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2019 Medicare Advantage

Special Needs Plans and Model of Care overview

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

- In 2003, Congress passed the *Medicare Modernization Act* (*MMA*), which enables insurance companies to create, market and sell a different kind of MA plan — SNP.
- SNPs are different from most types of MA plans in that they focus on members that have special needs and could benefit from enhanced coordination of care as described in our SNP Models of Care (MOCs).
- As provided under section 1859(f)(7) of the *Social Security Act*, every SNP must have a MOC approved by the National Committee for Quality Assurance (NCQA).
- The MOC provides the basic framework under which the SNP meets the needs of each member.
- The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each member are identified by the SNP and addressed care management practices.
- The MOC provides the foundation for promoting SNP quality, care management and care coordination processes.
- MOC requirements apply to all SNP plan types.

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SNPs

- Below are the types of Special Needs Plans:
  - **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 that 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)** are for members who are eligible for Medicare and Medicaid..

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C-SNPs

- Members must be enrolled in Medicare.
- They 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).
- The condition must be confirmed by a provider, and additional forms may be required.
- In California, Connitictu, New Jersey, Texas and Virginia, we contract with DaVita Integrated Kidney Care to deliver care management to ESRD C-SNP members. Each ESRD CSNP member has an assigned integrated care nurse as well as an individualized interdisciplinary care team (ICT) that may include any of the following members: nurses, nephrologists, social workers, dieticians, pharmacists and other participants as determined by the member.

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D-SNPs

Characteristics of dual-eligible members:

- They meet eligibility requirements for both Medicare and Medicaid and are enrolled in both programs.
  - Those that lose Medicaid eligibility have a special election period beginning the month they receive the notice of the loss of eligibility plus two additional months to make an enrollment choice.
- This is a more vulnerable subgroup of Medicare members who are typically more costly and have more health care needs.
- Members are a mix of over 65 and under 65 who qualified based on a disability.
- These members tend to have a lower income and report a lower health status than other members. They make up 20 percent of Medicare enrollment and spend 31 percent of the dollars spent.
- Members must live in our service area to be enrolled and not have ESRD at the time of enrollment .

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Who is eligible for our D-SNPs?

- For all states except Florida, eligibility varies by plan and location and not all members have full Medicaid benefits.
- Those who have coverage of Medicare premiums and Medicare cost share are eligible.
- Covered dual-eligible categories vary by state.
- **New Jersey — Fully Integrated Dual Eligible SNP (FIDE):** We cover those with full Medicaid coverage and some with additional long-term support and services (LTSS) coverage under the plan. Medicaid benefits are integrated within the D-SNP and LTSS benefits for those that qualify.
- **Texas —** We cover dual-eligible members that have at a minimum protection of all Medicare cost share responsibilities **and** process that cost share under the D-SNP on behalf of the state. Any Medicaid-only service benefits are covered by the plan administering their Medicaid benefits and not the D-SNP directly.

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Who is eligible for our D-SNPs? (cont.)

- **Florida —** We offer several plans that have varying eligibility categories. D-SNPs are required to cover certain Medicaid benefits that are not covered by Medicare.
  - Some plans are available to all dual categories except QDWI.
  - Some plans are available to full benefit dual eligibles (FBDE) and full duals (QMB+, SLMB+).
  - Some plans are available to QMB only.
- **All other D-SNP states —** We cover dual-eligible members that have at a minimum protection of all Medicare cost share responsibilities; however any cost share or Medicaid-only benefits are covered by the plan administering their Medicaid benefits.

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D-SNPs and state SNP agreements

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 is key!

- When dual-eligible members need care or access benefits, it is everyone's responsibility to help and coordinate that care.
  - Where do they go for that care?
  - What services are covered under the Medicare and Medicaid plans?
  - How do Medicare and Medicaid work together?
- The following information will assist in managing billing and service issues and to coordinating care:
  - Dual-eligible members (except in New Jersey) should show **both** the plan ID and Medicaid cards to all providers. This reduces the error of balance billing.
  - New Jersey D-SNP members should only show the D-SNP ID card.
  - Most states require a provider to have a Medicaid ID number to receive payment from the state.

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MOC structure and requirements

- The MOC is a CMS requirement for organizations that offer any of the SNPs and are designed to meet the needs of the targeted population.
- The MOC addresses each of the following areas:
  - Description/assessment of the SNP population
  - Care coordination
  - Provider Network to care for the needs of the members
  - Quality measurement and performance improvement.

MOC elements

- **Population assessment:** We assess our population and identify health conditions and unique characteristics that make up our membership. We work to develop a robust provider network and specialty tailored services or programs to assist in the management of the most vulnerable members.
- **Staff structure:** Our staff structure and care management roles are designed to manage the special needs population. A case manager attempts to contact each SNP member, and an individualized interdisciplinary care team is assigned.

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MOC elements (cont.)

- **Health Risk Assessment (HRA)**
  - We work to complete HRA on each member within 90 days of eligibility date and conduct an annual reassessment.
  - The HRA covers physical, behavioral, cognitive, psychosocial and functional topics and serves as the basis for the member's individualized care plan (ICP).
- Each member has an **individualized care plan (ICP).**
  - Working with the member and the ICT, the case manager develops the ICP based on identified needs.
- 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.

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MOC elements (cont.)

- An **ICT** is assigned to each member.
  - The ICT is led by the case manager and is responsible for reviewing the care plans, collaborating with you and other network providers, and providing recommendations for management of care. You may be asked to participate in the care planning and management of the plan of care.
  - The structure and frequency of the ICT is based on the identified needs and complexity of the member.
- We have a contracted provider network having special expertise to manage the special needs population and monitor the use of *Clinical Practice Guidelines* by the contracted providers.
  - The roles of providers include managing transitions, advocating, informing and educating members, performing assessments, diagnosing, and treating.

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MOC elements (cont.)

- **Communication plan:** 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 utilization, transitions and care management is available on the secure provider portal.
- SNP members typically have many providers and may transition into and out of health care institutions. You are essential in coordinating care during transitions.
  - Contact us if you would like our team to assist in coordinating care for your patient.
  - Our care management 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.
  - We have identified care transition protocols that are also documented for you in your provider manual.

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MOC elements (cont.)

- 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:
  - Healthcare Effectiveness Data and Information Set (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

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 healthcare 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
- 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.

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2019 D-SNPs

State(s)	Plan name
NJ, TN, TX, WA	Amerivantage Dual Coordination (HMO SNP)
TX	Amerivantage Dual Premier (HMO SNP)
TX	Amerivantage Dual Secure (HMO SNP)
CA	Anthem Connect (HMO SNP)
CA, CO, CT, GA, IN, KY, ME, MO, OH, VA, WI	Anthem MediBlue Dual Advantage (HMO SNP)
CA	Anthem MediBlue Dual Plus (HMO SNP)
NY	Empire MediBlue Dual Advantage (HMO SNP)
NY	Empire MediBlue Dual Advantage Select (HMO SNP)
FL	Simply Advantage (HMO SNP)
FL	Simply Complete (HMO SNP)

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2019 C-SNPs

State(s)	Plan name	C-SNP type
TX	Amerivantage COPD (HMO SNP)	C-SNP Chronic Lung
TX	Amerivantage Diabetes (HMO SNP)	C-SNP Diabetes
TX, NJ	Amerivantage ESRD (HMO-POS SNP)	C-SNP ESRD
TX	Amerivantage Heart (HMO SNP)	C-SNP Heart (cardiovascular disorders and CHF)
CA	Anthem ESRD (HMO SNP)	C-SNP ESRD
VA	Anthem MediBlue COPD (HMO SNP)	C-SNP COPD
VA	Anthem MediBlue Diabetes (HMO SNP)	C-SNP Diabetes
VA, CT	Anthem MediBlue ESRD (HMO-POS SNP)	C-SNP ESRD
CA	Anthem MediBlue ESRD (PPO SNP)	C-SNP ESRD
FL	Simply Level (HMO SNP)	C-SNP DIAB

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2019 I-SNPs and IE-SNPs

State(s)	Plan name	I-SNP or IE-SNP
VA	Anthem MediBlue Care on Site (HMO SNP)	I-SNP
FL	Simply Care (HMO SNP)	I-SNP
FL	Simply Comfort (HMO SNP)	IE-SNP

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2019 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.

LIS level	Part D deductible	Generic copay	Brand copay
1	Covered	$3.40	$8.50
2	Covered	$1.25	$3.80
3	Covered	$0.00	$0.00
4	Partially covered	15%	15%

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How our D-SNPs are structured?

- 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.
- Most plans do not have out-of-network benefits unless it is urgent/emergent or out-of-area renal dialysis.
- Please call the plan if you need to refer outside of the plan network.

Benefit	As filed with CMS	Member responsibility
Inpatient copay	Medicare defined	$0 copay
SNF copay	Medicare defined	$0 copay
PCP copay	Medicare defined	$0 copay
Specialist copay	Medicare defined	$0 copay
Ambulatory surgery	Medicare defined	$0 copay
Outpatient hospital	Medicare defined	$0 copay
Emergency room	Medicare defined	$0 copay
Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Medicare defined	$0 copay
Diagnostic imaging	Medicare defined	$0 copay
Part D drug copays	Standard Medicare Part D	Lower of filed benefit or LIS copay
Supplemental benefits	$0 copay; Member is eligible for all Medicaid benefits entitled to.	

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D-SNP claims processing

- D-SNP members are protected by state and federal regulations from balance billing. Providers cannot balance bill and must accept the Medicare and Medicaid (if applicable) payments as payment in full.
- 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.*
- 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.)
    - For example, for a claim covered by Medicare and Medicaid for $100, Medicare will pay $80 as the allowed amount. Medicaid will pay only up to the allowed amount as well, so if the $80 Medicare paid is more than the Medicaid allowed amount, the provider will not receive additional payment.
- 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.
- Not all members will have full Medicaid benefits (for instance, QMB members).
- Federal rules dictate that Medicaid is the payer of last resort.

D-SNP claims processing (cont.)

For members enrolled in more than one of our 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.
- *Explanation of Payment* (*EOP*) will provide further guidance on next steps or pending payments.
- 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 Portal
- 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!

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Model of Care Attestation

As the below 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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