2021 Medicare Advantage

Special Needs Plans and Model of Care overview

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Background of Special Needs Plans (SNPs)

2003

- SNPs were created as part of the *Medicare Modernization Act*

2011

- The *Patient Protection and Affordable Care Act (ACA)* required all SNPs to submit models of care (MOCs); MOCs comply with an approval process based on CMS standards
- NCQA must review and approve the MOCs

2019

- Effective 2021, CMS redefined D-SNP types requiring either a Data Sharing, Highly Integrated Dual Eligible Plan (HIDE) or Fully Integrated Dual Eligible Plan (FIDE)

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Types of Special Needs Plans

- Chronic Condition Special Needs Plans (C-SNP) are for members with disabling chronic conditions (categories defined by CMS).
- Institutional Special Needs Plans (I-SNP) are 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 Plans (IE-SNP) are 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 Eligible Special Needs Plans (D-SNP) are for members who are eligible for both Medicare and Medicaid.

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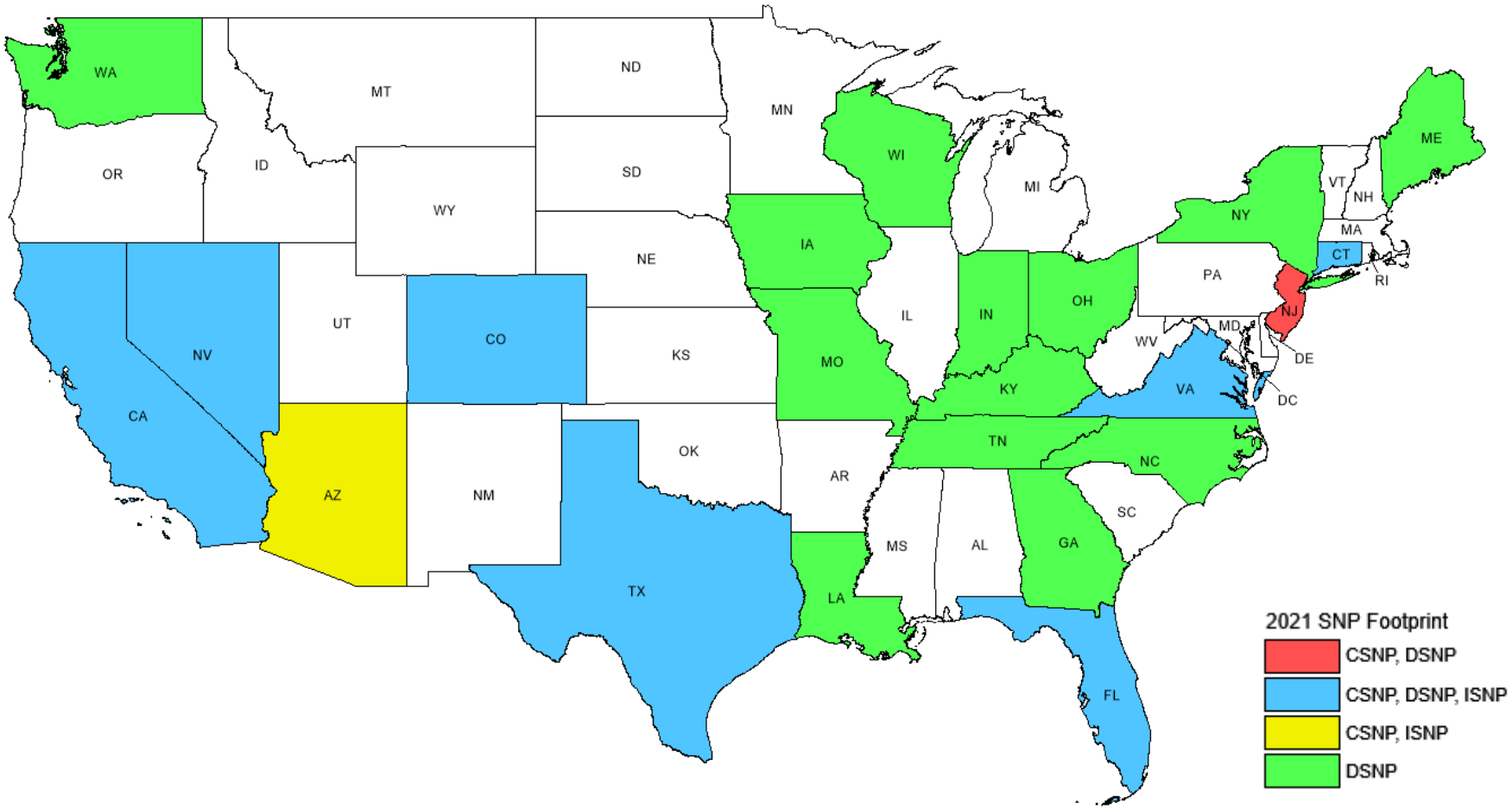
2021 Special Needs Plan footprint



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Chronic Condition Special Needs Plans (C-SNP)

- Members must be enrolled in Medicare.
- May have Medicaid coverage, but it is not required.
  - Must have the qualifying condition of the C-SNP plan.
    - We have the following C-SNP plans:
    - Diabetes mellitus
    - End-stage renal disease (ESRD)
    - Chronic lung disorders
    - Cardiovascular disorders and/or congestive heart failure (CHF)
    - Multiple condition C-SNP with combination of two or more of the above conditions
- The condition must be confirmed by a provider, and additional forms may be required.
- In some of our markets, we may contract with vendors or providers to administer some of the MOC elements to our C-SNP members.

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Institutional Special Needs Plans (I-SNP)

- Members must be enrolled in Medicare.
- May have Medicaid coverage, but it is not required.
- In some of our markets, we may contract with vendors or providers to administer some of the MOC elements to our I-SNP members.
- Members may be in a facility or have comparable care needs in the community.
- Have multiple chronic conditions.
- Require more outreach and face-to-face visits.
- More frequent interaction by the Interdisciplinary Care Team (ICT).

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Dual-eligible member requirements to enroll

- Live in our service areas, maintain eligibility requirements and be enrolled in both Medicare and Medicaid.
- May change plans once during each of the first three quarters of the year.
- 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 of the Medicare premiums and cost sharing.
  - States set asset levels to determine full benefit status.

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Dual-eligible member characteristics

- Member characteristics:
  - More vulnerable subgroup of Medicare members.
  - More costly to manage.
  - Have more healthcare needs.
- 60% have multiple chronic conditions/illnesses.
- 41% experience behavioral health conditions.
- May be over or under 65 years of age.
- Report a lower income and health status compared to other members.
- Experience functional difficulties and may have limitations performing activities of daily living and instrumental activities of daily living.

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New D-SNP categories for 2021

Based on CMS guidance, all D-SNPs must be in one of the following categories starting in 2021 as defined in the State Medicaid Agency Contract (SMAC).

- Data Sharing D-SNP
- Highly Integrated Dual Eligible D-SNP (HIDE)
  Unaligned
- Highly Integrated Dual Eligible D-SNP (HIDE)
  Exclusively aligned
- Fully Integrated Dual Eligible SNP (FIDE) D-SNP

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D-SNPs and *State Medicaid Agency Contracts*

- The Affordable Care Act (ACA) requires D-SNPs to have a State Medicaid Agency Contract (SMAC).
- Agreements are only linked to the D-SNP in the specific 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, data sharing and reporting requirements.
- The agreement also includes coordination requirements between Medicare and Medicaid to assist members.

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Data Sharing D-SNP

- Requirement to share data on inpatient and skilled nursing facility admits with Medicaid agency or designee.
- Communication should occur within 48 hours unless modified in the SMAC.
- Some states will have additional data sharing requirements.

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Fully Integrated Dual Eligible (FIDE) D-SNP

- FIDE plans are considered integrated plans.
- Provide both Medicare and Medicaid benefits under one plan.
- Must include long-term services and supports benefits (if the member meets state eligibility guidelines).
- States may carve out Medicaid behavioral health benefits from the FIDE contract.
- Members will have one identification card to access both Medicare and Medicaid services.
- Integrated materials and processes.

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Highly Integrated Dual Eligible (HIDE) D-SNP (unaligned)

- Unaligned HIDE D-SNP:
  - Provide members and Medicaid carrier with data for coordination and Medicaid coverage of Medicare cost share and/or additional Medicaid benefits (either long-term services and supports or behavioral health).
  - Members may be enrolled with us for both Medicare and Medicaid or could be with a State Medicaid Agency or another MCO for the Medicaid benefits.
  - May enroll partial duals (members who do not have full Medicaid benefits).

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Highly Integrated Dual Eligible (HIDE) D-SNP (aligned)

- Exclusively aligned HIDE D-SNP:
  - Considered an integrated plan.
  - Provide members and Medicaid carrier with data for coordination and Medicaid coverage of Medicare cost share and/or additional Medicaid benefits (either long-term services and supports or behavioral health).
  - Provide Medicare and Medicaid benefits under one plan.
  - Will have one ID card to access Medicare and Medicaid benefits.
  - Will not include partial duals.

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Coordination of care for D-SNP members

- When dual-eligible members need care or to access benefits, it is everyone's responsibility to assist in coordinating the care.
- The following will assist in coordinating care, and in the management of billing and service issues:
  - Dual-eligible members (unless a FIDE or aligned HIDE) should show both the plan ID and Medicaid card to all providers.
  - Check the Medicaid coverage prior to billing.
    - In some dual types, CMS prohibits balance billing.
  - Know what services are covered under both plans.
  - Access tools and information on the provider website, including:
    - Benefit information.
    - Results of health risk assessment and the member's care plan.
    - Transition information.
    - Medications.

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What is included in the Model of Care

Description of the population

Care coordination

Provider network

Quality measurement & performance improvement

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Program components

Tools/processes	→	Goals/outcomes
Health risk assessment Care management Managing transitions of care Individualized care plans Interdisciplinary Care Team Specialized benefit plans with supplemental benefits		Coordination of care Member education Continuity of care Stratification of complexity Seamless or improved transitions Identification of needed services Improved outcomes

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

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Health risk assessment (HRA)

- Completed within 90 days of enrollment and repeated annually.
- Multiple and ongoing attempts are made to contact the member including telephonically, by mail, through provider outreach, in person or electronically.
- Assesses physical, behavioral, cognitive, psychosocial and functional areas.
- Used to help create the member's individualized care plan (ICP).
- Is an important part of care coordination.
- Additional assessments may be completed based on a significant change in condition, disease specific needs or enrollment in other programs.
- Helps identify members with most urgent needs.
- Contains member self-reported information.
- Results may lead to referrals for other programs.
- Results are available to providers and members on the secure portal.

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Individualized care plan (ICP)

- Working with the member and the Interdisciplinary Care Team (ICT), the case manager helps develop the ICP for each SNP member.
- Has member-specific goals and interventions, addressing issues identified during the HRA process and other team interactions.
- 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.
- Includes member preferences and personal goals as applicable.
- Updated as the member's needs change.

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Interdisciplinary Care Team (ICT)

- Each member has a care team.
- Care is coordinated with the member, the member's PCP and other participants of the member's ICT.
- ICT members are responsible for reviewing the care plans, collaborating with multiple providers, coordinating with other carriers (Medicaid) and assisting in accessing community resources.
- The structure and frequency of the ICT is based on the member's preference, identified needs and complexity.
- The PCP or the attending provider (if plan does not require a PCP selection) is a key member of the ICT responsible for coordinating care and managing transitions.
    - Other provider responsibilities include communicating treatment options, advocating, informing and educating members, performing assessments, diagnosing/treating, and accessing information on the portal.

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Additional provider responsibilities

- Communicate and participate with care managers, ICT members, members and caregivers.
- Collaborate on the ICP development.
- Review and respond to patient-specific communication.
- Review the HRA results and the ICP on the secure provider portal.
- Remind the member of the importance of the HRA.
- Encourage the member to work with your office, the care team, keep all appointments and comply with treatment plans.
- Complete the SNP training annually and during onboarding.
- Coordinate care with Medicaid when applicable.

Our provider partners are an invaluable part of the care team.

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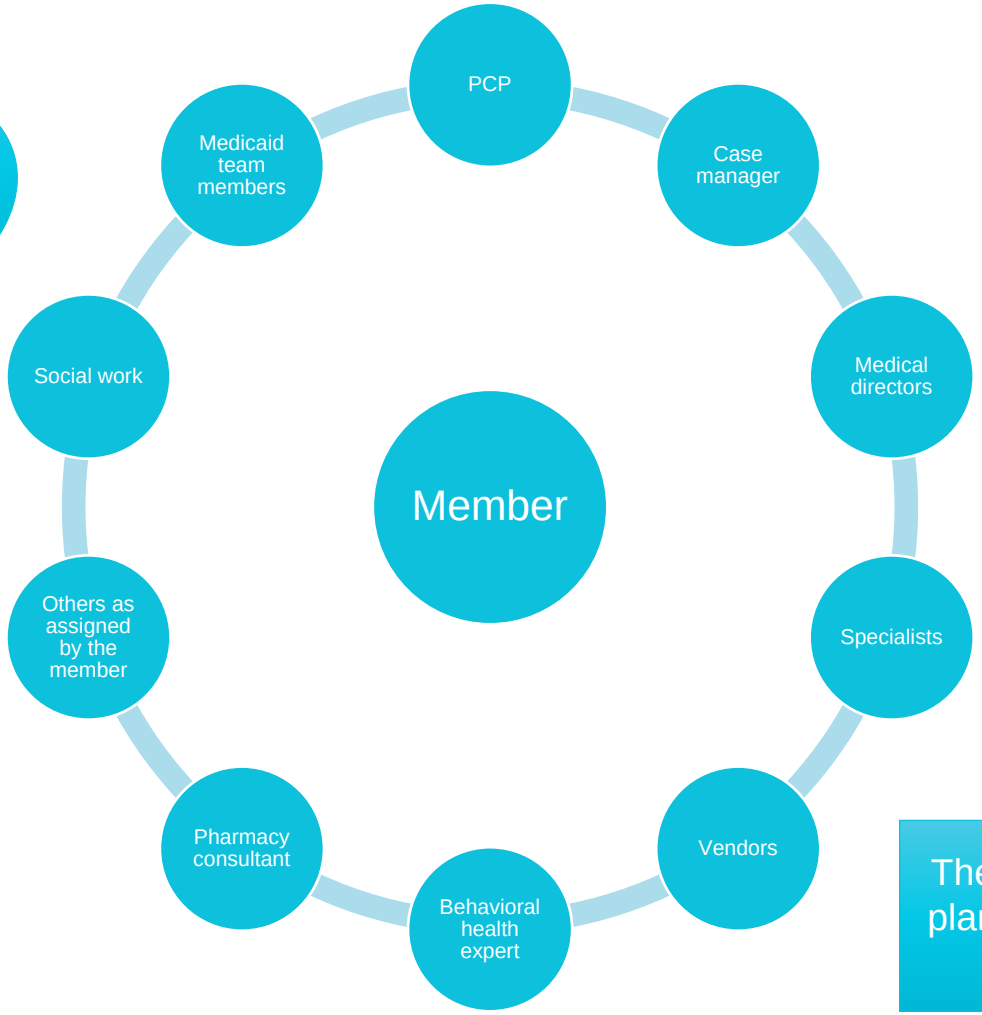
ICT

The PCP is the gatekeeper



The gatekeeper in a PPO plan is the provider caring for the member.

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Communication and care transitions

- We are committed to effective, efficient communication with you.
  - Valuable information on member utilization, transitions and care management is available to you on the secure provider portal.
  - You may reach the care team by calling the number provided to you on any correspondence from us or the number on the member's identification card.
- SNP members typically have many providers and may transition into and out of healthcare institutions. Providers 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.

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Performance and quality outcomes

- 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) — used to gather valid, reliable, and clinically meaningful health status data from the population to use in quality improvement activities, pay for performance, program oversight, public reporting, and to improve health
  - 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

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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 healthcare settings.
  - Ensure appropriate use of services for preventive health and chronic conditions.

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Program evaluation and process improvements (cont.)

- 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 postdischarge
  - Visits to the PCP
  - Utilization rates of ER and inpatient admissions
- A program evaluation occurs annually and results are communicated.

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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.
- If no LIS, member pays the lessor of the filed benefit or drug cost.
- D-SNP members may pay $0 or a reduced premium for Part D coverage, depending on their LIS premium subsidy level (100%, 75%, 50%, 25%, 0%).

LIS level	Part D deductible	Generic copay	Brand copay
1	Covered	$3.70	$9.20
2	Covered	$1.30	$4
3	Covered	$0	$0
4	Partially covered	15%	15%

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How our D-SNPs are structured

- For Qualified Medicare Beneficiaries (QMBs) and those with full Medicaid benefits,* any Medicare cost sharing applied to a claim is covered under the member's Medicaid coverage, which may be provided by any of the following:
  - The plan under an agreement with the state
  - Another Medicaid managed care organization
  - Fee-for-service Medicaid
- For all other Medicaid eligibility categories applicable to the D-SNP, any Medicare cost sharing applied to a claim can be billed to the member after claim is filed with Medicaid.
- Most plans do not have out-of-network benefits unless it is urgent/emergent or out-of-area renal dialysis.
- PPO D-SNP plans may allow access to some out-of-network providers; refer to the plan details for limitations or contact the plan for more information.

* Those with full Medicaid benefits — Medicaid covers Medicare cost sharing up to the Medicaid allowable amount if the service is covered by Medicaid.

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D-SNP member cost share or copay

Benefit	As filed with CMS	Responsibility for QMBs and those with full Medicare cost share protection	Responsibility for all other Medicaid eligibility categories*
Inpatient copay	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost sharing
SNF copay	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost sharing
PCP copay	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost sharing
Specialist copay	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost sharing
Ambulatory surgery	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost sharing
Outpatient hospital	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost sharing
Emergency room	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost sharing
Durable medical equipment, prosthetics, orthotics and supplies	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost sharing
Diagnostic imaging	Medicare defined	$0 copay	$0 or the lower of filed benefit or Medicare cost sharing
Part D drug copays	Standard Medicare Part D or copays	Lower of filed benefit, LIS copay, or the cost of the drug	$0 or the lower of filed benefit or LIS copay or the cost of the drug
D-SNP supplemental benefits	$0 copay		
Medicaid benefits	Medicaid benefits and coverage are based on Medicaid eligibility. For FIDEs and aligned HIDEs only, Medicaid benefits are covered through the D-SNP.		

* Not applicable to FIDEs and aligned HIDEs.

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D-SNP claims processing

- Most D-SNP members are protected by state and federal regulations from balance billing. Providers cannot balance bill members that have Medicare cost share protection and must accept the Medicare and Medicaid (if applicable) payments as payment in full.
- Members who have Medicare cost share protection are classified as QMBs.
- Claims are processed in accordance with 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 coordination of benefit requirements for the state may be used).
- Rules differ by state, and it is possible some providers will receive the full Medicare-allowed amount.
- Most states require a Medicaid provider ID in order to bill and receive payment.
- Check the member's Medicaid coverage prior to billing and verify cost share or benefit copay.
- Federal rules dictate that Medicaid is the payer of last resort.

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D-SNP claims processing (cont.)

For members enrolled in both our Medicare D-SNP and Medicaid plan:

- In most 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 (some exceptions apply).
- 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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D-SNP claims processing (cont.)

For members enrolled in a FIDE or aligned HIDE:

- FIDEs and aligned HIDEs contract with the state Medicaid agency to cover certain/all Medicaid benefits under the D-SNP.
- For Medicare-covered services as well as Medicaid-only covered services for which the D-SNP is contractually obligated to cover, a single claim will be processed and payment made according to payment rules governing your state's Medicaid program or our contract with the state (some exceptions apply).
- *Explanation of Payment* (EOP) will provide further guidance on next steps or pending payments.

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Helpful resources

- Provider website
- 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 and accessing member information on the portal.
  - Participation in ICT.
  - Being 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:_____

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Please sign and fax to **1-855-328-8562.**

Thank you

Simply Healthcare Plans, Inc. is a Medicare-contracted coordinated care plan that has a Medicaid contract with the State of Florida Agency for Health Care Administration to provide benefits or arrange for benefits to be provided to enrollees. Enrollment in Simply Healthcare Plans, Inc. depends on contract renewal.

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