Special Needs Plans

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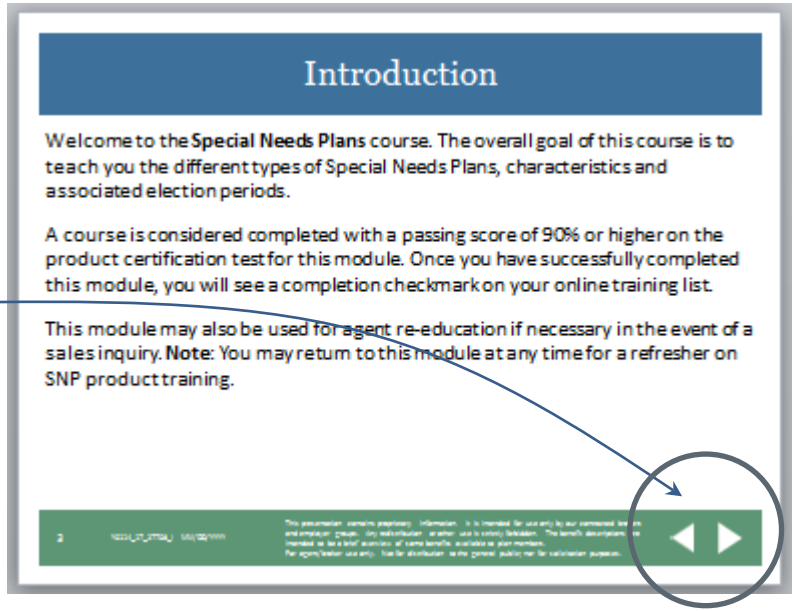


Introduction

Welcome to the **Special Needs Plans** course. The overall goal of this course is to teach you the different types of Special Needs Plans, characteristics and associated election periods.

A course is considered completed with a passing score of 90% or higher on the product certification test for this module. Once you have successfully completed this module, you will see a completion checkmark on your online training list.

This module may also be used for agent re-education if necessary in the event of a sales inquiry. **Note**: You may return to this module at any time for a refresher on SNP product training.

Learning Objectives

After completing this course, you will be able to:

- Identify the types of Special Needs Plans and their characteristics
- Explain the SNP Model of Care (MOC) and its significance in improving health outcomes
- Recognize specific enrollment and disenrollment opportunities
- Describe the difference between MMPs (Medicare Medicaid Plans) and D-SNPs (Dual Special Needs Plans)
- Recall the special requirements to enroll in a Chronic Special Needs plan and the recent changes to those requirements
- Provide examples of the types of facilities that qualify with respect to an I-SNP

Medicare Advantage Overview

The Medicare Advantage (MA) Program, sometimes called “Part C”, combines coverage for Parts A & B benefits and is administered by private health plans. Private health plans contract with the Centers for Medicare & Medicaid Services (CMS) to administer benefits on behalf of CMS.

Private plans may include HMOs, PPOs, Special Needs Plans (SNPs), and Private Fee-for-Service (PFFS) plans. Medicare pays a fixed monthly amount to the companies offering MA Plans to coordinate beneficiary care. An organization offering MA plans must offer at least one MA plan (known as an MA-PD plan) with prescription drug coverage in every service area.

This course will focus on Special Needs Plans (SNPs).

NOTE: Agents wishing to sell SNP plans must take both the SNP and Part D modules as part of their certification, as well as the HMO or PPO module, depending on the type of SNP plan available to market in their area.

What is a Special Needs Plan (SNP)?

In **2003**, Congress passed the **Medicare Modernization Act** (MMA). It enabled insurance companies to create, market and sell a different kind of Medicare Advantage plan known as a **Special Needs Plan** (SNP).

There are three types of Special Needs Plans:

1. Dual Special Needs Plans (D-SNP)
2. Chronic Special Needs Plans (C-SNP)
3. Institutional Special Needs Plans (I-SNP)

Special Needs Plans are either **HMO or PPO** plans which means that all plans, regardless of type, include a contracted network of providers. These plans are intended to provide **targeted care to individuals with special needs**. Congress identifies "special needs individuals" as (1) dual eligible (a person eligible for both Medicare and Medicaid), (2) individuals with severe or disabling chronic conditions (as specified by CMS), and (3) institutionalized beneficiaries.

Model of Care

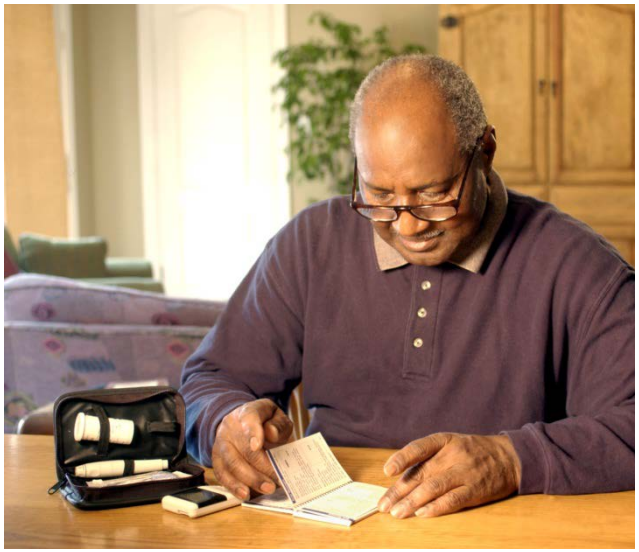
Each SNP is required to develop a **Model of Care** (MOC). The MOC has specific goals and objectives for the population it will serve.

The MOC includes:

- **Measurement**
  - Measuring performance against meeting the needs of individuals with multiple or complex conditions, including the frail and/or persons with disabilities, individuals with end-stage renal disease, or individuals who are at or near the end of life.

Model of Care (cont.)

- **Training**
  - Training for all providers, employees, and contractors to ensure a universal understanding of the model of care.
- **Staffing**
  - Maintaining a staffing structure with care management roles designed to manage SNP members.
- **Health Risk Assessments (HRAs)**
  - Assessing SNP members' physical, behavioral, psychosocial, and functional needs through HRAs. An initial HRA is performed for all new SNP members. Then each member is assessed annually.



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Model of Care (cont.)

- **Interdisciplinary Care Team (ICT)**
  - Assigning an ICT to each member, reviewing care plans, collaborating with our network providers, and providing recommendations for management of the member's care.
- **Communication**
  - Establishing a communication network between members, providers, and plan staff to support information sharing. Communication can occur via phone, mail, fax, in person, or electronically.
- **Clinical Practice Guidelines**
  - Providing use of clinical practice guidelines and current standards of care.

Model of Care (cont.)

- **Results**
  - Measuring and helping to improve performance and health outcomes by collecting, analyzing, and reporting results.
- **Evaluation**
  - Formally evaluating the effectiveness of the SNP Model of Care annually. Results of the evaluation and changes made to the SNP Model of Care are communicated to all stakeholders, including the members, providers, and internal departments.

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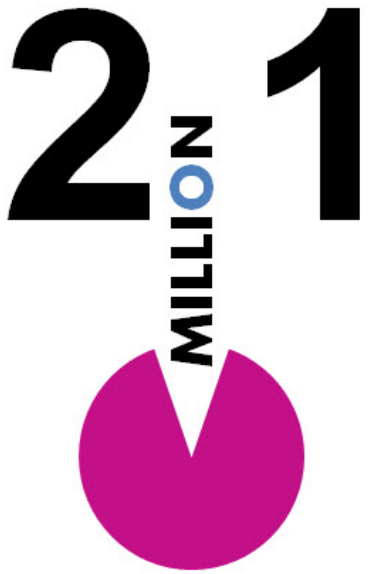
Compare and Contrast with Non-SNP

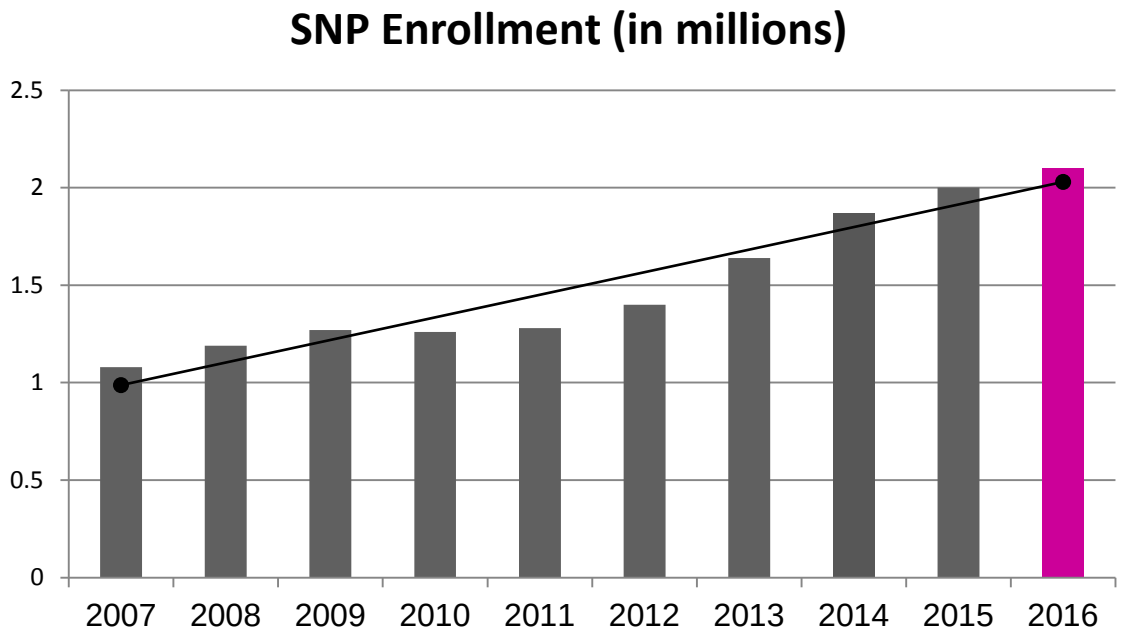
SNP	Non-SNP
• All include prescription drug coverage (Part D)	• Plans may choose to exclude Part D
• May enroll individuals with ESRD*	• Generally ESRD disqualifies an enrollee for coverage
	• Continue to exist into the foreseeable future

* In order to do so, **a SNP must obtain a waiver to be open for enrollment for individuals with ESRD**. The waiver should be part of the SNP application, and is available to all SNPs, not only C-SNPs. CMS's decision to grant an ESRD waiver is conditional upon the plan arranging access to services specifically targeted to individuals living with ESRD (e.g., nephrologists, hemodialysis centers, and renal transplant centers).

SNP Enrollment

Since 2006, the number of SNP enrollees has increased from 0.5 million to **over 2.1 million enrollees** in 2016, or about **12 percent of all MA enrollment**.





Source: http://kff.org/medicare/fact-sheet/medicare-advantage/

Dual Special Needs Plans (D-SNP)

In order to qualify to enroll in a D-SNP, beneficiaries must be entitled to both (1) Medicare, and (2) Medical Assistance from a State Plan (commonly referred to as Medicaid). You'll often hear dual eligibility referred to as "Medi-Medi"; Medicare-Medicaid.

Medicare is a federal program, whereas **Medicaid is a joint state and federal program**. Each state, to some extent, determines Medicaid eligibility criteria. The Medicaid eligibility categories, for the purposes of D-SNP eligibility, include all levels of Medicaid eligibility, including those referred to as Medicare Savings Programs.

Enrollment in SNPs for dual eligibles (D-SNP) accounts for 82% of total enrollment in all Special Needs Plans!

Dual Special Needs Plans (D-SNP)

Because D-SNPs are for people that qualify for both Medicare and Medicaid, and because we now know that SNPs are Medicare Advantage plans, you may have guessed that there are contracts between a plan and the government. In the past, a D-SNP could function without a state contract; not anymore.

In 2008, MedPAC, the Medicare Payment Advisory Commission, advised Congress to make changes to D-SNPs. “The Congress should require dual-eligible special needs plans within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits. This provision was included in MIPPA. As of 2013, all dual-eligible SNPs must have state contracts.”

Medicare Savings Programs (MSP)

With respect to Medicaid, an individual is eligible for either full or partial benefits. Dual eligibles whose benefits are limited (partial) include:

1. Qualified Medicare Beneficiary (QMB, or "quimby");
2. Specified Low-Income Medicare Beneficiaries (SLMB, or "slimby");
3. Qualifying Individuals (QI); and
4. Qualified Disabled Working Individuals (QDWI).

These four categories are referred to as Medicare Savings Programs (MSP). **If an individual qualifies for QMB, SLMB, or QI, he or she automatically qualifies to get Extra Help paying for Medicare prescription drug coverage.**

Qualification can vary by state. This program provides a Low Income Subsidy (LIS) for qualifying individuals.

For more information on Extra Help/LIS, visit www.socialsecurity.gov/prescriptionhelp.

Medicare Savings Programs (cont.)

Those eligible for full Medicaid benefits are called Full Benefit Dual Eligible (FBDE). At times, individuals may qualify for both limited coverage of Medicare cost-sharing as well as full Medicaid benefits.

Remember “Quimby” and “Slimby”? Each of those Medicare Savings Programs (MSP) has a second level of benefit coverage: QMB Plus (QMB+) and SLMB Plus (SLMB+).

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Medicare Savings Program – Eligibility

QMB+	An individual entitled to Medicare Part A, with income of 100% Federal Poverty Level (FPL) or less and resources that do not exceed the limit for MSP eligibility, and who is eligible for full Medicaid benefits.
QMB	An individual entitled to Medicare Part A, with an income of 100% FPL or less and resources that do not exceed the limit for MSP eligibility, and who is not otherwise eligible for full Medicaid benefits through the State.
SLMB+	An individual entitled to Medicare Part A, with an income that exceeds 100% FPL but less than 120% FPL, with resources that do not exceed the limit for MSP eligibility, and who also meets the criteria for full State Medicaid benefits.
SLMB	An individual entitled to Medicare Part A, with an income that exceeds 100% FPL but less than 120% FPL, with resources that do not exceed the limit for MSP eligibility, and who is not otherwise eligible for Medicaid.

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Medicare Savings Program – Eligibility

Other Full Benefit Dual Eligible (FBDE)	An individual who does not meet the income or resource criteria for QMB or SLMB, but is eligible for Medicaid either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers
QI	An individual entitled to Medicare Part A, with an income at least 120% FPL but less than 135% FPL, and resources that do not exceed the limit for MSP eligibility, and who is not otherwise eligible for Medicaid benefits.
QDWI	An individual who has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed the limit for MSP eligibility. The individual may not be otherwise eligible for Medicaid.

Medicare Savings Programs (MSP) Eligibility Overview

NOTE: Only Eligibility options in **RED** pertain to our plans. ***SLMB+ is only available in some states.***

Beneficiary Group	Income Criteria	Resource Limit Criteria	Medicare Part A Criteria	Other
FBDE	N/A	N/A	N/A	Does not meet the income or resources criteria for a QMB or SLMB
QMB+	$ ≤ 100% FPL	$7,280/Individual or $10,930/Couple	√	Eligible for full Medicaid
QMB Only	$ ≤ 100% FPL	$7,280/Individual or $10,930/Couple	√	N/A
SLMB+	100% > $ < 120% FPL	$7,280/Individual or $10,930/Couple	√	Eligible for full Medicaid
SLMB Only	100% > $ < 120% FPL	$7,280/Individual or $10,930/Couple	√	N/A
QI	120% ≥ $ < 135% FPL	$7,280/Individual or $10,930/Couple	√	N/A
QDWI	$ ≤ 200% FPL	$4,000/Individual or $6,000/Couple	Lost benefits due to returning to work, but …	N/A

Medicare Savings Program – Benefits

QMB+	Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance, and provides full Medicaid benefits to the extent consistent with the State Plan. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically Needy level. Medicaid does not pay towards the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
QMB	Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

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Medicare Savings Program – Benefits (cont.)

SLMB+	The individuals are entitled to payment of the Medicare Part B premium, in addition to full State Medicaid benefits. These individuals often qualify for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
SLMB	These individuals are eligible for Medicaid payment of the Medicare Part B premium only. They do not qualify for any additional Medicaid benefits. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Medicare Savings Program – Benefits (cont.)

QI This individual is eligible for Medicaid payment of the Medicare Part B premium. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

QDWI These individuals are eligible for Medicaid payment of the Part A premium only. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Medicare Savings Program – Benefits Grid

	QMB	QMB+	SLMB	SLMB+	QI	QDWI
Part A Premium	√	√				√
Part B Premium	√	√	√	√	√	
Deductibles & Coinsurance	√	√				
Full Medicaid Benefits		√		√		
OOP Rx Costs						

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D-SNP Types

All Dual
Full Benefit
Medicare Zero Cost Sharing
Dual Eligible Subset – Zero Cost Share
Dual Eligible Subset

Although D-SNPs are available to beneficiaries in all Medicaid eligibility categories, D-SNPs may further restrict enrollment to beneficiaries that belong to certain Medicaid eligibility categories. **CMS divides D-SNPs into the following five categories**, according to the types of beneficiaries that the SNP enrolls.

D-SNP Types (cont.)

All Dual

Full Benefit

Medicare Zero Cost Sharing

Dual Eligible Subset – Zero Cost Share

Dual Eligible Subset

An All Dual D-SNP enrolls beneficiaries who are eligible for Medicare Advantage and who are entitled to Medicaid assistance under a State/Territorial plan. An All Dual D-SNP **must enroll all categories of dual eligible individuals**, including those with comprehensive Medicaid benefits as well as those with more limited cost-sharing such as QMBs, SLMBs, and QIs.

D-SNP Types (cont.)

All Dual

Full Benefit

Medicare Zero Cost Sharing

Dual Eligible Subset – Zero Cost Share

Dual Eligible Subset

A Full Benefit D-SNP enrolls individuals who are eligible for:

1. Medical assistance for full Medicaid benefits for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under section 1115 of the Act; or
2. Medical assistance under section 1902(a)(10)(C) of the Act (Medically Needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

D-SNP Types (cont.)

All Dual

Full Benefit

Medicare Zero Cost Sharing

Dual Eligible Subset – Zero Cost Share

Dual Eligible Subset

This type of D-SNP **limits enrollment to QMBs only and QMBs with comprehensive Medicaid benefits** (QMB+)—the two categories of dual eligible beneficiaries who are not financially responsible for cost-sharing for Medicare Parts A or B. Because QMB-only individuals are not entitled to full Medicaid benefits, there may be Medicaid cost-sharing required.

D-SNP Types (cont.)

All Dual

Full Benefit

Medicare Zero Cost Sharing

Dual Eligible Subset – Zero Cost Share

Dual Eligible Subset

Dual Eligible Subset – Zero Cost Share enrolls individuals other than just QMB and QMB+ for whom the state pays Medicare cost-sharing.

D-SNP Types (cont.)

All Dual

Full Benefit

Medicare Zero Cost Sharing

Dual Eligible Subset – Zero Cost Share

Dual Eligible Subset

MA organizations that offer D-SNPs may exclude specific groups of dual eligibles based on the MA organization's coordination efforts with State Medicaid agencies. CMS reviews and approves requests for coverage of dual eligible subsets on a case-by-case basis.

To the extent a State Medicaid agency excludes specific groups of dual eligibles from their Medicaid contracts or agreements, those same groups may also be excluded from enrollment in the SNP, provided that the enrollment limitations parallel the structure and care delivery patterns of the State Medicaid program.

D-SNP Types (cont.)

All Dual
Full Benefit
Medicare Zero Cost Sharing
Dual Eligible Subset – Zero Cost Share
Dual Eligible Subset

Fully Integrated Dual Eligible (FIDE) SNPs are a CMS-approved SNPs subset that can be applied to any of the five types listed. FIDE SNPs **represent true full integration with the state** and its through the plan that a member receives all Medicaid benefits, in addition to what's offered under the plan.

Special Election Periods (SEP) – D-SNP

SEP for Dual-eligible Individuals

There is an SEP for individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program. This includes both "full benefit" dual eligible individuals as well as individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid (e.g. QMB-only, SLMB-only, etc.).

This SEP begins the month the individual becomes dually-eligible and exists as long as she or he receives Medicaid benefits. This SEP allows an individual to enroll in, or disenroll from, an MA plan. The effective date of an enrollment request made using this SEP would be the first of the month following receipt of an enrollment request. However, as described in §40.1.5, the effective date for auto-enrollments of full-benefit dual-eligible individuals may be retroactive.

Special Election Periods (SEP) – D-SNP (cont.)

Individuals Who Lose Their Dual-eligibility

In addition, MA-eligible individuals who are no longer eligible for Title XIX (Medicaid) benefits have an SEP beginning the month they receive notice of the loss of eligibility plus two additional months to make an enrollment choice in another MA plan.

You may consult chapter two of the Medicare Managed Care Manual for more enrollment periods and information.

MMP (Medicare-Medicaid Plan)

- An MMP exists as a three-way contract between CMS, the State and the Health Plan
- It includes Medicare, Medicaid, LTSS (Long-Term Services & Support) and Rx benefits in a single plan
- No cost-sharing, except LIS (Low Income Subsidy) prescription copays
- MMPs are subject to Medicare Advantage rules unless otherwise modified by the state contract
- **MMPs are not "sold"; eligible beneficiaries are enrolled (1) passively, or (2) by/through the state once qualified. They are not the same as DSNP plans.**

Differences between MMP and D-SNP

- **MMP**
  - Includes Medicaid benefits by design
  - Single billing process for providers
  - Not offered in every state
- **D-SNP**
  - Not required to include Medicaid benefits
  - Providers may have to separately bill Medicare and the State and/or Health Plan
  - Available in most states, although service areas vary by organization and plan(s)

Chronic Special Needs Plans (C-SNP)

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.

Chronic SNPs (C-SNPs) are SNPs that **restrict enrollment to special needs individuals with specific severe or disabling chronic conditions**. Congress has the power, authority and responsibility to make changes to the list of specific conditions.

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C-SNP – Conditions & Groups

There are 15 conditions currently approved for C-SNPs. The list of SNP-specific chronic conditions is not intended for purposes other than clarifying eligibility for a C-SNP. CMS will periodically re-evaluate the 15 chronic conditions as it gathers evidence on the effectiveness of care coordination through the SNP product, and as health care research demonstrates advancements in chronic condition management.

1. Diabetes mellitus
2. End-state renal disease requiring dialysis
3. Chronic alcohol and other drug dependence
4. Autoimmune disorders (Ex: Rheumatoid arthritis)
5. Cancer excluding pre-cancer conditions or in-situ status
6. Cardiovascular disorders (Ex: Coronary Artery Disease)

C-SNP – Conditions & Groups (cont.)

7. Chronic heart failure
8. Dementia
9. End-stage liver disease
10. Severe hematologic disorders (Ex: Hemophilia)
11. HIV/AIDS
12. Chronic Lung disorders (Ex: Asthma)
13. Chronic and disabling mental health conditions (Ex: Bipolar disorder)
14. Neurologic disorders (Ex: Multiple sclerosis)
15. Stroke

Eligibility & Enrollment

To determine eligibility for a special needs individual to enroll in a C-SNP, CMS requires that the C-SNP contact the applicant's existing provider or provider's office to verify the enrollee has the targeted condition.

Chapter 16b (Special Needs Plans) of the Medicare Managed Care Manual details how MA organizations can use a Pre-enrollment Qualification Assessment Tool or Alternative Verification Methodology to verify that a beneficiary is eligible to enroll in a particular C-SNP.

C-SNPs must reconfirm a beneficiary's eligibility at least annually.

Eligibility & Enrollment (cont.)

The MA organization has until the end of the first month of enrollment to confirm that the enrollee has the qualifying condition necessary for enrollment into the severe/chronic disabling condition SNP.

If the MA organization cannot confirm that the enrollee has the qualifying condition within that time, the organization has the first seven calendar days of the following month (i.e., the second month of enrollment) in which to send the beneficiary notice of disenrollment for not having the qualifying condition.

Special Election Periods (SEP) – C-SNP

SEP for Enrollment Into a Chronic Care SNP

CMS will provide a Special Election Period (for MA and Part D) for those individuals with severe or disabling chronic conditions to enroll in a SNP designed to serve individuals with those conditions.

This SEP will apply as long as the individual has the qualifying condition and will end once he or she enrolls in a SNP. Once the SEP ends, that individual may make enrollment changes only during applicable MA election periods.

Institutional Special Needs Plans (I-SNP)

I-SNPs are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in:

1. a long-term care (LTC) skilled nursing facility (SNF);
2. a LTC nursing facility (NF);
3. a SNF/NF;
4. an intermediate care facility for the mentally retarded (ICF/MR); or
5. an inpatient psychiatric facility.

I-SNPs may also enroll MA eligible individuals living in the community, but requiring an institutional level of care, known as **Institutional Equivalent SNPs** (as defined in Chapter 16b of the Medicare Managed Care Manual).

A complete list of acceptable types of institutions can be found in Chapter 2 of the Medicare Managed Care Manual.

I-SNP Service Area Requirement and Change of Residence

CMS may allow an I-SNP to establish a county-based service area as long as it has at least one LTC facility that can accept enrollment and is accessible to the county residents.

If an I-SNP enrollee changes residence, the SNP must document that it is prepared to implement a CMS-approved MOC at the enrollee's new residence in another institution, or in another setting that provides an institutional level of care, as long as the enrollee still resides within the I-SNP's service area.

Enrollment – OEPI

The Open Enrollment Period (Institutional), or OEPI, is continuous for eligible individuals. For purposes of enrollment under the OEPI election period, an institutionalized individual is defined as an individual who moves into, resides in, or moves out of an institution. **The OEPI ends two months after the month the individual moves out of the institution**.

When an I-SNP opts to enroll individuals prior to having at least 90-days of institutional level care, a CMS-approved needs-assessment must show that the individual's condition makes it likely that either the length-of-stay or the need for an institutional level-of-care will be at least 90 days.

Enrollment – OEPI (cont.)

An MA eligible institutionalized individual can make an **unlimited number of MA enrollment requests during the OEPI**. An MA organization is not required to accept requests to enroll into its plan during the OEPI, but if it is open for these enrollment requests, it must accept all OEPI requests to enroll into the plan.

Since the OEPI is continuous for eligible individuals, Original Medicare is also open continuously. Therefore, MA organizations must accept requests for disenrollment from their MA plans during the OEPI whether or not the MA plan is open to accept enrollment.

SNP Assessment

An assessment will be given to test your knowledge on the information presented. A score of 90% or above on the assessment is required to successfully pass this module.

Please click the “Certification Portal” link at the upper left portion of the screen to return to your home page to access the assessment.

After completing the assessment for this course, refer to your online training summary for your certification progress.