

2018 Medicare Advantage Dual Eligible Special Needs Plan (DSNP) & Model of Care (MOC) Overview

Medicare Advantage (MA) Program

Part C Medicare Advantage

- Medicare Part A and B benefits are administered through private “coordinated care” plans approved by CMS
- MA plans provide statutory and supplemental benefits
 - MA plans must meet CMS standards for provider networks, quality programs, appeal processes, other key functions
 - CMS sets capitation payment rates by county using federal formula
 - Plan capitation payments are risk-adjusted to reflect beneficiary health status and demographics
- In 2003, Congress passed the Medicare Modernization Act (MMA). It enabled insurance companies to create, market and sell a different kind of Medicare Advantage plan known as Special Needs Plans (SNP). These plans are intended to provide targeted care to individuals with special needs.

What is a Special Needs Plan?

The Medicare Improvements for Patients & Providers Act of 2008 (MIPPA) requires the Managed Care Organization (MCO) to have a SNP agreement with each state where we offer a DSNP.

- Each Medicare Advantage Plan must hold a:
 - Medicare contract with CMS that:
 - Covers all Medicare Part A, B and D benefits
 - Offers Supplemental benefits
 - Has an approved D-SNP Contract and Model Of Care (MOC)
 - Agreement with the with State Medicaid Office that:
 - Determines who can enroll into the DSNP (aid categories)
 - Identification of what additional items are covered under the agreement such as:
 - Coverage for Medicare cost sharing
 - Coverage of Medicaid, LTC or HCBS benefits
 - Who and how providers bill for the above services
 - DSNP plans are NOT Medicare Medicaid Plans (MMPs).

Dual Eligible Special Needs Plan (DSNP)

There are three types of Special Needs Plans

1. Dual Special Needs Plans (DSNP); For members who are eligible for Medicare and Medicaid
2. Chronic Special Needs Plans (CSNP); for members with disabling chronic conditions
3. Institutional Special Needs Plans (ISNP); for beneficiaries who are institutionalized

For purposes of this presentation, we will focus on DSNPs (#1 above) only. Information on our CSNP ESRD plans will be provided separately if you are in California, Texas or New Jersey

Who are Dual Eligibles?

Who are Dual Eligibles?

- Beneficiaries that meet eligibility requirements for both Medicare and Medicaid and are enrolled in both programs
- More vulnerable subgroup of Medicare beneficiaries
- Mix of over 65 and under 65 who qualified based on a disability
- Typically more costly based on health care needs
- Tend to have lower income and report lower health status than other beneficiaries

Who do we enroll in our DSNP?

- **We only enroll Dual Eligible members who have coverage of Medicare Premiums & Medicare Cost Share**
 - **With the exception of the following: Simply plans in Florida have 2 products (Polk/Miami-Dade) that enroll all dual types except for QDWIs**
- **DSNP members (except QI & SLMB members in Florida plans) are protected from balance billing, providers cannot balance bill and must accept the Medicare & Medicaid payments as payment in full.**
- However - Not all members will have full Medicaid benefits (example: QMB, QI, SLMB)

Who is eligible for our Dual Eligible Special Needs Plan (DSNP)?

- NJ - We cover those with Full Medicaid coverage and some with additional LTSS coverage under the plan. Medicaid benefits are integrated within the DSNP and LTSS benefits for those that qualify.
- TX - We cover Duals that have at a minimum protection of all Medicare cost share responsibilities AND process that cost share under the DSNP on behalf of the state. Any Medicaid service benefits are covered by the plan administering their Medicaid benefits and not the DSNP directly. Note that Medicare-Medicaid Plan (MMP) Members have coverage under the MMP and not DSNP.

Who is eligible for our Dual Eligible Special Needs Plan (DSNP)?

- For all other DSNP states - We cover Duals that have at a minimum protection of all Medicare cost share responsibilities however any cost share or Medicaid benefits are covered by the plan administering their Medicaid benefits.
- *Any state that we can have dual citizens (on our DSNP and separate AGP/Anthem Medicaid)* Note: State allows Duals to be enrolled in both a Medicare DSNP and Medicaid Managed Care Plan administered by Anthem/Amerigroup, so Dual may be enrolled in both plans separately.

Special Needs Plans - *fundamental characteristics*

- **Model of Care (MOC)** - specific goals and objectives for the SNP population including conducting the Health Risk Assessments (HRA) and working with an Interdisciplinary Care Team (ICT) who is tasked with coordinating delivery of services and benefits to members. The team consults with the member to develop a comprehensive individualized care plan that addresses that person's specific needs.
- **State SNP Agreements** - Affordable Care Act (ACA) 2010, a.k.a. health reform law, required DSNP to have contracts with state Medicaid agencies. Those Agreements dictate the categories of dual eligibles that can enroll in the DSNP and as well as any additional requirements such as reporting or coverage of Medicaid benefits and Medicare cost sharing responsibility. The SNP Agreements are linked to the DSNP in that market but ARE NOT linked to any other Product we offer. They are their own contract and are not Medicare-Medicaid Plans (MMPs). The states propose what is included in the contract as long as the 8 CMS elements are included.
- **Coordination** - the process by which we help coordinate care for the member between their Medicare and Medicaid benefits.

State SNP Agreements - 3

Principle Models

- Agreements specify benefits, cost sharing, member protections, exchange of member eligibility and provider information.
- State can impose additional coordination & reporting requirements
- Notice the constants: Data Sharing & Coordination.

Model 1 Data Sharing & Coordination	Model 2 Data Sharing, Coordination & Cost Sharing	Model 3 Data Sharing, Coordination, Cost Sharing & Benefits
a) Share Medicaid provider participation data	a) Share Medicaid provider participation data	a) Share Medicaid provider participation data
b) Exchange Medicare/Medicaid eligibility data	b) Exchange Medicare/Medicaid eligibility data	b) Exchange Medicare/Medicaid eligibility data
c) Exchange of medical/ drug utilization data	c) Exchange of medical/ drug utilization data	c) Exchange of medical/ drug utilization data
d) Coordinate Care for all benefits to help Beneficiary	d) Coordinate Care for all benefits to help Beneficiary	d) Coordinate Care for all benefits to help Beneficiary
e) Medicare cost sharing remain with state Medicaid Program	e) Medicaid benefits remain with state Medicaid Program	e) DSNP administers some or all Medicaid and/or LTC benefits
f) Medicaid benefits remain with state Medicaid Program	f) DSNP administers Medicare cost sharing	f) DSNP administers Medicare cost sharing

Eligibility for Enrollment in our DSNP

- Live in plan's **service area**
- Entitled to **Medicare Part A**
- Enrolled in **Medicare Part B**
- Does not have **End Stage Renal Disease** (ESRD) at time of enrollment
- Join during an **enrollment period or SEP**
- **Special Election Period (SEP)** – all DSNP members can move from plan to plan each month while they are Medicaid Eligible.
- For those that lose Medicaid Eligibility, they have a **SEP** beginning the month they receive the notice of the loss of eligibility, plus two additional months to make an enrollment choice.
- Must receive care from contracted plan providers (unless urgent/emergent or out of area renal dialysis or when prior approved by the plan)
- ***Meets Medicaid eligibility requirement for their state as determined in the DSNP Agreement***

Coordination is Key!

- **When Dual eligibles need care or to access benefits, it is everyone's responsibility to help and coordinate that care.**
 - Where do they go for that care?
 - What services are covered under the Medicare and Medicaid plans?
 - How do Medicare and Medicaid work together?
- The following will assist you in coordinating care:
 - **Dual Members should show BOTH (Plan ID and Medicaid) cards to all providers to assist with billing and service issues**
 - **This reduces the error of balance billing**
 - **New Jersey DSNP members should only show the DSNP ID card**
 - Most states require a provider to have a Medicaid ID number to receive payment from the state

2018 Dual Eligible Special Needs Plans Copays on LIS Levels

- All of our DSNPs have coverage of Medicare Part D Prescription Drugs
- The below LIS Levels are determined by the Federal Government, actual cost share for Part D Prescription Drugs covered under the plan may be less.
- DSNP Members will 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 formulary for covered prescriptions under the plan.

LIS Level	Part D Deductible	Generic Copay	Brand Copay
1	Covered	\$3.35	\$8.35
2	Covered	\$1.25	\$3.70
3	Covered	\$0.00	\$0.00
4	Partially Covered	15%	15%

How *our* DSNPs are Structured

- We only enroll Beneficiaries that have no responsibility for Medicare cost sharing for any medical services under the DSNP based on their level of Medicaid eligibility and ALL will receive Extra Help for Part D Prescription Drugs.
- Any Medicare cost sharing applied to a claim is covered under the member's Medicaid coverage, which may be:
 - The plan under an agreement with the state
 - Another Medicaid MCO
 - Fee-for-Service Medicaid
- There are no out of network benefits unless urgent/emergent or out of area renal dialysis. Please call the plan if the need arises to refer outside of the plans network.

Benefit	As filed with CMS	Member Responsibility
Inpatient copay	Medicare Defined	\$0 copay
SNF copay	Medicare Defined	\$0 copay
PCP copay	Medicare Defined	\$0 copay
Specialist copay	Medicare Defined	\$0 copay
Ambulatory surgery	Medicare Defined	\$0 copay
Outpatient hospital	Medicare Defined	\$0 copay
Emergency room	Medicare Defined	\$0 copay
DMEPOS	Medicare Defined	\$0 copay
Diagnostic imaging	Medicare Defined	\$0 copay
Part D drug copays	Standard Medicare Part D	Lower of filed benefit or Low Income Subsidy (LIS) Copay
Supplemental Benefits	\$0 copay Member is eligible for all Medicaid Benefits entitled to	

DSNP Claims Processing

Important Information on Claims processing:

- DSNP members are protected by state (State plan) and federal (Social Security act) regulations from balance billing, providers cannot balance bill and must accept the Medicare & Medicaid (if applicable) payments as payment in full.
- Claims are processed in accordance to the benefits filed within those plans and are subject to Medicare cost sharing. Refer to your Medicare Advantage Agreement
- Coverage of Medicare Cost Share will depend on the services performed and Medicaid allowed amounts (Lesser of Logic or COB requirements for the state may be used)
- For example, if claim is for a service covered by Medicare & Medicaid and it is \$100, Medicare (health plan) will pay \$80 as the allowed amount. Medicaid will pay only up to the allowed amount as well, so if the \$80 Medicare paid is more than the Medicaid allowed amount, the provider will not receive additional payment
- Rules differ by state and it is possible some providers will receive the full Medicare allowed amount
- Most states require that you have a Medicaid provider ID in order to bill and receive payment
- Not all members will have full Medicaid benefits (Example: QMB members)
- **Federal rules dictate that Medicaid is the payer of last resort**

**** If you do not accept Medicaid, please direct members to a Medicaid provider to perform Medicaid covered services. Our Provider Directory will illustrate which providers those are**

DSNP Claims Processing Continued

For members enrolled in more than one of our plans (for example: our Medicaid plan)

- 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.
- 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.

DSNP Reminders

DSNPs have an agreement with the state Medicaid agency in which they operate that governs each plan in conjunction with CMS regulations

Coordination of Care

- Working together to integrating the different elements of Medicare & Medicaid, delivering the most appropriate , highest quality care of both programs.
- Helping members (and their representatives) to understand their care, benefits and coverage under both Medicare & Medicaid coverage
- Sharing of information (between you and us!)
- Education and lending a hand to understand next steps for our members

Model of Care

- Each Provider needs to complete the Model of Care Training and Attestation
- You have access through the secure provider portal to the member's Health Risk Assessment (HRA) Results, the Individualized Care Plan (ICP) and the members on the Interdisciplinary Care Team (ICT).
- As the provider, you may participate in our ICT or provide feedback to the Case Manager who will represent your concerns to the team.

Claims

- Submit claims to the Plan
- Plan will adjudicate according to Medicare benefits filed & Providers DSNP contract with the plan
- EOP will explain claims processing information and next steps for the provider
- Medicare Cost Share can be billed to Medicaid for consideration
- Members are protected from liability (balance billing) **DO NOT BILL THE DSNP MEMBER**

Model of Care (MOC) Structure & Requirements

The Model of Care (MOC) is a CMS requirement for organizations that apply to offer a Special Needs Plan (SNP).

SNPs are required to have robust models of care designed to meet the needs of the targeted population and address the following areas:

- Population Assessment

- Care Coordination

- Provider Network

- Quality Measurement and Performance Improvement

Specific Elements and description about our model are discussed in the following slides.

MOC Elements:

- Population Assessment
 - We assess our population and identify health conditions and unique characteristics that make up our membership. We work to develop a robust provider network and specialty tailored services or programs to assist in the management of the most vulnerable members.
- Staff Structure
 - Our staff structure and care management roles are designed to manage the special needs population. A case manager will attempt to contact each SNP member, as well as an individualized interdisciplinary care team will be assigned, which may include any of the following members: nurses, physicians, social workers, pharmacists, our member, behavioral health specialists, or other participants as determined by the member.

MOC Elements:

- We work to complete a telephonic health risk assessment (HRA) on each member. The members receive an initial HRA within 90 days then annually. Our team may contact your office for updated contact information for those members we are unable to reach.
 - Our assessment covers physical, behavioral, cognitive, psychosocial, functional and environmental domains and serves as the basis for the member's individualized care plan. The HRA is available to you on the secure provider portal.
- Each member has an individualized care plan (ICP) based on the results of the health risk assessment. The case manager develops the ICP working with the member and the interdisciplinary care team (ICT).
 - The care plan includes interventions designed to educate, inform and serve as an advocate for our members. Use of community resources is facilitated for the member, and benefits are coordinated between Medicare and Medicaid. In order to ensure optimal coordination during the care planning process, a member of our case management team may contact you requesting a care coordination conference to discuss a complex member or provide you information.
 - You have access to the ICP through the secure provider portal

MOC Elements:

- An interdisciplinary care team (ICT) is assigned to each member.
 - The ICT is responsible for reviewing the care plans, collaborating with you and other network providers and providing recommendations for management of care. You may be asked to participate in the care planning and management of the plan of care.
- We have a contracted provider network having special expertise to manage the special needs population and monitor the use of clinical practice guidelines by the contracted providers.
 - Roles of providers include managing transitions, advocating, informing and educating members, performing assessments, diagnosing and treating. If you believe our local network does not meet all of your members' specialized needs, and would like to recommend possible additions to our network, please contact provider relations at the number on the members' identification card or discuss with the case manager.

MOC Elements:

- **Communication Plan:** We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, your members and our care team.
 - You may reach your members' care team by calling the number provided to you on any correspondence from us or the number on the members' identification card.
 - Valuable information on utilization, transitions, and care management is available on the secure provider portal
- **Special needs plan members typically have many providers and may transition into and out of health care institutions. You are essential in coordinating care during transitions.**
 - Contact us if you would like our team to assist in coordinating care for your patient.
 - Our care management 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.
 - We have identified care transition protocols that are also documented for you in your provider manual.

MOC Elements:

- Performance, quality and health outcome measurements are collected, analyzed and reported to evaluate the effectiveness of the model of care. 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) member survey is multi-purpose and used to compute physician and mental component scores to measure the health status
 - CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations and procedure frequency
 - Medication therapy measurement measures
 - Clinical and administrative/service quality improvement projects

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 health care settings
 - Ensure appropriate utilization of services for preventive health and chronic conditions
- The goals we have in place to improve the care our members receive address the following:
 - Adequacy of our network
 - Our rates of completion of the health risk assessments, developing member care plans and completing an interdisciplinary care team review
 - Rates on certain preventive care services and chronic condition management
 - Frequency of follow up care post discharge
 - Visits to the primary care provider
 - Utilization rates of emergency room and inpatient admissions

Provider Attestation Required

- Please print the last page of this presentation attesting that you have reviewed this presentation and have an understanding of the DSNP and MOC requirements.

Questions? - Helpful References

- Provider Portal
- Provider Solutions – Please call the number on the back of the members ID card
- Medicare Managed Care Manual (Chapter 16-B: Special Needs Plans) <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf>

Don't forget your attestation on the next page!



Amerigroup

Model of Care Attestation

As the below provider I attest that my practice has reviewed the DSNP & MOC presentation.

I understand:

- the goals of the program and the requirements of the MOC
 - Plan of Care feedback and consensus
 - Clinical coordination for the member
 - Participation in ICT
 - 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: _____

- PLEASE SIGN AND FAX TO: 855-328-8562

In New Mexico, Amerigroup Community Care of New Mexico, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup Texas, Inc. In Washington, Amerigroup Washington, Inc.

Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program. In New Mexico: Amerivantage is an HMO with a Medicare contract. Enrollment in Amerivantage depends on contract renewal.