Special Needs Plans (SNPs) and Model of Care (MOC) overview
2020 Medicare Advantage

Medicare Advantage (MA) and Special Needs Plans (SNP)

- In 2003, Congress passed the *Medicare Modernization Act* (*MMA*), which enabled insurance companies to create, market and sell Special Needs Plans (SNPs).

- SNPs are different from most types of MA plans in that they focus on members who have special needs and could benefit from enhanced coordination of care, as described in our Model of Care (MOC).

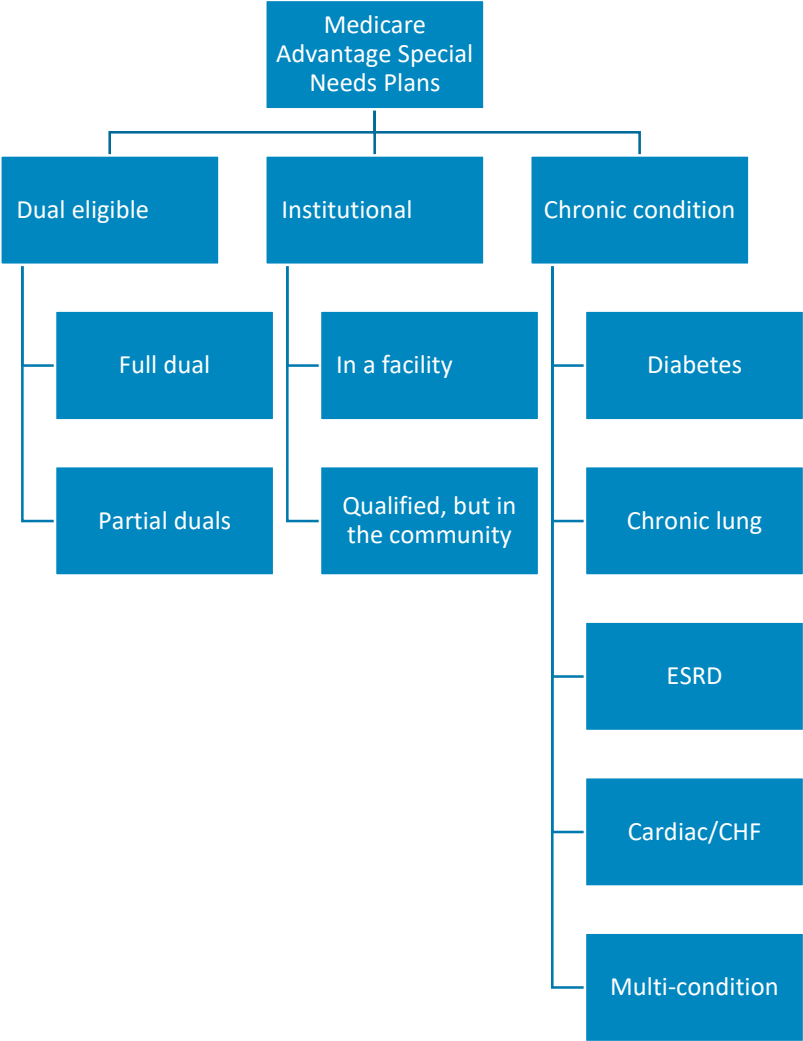# Medicare Advantage (MA) and Special Needs Plans (SNP) (cont.)

- As provided under section 1859(f)(7) of the *Social Security Act*, every SNP must have a MOC approved by NCQA and CMS.

- CMS requires all contracted providers and our staff to receive training about the SNP plans.

Our SNP program is designed to optimize the health and well-being of our aging, vulnerable and chronically ill members.

Types of SNPs

- **Chronic special needs plans (C-SNP):** for members with disabling chronic conditions (categories defined by CMS)

- **Institutional special needs plan (I-SNP):** for beneficiaries who are expected to reside for 90 days or longer in a long-term care facility (skilled nursing facility, intermediate care facility or inpatient care facility)

- **Institutional equivalent special needs plan (IE-SNP):** for individuals who reside at home or in an assisted living facility but require an equivalent level of care as a long-term facility

- **Dual special needs plans (D-SNP):** for members who are eligible for both Medicare and Medicaid

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Our SNP types

Medicare Advantage Special Needs Plans

- Dual eligible
  - Full dual
  - Partial duals
- Institutional
  - In a facility
  - Qualified, but in the community
- Chronic condition
  - Diabetes
  - Chronic lung
  - ESRD
  - Cardiac/CHF
  - Multi-condition

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Chronic special needs plans (C-SNPs)

- Members must be enrolled in Medicare.
- Members may have Medicaid coverage, but it is not required.
- Members must have the qualifying condition of the C-SNP plan.
    - Examples of C-SNP plans include:
        - Diabetes mellitus.
        - End-Stage Renal Disease (ESRD).
        - Chronic lung disorders.
        - Cardiovascular disorders and/or chronic heart failure (CHF).
        - Multiple condition or combination C-SNP plans.
- The condition must be confirmed by a provider, and additional forms may be required.
- In some of our markets, we may contract with vendors or providers to administer aspects of the MOC to our C-SNP members.

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Institutional special needs plans (I-SNP)

- Members must be enrolled in Medicare.
- Members may have Medicaid coverage, but it is not required.
- In some of our markets, we may contract with vendors or providers to administer some of the MOC elements to our I-SNP members.
- Members may be in a facility or have comparable care needs in the community.
- Members have multiple chronic conditions.
- Members may require more outreach and face-to-face visits.
- Members may need more frequent interaction by the interdisciplinary care team (ICT).

Characteristics and requirements of dual-eligible members

- Members must maintain eligibility requirements for both Medicare and Medicaid, be enrolled in both programs and live in our service area.
- Individuals who are dually eligible may change their coverage during the year.
- Duals may be *full benefit duals* or *partial benefit duals*:
    - Full duals are eligible for Medicaid benefits.
    - Partial duals are only eligible for premium and for some levels, assistance with Medicare cost share.
    - States set asset levels to determine full benefit status.

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Characteristics and requirements of dual-eligible members (cont.)

- Fully Integrated Dual Eligible SNP (FIDE SNP): Medicaid benefits including   long- term services and supports (LTSS), if qualified, are integrated within the D-SNP plan.
- Population is a more vulnerable subgroup of Medicare members who are typically more costly and have more health care needs.
- Population includes members over and under 65 years of age.
- Dual-eligible members report a lower income and health status compared to other members.

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D-SNPs and state SNP agreements

- *The Affordable Care Act* (*ACA*) requires D-SNPs to have contracts with state Medicaid agencies.

- Agreements are only linked to the D-SNP in that market and **are not** linked to any other product we offer.

- The agreement must specify benefits, member cost sharing protections, data sharing of member eligibility and provider information.

- The state can impose additional coordination and reporting requirements.

- The agreement also includes coordination requirements between Medicare and Medicaid to assist members.

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Coordination of care for dual-eligible members

- When dual-eligible members need care or access to benefits, it is everyone's responsibility to help and coordinate that care.

- The following will assist in coordinating care, and in the management of billing and service issues:

  - Dual-eligible members (unless a FIDE plan) should show **both** the plan ID and Medicaid card to all providers.

  - Check Medicaid coverage prior to billing.
    - In some dual types, CMS prohibits balance billing.

  - Know what services are covered under both plans.

  - Access tools and information on the provider website including:
    - Benefit information.
    - Results of HRA and the member's care plan.
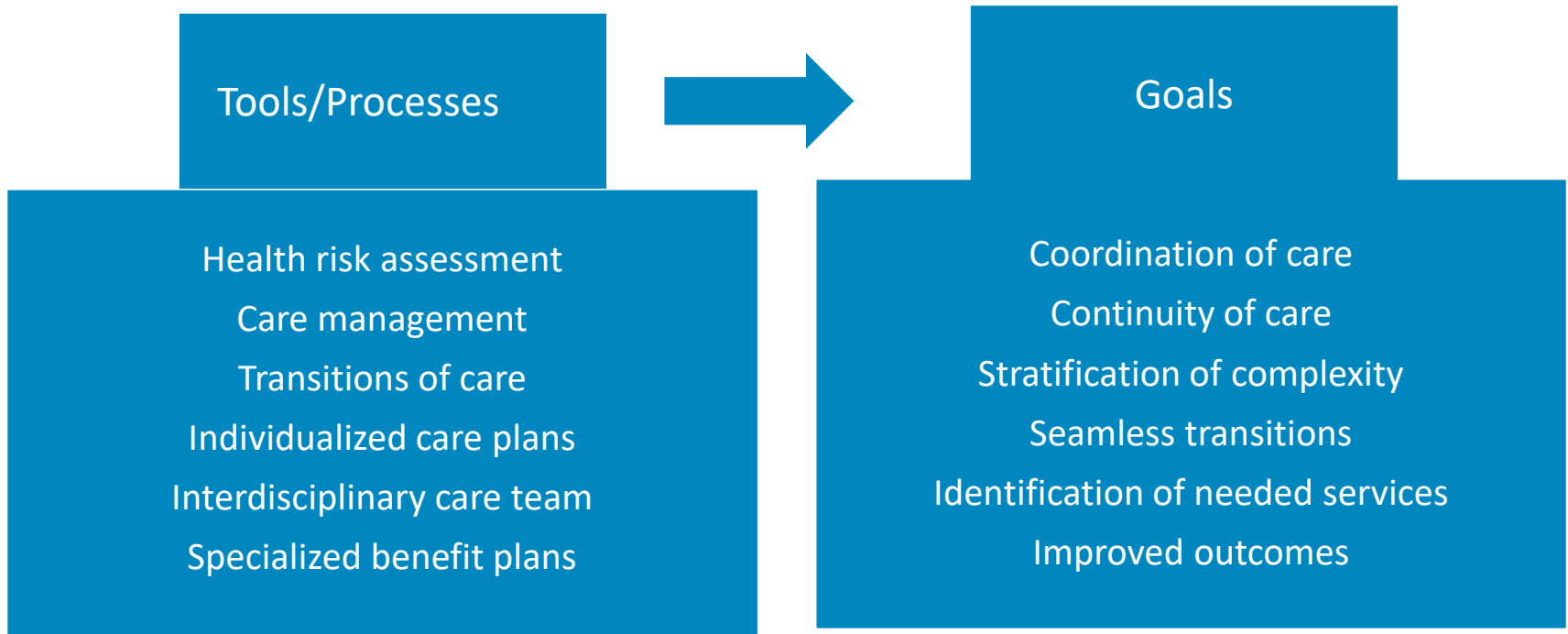   - Transition information.
    - Medications.

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What is included in an MOC?

Description of the population

Care coordination

Provider network

Quality measurement & performance improvement

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Program components

Tools/Processes

Health risk assessment

Care management

Transitions of care

Individualized care plans

Interdisciplinary care team

Specialized benefit plans

Goals

Coordination of care

Continuity of care

Stratification of complexity

Seamless transitions

Identification of needed services

Improved outcomes

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Health risk assessment (HRA)

HRAs:

- Are completed within 90 days of enrollment and repeated within 365 days.
- Require multiple and ongoing attempts to contact the member including by phone, mail, through provider outreach, in person or electronically.
- Assesses physical, behavioral, cognitive, psychosocial and functional areas.
- Used to help create the member's individualized care plan (ICP).
- Are an important part of care coordination.
- Help identify members with most urgent needs.
- Contain member self-reported information.

Health risk assessment (HRA) (cont.)

Results are available to providers and members on the secure portal. Results may lead to referrals for other programs. Additional assessments may be completed based on a significant change in condition, disease specific needs, or enrollment in other programs.

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Individualized care plan (ICP)

- Working with the member and the Interdisciplinary Care Team (ICT), the case manager helps develop the ICP for each member.
- The ICP has member-specific goals and interventions, addressing issues identified during the HRA process and other team interactions.
- Our team may contact your office for updated contact information for those members we are unable to reach or to coordinate the care needs of your patient.
- You have access to the HRA results and the ICP through the secure provider portal.
- The ICP includes member preferences and personal goals as applicable.
- The ICP is updated as the member's needs change.
- You can access your member's ICP on the secure provider website.

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# Interdisciplinary care team (ICT)

- Each member is managed by an ICT.
    - The ICT coordinates care with the member, the member's PCP and other participants of the member's ICT.
    - ICT members are responsible for reviewing care plans, collaborating with multiple providers, coordinating with other carriers (Medicaid) or community resources, and providing recommendations for management.
    - Providers may be asked to participate in initial care planning and ongoing ICP management.
    - The structure and frequency of the ICT is based on the member's preference, identified needs and complexity.

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Interdisciplinary care team (ICT) (cont.)

- The PCP or attending provider (if plan does not require a PCP selection) is a key member of the ICT responsible for coordinating care and managing transitions.
  - Other provider responsibilities include: communicating treatment options, advocating, informing and educating members, performing assessments, diagnosing/treating, and accessing information on the portal.

ICT (cont.)

The PCP is the gatekeeper.
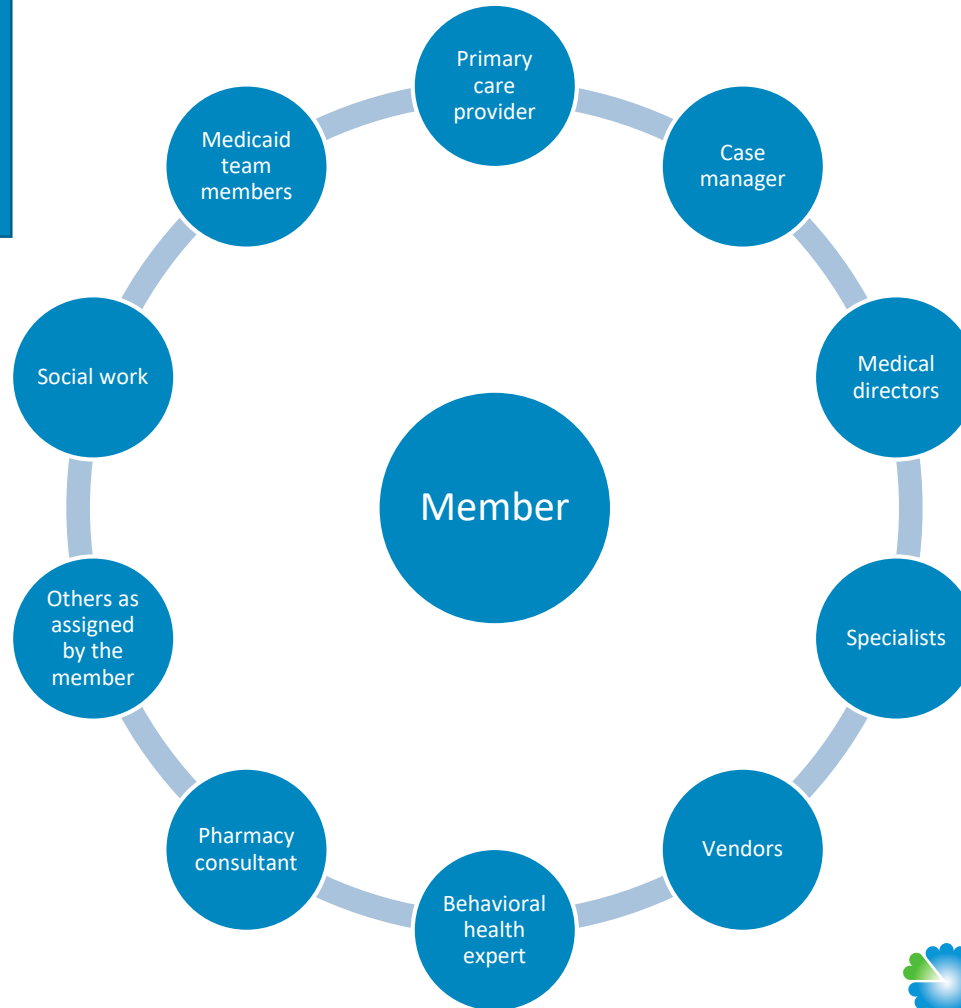
Communication and care transitions

- We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, your members and our care team.
    - You may reach your members' care team by calling the number provided to you on any correspondence from us or the number on the members' identification card.
    - Valuable information on member utilization, transitions and care management is available on the secure provider website.

Communication and care transitions (cont.)

- SNP members typically have many providers and may transition into and out of health care institutions. Providers are key to successful coordination of care during transitions.
    - Contact us if you would like our team to assist in coordinating care for your patient.
    - Our care team may be contacting you and your patient at times of transitions to ensure needs are met, services are coordinated, prescriptions are filled and medications are taken correctly.
    - Care transition protocols are documented in the provider manual.
    - Members may also contact customer service for assistance.

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Performance and quality outcomes

- Performance, quality and health outcome measurements are collected, analyzed and reported to evaluate the effectiveness of the MOC. These measurements are used by our Quality Management Program and include the following measures:
  - HEDIS® — used to measure performance on dimensions of care and service
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) — member satisfaction survey
  - *Health Outcomes Survey* (HOS) — multi-purpose member survey used to compute physician and mental component scores to measure the health status
  - CMS Part C Reporting Elements including benefit utilization, adverse events, organizational determinations and procedure frequency
  - Medication therapy measurement measures
  - Clinical and administrative/service quality projects

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

Program evaluation and process improvements

- Measurable goals must be in place to evaluate the performance of SNP plans in the following areas:
  - Improve access and affordability of health care needs
  - Improve coordination of care and delivery of services
  - Improve transitions of care across health care settings
  - Ensure appropriate use of services for preventive health and chronic conditions

Program evaluation and process improvements (cont.)

- Below are some areas we monitor to improve the care our members receive:
    - Adequacy of our network
    - Our rates of completion of the HRA, developing member care plans and completing an ICT review
    - Rates on certain preventive care services and chronic condition management
    - Frequency of follow-up care post discharge
    - Visits to the PCP
    - Utilization rates of ER and inpatient admissions
- A program evaluation occurs annually and results communicated.

D-SNP copays on low-income subsidy (LIS) levels

- All of our D-SNPs cover Medicare Part D prescription drugs.
- The LIS levels below are determined by the federal government.
- Actual cost share for Part D prescription drugs covered under the plan may be less.
- D-SNP members never pay more than the filed benefit, state coverage or actual cost of the drug.
- Prior authorization, step therapy or B vs. D determinations may apply. See the formulary for covered prescriptions under the plan.
- If no LIS, member pays the lessor of the filed benefit or drug cost.

LIS level	Part D deductible	Generic copay	Brand copay
1	Covered	$3.60	$8.95
2	Covered	$1.30	$3.90
3	Covered	$0.00	$0.00
4	Partially covered	15%	15%

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How are our D-SNPs structured?

- For QMBs and those with full Medicaid benefits, any Medicare cost sharing applied to a claim is covered under the member's Medicaid coverage, which may be:
    - The plan under an agreement with the state.
    - Another Medicaid managed care organization.
    - Fee-for-service Medicaid.
  - For all other Medicaid eligibility categories applicable to the DSNP, any Medicare cost sharing applied to a claim can be billed to the member after claim is filed with Medicaid.
  - Verify cost share or benefit copay.
- Most plans do not have out-of-network benefits unless it is urgent/emergent or out-of-area renal dialysis. PPO D-SNP plans may allow access to some out-of-network providers.
- Please call the plan if you need to refer outside of the plan network or refer to the plan details for limitations if the plan is a PPO plan.

D-SNP member cost share or copay

Benefit	As filed with CMS	Responsibility for QMBs and those with full Medicaid benefits	Responsibility for all other Medicaid eligibility categories
Inpatient copay	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost-sharing
SNF copay	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost-sharing
PCP copay	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost-sharing
Specialist copay	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost-sharing
Ambulatory surgery	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost-sharing
Outpatient hospital	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost-sharing
Emergency room	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost-sharing
Durable medical equipment, prosthetics, orthotics and supplies	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost-sharing
Diagnostic imaging	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost-sharing
Part D drug copays	Standard Medicare Part D	Lower of filed benefit or LIS copay	$0 or the lower of filed benefit or LIS copay
Supplemental benefits	$0 copay; Member is eligible for all Medicaid benefits based on coverage .		

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D-SNP claims processing

- Most D-SNP members are protected by state and federal regulations from balance billing. Providers cannot balance bill members who have Medicare cost share protection and must accept the Medicare and Medicaid (if applicable) payments as payment in full.

- Members who have Medicare cost share protection are classified as QMBs or those with full Medicaid benefits.

- Claims are processed in accordance to the benefits filed within those plans and are subject to Medicare cost sharing. Refer to your *Medicare Advantage Agreement.*

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D-SNP claims processing (cont.)

- Coverage of Medicare cost share depends on the services performed and Medicaid allowed amounts (lesser of Logic or COB requirements for the state may be used).
- Rules differ by state, and it is possible some providers will receive the full Medicare-allowed amount.
- Most states require that you have a Medicaid provider ID in order to bill and receive payment.
- Check the member's Medicaid coverage prior to billing.
- Federal rules dictate that Medicaid is the payer of last resort.

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D-SNP claims processing (cont.)

For members enrolled in both our Medicare D-SNP and Medicaid plan:

- In most plans, if a service is covered under both Medicare and Medicaid, we will send the appropriate amounts for both automatically. A single claim will be processed under each plan and payment made according to payment rules governing your state's Medicaid program or our contract with the state (some exceptions apply).

- *Explanation of Payment* (*EOP*) will provide further guidance on next steps or pending payments.

D-SNP claims processing (cont.)

- The member must be actively enrolled in both plans on the date of service.
- Service(s) must be covered under the respective plan.
- For non-Medicare covered services, the service must be one the plan has contracted with CMS to cover, or the state has contracted with the Medicare SNP plan to cover (for example, unlimited inpatient days).
- You must be contracted for Medicare with us as well as Medicaid (with the state or with us) in order to receive payments for cost-sharing or Medicaid only services.

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Helpful resources

- Provider website https://providers.amerigroup.com

- Provider services — Please call the number on the back of the member's ID card.

- *Medicare Managed Care Manual* (Chapter 16-B: Special Needs Plans) (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf).

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Provider attestation

- **Provider attestation is required.**

- Please print the next slide of this presentation attesting that you have reviewed this presentation and have an understanding of the SNP plans and MOC requirements.

- Don't forget your attestation on the next page!

Model of Care Attestation

As the provider, I attest that my practice has reviewed the SNP and MOC presentation.

I understand:

- The goals of the program and the requirements of the MOC including:
    - Plan of care feedback and consensus.
    - Clinical coordination for the member.
    - Participation in ICT.
    - Responsive and cooperative with the plan clinical representatives.
    - Referring member to medically necessary services in accordance with plan benefits.
    - Appropriate communication with the member's family or legal representative.
    - Timely submission of documentation.
- How to obtain additional information or resources.
- This presentation and attestation are yearly requirements.

Provider name: _____

ID #: _____

Address: _____

Phone: _____

Fax: _____

Signature: _____ Date: _____

Please sign and fax to: 1-855-328-8562

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