Improving Quality and Performance in Integrated Dual Eligible Special Needs Plans (D-SNPs)

Tips for States on Incorporating D-SNPs into Medicaid Quality Improvement Activities

By Ryan Stringer, Erin Weir Lakhmani, and Emily Costello, Mathematica

State Medicaid agencies that contract with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) to provide Medicaid benefits beyond cost sharing (for example, long-term services and supports (LTSS), behavioral health, and/or dental benefits) – or contract with D-SNPs that are affiliated with Medicaid managed care plans – share responsibility with the Centers for Medicare & Medicaid Services (CMS) to oversee and improve the quality of care delivered to dually eligible enrollees in those plans. (Note that Medicaid managed care regulations issued at 42 CFR Part 438 apply not only to Medicaid managed care plans, but also to D-SNPs that receive capitated payments from states to provide Medicaid benefits.)

ABOUT THIS TIP SHEET

This tip sheet describes the Medicare resources available to states to monitor Dual Eligible Special Needs Plan (D-SNP) performance, explains how states can leverage those resources for Medicaid managed care quality oversight and improvement, and provides tips for states on incorporating D-SNPs into Medicaid quality improvement activities.

Despite this shared responsibility, Medicaid and Medicare have separate quality oversight and improvement tools, such as Medicaid Quality Assessment and Performance Improvement (QAPI) programs, Medicare Quality Improvement (QI) Programs, and D-SNP Models of Care (MOC). Additionally, except for Healthcare Effectiveness Data and Information Set (HEDIS) data, many Medicare quality and performance improvement resources such as Medicare audits and corrective action plans (CAPs) are not available to states or Medicaid managed care plans unless a state requires its D-SNPs to submit those resources to the state or obtains them from CMS.

This tip sheet, which adds to the Integrated Care Resource Center (ICRC)'s existing tools for states on D-SNP monitoring and oversight,[1] describes the Medicare resources available to states to monitor D-SNP performance and explains how states can leverage those resources for Medicaid managed care quality oversight and improvement. It also provides tips for states on incorporating D-SNPs into Medicaid quality improvement activities. These tips fall into the following three areas:

1. Integrating D-SNPs and D-SNP quality measures into Medicaid quality strategies;
2. Requiring D-SNP involvement in Medicaid QAPI programs; and
3. Using Medicare data and tools to streamline Medicaid External Quality Review (EQR) processes for D-SNPs or their affiliated Medicaid managed care plans.

In implementing the tips described within this TA tool, states can leverage Medicare resources and thereby streamline Medicare and Medicaid quality oversight processes while monitoring the quality of care delivered by D-SNPs that are responsible for providing Medicaid benefits.

This tip sheet is intended for states that: (1) contract directly with D-SNPs to cover Medicaid benefits; or (2) contract with D-SNPs that are affiliated with Medicaid managed care plans offered by the same parent company. Many activities described in this tool as being possible with "capitated" or "integrated" D-SNPs can also be implemented when Medicaid managed care plans are "affiliated" or "aligned" with D-SNPs offered by the same parent company.

Medicare Resources to Monitor D-SNP Performance and Quality Improvement

The Medicare Advantage program uses a variety of resources (detailed in **Appendix A**) for monitoring plan performance that may also be useful for states in monitoring their D-SNPs. Examples of these resources include HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures,[2] the Medicare Health Outcomes Survey (HOS),[3] Medicare star ratings, Medicare audits,[4] CAPs, and past performance information. For information on how to access and use these resources, see ICRC's guide to CMS data resources.[5]

Plan-level Medicare resources allow states to oversee the quality of care delivered to dually eligible enrollees within an individual D-SNP. For example, like Medicaid HEDIS measures, Medicare's Special Needs Plan (SNP)-specific HEDIS measures (detailed in **Appendix B**) identify each D-SNP's performance scores on measures such as follow-up after hospitalization for mental illness and plan all-cause readmissions.[6]

However, some Medicare resources are only available at the contract or organization (or "sponsor") levels. A D-SNP may often be only one of several plans incorporated into a single Medicare Advantage contract, which dilutes states' ability to leverage contract-level resources for monitoring D-SNP performance. Similarly, a Medicare Advantage organization can sponsor multiple plans across multiple contracts, which also dilutes states' ability to leverage these resources for monitoring D-SNP performance. For example, Medicare audit results are only available at the sponsor level. In addition, CAHPS measure results, the Medicare HOS, and many Medicare star ratings and the quality measures used to inform them are compiled at the contract level.[7] **Exhibit 1** describes how states can gather D-SNP-specific data from Medicare resources that provide information at the contract level.

Appendix A contains more information on the levels (plan, contract, and sponsor) at which the information in each Medicare resource is collected, and the remainder of this tip sheet provides examples of how to use these resources in each stage of the Medicaid managed care quality oversight and improvement cycle.

Exhibit 1. Opportunities for States to Gather Data Specific to a D-SNP from Medicare Resources that Provide Information at the Contract Level

Although Medicare star rating information is publicly available for all Medicare Advantage plans, including D-SNPs, many star ratings and the quality measures used to inform them – as well as CAHPS results – are compiled at the contract level, not the plan level.[8] To help states gather this particular quality measurement data in ways that can be used to better monitor D-SNP performance, CMS included a provision in a May 2022 final rule that enables states to use their State Medicaid Agency Contracts (SMACs) with D-SNPs to require D-SNPs operating with exclusively aligned enrollment to have state-specific, D-SNP-only contracts.[9] CMS issued sub-regulatory guidance for states on August 25, 2022 regarding key considerations and processes for pursuing this opportunity, which not only allows states to use Medicare star ratings for D-SNP performance oversight, but also establishes processes for state-CMS coordination of program audits and grants state access to the CMS Health Plan Management System for oversight purposes.[10]

When states are unable to take advantage of this new opportunity to require state-specific, D-SNP only contracts (for example, because the state does not require D-SNPs to operate with exclusively aligned enrollment), Medicare's SNP-specific HEDIS measure results may be helpful, as those measures are reported at the plan level, as discussed above.[11] States may also wish to use their SMACs with D-SNPs to require D-SNPs to send certain plan-level quality measure data directly to the state, such as HEDIS measure data, to facilitate state use of that information in D-SNP oversight. It is important to note, though, that some plans may have insufficient membership to collect this data at the plan level.[12]

Leveraging Medicare Data and Tools in the Medicaid Managed Care Quality Oversight and Improvement Cycle

Medicaid and Children's Health Insurance Program (CHIP) managed care quality improvement efforts are strategized, implemented, and assessed through a cycle of state activities mandated by Section 1932(c)(2) of the Social Security Act and 42 CFR 438.330 - 370. These activities (depicted in **Figure 1** below) include the development of state-level quality strategies, implementation of QAPI programs, and use of EQR to evaluate progress toward quality improvement goals. A state's quality strategy, informed by past EQR findings, articulates the vision and mission for a state's Medicaid and CHIP managed care program(s), including goals and objectives for quality improvement. QAPI performance measures and performance improvement projects (PIPs) are informed by the goals and objectives described in the quality strategy. EQR, conducted by an independent organization, assesses the quality of care provided to Medicaid managed care enrollees and identifies opportunities for quality improvement. This assessment is then used to inform the state's future quality strategy.

Figure 1. The Medicaid Managed Care Quality Oversight and Improvement Cycle

Incorporating D-SNPs into State Medicaid Quality Oversight Activities

The following sections provide tips for states on incorporating D-SNPs into state Medicaid quality oversight activities by:

1. Integrating D-SNPs and D-SNP quality measures into Medicaid quality strategies;
2. Requiring D-SNP involvement in Medicaid QAPI programs; and
3. Using Medicare data and tools to streamline Medicaid EQR processes for D-SNPs or their affiliated Medicaid managed care plans.

1 Integrating D-SNPs and Quality Improvement Priorities for D-SNP Enrollees into Medicaid Quality Strategies

Medicaid quality strategies – required under 42 CFR 438.340 – are roadmaps for states to oversee and improve the quality of care provided by their contracted managed care plans, including D-SNPs.[13] For example, quality strategies articulate states' managed care priorities, including goals and objectives for quality improvement, quality measures and performance targets, PIPs, and plans to address health disparities within populations served by the managed

care program(s).[14] To promote continuous quality improvement in care delivered to D-SNP enrollees, states can include in their quality strategies: (1) goals and objectives that address the Medicaid benefits provided by D-SNPs, the quality of care provided by D-SNPs, and the quality of care received by D-SNP enrollees; and (2) plans to address health disparities impacting dually eligible populations, including disparities impacting particular sub-populations of dually eligible enrollees.

Medicare Resources for Developing Medicaid Quality Strategies

When developing Medicaid quality strategies, states can consider using HEDIS, CAHPS, and HOS measure results, Medicare star ratings, Medicare audit reports, CAPs, and past performance information to identify opportunities for D-SNP quality improvement. **Appendix A** contains more information on which Medicare resources are useful when developing a Medicaid quality strategy.

Medicaid managed care quality strategy goals and objectives should incorporate state priorities for quality improvement and include opportunities to improve care for dually eligible enrollees. For example, after identifying an opportunity to improve care transitions between hospitals and home for dually eligible enrollees with behavioral health and/or home and community-based services (HCBS) needs, a state might set a goal in its quality strategy to "improve coordination during care transitions," with an objective to "increase follow-up rates after discharge from hospitals for dually eligible enrollees with [behavioral health and/or LTSS] needs." If the state chooses to set an objective to increase follow-up rates after discharge for dually eligible individuals with behavioral health needs, the HEDIS measure "Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge" might be selected as a quality measure to be used in monitoring D-SNP performance for the objective.

The state might also set an objective to "increase collaboration between D-SNPs and providers of [behavioral health services and/or HCBS] for dually eligible enrollees with [behavioral health and/or

Developing Quality Strategy Goals and Objectives

Goals are high-level managed care performance aims providing direction for the state.

Objectives are measurable steps toward meeting the state's goals, and typically include quality measures. To translate high-level goals into measurable objectives, states should understand the measurement and benchmarking resources available to them. **Appendix A** provides examples of Medicare resources that states can use when developing their Medicaid quality strategy goals and objectives.

More information on Medicaid quality strategies is available in the CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit at: https://www.medicaid.gov/sites/default/files/2021-12/managed-care-quality-strategy-toolkit.pdf.

HCBS needs]" for this goal. To implement and monitor progress toward meeting this goal and objective, the state could choose to require D-SNPs to collaborate with behavioral health providers and/or HCBS case management agencies when D-SNP enrollees with behavioral health and/or LTSS needs are discharged (see **Exhibit 2** for a summary of contract language from Tennessee), submit regular reports to the state regarding their discharge-related collaboration with those entities, and monitor the reports for indications of increased collaboration.

Exhibit 2. Tennessee D-SNP and MCO Requirements Regarding Collaboration During Hospital Discharge

Tennessee requires its D-SNPs to coordinate with D-SNP enrollees' Medicaid managed care organizations (MCOs) during hospital discharge to facilitate access to important Medicaid-covered services, such as HCBS or behavioral health services. Tennessee's SMAC with its D-SNPs describes several detailed requirements for that collaboration, including requirements for post-discharge communications with the plan enrollee, referral for HCBS services/assessments, and use of a state-developed coordination report to support timely and detailed D-SNP/MCO communications. The state also requires its D-SNPs to submit to the state a quarterly care coordination report that includes information about the D-SNP's coordination with its enrollees' Medicaid MCOs during hospital discharge, so the state can monitor the extent and effectiveness of the plans' collaborative efforts.

In addition, the state requires its Medicaid MCOs to coordinate discharge planning with D-SNPs, including triage of inpatient admission notifications and coordinating discharge planning when Medicaid LTSS or other Medicaid services are needed upon discharge.

Source: Tennessee 2023 D-SNP SMAC (not available online) and Tennessee Division of TennCare MCO Statewide Contract section 2.9.7.3.27.11.4, December 31, 2022. Available at: https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf

States can also leverage a variety of Medicare resources to develop and measure progress toward Medicaid quality strategy goals and objectives impacting dually eligible D-SNP enrollees. For example, certain HEDIS measures may be well-suited to developing and measuring D-SNP progress toward state quality improvement goals,[15] and CMS partners with NCQA to publish a specialized sub-set of HEDIS measures for use by Medicare Advantage SNPs, including D-SNPs.[16] In addition, in states that choose to require D-SNPs to operate within state-specific, D-SNP-only contracts,[17] certain CAHPS measures and Medicare star ratings may also be an option for developing and measuring progress toward certain quality strategy goals because those states can gather this information specific to the D-SNPs within each state. As explained above and in **Exhibit 1**, CAHPS measures and many Medicare star ratings are only available at the Medicare Advantage contract level (which in most states may contain performance information on multiple Medicare Advantage plans operating across states, including D-SNPs). States can also review Medicare audit reports, CAPs, and past performance information to identify

opportunities for D-SNP quality improvement that may be ripe targets for quality strategy goals.[18]

Exhibit 3 provides examples of goals and objectives developed by Massachusetts in its 2022 quality strategy that impact dually eligible managed care enrollees. To measure integrated D-SNPs' progress in advancing these goals and objectives, Massachusetts uses several quality measures specific to integrated D-SNP enrollees – including a variety of existing SNP-specific HEDIS and CAHPS measures – which are described in detail in **Appendix C**.

Exhibit 3. Examples of Massachusetts' 2022 Quality Strategy Goals and Objectives with Relevant D-SNP Quality Measures

In its 2022 quality strategy, Massachusetts sought to leverage several specific quality measures solely within its Senior Care Options (SCO) fully integrated D-SNP (FIDE SNP) program to evaluate FIDE SNPs' progress toward advancing the state's broader Medicaid quality improvement goals. Similarly, the state also identified specific quality measures to be used within its OneCare Financial Alignment Initiative demonstration to evaluate Medicare-Medicaid Plans' progress toward these goals. Examples include:

- Several SNP-specific HEDIS measures, such as measures of colorectal cancer screening, controlling high blood pressure, and follow-up after hospitalization for mental illness;
- CAHPS survey measures, including a measure of influenza immunizations among individuals age 65+; and
- Some state-specific measures, like the percentage of plan enrollees with LTSS needs who have a referral to an LTSS coordinator within 90 days of enrollment and the percentage of plan enrollees whose demographic data are collected and maintained in the centralized enrollee record.

For a full list of the SCO FIDE SNP and OneCare demonstration quality measures incorporated into Massachusetts' 2022 quality strategy, see **Appendix C**.

Source: Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. "MassHealth 2022 Comprehensive Quality Strategy." Available at https://www.mass.gov/doc/masshealth-2022-comprehensive-quality-strategy-2/download.

States can use quality strategies to address health disparities impacting dually eligible populations or sub-groups of dually eligible populations. Specifically, Medicaid quality strategies must describe states' plans to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. Because dually eligible individuals often experience disparities in care quality when compared to non-dually eligible populations, and certain subgroups of dually eligible individuals may be disproportionately impacted by those disparities,[19] incorporating goals that focus on reducing health disparities within these populations (and the D-SNPs that serve them) into states' Medicaid quality strategies can be a critical step in improving care for dually eligible populations.

To identify health disparities between dually eligible individuals and other groups of Medicaid managed care enrollees, states can stratify data from Medicaid quality measures using demographic eligibility and enrollment information, including information that identifies dually eligible enrollees.

Identifying Dually Eligible Individuals

States can use their Medicare Modernization Act (MMA) file submissions to identify dually eligible individuals for purposes of stratifying Medicare and/or Medicaid quality measure data.[1] For tips on using MMA files to identify dually eligible individuals, see ICRC's July 2020 tip sheet on that topic at: https://integratedcareresourcecenter.com/resource/using-medicare-modernization-act-mma-files-identify-dually-eligible-individuals.

States can also use stratified Medicare data to identify disparities within sub-groups of dually eligible populations. For example, states that require D-SNPs to operate within state-specific, D-SNP-only contracts can use the stratified (by race, ethnicity, and sex) HEDIS and CAHPS measure summaries posted publicly by CMS to identify disparities in performance across particular populations and use that information to develop population-specific quality improvement goals for D-SNPs.[20] Additionally, all states that contract with D-SNPs can use their SMACs to require D-SNPs to share results from measures included in their Medicare QI programs and MOCs with the state, focusing on disparity-sensitive HEDIS measures, SNP-specific HEDIS measures, and experience of care measures for dually eligible enrollees, such as hospital readmissions. States can then use this information to assess the extent to which disparities may exist in D-SNP enrollees' experiences of care and design goals, objectives, and quality measure targets to address those disparities.

In addition, states can identify disparities and monitor D-SNP performance in reducing disparities through the CMS Health Equity Index (HEI), which CMS will make available in the star ratings beginning in the 2027.[21] The HEI will summarize contract-level performance among enrollees with social risk factors (SRF) across multiple, existing star ratings measures in a single score. SRFs included in the HEI are: (1) low-income subsidy status; (2) dually eligible status; and (3) disability status. As explained above and in **Exhibit 1** for star ratings, although CMS will make the HEI available at the contract level (which can contain multiple types of types of Medicare Advantage plans operating across states), states that require D-SNPs to operate within state-specific, D-SNP-only contracts can gather HEI data specifically for the D-SNP(s) in their state.

2 Requiring D-SNP Involvement in Medicaid QAPI Programs

QAPI programs are required for Medicaid managed care plans under 42 CFR 438.330 and use tools such as performance measures, performance targets, and PIPs to improve the quality of care provided to Medicaid enrollees.

D-SNP involvement with Medicaid QAPI programs follows two pathways. First, like Medicaid managed care plans, D-SNPs that receive capitated payments from the state Medicaid agency to cover Medicaid benefits such as LTSS, behavioral health, and dental benefits are required to implement QAPI programs.[22] Second, D-SNPs with affiliated Medicaid managed care plans should be involved with implementing the Medicaid managed care plan's QAPI program, particularly when the QAPI program focuses on or includes services for which the D-SNP is the primary payer, such as inpatient and physician services. Minnesota's SMAC details QAPI requirements for its D-SNPs (see **Exhibit 4**).

Medicare Resources for Administering Medicaid QAPI Programs

When administering Medicaid QAPI programs to implement and streamline quality oversight and improvement priorities, states can consider leveraging HEDIS, CAHPS, and HOS measures as well as Medicare Chronic Care Improvement Projects (CCIP). **Appendix A** contains more information on what Medicare resources are useful when administering Medicaid QAPI programs.

States can also require D-SNPs to incorporate specific state goals, objectives, and/or measures into their QAPI programs to drive a consistent focus on those goals and objectives. For example, Minnesota encourages its Minnesota Senior Health Options (MSHO) FIDE SNPs to participate in quality improvement collaborative initiatives that coordinate quality improvement topics and designs across managed care plans.[23] As part of the collaborative process, the state and its Medicaid contracted managed care plans (including FIDE SNPs) select topics for quality improvement programs to be conducted by all participating plans over a three-year period, and each plan or collaborative group of plans submits a proposal to the state for how they will work to improve care within the designated focus area. For example, in 2022, participating plans worked to improve comprehensive diabetes care, and most plans used the Comprehensive Diabetes Care HEDIS measure to monitor progress and demonstrate performance.

Exhibit 4. Minnesota SMAC QAPI Program Language

Article 7 of Minnesota's SMAC for its Minnesota Senior Health Options (MSHO) FIDE SNPs specifies that "The MCO shall provide an ongoing quality assessment and performance improvement program for the services it furnishes to all Enrollees ensuring the delivery of high-quality health care" and that "the Quality Assessment and Performance Improvement Program must be consistent with federal [Medicaid managed care] requirements under Title XIX of the SSA, 42 CFR Part 438, Subpart E." For example, as part of a FIDE SNP's QAPI program, the plan must submit to the state a written description of the plan's proposed PIP for state review and approval, as well as annual PIP performance reports.

Source: Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, January 1, 2023. Available at https://mn.gov/dhs/assets/2023-seniors-model-contract_tcm1053-552961.pdf.

Using Medicare Quality Measures in Medicaid QAPI Programs

States can also leverage Medicare quality measures in D-SNP QAPI programs to improve quality oversight for dually eligible enrollees. For example, if a state uses the SNP-specific HEDIS measure "Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge" in its quality strategy goals and objectives, the state can also require D-SNPs to include this measure in their quality improvement initiatives and report progress on that measure to the state as part of the state's Medicaid QAPI program. Requiring D-SNPs to use consistent measures and measure specifications for dually eligible enrollees to the extent appropriate across QAPI programs, Medicare QI programs, and MOCs helps to streamline D-SNP administrative responsibilities, and aligning measures across D-SNPs and Medicaid managed care plans can support effective state assessment of plan performance.

Several of the SNP-specific HEDIS measures required by CMS are identical to measures used by some states in their existing Medicaid QAPI programs, so states can easily leverage these measures to increase oversight of care delivered to dually eligible enrollees in D-SNPs. For example, the HEDIS measure "Antidepressant Medication Management" is part of both the Core Set of Adult Health Care Quality Measures for Medicaid (developed by CMS)[24] and the SNP-specific HEDIS measures. As of 2021, 43 states with Medicaid managed care programs are reporting this measure as part of their Medicaid and CHIP QAPI programs, so requiring D-SNPs to report that measure should be a relatively simple addition in those states.[25] **Exhibit 5** provides an additional example from Massachusetts of leveraging Medicare quality measures in D-SNP QAPI programs.

Aligning Medicaid QAPI Programs with Other Medicare Quality Improvement Tools

In addition to leveraging Medicare quality measures in QAPI programs, states can also seek to align Medicaid QAPI programs with D-SNPs Medicare Advantage QI programs and/or CMS MOC requirements to reduce burden among state staff, plans, and providers. CMS requires all Medicare Advantage plans (including D-SNPs) to implement Medicare Advantage QI Programs, which include CCIPs.[26] Additionally, D-SNP MOCs must describe the plan's population, care coordination activities, provider network, and quality measurement and improvement activities; D-SNP MOC quality measurement and improvement activities include the D-SNP's quality performance improvement plan, measurable goals and objectives, and how the plan will measure experience of care.[27] Examples of ways that states can align Medicaid QAPI programs with Medicare Advantage QI programs and/or D-SNP MOCs include:

- **Aligning D-SNP Medicaid and Medicare quality projects.** States can use their SMACs to require D-SNPs to align their Medicaid PIP and Medicare CCIP topics, measures, and interventions for dually eligible populations to the extent appropriate, while having separate PIPs for non-dually eligible populations.

- **Aligning D-SNP Medicaid and Medicare quality reporting requirements.** In addition to aligning quality measures and projects, states can streamline D-SNP quality reporting requirements. For example, Minnesota allows its MSHO FIDE SNPs to combine their Medicaid and Medicare quality assurance work plans to the extent applicable for the MSHO population. In addition, these FIDE SNPs are allowed to combine their annual QAPI evaluations with their Medicare project evaluations.[28]

Exhibit 5. Massachusetts Uses Medicare Measures in D-SNP QAPI Programs

Massachusetts requires its Senior Care Options (SCO) FIDE SNPs to implement SNP-specific HEDIS measures into their QAPI programs and use results from those measures to design quality improvement activities. Massachusetts also requires SCO FIDE SNPs to develop PIPs with foci that align with the state's overarching quality improvement goals for its managed care programs, including those that serve dually eligible populations. From 2018-2020, the state required SCO FIDE SNPs to develop PIPs focused on behavioral health and chronic disease management. In 2021, in response to the COVID-19 public health emergency, SCO D-SNPs participated in short-term PIPs focused on increasing vaccinations (for influenza and COVID-19) and telehealth utilization. From 2022-2025, SCO D-SNPs are required to develop PIPs focused on care coordination, disease prevention and wellness/care for chronic conditions, or areas of improvement based on low performing SNP-specific HEDIS measures.

For its 2021 PIP focused on telehealth, one SCO FIDE SNP focused on "Improving Telehealth Utilization for Behavioral Health Services for SCO Members." The FIDE SNP used the HEDIS measure "Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge" as one of two performance measures used to assess the success of the PIP. This measure also served as a performance measure for the quality strategy goals and objectives.

Sources: MassHealth Comprehensive Quality Strategy, November 2018. Available at: https://www.mass.gov/doc/masshealth-comprehensive-quality-strategy-november-2018-0/download; Senior Care Organizations External Quality Review, Calendar Year 2021. Available at: https://www.mass.gov/doc/masshealth-senior-care-organizations-sco-eqr-technical-report-2021-0/download; and MassHealth Comprehensive Quality Strategy, June 2022. Available at: https://www.mass.gov/doc/masshealth-2022-comprehensive-quality-strategy-2/download.

3 Using Medicare Data and Tools to Streamline Medicaid EQR Processes for D-SNPs or Their Affiliated Medicaid Managed Care Plans

Although the Medicaid and Medicare programs both require external performance audits for Medicaid and Medicare plans, they have different standards and auditing tools that reflect the beneficiaries they serve, benefits they cover, and the unique nature of joint state and federal oversight of Medicaid managed care programs. Medicaid EQR – performed by an independent organization – involves analysis and evaluation of aggregate information on quality, timeliness, and access to evaluate the care that a Medicaid managed care plan provides to its enrollees.[29]

States can use EQR to assess D-SNP performance in implementing state quality improvement priorities for the Medicaid services that D-SNPs and aligned Medicaid managed care plans deliver, such as LTSS and behavioral health.[30]

Medicare Resources for Streamlining Medicaid EQR

States can leverage validated Medicare HEDIS, CAHPS, and HOS measures as well as validated Medicare Chronic Care Improvement Projects (CCIP) to streamline Medicaid EQR for D-SNPs or their affiliated Medicaid managed care plans. See **Appendix A** for information on useful Medicare resources for streamlining EQR.

Further, Medicaid managed care regulations provide opportunities to align Medicare oversight and Medicaid EQR to reduce burden and align activities across each program through use of the EQR exemption and non-duplication options, which are explained in **Exhibit 6**.

Exhibit 6. D-SNP EQR Exemption and Non-duplication Options for D-SNPs that Cover Medicaid Benefits Such as LTSS, Dental, and Behavioral Health

Exemption. States can use the EQR exemption option under 42 CFR 438.362 to exempt from EQR D-SNPs that provide Medicaid benefits as Medicaid MCOs in certain circumstances. Specifically, the D-SNP's Medicare Advantage contract must cover all or part of the same geographic area in the state as the D-SNP's Medicaid contract with the state, and the D-SNP's Medicaid contract must have been in effect for at least two consecutive years before the exemption date. Finally, during those same two years, the D-SNP must have been subject to EQR and met the quality, timeliness, and access to health care services standards for Medicaid beneficiaries. If a state's D-SNPs are eligible for this exemption and the state wishes to use it, the state must obtain the D-SNP's most recent Medicare review findings or accreditation review findings. States can use their SMACs to require D-SNPs to share these findings with the state.

Non-duplication. States can also use the non-duplication option under 42 CFR 438.360 to allow their EQROs to accept information yielded by a Medicare or private accreditation review conducted by a qualified third party instead of conducting one or more mandated EQR activities (compliance review, performance measure validation, and PIP validation) for the Medicaid services that their D-SNPs cover, provided that the Medicare or private accreditation review standards are comparable to those under EQR. Unlike the exemption option, if a state uses the non-duplication option for a D-SNP, the D-SNP must undergo EQR. However, the non-duplication option allows states to integrate D-SNPs into their EQR activities without duplicating Medicaid and Medicare review activities. For example, if a state decides to use the non-duplication option for a D-SNP, the state could direct its EQRO to use information from a Medicare review for the EQR process instead of conducting one or more EQR activities.

More information on streamlining Medicare and Medicaid quality assessment activities through the EQR exemption and non-duplication options, including detailed requirements, is available in the CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit.[31]

Requiring D-SNPs to Undergo EQR

Like other Medicaid managed care plans, D-SNPs that receive capitated payments from the state Medicaid agency to provide Medicaid benefits are required to undergo annual EQR unless they meet the requirements for exemption described in **Exhibit 6**, and the state chooses to exempt the D-SNP. **Exhibit 7** provides an example of how Minnesota requires its FIDE-SNPs to participate in the state's Medicaid EQR activities for the Medicaid services covered by the D-SNPs, such as LTSS and behavioral health.

Exhibit 7. Minnesota SMAC EQR Language

Example contract language: Article 7.6 of Minnesota's Senior Health Options and Senior Care Plus Services SMAC requires FIDE SNPs to "cooperate with the entity as arranged for by the STATE in an annual independent, external review of the quality of services furnished under this Contract. Such cooperation shall include, but is not limited to 1) meeting with the entity and responding to questions, 2) providing requested medical records and other data in the requested format; and 3) providing copies (on site or by other means) of MCO policies and procedures, and other records, reports and/or data."

Source: Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, January 1, 2023. Available at: https://mn.gov/dhs/assets/2023-seniors-model-contract_tcm1053-552961.pdf.

Streamlining EQR and Medicare Review Activities Through the Non-duplication Option

States can leverage Medicare reviews to streamline EQR activities for the Medicaid services covered by their D-SNPs (such as behavioral health and LTSS) through the non-duplication option, depending on: (1) the extent to which the Medicare review standards are comparable to those used in EQR; (2) states' relationships with their D-SNPs; (3) the degree of benefit integration that the D-SNPs offer to their dually eligible enrollees; and (4) the maturity of the states' integrated D-SNP programs. A state and its external quality review organization (EQRO) should work closely with the state's D-SNPs to understand the D-SNP's approach to Medicare quality improvement to balance state oversight needs with reducing administrative burden for the state, its EQRO, and D-SNPs.

For example, to implement the non-duplication option for performance measure validation, states could use information from a Medicare review of a D-SNP's CAHPS results (where a single D-SNP operates in a D-SNP-only contract, as explained in **Exhibit 1**) and SNP-specific HEDIS measure results instead of having the EQRO validate performance measures independently. States could also use information from a Medicare review of the D-SNP's CCIP for EQR PIP validation provided that the CCIP and PIP are aligned.

Summary

This tool highlights several tips for states that: (1) pay capitated payments to D-SNPs to cover Medicaid benefits; and/or (2) contract with D-SNPs that have affiliated with Medicaid managed care plans regarding ways those states can incorporate D-SNPs into Medicaid quality improvement activities. States can include D-SNPs in the goals and objectives laid out in Medicaid quality strategies, require D-SNPs to participate in state QAPI programs, and leverage Medicaid EQR for D-SNP performance oversight. Within each of these stages of the Medicaid quality improvement cycle, states can also leverage a variety of Medicare tools and resources, including HEDIS, CAHPS, and HOS measures, Medicare CCIPs, and Medicare audit reports and compliance actions. By incorporating D-SNPs into Medicaid quality improvement activities, states can better prioritize improvements in quality of care for dually eligible enrollees – a population that often faces disproportionate rates of health disparities,[32] gain a clearer understanding of the quality of care provided by D-SNPs and opportunities for improvement, and streamline CMS, state, and plan administration and oversight activities.

Appendix A: Medicare Resources Available to States to Monitor D-SNP Performance and Quality Improvement

Medicare Resource	Description of Resource	Frequency of Data Reporting	Level at Which Data is Reported (Plan, Contract, or Sponsor)	Stage(s) of Medicaid Quality Oversight in Which Medicare Resource Would Be Helpful
CAHPS measures[a]	CAHPS measures contain information collected via surveys about enrollees' experiences with their Medicare Advantage plans, including D-SNPs. CAHPS measures also contribute to Medicare star ratings.	Annual	Contract	QS, QAPI, EQR
CAPs[b]	CAPs are issued by CMS to Medicare Advantage sponsors to address persistent and/or serious performance issues.	Varies by Medicare Advantage sponsor; CAPs are issued on an ad hoc basis	Sponsor	QS
CCIPs[c]	As part of Medicare Advantage QI programs, all Medicare Advantage plans (including D-SNPs) implement CCIPs, which promote improved health outcomes for enrollees with chronic conditions.	Varies by plan; Medicare Advantage organizations must report CCIP information to CMS as requested	Plan	QAPI, EQR
HEDIS measures[d]	HEDIS measures are a set of standardized quality measures calculated using data submitted by plans, including D-SNPs, on topics such as effectiveness of care, access, and utilization. HEDIS data also contribute to Medicare star ratings.	Annual	Plan/contract	QS, QAPI, EQR
Medicare HOS[e]	The Medicare HOS is a physical and mental health survey of enrollees in Medicare Advantage plans, including D-SNPs. HOS data also contribute to Medicare star ratings and HEDIS measures.	Annual	Plan/contract	QS, QAPI, EQR
Medicare star ratings[f]	Medicare star ratings provide performance scores for Medicare Advantage plans, including D-SNPs, based on outcome, patient experience, access, and process measures.[g]	Annual	Contract	QS
Past performance[h]	CMS can provide 'intent to deny' and 'application denial' notices for a Medicare Advantage contract application due to past performance issues, such as having summary Medicare star ratings of 2.5 or less in the two most recent star ratings periods.	Varies by contract	Contract	QS

Medicare Resource	Description of Resource	Frequency of Data Reporting	Level at Which Data is Reported (Plan, Contract, or Sponsor)	Stage(s) of Medicaid Quality Oversight in Which Medicare Resource Would Be Helpful
Program audit results[i]	Program audit results provide information on Medicare Advantage sponsors' performance on core program requirements, such as compliance program effectiveness, organization determinations, appeals, and grievances, and Special Needs Plan Models of Care.	Varies by Medicare Advantage sponsor; program audits are conducted by CMS periodically	Sponsor	QS
SNP-specific HEDIS measures[j]	SNP-specific HEDIS measures are a set of standardized quality measures that are calculated specifically for Medicare Advantage Special Needs Plans, including D-SNPs. These measures identify each SNP's performance scores on measures such as follow-up after hospitalization for mental illness and plan all-cause readmissions.	Annual	Plan	QS, QAPI, EQR

[a] More information on CAHPS survey data is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/MCAHPS.
[b] More information on Medicare CAPs is available at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDComplianceActions.
[c] More information on Medicare CCIPs is available at: https://www.cms.gov/medicare/health-plans/medicare-advantage-quality-improvement-program/5ccip.
[d] More information on HEDIS measures is available at: https://resdac.org/cms-data/files/hedis-rif.
[e] More information on the Medicare HOS is available at: https://www.cms.gov/research-statistics-data-and-systems/research/hos.
[f] More information on Medicare star ratings and associated SNP-specific star rating measures is available at: https://www.integratedcareresourcecenter.com/resource/how-states-can-use-medicare-advantage-star-ratings-assess-d-snp-quality-and-performance.
[g] Process measures include, for example, cancer screenings and annual flu vaccines.
[h] More information on past performance is available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-K/section-422.502
[i] More information on Medicare audits is available at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAuditResults.
[j] SNP-specific HEDIS public use files are available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/SNP-HEDIS-Public-Use-Files.

Appendix B: SNP-Specific HEDIS Measures[33]

Measure Name	Measure Description
AMM - Antidepressant Medication Management	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported: • Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). • Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
CBP - Controlling High Blood Pressure	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled during the measurement year.
COA - Care for Older Adults	The percentage of adults 66 years of age and older who had each of the following during the measurement year: • Advance care planning • Medication review • Functional status assessment • Pain assessment
COL - Colorectal Cancer Screening	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.
DAE - Use of High-Risk Medications in the Elderly	The percentage of Medicare members 66 years of age and older who received at least one high-risk medication. The percentage of Medicare members 66 years of age and older who received at least two different high-risk medications.
DDE - Potentially Harmful Drug-Disease Interactions in the Elderly	The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. • A history of falls and a prescription for anticonvulsants, SSRIs, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or tricyclic antidepressants. • Dementia and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, H2 receptor antagonists or anticholinergic agents. • Chronic kidney disease and prescription for Cox-2 selective NSAIDs or non-aspirin NSAIDs. • Total rate (the sum of the three numerators divided by the sum of the three denominators).
FUH – Follow-up after Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the member received follow-up within 30 days of discharge. • The percentage of discharges for which the member received follow-up within 7 days of discharge.
OMW - Osteoporosis Management in Women Who Had a Fracture	The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Measure Name	Measure Description
PBH - Persistence of Beta-Blocker Treatment After a Heart Attack	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge.
PCE - Pharmacotherapy Management of COPD Exacerbation	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported: • Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event. • Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.
PCR - Plan All-Cause Readmissions	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: • Count of Index Hospital Stays (denominator). • Count of 30-Day Readmissions (numerator). • Expected Readmissions Rate.
SPR - Use of Spirometry Testing in the Assessment and Diagnosis of COPD	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.
TRC - Transitions of Care	The percentage of discharges for members 18 years of age and older who had each of the following during the measurement year. Four rates are reported: • Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission or the following day. • Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge or the following day. • Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. • Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Appendix C: Quality Measures for Integrated D-SNPs and Medicare-Medicaid Plans in Massachusetts' 2022 Medicaid Quality Strategy[34]

Quality Strategy Goal	Objective(s)	Senior Care Options (SCO) FIDE SNP Quality Measure(s)	One Care Demonstration Quality Measure(s)
Promote better care: Promote safe and high-quality care for MassHealth members	1.1 Focus on timely, preventative, primary care services with access to integrated care and community-based services and supports	• Colorectal Cancer Screening • Influenza Immunization (age 65+) (CAHPS) • Pneumococcal Immunization • Care For Older Adults: Advance Care Plan • Persistence of Beta Blocker Treatment After Heart Attack • Pharmacotherapy Management of COPD Exacerbation (Corticosteroids and Bronchodilator sub-rates)	• Access to LTS Coordinator - Percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment
	1.2 Promote effective prevention and treatment to address acute and chronic conditions in at-risk populations	• Transitions of Care: Medication Reconciliation Post-Discharge • Persistence of Beta Blocker Treatment After Heart Attack • Pharmacotherapy Management of COPD Exacerbation (Corticosteroids and Bronchodilator sub-rates) • Use of Spirometry Testing in the Assessment and Diagnosis of COPD • Use of High-Risk Medications in the Elderly • Potentially Harmful Drug Disease Interactions in the Elderly • Osteoporosis Management in Women Who Had a Fracture	*N/A*
	1.3 Strengthen access, accommodations, and experience for members with disabilities, including enhanced identification and screening, and improvements to coordinated care	*N/A*	• Access to LTS Coordinator - Percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment • Tracking of Demographic Information - Percent of members whose demographic data are collected and maintained in the MMP Centralized Enrollee Record (race/ethnicity/primary language/homelessness/disability type/LGBTQ identity)

Quality Strategy Goal	Objective(s)	Senior Care Options (SCO) FIDE SNP Quality Measure(s)	One Care Demonstration Quality Measure(s)
Promote equitable care: Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity and other social risk factors that MassHealth members experience	2.2 Assess and prioritize opportunities to reduce health disparities through stratification of quality measures by SRFs and assessment of member health-related social needs	• Colorectal Cancer Screening	*N/A*
	2.3 Implement strategies to address disparities for at-risk populations including mothers and newborns, justice-involved individuals, and members with disabilities	*N/A*	• Access to LTS Coordinator - Percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment
Make care more value-based	3.4 Implement robust quality reporting, performance and improvement, and evaluation processes	• Colorectal Cancer Screening • Influenza Immunization (age 65+) (CAHPS) • Pneumococcal Immunization • Care For Older Adults: Advance Care Plan • Transitions of Care: Medication Reconciliation Post-Discharge • Persistence of Beta Blocker Treatment After Heart Attack • Pharmacotherapy Management of COPD Exacerbation (Corticosteroids and Bronchodilator sub-rates) • Use of Spirometry Testing in the Assessment and Diagnosis of COPD • Use of High-Risk Medications in the Elderly • Potentially Harmful Drug Disease Interactions in the Elderly	• Access to LTS Coordinator - Percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment • Tracking of Demographic Information - Percent of members whose demographic data are collected and maintained in the MMP Centralized Enrollee Record (race/ethnicity/primary language/homelessness/disability type/LGBTQ identity) • Medicare Advantage Prescription Drug Plan CAHPS • Timely Assessment - Percent of members with an initial assessment completed within 90 days of enrollment

Quality Strategy Goal	Objective(s)	Senior Care Options (SCO) FIDE SNP Quality Measure(s)	One Care Demonstration Quality Measure(s)
Promote person and family-centered care: Strengthen member and family-centered approaches to care and focus on engaging members in their health	4.1 Promote requirements and activities that engage providers and members in their care decisions through communications that are clear, timely, accessible, and culturally and linguistically appropriate	• Care For Older Adults: Advance Care Plan	*N/A*
	4.2 Capture member experience across our populations for members receiving acute care, primary care, behavioral health, and long-term services and supports	• Influenza Immunization (age 65+) (CAHPS)	• Medicare Advantage Prescription Drug Plan CAHPS – Timely Assessment - Percent of members with an initial assessment completed within 90 days of enrollment
Improve care through better integration, communication, and coordination across the care continuum and across care teams for our members	5.2 Proactively engage high and rising-risk members to streamline care coordination and ensure members have an identified single accountable point of contact	*N/A*	• Medicare Advantage Prescription Drug Plan CAHPS – Timely Assessment - Percent of members with an initial assessment completed within 90 days of enrollment • Documentation of Care Plan Goals - Percent of members with documented discussions of care goals

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 and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

Endnotes

[1] Other ICRC tools on D-SNP monitoring and oversight are available at: https://integratedcareresourcecenter.com/resources-by-topic/oversight-and-monitoring-dual-eligible-special-needs-plans.

[2] More information on CAHPS is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/MCAHPS.

[3] More information on the Medicare HOS is available at: https://www.cms.gov/research-statistics-data-and-systems/research/hos.

[4] For information about leveraging Medicare audits and other compliance tools for D-SNP oversight, see ICRC's 2018 tip sheet at: https://integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-using-medicare-program-audit.

[5] ICRC's 2018 guide to using CMS data resources is available at: https://www.integratedcareresourcecenter.com/resource/how-states-can-monitor-dual-eligible-special-needs-plan-performance-guide-using-cms-data.

[6] SNP-specific HEDIS measures are calculated specifically for Medicare Advantage Special Needs Plans. More information on these measures is available at: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-HEDIS.

[7] CMS. "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs." Proposed Rule posted in the Federal Register on January 12, 2022. See page 1870. Available at: https://www.federalregister.gov/documents/2022/01/12/2022-00117/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and#footnote-86-p1870.

[8] Medicare star rating information is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData. For information about ways that states can use Medicare star ratings for D-SNP oversight, see ICRC's 2020 guide on this topic at: https://integratedcareresourcecenter.com/resource/how-states-can-use-medicare-advantage-star-ratings-assess-d-snp-quality-and-performance.

[9] 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.

[10] CMS. "Guidance for States Seeking to Leverage New Opportunities for Integrated Care Programs." August 25, 2022. Available at: https://www.cms.gov/files/document/stateoppsintegratedcareprogs.pdf.

[11] Information about the SNP-specific HEDIS measures is available at: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-HEDIS.

[12] CMS collects audited HEDIS data from D-SNPs with 30 or more enrollees.

[13] Quality strategy requirements are detailed at 42 CFR 438.340.

[14] More information on Medicaid managed care quality strategies, including regulatory requirements, considerations for states, and templates is available in the 2021 Medicaid and CHIP Quality Strategy Toolkit. Available at: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf.

[15] CMS collects audited HEDIS data from D-SNPs with 30 or more enrollees. For more information, see "Medicare Managed Care Manual Chapter 5 - Quality Assessment." Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf.

[16] Information about the Medicare Advantage SNP-specific HEDIS measure set is available at: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-HEDIS.

[17] For more information on this opportunity, see the August 25, 2022 sub-regulatory guidance memo issued by CMS "Guidance for States Seeking to Leverage New Opportunities for Integrated Care Programs." Available at: https://www.cms.gov/files/document/stateoppsintegratedcareprogs.pdf.

[18] For information about leveraging Medicare audit reports for D-SNP and Medicaid managed care oversight, see ICRC's 2018 tip sheet, "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Using Medicare Program Audit Reports to Improve Managed Care Organization Oversight." Available at: https://integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-using-medicare-program-audit.

[19] CMS Office of Minority Health in Collaboration with the RAND Corporation. "Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility or Eligibility for a Low-Income Subsidy." May 2023. Available at: https://www.cms.gov/files/document/2023-disparities-health-care-medicare-advantage-associated-dual-eligibility-or-eligibility-low.pdf.

[20] Contract-level HEDIS and CAHPS scores, stratified by race/ethnicity, are provided publicly at: https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting.

[21] More information on the HEI is available at: https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program. See also 42 CFR 422.166(f)(3) and 42 CFR 423.186(f)(3).

[22] QAPI requirements are detailed at 42 CFR 438.330.

[23] More information on the Minnesota PIP collaborative initiative is available at: https://mn.gov/dhs/assets/2023-seniors-model-contract_tcm1053-552961.pdf.

[24] The Core Set Adult Health Care Quality Measures are available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

[25] More information on Medicaid and CHIP metric reporting is available at: https://www.medicaid.gov/state-overviews/scorecard/child-adult-core-sets/index.html.

[26] More information on Medicare Advantage QI programs is available at: https://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Overview.

[27] More information on D-SNP MOCs is available at: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.

[28] Minnesota's 2023 Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services is available at: https://mn.gov/dhs/assets/2023-seniors-model-contract_tcm1053-552961.pdf.

[29] More information about EQR is available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html.

[30] EQR requirements are detailed at 42 CFR 438.350 – 42 CFR 438.370.

[31] The CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit is available at: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf.

[32] CMS. "Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility or Eligibility for a Low-Income Subsidy." RAND Health Care Report for CMS, September 2021. Available at: https://www.cms.gov/files/document/2021-delis-national-disparities-stratified-report.pdf.

[33] These measures are drawn from the 2022 SNP-specific HEDIS Public Use Files. More information on SNP-specific HEDIS measures and SNP-specific HEDIS public use files is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/SNP-HEDIS-Public-Use-Files.

[34] Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid, "MassHealth 2022 Comprehensive Quality Strategy." Available at: https://www.mass.gov/doc/masshealth-2022-comprehensive-quality-strategy-2/download.