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2024 Medicare Advantage

Special Needs Plans and Model of Care overview

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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 and Medicare Medicaid Plans (MMP)
- Understand the components/requirements of the Model of Care:
  - Description of the SNP and MMP population
  - Care coordination
  - Provider network
  - Quality measurement and performance Improvement
- Understand your responsibilities as a provider
- Availability of resources and references
- Complete attestation

Types of Special Needs Plans

- **D-SNP:** for members who are eligible for both 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
- **Medicare Medicaid Plan (MMP):** for members who receive both Medicare and Medicaid through a demonstration

Dual Special Needs Plan (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 for assistance with some or all Medicare premiums and cost-sharing.
- A member may change plans once during the year's first three quarters.
- 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), and MMP.

Fully Integrated Dual Eligible (FIDE) D-SNP

- Provides Medicare and Medicaid benefits.*
- Includes LTSS benefits (eligibility rules apply).*
- One identification card is used to access both Medicare and Medicaid services.*
- It integrates materials and processes.*
- 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

Chronic Condition Special Needs Plans (C-SNP)

- There are C-SNP plans for the following conditions (enrollment is 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 a combination of two or more of the above conditions (Group 4)
- Vendors or providers are contracted in some markets to administer some of the MOC requirements.

Care coordination strategies

Health Risk Assessment (HRA):

- It 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.
- 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 portal.**

Interdisciplinary Care Team (ICT):

- Care is 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 any of the following: 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):

- The plan includes member-specific goals and interventions, addressing issues identified during the HRA process and other interactions.
- Intended for 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 (*doesn't apply to MMP).
- It is updated annually or as the member's needs change.
- **The ICP is available on the portal 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.

Interdisciplinary Care Team (ICT)

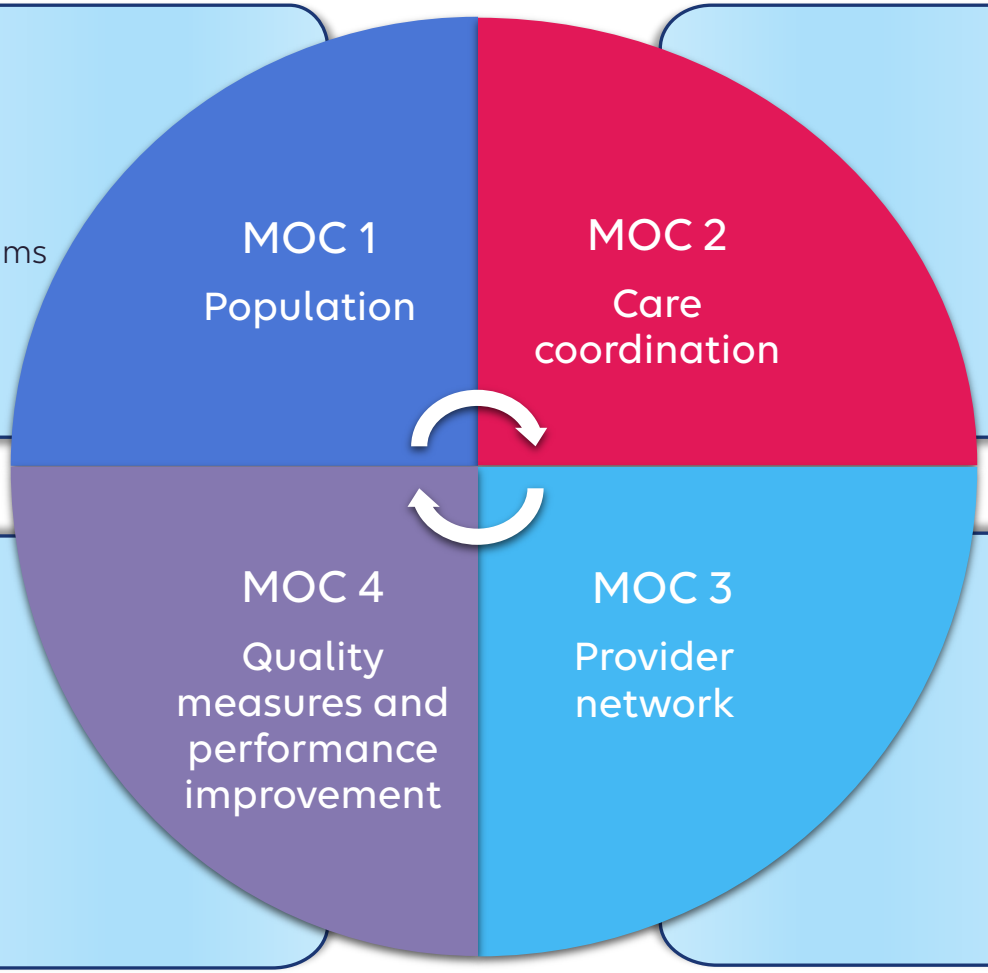
- Each member has an ICT developed based on assessment results, identified needs, and complexity.
- ICT may include the following participants: members, PCP, specialty care providers, and our healthcare team, including behavioral health or pharmacy attendees.
- Meeting frequency is determined by the patient's needs and occur at least once per year.

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, telephone, 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.**

Model of Care (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 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 and MMP 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 contact you and your patient during 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:
  - 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

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.

Begin Attestation

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