# **Dual Eligible Special Needs Plans (D-SNPs)**
## Model of Care Training and Attestation

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# CMS Requirements

The Centers for Medicare & Medicaid Services (CMS) requires that all contracted medical providers and staff receive basic training about the Special Needs Plans (SNPs) Model of Care. This training and completion of an attestation are required for new providers. And they must be completed yearly.

The SNPs Model of Care is the plan for delivering coordinated care and care management to special needs members.

This course will describe how we work together with our contracted providers to successfully deliver the SNPs Model of Care.

# Our Mission

Our Special Needs Plan (SNP) program is designed to optimize the health and well-being of our aging, vulnerable and chronically ill members.
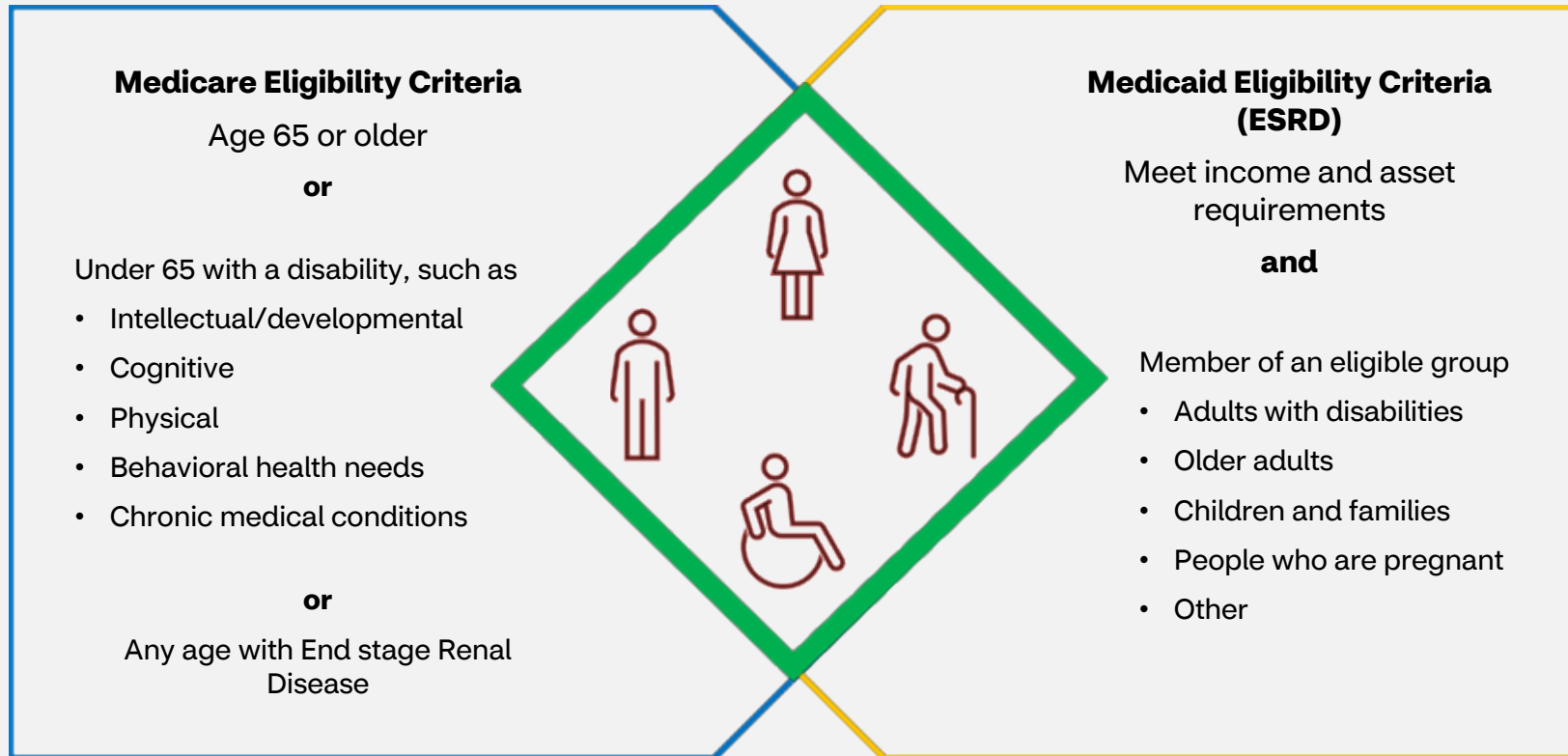
We're emerging as an **industry leader** in serving **dual populations** by:

- Developing **best-in-class operating** and **clinical models**
- Collaborating with **members, providers** and **community organizations**
- Pursuing quality solutions that address the **full continuum** of our **members' health care** and **social determinant needs**

# Our Objectives

- Explain Dual Eligible Special Needs Plans (D-SNPs)
- Describe what D-SNPs offer
- Describe which dually eligible individuals qualify for these plans
- Describe our Model of Care and care plan management programs
- Describe how Medicare and Medicaid benefits are coordinated under the plans
- Expand on the enhanced benefits of D-SNPs
- Complete your D-SNP Model of Care training Attestation to receive credit
- Explain how to get answers to your questions

# Who is Dual Eligible?



**Medicare Eligibility Criteria**

Age 65 or older

**or**

Under 65 with a disability, such as

- Intellectual/developmental
- Cognitive
- Physical
- Behavioral health needs
- Chronic medical conditions

**or**

Any age with End stage Renal Disease

**Medicaid Eligibility Criteria (ESRD)**

Meet income and asset requirements

**and**

Member of an eligible group

- Adults with disabilities
- Older adults
- Children and families
- People who are pregnant
- Other

# Two Types of Dually Eligible



**Full-benefit dually eligible individuals:**

- ✓ Qualify for Medicare
- ✓ Qualify for full state Medicaid benefits
- ~ May receive financial assistance with Medicare premiums (and in many cases, cost sharing)

**Partial-benefit dually eligible individuals:**

- ✓ Qualify for Medicare
- ✗ Don't qualify for full Medicaid benefits
- ~ May receive financial assistance with Medicare premiums (and in many cases, cost sharing)

**Cost sharing is a term used to describe a member's copayments, deductibles and coinsurance.**

# Types of Assistance for Low-Income Medicare Beneficiaries

**Know the differences:**

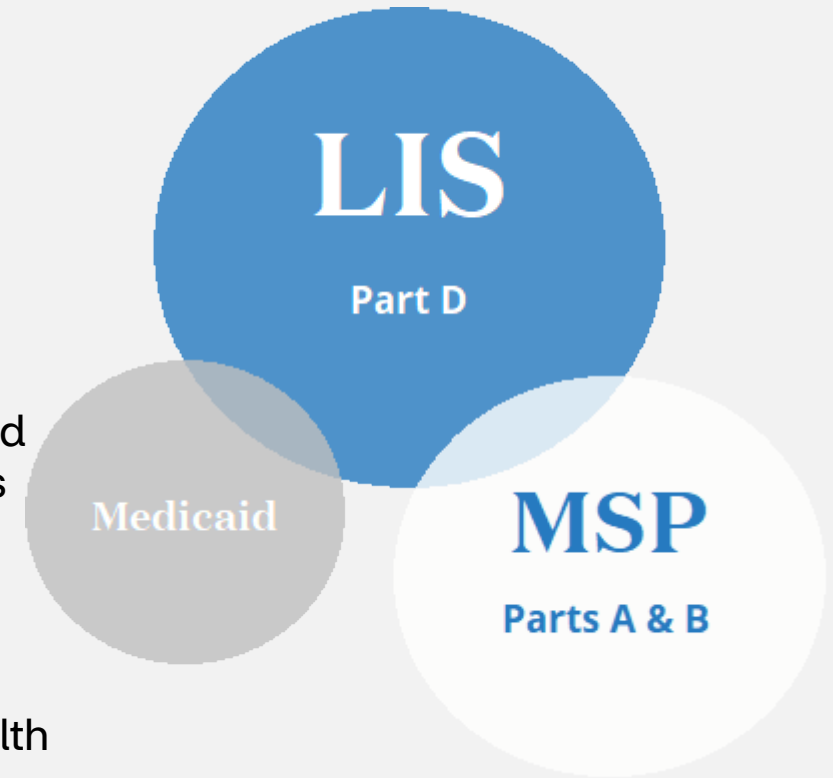**Low-Income Subsidy (LIS), aka "Extra Help" – Part D**

- LIS is a federally funded program that helps members pay for Part D prescription drugs

**Medicare Savings Programs (MSP) – Parts A & B**

- MSP is a federally funded program, administered by each state's Medicaid agency, that pays for things like Medicare copays, deductibles, premiums and coinsurance

**Medicaid**

- Medicaid is a federal-state program run by each state that helps with health care costs and extra supplementary benefits

**All dual eligibles qualify for LIS. Not all LIS eligibles are dual-eligible.**

LIS
Part D

Medicaid

MSP
Parts A & B

# Part D Extra Help, or Low-Income Subsidy (LIS) Program

Dual members are eligible to get full or partial help paying for prescription drugs. This depends on what LIS level they fall into.
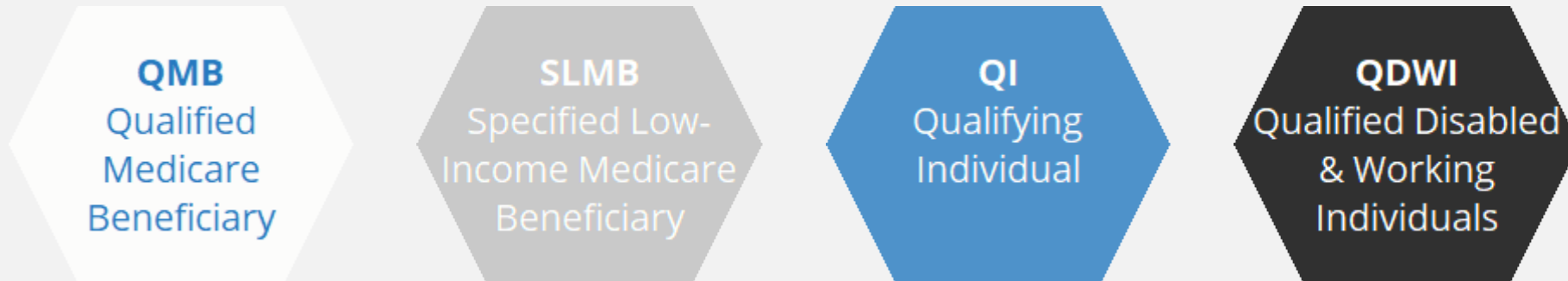
Low-Income Subsidy helps pay for Part D:

- Premiums
- Deductibles
- Copayments
- Late enrollment penalties

# Medicare Savings Program (MSP)

- Federally-funded program
- Administered by each individual state's Medicaid agency
- For individuals with limited income and resources
- Medicaid helps to pay some or all <u>Medicare</u> premiums, deductibles, copayments and coinsurance

## Four MSP Categories:

**QMB**
Qualified Medicare Beneficiary

**SLMB**
Specified Low-Income Medicare Beneficiary

**QI**
Qualifying Individual

**QDWI**
Qualified Disabled & Working Individuals

Note: There are also individuals who are dual eligible who don't fall into one of these MSP categories called **Full Benefit Dual Eligible (FBDE).**

# MSP Levels and Medicaid Eligibility Categories

| Full Dual | | | Partial Dual | | | |
|---|---|---|---|---|---|---|
| (Full Medicaid Benefits) | | | (Financial Support Only) | | | |
| QMB+ | FBDE | SLMB+ | QMB | SLMB | QDWI | QI |
| Cost Share Protected | Cost share protection varies by state* | Cost share protection varies by state* | Cost Share Protected | NOT Cost Share Protected | NOT Cost Share Protected | NOT Cost Share Protected |
| Full Medicaid Benefits | Full Medicaid Benefits | Full Medicaid Benefits | Does NOT have full Medicaid benefits | Does NOT have full Medicaid benefits | Does NOT have full Medicaid benefits | Does NOT have full Medicaid benefits |

*All SLMB+ and FBDE in Aetna® Medicare 2022 DSNP plans are cost share protected

# Cost Share Protection - What Does That Mean?

**Cost share:**

- Cost share is a term used to describe a member's Medicare Parts A and B:
  - Copayments
  - Deductibles
  - Coinsurance

**When we say that a member is cost share protected:**

- We mean that the state Medicaid program pays the member's Medicare (Parts A and B) cost share on their behalf
- The member is not personally financially responsible for these costs and the provider can't balance bill the member

**QMB and QMB+ guidance:**

- Federal law forbids Medicare providers and suppliers, including pharmacies, from billing people in the QMB program for Medicare Parts A and B cost sharing

# What is a Special Needs Plan?

A Special Needs Plan (SNP) is a Medicare Advantage (MA) Coordinated Care Plan (CCP). It is specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be any one of the following:

- An institutionalized individual
- A dual eligible
- An individual with a severe or disabling chronic condition, as specified by CMS

A SNP may be any type of MA CCP including:

- A local or regional preferred provider organization (i.e., LPPO or RPPO) plan
- A health maintenance organization (HMO) plan
- An HMO Point-of-Service (HMO-POS) plan

| SNP Type | Membership Limited to: |
|---|---|
| Chronic Condition SNP (C-SNP) | People who have specific chronic or disabling conditions such as Renal Disease (ESRD), HIV/AIDS, chronic heart failure or dementia) |
| Institutional SNP (I-SNP) | People who live in certain institutions (like a nursing home) or who require nursing care at home |
| Dual Eligible SNP (D-SNP) | People who are eligible for both Medicare and Medicaid |

*We only offer D-SNPs

# CMS Requirements for Model of Care (MOC)

## Each DNSP state is required by CMS to submit a MOC document detailing the 4 areas below:

**Description of SNP Population**

- Documentation of how the health plan will determine, verify and track eligibility
- Detailed profile of medical, social, cognitive, environmental conditions, etc. associated with SNP population
- Health conditions impacting beneficiaries & plan for especially vulnerable beneficiaries

**SNP Provider Network**

- Specialized expertise available to SNP beneficiaries & how health plan evaluates competency of network
- Use of clinical practice guidelines & care transition protocols by providers
- MOC training for provider network

**Care Coordination**

- SNP staff structure, roles and training defined
- HRA tool description and plan for analyzing results
- ICP development process, beneficiary goals & health preferences
- Interdisciplinary Care Team (ICT) composition, member selection, health care outcomes evaluation
- Care transition protocols

**Quality Measurement & Performance Improvement**

- MOC Quality Performance Improvement Plan-process to collect and analyze data
- Measurable goals & health outcomes for the MOC
- Measure patient experience of care survey and analyze integrated results
- Ongoing performance improvement evaluation
- Disseminate SNP quality performance to stakeholders, regulatory agencies & general public

# Care Management

Focusing on maintaining an effective Model of Care through successful outcomes on the following goals.

## Goals and vision

**Improve quality**
through early intervention and education

**Improve access to care,**
essential medical, behavioral health and social services

**Improve access to affordable care**

**Integrate and coordinate care**
across specialty, multi-setting care continuum through a central point of contact

**Provide seamless transitions**
across health care settings, care providers and health services

**Improve access to preventive**
health services

**Assure appropriate use**
of services and deliver cost-effective health services

# D-SNP Care Management

We offer every D-SNP member a dedicated care team. They help members achieve their best health.

Our care management program goes beyond traditional case and disease management. We care manage our members holistically. We assign a dedicated care team member to each D-SNP member. This occurs as soon as they become effective on our D-SNP.

The care team is available to the member for as long as they are enrolled in the plan.

Core care team members:
- **Health Survey Specialist** - Completes initial outreach and health risk assessment, also known as the health survey
- **Registered Nurse** - Assesses member's needs and risk levels; develops and oversees care plan
- **Social Worker** - Identifies and addresses social determinants of health and provides assistance with accessing community resources and support
- **Care Coordinator** - Assists with benefit navigation and appointment scheduling
- **Member Advocate** - Assists member with Medicaid recertification and accessing Medicaid benefits

Supported by:
- **Pharmacist**
- **Behavioral Health Specialist**
- **Medical Director**

# How the Care Team Supports the Member

The care team can work with a caregiver if the member is unable to speak for themselves.

1. Learn the member's needs and priorities
   - Complete a Health Survey to understand the medical, functional, cognitive, psychosocial and mental health needs of each D-SNP member
     - Outreach completed by a non-clinical team within 90 days of the member's effective date
     - Caller area code will be "860" and the ID should say "Aetna"
   - **Learn about barriers** preventing the member from taking care of their health
   - Understand the member's **health goals and priorities**

2. Help the member to proactively take care of their health
   - Educate the member on recommended preventive care and how to manage their conditions
   - Make medical appointments, arrange for transportation and take other actions to facilitate care access
   - Find resources to address social needs, such as food insecurity
   - Answer the member's questions about their health conditions(s) or doctors' instructions
   - Help the member to re-certify Medicaid eligibility so they can remain in our D-SNP plan

3. Serve as the member's advocate if they become sick
   - Help the member get necessary information to make informed health care decisions
   - Facilitate access to care and benefits
   - Coordinate care across the member's providers

# Interdisciplinary Care Team (ICT)

About the team:

- ICT participants based on the member's needs
- Care managers keep the team updated with information involving the member's care plan
- Team meets formally
- Smaller meetings occur, as needed

# Health Risk Assessment (HRA)

- This is a health survey that helps identify the member's most urgent needs
- Is an important part of the member's care coordination
- Contains member self-reported information
- Helps create the member's Individualized Care Plan (ICP)
- Assesses the following needs of each member:

| **Medical** | **Functional** | **Cognitive** | **Psychosocial** | **Mental health** |
|---|---|---|---|---|

- Are completed by phone
- Within 90 days of enrollment
- Repeated within 365 days of last HRA

# Individualized Care Plan (ICP)

An ICP is the mechanism for evaluating the member's current health status. It is the ongoing action plan to address the member's care needs in conjunction with the ICT and member.

These plans contain member-specific problems, goals and interventions, addressing issues found during the HRA and any team interactions. An ICP is developed and maintained for each D-SNP member using:

- Health risk assessment results

- Laboratory results, pharmacy, emergency department and hospital claims data

- Care manager interaction

- Interdisciplinary care team input

- Member preferences and personal goals

This is a living document that changes as the member changes.

# Care Coordination

**Integrate and coordinate care across specialties**

The health plan integrates and coordinates care for D-SNP members across the care continuum through a central point of contact. The care manager (CM) functions as this central contact across all settings and providers.

**To improve coordination of care:**

- The **Primary Care Physician (PCP)** is the gatekeeper and responsible for identifying the needs of the beneficiary
- The **CM coordinates care** with the member, the member's PCP and other participants of the member's ICT
- All **SNP members have a PCP and a CM**

To assist with seamless transitions between care settings:

- Notify the member's PCP of the transition
- Share the member's ICP with the PCP, the hospitalist, the facility, and/or the member/caregiver (where applicable)
- Contact the member prior to a planned transition to provide educational materials and answer questions related to the upcoming transition

# Care Coordination

**Post-hospitalization transition of care:**

This program includes phone calls after D-SNP members are discharged home from the hospital. Members receive a call within three business days of discharge. They can get more contact as needed.

- During these calls, the CM:
  - Helps the member understand discharge diagnosis and instructions
  - Facilitates follow-up appointments
  - Helps schedule transportation
  - Helps with needed home health care and medical equipment
  - Resolves barriers to obtaining medications
  - Educates the member on new or continuing medical conditions

# Additional Benefits for D-SNPs May Include:

- Medication therapy management
- Diet and nutritional education
- Behavioral health services
- End-of-life support services
- Social work support
- Home and community-based services partnerships
- Non-emergency transportation
- Meal programs
- Over-the-counter allowance
- Healthy foods card
- Fall prevention
- $0 drugs
- Rx 100-day supply on certain covered drugs
- Personal emergency response system (PERS)

# Working With Our Providers

Provider partners are an invaluable part of the interdisciplinary care team. Our D-SNP Model of Care offers an opportunity for us to work together for the benefit of our members and your patients by:

- Enhancing **communication**

- Focusing on each individual member's **special needs**

- Delivering **care management** programs to help with the patient's medical and non-medical needs

- **Supporting** the member's plan of care

Providers can access your members' **HRA** and **ICP** by visiting our secure provider portal:

- For all **D-SNP markets (except VA and NJ): Aetna-prd.assurecare.com/provider/**

- **For VA: Aetnabetterhealth.com/virginia-hmosnp/providers/portal**

- **For NJ: AetnaBetterHealth.com/New-Jersey-hmosnp/providers/index**

# Provider Role

- **Communicates** with D-SNP care managers, Individual Care Team (ICT), members and caregivers
- **Collaborates** with our organization on the Individual Care Plan (ICP)
- **Reviews and responds** to patient-specific communication
- **Maintains ICP** in member's medical record
- Participates in the **ICT**
- Reminds the member of the importance of completing their **Health Survey (also known as HRA),** which is essential in the development of the ICP
- **Encourages** the member to work with their care management team
- Completes Model of Care (MOC) training upon onboarding and again annually

   **Direct link: Aetna.com/healthcare-professionals/documents-forms/dsnps-model-of-care.pdf**

# Staff Role

**What can you do to help D-SNP members?**

- Remind members of the importance of completing their Health Survey (HRA), which is essential in the development of the Individualized Care Plan (ICP)

- Encourage members to work with their SNP Care Management team

- Encourage Primary Care Physicians (PCPs) and other providers to participate with the member's Interdisciplinary Care Team (ICT)

- Remind the PCP to access the D-SNP member's ICPs

- Remind providers and their staff to perform their Model of Care (MOC) training annually

# Complete Your Attestation to Receive Credit



**Evidence of training completion required**

You are a "first-tier entity." This means you must stay in accordance with the Centers for Medicare and Medicaid Services ("CMS") regulations for Managed Care Organizations and your contractual relationship with us. There are specific compliance regulations that you must adhere to. This includes the Special Needs Plan Model of Care ("SNP MOC"). You must complete the D-SNP attestation and training. It needs to be completed within 90 days of your hire/contracting. And it needs to be completed yearly.

Complete the 2022 SNP MOC attestation online at the link that pertains to you.

D-SNP/FIDE MOC Attestation for Providers: [link](link)

D-SNP/FIDE MOC Attestation for Delegates in MA/MMP: [link](link)

D-SNP/FIDE MOC Attestation for Delegates in MA & D-SNP/FIDE Plans: [link](link)

See next slide for attestation support.

# Complete Your Attestation Support

## D-SNP MOC Attestation completion support

- If you or your authorized representative have already completed the **D-SNP MOC Attestation**, there's nothing else you need to do.

- If you receive an error message at the **D-SNP MOC Attestation** link, check your browser settings and ensure it complies with: Microsoft Windows 10 **using** Microsoft Edge, Internet Explorer 11, or a current version of Firefox, or Chrome. Microsoft Windows 8 **using** Internet Explorer 11 or later, or a current version of Firefox, or Chrome. Mac OS X v11 or later **using** Safari 7 or later, or a current version of Firefox, or Chrome

- An authorized representative may complete one attestation for multiple providers, groups or organizations if all tax IDs are identified with the attestation. Credit is given at the **tax ID/EIN level only**. No other provider identifier will be accepted for credit.

- Once the DSNP MOC Attestation is completed, you'll receive an email asking you to verify your email address. <u>After you verify your email</u>, you'll receive a copy of your signed Attestation for your records.

- Did you **not** receive the **"Click to Sign"** option in the attestation? You must click the **START** button which begins on the second page, select an answer and/or **respond to all** drop down or form fields. If you missed answering any fields, you won't receive the **"Click to Sign"** link at bottom of the page

- Tax ID#(s) must be only numbers (a total of 9 digits) with no hyphens, spaces or letters: 123456789. If your Tax ID# has zeros in the beginning or end, you must add those to get to the required 9 digits.

If you have any questions or need help with this requirement, please email us at **DSNPMOC@Aetna.com** or call us at **1-800-624-0756 (TTY:711).**

# Contact Us

For **general MOC attestation questions** please email us at **DSNPMOC@Aetna.com**

For Care Management, email:

All D-SNP markets (except VA and NJ): **MCRDSNP@Aetna.com**

VA: **ABH_VA_DSNP@Aetna.com**

NJ: **NJ_FIDE_SNP_CM@Aetna.com**

To request access to the secure provider portal, email:

All D-SNP markets (except VA and NJ): **MCRDSNP@Aetna.com**

VA: **VA_DSNP_Providers@Aetna.com**

NJ: **NJ_FIDESNP_Providers@Aetna.com**

# Thank You