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

Coventry Health Care is now part of the Aetna family. Aetna Health Inc., a Florida corporation, is contracted with CMS to offer our D-SNPs in Florida. Our D-SNPs operate under these **product names** in Florida:

- **Aetna Medicare Maximum Plan**
- **Coventry Summit Maximum**
- **Coventry Vista Maximum**
Our mission

Our Special Needs Plan (SNPs) 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 Florida 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
• Give you resources to contact with questions
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 case 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.
Dual Eligible Special Needs Plans
SNPs were created as part of the Medicare Modernization Act.

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

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
- Members may change their coverage during additional election periods throughout the year

Medicare Advantage SNPs feature:
- Three types designed for specific groups of members with special health care needs.
  - Individuals dually eligible for Medicare and Medicaid
  - Individuals with chronic conditions
  - Individuals who are institutionalized or eligible for nursing home care
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

Dual eligibility qualification is determined by the member’s participation in:
• Federally administered Medicare program
• The state-administered Medicaid program based on low income, assets, and age or disability status
Florida’s Medicaid agency

The Agency for Health Care Administration (AHCA) pays the health plan to provide benefits covered by Medicaid to our Florida D-SNP members.

The Florida D-SNPs program coordinates the member’s Medicare and Medicaid benefits.
Model of Care
Model of Care

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 case management and care coordination.

• The MOC uses an Interdisciplinary Care Team approach. This team includes the member, the member’s support system and the member’s PCP, as well as nurse case managers and pharmacists, social workers and other clinical team members based on the member’s needs.
Model of Care goals

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

Improve quality of care through early intervention and education

The health plan uses the following to help meet this goal:

- Health risk assessments (HRAs)*
- Personal nurse case managers
- Interdisciplinary care teams
- Individualized care plans

*Completion is now tracked as a Medicare Stars measure.
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
- Are taken over the telephone by the HRA team:
  - Within 90 days of enrollment, and then
  - Repeated within 365 days

Personal nurse case managers (CMs):

- Are assigned to every member in the Florida D-SNPs
- Will contact members to support their overall health and well-being
- Can be contacted by members and providers at 1-877-691-8138
- Place the member and his/her caregiver at the center of each interdisciplinary care team interaction
The Interdisciplinary Care Team (ICT):

- Each member is managed by a team.
- Participants are based on the member’s needs.
- Case managers will keep the team updated with information involving the member’s care plan.
- Team meets formally every two weeks.
- Smaller meetings occur as needed.
The Individualized Care Plan (ICP):

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
• Case manager interaction
• Interdisciplinary care team input
• Member preferences and personal goals

This is a living document that changes as the member changes.
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.

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.
D-SNP members are tiered

**High tier 3** contains the **most vulnerable members**, including those at risk for unplanned transitions of care.

**Medium tier 2** members are generally enrolled in several **disease-specific** programs.

**Low tier 1** contains the **most stable** SNP members.
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 a secure website: [www.careplanregistry.com](http://www.careplanregistry.com).

Contact **snpflorida@aetna.com** for your secure sign on.
Goal 2

Increase access to care and essential services

**Specialized providers support members:**

- Vital Decisions®: an advanced-illness support vendor
- Beacon®: Behavioral health vendor
- Medtronic® (formerly Cardiocom): home telephone monitoring system
- Medical Doctors’ House Calls: home doctor visits

Social workers and care coordinators help members obtain available home and community-based resources.
Goal 3

Create access to affordable care

Benefit Plans

Additional benefits for D-SNP members:

• Non-emergency transportation
• Meal programs
• Over-the-counter allowance
Goal 4

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 case manager functions as this central point of 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**.
Goal 5

Provide seamless transitions

Transitions of care include:

- **Planned admissions** to hospital or skilled nursing facility
- **Unplanned admission** to hospital (for example, from the ER)
- **Discharge** home
Seamless transitions of D-SNP members 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 the member or caregiver (where applicable)

• **Contacting the member** prior to a planned transition to provide educational materials and answer questions related to the upcoming transition
Seamless transitions of D-SNP members through:

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
Goal 6
Improve use of preventive health services

To improve access to preventive health services, the health plan provides:

- Preventive medical services with no copay for CMS required services
- Outreach and education describing the importance of these services
- Assistance with:
  - Making appointments for preventive screenings
  - Arranging non-emergency transportation

Additionally, the plan rewards the D-SNP member with credits for preventive care services. The credits can be used to obtain health and wellness items.
Goal 7

Encourage appropriate utilization and cost effectiveness

1. Ensuring **appropriate utilization** of services and cost-effective health services delivery through the prior authorization and review process.

2. Placing members into **specialized clinical programs** based on their individual needs and/or conditions.

3. Aiming to give members **the right care, at the right time, in the right setting** to enable the best health outcome.
Goal 8

Improve member health outcomes through reducing hospitalizations

All D-SNP members are managed by an interdisciplinary care team that helps them remain in the least restrictive care setting. Several other programs are in place to assist D-SNP members who are at risk for hospitalization:

• Home **tele-monitoring** for members with specific conditions
  - Daily reports are monitored by the member’s case manager
  - Case manager works with members and providers to avoid hospitalizations
• **Post-Hospitalization** Program
  - Follow-up after discharge
• Complex **case management**
  - For members with frequent ER use and/or recurrent readmissions
  - Increased care management intensity to help prevent relapse
• **House calls**
  - Practitioners visit members who have physical, mental or functional impairments that keep them from visiting their PCP

• **Medication therapy management**
  - Pharmacist participates in member’s ICT

• **Diet and nutrition**
  - Nutritional counselling
  - Home meal delivery

• **Behavioral health services**

• **End-of-life support services**

• **Social work support**

• **Home and community-based services partnerships**
Interdisciplinary care team
Interdisciplinary care team (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
- Prepare members, or caregivers, for **provider visits**
- 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**
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
Provider role

- **Communicate** with D-SNP case 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 his/her personal case manager and care coordination team
What can you do to help D-SNP members?

- Remind members of the importance of the HRA
- Encourage members to work with their CM and CC teams
- Encourage our PCPs and other providers to participate with the member’s ICT
- Remind the PCP to access the D-SNP members’ ICPs at www.careplanregistry.com
- Remind providers to perform their MOC training annually via careplanregistry.com or directprovider.com
Contact us

Micheyle Carlini, RN
Director SNP Program: 305-222-3041

Lissette Gomez, Project Coordinator
SNP Program: 305-222-3041

Mary R Mailloux, MD, MMM, FACEP
Medical Director SNP Program 954-858-3174

Marilyn Hernandez, CM Team Lead 305-222-3049

SNP Case Management 1-877-691-8138
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).