



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

Proprietary and confidential;
Not for further distribution
without Aetna approval



September 2019

Our mission

Our Special Needs Plan (SNP) program is 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 special election periods throughout the year during which members **may change their plan**
- 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

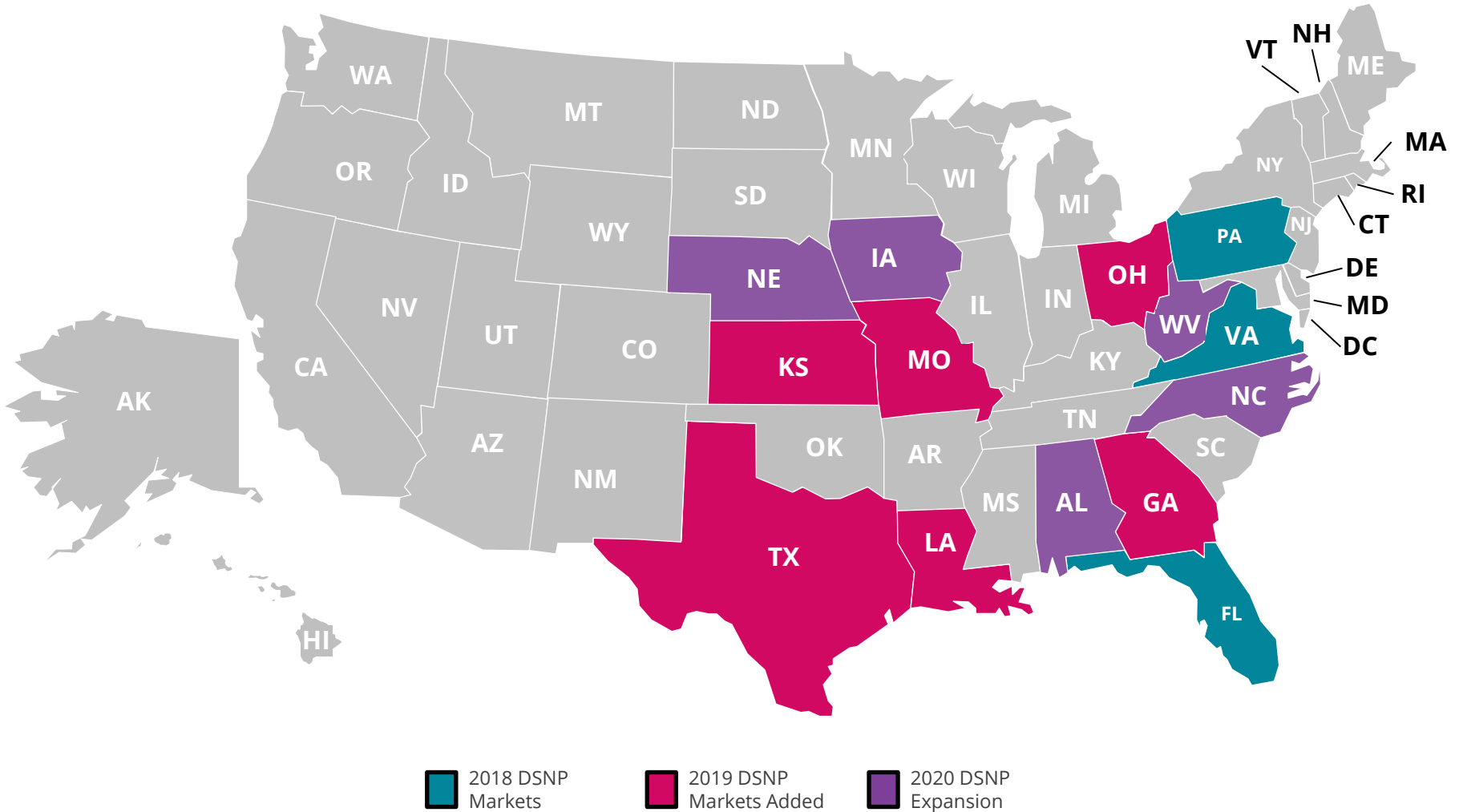
D-SNPs are available to members who:

- Reside within the plan's service area
- Meet the dual eligibility status requirement
 - In many states, Aetna has D-SNPs that enroll partial benefit duals as well as full benefit duals

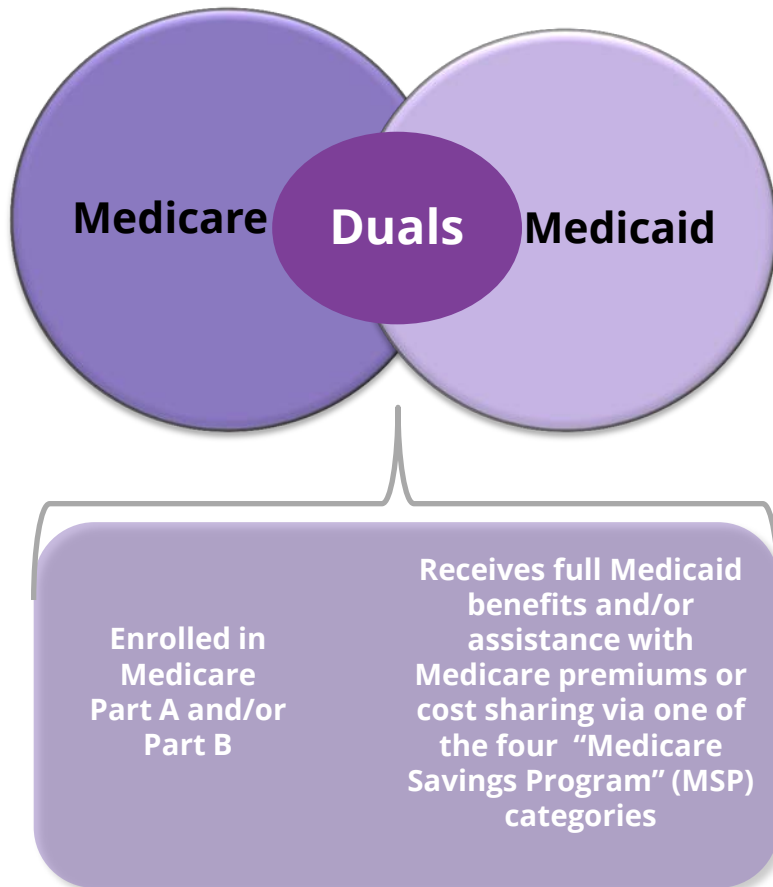
Dual Eligible Qualifications:

- Members must be eligible/enrolled in Medicare Part A and/or B and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of the following Medicare Savings Program (MSP) categories:
 - Qualified Medicare Beneficiary (QMB)
 - Specified Low-Income Medicare Beneficiary (SLMB)
 - Qualifying Individual (QI)
 - Qualified Disabled Working Individual (QDWI)

Aetna D-SNP footprint



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?

- Meet State income and asset criteria for the State's Medicare Savings Program; and
- Eligible for, or enrolled in Medicare Part A; or
- Have full Medicaid coverage through either mandatory coverage groups (e.g. SSI) or optional coverage groups such as institutionalized, home and community based, or medically needy individuals



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-DSNP benefits

Provider role

Staff role

**HRA completion is a STARS measure*

©2019 Aetna Inc.



Health risk assessment

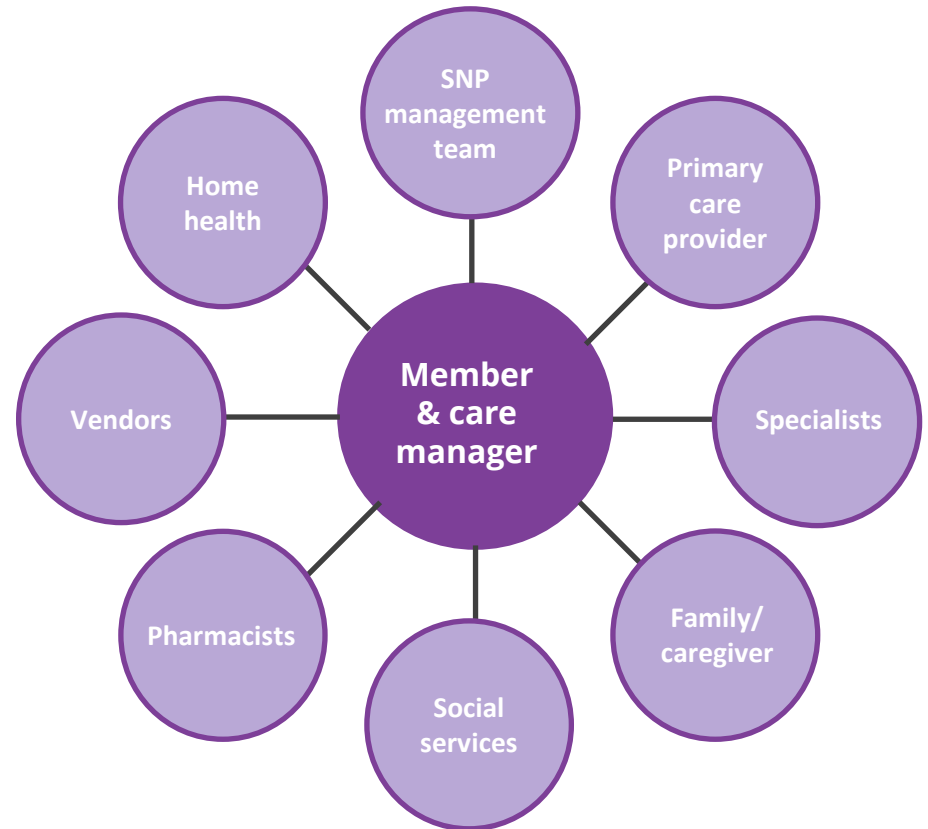
The health risk assessments (HRAs):

- 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 member's Individualized care plan
- Assess the following needs of each member:
 - Medical
 - Functional
 - Cognitive
 - Psychosocial
 - Mental health
- Are completed by phone by the care management team:
 - Within 90 days of enrollment
 - Repeated within 365 days of last HRA

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 member crisis
- 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

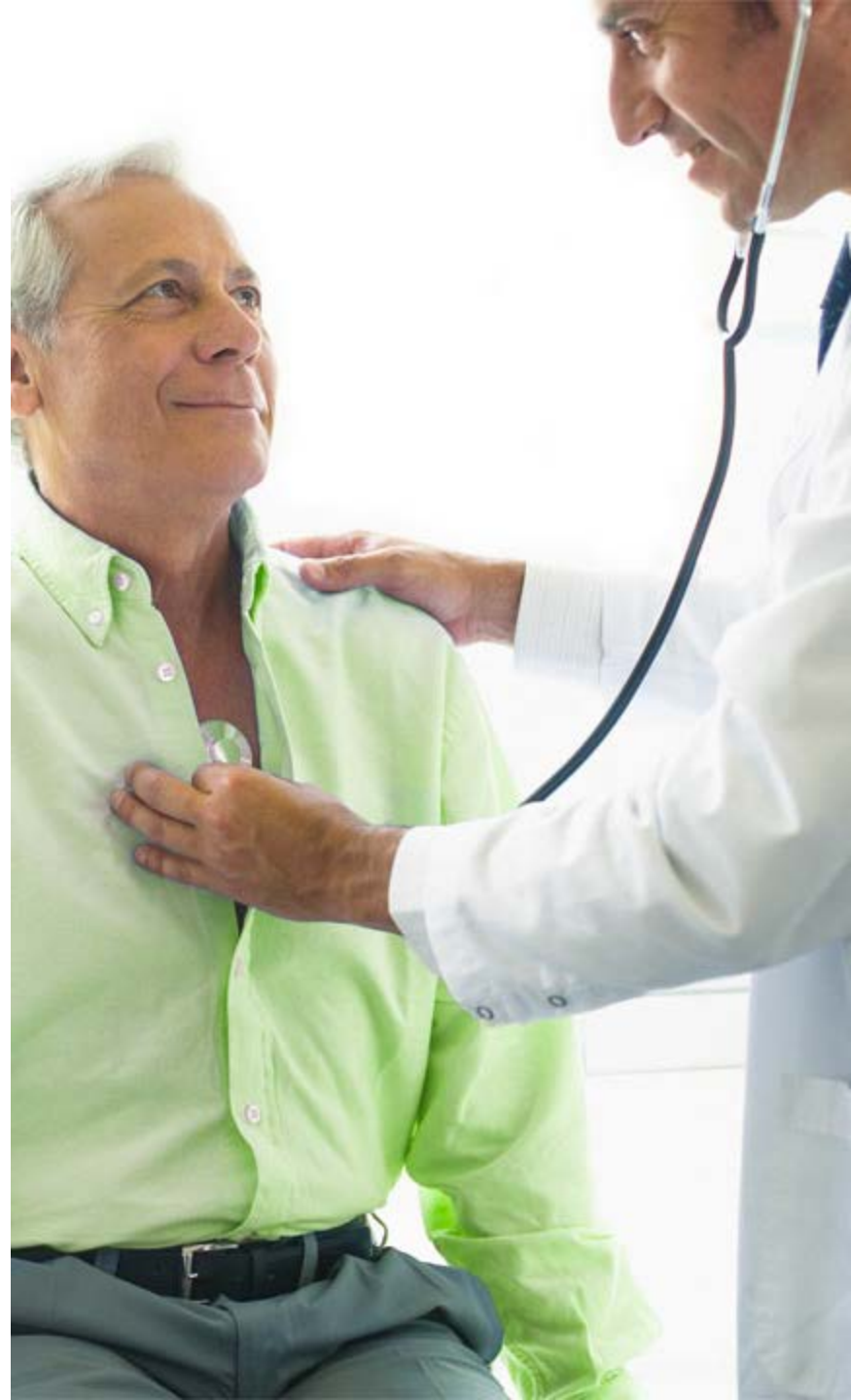
Individualized care plan (ICP)

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 ...

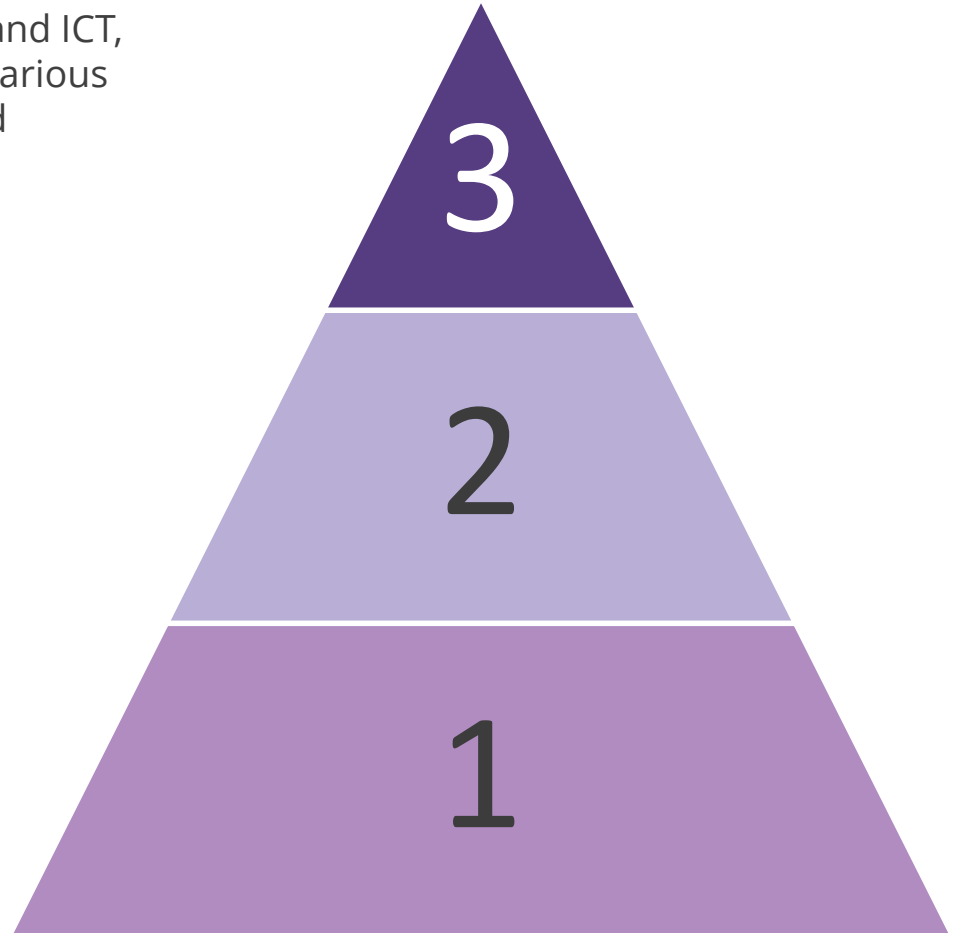
D-SNP members are tiered

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 and 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 and ICP** for each member are always available to the **primary care physician** 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
- Helps schedule transportation
- Assists with needed home health care and medical 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:

- Enhancing **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 secure website:

- **For all DSNP markets (except VA):** <https://aetna-prd.assurecare.com/provider/>
- **For VA:** aetnabetterhealth.com/virginia-hmosnp/providers/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 members 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 member's ICPs
 - **For all DSNP markets (except VA):** <https://aetna-prd.assurecare.com/provider/>
 - **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](https://aetna.com/healthcare-professionals/documents/forms/dsnps-model-of-care.pdf)



Contact us

Mailbox for all DSNP markets (except VA):

- For CM needs: MCRDSNP@aetna.com
- For Provider needs: 1-800-624-0756

Mailboxes for VA DSNP:

- For CM needs: AetnaBetterHealthVA-CaseManagement@aetna.com
- For Provider needs: AetnaBetterHealth-VAProviderRelations@aetna.com



Thank you

Aetna individual health benefits plans are underwritten by Aetna Health Inc. (Aetna).

Aetna does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).