • Nineteen parent organizations (1 year–16 years)

TABLE 2B-1. (continued)

State	Description
District of Columbia	Population Dually eligible individuals, 2022: • Full benefit: 26,330 (70 percent) • Partial benefit: 11,059 (30 percent) As of September 2023, full-benefit dually eligible individuals received their Medicare coverage through: • Traditional Medicare fee for service or traditional MA: 17,219 (65 percent) • AIP HIDE SNP: 9,111 (35 percent) As of September 2023, partial-benefit dually eligible individuals received their Medicare coverage through: • Traditional Medicare fee-for-service or traditional MA: 5,239 (47 percent) • CO D-SNP: 5,820 (53 percent) Services • Most services are included in the D-SNP capitated rate, excluding some behavioral health services D-SNP parent companies • One parent organization (5 years–7 years)
Idaho	Population Dually eligible individuals, 2022: • Full benefit: 34,524 (63 percent) • Partial benefit: 20,324 (37 percent) As of September 2023, full-benefit dually eligible individuals received their Medicare coverage through: • Traditional Medicare fee for service or traditional MA: 20,192 (58 percent) • AIP FIDE SNP: 14,332 (42 percent) As of September 2023, partial-benefit dually eligible individuals received their Medicare coverage through: • Traditional Medicare fee for service or traditional MA: 19,149 (94 percent) • CO D-SNP: 1,175 (6 percent) Services • AIP FIDE SNPs, known in Idaho as Medicare-Medicaid Coordinated Plans, cover all services except Medicare cost sharing, which the state Medicaid agency pays to providers directly D-SNP parent companies • Two parent organizations (5 years–15 years)

TABLE 2B-1. (continued)

State	Description
Minnesota	Population Dually eligible individuals, 2022: • Full benefit: 137,246 (90 percent) • Partial benefit: 16,066 (10 percent) As of September 2023, full-benefit dually eligible individuals received their Medicare coverage through: • Traditional Medicare fee for service or traditional MA: 78,777 (57 percent) • AIP HIDE SNP: 11,618 (9 percent) • AIP FIDE SNP: 46,851 (34 percent) As of September 2023, partial-benefit dually eligible individuals received their Medicare coverage through: • Traditional Medicare fee-for-service or traditional MA: 19,149 (94 percent) Services • All services are provided by Minnesota Senior Health Options plans for AIP FIDE SNPs or through affiliated Special Needs Basic Care plans for AIP HIDE SNPs. The state Medicaid agency pays Medicare cost sharing directly to D-SNPs D-SNP parent companies • Eight parent organizations (1 year–16 years)
New Jersey	Population Dually eligible individuals, 2022: • Full benefit: 222,243 (88 percent) • Partial benefit: 29,489 (12 percent) As of September 2023, full-benefit dually eligible individuals received their Medicare coverage through: • Traditional Medicare fee for service or traditional MA: 129,118 (58 percent) • AIP FIDE SNP: 93,125 (42 percent) As of September 2023, partial-benefit dually eligible individuals received their Medicare coverage through: • Traditional Medicare fee for service or traditional MA: 29,489 (100 percent) Services • All services are included in the D-SNP capitated rate D-SNP parent companies • Five parent organizations (2 years–15 years)

Notes: MA is Medicare Advantage. Co D-SNP is coordination-only dual eligible special needs plan. AIP is applicable integrated plan. FIDE SNP is fully integrated dual eligible special needs plan. HIDE SNP is highly integrated dual eligible special needs plan. D-SNP is dual eligible special needs plan.

Sources: California DHCS 2024a, 2024b, 2023, 2022; CMS 2023a, 2023b, 2023c, 2022; DC DHCF 2022; Idaho DHW 2023; Minnesota DHS 2023, 2021, 2019; interviews with New Jersey Department of Human Services Division of Medical Assistance and Health Services staff.

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on April 12, 2024.

Optimizing State Medicaid Agency Contracts

2.1 State Medicaid agencies should use their contracting authority at 42 CFR 422.107 to require that Medicare Advantage dual eligible special needs plans (D-SNPs) operating in their state regularly submit data on care coordination and Medicare Advantage encounters to the state for purposes of monitoring, oversight, and assurance that plans are coordinating care according to state requirements. If states were required by Congress (as previously recommended by the Commission) to develop a strategy to integrate Medicaid and Medicare coverage for their dually eligible beneficiaries, states that include D-SNPs in their integration approach should describe how they will incorporate care coordination and utilization data and how these elements can advance state goals.

2.2 The Centers for Medicare & Medicaid Services should issue guidance that supports states in their development of a strategy to integrate care that is tailored to each state's health coverage landscape. The guidance should also emphasize how states that contract with Medicare Advantage dual eligible special needs plans can use their state Medicaid agency contracts to advance state policy goals.

2.1-2.2 voting results	#	Commissioner
Yes	16	Allen, Bella, Bjork, Brooks, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McCarthy, McFadden, Snyder, Weno
Not present	1	Medows