Mass General Brigham
Health Plan

Model of Care Training

Mass General Brigham Health Plan DSNP Program

Plan Year 2026

Model of Care

Training Agenda

01 Key Elements of the SCO and One Care MOCs

02 Populations Served by SCO and One Care

03 Care Coordination

04 Provider Network: Roles & Responsibilities

05 Quality Measurement & Performance Improvement

Key Elements

What is a Dual Eligible Special Needs Plan (DSNP)?

A Dual Eligible Special Needs Plan (DSNP) is designed to help people with the most of complex health needs navigate complex healthcare systems.

Patient-centered Expansive Benefits

Simplified Billing

Enhanced Care Coordination

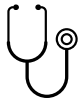
Benefits of DSNP

Coordinated Care

- Integrated services
- Dedicated single point of contact
- Integrated care team structure

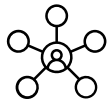
Cost Savings

- No premiums
- No co-pays



Focus on Preventative Care

- Health promotion
- Wellness Services

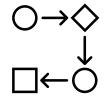


Personalized Support

- Care management and individualized care plan
- Chronic disease management
- Behavioral Health care management

Comprehensive and Streamlined Access to services

- Medical and long-term care
- Prescription drugs
- Care management
- Long term services and supports (LTSS)



Simplified Processes

- Minimizes administrative burden
- One plan, one card

Key Elements

What is a Model of Care (MOC)?

The Centers for Medicare & Medicaid Services (CMS) and the Massachusetts Executive Office of Health & Human Services (EOHHS) require Mass General Brigham Health Plan to annually train providers on its Senior Care Options (SCO) and One Care NCQA Approved Models of Care.*

CMS and EOHHS require DSNP plans to have an NCQA-approved Model of Care (MOC).

Since One Care and SCO are separate DSNPs, they each have their own distinct MOC.

The MOCs generally describe how MGBHP supports SCO and One Care members across four proscribed domains.

1. Description of the Population
2. Care Coordination
3. Provider Network
4. Quality Measurement / Performance Improvement

* Since this is a requirement for all One Care and SCO plans, you may be asked to complete multiple MOC trainings for members enrolled in the different health plans.

Key Elements

Features of Senior Care Options (SCO) and One Care MOCs

Category	Senior Care Options (SCO)	One Care
Eligibility	Age 65+, Medicare + MassHealth Standard	*Age 21-64, Medicare + MassHealth Standard/CommonHealth
Integration	Fully integrated: MassHealth, Frail Elder Waiver Services (FEW) + Medicare, Supplemental/Flexible	Fully integrated: MassHealth + Medicare, Flexible
Behavioral Health	Integrated within care team and provider network	
LTSS/HCBS services	PCA, homemaker, adult day health, respite, adult foster care	PCA, adult foster care, adult day health
Supplemental and/or expanded benefits through MassHealth	Dental (DentaQuest), Vision (EyeMed), OTC (Convey), Fitness, Transportation (CTS), Home-delivered meals	Dental (DentaQuest), Vision (EyeMed), Transportation (CTS)
Care coordination	Interdisciplinary Care Team (ICT), includes RN, GSSC, BH, Community Health Worker (CHW)	Interdisciplinary Care Team (ICT), includes RN, LTSC, BH, Community Health Worker (CWH)
Service area (MGB)	Dukes, Nantucket, Bristol, Norfolk, Plymouth, Middlesex, Essex, Suffolk	

**Enrollees who turn 65 may remain in One Care if they continue to meet eligibility requirements.*

Model of Care Training

Populations Served by SCO and One Care

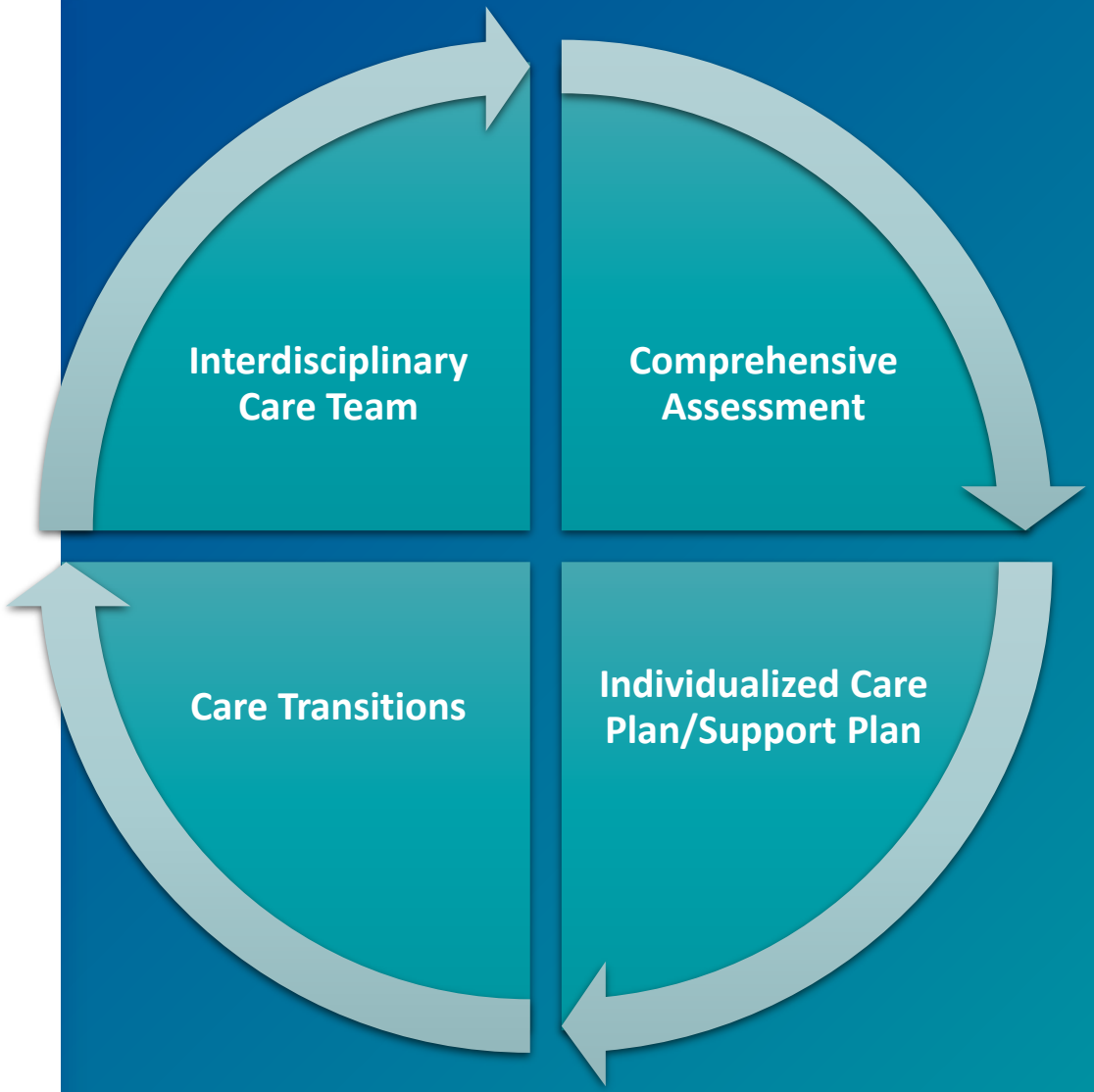
Both populations have complex needs (e.g., chronic illnesses, behavioral health challenges, functional impairments, social isolation, food insecurity, etc.) requiring a coordinated, person-centered care model delivered according to an individualized care plan.

One Care *Focuses on recovery, behavioral health, and independent living for younger members with disabilities.*	**Senior Care Options (SCO)** *Emphasizes aging in place, chronic condition management, and LTSS coordination for elderly adults.*
Serves younger adults (21-64) with disabilities; dual-eligible for Medicare and MassHealth Standard or CommonHealth; not required but may transition to SCO at 65	Serves elderly adults (65+), focusing on age-related needs; dual-eligible for Medicare and MassHealth Standard
Emphasizes behavioral health, developmental disabilities, and social determinants of health (e.g., housing, employment)	Focuses on chronic aging-related conditions (e.g., multiple comorbidities, mobility issues) and long-term services and supports (LTSS) to support independence
Integrated care with consumer-directed models, community and peer support, along with behavioral health specialists on the Interdisciplinary Care Team (ICT)	Community members are assigned a GSSC (geriatric support service coordinator)
Integrated care with consumer-directed models, community and peer support, along with behavioral health specialists on the Interdisciplinary Care Team (ICT)	Chronic condition management with care coordinators/GSSCs, emphasizing formal and informal support to receive home-based care
At minimum annual assessments; documents LTSS care decisions and social needs	At minimum bi-annual assessments; documents GSSC assignments and Frail Elder Waiver benefits (where applicable), with a focus on aging in place
Tackles social instability (e.g., housing, employment); leverages telehealth and mobile services	Addresses financial challenges (e.g., medications, co-pays) with programs and meal delivery services

Care Coordination

Overview

- When the member enrolls, they are assigned a care manager to serve as primary point of contact and convene the **Interdisciplinary Care Team (ICT)**
- MGBHP is responsible for **assessing** all enrollees at minimum on an annual basis to inform the care plan
- Working collaboratively with the ICT, the care manager is responsible for creating and updating an integrated **care plan** that supports members reaching their goals, improved outcomes, and directly ties supportive service requests back to the members goals
- The ICT lead, members of the ICT and the members or caregivers themselves may **initiate requests for services**; if **prior authorization is required**, providers would submit through the portal using their current workflows
- D-SNPs offer comprehensive **transition of care** support to limit risk of readmission and ensure a safe return to community

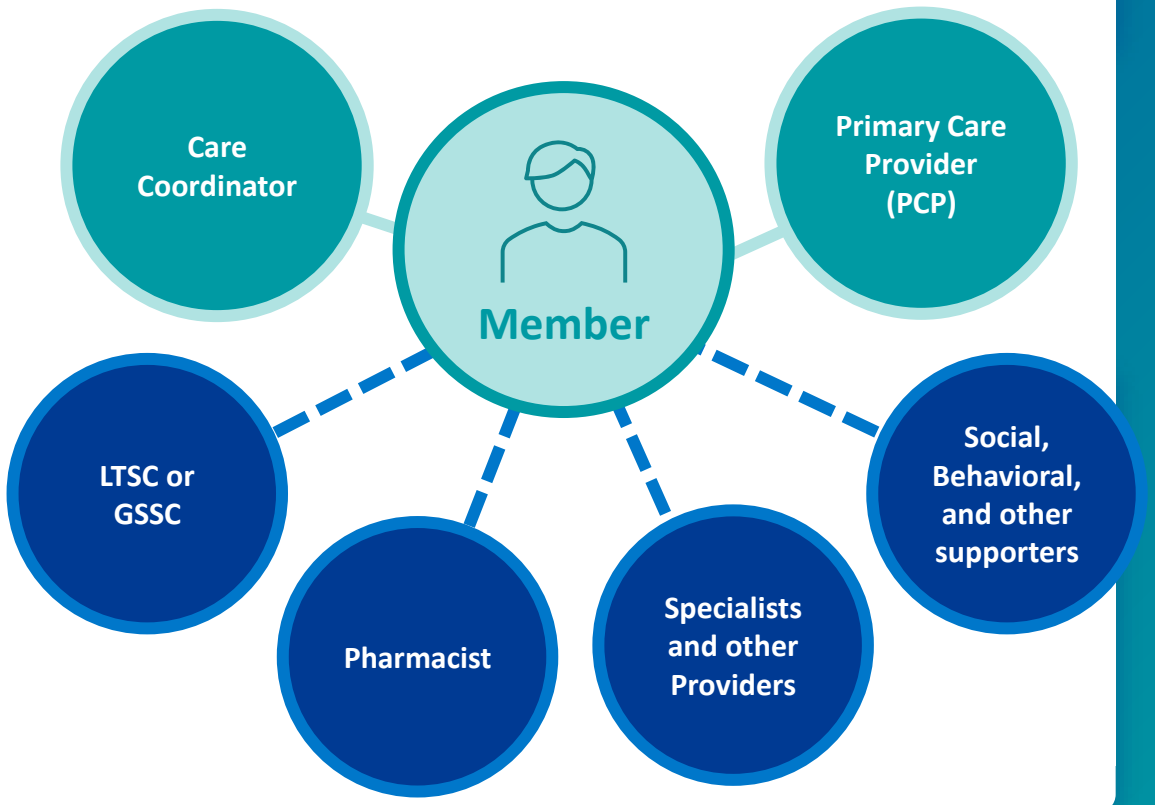


Care Coordination

Interdisciplinary Care Team (ICT)

Purpose: *Deliver integrated medical, behavioral health, and Long-Term Services or Home and Community Based Supports through a unified, person-centered Individualized Care Plan (ICP) that reflects both Medicare and MassHealth requirements.*

- Interdisciplinary Care Team (ICT) composition will vary to reflect the unique needs and priorities of individual One Care and SCO members
- Of note, Geriatric Support Services Coordinators (GSSCs) are only available to SCO members, while Long Term Supports Coordinators (LTSCs) are only available to One Care members
- MGBHP's systems support the ICT by enabling documentation of care plans, assessments, SDOH needs, tasks and care coordination activities in a single "Centralized Enrollee Record", ensuring transparency and real-time communication



Care Coordination

Care Planning

Individualized Care Plans are developed as a guide to care delivery based upon findings from the Comprehensive Assessment.

The ICP is created in conjunction with the member/caregiver, primary care provider, appropriate specialists, and other key community or institutional professionals.

Care Plans include:

- Summary of Enrollee's health history
- A prioritized list of concerns, goals, and strengths
- The plan for addressing concerns or goals
- The person(s) responsible for specific interventions
- The due date for each intervention

- All ICP include member reported care needs and the agreed upon interventions to meet those needs.
- The ICP contains a description of the member's strengths and barriers to meeting these identified goals.
- The ICP includes any Long-Term Support Services the member receives and any assistance the member needs to meet their goals.

Covered Services

Request for Service

- Can be initiated by the member, their providers or caregivers
- For services requiring PA, providers would submit through the portal and their current workflows
- For services not requiring auth, the care manager or care coordinator can intake the request for processing

Assess for Appropriateness

- If not already completed, and required for the requested service, the care team will schedule a time with the member to complete an assessment for appropriateness of the service
- Assessments are based on service requested.
- SDOH Assessment for Services (e.g., home delivered meals)
- Clinical Assessments for Services (e.g., personal care services)
- Services will be tied to the Individualized Care Plan

Coordination with LTSC/GSSC

- The care manager will coordinate with the GSSC for SCO members
- If a One Care member has not agreed to work with an LTSC, the care manager will offer a referral

If the member declines, the care team will work to coordinate the service if approved

Service Requested

- The care team will request the service via the portal
- Utilization Management will decision the authorization
- Any decision that is not approved is discussed with the care team before a denial is issued

Provider Network

Roles & Responsibilities

- ✓ **Communicate and collaborate** with Care Managers, ICT members, MGBHP members and their caregivers
- ✓ **Encourage your patient** to work with your office, keep appointments, comply with all treatment plans, participate with their care team, and complete their assessment
- ✓ **Review and respond** to correspondence sent by our case managers including the HRA results, the ICP and any request for information or meeting participation
- ✓ **Collaborate with MGBHP Care Management and Quality teams** to review and develop performance improvement opportunities through communication channels such as ICT meetings, provider newsletters, quality reporting, etc.
- ✓ **Participate in achieving applicable quality measures** including, but not limited to, efforts to improve member experience
- ✓ **Share feedback** supporting quality measurement and performance improvement through ICT meetings, committees, workgroups or directly to your Provider Relations Team
- ✓ **Attest to completion** of the annual MOC provider training

Additional Provider Resources

- SCO and One Care Provider FAQ
- Provider Manual
- SCO and One Care Provider Directory
- SCO One and Care Provider Landing Page
- Prior Authorization Information

Model of Care Training

Quality Measurement & Performance Improvement

Sample Measures for MOC* Improvement		
PCP Assignment	Follow up After Discharge	Breast Cancer Screening
Annual Wellness Visits	Medication Reconciliation	Colorectal Cancer Screening
Assessment Completion	Confirmation of ADT Receipt	Controlling High Blood Pressure
Member Satisfaction		

Model of Care Training

Resources

Review these resources if you have any questions on this training or how to support our SCO & One Care members.

Questions on…	Review and/or contact…
The Model of Care	Dual Eligible Special Needs Plans (D-SNPs) | Mass General Brigham Health Plan
Using the Optum Behavioral Health Provider Express secure portal • Review member eligibility and benefits, check prior authorization requirements and submit requests,* get updates on claims, reconsiderations and appeals, and more.	Provider Express Secure Portal QRG
Accessing secure portal IT support	Provider Express Support OR Provider Express Hotline 1-866-209-9320
Submitting or correcting claims, managing claim issues, how to submit an appeal	Claim Tips OR Provider Services 1-877-614-0484
Understanding Optum's provider credentialing/recredentialing requirements	2025-2026 UBH Credentialing Plan
Updating demographic or directory information with Optum Behavioral Health	Updating Your Practice Information
Reviewing key policies, criteria and guidelines	Clinical Criteria & Guidelines Clinical Practice Guidelines Prior Authorization Code Lists and Resources Mobile Crisis Resources in Massachusetts Reimbursement Policies MGBHP Provider Manual Addendum Frequently Accessed Optum Forms Medical Record Documentation Protocols

*If a service requires Prior Authorization, providers can click on **Auth Request** after signing into Provider Express and navigating to the Auth menu to initiate a Prior Authorization request. Requests can also be requested by calling 1-877-614-0484.

Model of Care Training

Attestation and Thank you!

Thank you for completing the Mass General Brigham Health Plan's SCO & One Care Model of Care training. To acknowledge your completion of this course, please complete a short attestation. Doing so will help ensure you do not receive further reminders to complete the Model of Care training.

Provider Type	Attestation
Individual Clinicians and Groups (non-delegated)	**Complete attestation**

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