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Optimizing State Medicaid Agency Contracts

Review of recommendations and draft chapter for June report

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Overview

- Background
  - Medicare Advantage (MA) dual eligible special needs plans (D-SNPs)
  - State Medicaid agency contracts (SMACs)
- Leveraging SMACs
- Optimizing and overseeing SMACs
- Considerations for states
- Recommendations
- Next steps

Background

Dually Eligible Beneficiaries and D-SNPs

- MA D-SNPs are a type of special needs plan (SNP) designed to provide targeted care to dually eligible beneficiaries
- In calendar year 2021, there were 12.8 million dually eligible individuals
  - Of full-benefit individuals that received Medicare benefits exclusively from managed care, 60 percent were enrolled in a D-SNP
- About 1.75 million full-benefit dually eligible individuals (21 percent) were enrolled in an integrated care plan
  - Levels of Medicaid-Medicare integration in a D-SNP vary
- D-SNPs are different from traditional MA plans
  - All SNPs are required to establish a model of care that describes the basic framework for how the plan will meet the care coordination needs of its enrollees
  - Unlike other SNPs, D-SNPs are required to contract with state Medicaid agencies through the state Medicaid agency contract (SMAC)

SMACs

- D-SNPs are required to sign a SMAC in order to operate within a state, but states are not obligated to contract with every D-SNP
- Federal law sets minimum requirements for coordination of Medicaid benefits in the SMAC
  - States can go beyond these requirements to require greater integration or better tailor how D-SNPs serve their population
- Minimum requirements for coordination of Medicaid benefits were established by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)
  - Additional requirements were included in the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) and continue to be refined in rulemaking

Leveraging SMACs

Review of contract year 2023 SMACs

Contract Review

- We reviewed SMAC language for D-SNPs operating during contract year 2023 and found most provisions fell within five domains
  - Coverage of Medicaid benefits
  - Care coordination
  - Integrated materials and member experience
  - Data sharing
  - Reducing health disparities and improving quality
- State adoption of SMAC provisions is uneven
- More information was needed to understand why states include the provisions they do and how they oversee their contract requirements

Optimizing and Overseeing SMACs

Interviews With Key Stakeholders

- Through a series of interviews, we 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
  - How states oversee and enforce their SMAC requirements
- Interviewees included state officials, federal officials at the Medicare-Medicaid Coordination Office (MMCO) within CMS, and health plan representatives for two plans operating across our case study states
  - California
  - District of Columbia
  - Idaho
  - Minnesota
  - New Jersey

Key Themes

- Our interviews with SMAC stakeholders highlighted key themes within four domains
  - Contracting considerations
  - Data and reporting requirements
  - Monitoring and oversight processes
  - Performance improvement and enforcement
- Interviews also surfaced barriers that state Medicaid agencies encounter in optimizing and overseeing their SMACs with D-SNPs

Considerations for States

Barriers to Optimizing SMACs

- States face barriers in leveraging and overseeing their SMACs with D-SNPs that mirror the larger challenges that states have in pursuing integrated care models
- The Commission made recommendations to Congress in 2020 and 2022 to support building state capacity to pursue integrated care for dually eligible individuals

Strategies for Effective Oversight

- 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
- Our interviews identified two tools that could represent a starting point for states to optimize and oversee their contracts
  - Care coordination data
  - MA encounter data

Recommendations

Rationale and implications

Recommendation 2.1 (as approved)

- 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 and Implications

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
- Few states currently collect and use MA encounter data to oversee D-SNPs, but officials said these data are necessary to understanding the health of the dually eligible population and for informing quality improvement efforts
- These data requirements could apply to D-SNPs across the integration spectrum

Implications

- Federal spending
  - No direct effect
- States
  - Substantial upfront administrative burden, especially to process MA encounter data
- Enrollees
  - No direct effect, but enrollees may receive more integrated care
- Plans
  - Administrative burden to submit these data
- Providers
  - No direct effect

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 and Implications

Rationale

- CMS guidance could prompt development of a strategy by outlining tools available
- Federal officials said a lack of awareness of state contracting authority and its limitations, as well as the value of leveraging the SMAC, hinders. Guidance could inform states and emphasize how leveraging SMACs can add value

Implications

- Federal spending
  - No effect on direct spending
- States
  - Guidance could benefit states in need of clarity on their SMAC authority and may catalyze state Medicaid agencies and their leadership to determine how integrated care may fit their state circumstances
- Enrollees
  - No direct effect, but enrollees may gain greater access to integrated care options
- Plans
  - No direct effect
- Providers
  - No direct effect, but some providers may benefit from information on available integrated care models

Next Steps

- Votes on recommendations tomorrow
- Finalize chapter for June report to Congress
- Staff will continue to track legislation in Congress and CMS rulemaking on integrated care models for dually eligible beneficiaries

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