Anthem

Medicare Advantage

2022 Medicare Advantage

Special Needs Plans and Model of Care overview

Learning objectives

- Describe the different types of Special Needs Plans (SNP).
- Understand impacts of the State Medicaid Agency Contract on Dual Eligible Special Needs Plans (D-SNP) plans.
- Understand the components/requirements of the Model of Care:
  - Description of the SNP population
  - Care coordination
  - Provider network
  - Quality measurement and performance improvement
- Understand your responsibilities as a network provider.
- Availability of resources and references.
- Complete attestation.

Types of SNP

- **Chronic Condition Special Needs Plans (C-SNP):** for members with disabling chronic conditions (categories defined by CMS).
- **Institutional/Institutional Equivalent Special Needs Plan (I-SNP/IE-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) or equivalent living in the community.
- **D-SNP:** for members who are eligible for both Medicare and Medicaid.

C-SNP

- We have C-SNP plans for the following conditions (enrollment limited to those with the qualifying conditions):
  - Diabetes mellitus.
  - End-Stage Renal Disease (ESRD).
  - Chronic lung disorders.
  - Cardiovascular disorders and/or chronic heart failure (CHF).
  - Multiple condition C-SNP with combination of two or more of the above conditions.
- In some of our markets, we may contract with vendors or providers to administer some of the MOC requirements.

D-SNP

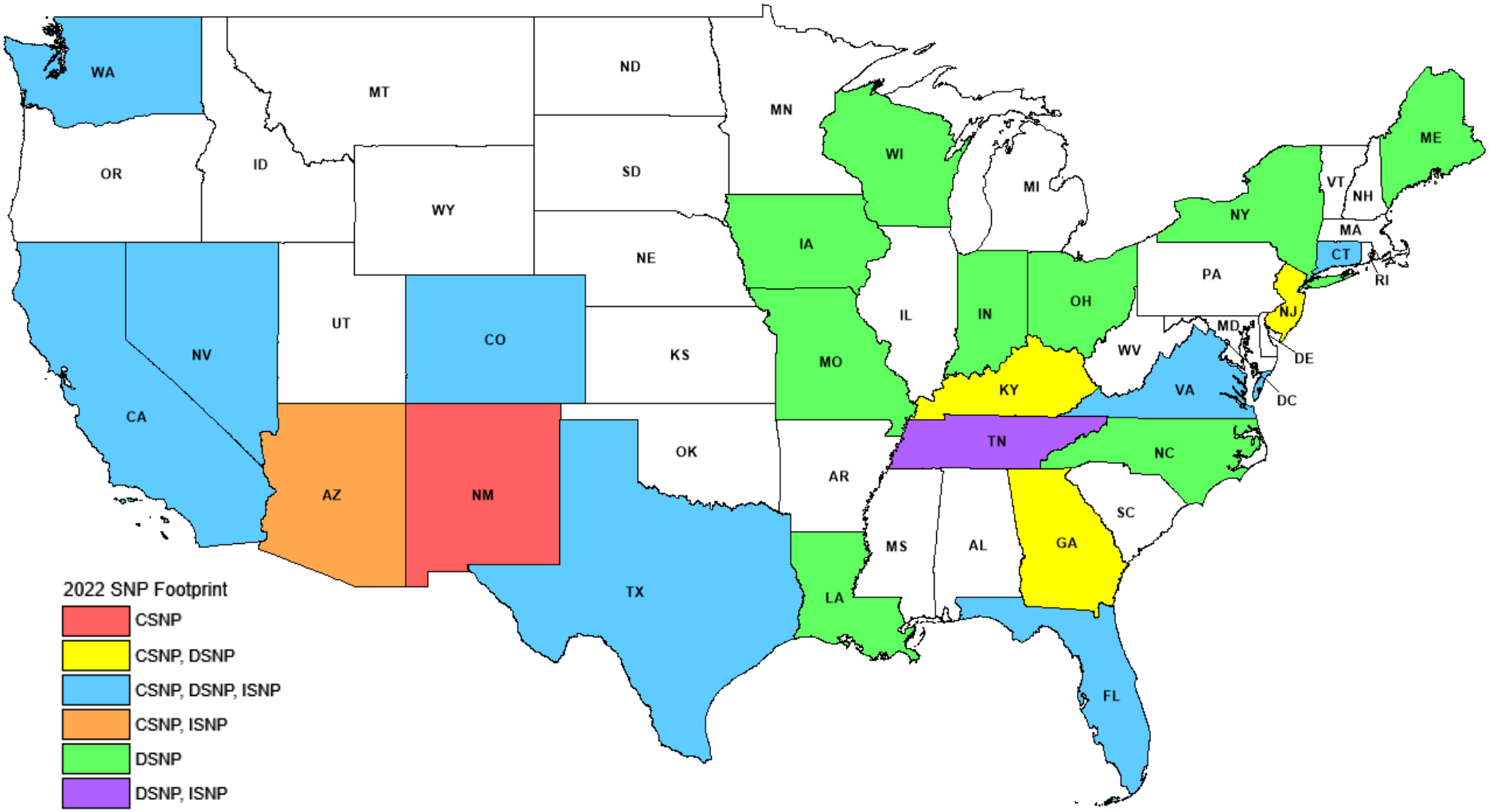
- Members are eligible for both Medicare and Medicaid.
- May be *full benefit duals* or *partial benefit duals*:
  - Full benefit duals are eligible for Medicaid benefits.
  - Partial benefit duals are only eligible to receive assistance with some or all Medicare premiums and cost sharing.
- A member may change plans once during each of the first three quarters of the year.
- Providers must adhere to coordination and cost share requirements which may vary by D-SNP type (refer to your provider manual).
- D-SNP types include data coordination, highly integrated dual eligible (HIDE) and fully integrated dual eligible (FIDE).

Fully Integrated Dual Eligible (FIDE) D-SNP

- Provide Medicare and Medicaid benefits.*
- Include long-term services and supports (LTSS) benefits (eligibility rules apply).*
- One identification card used to access both Medicare and Medicaid services.*
- Integrated materials and processes.*
- States may carve out Medicaid Behavioral Health benefits from the contract.
- If unaligned coordination between Medicare and Medicaid plans or other agencies required.

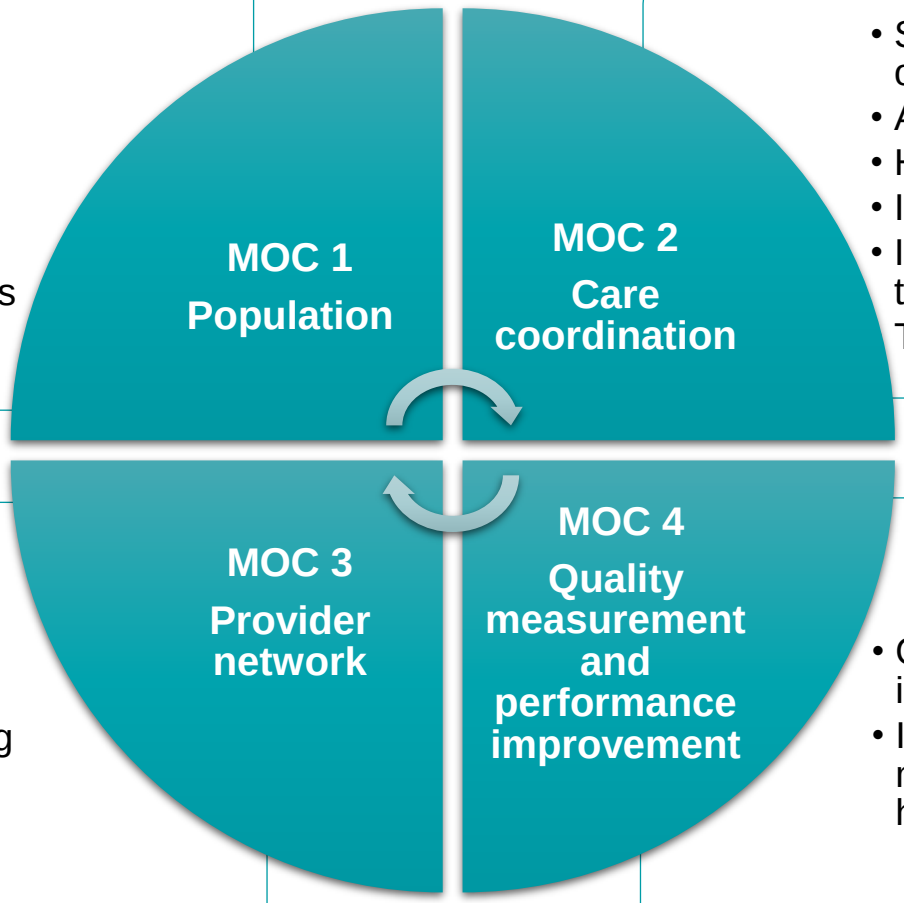
* Applicable only in an aligned FIDE.

2022 SNP footprint



Model of Care (MOC) elements

- SNP population description
- Eligibility requirements
- Define most vulnerable members and clinical programs
- Describe relationships with community partners



- Staff structure and oversight
- Associate annual training
- Health risk assessment
- Individualized care plan
- Interdisciplinary care team

Transition management

- Expertise of provider network
- Provider annual training
- Use of practice guidelines and care transition protocols

- Quality performance improvement plan
- Identifying, defining, and measuring goals and health outcomes

Care coordination strategies

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

Health Risk Assessment (HRA) (Initial and reassessment):

- Completed within 90 days of enrollment and repeated within 365 days of last HRA.
- Assesses physical, behavioral, cognitive, psychosocial, and functional areas.
- Results used to create individualized care plan (ICP).
- Assists in care coordination and identifies urgent needs.
- Additional assessments completed for significant change in condition, disease specific needs, or as part of other programs requirements.
- **Results of the HRA are available to the member and the provider on the portal.**

Care coordination strategies (cont.)

Interdisciplinary Care Team (ICT):

- Care coordinated with the member, the member's PCP and other participants.
- Providers are key members of the ICT and responsible for coordinating care and managing transitions.
- ICT role-based actions may include any of the following:

Diagnosing/treating	Communicating treatment and management options	Advocating, informing, and educating members	Completing assessments
Reviewing HRA and ICP results	Collaborating with providers	Coordinating with other carriers (Medicaid)	Arranging community resources

Care coordination strategies (cont.)

Individualized Care Plan (ICP):

- Includes member-specific goals and interventions, addressing issues identified during the HRA process, and other interactions.
- Members we are unable to reach or do not complete the HRA will receive an ICP based on claims or other information available to the case manager.
- Updated annually or as the member's needs change.
- **The ICP is available on the portal for the member and the providers.**

ICT

- Each member has an ICT developed based on, assessment results, identified needs, and complexity.
- ICT may include the following participants: member, PCP, specialty care provider, and our healthcare team including behavioral health or pharmacy attendees.
- Meeting frequency determined by patient needs, occurs a minimum of annually.

The ICT:

- Develops or contributes to a comprehensive plan of care.
- Coordinates care with the member, the member's PCP/other providers and members of the ICT.
- We may collaborate with members of the ICT by mail, phone, provider portal, email, fax, or a meeting may occur.
- **If a formal meeting occurs, the case manager will inform your office of the details on a case-by-case basis.**

Care transitions and provider communication

- Our goal is effective, efficient communication with our providers:
  - Valuable information on member utilization, transitions, and care management is **available to you on the secure provider website**.
  - You may reach the care team by calling the number provided to you on any correspondence from us or the number on the members' identification card.
- SNP members have many providers and have multiple transitions. You 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.

Provider responsibilities

- Communicate and collaborate with care managers, the ICT, members and caregivers. Coordinate care with Medicaid (D-SNP), which may include state agencies or other carriers.
- Review and respond to patient specific communication including the ICP development and invitations to attend the ICT meeting.
- Review the HRA results, the ICP, and other clinical data on the secure provider portal.
- Encourage the member to work with your office, the care team, keeping all appointments, completing the HRA, and complying with treatment plans.
- Complete the annual SNP provider training.

New in 2021, our PCPs can register through the Availity* Preference Center, to generate a daily alert with a list of your patients who have received an updated ICP and/or HRA posted to the portal.

Performance and quality outcomes

- Quality and health outcome measurements are collected, analyzed and reported to evaluate the effectiveness of our MOC in the following areas:
  - Improve access and affordability of healthcare needs.
  - Improve coordination of care and delivery of services.
  - Improve transitions of care across healthcare settings.
  - Ensure appropriate use of services for preventive health and chronic conditions.
- Additional goals and measures are implemented based on program design and our population.
- Actions are taken to improve outcomes and the quality of care our members receive.

Provider attestation and resources

- Resources and references:
  - Access tools and information on the provider website including:
    - Benefit information, claims processing rules, and covered medications.
    - Transition protocols.
    - Results of the member's HRA and the Individualized Care Plan.
- Contact our Provider Services team (at the number on the back of the member's ID card) with any questions.
- Medicare Managed Care Manuals (Chapter 16-B: Special Needs Plans and Chapter 5: Quality Assessment: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.
- Provider attestation of training completion is required.

Model of Care Training Attestation

Anthem Blue Cross is required to maintain a record of your annual Model of Care training. To receive credit for completing this course, please select the begin attestation button below and complete the attestation.

Begin Attestation

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross.

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