## Highlights from MACPAC November Public Meeting

**Overview:** On November 2 and 3rd, 2023 the Medicaid and CHIP Payment and Access Commission (MACPAC) held a public meeting. Presentation slides and the agenda for this meeting can be found on MACPAC's website.

### Session 1: Improving the Managed Care Appeals Process

***Presenters:***

- Lesley Baseman, Senior Analyst
- Amy Zettle, Principal Analyst

**Background**

- During the meeting, MACPAC staff discussed potential changes to the appeal procedures in Medicaid's managed care system. This has been a focus for MACPAC over the past year. Medicaid managed care organizations (MCOs) are responsible for overseeing and funding the healthcare of their members and ensuring that only necessary medical treatments are given. If a member disagrees with an MCO's denial decision, they can appeal it. The meeting highlighted issues with the current appeal rules and looked into possible solutions. The team also sought opinions from Commissioners on these potential solutions.

**Focus Group**

- MACPAC contracted Mathematica to do a focus group of people who appealed a managed care denial in the last three years, including both beneficiaries and caregivers. These individuals were identified by state ombudsman offices, and consisted of 22 beneficiaries and caregivers across eight states.

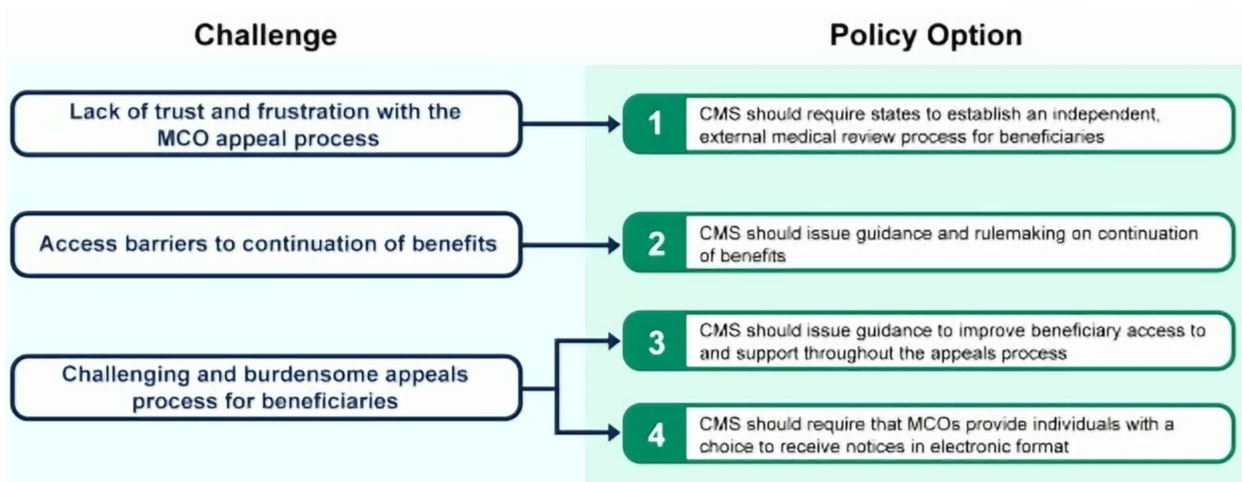
**Findings**

- Lack of Trust and Frustration with the Appeals Process: Many participants had negative experiences with their MCOs. They found member services representatives to be uninformed and unhelpful. Many felt powerless against the MCOs. Those who had experience filing appeals in the past were less optimistic about the process than those who had never filed an appeal.
- Access Barriers to Continuation of Benefits: Participants were generally unaware of their rights to a continuation of benefits during the appeal process. Many believed the 10-day timeline from the date of the denial notice to file an appeal was too short. The potential need to repay for services discouraged beneficiaries from continuing their services.
- Challenging and Burdensome Appeals Process: Some participants either received the denial notices too late to appeal or never received them at all. They found the process time-consuming, especially when gathering clinical

documentation. Many sought external help, including from medical providers, community organizations, and the state ombudsman's office, to navigate their appeal.

**Policy Options and Rationale**

- External Medical Review: CMS should require states to establish an independent, external medical review (EMR) process for beneficiaries after they've gone through the internal MCO appeal. The rationale is that an independent clinical review would improve trust and ensure access to necessary medical services. 46% of appeals to an EMR were overturned in favor of the beneficiary, making it a useful tool for monitoring MCO denials and overturn rates. This is already done in 14 states.
- Continuation of Benefits: CMS should issue rulemaking to extend the timeline for beneficiaries to request the continuation of benefits and require monitoring of this process. The rationale being hat beneficiaries were often unaware of their rights, and the short timeframes and the fear of potential repayments in the case of improper payments were barriers.
- Beneficiary Access and Support: CMS should issue guidance detailing tools and approaches to support beneficiaries navigating the appeals process. The rationale is that few beneficiaries appeal services, and the complexity of the process highlights the need for significant external support.
- Electronic Notices: CMS should require MCOs to offer beneficiaries the choice to receive electronic notices (e.g., phone, email, text). The rationale is that mailed notices are often late or never arrive, and beneficiaries supported additional communication modes.



**Commissioners' Comments**
Commissioners had varying opinions on the recommendations. Recommendation 1 (on EMRs) proved to be the most controversial. Commissioners cited the potential cost and the burden on states given the automatic nature of the review. Others suggested that EMR overturn rates could provide useful insight for quality measures for plan ratings. Commissioners proposed a recommendation that the federal government pay an enhanced FMAP for additional EMRs. Recommendation 3 was supported by Commissioners, with the caveat that anything CMS does should not add to the administrative burden of the beneficiary. Recommendations 2 and 4 saw broad support by Commissioners, with some debate over whether mail notices are a duplicative requirement if the notice is sent by other means. Commissioners described the appeals process as arduous, bureaucratic and demoralizing for beneficiaries and caregivers alike. They had strong general interest in policies that would improve the transparency of the process and reduce burden on providers, beneficiaries and caregivers alike. All four recommendations will be voted on at the January MACPAC meeting.

**Public Comment**
Dr. Arvind Goyal, the Chief Medical Officer (CMO) of Illinois Medicaid, spoke about this issue as he did in September. He recommended MACPAC convene a provider focus group to hear their perspectives as well about the burdens of prior authorization, which he suggested was driving serious abrasion. Dr. Goyal also suggested that the commission recommend a financial penalty on plans that have a high number of denials later overturned.

## Session 2: Medicaid Primary Language and Limited English Proficiency Data Collection

***Presenter:***

- *Linn Jennings, Senior Analyst*

**Background**
MACPAC is studying how data on primary language, limited English proficiency (LEP), sexual orientation, gender identity, and disability can help understand and tackle health disparities. This presentation specifically delved into the collection of primary language and LEP data, discussing its importance, its role in ensuring language accessibility and gauging health disparities, and methods to collect this information from Medicaid beneficiaries. Individuals with LEP often face enrollment obstacles, report adverse health outcomes, and struggle with healthcare communication.

**Definitions and Health Disparities:**

- Primary Language: Refers to an individual's main spoken or written language, often used to determine language service needs.
- Limited English Proficiency (LEP):  Identifies individuals with challenges in English communication.

**Medicaid Language Data Collection and Purpose**

- Medicaid Application: Beneficiary's primary language informs states about language service needs. Most Medicaid programs collect primary language data, with only a few collecting LEP data. HHS has developed a model application, which includes questions about primary language, but not other categories. However, states are able to make their own applications with CMS approval or to add to the model application.
- Federal Surveys: Less than half of the federal health surveys include questions about primary language and LEP. Federal surveys have population-level information that can be disaggregated to assess the experiences of Medicaid-covered individuals with language service needs with accessing and using health services, satisfaction with providers, and quality of care.

**Considerations**

- Application and Data System Updates: Both are resource-intensive, especially when translating into multiple languages or updating data systems.
- Data Quality: Self-reported data is preferred, but language characteristics can change over time. Ensuring data privacy and representativeness is crucial.
- Next Steps: Upcoming demographic data collection topics include sexual orientation and gender identity (SOGI) and self-reported disability. Feedback from Commissioners is sought for future policy development.

**Commissioners' Comments**

Commissioners' emphasized the importance of this work, and appreciated spending a session every meeting focused on data collection, viewing it as critical to advancing health equity. Commissioners emphasized that CMS needs to offer more flexibility to states in changing their applications. They also noted that any change to Medicaid forms should be mindful to avoid exacerbating the administrative burden on the beneficiary.

## Session 3: Panel Discussion: Unwinding the Continuous Coverage Requirement in Medicaid: State and Managed Care Plan Strategies

***Introduction:***

- *Martha Heberlein, Principal Analyst and Research Advisor*

***Panelists:***

- *Amir Bassiri, Deputy Commissioner of the Office of Health Insurance Programs and Acting Medicaid Director, New York State Department of Health*
- *Cora Steinmetz, Medicaid Director, Indiana Family and Social Services Administration (FSSA)*
- *Stephanie Myers, State Affairs Director, Medicaid Health Plans of America (MHPA)*

**Stephanie Myers, State Affairs Director, Medicaid Health Plans of America (MHPA)**

- Myers emphasized that MCOs prioritize maintaining coverage, wherever that may come from. They have adopted various outreach methods, with texting proving highly effective. Some MCOs collaborate with retail businesses, schools, employers, and even other MCOs. They have also provided health navigator grants to federally qualified health centers (FQHCs) and partnered with food banks in Kentucky for outreach. In Hawaii, MCOs fund an organization specifically for outreach, and one MCO even funded a TV advertisement. Myers expressed support for (e)(14) waivers allowing MCOs to assist members with paperwork and expressed a desire for more states to adopt them. She mentioned challenges related to data transitions between Medicaid and CHIP, depending on the state and how it handles CHIP procurement. She concluded by expressing gratitude for state partners.

**Cora Steinmetz, Medicaid Director, Indiana Family and Social Services Administration (FSSA)**

- Steinmetz highlighted Indiana's close collaboration with ground partners, who offered to handle member outreach if provided with sufficient data. The Healthy Indiana (expansion population) plan had the highest procedural disenrollment, leading to a shift in messaging. Indiana adopted innovative outreach methods, collaborating with various state agencies. MCO partners maintained a consistent message, making multiple contact attempts for redeterminations. Indiana adopted several flexibilities, yielding positive results, especially with MCOs. Challenges included staffing uncertainties due to the unpredictable end of the unwinding process and communication barriers with providers. They faced no issues with ex parte renewals and observed no significant shifts in utilization.

**Amir Bassiri, Deputy Commissioner of the Office of Health Insurance Programs**

**and Acting Medicaid Director, New York State Department of Health**

- Bassiri shared that they are only a third of the way through the unwinding process, expecting completion by May 2024. They initially planned to use federal authorities for the non-median adjusted gross income (MAGI) population but integrated some flexibilities into a modern system. Texting proved impactful, especially for the 19-34 age group. Collaborations with providers and pharmacies were beneficial, with call centers directly reaching out to members. They aim for transparency, with a focus on health equity measures. Challenges included a tight four-month compliance window from CMS and concerns about the capacity of local counties, who handle the aged/blind/disabled population. CHIP renewal rates were the highest of all groups, and they observed no increase in eligibility-related fair hearing requests. They have monitored utilization trends (no big changes) and have faced pushback from plans concerned about treating higher acuity members when low utilization members are moved to fee-for service.

**Commissioners' Comments**

The commissioners noted that states are at different stages of employing (e)(14) waivers, and it's not necessarily based on political alignment. For instance, Tennessee has performed well and taken advantage of many flexibilities. The challenge lies in understanding the barriers preventing states from leveraging flexibilities. Renewal data has been invaluable, but there's a risk of losing it when CAA requirements expire in June. The aim is to learn from the current situation to enhance the system. The commissioners suggested that MACPAC should commission research on how Medicaid programs prioritize populations for redeterminations.

### Session 4: Medical Care Advisory Committees (MCACs) and Beneficiary Engagement

***Presenter:***

- *Audrey Nuamah, Senior Analyst*

**Background:**

MACPAC senior analyst continued the conversation as it relates to potential recommendations to Medical Care Advisory Committees (MCACs). For previous MACPAC discussions on this topic, please read here. Since their last discussion on this topic in September, CMS released a notice of proposed rulemaking (NPRM) that would change federal MCAC rules. Those changes include; the renaming of MCACs to Medicaid Advisory Committee (MAC), expansion of the range of topics addressed beyond health and medical services, establishing Beneficiary Advisory Groups (BAGs), and requiring state agencies to publicly post information related to MAC and BAG

activities. In this session, MACPAC presented their key findings as well as potential policy options for the Commission to consider for inclusion in their March report to Congress.

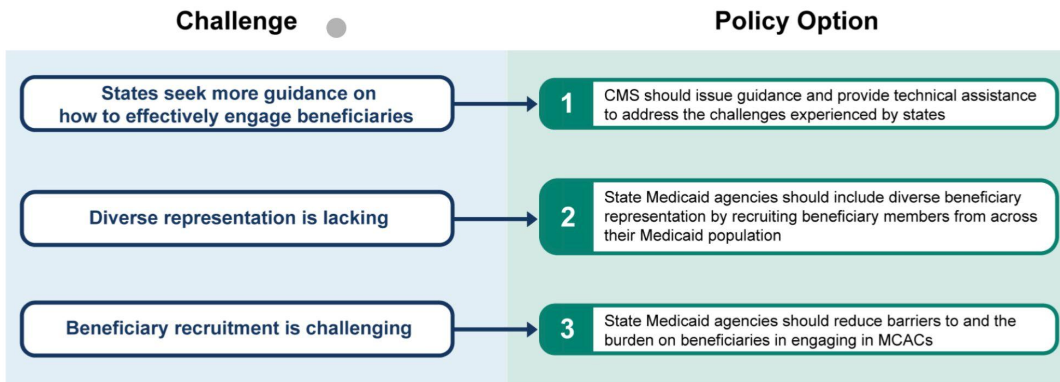
**Key Findings:**

- States seek more guidance on effectively engaging beneficiaries:
    - States face limitations in their efforts to enhance beneficiary engagement due to resource constraints. Beneficiaries the desire for more support from state Medicaid agencies providing more support for their effective participation MCAC discussions. State Medicaid officials raised concerns about offering financial incentives for beneficiary engagement.
- Diverse beneficiary representation is lacking:
    - While federal rules require beneficiary membership in MCACs, they don't specify the diversity of these beneficiaries. Most states require beneficiary or consumer group representation, but few mandate representation from historically marginalized groups.
- Beneficiary recruitment is challenging:
    - State Medicaid agencies find it hard to recruit beneficiaries for MCACs due to complex application processes and other barriers. The NPRM suggests that more guidance on recruitment strategies might be provided in the future.

**Policy Options & Rationale:**

1. Issue CMS guidance: CMS should offer guidance and technical assistance to address state challenges in recruiting MCAC participants, facilitating beneficiary engagement, and providing financial arrangements for beneficiary participation.
    a. Rationale: States expressed the need for CMS to assist in providing specific guidance and technical assistance on how to leverage MCACs. They seek assistance in utilizing MCACs to gather input from beneficiaries, which would help shape and improve their program policies and operations.
2. Include diverse beneficiary representation: State Medicaid agencies should ensure diverse beneficiary representation in MCACs, especially from historically marginalized communities.
    a. Rationale: collaborating with beneficiaries from historically marginalized backgrounds allows for their unique experiences and concerns to be represented by the committee.
3. Reduce beneficiary burden: State Medicaid agencies should reduce barriers for beneficiaries by streamlining application processes and offering support for MCAC participation.

a. Rationale: Overcoming obstacles and offering beneficiaries extra support will help make it easier for beneficiaries to engage in MCAC activities.




**Commissioners' Comments**

There was overall support from the Commissioners on the policy options presented by the analyst, specifically for policies one and three. There was more discussion by the Commissioners as it related to policy two and the current wording. Specifically, as it relates to what exactly they are trying to achieve. Commissioners discussed option two and whether it should be framed to achieve a certain outcome, or better the process of selecting beneficiaries entirely. Ultimately the Commissioners agreed that it is imperative to include the voice of all beneficiaries if MACPAC wants to attempt to better this program. The session concluded with the Commission requesting a draft chapter be brought back for a vote on potential inclusion in their Spring 2024 report to Congress.

## Session 5: School-Based Behavioral Health Services: Findings from Stakeholder Interviews

***Presenters:***

- *Audrey Nuamah, Senior Analyst*
- *Melinda Becker Roach, Principal Analyst*

**Background**

Schools play a crucial role in offering health services to young individuals under Medicaid, especially given the rising behavioral health issues among the youth. To delve deeper into how these young individuals access behavioral health care, MACPAC engaged in discussions with stakeholders to explore the collaboration between states and schools in delivering behavioral health services to Medicaid-covered students and the factors to consider. The presentation shared insights from these discussions.

Although MACPAC's primary focus was on understanding school and state experiences in delivering behavioral health services within schools, many insights apply to general school-based services. The session also pointed out potential policy topics that MACPAC might explore in the future.

**Approach**

MACPAC conducted stakeholder interviews in five states: Arkansas, California, Michigan, Missouri, and New York. They engaged with state Medicaid and education agencies, school districts, advocacy organizations, and select national experts. These interviews were conducted before CMS released new guidance on May 18, 2023. MACPAC has since collaborated with more state and national experts, including CMS.

**Key Findings**

- Four of the studied states provide behavioral health services outside of an individualized education plan (IEP) or individualized family service plan (IFSP). However, the extent to which local education agencies bill for these services varies.
- States have limited data on the effects of covering non-IEP/IFSP services due to recent implementation and the pandemic's impact on school utilization.
- Stakeholders identified a lack of clear and updated federal guidance as a significant barrier to expanding access to behavioral health and other school-based services.
- Provider availability is a significant challenge to expanding access to behavioral health services in schools. States are taking measures to bolster the behavioral health workforce in schools.
- Stakeholders expressed the need for clear federal guidance on the types of providers that can bill Medicaid in schools.
- There are concerns about coordination and duplication of services, especially concerning services students receive in school through an IEP/IFSP.
- The use of federal matching funds for certified public expenditures can deter school billing.
- Stakeholders raised concerns about the random moment time study (RMTS) due to short notification and response times.
- Obtaining parental consent can delay care, and schools must navigate both state and federal laws.
- Determining medical necessity in a school setting can be challenging for providers.
- Third-party liability is an administrative burden that can prevent schools from obtaining Medicaid payment for covered services.
- The fear of federal audits can discourage states from covering non-IEP/IFSP services.

**Considerations & Next Steps**

- The staff identified three policy issues for the Commission's attention: coordination and duplication of services, ordering, referring, and prescribing requirements, and third-party liability. Future work could focus on identifying federal Medicaid policy levers to address these issues.
- Stakeholders are still analyzing the new federal guidance and its implications. MACPAC will continue monitoring for additional guidance and support, as well as information about the funding opportunity expected in early 2024. They also plan to publish an issue brief on Medicaid school-based services.

**Commissioners' Comments**

Commissioners questioned how managed care were being engaged in school-based services. Staff responded that a recent trend has been the carving out of school-based services from MCO contracts. Staff also asked about how benefits are aligned with free and reduced lunch eligibility, and how children are fed while on summer break. Commissioners debated whether eligibility standards for school-based providers should be eased, with some saying that it might allow lower quality providers into Medicaid while others said it was a needed flexibility. MACPAC is preparing an issue brief on the topic, and will not pursue recommendations at this time.

## Session 6: Medicaid Home- and Community-Based Services (HCBS): Comparing Requirements for States

***Presenters:***

- *Tamara Huson, Senior Analyst*
- *Asmaa Albaroudi, Senior Analyst*

**Background:**

MACPAC analysts returned to present to the Commission following previous work on Medicaid Home- and Community-Based Services (HCBS), with respect to the framework of authorities they discussed in their June 2023 report to Congress. For more information on the Commission's recent work on this topic, please read here. In this month's meeting, MACPAC analysts focused on the 4th domain, administrative authorities, included in MACPAC's report.

HCBS authorities include 4 different state plan options, these options offer design flexibilities and the ability to waive various requirements, such as statewide services, comparability of services, and community income rules:

- Section 1915(i) –for people who need less than an institutional level of care
- Section 1915(j) –for self-directed personal assistance services

- Section 1915(k) –also known as Community First Choice (CFC), provides a 6% point increase in the federal medical assistance percentage (FMAP) for attendant services
- Section 1915(c) –a waiver authority that allows for a broad range of services and design flexibilities for individuals with an institutional level of care

States consider various factors when selecting HCBS authorities, including state resources and capacity, the needs of different HCBS populations, state policy goals, legislative direction, and lawsuits.

**Methods:**

- MACPAC collaborated with Mathematica to explore the complexity of federal administrative requirements across HCBS Section 1915 authorities in the following categories: reporting, monitoring, quality improvement, application, approval, renewal, public input, cost neutrality, and conflict of interest. Their research involved 17 interviews with state officials in five states, as well as federal officials and policy experts.

**Key Findings:**

- Reporting, Monitoring, and Quality Improvement: All HCBS authorities have annual reporting requirements, but the elements and guidance differ. States generally found Section 1915(c) waivers to be the most prescriptive.
- Application, Approval, and Renewal: HCBS waiver and state plan options differ in application length, completion time, and technical guides. Waivers have shorter approval timelines and require renewals, while state plan options require one-time approvals.
- Public Input: All HCBS authorities must comply with federal regulations for public input. The requirements differ across authorities, with Section 1915(c) having the most detailed public comment process.
- Cost Neutrality: Only Section 1915(c) must comply with cost neutrality requirements, ensuring waiver services do not exceed institutional care costs.
- Conflict of Interest: All HCBS authorities must ensure conflict-free case management services. The requirements differ across authorities, with specific mandates for each.

The findings mainly reflect the perspective of states. MACPAC plans to follow up with CMS to understand their policy goals and compliance obligations. MACPAC analysts request feedback from the Commission on what areas they wish them to explore further and will return in January with policy options.

**Commissioners' Comments**

Commissioners expressed their concerns about requirements and fear too many make it harder for states to be successful. There was overall support for the analysts' work

and the importance of streamlining this process. It was encouraged by the Commission to try, when speaking to CMS, and gather their [CMS] perspective of the utilization of 1915 waivers in supporting a state's HCBS populations. The Commission is eager to hear what is found from MACPAC's work, especially their interviews with CMS, and look forward to their next presentation on this topic in 2024.

### Session 7: Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce

***Presenters:***

- *Rob Nelb, Principal Analyst*
- *Asmaa Albaroudi, Senior Analyst*

**Background:**

MACPAC analysts presented on how Medicaid payment policies for home- and community-based services (HCBS) support HCBS workers, including direct care workers, direct support professionals, and independent providers. The session included an overview of state payment policies and insights from interviews with national experts. The presentation highlighted five policy areas that require further examination in future research:

1. The data used to develop fee-for-service (FFS) rate setting;
2. Budget constraints that affect a state's ability to finance HCBS rates at levels recommended during the rate-setting process;
3. The use of self-directed services and managed care to pay rates that may differ from FFS;
4. Policies to regulate the share of HCBS payments agencies spend on HCBS worker wages
5. Non-financial policies to increase HCBS worker recruitment and retention.

**HCBS Workforce:**

- The HCBS workforce is composed of direct care workers, direct support professionals, and independent providers. In 2022, there were roughly 3.5 million HCBS workers. The demand for HCBS is growing faster than the workforce, with the COVID-19 pandemic exacerbating these challenges. Almost all states have reported shortages in one or more HCBS settings.

**Initial Interview Findings:**

MACPAC analysts collaborated with Milliman to review state HCBS payment policies reported in Section 1915(c) waivers and interview experts. In conducting their review of HCBS payment methods they examined three service categories; home-based services, day services, and round-the-clock care. Their initial findings were:

- FFS Rate Assumptions: Most states use data from the Bureau of Labor Statistics (BLS) to develop HCBS wage assumptions. However, those wage assumptions

do not reflect the level needed to ensure access and it's important to note that the BLS does not include any categories specific to the HCBS workforce.

- State Budget Constraints: States' ability to pay providers as per rate studies is limited by budget constraints. To try and help this issue, Congress temporarily increased federal funding under the American Rescue Plan Act (ARPA). Through the increased funding, states have until March 31, 2025 to spend their allotted ARPA funding.
- Self-Directed Services and Managed Care: States can allow beneficiaries to self-direct HCBS and pay rates different from fee-for-service (FFS). Plans are provided the flexibility to negotiate rates within their overall capitation rate.
- Payments Spend on Worker Wages: Many states are implementing wage pass-through requirements that increase direct rates to worker wages. However, concerns have been raised about these requirements being difficult to monitor and enforce. In May 2023, CMS proposed in rulemaking that 80% of Medicaid payments for specific services be spent on direct care worker compensation.
- Non-Financial Workforce Policies: Strategies for workforce recruitment and retention are being implemented alongside payment changes. A few of those recruitment strategies are public awareness campaigns, expanding the use of family caregivers, and including additional benefits for self-directed workers.

Analysts next phase of their HCBS project will involve discussions with state officials, provider associations, consumer advocates, and managed care organizations in five states. MACPAC analysts plan publicly releasing Milliman's compendium of Section 1915(c) waiver payment policies in the future and seek support from the Commissioners on the issues raised to help direct their process in interviewing state and stakeholders.

**Commissioners' Comments**

The Commissioners asked MACPAC analysts to provide any concerning findings MACPAC analysts came across. The analysts highlighted the difficulties states encounter when using BLS data and making wage assumptions. It was unexpected to see the significant dependence of states on BLS data. The Commissioners extensively debated the scarcity of reliable data and are optimistic that MACPAC analysts' research will lead to more insightful suggestions. The results from MACPAC's discussions are scheduled for presentation to the Commissioners in March.

## Session 8: Optimizing Contracts with Medicare Advantage D-SNPs: State Medicaid Agency Contracts (SMACs)

***Presenters:***

- *Kirstin Blom, Policy Director*
- *Drew Gerber, Analyst*

**Background on D-SNPs:**

- MACPAC analysts delved into the background of Medicare Advantage dual eligible special needs plans (D-SNPs), the contracts between these plans and state Medicaid agencies, and the main themes emerging from a review of these contracts. Medicare Advantage D-SNPs are specialized plans within the broader category of Special Needs Plans (SNPs) tailored specifically for individuals who qualify for both Medicare and Medicaid. What sets D-SNPs apart from other SNPs is their obligation to form agreements with state Medicaid agencies, ensuring they not only coordinate but occasionally also provide Medicaid services. Every SNP, including D-SNPs, must develop a "Model of Care" that outlines their strategy to cater to their members' needs. It's worth noting that this "Model of Care" stipulation is exclusive to SNPs and isn't a mandate for other Medicare Advantage plans.
- D-SNPs act as a primary mechanism for consolidating care services. In 2020, 51% 1% of MA enrollees who were duals were in D-SNPs. While D-SNPs are becoming more a more preferred choice for integrated care for dual-eligible individuals, the depth of integration can differ considerably between various plan options. By October 2023, out of the 5.7 million dual-eligible beneficiaries (which represents about 40% of all such individuals), a significant majority, 3.1 million to be precise, were part of the less integrated "coordination-only D-SNPs" (CO D-SNPs).

**D-SNP Integration Levels, Ranked from Least to Most Integrated:**

- CO D-SNPs (Coordination Only): These plans offer basic integration levels, encompassing all Medicare services. However, Medicaid services are usually provided by the state. As of 2023, they're available in 38 states and the District of Columbia.
- HIDE SNPs (Highly Integrated Dual Eligible Special Needs Plans): These plans are mandated to include Medicaid's long-term services and supports (LTSS), behavioral health services, or both, via a connected Medicaid managed care plan. In 2023, they're accessible in 15 states and the District of Columbia.
- FIDE SNPs (Fully Integrated Dual Eligible Special Needs Plans): By 2025, these plans will be obligated to cover both LTSS and behavioral health through a linked Medicaid managed care plan. As of 2023, they're operational in 12 states.

**State Medicaid Agency Contracts (SMACs):**

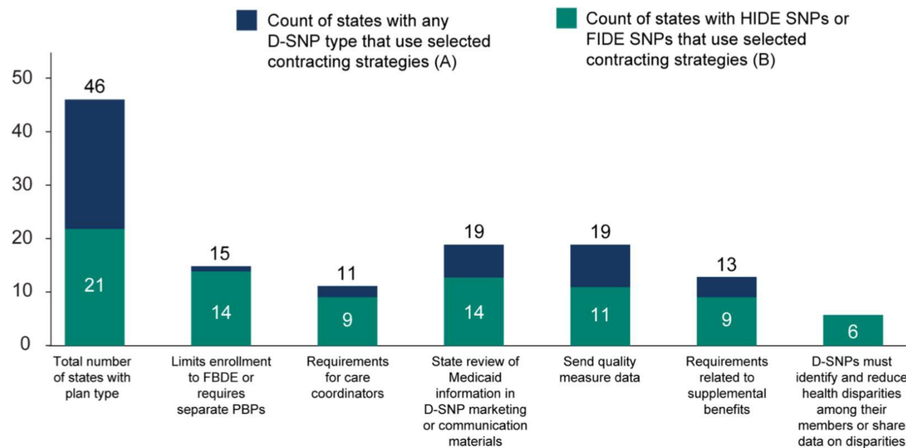
- While D-SNPs are obligated to form agreements with Medicaid agencies in the states they function in, the states themselves aren't mandated to enter into contracts with D-SNPs. The foundational guidelines for coordinating Medicaid benefits for D-SNPs were set by the Medicare Improvements for Patients and Providers Act (MIPPA) in 2008. Further stipulations, which include the definitions for HIDE SNPs and FIDE SNPs, were introduced in the Bipartisan Budget Act of 2018. States have the flexibility to exceed these basic guidelines, allowing them to demand more comprehensive integration or to customize how D-SNPs cater to their populations.
- In 2021, the Commission outlined various tactics that states could employ using their SMACs to enhance integrated care for those eligible for both Medicare and Medicaid. While certain tactics are accessible to all states that have D-SNPs, some are exclusive to states that utilize Medicaid-managed care. For instance, any state can restrict D-SNP registration solely to beneficiaries with full dual eligibility. However, only those states that have adopted Medicaid-managed care can mandate D-SNPs to function with a purely aligned enrollment in conjunction with their associated Medicaid-managed care plan.

**Key Themes from Review of SMACs:**

The presentation highlighted findings from a review of SMAC contract language for D-SNPs in 2023. The review was categorized into five areas:

- Coverage of Medicaid benefits
- Care coordination
- Integrated materials and member communications
- Data sharing
- Efforts to reduce health disparities and improve quality

The analysis revealed that states use various strategies in their contracts to enhance integration. Some strategies, like data-sharing provisions, were commonly used, while others, like requirements for enrollee advisory committees, were less frequent.




**Conclusions from SMAC Review and Next Steps:**
The next phase of the project involves interviews with state and federal officials and health plan representatives to gain deeper insights into how states develop and oversee their contracts. The aim is to understand the challenges and successes in optimizing these contracts for better care integration. The findings from these interviews will be presented in January, and based on the interest of the commissioners, potential policy options may be developed.

**Commissioners' Comments**
There was consistent interest among the Commissioners for understanding why certain states aren't utilizing these available resources, compared to discussions with states that are. Commissioners suggested it be beneficial to further research the reasons behind states' reluctance, or inability, to adopt these measures. For further work from the analysts, Commissioners provided potential interview topics, which included identifying obstacles to effectively understanding state capacity constraints, and pinpointing specific suggestions to overcome these challenges. It's also important to discuss any federal restrictions that hinder improvements. Consideration should be given to not just how states are using SMACs to promote integration, but also how they could optimize the use of SMACs for better integration outcomes.