# Dual Eligible Special Needs Plans (D-SNPs) Model of Care training



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# Our mission

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

# 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
- Explain how to get answers to your questions

# CMS requirements

The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff receive basic training about the Special Needs Plans (SNPs) Model of Care.

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

This course will describe how Aetna, Coventry and their contracted providers can work together to successfully deliver the SNPs Model of Care.

# Background

## 2003

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

## 2008

**CMS** contracted with the National Committee for Quality Assurance (NCQA) to develop a strategy to **evaluate the quality** of care provided by SNPs.

## 2011

The **Patient Protection** and **Affordable Care Act (ACA)** mandated further SNPs program changes:

- Requires all SNPs to submit **Models of Care** (MOCs) that comply with an approval process based on CMS standards
- **NCQA** must **review and approve** these MOCs

# Special Needs Plans features

**Medicare SNPs feature:**

- Enrollment limited to beneficiaries within the **target SNP population**
- Benefit plans are **custom designed** to meet the needs of the target population
- Additional election periods throughout the year during which members **may change their coverage**
- Three types of SNPs designed for specific groups of members with special health care needs.

    1. Individuals **dually eligible** for Medicare and Medicaid (D-SNP)
    2. Individuals with **chronic conditions** (C-SNP)
    3. Individuals who are **institutionalized** or eligible for nursing home care (I-SNP)

# D-SNPs are custom designed to have the following structures

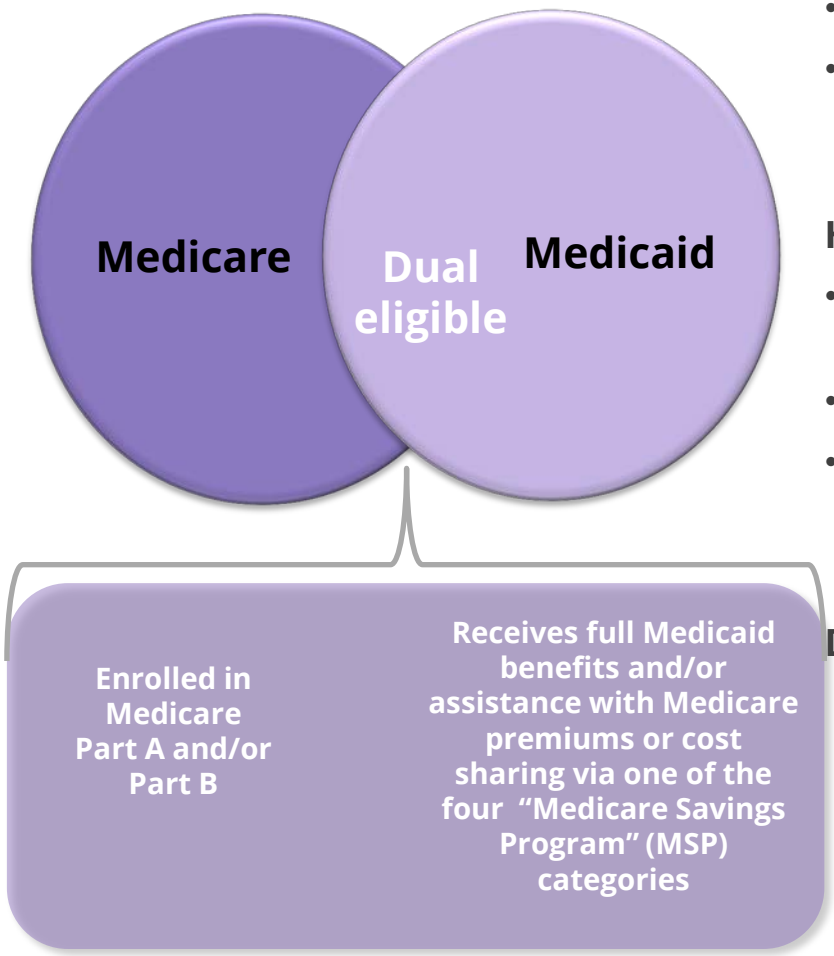
**The D-SNPs program is available to eligible members:**

- Residing within the program's service area
- Meeting dual eligibility status requirements
  - In many states, we'll  enroll partial benefit duals as well as full benefit duals

**Dual eligibility qualification is determined by the member's enrollment in:**

- A federally administered Medicare program based on age and/or disability status
- The state-administered Medicaid program based on low income and assets

# Who are dual eligibles?




**Primary coverage for dual eligibles:**

- Medicare is always primary
- Medicaid is the payer of last resort and supplements Medicare coverage

**How do people become dual eligible?**

- Qualify on the basis of assets and income through the Medicare Savings Program (MSP)
- Eligibility for SSI
- Other optional means such as medically needy or through Section 1115 waiver; state specific

**Duals may be "full benefit duals" or "partial benefit duals"**

- Full duals are eligible for Medicaid benefits
- Partial duals are only eligible for premium and for some levels, assistance with Medicare cost share
- States set asset levels that determine full benefit status

# Model of Care goals

Each Special Needs Plan program must develop a Model of Care (MOC) and a Quality Improvement Plan to evaluate its effectiveness.

The MOC is a plan for delivering care management and care coordination to:

1. Improve quality
2. Increase access
3. Create affordability
4. Integrate and coordinate care across specialties
5. Provide seamless transitions of care
6. Improve use of preventive health services
7. Encourage appropriate utilization and cost effectiveness
8. Improve member health

# The Model of Care design includes the following

Health risk assessment tool (HRAT)*

Interdisciplinary care team (ICT)

Care management team

Individualized care plan (ICP)

Care coordination

D-SNP benefits

Provider role

Staff role

**HRA completion is a STARS measure*

# Health risk assessment

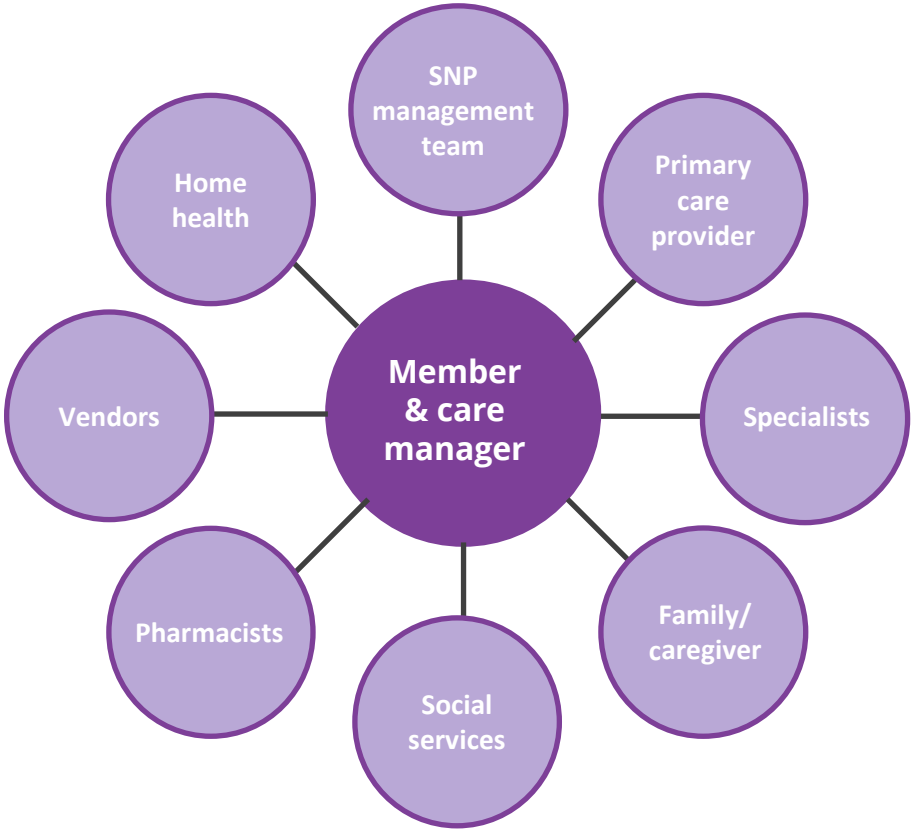
## The health risk assessments (HRAs):

- Help identify members with the most urgent needs
- Are an important part of the member's care coordination
- Contain member self-reported information
- Help create the members Individualized care plan
- Assess the following needs of each member:
  - Medical
  - Functional
  - Cognitive
  - Psychosocial
  - Mental health
- Are completed telephonically by the care management team:
  - Within 90 days of enrollment
  - Repeated within 365 days

# Interdisciplinary care team (ICT)

## The interdisciplinary care team (ICT):

- Each member is managed by a care team
- Participants are based on the member's needs
- Care managers will keep the team updated with information involving the member's care plan
- Team meets formally
- Smaller meetings occur, as needed



# Interdisciplinary care team's (ICT) role

- Determine each member's goals and needs
- Coordinate member care
- Identify problems and anticipate crises
- Educate members about their conditions and medications
- Coach members to use their individualized care plan
- Refer members to community resources
- Manage transitions
  - Identify problems that could cause transitions
  - Try to prevent unplanned transitions
- Coordinate Medicare and Medicaid benefits for members
- Identify and assist members with changes in their Medicaid eligibility

# 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.

# ICP continued …

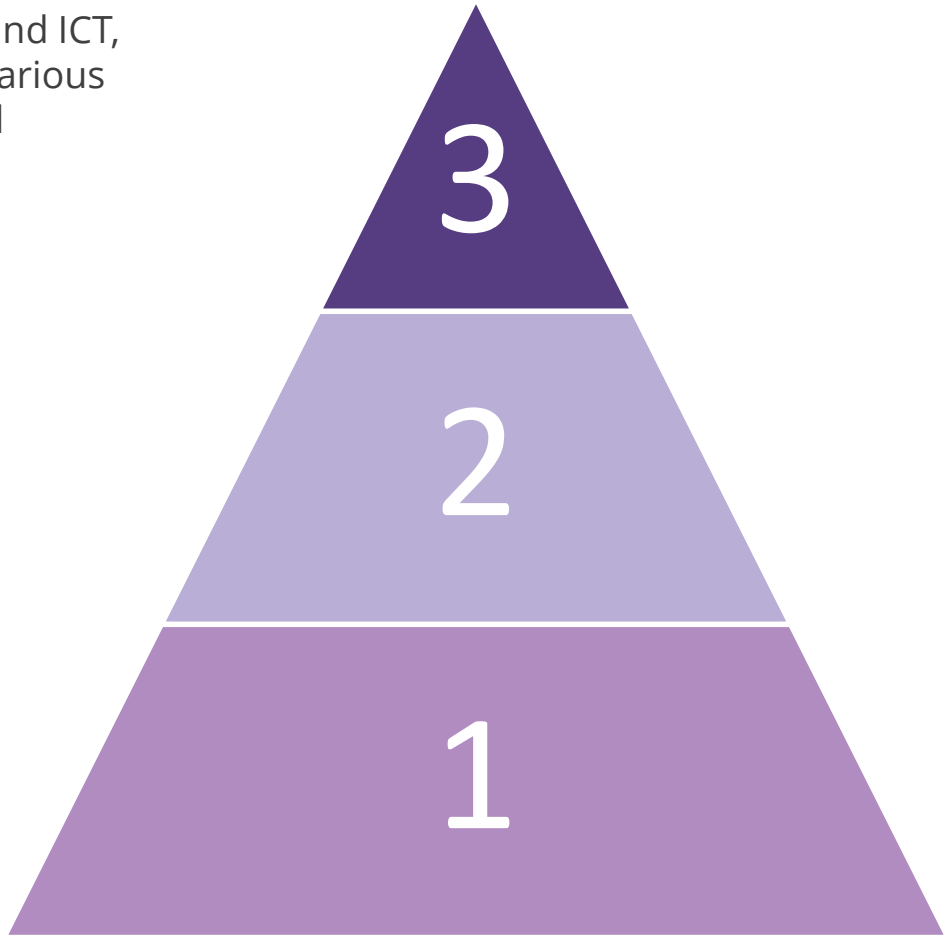
## D-SNP members are tiered

Using the information obtained by the HRA and ICT, D-SNP members are tiered and placed into various clinical programs to improve their health and well-being.

**High tier 3** are the most vulnerable members, includes those with high utilization and multiple unmanaged chronic conditions that put them at risk for unplanned transitions of care.

**Medium tier 2** members generally have multiple chronic conditions, some of which may not be managed.

**Low tier 1** contains the most stable SNP members.



# ICP continued …

## Member profile

- Summarizes the individualized care plan (ICP)
- Captures HEDIS gaps in care
- Contains medication review notes from health plan pharmacists
- Includes diagnoses from claims data, certain lab results and a list of current medications filled by member

The **HRA, ICP and member profile** for each member are available to the PCP at all times through our secure member/provider portal

# 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 **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**.

Through **seamless transitions** between care settings by:

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

# Care coordination continued...

## Post-hospitalization transition of care:

The **post-hospitalization** program for D-SNP members, which includes phone calls after being discharged home from the hospital. Members receive a 3-day post-hospital call and a 14-day follow-up call. They can receive additional contact as needed.

During these calls, the CM:

- Helps the member understand discharge diagnosis and instructions
- Facilitates follow-up appointments
- Assists with needed home health and 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
- Nonemergency transportation
- Meal programs
- Over-the-counter allowance

# 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 member, your patient, by:

- Enhanced **communication**
- Focusing on each individual member's **special needs**
- Delivering **care management** programs to assist with the patient's medical and non-medical needs
- **Supporting** the member's plan of care

You can access your member's **HRA and ICP** by visiting our website:

- **For TX**: **aetnabetterhealth.com/texas-hmosnp/providers/login**
- **For OH**: **aetnabetterhealth.com/ohio-hmosnp/providers/portal**
- **For VA: aetnabetterhealth.com/virginia-hmosnp/portal**

# Provider role

- **Communicate** with D-SNP care managers, ICT members, members and caregivers
- **Collaborate** with our organization on the ICP
- **Review and respond** to patient-specific communication
- **Maintain ICP** in member's medical record
- Participate in the **ICT**
- Remind member of the importance of the **HRA**, which is essential in the development of the ICP
- **Encourage** the member to work with their care management team
- Complete MOC training upon onboarding and again annually. Direct link:

**http://www.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 the HRA
- Encourage member's to work with their SNP Care Management team
- Encourage our PCPs and other providers to participate with the member's ICT
- Remind the PCP to access the D-SNP members' ICPs
  - **For TX: aetnabetterhealth.com/texas-hmosnp/providers/login**
  - **For OH: aetnabetterhealth.com/ohio-hmosnp/providers/portal**
  - **For VA: aetnabetterhealth.com/virginia-hmosnp/providers/portal**
- Remind providers and their staff to perform their MOC training annually
  - **Direct link aetna.com/healthcare-professionals/documents-forms/dsnps-model-of-care.pdf**

# Contact us

**Mailbox's for TX and OH:**

- **For CM needs: OH_CM_DSNP@aetna.com and TX_CM_DSNP@aetna.com**
- **For provider needs: OH_ProviderServices@aetna.com**

**Mailbox's for VA needs:**

- **For CM needs: AetnaBetterHealthofVACCCPlusShare@aetna.com**
- **For provider needs: VA_ProviderServices@aetna.com**

# Thank you

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