Dual Eligible Special Needs Plans (D-SNPs)

Model of Care training & Attestation Requirement

Proprietary and confidential;
Not for further distribution
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July 2020

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.

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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
- Complete your D-SNP Model of Care Training Attestation to receive credit
- Explain how to get answers to your questions

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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. This training and completion of an attestation are required for new providers and annually thereafter.

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 and their contracted providers can work together to successfully deliver the SNPs Model of Care.

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Aetna is emerging as an **industry leader** in serving **dual populations** by:

- Developing **best-in-class operating** and **clinical models**
- Collaborating with **members**, **providers** and **community organizations**
- Pursuing quality solutions that address the **full continuum** of our **members' health care** and **social determinant needs**

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Changing DSNP regulatory environment

2018 All SNPs made permanent

Balanced Budget Act

2020 New coordination requirements

New requirements for 2020 on assistance with Medicaid services and supporting appeals process

2021 New minimum integration requirements

No further enrollment allowed if not in compliance. Individual states determine approach to integration

- States afforded flexibility; multiple options
- States may link DSNP contracts to Medicaid MCOs or require bids

2021

Enhanced Coordinated DSNP Model

- DSNP is responsible to **coordinate the delivery** of Medicare and Medicaid services
- States define process for **DSNPs to notify the State** when "high-risk" full dual is admitted to hospital or SNF

Highly Integrated DSNP (HIDE SNP)

- Single parent organization **offers both DSNP** and **Medicaid MCO with MLTSS** or behavioral health services
- **Partially or fully aligned models**; States may limit to fully aligned model

Modified Fully Integrated DSNP (FIDE SNP)

- DSNP operates as a **single managed care organization** that is responsible for all Medicare and Medicaid covered benefits

Limited Integration

Mid-Level Integration

Full Integration

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Future State: Types of DSNPs

DSNP Non-Integrated

A Dual Eligible Special Needs Plan that may or may not have membership aligned with another MCO.

- D-SNP notifies the state when a high-risk dual (determined by state) is admitted to hospital or SNF
- States have flexibility in the determining who is included in the data to be shared, how and where the data will be sent and timeframes around when notification will occur.
- Most of Aetna's current plans are DSNP Non-Integrated

HIDE SNP

A Highly Integrated Dual Eligible (HIDE) Special Needs Plan has a single parent organization that offers both DSNP and Medicaid MCO with MLTSS or behavioral health services

Partially aligned model:

- Non-exclusively aligned membership

Fully aligned model:

- Exclusively aligned membership
- Considered an applicable integrated plan and require integrated G&A
- Some states may limit to fully aligned model only

FIDE SNP

A Fully-Integrated Dual Eligible (FIDE) Special Needs Plan fully integrates care for dually eligible beneficiaries. FIDE operates as a single managed care organization (entity) that is responsible for all Medicare and Medicaid covered benefits

- DSNP limited to Medicaid MCOs, No opportunity to participate if we were not Medicaid MCO
- Exclusively aligned membership
- Like a fully aligned HIDE, a FIDE requires integrated G&A procedures and denial notice

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What is a Special Needs Plan?

A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be any one of the following:

- An institutionalized individual,
- A dual eligible, or
- An individual with a severe or disabling chronic condition, as specified by CMS

A SNP may be any type of MA CCP including:

- a local or regional preferred provider organization (i.e., LPPO or RPPO) plan
- a health maintenance organization (HMO) plan; or
- an HMO Point-of-Service (HMO-POS) plan.

SNP Type	Membership Limited to:
Chronic Condition SNP (C-SNP)	People who have specific chronic or disabling conditions Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia)
Institutional SNP (I-SNP)	People who live in certain institutions (like a nursing home) or who require nursing care at home
Dual Eligible SNP (DSNP)	**People who are eligible for both Medicare and Medicaid**

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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 are 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)

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Duals Special Needs Plan Operating Requirements

Special Needs Plans (SNP) must meet all core Medicare Advantage (Part C and Part D) requirements **and** specific incremental or modified requirements

- Some SNP specific requirements apply to all SNPs and some to DSNPs only

Key SNP Requirements

1. MA-PD Plan, SNP, and Service Area Approval
2. Part D Prescription Coverage
3. Eligibility
4. State Medicaid Agency Contracts (SMACs) which may include additional state specific requirements
5. Model of Care
6. Enrollment
7. Benefit Flexibility
8. Cost Sharing
9. SNP-Specific Plan Benefit Packages
10. Marketing and Sales
11. Member materials
12. Network Directory

Note: Medicare-Medicaid Plans (MMPs) are not DSNPs; they are demonstration plans that operate under state-specific 3 way contracts which include additional requirements and modifications of core MA-PD operating requirements

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State Medicaid Agency Contracts (SMAC)

A **State Medicaid Agency Contract (SMAC)** is a contract between the State and MCO put into effect by the Medicare Improvement for Patient & Providers Act (MIPPA) 2008 law.

Why do we need a SMAC?

CMS requires all Medicare Advantage Organizations seeking to offer a DSNP to enter into an agreement with each state's Medicaid Agency.

State Payments to D-SNPs for Medicaid Services

States may make capitated payments to D-SNPs for Medicaid services, including (in order of increasing complexity):

- Medicare beneficiary cost sharing
- Drugs excluded from Part D
- "Wraparound" Medicaid acute care services (vision, dental, hearing, transportation)
- Other Medicaid services that overlap with Medicare (behavioral health, DME)
- Long-term supports and services (nursing facility, HCBS, home health, personal care assistance)

State payments may go to D-SNPs that are aligned with companion Medicaid plans, or to "stand-alone" D-SNPs that are not affiliated with Medicaid plans

Opportunities for financial and clinical integration are greater when plans are aligned

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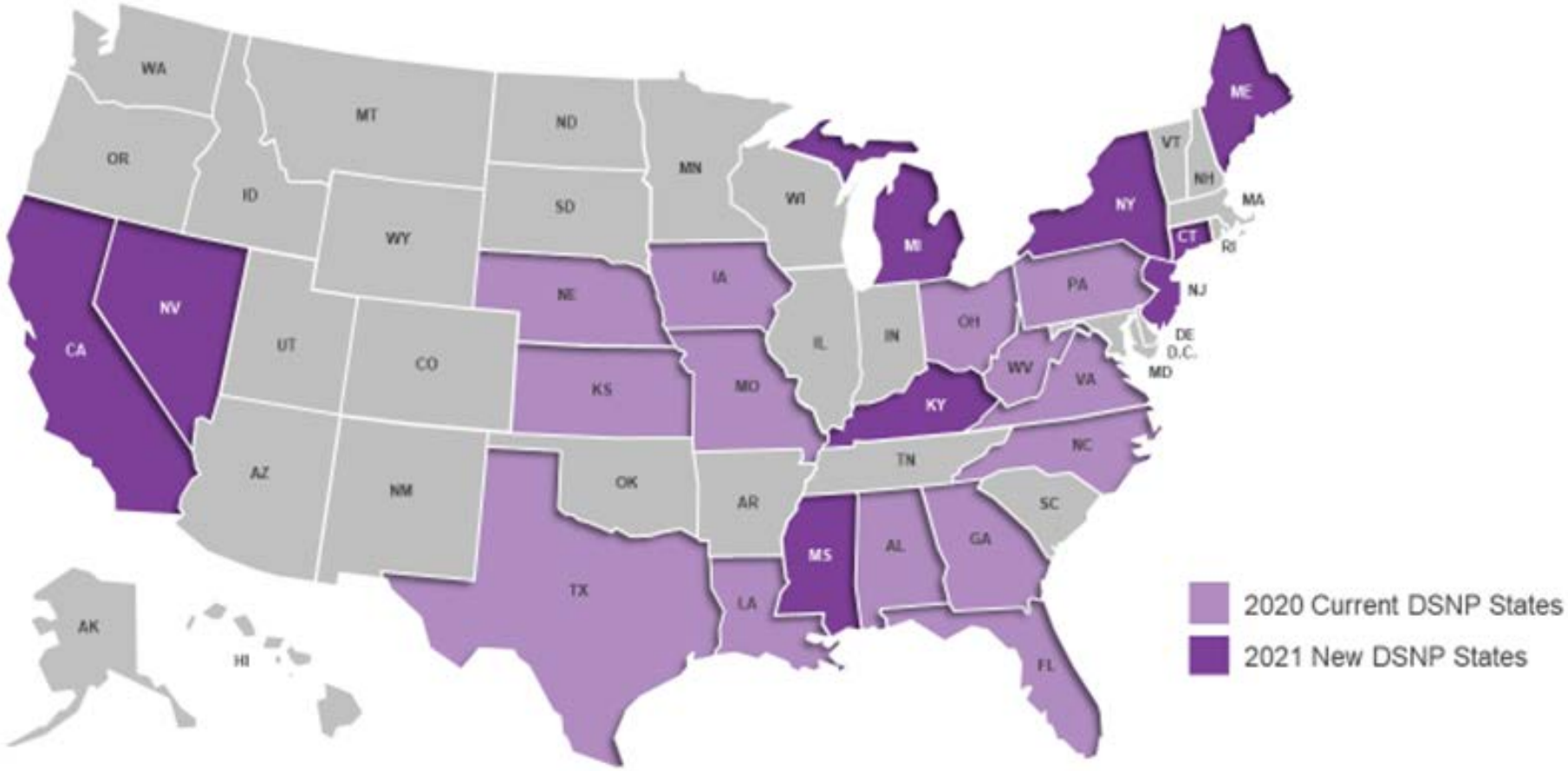
Aetna D-SNP 2021 footprint



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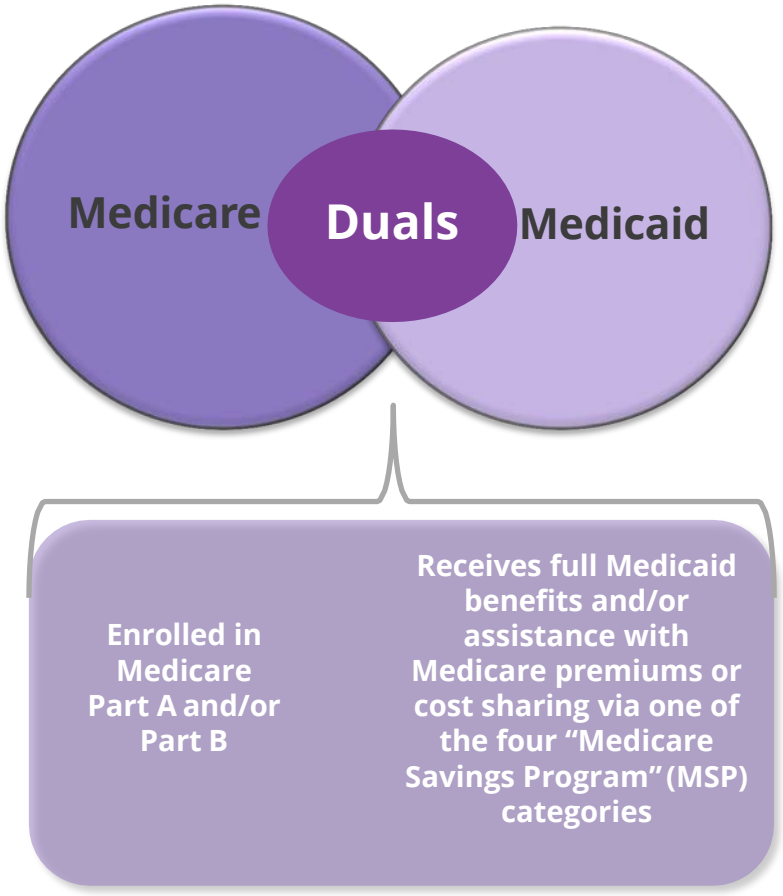
Who are dual eligibles?



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

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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.

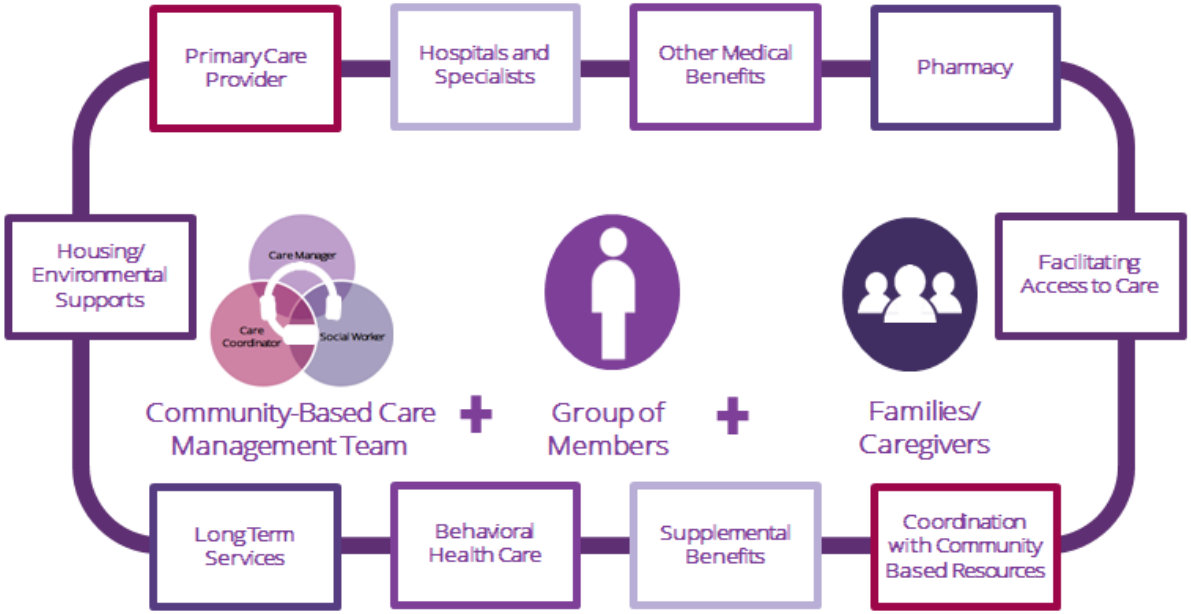
The MOC is a plan for delivering care management and care coordination to:

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 use and cost effectiveness
8. Improve member health

DSNP Care Team

DSNP Care Management Program extends beyond traditional case and disease management programs, offering personal, comprehensive support for 100 percent of DSNP members.

- Integrated team-based care management model with a personal touch
- Balanced clinical approach that integrates medical, functional, environmental , behavioral health and psycho-social needs through a core care management team



Care Management Team

- Nurse care managers
- Social workers
- Care coordinators
- Member advocate

Supported by

- Pharmacists
- Medical director
- Behavioral health
- Other Aetna clinical programs & services

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Our personalized, holistic and local care management strategy

Every DSNP Member is supported by a dedicated DSNP Care Team

- Comprehensive health risk assessment
- Individualized and personalized care plan
- Transitional care if discharged from the hospital
- Assistance with accessing community resources and support
- Coordination of Medicare and Medicaid benefits, services and providers
- Help navigating the health care system

Our care team

Registered nurse

Assesses member's needs and risk levels; develops and oversees care plan

Social worker

Identifies and addresses social determinants of health

Care coordinator

Completes initial outreach, Health Risk Assessment and assists with benefit navigation and appointment scheduling

Member advocate

Assists member with Medicaid recertification and accessing MCD benefits

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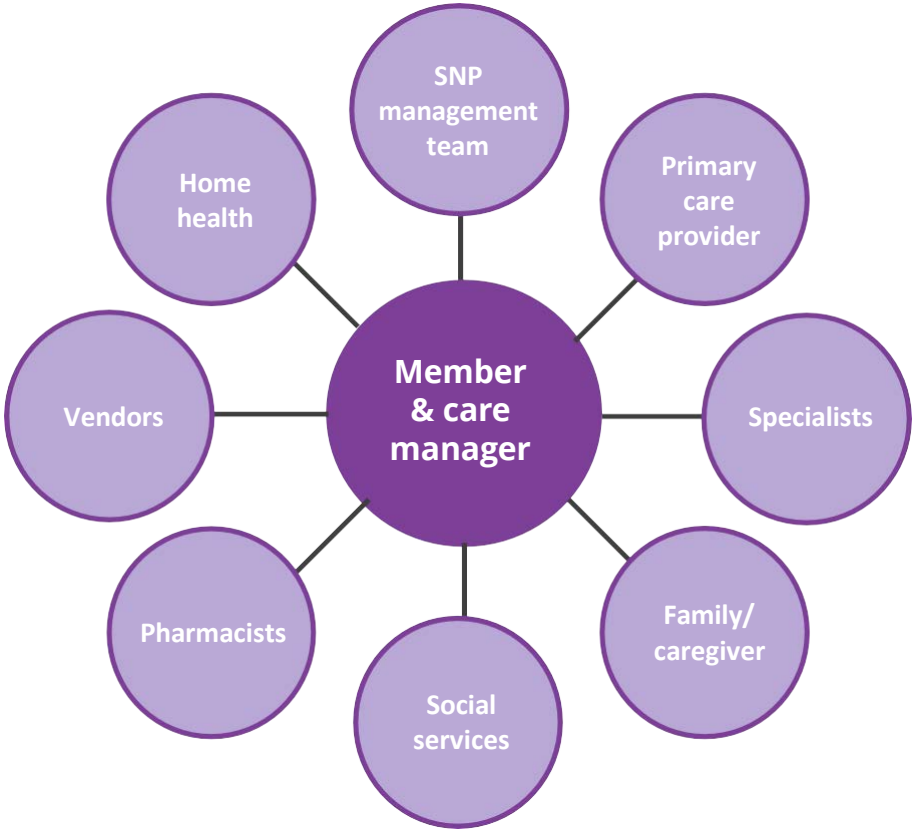
Interdisciplinary care team (ICT)

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



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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

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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

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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.

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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

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Care coordination continued…

Post-hospitalization transition of care:

This is 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 get more contact as needed.

During these calls, the CM:

- Helps the member understand discharge diagnosis and instructions
- Facilitates follow-up appointments
- Helps schedule transportation
- Helps with needed home health care and medical equipment
- Resolves barriers to obtaining medications
- Educates the member on new or continuing medical conditions

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A Recap: Why we are unique

Each DSNP member has a **personal care team** that includes a nurse case manager, social worker, pharmacist, behavioral health specialist and non-clinical support staff.

- The care team helps the member **manage** their conditions and medications, coordinate access to benefits across Medicare and Medicaid, schedule their medical appointments and arrange transportation
- The care team will also **collaborate** with caregivers and providers when needed.

Each DSNP member receives an **individualized** care plan, **tailored** to their specific needs.

Each DSNP member has a designated care manager assigned to them that will **walk with the member** and **share their journey** through the health care continuum.

Note: Other MCOs do not always designate specific care managers to their DSNP members.

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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
- Non-emergency transportation
- Meal programs
- Over-the-counter allowance

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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 help 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 provider portal:

- **For all DSNP markets (except VA and NJ):** https://aetna-prd.assurecare.com/provider/
- **For VA:** aetnabetterhealth.com/virginia-hmosnp/providers/portal
- **For NJ:** AetnaBetterHealth.com/New-Jersey-hmosnp/providers/index

See slide 29 for instructions on how to **request access** to the p**rovider portal**

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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 and NJ)**: https://aetna-prd.assurecare.com/provider/
  - **For VA:** aetnabetterhealth.com/virginia-hmosnp/providers/portal
  - **For NJ:** AetnaBetterHealth.com/New-Jersey-hmosnp/providers/index
- Remind providers and their staff to perform their MOC training annually
  - **Direct link:** aetna.com/healthcare-professionals/documents-forms/dsnps-model-of-care.pdf

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Complete your Attestation to receive credit

EVIDENCE OF TRAINING COMPLETION REQUIRED

In accordance with the Centers for Medicare and Medicaid Services ("CMS") regulations for Managed Care Organizations and your contractual relationship with us, there are specific compliance regulations that must be adhered to by you as our "first-tier entity" including this Special Needs Plan Model of Care (“SNP MOC”). Training and completion of a D-SNP Attestation confirming this training was completed initially within 90 days of hire/contracting and annually thereafter.

Complete the 2021 SNP MOC Attestation online at this **link.**

See next slide for Attestation support.

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Complete your Attestation Support

D-SNP MOC ATTESTATION COMPLETION SUPPORT

- If you or your authorized representative have already completed the **D-SNP MOC ATTESTATION** , you may disregard this notice.
- If you receive an error message at the **D-SNP MOC ATTESTATION** link, check your browser settings and ensure it complies with: Microsoft Windows 10 **using** Microsoft Edge, Internet Explorer 11, or a current version of Firefox, or Chrome. Microsoft Windows 8 **using** Internet Explorer 11 or later, or a current version of Firefox, or Chrome. Mac OS X v11 or later **using** Safari 7 or later, or a current version of Firefox, or Chrome.
- An authorized representative may complete one attestation for multiple providers, groups or organizations if all Tax ID's are identified with the attestation. Credit is given at the **Tax ID/EIN level only**. No other provider identifier will be accepted for credit.
- Once the DSNP MOC Attestation is completed, you'll receive an email asking you to verify your email address. After you verify your email you'll receive a copy of your signed Attestation for your records.
- Did you **not** receive the **"Click to Sign"** option in the attestation? You must click the **START** button which begins on the second page, select an answer and/or **respond to all** drop down or form fields. If you missed answering any fields, you won't receive the "Click to Sign" link at bottom of the page.
- Tax ID#(s) must be only numbers (a total of 9 digits) with no hyphens, spaces or letters: 123456789; if your Tax ID# has zeros in the beginning or end, you must add those to get to the required 9 digits.

If you have any questions or need help with this requirement, please email us at **DSNPMOC@aetna.com** or call us at **1-800-624-0756 (TTY:711)**.

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Contact us

For general MOC attestation questions please email us at DSNPMOC@aetna.com

For Care Management, email:

- **All DSNP markets (except VA and NJ): MCRDSNP@aetna.com**
- **VA: ABH_VA_DSNP@Aetna.com**
- **NJ: NJ_FIDE_SNP_CM@Aetna.com**

To request access to the secure provider portal, email:

- **All DSNP markets (except VA and NJ): MCRDSNP@aetna.com**
- **VA: Aetnabetterhealth-VAProviderRelations@aetna.com**
- **NJ: NJ_FIDESNP_Providers@Aetna.com**

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Thank you

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