



# Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Integrating Medicaid Managed Long-Term Services and Supports into D-SNP Models of Care

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States are increasingly contracting with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) that are paired with “affiliated” Medicaid managed care plans to better coordinate care for Medicaid beneficiaries who are dually eligible for Medicare. The D-SNPs cover Medicare benefits (e.g., hospital, physician, prescription drugs, and other primary and acute care services), while the Medicaid plans generally cover long-term services and supports (LTSS) and other “wraparound” Medicaid services. D-SNPs and Medicaid managed long-term services and support (MLTSS) plans that are affiliated – owned by the same company, operating in the same geographic area, and aligned administratively – have an opportunity to provide more seamless and coordinated care for dually eligible beneficiaries who receive both their Medicare and Medicaid services from the aligned plans.

**Medicaid services are not typically described in D-SNP Models of Care.** D-SNPs are required to develop a Model of Care (MOC) that describes enrollees’ unique characteristics and needs, the plan’s care coordination and management processes, and health risk assessment processes, among other topics.<sup>1,2,3</sup>

However, these requirements apply only to the Medicare benefits provided by a D-SNP. As a result, most D-SNP MOCs only describe Medicare services, despite the importance of Medicaid services to dually eligible enrollees. States can foster enhanced quality and service coordination by requiring that D-SNPs develop integrated MOCs that describe how the plan provides and/or coordinates Medicaid MLTSS benefits (and/or other Medicaid services provided by the plan, such as behavioral health) with the Medicare medical and prescription drug benefits provided by the D-SNP.

This tip sheet discusses the benefits of an integrated D-SNP MOC for both aligned and non-aligned D-SNPs, describes steps states can take to require integrated MOCs, and provides examples of how D-SNPs have operationalized state MOC requirements.

## What are the Benefits of an Integrated Model of Care?

**For States:** Provides a way of requiring plans to describe in detail how they will coordinate Medicare and Medicaid services.

**For Health Plans:** Establishes a framework and guidelines for how to operationalize coordinated care for plan management and staff.

**The Centers for Medicare & Medicaid Services (CMS) encourages states to require that D-SNPs include Medicaid services in their MOCs.** The draft (pp. 189-190) and final (p. 216) Calendar Year (CY) 2019 Medicare Advantage and Part D Call Letter (released in February and April 2018, respectively), describe the state option to require, via MIPPA contracts with D-SNPs,<sup>4,5,6</sup> that these plans create more robust MOCs that include information about the provision of Medicaid MLTSS and their integration with the medical and prescription drug benefits provided by the D-SNP. CMS' Medicare-Medicaid Coordination Office (MMCO) is available to provide technical assistance to states on this topic. **Interested state Medicaid officials should contact the MMCO at: [MMCO\\_DSNPOperations@cms.hhs.gov](mailto:MMCO_DSNPOperations@cms.hhs.gov).**

## Background

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All Medicare Advantage Organizations offering D-SNPs must submit a MOC to CMS for evaluation and approval by the National Committee for Quality Assurance (NCQA). D-SNP MOCs must include four standard elements: (1) a description of the D-SNP's population; (2) the plan's approach to care coordination; (3) how the D-SNP implements key provisions of the MOC among its provider network (e.g., via the use of clinical practice guidelines or care transition protocols); and (4) how the D-SNP conducts quality measurement and performance improvement. Each element is described in detail in a standard MOC Matrix Upload Document that D-SNPs must use to indicate the document, page number, and section of the corresponding description in the MOC. Plans submit the MOC and accompanying Matrix Upload Document to CMS via the Health Plan Management System for review and approval.<sup>7</sup> NCQA uses detailed scoring guidelines to assess MOCs, and, depending on the score received, a MOC is approved for a one-, two-, or three-year period.<sup>8</sup> Notably, NCQA's review of MOCs only evaluates the standard Medicare-required elements; NCQA will not review any added state-specific elements.

Medicare rules require that MOCs be submitted for approval when: (1) a Medicare Advantage Organization seeks to offer a new D-SNP; (2) the D-SNP MOC approval period ends; or (3) CMS deems it necessary to ensure compliance with applicable regulation(s), for example based on audit findings. In addition, 2016 CMS guidance established an off-cycle process for MOC changes; this guidance specifies that D-SNPs must notify CMS of any substantive modifications to the MOC, such as new benefits, or changes in policies and/or procedures related to the health risk assessment or individualized care plan process.<sup>9</sup> NCQA's website includes detailed guidance about various aspects of the MOC including: the standard timeline for MOC submission and approval; MOC scoring guidelines; details about the off-cycle revision process; and MOC training and technical assistance opportunities for health plans.<sup>10</sup>

## Benefits of Developing an Integrated MOC

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To inform the development of this tip sheet, Integrated Care Resource Center staff interviewed Medicaid officials and D-SNP staff in Minnesota and Massachusetts, who described some of the benefits of integrated MOCs:



- ✓ **For states, an integrated MOC provides a way to require plans to describe in detail how they will improve coordination of Medicare and Medicaid services.** State staff in Minnesota described their view of the relationship between the state’s contract with its D-SNPs and the D-SNP MOC as follows: “The contract describes what the plans have to do, and the MOC describes how they do it.” However, for a variety of reasons, MOCs may not fully reflect the integrated care a state expects the D-SNP to provide to enrollees. First, as noted above, MOC requirements only apply to the Medicare benefits provided by a D-SNP. In addition, D-SNP MOCs are written at the Medicare Advantage Organization contract level rather than at the plan level, and a Medicare Advantage Organization’s contract may cover several plans, some of which may operate in other states. For all of these reasons, without specific state requirements, MOC language may be fairly generic and may in some cases even contradict state-level, D-SNP-related requirements or processes. To help foster increased coordination of Medicare and Medicaid services, and to ensure that MOCs accurately reflect plan care management processes for dually eligible enrollees, states can:

- ◆ Require that the D-SNP MOC include state-specific provisions aimed at better coordinating Medicaid and Medicare services.
- ◆ Review a plan’s MOC to confirm that the description of the SNP population is accurate and complete, and to identify any inconsistencies with state contract requirements, or areas where additional state-specific language may be needed.

- ✓ **For beneficiaries, an integrated MOC promotes increased coordination of services for enrollees.** Staff from one Minnesota D-SNP described the importance of working with multiple health plan departments (e.g., provider network and utilization management, as opposed to only working with care management staff), to develop a comprehensive MOC that: (1) includes department-specific goals; and (2) describes in detail how all departments will work together, rather than in silos, to benefit their members. A plan staff member stressed, “You can’t deliver holistic and complete services without including Medicaid services in the model of care. That’s what I appreciate about including these Medicaid elderly waiver and other services in the model of care. Otherwise those wouldn’t be addressed.”

***“The contract describes what the [D-SNPs] have to do, and the MOC describes how they do it.”***

***– Minnesota State Official***

***“The MOC is a surprisingly useful tool. We use it almost every day. It paints a complete picture of the membership that allows you to look at the population profile and how that connects to the case management and benefit design. It also forces you to think through the operational and functional details of how care coordination will happen on the ground.”***

***– Minnesota D-SNP Staff***

- ✓ **For plans, an integrated MOC establishes a framework and guidelines for management and staff on how to operationalize coordinated care.** A MOC’s primary purpose is to guide plan operations. Staff from a second Minnesota D-SNP explained that they use their MOC to ensure their processes remain aligned with program goals: “Any time we are considering a change to how we deliver service to our members, we go back to the MOC to see if it would be compliant or not.”

## Implementation Steps for States



Key steps in developing and implementing an integrated MOC include:

### 1. Add a requirement to the MIPPA contract that D-SNPs submit their MOC to the state for review.

As previously discussed, states can add a requirement to their MIPPA contract that D-SNPs submit their MOC to the state for review concurrently with submission to NCQA. An example of Minnesota’s contract language is provided in Exhibit 1.

#### Exhibit 1. Minnesota Contract Language Requiring that D-SNPs Submit the MOC to the State

“The following reports, not described elsewhere in the contract, are required: .... (b) The most recent SNP model of care as submitted to CMS, unless already submitted to the STATE and there has been no change since the submission” (MSHO Seniors Model Contract, p. 210)

### 2. Review existing D-SNP MOCs.

States can then review existing D-SNP MOCs to identify any language that is inconsistent with state requirements and processes, or is insufficiently detailed, to inform new state-specific requirements.

### 3. Develop state-specific MOC requirements and a MOC review and approval process.

After reviewing current D-SNP MOCs, states will be in a position to develop additional state-specific requirements for MOC content that address the provision of MLTSS and/or other Medicaid benefits their integration with medical and prescription drug benefits. Appendix 1 lists all of the state-specific D-SNP contract requirements used by Minnesota and Massachusetts.

#### Developing State-Specific MOC Requirements

Both Massachusetts and Minnesota require D-SNPs to describe how MLTSS care coordinators communicate information about beneficiaries’ Medicare and Medicaid services, including MLTSS, to the beneficiary’s primary care or other key providers. Other states may want to consider incorporating this communication element or a modified version into MOC requirements for D-SNPs. States may also wish to create additional or different MOC requirements, depending on their unique program and D-SNP landscape. Exhibit 2 highlights Minnesota’s provider communication requirement and one plan’s corresponding MOC language. Appendix 1 lists each of the state-specific MOC requirements that Massachusetts and Minnesota

added to the standard MOC Upload Document for D-SNPs operating in their state. Appendix 2 provides a selection of examples of state-specific MOC requirements from Minnesota and Massachusetts with corresponding MOC language from D-SNPs in those states.

Another area of the MOC where both Massachusetts and Minnesota have required greater integration with Medicaid is in the section of the MOC devoted to describing the plan's Health Risk Assessment (HRA) tool(s). Both states require their D-SNPs to describe how their HRA process is coordinated with state-specific LTSS assessment tools<sup>11</sup> as well as how the HRA process meets state requirements for face-to-face initial assessments. To comply with these requirements and achieve full HRA integration, one D-SNP simply replaced its Medicare HRA tool with state assessment tools. When developing requirements for integrating MLTSS components into the HRA section of the MOC, states may want to review existing D-SNP HRA tools and compare them to state assessment tools, in order to help D-SNPs find efficient ways of accomplishing the goals of both assessments through a single, streamlined process when possible.

#### Exhibit 2. Minnesota's MOC Requirement Regarding Provider Communication and Corresponding D-SNP MOC Language

**State MOC Requirement:** "Describe that information about beneficiaries' Medicare and Medicaid services, including MLTSS, is communicated from the MLTSS care coordinator to the primary care or health care home provider."

**Corresponding D-SNP MOC Language:** "Information about a member's Medicare and Medical Assistance (Medicaid) services, including MLTSS, are incorporated into the Integrated Care Plan. The ICP is shared with all members of the Integrated Care Team. In [D-SNP A's] business structure, the MLTSS care coordinator is the member's assigned CCM who is part of the ICT and the main point of contact. In addition to active participation on the ICT, all providers, including primary care and HCHs, when/if applicable, receive a copy of or are given access to the electronic ICP. In the ICP, they can see and review in real time the current Medical Assistance (Medicaid) and Medicare long-term supports and services that the member has in order to support efforts to maintain the member in the least restrictive, most person-centered environment possible."

#### Developing MOC Submission, Review, and Approval Processes and Timeframes

- ◆ **MOC requirements and submission timetable.** As previously noted, MOCs are reviewed every 1-3 years, based on the score received from NCQA. States should provide plans with sufficient time to review draft MOC requirements, provide feedback on initial and revised draft elements, and develop the integrated MOC components in accordance with the new requirements. States should also consider aligning rollout of state-specific MOC requirements with D-SNP MOC submission timetables. Appendix 3 includes key dates in the standard MOC and D-SNP contracting schedule.
- ◆ **MOC submission for state review.** States will also need to develop and communicate a process by which D-SNPs will submit their MOCs to the state for review and approval. D-SNPs submit their MOCs to CMS via the Health Plan Management System, but states cannot review MOC submissions directly in that system, so a separate process for state review must be established. Minnesota and Massachusetts, for example, both require D-SNPs to submit their MOCs to the state for review concurrently with each MOC submission to CMS/NCQA.<sup>12</sup> Notably, CMS and NCQA do not evaluate

any state-specific MOC elements (e.g. MLTSS-related elements) in the MOC; states must conduct their own review to verify compliance with state-specific MOC requirements.

- ◆ **Evaluation criteria.** In addition to developing a MOC submission process, states should consider the criteria they will use to evaluate each MOC, and the process for communicating review findings back to D-SNPs. To ensure that plan responses to state-specific requirements are adequate and appropriate, states should be as explicit as possible about MOC review criteria in advance and provide sufficient time for D-SNPs to develop and submit their MOC (see Appendix 3 for MOC standard timeframes). States can spell out these criteria in D-SNP contracts or in less formal guidelines or protocols, depending on the normal practice in each state.

#### **4. Review MOCs, approve or request revisions and resubmission.**

After reviewing the MOCs, states should provide feedback in time for plans to make any corrections needed before finalizing the MOC.

### **Additional State Examples**

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#### **New Jersey Implementation of Integrated MOCs using MIPPA Contract Requirements**

New Jersey recently completed each of the implementation steps described above to develop a process by which the state's Fully Integrated D-SNPs (FIDE SNPs) will integrate aspects of the state's MLTSS requirements into their MOCs. As of January 1, 2018, New Jersey's standard D-SNP contract required that FIDE SNPs incorporate required MLTSS-related contract elements and state-specific care management processes into their MOCs (see Exhibit 3 for sample contract language). Although these requirements are enumerated in the D-SNP contract, the state has not prescribed standardized language to be included in the MOC. FIDE SNPs are expected to interpret and incorporate the state's MLTSS contract requirements into the proper sections of the MOC.

Prior to implementing the new integrated MOC requirement, New Jersey notified the FIDE SNPs of the forthcoming requirements and January 1, 2018 implementation date, and sought feedback from the plans. The state then requested and reviewed each plan's existing MOC and assessed the degree to which each was aligned with the forthcoming MLTSS integration requirements.

In reviewing the FIDE SNP MOCs, New Jersey state staff noted that plans that involved multiple departments in the development of the MOC and plans with strong Interdisciplinary Care Teams (ICTs) tended to submit the most robust integrated MOCs. After reviewing each MOC, state staff met with each plan one-on-one to discuss MOC areas needing revisions. The state will continue to work with all FIDE SNPs to ensure that each plan integrates the state's MLTSS-related contract requirements into the MOC in a way that fits the state's expectations.

#### **Massachusetts State-Specific Additions to MOC Requirements**

As previously noted, the CMS MOC matrix upload document describes the content that must be included in each MOC. States can find this document on pages 79 to 86 of the Medicare Part C – Medicare

Advantage and 1876 Cost Plan Expansion Application.<sup>13</sup> State-specific elements may be listed directly after the standard context included each of the four main sections (or their sub-sections) of the MOC. Exhibit 4 includes an example of state-specific element added by Massachusetts (the third bullet), in *Section 3: SNP Provider Network, Item B: Use of Clinical Practice Guidelines & Care Transitions Protocols*.

### Exhibit 3. New Jersey Integrated MOC MIPPA Contract Requirements

- ◆ “The Contractor shall incorporate the provisions of Article 9 [which includes information specific to the provision and coordination of Managed Long Term Services and Supports (MLTSS) to eligible Members], into its FIDE SNP Model of Care.” (MIPPA Contract between State of New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) and Contractor. 2018. Section 10.9.1, p.40)
- ◆ “Contractor shall use its best efforts to incorporate the requirements of 4.6.5 [which enumerate state care management requirements] into its FIDE SNP Model of Care during CY 2018 and seek to minimize duplicative enrollee screenings and assessments.” (Section 10.4.6.5. p.23)
- ◆ “Within the Contractor’s Model of Care and operation, the Contractor shall implement a transition of care policy that is consistent with Federal Requirements and at least meets the state defined transition of care policy.” (Section 10.4.6.5, p.23)
- ◆ “The Contractor shall provide to [the state] within 5 business days of submission to, or receipt from CMS, the following documents, pursuant to maintaining a Medicare Advantage contract... NCQA Model of Care score (triennially, or with any change).” (Section 10.10.12. p.72)
- ◆ “CMS Filings Requiring Prior Approval from [the state]. The Contractor shall provide to [the state] the maximum review time possible prior to submission to CMS the following documents...- State Medicaid Agency Contract Matrix and Fully Integrated D-SNP Upload Matrix (filing requires prior approval from DMAHS) - Model of Care (requires prior review and approval of DMAHS).” (Section 10.10.12.A. p.73)

(Contract between State of New Jersey Department of Human Services, Division of Medical Assistance and Health Services and Contractor. Effective date: 1/2018.)

### Exhibit 4. Massachusetts’ Insertion of a State-Specific MOC Requirement into the CMS SNP MOC Matrix Upload Document

SNP Provider Network, Item B: Use of Clinical Practice Guidelines & Care Transitions Protocols: Regulations at 42 CFR §422.101 (f)(2)(iii)-(v); 42 CFR §422.151(g)(2)(ix) require SNPs to demonstrate the use of clinical practice guidelines and care transition protocols:

- ◆ Explain the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols. This may include, but is not limited to: use of electronic database, web technology, and manual medical record review to ensure appropriate documentation.
- ◆ Define any challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable SNP beneficiaries. Provide details regarding how these decisions are made, incorporated into the ICP (MOC Element 2C), communicated with the ICT (MOC Element 2D) and acted upon.
- ◆ Applicable to Senior Care Options D-SNPs Only: Explain how the plan tailors or modifies its interpretation of clinical practice guidelines to ensure they are appropriate and account for differences in frailty levels, including for those members receiving HCBS and LTSS.

## Building Knowledge



For more information about contracting with D-SNPs to enhance care integration for dually eligible beneficiaries, see the following resources:

- ◆ SNP Approval and Model of Care Review Process. Information available at: <https://snpmoc.ncqa.org/>.
- ◆ Key Medicare Advantage Dates and Action Items for States Contracting with Dual Eligible Special Needs Plans (September 2017):  
[http://www.integratedcareresourcecenter.com/PDFs/Key\\_MA\\_Dates\\_for\\_States\\_Contracting\\_with\\_D-SNPs.pdf](http://www.integratedcareresourcecenter.com/PDFs/Key_MA_Dates_for_States_Contracting_with_D-SNPs.pdf).
- ◆ SNP Approval Training Off-cycle Submission of MOC Changes (November 2016):  
<https://snpmoc.ncqa.org/wp-content/uploads/11.20.2016.SNPMOC-Revisions-Training.pdf>.
- ◆ Webinar on State Contracting with D-SNPs (December 2017):  
[https://www.integratedcareresourcecenter.com/PDFs/ICRC\\_WWM\\_D-SNP\\_Contracting%20DRAFT%2012-12-17%20for%20508%20review.pdf](https://www.integratedcareresourcecenter.com/PDFs/ICRC_WWM_D-SNP_Contracting%20DRAFT%2012-12-17%20for%20508%20review.pdf).
- ◆ Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment (April 2018):  
[https://www.integratedcareresourcecenter.com/PDFs/ICRC\\_DSNP\\_Aligning\\_Enrollment.pdf](https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Aligning_Enrollment.pdf).
- ◆ Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Designing an Integrated Summary of Benefits Document (June 2018): [http://www.integratedcareresourcecenter.com/PDFs/DSNP\\_SB\\_Tip\\_Sheet.pdf](http://www.integratedcareresourcecenter.com/PDFs/DSNP_SB_Tip_Sheet.pdf).
- ◆ Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Using Medicare Program Audit Reports to Improve Managed Care Organization Oversight (June 2018):  
[https://www.integratedcareresourcecenter.com/PDFs/ICRC\\_DSNP\\_TipSheet\\_Using\\_Audit\\_Reports\\_June\\_2018.pdf](https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_TipSheet_Using_Audit_Reports_June_2018.pdf).



ICRC staff are also available to provide technical assistance to states wishing to explore integrated MOCs. Requests for ICRC technical assistance can be sent to [ICRC@chcs.org](mailto:ICRC@chcs.org).

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### TIPS TO IMPROVE MEDICARE-MEDICAID ALIGNMENT USING D-SNPS SERIES

This tip sheet series describes policy steps states can take to improve the integration of Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) with their Medicaid behavioral health and managed long-term services and supports programs. Better integration of Medicare and Medicaid helps to promote higher-quality more coordinated care for dually eligible beneficiaries.

### ABOUT THE INTEGRATED CARE RESOURCE CENTER

The *Integrated Care Resource Center* is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by [Mathematica Policy Research](#) and the [Center for Health Care Strategies](#). For more information, visit [www.integratedcareresourcecenter.com](http://www.integratedcareresourcecenter.com).



## ENDNOTES

<sup>1</sup> Social Security Act, Section 1859. [https://www.ssa.gov/OP\\_Home/ssact/title18/1859.htm](https://www.ssa.gov/OP_Home/ssact/title18/1859.htm)

<sup>2</sup> Section 20.2 of The Medicare Managed Care Manual describes MOC requirements for SNPs. Details available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf>

<sup>3</sup> The MOC section of the CMS website describes the MOC purpose, approval process, and has links to additional resources. For more information see: <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.html>

<sup>4</sup> CMS. “Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter.” February 1, 2018. Available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part2.pdf> and “CMS. “Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter.” April 2, 2019. Available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>

<sup>5</sup> State Medicaid agency contracts with D-SNPs are often referred to as “MIPPA” contracts because these state-plan contracts were originally required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). They are also referred to as State Medicaid Agency Contracts, or SMACs.

<sup>6</sup> The state option to require D-SNPs to integrated Medicaid services into the MOC was reiterated in the final CY2020 Medicare Advantage and Part D Call Letter. Available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf> (p. 194).

<sup>7</sup> Standard Model of Care Matrix Upload Document is included in the Part C – Medicare Advantage and 1876 Cost Plan Expansion Application. Available at: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY-19-Application-v2.pdf>

<sup>8</sup> For more information on the scoring guidelines, see: <https://snpmoc.ncqa.org/resources-for-snp/score-guidelines/>

<sup>9</sup> The off-cycle review process is described in: “Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter.” Available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf> (p. 40). A summary of the process is available at: <https://snpmoc.ncqa.org/snp-mmp-model-of-care-off-cycle-revisions-faqs-and-clarifications/>

<sup>10</sup> For more information, see: <https://snpmoc.ncqa.org/resources-for-snp/>

<sup>11</sup> In order to comply with LTSS regulations, such as Pre-admission Screening and Resident Review (PASRR) regulations and 1915(c) waiver requirements, states generally require that individuals receiving LTSS be assessed for level of need across a variety of domains. Assessments used to determine LTSS eligibility may be different from D-SNP HRA tools, but may cover overlapping topics. To avoid confusing or overburdening beneficiaries with multiple, overlapping assessments, states may want to consider whether D-SNPs may be able to replace or supplement their HRA tool/process with state-specific LTSS assessment tools/processes.

<sup>12</sup> Page 210 of the 2019 Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services D-SNP contract (available at: [https://mn.gov/dhs/assets/2019-seniors-model-contract\\_tcm1053-370133.pdf](https://mn.gov/dhs/assets/2019-seniors-model-contract_tcm1053-370133.pdf)), includes a requirement that each D-SNP submit the MOC to the state for review. Massachusetts required D-SNPs to submit their MOC to the state via a memo sent to D-SNPs operating in the state.

<sup>13</sup> CMS. “Medicare Part C – Medicare Advantage and 1876 Cost Plan Expansion Application.” Available at: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY-19-Application-v2.pdf>

## Appendix 1. Minnesota and Massachusetts State-Specific Model of Care Requirements

This table includes the state-specific requirements that Minnesota and Massachusetts added to the standard requirements in the MOC matrix upload document.

	MINNESOTA	MASSACHUSETTS
<b>1. Description of SNP Population</b>		
	—	—
<b>2. Care Coordination</b>		
<b>Element A: SNP staff structure</b>	Describe that the training for MSHO care coordinators incorporates the State’s MLTSS requirements.	Applicable to Senior Care Options (SCO) D-SNPs Only: Describe how the training for Geriatric Social Services Coordinators (GSSCs) and SCO Care Managers incorporates the state’s home- and community-based Services (HCBS) and long-term services and supports (LTSS) requirements.
<b>Element B: Health Risk Assessment Tool (HRAT)</b>	Describe how: 1) the state MLTSS assessment and LOC tools are coordinated with the HRA; 2) the assessment process meets the State contract requirement for face-to-face MLTSS assessment, is consistent with state criteria, and continues to meet Part C requirements, including established timeframes; and 3) primary, acute and long-term care needs are addressed.	Applicable to SCO D-SNPs Only: Describe how: 1) the Initial Assessment and the MDS-HC and LOC tools are coordinated with the HRA; 2) the assessment process meets the state contract requirement for face-to-face Initial Assessment, is consistent with state criteria, and continues to meet Part C requirements, including established timeframes; and 3) primary, acute and long-term care needs are addressed.
<b>Element C: Individualized Care Plan (ICP)</b>	Describe that the ICP: 1) integrates Medicare/Medicaid services, including MLTSS; 2) addresses state-required MLTSS care plan elements; and 3) addresses the process for coordinating medical and social services identified in the ICP.	Applicable to SCO D-SNPs Only: Describe how the ICP: 1) integrates Medicare/Medicaid services, including HCBS and LTSS; 2) addresses state-required MLTSS care plan elements; and 3) addresses the process for coordinating medical and social services identified in the ICP.
<b>Element D: Interdisciplinary Care Team (ICT)</b>	That information about beneficiaries’ Medicare and Medicaid services, including MLTSS, is communicated from the MLTSS care coordinator to the primary care or health care home provider; and that the care coordination models are tailored to the differences in settings and needs between institutional and community members.	Applicable to SCO D-SNPs Only: That information about beneficiaries’ Medicare and Medicaid services, including MLTSS, is communicated from the GSSC or the SCO Care Manager to the primary care provider or team; and that the care coordination models are tailored to the differences in settings and needs between institutional and community members.
<b>Element E: Care Transitions Protocols</b>	—	Applicable to SCO D-SNPs Only: Explain how the SNP confirms LTSS services restart at the time of discharge.

	MINNESOTA	MASSACHUSETTS
<b>3. SNP Provider Network</b>		
<b>Element B: Use of Clinical Practice Guidelines &amp; Care Transitions Protocols</b>	Explain that clinical practice guidelines are appropriate for and tailored to differences in frailty levels, including those members receiving MLTSS.	Applicable to SCO D-SNPs Only: Explain how the plan tailors or modifies its interpretation of clinical practice guidelines to ensure they are appropriate and account for differences in frailty levels, including for those members receiving HCBS and LTSS.
<b>4. MOC Quality Measurement and Performance Improvement</b>		
<b>Element B: Measureable Goals and Health Outcomes for the MOC</b>	Describe measures the D-SNP will use that are specifically tailored to the frail elderly, including those receiving MLTSS, and account for differences in care delivery models and settings of care among beneficiaries.	Applicable to SCO D-SNPs Only: Describe measures the D-SNP will use and interpret to account for differences in care delivery models and settings of care among beneficiaries, including for the frail elderly (and particularly those receiving HCBS and LTSS).

## Appendix 2. Examples of Minnesota and Massachusetts State-Specific MOC Requirements and Corresponding D-SNP MOC Language

### 2A SNP Staff Structure

**MN State-Specific Requirement:** Describe that the training for Minnesota Senior Health Options (MSHO) care coordinators incorporates the state’s MLTSS requirements.

#### Minnesota D-SNP A MOC Language

- ◆ “Trainings specific to care coordination and case management and other topics related to MSHO are regularly scheduled. Training goals include the following: 1. Understand current DHS strategic MLTSS vision and be aware of new initiatives 2. Learn how to inform and educate members about MLTSS 3. Learn how to inform and educate other staff about MLTSS, 4. Increase knowledge of services and initiatives to allow for more comprehensive service provision, 5. Learn how to address challenges, opportunities, and policy implications of MLTSS requirements, 6. Learn and implement the principles of person-centered planning, 7. Understand Minnesota’s Olmstead Plan, which promotes: • Employment first • Planning protocols for individuals to make decisions about supports for community living • Opportunities for community-engagement and self determination 8. Increase knowledge on the positive supports rule”
- ◆ “The MOC describes the activities D-SNP A Health complete to develop and conducts the trainings, for example: participate in DHS video conferences and webinars; participate in multiple DHS work/stakeholder groups; attend local, regional, State and national conferences; and attend or view presentations by outside experts in the field of MLTSS oversight, management, and outcomes measurement.”

#### Minnesota D-SNP B MOC Language

- ◆ “D-SNP B’s goal is to ensure that all Care Coordinators have the information they need to best assist the members in their care. D-SNP B therefore requires Care Coordinators to attend regularly scheduled trainings, including those that include content on the State’s MLTSS requirements. D-SNP B may directly provide trainings or encourage delegates to attend trainings provided by DHS related to MLTSS topics. The D-SNP B Partner Relations Team also attends DHS-provided trainings to stay up to date on topics related to Care Coordination. In addition to formally provided trainings, D-SNP B routinely communicates any changes in MLTSS processes to Care Coordinators via electronic Communiqués. Furthermore, D-SNP B’s Partner Relations Team is available as an ongoing resource for Care Coordinators with questions related to MLTSS requirements.”

**MA State-Specific Requirement:** Applicable to Senior Care Options (SCO) D-SNPs Only: Describe how the training for Geriatric Social Services Coordinators (GSSCs) and SCO Care Managers incorporates the State’s Home and Community Based Services (HCBS) and Long Term Services and Supports (LTSS) requirements.

#### Massachusetts D-SNP MOC Language

- ◆ “[MA D-SNP] offers extensive training to new staff involved in delivering the Model of Care... RNs and NPs receive [a web-based training] and live training in completing the MDS assessment (the state’s mandated health risk assessment tool) and Care Plan, and participate in a 90 day orientation with a Preceptor. Care partners who do not have appropriate licensure to complete an MDS ... receive training in Care Planning. In addition, periodic workshops using case examples are held to improve assessment and care planning skills.”
- ◆ “Care Partners...become versed in [the D-SNP’s] Care Management and Care Delivery model, which includes demonstrating a knowledge of Long Term Services and Supports, and how to order appropriate services and time frames for authorization, documentation of care discussions, discharge planning and post-discharge assessment and communications with the ICT. Oversight of clinical competencies and Care Management are extensive.”
- ◆ “Included in these training courses are topics that are central to the model of care, such as: - The role in care coordination of community resources provided by the State of Massachusetts, such as Aging Services Access Points (ASAP) and Geriatric Social Service Coordinators (GSSC). - The role of the Interdisciplinary Care Team (ICT) to provide oversight and care coordination of the beneficiary across the continuum. - Clinical decision-support tools to guide staff choices regarding service planning”

## 2D Interdisciplinary Care Team (ICT)

**MN State-Specific Requirement:** Describe that information about beneficiaries' Medicare and Medicaid services, including MLTSS, is communicated from the MLTSS care coordinator to the primary care or health care home provider; and that the care coordination models are tailored to the differences in settings and needs between institutional and community members.

### Minnesota D-SNP A MOC Language

- ◆ “Information about a member’s Medicare and Medical Assistance (Medicaid) services, including MLTSS, are incorporated into the ICP. The ICP is shared with all members of the ICT. In D-SNP A Health’s business structure, the MLTSS care coordinator is the member’s assigned CCM who is part of the ICT and the main point of contact. In addition to active participation on the ICT, all providers, including primary care and HCHs, when/if applicable, receive a copy of or are given access to the electronic ICP. In the ICP, they can see and review in real time the current Medical Assistance (Medicaid) and Medicare long-term supports and services that the member has in order to support efforts to maintain the member in the least restrictive, most person-centered environment possible.”
- ◆ “The CCM and/or D-SNP A Health Care Coordinator work with the primary care provider and ICT to ensure that all preventive measures, clinical monitoring, and other clinical practice guidelines are being used, unless the individual practitioner and member have determined that the guidelines and protocols are not appropriate based on the unique needs or preferences of the member.”

### Minnesota D-SNP B MOC Language

- ◆ “Based on assessed needs, members may receive services such as home delivered meals, home health aides, and homemaker services intended to provide assistance with activities of daily living and/or instrumental activities of daily living and prevent or delay nursing facility placement. The Care Coordinator informs the Primary Care Physician of the member’s Medicare and Medicaid services, and any Home and Community Based services, by sending the PCP a copy of the Care Plan or a Care Plan summary letter initially and as it’s updated.”
- ◆ “The Nursing Facility Care Plan is created in collaboration with the member’s primary care physician and a copy of the Nursing Home Member Assessment/Care Plan Review conducted by the Care Coordinator is provided to the member’s physician. The Care Coordinator may schedule regular care conferences and other communication touch points as needed with the member’s physician.”
- ◆ “[The] tailored HRA process enables the Care Coordinator to review the Waiver Care Plan for inclusion of information related to preventive care and ongoing medical needs to update it accordingly. The Care Coordinator is responsible for communicating the information from both the Waiver Care D-SNP And Collaborative Care Plan to the member’s Primary Care Physician”

**MA State-Specific Requirement:** That information about beneficiaries' Medicare and Medicaid services, including MLTSS, is communicated from the GSSC or the SCO Care Manager to the primary care provider or team.

### Massachusetts D-SNP MOC Language

- ◆ “A Geriatric Services Support Coordinator (GSSC) participates in every SCO member’s ICT. The GSSC responsibilities include...
  - Arrange for (with the agreement of the ICT and in accordance with requirements set forth by the SCO) and coordinate the provision of appropriate community long-term care and social support services such as: ADL and IADL assistance, home-delivered meals, homemaker services...
  - Assist the ICT or PCP in promoting independent functioning of the enrollee and services in the most appropriate, least restrictive setting....
  - Participate in case conferences with the rest of the ICT members to identify the optimal plan of care for SCO beneficiaries.
  - Participate in the determination of appropriate discharge plans after admission to an institution in collaboration with other beneficiaries of the ICT, the beneficiary, the beneficiary’s designated representative, and providers of community-based services...”

- ◆ “In addition to scheduled meetings within the ICT, there are frequent ad hoc communications and care planning between the Care Partner, beneficiary, GSSC, formal and formal supports, PCP, and other pertinent team members....”
- ◆ “The ICP includes the service plan, so it is a primary communication tool between care partners and the GSSC regarding long term services and supports. All members of the care team and the GSSC document in the Centralized Enrollee Record (CER)... [which] it is the primary communication tool regarding beneficiary care decisions.”

### 3B. Use of Clinical Practice Guidelines & Care Transitions Protocols

**MN State-Specific Requirement:** Explain that clinical practice guidelines are appropriate for and tailored to differences in frailty levels, including those members receiving MLTSS.

#### Minnesota D-SNP A MOC Language

- ◆ “D-SNP A Health QCCC and the JPB have adopted preventive, behavioral health, and chronic disease clinical practice guidelines appropriate for members ages 65 and over, consistent with accepted geriatric practices. D-SNP A Health ensures that adopted guidelines are used in UM decisions, member education, and service coverage when appropriate. D-SNP A Health recognizes that clinical practice guidelines are guidelines only and, in some circumstances, members may not benefit from strict adherence to these guidelines. The final decision about clinical practice is left to the practitioner’s professional judgment.”

#### Minnesota D-SNP B MOC Language

- ◆ “Clinical Practice Guidelines are inclusive of a wide range of ages including infants, children and adults. Guidelines are tailored to a member’s specific needs as identified by their provider, integrated care team (ICT), Care Coordinator or Health Coach. Recommendations for altering clinical practice guidelines are dependent upon the member’s medical history, clinical experience and judgment.”

**MA State-Specific Requirement:** Explain how the plan tailors or modifies its interpretation of clinical practice guidelines to ensure they are appropriate and account for differences in frailty levels, including for those members receiving HCBS and LTSS.

#### Massachusetts D-SNP MOC Language

- ◆ “[Plan] care partners and other members of the [D-SNP’s] ICTs are trained to utilize evidence-based clinical practice guidelines and nationally recognized protocols as a starting point for determining appropriate care and services for beneficiaries. However...they are also trained and expected to consider how each beneficiary’s clinical status and goals may differ from the “typical” patient population...and adjust their decisions/care plan to match more closely to the appropriate risk/benefit calculation for that individual. For example, some of the most common situations in which patient-centered care may deviate from existing guidelines are in preventive care screening decisions and in management of diabetes or cardiovascular disease risk factors. In these situations, the actual risks and benefits for a frail elder with multiple chronic conditions and/or limited functional status, and/or shortened life-expectancy are usually very different than the risks and benefit calculations used to determine population-based guidelines. [In these cases], deviation from the guidelines is not only warranted, it is required to assure that care and care plans remain patient-centered.”

## Appendix 3. Standard Medicare MOC Submission Timeline

Date	Description
January	<ul style="list-style-type: none"> <li>◆ MOC renewal submission period begins                             <ul style="list-style-type: none"> <li>○ Industry training and technical assistance on the four MOC topic area requirements, as well as training and TA on the MOC application and submission process</li> </ul> </li> </ul>
February	<ul style="list-style-type: none"> <li>◆ MOC submissions due in CMS Health Plan Management System</li> </ul>
March	<ul style="list-style-type: none"> <li>◆ NCQA publishes D-SNP MOC scores (<a href="https://snpmoc.ncqa.org/model-of-care-scores/">https://snpmoc.ncqa.org/model-of-care-scores/</a>)</li> <li>◆ To receive MOC approval for 1 year, 2 years, or 3 years, plans must receive the following scores:                             <ul style="list-style-type: none"> <li>○ 3-year approval: score of 85% or higher</li> <li>○ 2-year approval: score of 75-84%</li> <li>○ 1-year approval: score of 70-74%</li> </ul> </li> </ul>
April	<ul style="list-style-type: none"> <li>◆ CMS issues Notices of Intent to Deny to plans whose bids have not met CMS requirements for approval</li> <li>◆ D-SNPs with MOC scores of &lt;70% attend a technical assistance call on how to resubmit their MOCs to achieve a score of 70% or higher. This one-time opportunity is called a “cure.” D-SNPs that require a cure can only achieve a 1-year approval status regardless of their final score.</li> <li>◆ Cure submissions due in HPMS (for D-SNPs with scores of &lt;70%)</li> </ul>
May	<ul style="list-style-type: none"> <li>◆ NCQA publishes cure results</li> <li>◆ CMS issues SNP approval or denial notices</li> </ul>
June	<ul style="list-style-type: none"> <li>◆ All Medicare Advantage D-SNP bids due to CMS</li> </ul>
July	<ul style="list-style-type: none"> <li>◆ Deadline for D-SNPs to upload required State Medicaid Agency Contract (aka “MIPPA contract”) and contract matrix to HPMS.</li> </ul>

This timeline combines elements of the following two timelines:

- ◆ The CY2020 Medicare Advantage timeline available on page 113 of the Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, which is available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf>; and
- ◆ The NCQA Special Needs Plan Model of Care Approvals timeline, which is available at: <https://snpmoc.ncqa.org/resources-for-snps/timeline/>.

As previously noted, CMS also offers an off-cycle MOC update process, details of which can be found on page 40 of the Final Call Letter (<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>).