MedStar Medicare Choice Special Needs Plans

Table of Contents

Overview

MedStar Medicare Choice Dual Advantage (known as DSNP) and MedStar Medicare Choice Care Advantage (known as CSNP) are Medicare Special Needs Plans (SNP) that provide medical and prescription drug benefits to eligible beneficiaries. This section includes information providers can reference when offering care to their members who are part of these special need plans.

Please note:

- MedStar recommends that providers verify member eligibility before any service is performed by visiting Provider OnLine through **www.MedStarProviderNetwork.com**.

- Providers should visit **www.MedStarProviderNetwork.com** for current information regarding benefits or other topics not addressed in this manual.

Member Cost Share

The annual Part B deductible and/or coinsurance may apply to plan services. Providers may be able to submit any unpaid balance remaining after Medicare Choice payments to the appropriate state source for consideration. Providers may not attempt to collect copayments or coinsurance from certain members enrolled in DSNP, including during the period of time in which a member has lost medical assistance coverage but is deemed “continued eligible” for the grace period of up to 120 days, depending on the type of Medicaid eligibility.

Billing member cost share is permitted for Medicare Choice (HMO), CSNP and DSNP members if they are classified as SLMB, SLMB+, QI, or QDWI. Members classified as QMB, QMB+, or FBDE will not have any cost share. Please refer to the chart below for further details. It is the provider’s responsibility to determine the status of their members to determine if they should submit an unpaid balance to Medical Assistance. Please contact Provider Services at 855-222-1042 for assistance in determining a member's Medicare Savings Program eligibility level.

Medicaid Assistance for Medicare Beneficiaries

With the assistance of Medicaid, dual eligible members do not have to pay full Medicare costs. This depends on the type of Medicaid category (aka Medicare Savings Program), the member qualifies for. The check marks below identify the Medicare costs that are covered by Medicaid assistance.

Medicare Savings Program Eligibility & Coverage

Type of Medicare Savings Program (MSP)	Medicare-Defined Monthly Part B Premium:	Medicare-Defined Part A Hospital Cost Shares:	Medicare-Defined Part B Plan Deductibles	MedStar's Part C Medical Cost Shares:	MedStar Monthly Premium:	DC/MD Medicaid Benefits
	• $134	• Hospital care • Skilled Nursing Facility Care • Hospice	• $183	• Physician services • Lab & x-ray services • DME • Outpatient services • Other	• $30.70	• Benefits vary by state
Full Benefit Dual Eligible (FBDE)	✓	✓	✓	✓	FBDEs will qualify for Extra Help.	✓
Qualified Medicare Beneficiary (QMB)	✓	✓	✓	✓	QMBs will qualify for Extra Help.	✓
Qualified Medicare Beneficiary Plus (QMB+)	✓	✓	✓	✓	QMB+ will qualify for Extra Help.	✓
Specified Low Income Medicare Beneficiary (SLMB)	✓				SLMBs will qualify for Extra Help.	
Specified Low Income Medicare Beneficiary Plus (SLMB+)	✓				SLMB+ will qualify for Extra Help.	✓
Qualifying Individual (QI)	✓				QIs will qualify for Extra Help.	
Qualified Disabled Working Individual (QDWI)					QDWIs will qualify for Extra Help.	

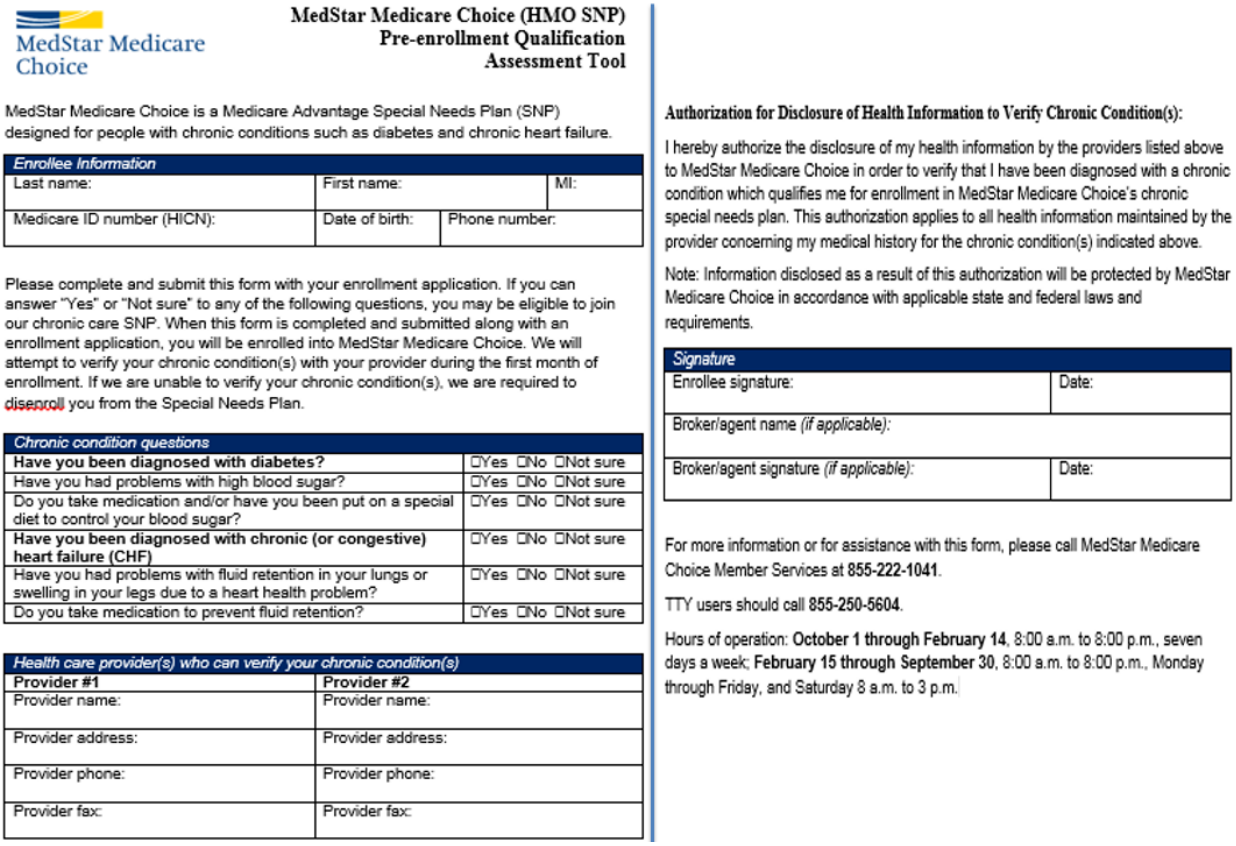
Grace Period

The grace period refers to the length of time following a member's loss of special needs status during which the plan continues to cover services under the benefit. For DSNP members, this period begins when the member loses status (e.g., through loss of Medical Assistance eligibility) and continues for a period of up to 120 days. During this time, all balance billing guidelines continue to apply. If a member does not regain his or her special needs status by the end of the grace period, he or she will be disenrolled from DSNP.

Enrollment

In order for DSNP applications to be accepted, the plan must confirm the member's eligibility at the state level for Medicare and Medicaid. A member must be fully qualified for both programs to be eligible for complete enrollment into DSNP.

In order for CSNP applications to be confirmed, the plan must confirm the member's conditions with their diagnosing provider. You may be required to complete a CSNP pre-qualification document before an application into the CSNP can be fully confirmed. A sample of this tool is included here:



MedStar Medicare Choice

MedStar Medicare Choice (HMO SNP)
Pre-enrollment Qualification Assessment Tool

MedStar Medicare Choice is a Medicare Advantage Special Needs Plan (SNP) designed for people with chronic conditions such as diabetes and chronic heart failure.

Enrollee Information		
Last name:	First name:	MI:
Medicare ID number (HICN):	Date of birth:	Phone number:

Please complete and submit this form with your enrollment application. If you can answer "Yes" or "Not sure" to any of the following questions, you may be eligible to join our chronic care SNP. When this form is completed and submitted along with an enrollment application, you will be enrolled into MedStar Medicare Choice. We will attempt to verify your chronic condition(s) with your provider during the first month of enrollment. If we are unable to verify your chronic condition(s), we are required to disenroll you from the Special Needs Plan.

Chronic condition questions	
Have you been diagnosed with diabetes?	☐Yes ☐No ☐Not sure
Have you had problems with high blood sugar?	☐Yes ☐No ☐Not sure
Do you take medication and/or have you been put on a special diet to control your blood sugar?	☐Yes ☐No ☐Not sure
Have you been diagnosed with chronic (or congestive) heart failure (CHF)	☐Yes ☐No ☐Not sure
Have you had problems with fluid retention in your lungs or swelling in your legs due to a heart health problem?	☐Yes ☐No ☐Not sure
Do you take medication to prevent fluid retention?	☐Yes ☐No ☐Not sure

Health care provider(s) who can verify your chronic condition(s)	
Provider #1	**Provider #2**
Provider name:	Provider name:
Provider address:	Provider address:
Provider phone:	Provider phone:
Provider fax:	Provider fax:

Authorization for Disclosure of Health Information to Verify Chronic Condition(s):

I hereby authorize the disclosure of my health information by the providers listed above to MedStar Medicare Choice in order to verify that I have been diagnosed with a chronic condition which qualifies me for enrollment in MedStar Medicare Choice's chronic special needs plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.

Note: Information disclosed as a result of this authorization will be protected by MedStar Medicare Choice in accordance with applicable state and federal laws and requirements.

Signature	
Enrollee signature:	Date:
Broker/agent name *(if applicable)*:	
Broker/agent signature *(if applicable)*:	Date:

For more information or for assistance with this form, please call MedStar Medicare Choice Member Services at **855-222-1041**.

TTY users should call **855-250-5604**.

Hours of operation: **October 1 through February 14**, 8:00 a.m. to 8:00 p.m., seven days a week; **February 15 through September 30**, 8:00 a.m. to 8:00 p.m., Monday through Friday, and Saturday 8 a.m. to 3 p.m.

Important Reminders about Enrollment

- A PCP is mandatory.
- According to CMS, each member enrolled in a SNP must complete a health risk assessment. This will be used to create a care plan with the member and your input. The Care Advisor will provide you with a copy of the care plan and updates made based on changes in the member's health status. The care plan may be used as a tool as you deliver care to your member.
- Each SNP member will have an identified Interdisciplinary Care Team (ICT). This will be, at a minimum, the member and their designated representative (as indicated), the PCP and the RN Care Advisor. Other participants in a member's ICT may include, but is not limited to, a social worker, a community health worker, specialty providers and a pharmacist. Each member's ICT is individualized based on the member's identified needs/issues that directly impact the member's ability to manage their health.
- High-risk SNP members will be presented by the Care Advisor at quarterly interdisciplinary care team meetings. You and your member that is high-risk will be asked by the Care Advisor to join.
- All medical providers who care for SNP members are required by CMS to participate in an annual SNP Model of Care (MOC) training provided by the health plan.
- Network providers and facilities must be used.
- Certain routine preventive care services are covered. A list of preventive services can be found in the Preventive Services section of this manual.
- Emergent care by any provider is covered if the member believes that his or her health is in serious danger.

- Urgent care is covered if the member believes that, if left untreated, his or her condition could rapidly become a medical emergency. Out-of-area urgent care is covered without prior authorization. Urgent care received within the service area must be performed by a network provider.
- Out-of-area dialysis does not require prior authorization.
- Inpatient hospital care requires an authorization before admission, except in an emergency.
- Inpatient mental healthcare may require a deductible even if services are performed in a network hospital. Members have a lifetime limit of 190 days in a freestanding psychiatric hospital.
- Outpatient mental health and substance abuse services are a covered benefit.
- Office visits to physicians, specialists, nurse practitioners, physician assistants, chiropractors, podiatrists or other participating healthcare professionals are covered.
- Outpatient rehabilitation therapy includes physical therapy, speech and language therapy, occupational therapy and cardiac/pulmonary therapy.
- Medicare-covered outpatient surgical procedures performed at an ambulatory surgical center, an outpatient hospital facility or the physician's office are covered.
- Certain podiatry services, such as treatment of injuries and diseases of the feet (e.g., hammertoe or heel spurs) are covered.
- Members receive comprehensive dental benefits, which include fillings and simple tooth extractions.

Covered Benefits and Services

Medicare Choice offers two types of SNPs—DSNP, a dual eligible special needs plan designed for members who are entitled to both Medicare and Medicaid benefits, and CSNP, a chronic condition special needs plan that is available to anyone with Medicare who has also been diagnosed with chronic heart failure and/or diabetes. Both of these special needs plans allow members to receive all the benefits offered by Original Medicare, as well as additional benefits. Plan members must use providers that participate in the MedStar Medicare Choice network. Some benefits and services require authorization.

For services and procedures that are NOT covered under the SNP benefit, a provider can bill his/her member directly only after that member is informed of the following information prior to receiving the service:

- Nature of the service
- That the service is not covered by either the Medicare Choice SNP or Medical Assistance
- That the Medicare Choice SNP will not pay for the service
- Estimated service cost

MedStar Medicare Choice has a process in place for members to request a pre-service/advance organizational determination to confirm if specific services are covered. Prior to rendering services, providers are expected to direct members to request a pre-service organizational determination when he/she believes the item or service may not be covered. A provider is also permitted to request the pre-service organizational determination on behalf of the member. Pre-service organizational determinations should be directed to the Medical Management Department at 855-242-4875. For services denied as non-covered, after the Organizational Determination is denied and the Notice of Intend to Deny is issued to the member the provider may bill the member for the service.

Note that use of the ABN is restricted to beneficiaries enrolled in Original Medicare and is not appropriate for members enrolled in a Medicare Advantage Program (MA) or for prescription drugs covered under the Medicare Prescription Drug Program (Part D.)

.

Providers should refer to **www.MedStarMedicareChoice.com** for detailed information about the member's specific benefits and possible service limitations.

Frequently Used Ancillary Services and Supplemental Benefits

Call Medical Management at **855-242-4875** for assistance with coordinating complex ancillary services for your SNP members. Ancillary services may include

- Chiropractic care
- Diagnostic services (e.g., lab, X-ray), including special diagnostics
- Home health care (including skilled/intermittent nursing; physical, speech, and occupational therapy; medical social services; home health aides and registered dietitian services)
- Home infusion therapy

- Durable medical equipment (DME), including custom wheelchairs and rehabilitation equipment
- Hospice care
- Laboratory services
- Non-emergency ambulance
- Nursing care at a licensed skilled nursing facility
- Orthotics and prosthetics
- Respiratory equipment, including oxygen therapy

Chiropractic Services
Manual manipulation of the spine to correct subluxation, which is the chiropractic coverage offered by Original Medicare, is available to all SNP members. These chiropractic services do not have to be coordinated by a member's PCP, but they must be performed by network providers. Coinsurance applies for Medicare-covered benefits.

Dental Services
MedStar Medicare Choice's routine dental benefit vendor is Avesis.

SNP members have coverage for preventive dental services (such as routine oral exams, cleanings, and X-rays) that are not covered by Original Medicare. These include
- One routine oral exam and cleaning every six months
- One dental X-ray and fluoride treatment per year

For CSNP members, a copay applies for these routine and preventative services. In addition, DSNP members receive a $1,000 benefit allowance for supplemental comprehensive dental benefits that include more complex non-routine dental procedures such as fillings, simple tooth extractions, root canals and periodontal scaling.

Providers should contact Avesis at **844-478-0511** for specific benefit information.

Non-Routine Dental Services
Coverage is provided via MedStar Medicare Choice SNPs (not by Avesis) for Medicare-covered non-routine dental procedures along with emergency coverage for accidents or injury to natural teeth.

For questions about non-routine dental services, providers may call Provider Services at **855-222-1042.** Members may call Member Services directly at **855-222-1041.**

Diagnostic Services
Diagnostic services include X-rays, laboratory services, tests, and diagnostic and therapeutic radiology services. All DSNP and CSNP members require prior authorization for select outpatient diagnostic tests and therapeutic services.

Please note:
- Providers should use the radiology decision support tool prior to prescribing high-technology imaging services
- The preferred provider for laboratory and diagnostic procedures is MedStar Labs. Members may also use Quest Diagnostics and LabCorp.

Emergency Department Care
All DSNP and CSNP members have a copay for emergency department care. The emergency copay is waived if the member is admitted to a hospital within one day for the same condition.

Exceptions:

- The emergency copayment is NOT waived if the member is admitted to the hospital under the worldwide coverage benefit
- CSNP members have an $80 emergency room copay
- DSNP members have a copay between 0% or 20% of the cost per item. The coinsurance amount is based on the member's Medicaid level determined by the state.

Members should notify their PCPs within 24 hours or as soon as reasonably possible after receiving the emergency service.

For true emergencies, out-of-network care, including ambulance transport, is covered.

Please note, the hospital or facility is expected to contact Medical Management at **855-242-4875** within 48 hours or on the next business day after the emergency admission.

Hearing Services
Coverage is provided for Medicare-covered diagnostic hearing exams. Routine hearing exams and hearing aids are not covered for CSNP and DSNP members.

Hospice Care
Coverage for hospice services is provided under Original Medicare when the member elects hospice benefits. The member must have a terminal condition with a six-month or less life expectancy and must waive his or her rights to Part B services for the terminal condition. The designated hospice provider is responsible for the medical treatment for the terminal condition, including pain medications. Services for any other medical conditions, including other prescriptions, are covered by CSNP and DSNP.

Inpatient Hospital Care
Inpatient hospital care requires authorization before admission, except in an emergency. Providers should call Medical Management at **855-242-4875** for authorization. For emergency admission, providers must also call Medical Management within 48 hours or on the next business day to authorize admissions.

CSNP and DSNP members have 90 days of inpatient coverage per benefit period plus an additional one-time use of 60 lifetime reserve (LTR) days. The applicable Part A deductible applies to the initial confinement in a benefit period.

A benefit period begins the day your CSNP and DSNP member is admitted to a hospital or skilled nursing facility and ends when the member has been discharged for at least 60 consecutive days. If the member is admitted to a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of

benefit periods a CSNP or DSNP member can have.

Medical Nutrition Therapy (MNT)
MNT is covered for CSNP and DSNP members who are diagnosed with diabetes or renal disease (but not on dialysis) or who have received a kidney transplant within the last three years. Services must be provided by a registered dietitian or nutrition professional. For the first year, the available benefit is three hours of one-on-one counseling. In subsequent years, the available benefit is two hours of one-on-one counseling.

CSNP and DSNP members have additional MNT benefits available if diagnosed with cancer, Alzheimer's disease, stroke or multiple sclerosis.

Mental Health and Substance Abuse Benefits
For mental health and substance abuse services for Medicare Choice SNP members, providers should contact Medical Management at **855-242-4875.**

Orthotics and Prosthetics
A network podiatrist may supply orthotics or prosthetics to their CSNP and DSNP members only if the podiatrist is also contracted as a home medical equipment (HME) provider. If a provider who is not contracted as an HME provider supplies these products, CSNP and DSNP will NOT reimburse the items, leaving the member responsible for any charges.

Podiatry Services
SNP members have coverage for the diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).

Preventive Services
SNP's offer members the following preventive services. Providers are encouraged to recommend these services to members as appropriate and to follow up with the results.

- Abdominal aortic aneurysm screening (one per lifetime; need referral)
- Annual wellness visit (personalized prevention plans services)
- Bone mass measurement
- Breast cancer screening (mammogram; including clinical breast exam)
- Cardiovascular, diabetic and obesity screening tests and behavioral therapy
- Cervical and vaginal cancer screening (Pap test and pelvic exam)
- Colorectal screening exam (screening sigmoidoscopy or colonoscopy) every five years
- Diabetic retinal eye exam
- Glaucoma screening exam (for those at risk)
- Influenza vaccine
- Hepatitis B vaccine
- HIV screening
- Intensive behavioral counseling for cardiovascular disease
- Mental health and substance abuse screening
- Pneumococcal vaccine
- Prostate cancer screening (Prostate Specific Antigen (PSA) test only– not the exam)
- Screening and behavioral counseling interventions in primary care to reduce alcohol

misuse
- Screening for depression in adults
- Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Welcome to Medicare preventive visit (initial preventive physical exam)

HIV screening is covered for members with Medicare who are pregnant and members at increased risk for the infection, including anyone who asks for the test. Medicare covers one screening exam once every 12 months or up to three times during a pregnancy.

Skilled Nursing Facility
A three-day hospital stay is not required prior to admission into a skilled nursing facility (SNF) for SNP members. This permits a member to be admitted to an SNF directly from the emergency department, home or a brief inpatient stay, as long as the care is medically appropriate.

To obtain prior authorization for skilled nursing facility admissions, providers must call Medical Management at **855-242-4875,** Monday through Friday, 8 a.m. to 5 p.m. Care in a network skilled nursing facility has a benefit period of up to 100 days, which is calculated by Original Medicare methodology.

Providers can verify benefits for specific members at **www.medstarprovidernetwork.com.**

A benefit period begins the day the SNP member is admitted to a skilled nursing facility and ends when the member has been discharged for at least 60 consecutive days. If the member is admitted to a skilled facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods a member may have.

Urgent Care
Urgent care is defined as any illness, injury or severe condition that, under reasonable standards of medical practice, would be diagnosed and treated within a 24-hour period and, if left untreated, could rapidly become an emergency medical condition. SNP members must go to a participating urgent care center if they are in the service area when services are needed. The copay for an urgent care visit is NOT waived if the member gets admitted to a hospital. Also, when the member is outside of the plan's service area he/she may use any urgent care clinic within the United States.

Routine Vision Services
Avesis provides routine vision services, including exams and eyewear (glasses or contacts).

MedStar Medicare Choice SNPs includes coverage for one routine eye exam once every year. Eyewear (one pair of glasses, frames and lenses or contact lenses) is covered every year up to an annual benefit limit. All SNPs offer a $100 allowance per year.

For additional information, contact Avesis at **844-478-0511** for information specific to the member's plan benefits. Plan members are eligible to receive Medicare-covered eye exams

and eyewear.

Non-Routine Vision Services

For information on balance billing for non-routine vision services, see the balance billing section of the provider manual.

Care for diagnosis and treatment of eye diseases and conditions, including eyewear following cataract surgery, is provided through the medical benefits for MedStar Medicare Choice SNP members.

Prescription Drug Coverage

All SNP members have coverage through Medicare Part D along with limited drug coverage as required by Medicare through Medicare Part B.

CSNP members must have a diagnosis of diabetes mellitus and/or chronic heart failure. The CSNP includes a preferred diabetic drug tier, which contains the majority of drugs for diabetes at a discounted monthly copayment during the initial coverage phase. CSNP members also benefit from $0 diabetic testing supplies, including preferred brand glucometers, test strips and lancets.

DSNP members qualify for the Low Income Subsidy (LIS) prescription drug program. LIS copayments for full dual eligible members are based on income level and whether the drug is classified as a brand or generic product. Plan members who have LIS and are on maintenance medications are eligible to receive a 90-day supply of their drugs for the same copayment as a 30-day supply. Members must use a participating retail or mail order pharmacy and have a prescription from their prescriber written for a 90-day supply.

The SNP's formulary provides a listing of covered drugs. To view the SNP's outpatient prescription drug benefits and LIS copayment information, visit: **www.medstarprovidernetwork.com.**

Services Not Covered

The following services and procedures are not covered under Original Medicare or by the SNPs:

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by the plan as covered services
- Experimental medical and surgical procedures, equipment and medications unless covered by Original Medicare or under a Medicare-approved clinical research study
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare
- Private room in a hospital, except when it is considered medically necessary
- Private duty nurses
- Personal items in a member's room at a hospital or skilled nursing facility, such as a telephone or a television
- Full-time nursing care in a member's home
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services
- Homemaker services, including basic household assistance and light housekeeping or light meal preparation
- Fees charged by a member's immediate relatives or household members
- Meals delivered to a member's home
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- Cosmetic surgery or procedures, unless due to an accidental injury or to improve a malformed part of the body. ***Please note, SNP covers reconstructive surgery following a mastectomy. The plans provides coverage for***
  - Reconstruction of the breast on which the mastectomy was performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses and treatment of physical complications at all stages of a mastectomy, including lymphedemas
  - Coverage for inpatient care following a mastectomy for the length of stay determined by the attending physician
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines
- Routine foot care, except for the limited coverage provided according to Medicare guidelines
- Orthopedic shoes unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a member with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for members with diabetic foot disease
- Routine hearing exams, hearing aids or exams to fit hearing aids
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids
  - However, eyeglasses are covered for members after cataract surgery.
- Reversal of sterilization procedures, sex change operations and non-prescription

contraceptive supplies
- Acupuncture
- Naturopath services (uses natural or alternative treatments)
- Services provided to veterans in Veterans Affairs (VA) facilities
  - However, when emergency services are received at a VA hospital and the VA cost sharing is more than the cost sharing under the SNP, the plan will reimburse veterans for the difference. Members are still responsible for cost-sharing amounts.

The plan will not cover the excluded services listed above. Even if the member receives the services at an emergency facility, the excluded services are still not covered.

Appeals and Grievances

Appeals

All SNP members have the right to appeal any decision regarding payment or any failure to approve, furnish, arrange for or continue what the member believes are covered services.

Member also may appeal any denial of payment for services that they believe SNPs are required to pay (including non-Medicare-covered benefits). Members may file an appeal or have someone else file the appeal for them.

For more information, refer to the Provider Disputes section located within Provider Standards and Procedures of the Provider Manual or contact Member Services for specific questions.

SNP's Model of Care (MOC)

Medicare Choice is committed to offering a Model of Care (MOC) that meets the unique needs of both DSNP and CSNP members. SNP members face chronic and often co-occurring physical and behavioral health conditions. These members also face complex psychosocial issues (poverty, homelessness, addiction and lack of resources) that impact their ability to effectively manage their care. Through the integration of physical, behavioral, social, medical and community resources, the SNP MOC aims to address barriers that impact the members' ability to self-manage care and coordinate Care Advising needs.

By developing and implementing a unique SNP MOC, members can experience improved health outcomes, access to essential services, coordination and seamless transitions of care, appropriate utilization of services and satisfaction.

The Centers for Medicare & Medicaid Services (CMS) requires that all contracted providers receive an annual training about the SNP MOC to better establish components, methods and management programs of care as envisioned by MedStar's SNPs.
The following information:

- Describes the basic components of the MOC
- Explains how Medicare Choice's Care Advising programs work (and how contracted providers can work with these programs)
- Further describes the essential role of providers in delivering the MOC

Description of MedStar's Special Needs Programs

As was mentioned previously, MedStar offers two SNPs, a Chronic Condition Special Needs program (CSNP) and a Dual Eligible Special Needs program (DSNP).

Our CSNP MOC has been designed to address the unique needs of people eligible for Medicare who also have diabetes or CHF, and our DSNP MOC has been designed to address the unique needs of people eligible for Medicare and Medicaid – both plans encapsulate medical, pharmacy and behavioral health. Our goal is to coordinate Care Advising needs with an emphasis on the coordination of benefits and services for our members, while providing the right care, at the right time and in the right place.

Both of our models focus on chronic conditions and socio-economic factors that may impact a member's ability to access quality care. We have drawn upon the experience of our partners and evidence-based medicine protocols to develop a comprehensive approach to delivering individualized care and support. We will achieve our goals by managing our population with a comprehensive care team led by our primary care physicians and supported by our Care Advising staff and a sophisticated technology platform, Identifi. An interdisciplinary care team (ICT), including the PCP, the member or their designated representative, the Care Advisor and other disciplines appropriate to meet the member's unique needs, help to develop the member's individualized care plans and uses this tool to monitor gaps in care and to track activities and progress.

Model of Care Elements

Description of the CSNP-Specific Target Population

CSNP's mission is to serve special needs individuals with specific severe or disabling chronic conditions with restricted enrollment for members with congestive heart failure (CHF) and/or diabetes. The program's focus is monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. The program uses a holistic, integrated model to ensure members receive timely access to quality care in a setting most appropriate for their needs.

To determine eligibility for a special needs individual to enroll in CSNP, CMS requires that the CSNP plan contact the applicant's existing provider or provider's office to verify the enrollee has the targeted condition. The plan may request reverification of a beneficiary's eligibility based on the member diagnosis of either CHF and/or diabetes.

Approximately two-thirds of Medicare beneficiaries have multiple chronic conditions requiring coordination of care among primary providers, medical and mental health specialists, inpatient and outpatient facilities and extensive ancillary services related to diagnostic testing and therapeutic management. CSNPs are designed to narrowly target enrollment to Medicare beneficiaries who have severe or disabling chronic conditions.

Individuals who enroll in a SNP have a variety of chronic illnesses and psychosocial needs. In addition to the diabetes and CHF diagnoses, we anticipate that CSNP members may have many co-existing chronic conditions such as asthma, chronic obstructive pulmonary disease, coronary artery disease, depression, and serious mental illness. Psychosocial issues include poverty, homelessness, family dysfunction, addiction and lack of resources. This makes the integration of behavioral health and physical health issues imperative in dealing with our population. On at least an annual basis, during the MOC review, the clinical leadership team will review MedStar demographic information for the SNP membership to determine if there have been changes in the population that warrant new or enhanced clinical programs.

Based on the experience, we anticipate these conditions to be common among our membership:

- **Hypertension** is high blood pressure and leads to an increased risk of heart attack and stroke
- **Diabetes** is a group of metabolic diseases in which a person has high blood sugar, either because the pancreas does not produce enough insulin or because cells do not respond to the insulin that is produced
- **COPD** or chronic obstructive pulmonary disease is a long-term lung disease that refers to both chronic bronchitis and emphysema
- **CAD** or coronary artery disease is when atherosclerosis happens in the coronary arteries
- **Depression** is a mental illness and can have a negative effect on a person's thoughts, behavior, feelings, world view and physical well-being
- **Asthma** is a common chronic inflammatory disease of the airways characterized by variable and recurring symptoms, reversible airflow obstruction and bronchospasm
- **SMI** or serious mental illness includes all mental illnesses that greatly impair one's ability to function in daily life

Congestive heart failure (CHF) is the leading cause of hospitalization for people over the age of 65.

Our MOC incorporates the following services to specifically address these needs:

- Medical services
- Behavioral health
- Pharmacy
- Social services
- Preventive services
- Community resources

The MOC includes programs for members living with diabetes or CHF, as well as each of the additional six chronic illnesses listed above. Understanding the unique needs of this population guided the design of clinical programs and the development of the infrastructure and staffing needed to manage the care coordination needs of our members. This led to the development of an integrated, interdisciplinary Care Advising model as part of the MOC.

The ICT for CSNP will include, at a minimum, the member and any applicable caregiver, the PCP and the RN Care Advisors. Other ICT participants may include a behavioral health clinician, social worker, pharmacist, nutritionist, diabetic educator, community health worker, a medical director and other specialties, as needed, depending on the unique needs of the individual. The care coordination and education for members will be administered using a holistic management philosophy. The member is the center of the ICT with the PCP managing the care and the ICT assisting the member and the PCP in carrying out the plan of care. A Care Advisor may function as the primary point person for assisting the PCP in coordinating the member's care across an individual's entire spectrum of needs. If the member does not have a well-established medical home, the primary Care Advisor will assist the member in finding a medical home that meets their needs.

Model of Care Elements

Description of the DSNP-Specific Target Population

Medicare Choice offers a DSNP for dual eligible members. Our plans accept all subsidy levels of Medicaid in Maryland and Washington, DC.

Type of Dual Eligible Individual

Eligible enrollees include individuals within the following categories:

- **QMB:** Medicaid pays for Part A and Part B premiums for an individual entitled under the State Medicaid Plan. Such individuals have income levels that are less than or equal to 100 percent of the Federal Poverty Line.
  - Eligible for enrollment in both Washington, DC and Maryland
- **QMB-plus**: An individual who meets all of the standards for QMB eligibility as described above but who also meets the financial criteria for full Medicaid coverage. Such individuals are entitled to all benefits available to a QMB under the state plan and are also eligible for full Medicaid benefits by meeting the Medically Needy standards or by spending down excess income.
  - Eligible for enrollment in both Washington, DC, and Maryland
- **Full Benefit Dual Eligible (FBDE)**: An individual who is eligible for full Medicaid benefits, either categorically or through optional coverage groups such as the medically

needy, special income levels for the institutionalized or home and community-based waivers. However, they are only eligible if they do not meet the income levels of QMB or SLMB-plus.
    - Eligible for enrollment in both Washington, DC, and Maryland
- **SLMB:** Medicaid pays for Part B premiums for individuals that have income levels greater than 100 percent of the Federal Poverty Line but less than 120 percent of the Federal Poverty Line
    - Eligible for enrollment in both Washington, DC and Maryland
- **SLMB-plus**: Individuals meet the financial criteria for full Medicaid coverage of benefits. Medicaid will also pay for Part B premiums for individuals entitled to the State Medicaid Plan.
    - Eligible for enrollment in Maryland
- **QDWI**: An individual is eligible as a qualified disabled and working individual when their income level is less than or equal to 200 percent of the Federal Poverty Line and Part A benefits are lost due to the individual's return to work. However, the individual is eligible to enroll in and purchase Part A coverage where Medicaid will then pay for Part A premiums.
    - Eligible for enrollment in both Washington, DC, and Maryland

Population Details
Individuals with Medicare and Medicaid who enroll in DSNP have a variety of chronic illnesses and psychosocial needs including co-existing chronic conditions such as asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, heart failure, depression and serious mental illness. Psychosocial issues include poverty, homelessness, family dysfunction, addiction and lack of resources. This makes the integration of behavioral health and physical health issues imperative in dealing with our population. On at least an annual basis, during the MOC review, the clinical leadership team will review MedStar demographic information for the SNP membership to determine if there have been changes in the population that warrant new or enhanced clinical programs.

Based on our experience, we anticipate these conditions to be common among our membership:
- **Hypertension** is high blood pressure and leads to an increased risk of heart attack and stroke.
- **Diabetes** is a group of metabolic diseases in which a person has high blood sugar either because the pancreas does not produce enough insulin or because cells do not respond to the insulin that is produced.
- **COPD** or chronic obstructive pulmonary disease is a long-term lung disease that refers to both chronic bronchitis and emphysema.
- **CAD** or coronary artery disease is when atherosclerosis happens in the coronary arteries.
- **Depression** is a mental illness and can have a negative effect on a person's thoughts, behavior, feelings, worldview and physical well-being.
- **Asthma** is a common chronic inflammatory disease of the airways characterized by variable and recurring symptoms, reversible airflow obstruction and bronchospasm.
- **SMI** or serious mental illness includes all mental illnesses that greatly impair one's ability to function in daily life.
- **CHF** or congestive heart failure is the leading cause of hospitalization for people over

the age of 65.

Our programs target individuals with the health conditions listed. We know that the vast majority of admissions may include psychosocial and behavioral health needs and have developed an integrated model to serve these needs. Our MOC incorporates the following services to specifically address these needs:

- Medical services
- Behavioral health
- Pharmacy
- Social services
- Preventive services
- Community resources

The MOC includes programs for members living with each of the eight chronic illnesses listed above. Understanding the unique needs of this population guided DSNP in designing the clinical programs and developing the infrastructure and staffing needed to manage the care coordination needs of our members. This led to developing an integrated, interdisciplinary Care Advising model as part of the MOC.

Staff Structure and Roles

Medicare Choice employs a matrix approach to the MOC structure and utilizes staff and providers across the organization to ensure the best possible support for members enrolled in these products. This includes staff and functions from Care Advising (including Utilization Management and Care Advising), Pharmacy, Quality, Enrollment, SNP Operations, Member Services, Claims Operations, Medicare and SNP Compliance, SNP Finance and Appeals and Grievances. Clinical staff coordinate care for members with multiple providers and educate members about health management, including making adjustments in lifestyle and promoting self-management techniques. Senior medical directors and health plan administrators provide clinical and administrative leadership oversight to verify licensure and staff competency, review encounter data for appropriateness and timeliness of services, assure provider use of clinical practice guidelines and ensure implementation of standards of care.

Interdisciplinary Care Team

The interdisciplinary care team (ICT) includes at a minimum, the member and any applicable caregivers, the member's PCP and an RN Care Advisor. Other healthcare providers (e.g., specialists, Registered Nurses, PharmDs, Registered Dieticians, social workers and community health workers) are included in the ICT based on the member's individual needs. The ICT is integral in bringing a multidisciplinary approach to the member's holistic care. The ICT incorporates physical, behavioral, social and functional needs in addition to assessing healthcare utilization patterns (e.g., medications, diagnostic procedures, ED visits, hospitalizations and specialist care). Through the ICT, the member is assigned to a primary Care Advisor who is responsible for working with the member and PCP and bridging gaps in communication with other participants of the member's ICT.

Provider Network

The SNP's provider network is made up of credentialed professionals from an array of clinical disciplines, including PCPs, physical and behavioral health specialists, nursing professionals, and allied health professionals (e.g., pharmacists, PTs, OTs, speech pathologists, lab specialists, and radiologists). In addition, the provider network includes

comprehensive service centers such as acute care hospitals, skilled nursing facilities, rehabilitation centers, long-term care facilities and ancillary facilities (e.g., outpatient and diagnostic service centers). This network is monitored and expanded to meet the needs of member demographics and healthcare conditions.

Model of Care Training

Initial and annual training provides information to individuals who are responsible for implementing the elements of the MOC to ensure access to essential services and to improve member health outcomes and satisfaction. Training is provided to all staff, including network providers, who are working with our special needs population. Training includes a description of members with characteristics for SNPs, as well as key elements of MOC, including staff structure, interdisciplinary care teams, provider network, health risk assessment, individualized plan of care, communication network, Care Advising programs for vulnerable subpopulations and measurement of quality outcomes. Annual training is required by CMS for providers to reinforce the MOC. Training includes information related to chronic conditions, evidence-based treatments, care of the elderly and fragile populations, end-of-life care, medication management, network services, cultural diversity, community programs, member engagement, communication skills, utilization management and product updates. Providers should contact the Provider Relations staff for a training schedule or to request an individual/group training session. SNP MOC training may be conveniently completed online and will provide 1.75 CMEs. Online completion can be accessed at **www.MedStarProviderNetwork.com**. Click on the link. SNP provider training may also be completed on paper. Upon reviewing the materials, answer the questions on the Attestation of Course Completion form and fax the completed form to **703-890-1636**. Failure to complete Model of Care training may negatively impact a provider's credentialing determination with the health plan.

Health Assessment Survey

The Health Assessment Survey (HAS) is a tool for gathering information from members on their self- perceptions of health status. A health risk assessment is required by CMS for every new SNP member and then annual completion thereafter. The tool assesses the member's physical and behavioral health status, utilization of services, caregiver and daily living supports, social needs and lifestyle risk factors. The assessment is used in developing the individualized care plan based on the member's goals, identification of gaps in preventive services and opportunities for improved self-management of chronic conditions. The Care Advisor may contact you for assistance if a member does not complete a HAS. The Care Advisor or their designee may also contact you for an updated address or contact information if they are unable to reach the member. Please encourage your members to complete the HAS and participate in the Complex Care program.

Members can complete the HAS by mail or over the phone. Care Advisors or their designees provide telephone outreach to members who do not return the survey. The HAS is one of the components used in developing the individualized care plan.

Individualized Care Plan

The individualized care plan (ICP), developed in consultation with the member and PCP, is a central MOC component that empowers the member to become involved in his or her own care. Every SNP member is required by CMS to have a care plan. The care plan is used by the interdisciplinary care team to coordinate care and to refer the member for

appropriate services including community programs. The plan is focused on holistic care and includes information from providers, caregivers and the member, as well as information from claims data, utilization management, discharge planning, pharmacy or other additional assessments**.**

Communication Network

SNP's employ a variety of structures and strategies to ensure constant communication between members, providers and ICT members. Communication among ICT members is facilitated through Identifi Care (Care Advising software) for tracking, utilization management, pharmacy management and member history. Regular in-person or telephone meetings among ICT members may be held. These meetings include a review of the ICP and any issues or barriers that are negatively impacting the member's health status. Written communication with members is prepared by the Marketing and Communications department and includes welcome kits, newsletters, a summary of benefits and an annual evidence of coverage. Healthcare concierges, clinical operations outreach representatives and health coaches interact with members by phone. Providers and practice-based Care Advisors interact with members face-to-face.

The Provider Network team facilitates provider communications. The team includes physician account executives, network managers and the manager of pharmacy provider network services. In addition to regularly scheduled office visits, information is provided through regional provider meetings, provider advisory committee meetings, telephone conferences, monthly email updates on new initiatives, a provider manual, monthly newsletters and email communication.

Care Advising for the Most Vulnerable Subpopulations

Certain subpopulation categories are more likely to have complex conditions or multifactorial issues that can be barriers to self-management. The MOC identifies these populations as vulnerable and requiring additional clinical, programmatic and community support. Populations may include members with complex conditions such as end-stage renal disease (ESRD), sickle cell disease, hemophilia or a serious mental illness (SMI); members who are institutionalized; and members who are frail elderly, disabled or near the end of life. Additional vulnerable populations may also include those who are prescribed multiple medications by multiple providers (polypharmacy), as well as those who frequently use the emergency department for non-emergent care. The MOC employs a variety of strategies for these populations.

Performance and Health Outcome Measurement

Developed by the Institute for Healthcare Improvement and supported by CMS administration, the "Triple Aim Principles" for improving health care in the United States guide evaluation on the effectiveness of an MOC. This pragmatic approach involves improving the health of the population, enhancing the member's experience of care and reducing, or at least controlling, the per capita cost of care. The MedStar Medicare Choice Special Needs Plans MOC is evaluated based on enrollment and claims data, diagnostic test results, inpatient admissions and readmissions, ED utilization, PCP and specialist utilization, lifestyle risk factors and functional status change, quality of life, health management programs, the plan of care, provider and member satisfaction (including CAHPS®) and member grievances and appeals.

SNP MOC Care Advising Programs

Complex Care Advising

The Complex Care Advising program coordinates services for members with varied clinical conditions and assists the members and their caregivers in accessing needed medical, behavioral health and community resources. These will be members who have experienced a critical event or diagnosis that requires the extensive use of resources, who require help in navigating the healthcare system and who may benefit from Care Advisors who facilitate the member's care. The goal of complex Care Advising is to assist members in improving their overall health and/or improving upon their functional capabilities through the right medical services.

Various data sources will be used to identify the member's Care Advising needs. The data sources used include the following:

- Claims or encounter data – identify members with specific diagnoses, high-cost members, and those who utilize specific services
- Hospital discharge data – identify specific diagnoses, inpatient stay services and readmission patterns
- Pharmacy data
- Data collected through the UM processes – identify members through hospital admissions, concurrent prior authorization review processes and retrospective review of ER visits
- Assessments including, but not limited to, HAS, Complex Care and Transition

All SNP members are included in the Complex Care Advising program. A member does have the ability to opt-out of the program. The PCP should encourage participation in the program for these special needs members. The program provides an additional safety net of care coordination for special needs individuals.

The Complex Care Advising program is structured to include an assessment of the member's medical, behavioral health, social, cultural, lifestyle and support needs. As these members are seeing multiple providers, possibly taking multiple drugs, and dealing with multiple chronic conditions, the primary Care Advisor will work with the member and their caregiver to identify a medical home for the member and complete a medication review. The Care Advisor coordinates care with the member's multiple providers and seeks the assistance of a pharmacist who is part of the ICT to identify any opportunities to improve the medication treatment or compliance issues. In addition, the Care Advisor supports the member and their caregivers by helping them understand their conditions and early symptoms, and how to best manage them.

Interventions include but are not limited to

- Coordination of care for multiple services including inpatient, outpatient and ancillary services
- Assistance with accessing care
- Establishing a safe and adequate support system through interactions with the member and/or applicable caregivers
- Intensive education on a member's specific diseases or conditions with continuing reinforcement of that education

Our Complex Care Advising program takes a holistic approach to managing members. The program includes engaging members and helping them to better manage their health. The program is based on evidence-based guidelines and is also designed to support the holistic management approach. In Complex Care Advising, the Care Advisor assists the member in managing all of their acute and chronic conditions, any related gaps in care and missing preventive services.

The program uses specific criteria that includes claims and pharmacy data along with laboratory values and blood pressure values, when available, to identify members who are not in clinical control, have gaps in care and have not seen their PCP or applicable specialists. Based on the aforementioned criteria, members will be stratified into three intervention levels. Members are enrolled in a SNP plan and, are contacted by a Care Advisor or another member of the ICT. Complex Care Advising stratifies members into high, moderate, and low risk. Members that are identified as high risk are contacted at least every two weeks by a Care Advisor and receive a comprehensive assessment; members that are moderate risk are contacted at least every three weeks by a Care Advisor and receive a comprehensive assessment; and members that are low risk are evaluated annually with a comprehensive assessment or health survey and receive quarterly outreach by a Care Advisor or their designee. A member's risk level can be modified based on member's response to the assessment or survey.

At least three attempts to contact the member will be made. Different channels may be used to complete outreach to a member, including but not limited to, telephonic, face to face and the provider's office. A Care Advisor or their designee may contact the PCP for assistance in reaching the member.

Pharmacy Interventions

Pharmacy provides alerts to the Care Advisor and members of the ICT to notify them of potential pharmacy-related issues. Pharmacy is an integral part of the ICT. Examples of pharmacy notification include medication compliance issues, over- and under-utilization and safety issues.

The pharmacy MTM program identifies clinical issues that may include but are not limited to gaps in care, adherence issues, drug interactions and utilization patterns. The provider is notified by fax about the potential medication issues. The fax will describe the potential issue, provide suggested interventions, include the member's recent prescription fill history and may include a reference to support the recommendation.

Information Sharing with Providers

Medicare Choice provides PCPs with written information about these programs that includes instructions on how to use the health management program and how Medicare Choice works with the PCPs and their members in the program. This information is provided to the PCPs, a critical ICT member whose members are enrolled in the program, and it is also provided for all network PCPs on Medicare Choice's website and in provider newsletters annually. If the ICT discovers member information that is of an urgent nature, a team member will contact the member's PCP.
The individualized care plan is provided to PCPs in order to assist them with clinical decision-making. The PCPs will be notified by the primary Care Advisor or their designee when their member has enrolled in the program. Updated care plans are shared with PCPs

about their individual members as updates to the care plan are made based on the member's changing healthcare needs.

Reports to these providers include feedback that identifies information about their members with chronic conditions and the rate at which those members are receiving specific services. The provider's performance on the measure is provided along with the performance of the entire network.