Arizona • Iowa • New Jersey • Tennessee • Texas • Washington | Medicare Advantage

2025 Medicare Advantage

Special Needs Plans and Model of Care overview

MULTI-WP-CR-070935-24-CPN70374 | November 2024

Wellpoint

Learning objectives

- Describe the different types of Special Needs Plans (SNP)
- Understand the 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
  - Care coordination
  - Provider network
  - Quality measurement and performance improvement
- Understand your responsibilities as a provider
- Availability of resources and references
- Complete *Attestation*

Types of SNP plans

- **Dual Eligible Special Needs Plans (D-SNP):** for members eligible for Medicare and Medicaid
- **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 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 plans

- Members are eligible for both Medicare and Medicaid.
- Plans may be *full benefit duals* or *partial benefit duals:*
  - Full benefit duals are eligible for Medicaid benefits.
  - Partial benefit duals are only eligible for assistance with some or all Medicare premiums and cost-sharing.
- A member may change plans once during 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).

D-SNP State Medicaid Agency Contracts (SMACs) always include clinical elements

In addition to being a dual D-SNP member, CMS requires each D-SNP to have a state Medicaid agency contract that includes defined requirements.

Who is eligible to enroll:

- Medicaid eligibility categories as defined by CMS: QMB (+), SLMB (+), QI, QDWI, FBDE
- Alignment requirements and limitations
- Subpopulation (limited to MLTSS or BH). *The Medicaid landscape also informs this.*
- *Age limitations*
- *Waiver populations*
- ***This informs if there is potentially a Medicaid plan that is also supporting the member. The Medicaid plan may not be ours.***

Responsibility to coordinate:

- D-SNPs must coordinate overlapping Medicare and Medicaid benefits to ensure that Medicaid remains the payer of last resort.
- D-SNPs are always required to navigate care not limited to Medicaid MCO, FFS, waiver programs, State case management agencies, CBOs, and the like.
- The model of Care is the foundation for how care is coordinated.
- When D-SNP supplemental benefits overlap traditional Medicaid benefits, the D-SNP must first exhaust the Medicare supplemental.
- Coordination of care transitions.
- **When you participate in the ICT, the D-SNP will help identify the Medicaid benefits being coordinated.**

Medicaid benefits:

- All D-SNPs are aware of Medicaid benefits regardless of who administers these benefits.
- A member may have their Medicaid managed under another Managed Care Organization (MCO)
- **When the enrollee has Medicaid benefits available under this health plan for both Medicare and Medicaid, you only have to submit your claim and authorization once.**
- ****For FIDE, the D-SNP authorizes everything for you.**

Integration types:

- FIDE: Integrated clinical model to include integrated benefit coverage.
- HIDE: Integrated and coordinated model with partial benefit carve-in or specific coordination/ connection requirements.
- CO: Coordination only.

SMAC informs the D-SNP type (model)

D-SNP model types	Provider impact
FIDE	• A single ID card is used. • There is a single determination that includes Medicare and Medicaid criteria. • There is a Single Care Management contact. • It must cover Medicaid primary and acute care services and LTSS, including at least 180 days of nursing facility coverage. • It must use specialized care management and network methods to coordinate care for high-risk beneficiaries. • D-SNP provides coverage for Medicaid benefits the same as the aligned Medicaid plan. • All members are exclusively aligned, and D-SNP covers additional Medicaid benefits. • D-SNP covers the entire service area of the aligned Medicaid. • There is a single *Provider Manual.* • There is **no** separate Medicaid contact
HIDE	• It must cover Medicaid behavioral health benefits, long-term services, and supports (LTSS), or both. Contract for coverage of Medicaid benefits may be with the D-SNP, the D-SNP's parent company, or another entity owned and controlled by the D-SNP's parent company. • The D-SNP service area aligns with or may be greater than Medicaid. • We coordinate with our affiliated Medicaid partners for aligned members to reduce duplication and overlap. • The members' Medicaid services continue to be provided by Medicaid. • Some services may remain excluded based on the state landscape. • The ICT assists in coordination, including Medicaid.
CO	• The D-SNP only administers the D-SNP and D-SNP supplemental benefits. • The D-SNP CM attempts to coordinate with Medicaid; however, Medicaid services remain excluded from the D-SNP. • Some members may have a cost based on their level of Medicaid. Review coverage to ensure compliance with federal balance billing.

States may require data coordination and HIDE models to maintain exclusively aligned enrollment.
These plans are referred to as *Applicable Integrated Plans*.

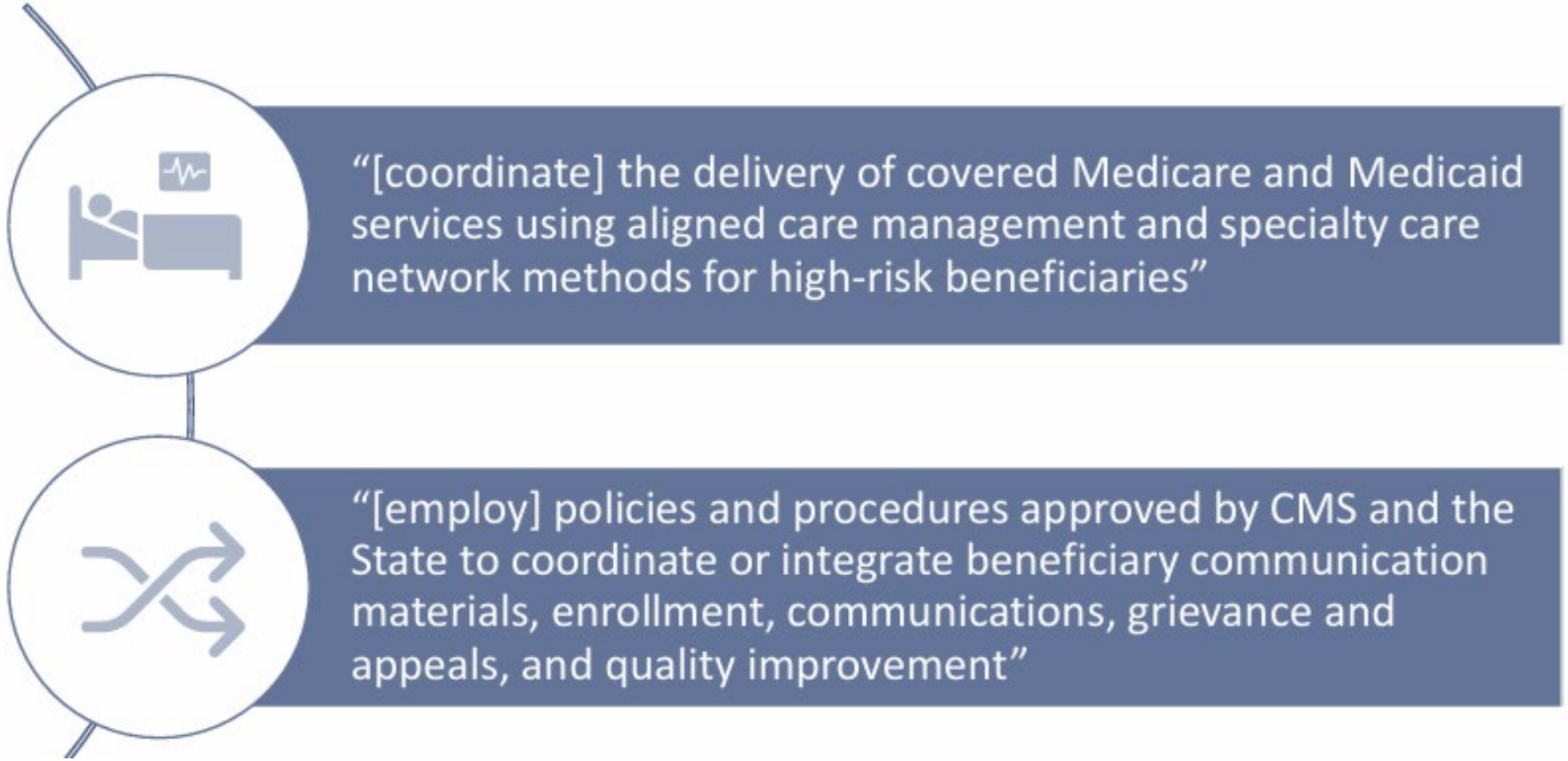
FIDE D-SNP

- The plans provide Medicare and Medicaid benefits.*
- They include long-term services and supports (LTSS) benefits (eligibility rules apply).*
- One identification card is used to access both Medicare and Medicaid services.*
- Materials and processes are integrated.*
- States may carve out Medicaid behavioral health benefits from the contract.
- Coordination between Medicare and Medicaid plans or other agencies is required if unaligned.

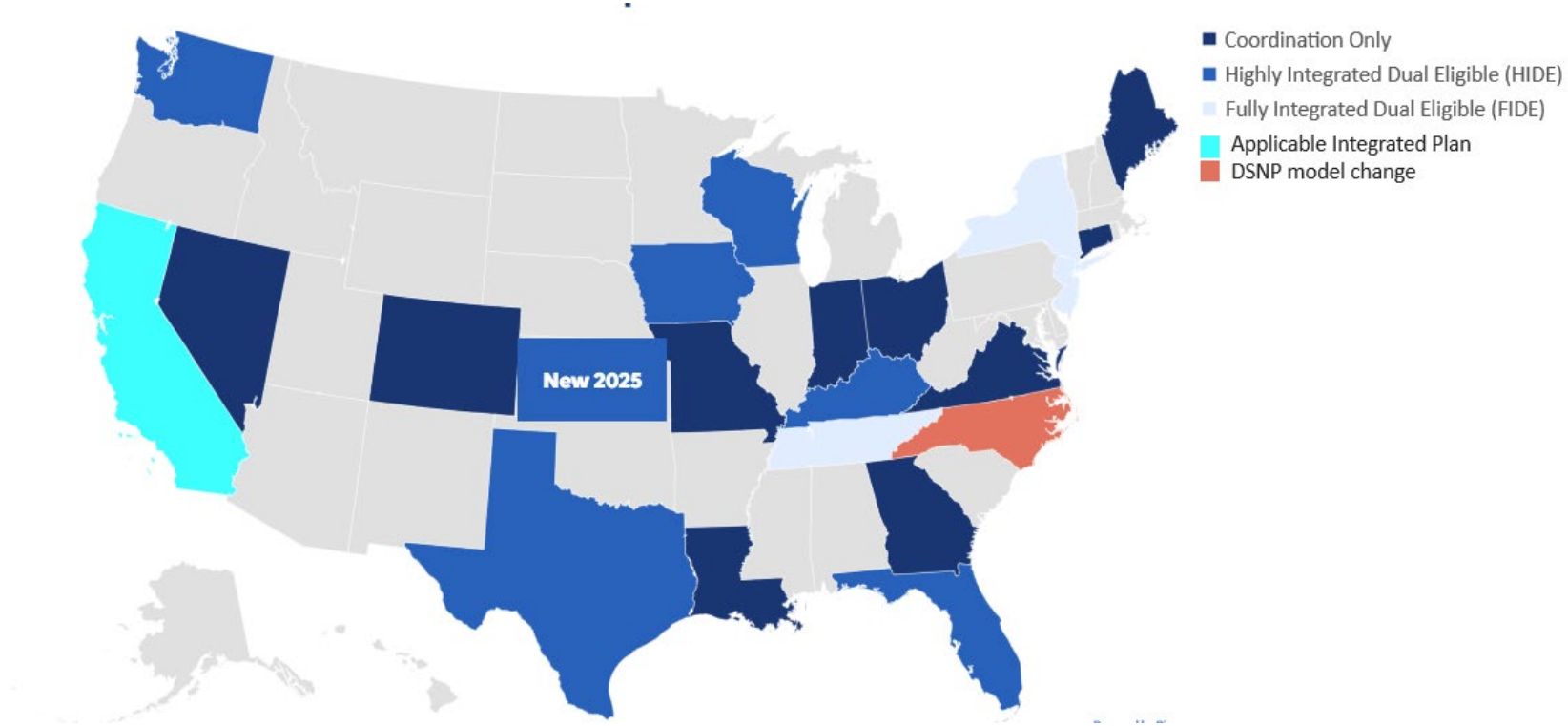
* Applicable only in an aligned FIDE

Additional requirements for FIDE D-SNP

Per *42 CFR 422.2,* fully integrated D-SNPs (FIDE SNPs) are also required to:



D-SNP footprint effective 2025



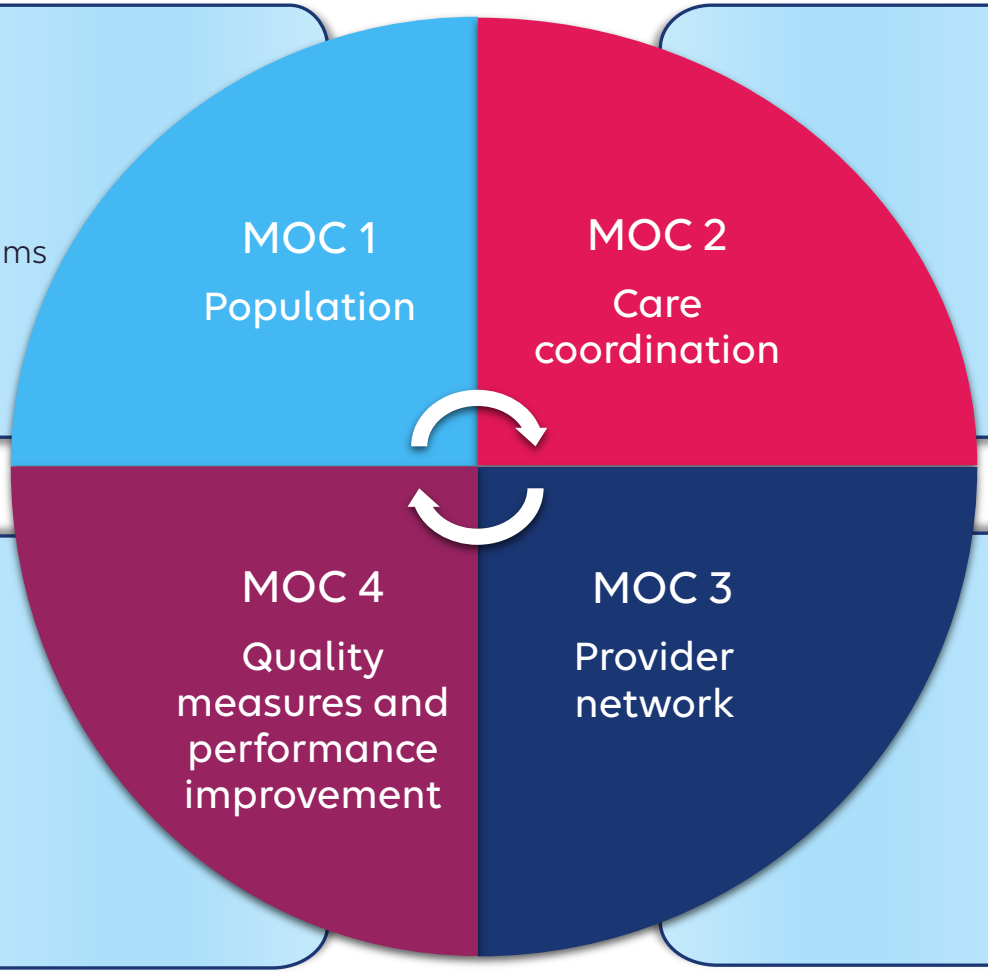
- Kansas is a new D-SNP (HIDE) based on the state RFP award.
- Virginia has an existing D-SNP; however, all HIDE and FIDE will transition to a FIDE.
- California is an exclusively aligned plan.
- CA, NY, TN, TX, KY, VA, and WA have multiple D-SNP models. The map reflects the highest integrated model.

C-SNP plans

- There are C-SNP plans for the following conditions (enrollment is limited to those with the qualifying conditions):
  - End-stage renal disease (ESRD)
  - Chronic lung disorders
  - Multiple condition C-SNP group 4: Diabetes, congestive heart failure (CHF), and cardiovascular disease (members can have just one of these conditions to qualify)
- Vendors or providers are contracted in some markets to administer some of the maintenance of certification (MOC) requirements.

MOC elements

- SNP population description
- Eligibility requirements
- Define the 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

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

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

Care coordination strategies

Health risk assessment (HRA):

- The HRA is completed within 90 days of enrollment and repeated within 365 days of the last HRA.
- It assesses physical, behavioral, cognitive, psychosocial, and functional areas.
- The results are used to create an individualized care plan (ICP).
- It assists in care coordination and identifies urgent needs.
- Additional assessments are completed for significant changes in condition, disease-specific needs, or as part of other program requirements.
- Results of the HRA are available to the member and the provider on the website.

Interdisciplinary care team (ICT):

- Care was coordinated with the member, PCP, and other participants.
- Providers are key members of the ICT and are responsible for coordinating care and managing transitions.
- ICT role-based actions may include diagnosing/treating, communicating treatment and management options, advocating, informing, and educating members, completing assessments, reviewing HRA results and ICP, collaborating with providers, coordinating with other carriers (Medicaid), and arranging community resources.

Individualized care plan (ICP):

- This includes member-specific goals and interventions, issues identified during the plan HRA process, and other interactions.
- Members we cannot reach or do not complete the HRA will receive an ICP based on claims or other information available to the case manager.
- It is updated annually or as the member's needs change.
- The ICP is available on the website for the members and the providers.

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

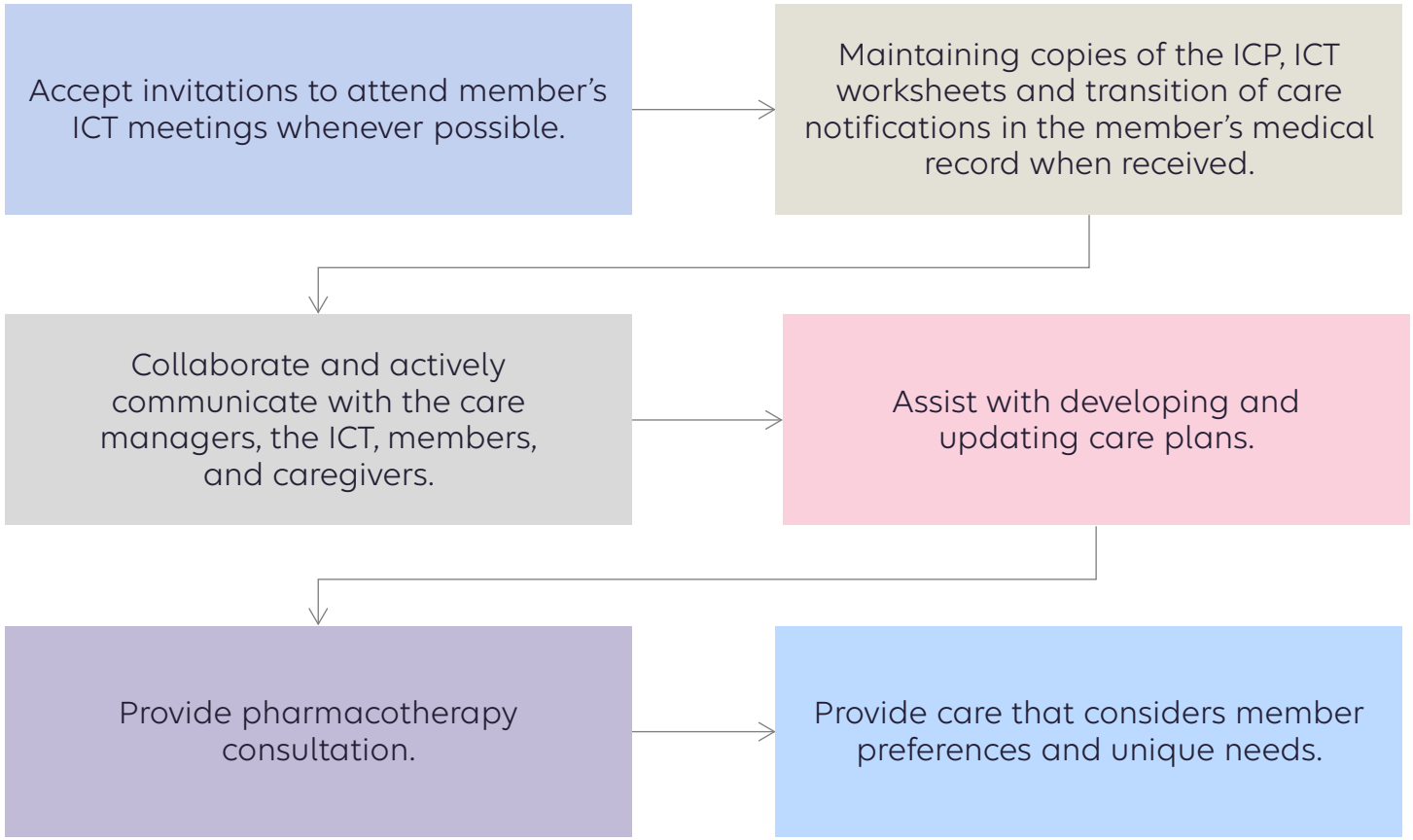
ICT team

- Each member has an ICT developed based on assessment results, identified needs, and complexity.
- Each member's ICT consists of the member, the case manager/coordinator, and the PCP.
- Additional ICT participants are added based on assessment results, identified needs, complexity, involvement in care, and member preferences.
- A member's ICT may include specialty care providers and our health care team in meetings, including behavioral health or pharmacy representatives.
- ICT meetings or reviews are held at a frequency determined by patient needs and complexity.

The ICT:

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

Provider responsibility for ICP



- Review the member ICP plan available on the provider website:
  - ICPs are updated and must be reviewed annually at a minimum.
  - ICPs are updated with significant changes in member health status.
  - Providers will review ICP post-member transitions from a hospital or other skilled setting.
  - Within the provider website, you may enroll in regular reporting for ICP updates to facilitate review.
  - Providers may review before, during, or after office visits with members before ICT meetings.
- Provide feedback to the case manager/coordinator if changes to the ICP are recommended.
- Support the ICP in collaboration with the ICT.

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 on the secure provider website**.
  - You may reach the care team by calling the number provided to you in any correspondence from us or the number on the member's identification card.
- SNP members have many providers and have multiple transitions. You are the 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.

Performance and quality outcomes

- Quality and health outcome measurements are collected, analyzed, and reported to evaluate the effectiveness of the MOC in the following areas:
  - Improving access for resolution of healthcare needs.
  - Improving coordination of care and appropriate delivery of services.
  - Improving transitions of care across healthcare settings and providers.
  - Ensuring 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.

Model of Care Training Attestation

The plan is required to maintain a record of your annual Model of Care training.

Select **Begin Attestation** and follow the instructions to receive credit for completing this course.

Thank you for your time in participating and completion of this training.

Begin Attestation

provider.wellpoint.com