ICRC | Integrated Care Resource Center

Leveraging the Dual Eligible Special Need Plan (D-SNP) Model of Care to Enhance Enrollee Care Coordination

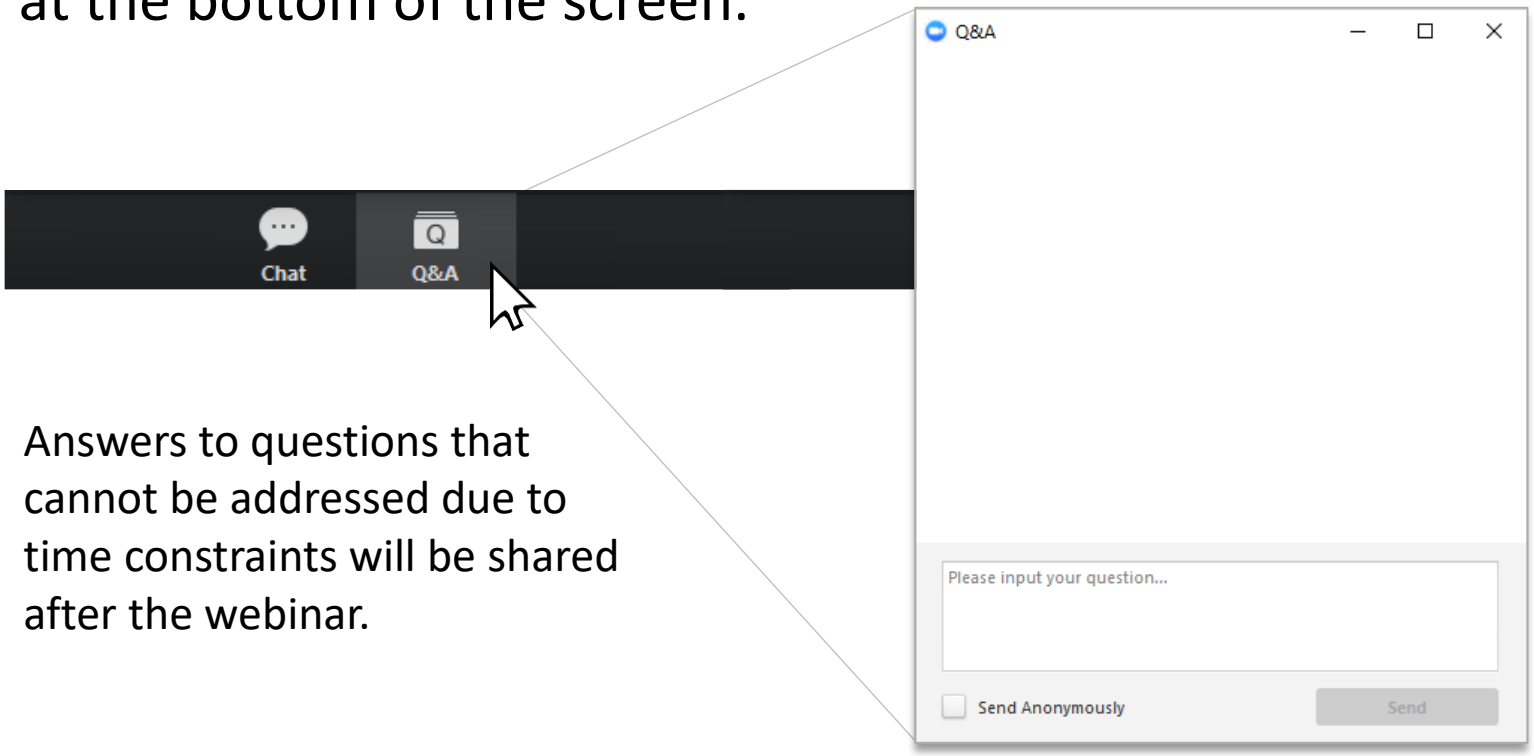
April 20, 2023

1:00-2:30 pm Eastern Time

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services' Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica and the Center for Health Care Strategies.

Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.



Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.

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Agenda

- Welcome and introductions
- Brief overview of D-SNPs and federal D-SNP care coordination requirements
- D-SNP Model of Care (MOC)
- Incorporating state-specific care coordination standards into State Medicaid Agency Contracts (SMACs)
- Key considerations for states when implementing state-specific care coordination requirements for D-SNPs
- Questions and answers

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What Are Dual Eligible Special Needs Plans (D-SNPs)?

What Are D-SNPs?

- D-SNPs are Medicare Advantage plans that **only enroll dually eligible individuals.**
- All D-SNPs must:
  - At least **"coordinate" Medicaid benefits** for their enrollees; and
  - Have a **Model of Care** that describes how the D-SNP will meet the needs of the dually eligible population being served.

State Contracting with D-SNPs

- In addition to contracts with CMS, D-SNPs must have a **State Medicaid Agency Contract** (SMAC) with each state in which they operate.

- State contracts with D-SNPs must include **minimum contract elements**, but states may include additional requirements to improve administrative, clinical, and financial integration for enrollees.

- States are **not required to contract with D-SNPs**, and states have the authority to deny contracts to potential D-SNPs.

Levels of D-SNP Integration

CO D-SNPs

Coordination-Only D-SNPs

- Must meet minimum CMS requirements for D-SNPs.
- Must notify the state Medicaid agency or its designee of hospital and skilled nursing facility admissions for at least one designated group of "high-risk," full-benefit dually eligible (FBDE) enrollees.

HIDE SNPs

Highly Integrated D-SNPs

- Must cover Medicaid behavioral health benefits, long-term services and supports (LTSS), or both.
- Contract for coverage of Medicaid benefits may be with the D-SNP, the D-SNP's parent company, or another entity owned and controlled by the D-SNP's parent company.
- In 2025, a HIDE SNP's capitated contract with the state Medicaid agency must cover the entire service area of the D-SNP.

FIDE SNPs

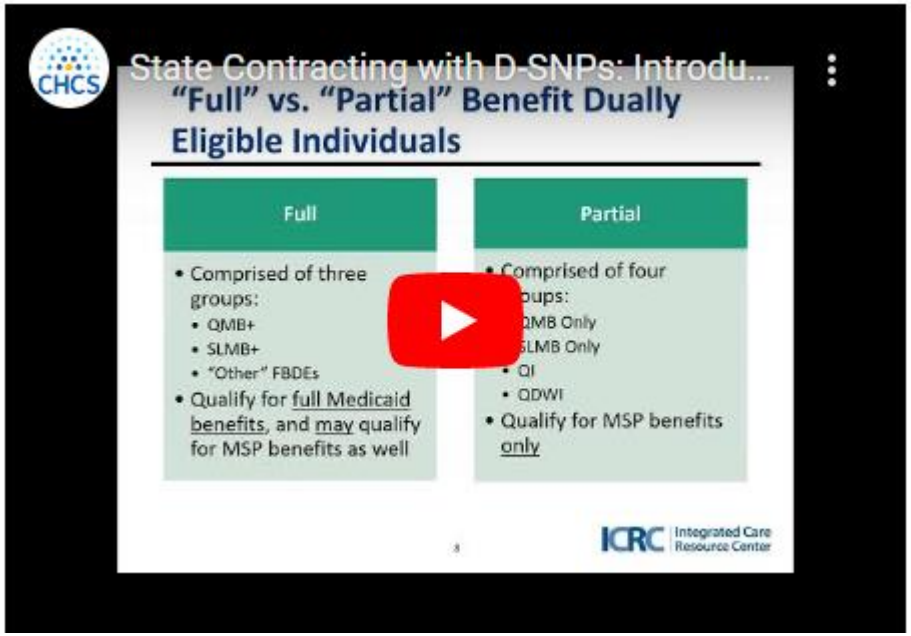
Fully Integrated D-SNPs

- Must cover Medicaid primary and acute care services and LTSS, including at least 180 days of nursing facility coverage.
- Must use specialized care management and network methods to coordinate care for high-risk beneficiaries.
- Entity contracted to cover Medicaid benefits must be the same legal entity that holds the D-SNP contract with CMS.
- In 2025, must operate with exclusively aligned enrollment and cover additional Medicaid benefits. The capitated contract with the state Medicaid agency must also cover the entire service area of the D-SNP.

For more information, see Weir Lakhmani, E. "Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025." Integrated Care Resource Center. December 2022. Available at: https://www.integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023

More Information on D-SNPs

For more information about D-SNPs and ways that states can leverage contracts with D-SNPs to better coordinate/ integrate benefits for dually eligible individuals, please see ICRC's December 2022 Working with Medicare webinar on D-SNP Contracting Basics.



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D-SNP Care Coordination Requirements

Essential D-SNP Care Coordination Requirements

Per 42 CFR 422.101(f)(1-3), all Medicare Advantage Special Needs Plans, including D-SNPs, must:

Assess enrollee's physical, psychosocial, and functional needs through initial and annual health risk assessments (HRAs)

- Starting in 2024, D-SNPs must incorporate questions into these assessments about enrollees' social needs related to housing, transportation, and food security. D-SNPs must select questions from validated screening instruments specified by CMS unless required to use different screening questions/instruments by the state(s) in which they operate.

Develop and implement individualized care plans for each enrollee

- Plans must develop the care plan in consultation with the enrollee to identify goals, objectives and measurable outcomes and identify specific services and benefits to be provided.

Use interdisciplinary care teams (ICTs) to address enrollee's health and functional needs

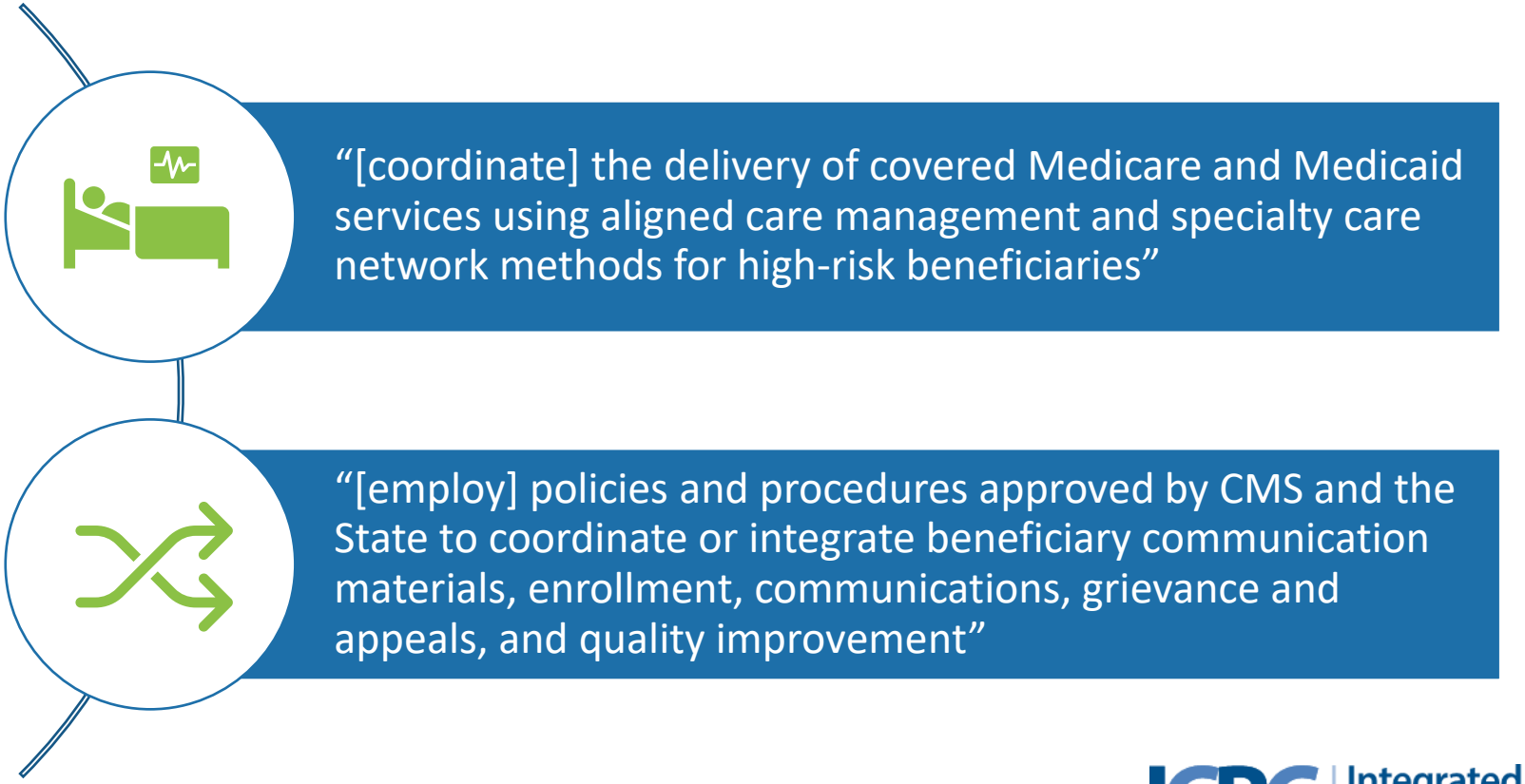
- ICTs should include a team of providers with demonstrated expertise and training, and, as applicable, training in a defined role appropriate to their licensure in treating individuals similar to the targeted population of the plan.

Use a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA) to "assure an effective care management structure"

- The MOC is a stand-alone document that is developed by the D-SNP, apart from the separate contracts the D-SNP is required to hold with CMS and state Medicaid Agency, and it is the basis for D-SNPs' internal care coordination processes.

Additional Requirements for FIDE SNPs

- Per 42 CFR 422.2, Fully Integrated D-SNPs (FIDE SNPs) are also required to:



Coordinating Medicaid Benefits

CMS requires D-SNPs to "coordinate" Medicaid benefits for their enrollees, and CMS has noted that "coordination" may encompass "a wide range of activities that a D-SNP may engage in for their dual[ly] eligible members." For example, for enrollees identified through health risk assessments and/or individualized care plans as having functional limitations and/or mental health needs, D-SNPs could work with the enrollees to:

Verify Eligibility	Determine Access	Coordinate Services
Verify enrollees' eligibility for Medicaid behavioral health and/or long-term services and supports	Determine how enrollees can receive such services (through FFS Medicaid or through another Medicaid managed care product)	Make arrangements with the applicable Medicaid program (state Medicaid agency or managed care plan) for the provision of such services by the appropriate payer or provider

D-SNPs must also assist enrollees with requesting service authorizations and filing grievances and appeals related to Medicaid services, in accordance with 42 CFR 422.562(a)(5).

Source: CMS. "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021." Federal Register, April 16, 2019. Available at: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf. *(See pages 15700-15704 for discussion regarding the requirement that D-SNPs coordinate Medicare and Medicaid benefits for their enrollees.)*

Coordinating Delivery of Medicare and Medicaid Benefits

- D-SNPs must coordinate overlapping Medicare and Medicaid benefits to ensure that Medicaid remains the payer of last resort.
- When one of the D-SNP's supplemental benefits overlaps with a benefit traditionally delivered under Medicaid, the D-SNP must first use up the Medicare supplemental benefit before billing the state (or sending the enrollee to a Medicaid payer/provider) for the Medicaid service.

Example: If a D-SNP offers coverage for dental crowns with a $1,000 limit each year as a supplemental benefit, the D-SNP pays the first $1,000 in costs and then the balance may be paid by Medicaid. The D-SNP should assist the enrollee in accessing a dental provider that will accept Medicaid payment.

D-SNP Care Coordination Reporting and Audit Requirements

- Under the Medicare Part C Reporting Requirements, SNPs must report to CMS on an annual basis (due in February of the following calendar year):
  - Number of new enrollees due for an initial HRA
  - Number of enrollees eligible for annual reassessment HRA
  - Number of HRAs performed (initial and annual reassessments)
  - Number of HRA refusals (initial and annual reassessments)
  - Number of HRAs (initial and annual reassessments) not performed because SNP unable to reach enrollees
- CMS performs audits of D-SNP care coordination activities as described in their MOCs in the following areas:
  - HRA administration
  - Individual Care Plans (ICPs) appropriateness and implementation
  - Interdisciplinary Care Team appropriateness, development, and implementation of enrollees' ICPs
  - Coordination of enrollee transitions across care settings

Sources: CMS. "Medicare Part C Reporting Requirements." January 2022. Available at: https://www.cms.gov/files/document/cy-2022-part-c-reporting-requirements.pdf; and CMS. "Special Needs Plans Care Coordination Program Audit Protocol and Data Request." September 2020. Available at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAudits

D-SNP Models of Care

Overview of the SNP MOC

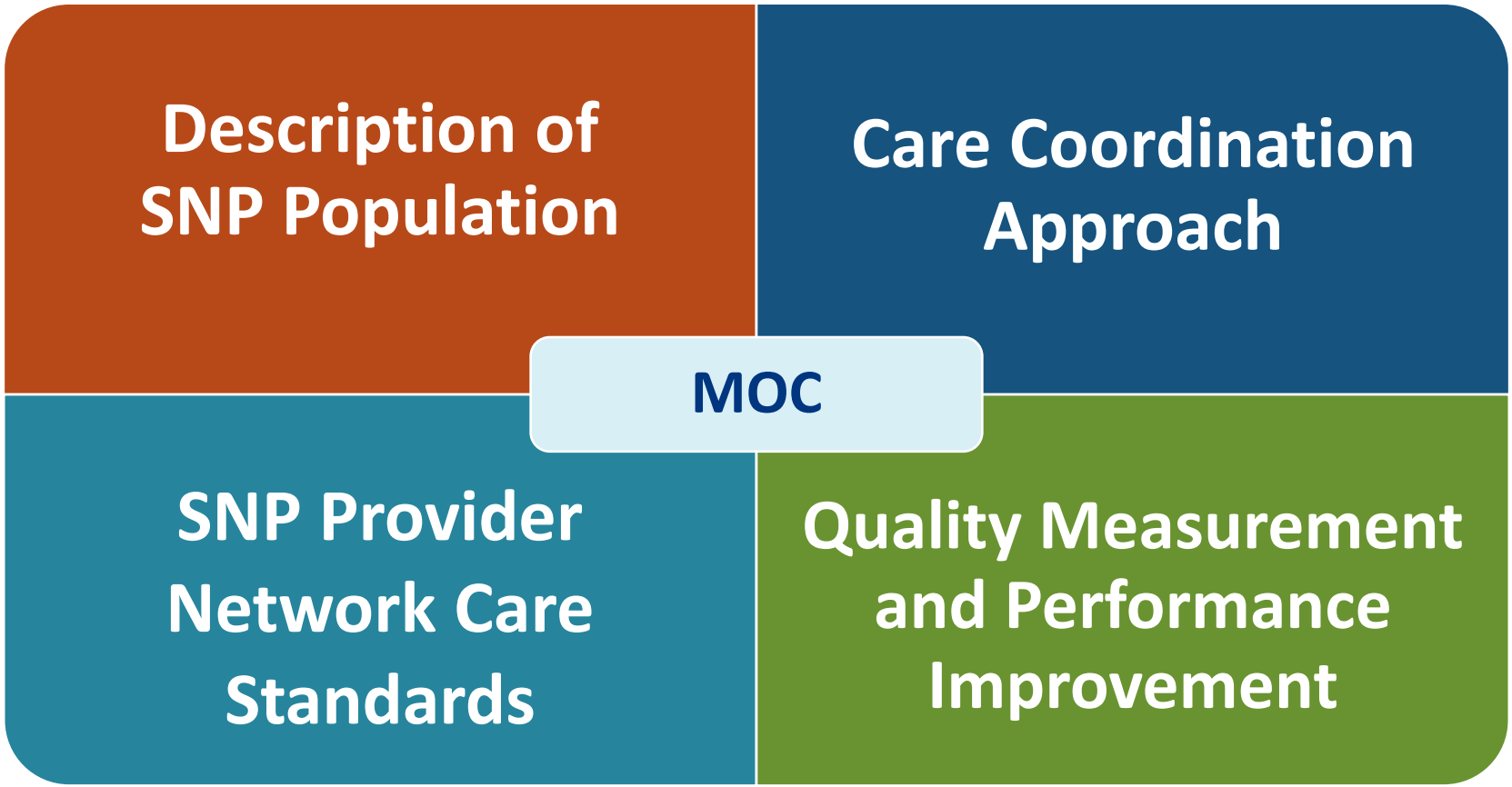
- D-SNPs submit MOCs to CMS that must be approved by the National Committee for Quality Assurance (NCQA).
- NCQA's review of the D-SNP MOC only evaluates the Medicare-required elements and not any state-specific elements requested by the state.
- An MOC is created at the contract level by SNP type, which can overlap several states and impact how state-specific care coordination requirements are incorporated into the MOC.
  - Starting in 2024, states can require D-SNPs with exclusively aligned enrollment to operate within state-specific, D-SNP-only contracts.
  - D-SNP-only contracts can facilitate customization of MOCs to reflect a state's specific care coordination policies and priorities.

Sources: NCQA. "Model of Care Scores." Available at: https://snpmoc.ncqa.org/; CMS. "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency." Final Rule posted in the Federal Register on May 9, 2022. Available at: https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

D-SNP MOC vs. Medicare-Medicaid Plan (MMP) Three-Way Contract

- In Financial Alignment Initiative demonstrations, three-way contracts between CMS, the state, and the MMP specify the care coordination requirements and how the MMPs must meet those requirements.
- With D-SNPs, the MOC specifies the required elements of care coordination, and the D-SNPs use the MOC to tell CMS *what* they will do, as well as *how* they will carry out those activities.

MOC Elements



Source: NCQA. "Model of Care Scores." Available at: https://snpmoc.ncqa.org/

NCQA MOC Resources

- NCQA MOC website: https://snpmoc.ncqa.org/
- MOC training materials: https://snpmoc.ncqa.org/trainings
- MOC scoring guidelines: https://snpmoc.ncqa.org/scoring-guidelines-2023
- MOC submission timeline: https://snpmoc.ncqa.org/static/media/SNP_MOC_Approval_Timeline_CY2024.74ce2242f158e17f916a.pdf

Source: NCQA. "Model of Care Scores." Available at: https://snpmoc.ncqa.org/

Timeline of MOC Review Process

- Key dates for CY 2024
  - February 15, 2023 – MOC submissions due to NCQA
  - April 17, 2023 – Notices of Intent to Deny (NOIDs) are sent
  - April 18, 2023 – "Cure" TA call
  - April 27, 2023 – "Cure" MOC resubmissions due to NCQA
  - May 2023 – CMS issues approvals/denials
- Approval period
  - D-SNP MOCs are approved for one, two, or three-year periods, depending on the score of the D-SNP initial MOC submission (i.e., higher scores result in longer approval periods).

Source: NCQA. "Model of Care Scores." Available at: https://snpmoc.ncqa.org/

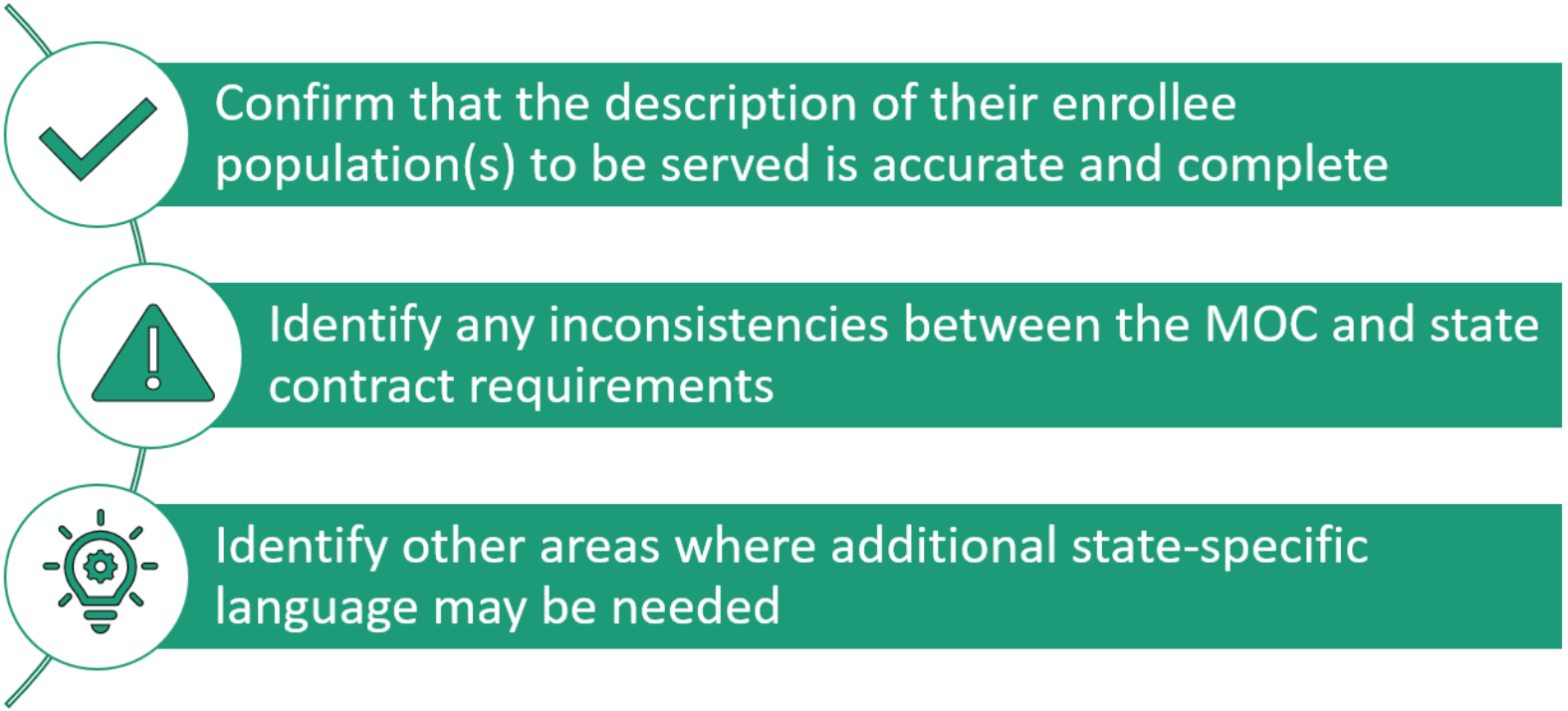
Incorporating State-Specific Care Coordination Standards into SMACs

State Approaches to Integrating State Care Coordination Requirements

- States can require D-SNPs to implement state-specific provisions aimed at better coordinating Medicare and Medicaid services by:
  - Specifying certain care coordination requirements within the state's SMAC(s) with the D-SNP(s); and/or
  - Specifying in the SMAC that the D-SNP(s) must include certain content within their MOC(s).
    - For example, a state could require its D-SNPs to describe within the MOC how the D-SNPs will coordinate specific Medicaid services covered in the SMAC, and how they will operationalize coordination with various entities within the state.

State Approaches to Integrating State Care Coordination Requirements

- States can require D-SNPs to submit their MOCs to the state, and then **review the MOCs** to:

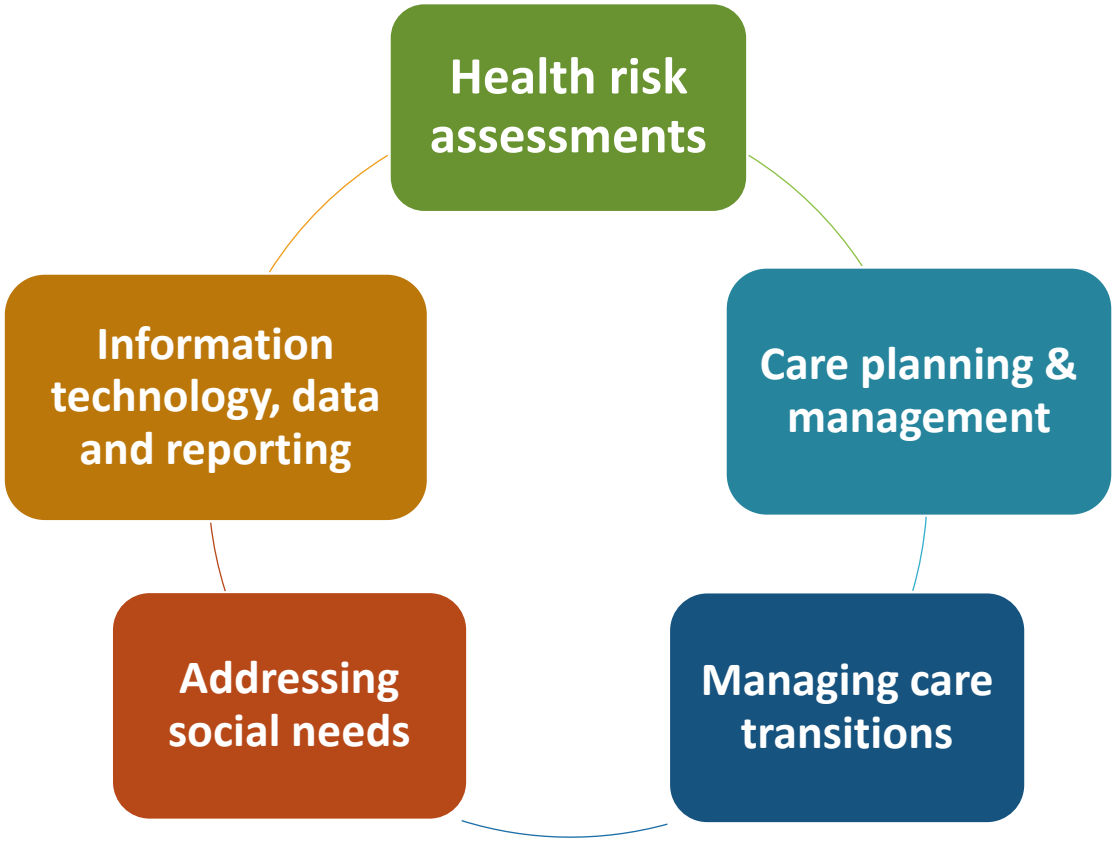


State Review of MOCs

- If a state asks D-SNPs to address state-specific requirements in the MOC, the state is responsible for reviewing how the D-SNP addresses its requirements, as NCQA only evaluates the **Medicare-required elements.**
- States will need to develop and communicate a process by which D-SNPs submit their MOCs to the state for review and the approach used to evaluate MOCs.
- States can require that D-SNPs add information to their MOC to be effective for a specific year that falls within a D-SNP's multi-year CMS MOC approval period.
  - D-SNPs can request an off-cycle review from CMS for substantive updates to ensure the MOC accurately depicts the D-SNPs' care coordination processes.
  - During off-cycle MOC submissions, NCQA only evaluate the specific updates made, rather than the entire MOC.

Source: NCQA. "Off-Cycle Model of Care (MOC) Submission Guidance." 2023. Available at: https://snpmoc.ncqa.org/static/media/SNP_MOC_Off-Cycle_Submission_Guidelines.6b195db271d66241dde2.pdf

Elements of Care Coordination



Health Risk Assessments (HRAs)

Overview

- Instruments and processes used to assess an enrollee's physical health status, risks, and habits
- Distinct from assessments used to: (1) determine Medicaid LTSS eligibility and (2) create individualized LTSS care plans, but may overlap in topics covered

State Options

- Require D-SNPs integrate Medicaid assessment tools or questions with the D-SNP HRA
- Require D-SNPs include Medicaid managed care plan or community agency representatives in the assessment process
- Require HRAs to be conducted within specific time frames
- Require use of specific assessment modalities, such as in-person meetings, for certain enrollees

State Examples: HRAs

- **California** requests that D-SNPs work with aligned Medicaid managed care plans to create a single, unified HRA that meets D-SNP and Medicaid requirements, including identifying current Medicaid services, LTSS needs, and more broadly, populations that may need additional screening or services specific to that population's needs (for example, people living with dementia).
- **Idaho** requires a comprehensive HRA be performed for each new enrollee within 20 to 90 days of enrollment, depending upon the enrollee's risk stratification level, and annual reassessment thereafter.

Care Planning and Management

Overview

- Assigning one or more D-SNP staff to work collaboratively with each enrollee to identify enrollees' care needs and goals
- D-SNP care management involves: (1) the assignment of a care manager, (2) the completion of an individualized integrated care plan, and (3) the use of an interdisciplinary care team

State Options

- Training care management staff about state Medicaid benefits, systems, and/or community support for social needs
- Incorporation of Medicaid services and supports into the care plan
- Involve family members or key LTSS, behavioral health and other Medicaid providers in the interdisciplinary care team
- Require D-SNPs to subcontract or collaborate with other entities for portions of their care management responsibility
- Specify care manager contact frequency and/or care manager caseload requirements

State Examples: Care Planning and Management

- **Washington** requires D-SNPs to train care coordinators on: (1) the plan's health home model; (2) the D-SNP's responsibility for coordination of Medicaid benefits and grievances and the D-SNPs' policies and processes for coordination of Medicare and Medicaid benefits, including services provided by behavioral health organizations; and (3) programs to address social and health disparities.
- States with Medicaid managed LTSS like **Arizona, Hawaii, Florida, Tennessee** and **Virginia**, specify enrollee-to-care manager ratios for care managers in the Medicaid managed care contracts that the states use with the Medicaid managed care plans that are affiliated with D-SNPs. States could consider applying similar requirements in SMACs, as well. **Minnesota** includes provisions in its SMAC that allow D-SNPs to establish their own ratios, but D-SNPs must submit these ratios to the state for review.

Managing Care Transitions

Overview

- D-SNP care managers and/or interdisciplinary care teams must coordinate with enrollees during transitions from one care setting to another to ensure that the enrollees have the services and supports they need for a successful transition

State Options

- Require D-SNPs to develop written protocols for how they will support enrollees as they transition from one setting to another
- Require D-SNPs to communicate/collaborate with Medicaid care management entities during enrollees' care transitions

State Examples: Managing Care Transitions

- **District of Columbia** requires that D-SNPs coordinate with other Medicaid entities (for example, Medicaid managed care organizations, health home providers, waiver case managers) as part of transitions between settings, programs, or enrollments.
- **Indiana** requires that D-SNPs coordinate with the state's Division of Aging and an enrollee's home and community-based waiver service coordinator regarding discharge/transition planning.

Addressing Social Needs

Overview

- Non-medical needs, such as housing, food security, transportation, or environmental conditions that can impact an individual's health and well-being

State Options

- Require care coordinators to be trained on community supports for social needs
- Require referral to or collaboration with community organizations that support social needs
- Require specific questions in the HRA about social needs

State Examples: Addressing Social Needs

- **Florida** requires that D-SNP HRAs include assessment of enrollees' social needs.
- **Tennessee** requires assessments and reporting on social determinants of health, including housing, food security, nutrition, social isolation, loneliness, employment and social supports, and community integration.
- **Virginia** requires D-SNPs to describe how care coordination trainings will incorporate information about Medicaid coverage of services that address social determinants of health.

Information Technology, Data, and Reporting

Overview

- States can use information technology, data, and reporting tools to support effective care coordination and oversee of D-SNP care coordination approaches

State Options

- Require sharing of care plan information with specific LTSS, behavioral health and other key Medicaid providers or Medicaid managed care plans
- Require issuing real-time notifications of emergency room visits and hospital inpatient stays
- Require interaction with state databases to exchange service use information with other entities
- Require submission of care management data or reports to the state

State Examples: Information Technology, Data, and Reporting

- **Massachusetts** requires D-SNPs to link clinical and management information systems among all providers and maintain a centralized record that documents enrollees' medical, functional, and social statuses.
- **Pennsylvania** requires D-SNPs to use a service coordination information system that allows service coordinators to view all relevant information related to enrollees (for example, Medicare and Medicaid encounters, assessments, eligibility status).
- **Tennessee** requires D-SNPs to coordinate and share enrollees' care plans with Medicaid managed care plans.

Key Considerations for States When Implementing State-Specific D-SNP Coordination Requirements

Key Considerations

- Aligning Timelines
- State Medicaid Delivery Systems
- State Oversight and Resource Needs

Key Consideration: Aligning MOC and SMAC Timelines

MOC	SMAC
Jan-Feb: D-SNPs submit new or renewal MOCs **Feb-Mar:** NCQA reviews and downloads MOCs **Apr:** D-SNPs receive Notices of Intent to Deny (NOIDs) where applicable, NCQA holds technical assistance call, and "Cure" MOC resubmissions are due **May:** CMS issues approvals or denials **Jun-Nov**: D-SNPs can submit Off-Cycle MOC documentation	**Jan:** Effective date for approved D-SNPs; SNP applications for following CY released **Feb:** SNP applications due to CMS **May:** States finalize SMACs with plans in the spring **Jul**: D-SNPs submit SMACs to CMS for each state they wish to operate in for upcoming CY **Aug**: CMS sends approval letters to approved D-SNPs **Sep:** States and D-SNPs finalize policies and procedures in the fall

Sources: Integrated Care Resource Center. "Key 2023 Medicare Advantage Dates." March 2023. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC-Key-2023-Medicare-Advantage-Dates-FINAL.pdf; NCQA. "SNP Approval Timeline CY 2024." Available at: https://snpmoc.ncqa.org/static/media/SNP_MOC_Approval_Timeline_CY2024.74ce2242f158e17f916a.pdf; and NCQA. "Off-Cycle Model of Care (MOC) Submission Guidance." 2023. Available at: https://snpmoc.ncqa.org/static/media/SNP_MOC_Off-Cycle_Submission_Guidelines.6b195db271d66241dde2.pdf.

Key Consideration: State Medicaid Delivery Systems

- Challenges
  - Some states' managed care programs exclude ('carve-out') LTSS or behavioral health benefits, which makes it harder for D-SNPs to coordinate these services.
  - D-SNPs face challenges in coordinating with unaffiliated Medicaid managed care plans for unaligned enrollees.
- Potential solutions:
  - States with Medicaid MLTSS and behavioral health organization (BHO) programs may wish to require D-SNPs to coordinate with MLTSS and BHO plans.
  - States with FFS programs may require D-SNPs to coordinate with Medicaid health homes, accountable care organizations, HCBS waiver programs, and other providers.
  - States can require D-SNPs to contract and/or coordinate with other community-based organizations.

Key Consideration: State Oversight and Resource Needs

- State investment in oversight is needed to ensure sufficient capacity to monitor D-SNPs for compliance with state-specific care coordination requirements
- States should consider the methods and types of data exchange that may be needed to support D-SNP coordination efforts, especially for carved-out benefits and coordination with unaligned Medicaid plans
- State investment may also be needed for system-related requirements, such as requirements that necessitate IT system upgrades or programming changes

States can require D-SNPs to submit reports and/or outcome measures to monitor D-SNPs' compliance with state requirements and determine effectiveness of coordination

Questions?

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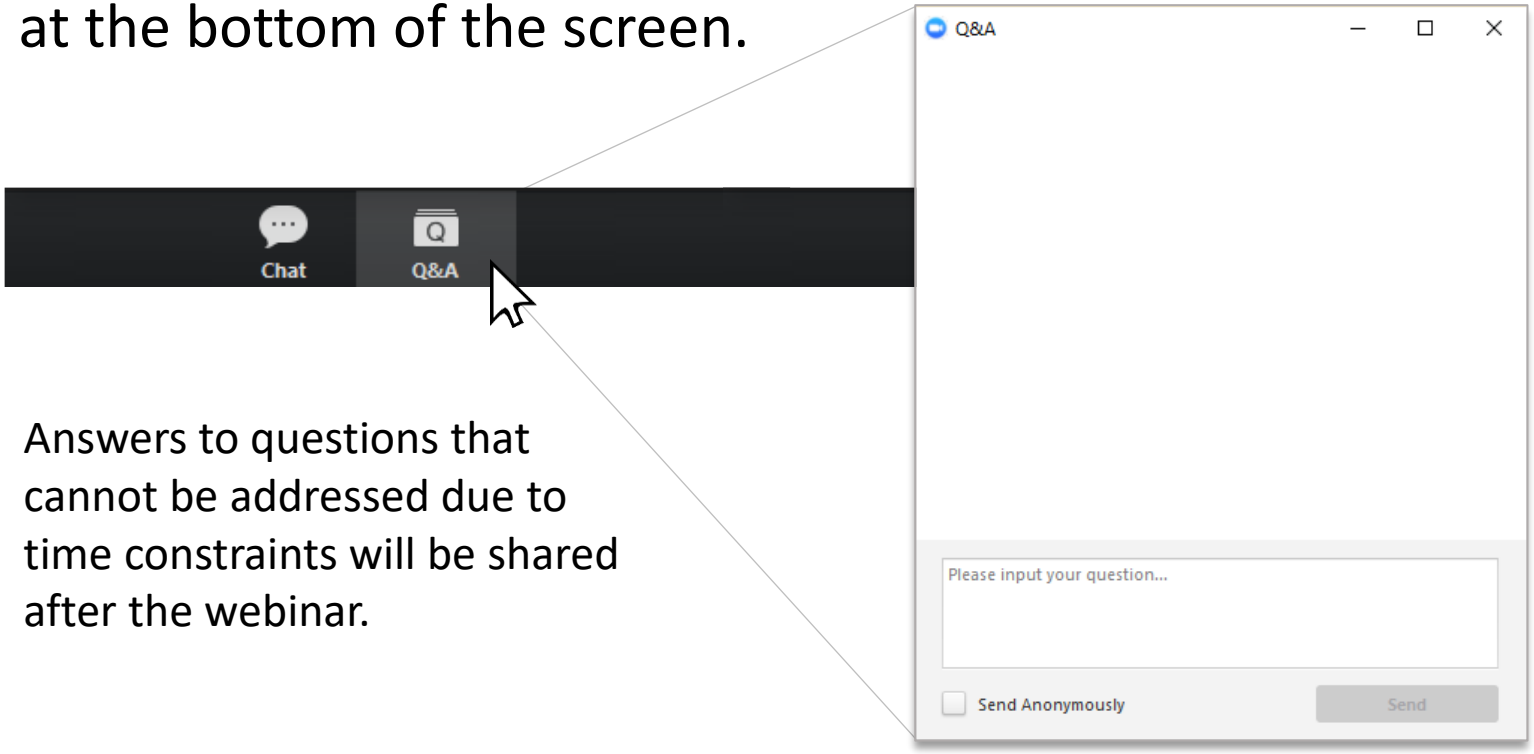

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About ICRC

- Established by CMS to advance integrated care models for dually eligible individuals
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send other ICRC questions to: integratedcareresourcecenter@chcs.org