Optima Health
Provider Training
Special Needs Plan (SNP)
Optima Community Complete

Subject Areas

I. Background on SNP
II. D-SNP Eligibility Requirements
III. Description of Targeted Populations
IV. D-SNP Benefits
V. Care Coordination
VI. UM
VII. Performance and Health Outcomes Measurement
VIII. Marketing and Outreach Process
IX. Cultural Competency
X. Claims Processing Requirements
XI. Appeals & Grievances Policies & Procedures
XII. Provider Portal
XIII. Communication and Plan Contact Information
XIV. Member Rights and Responsibilities
XV. Comparisons Between SNP & CCC Plus Programs

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I. BACKGROUND OF SNP

Established by Medicare Modernization Act of 2003 (MMA) as a different type of Medicare Advantage (MA) plan with focus on beneficiaries with special needs requiring focused care coordination.

I. BACKGROUND OF SNP

- All SNPs must submit a Model of Care (MOC) and are required to use the MOC element structure defined in the CMS manual.
  - MOC 1: Description of SNP Population
  - MOC 2: Care Coordination
  - MOC 3: Provider Network
  - MOC 4: MOC Quality Measurement and Performance
- All MOCs are audited by CMS.

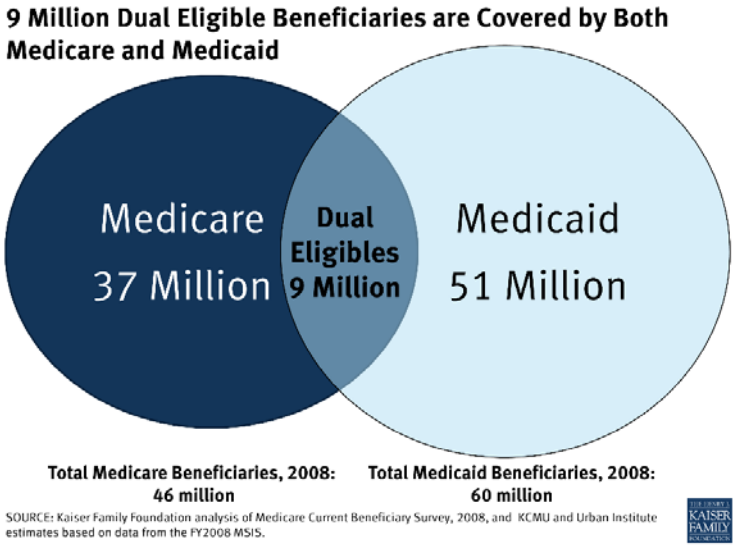
I. BACKGROUND OF SNP

- SNP Types
  - Dual Eligible Special Needs Plan (D-SNP)
    - Individuals who have both Medicare and Medicaid
  - Institutional Equivalent Special Needs Plan (IE-SNP)
    - Individuals who reside at home or an assisted living facility (ALF) but require an equivalent level of care of a long-term facility (skilled nursing facility (SNF/NF)), Intermediate Care Facility (ICF), or Inpatient Care Facility

I. BACKGROUND OF SNP

- SNP Types – continued
  - Institutional Special Needs Plan (I-SNP)
    - Individuals who reside or are expected to reside for 90 days or longer in a long-term care facility (SNF/NF), ICF, or Inpatient Care Facility
  - Chronic Condition Special Needs Plan (C-SNP)
    - Persons living with specific diseases

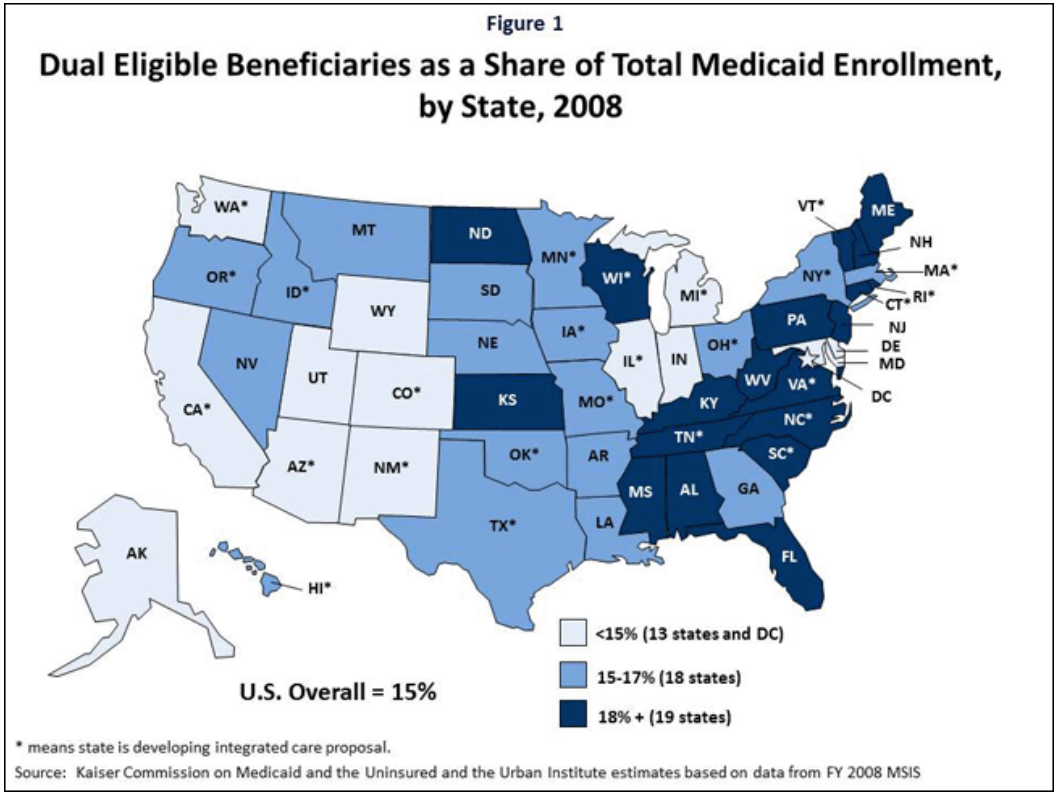
I. Background of SNP
Dual Eligibles Enrollment Numbers*



Location	Partial Dual Eligibles	Full Dual Eligibles	Total Dual Eligibles
Virginia	64,600	127,200	191,700

*https://www.kff.org/tag/dual-eligible/

I. Background of SNP Dual Eligibles Medicaid Enrollment**



**https://www.kff.org/health-reform/fact-sheet/quick-take-geographic-variation-in-dual-eligible/

I. Background of SNP
Virginians Covered by Medicaid/CHIP

1 in 8 Virginians rely on Medicaid

1 in 3 births covered in Virginia

2 in 3 nursing facility residents are supported by Medicaid

50% of Medicaid beneficiaries are children

62% of Long-Term Services & Supports spending is in the community

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II. D-SNP Eligibility Verification Process

The D-SNP is available to Medicare beneficiaries (Parts A, B and D) and one of the three designated Medicaid eligibility categories. They must live in the service area of the plan they choose.

D-SNP eligibility is verified through ongoing file data exchanges and updates.

Providers can also support members from lapsing in coverage through communications with Optima Health and the interdisciplinary care team that coordinates their care.

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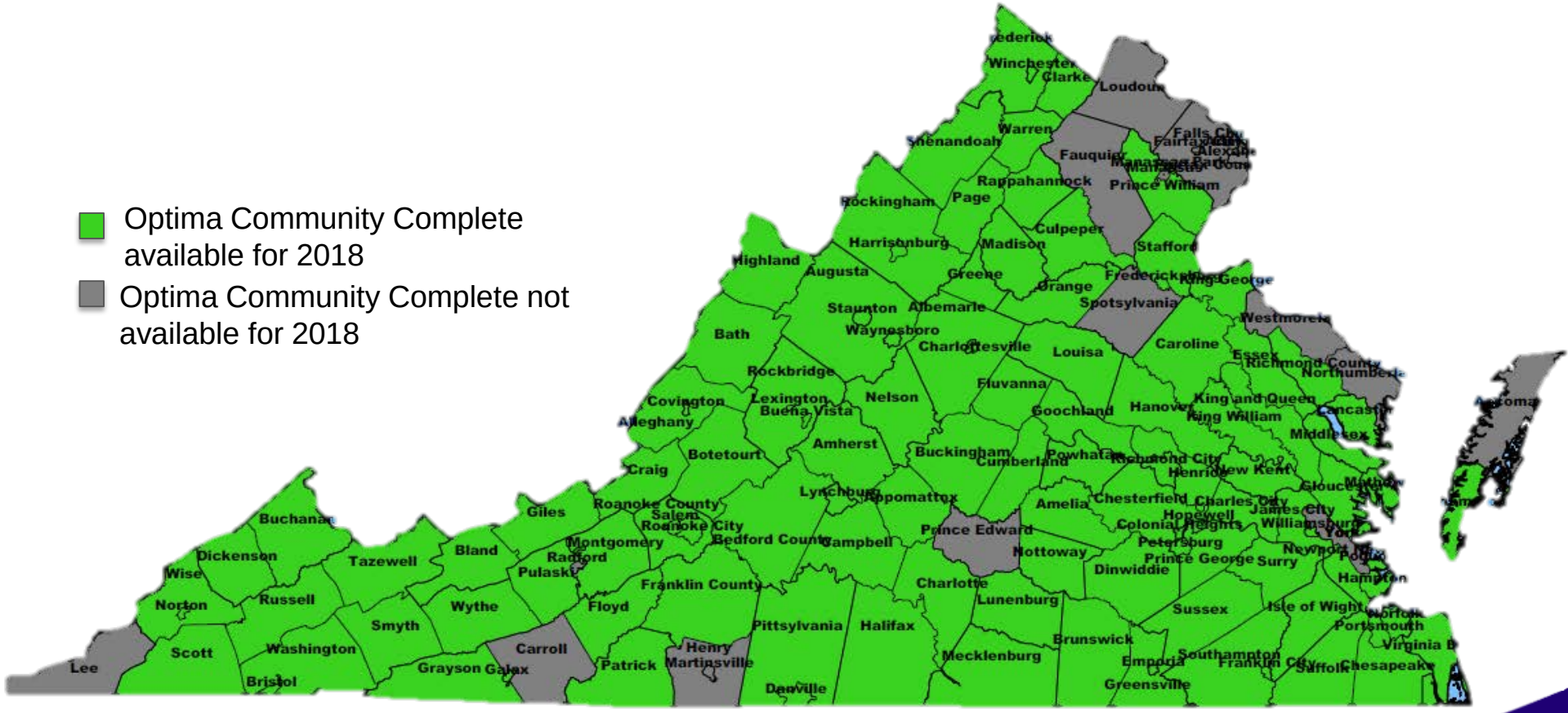
OCC Coverage Area

- Optima Community Complete available for 2018
- Optima Community Complete not available for 2018



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II. D-SNP Eligibility Requirements

It's even possible you can enroll in the same health plan for your Medicare and Medicaid benefits. This will enhance and simplify the coordination of your benefits and reduce your burden.

- If you are enrolled in a D-SNP, you will not have premiums or copays for doctor or specialist visits. You may have some copays for prescription drugs.
- D-SNPs often provide coverage for additional services not covered by Medicare or Medicaid.
- D-SNPs offer more focused care to ensure you receive the help you need to manage your health.

III. Description of Target Population

Optima Health already offers services to Medicaid members in the Managed Long-Term Services and Supports (MLTSS) program and notes some of those members are dual eligibles: 114,000, or 54%, are dual eligible.

III. Description of Target Population

Additionally there are clinical conditions noted in the dual-eligible population in Virginia that providers should be aware. The top 11 chronic conditions identified by CMS were:

- Diabetes
- Depression
- Heart Disease
- Congestive Heart Failure
- Arthritis
- Alzheimer's Disease and Dementia
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease
- Osteoporosis
- Stroke
- Cancer

III. Description of Target Population

Snapshot of the Special Needs Population

- Average age 70 and older
- 68% female
- Multiple chronic co-morbidities greater than 5
- An average of over 6 medications
- Assistance required with 2 or more activities of daily living
- Almost half have dementia
- 30% have major depressive disorders
- 15% have protein-calorie malnutrition

III. Description of Target Population

Creating an Interdisciplinary Care team (ICT) is essential to address what to expect when serving the member. **What can providers do?**

Encourage members to engage in program offerings:

- Initial and at least annual Health Risk Assessments.
- All members receive an Individual Care Plan (ICP) and are encouraged to develop and maintain the ICP. Providers review and assist in enhancing the ICP.
- Participate with the ICT. Team members include members and caretakers looking for provider support.

III. Description of Target Population

Getting a sharper picture of the populations YOU SERVE

- Optima Health annually reviews the population such as obtaining available information on membership's income, race, ethnicity, home ownership rate, language.
- This data collection, tracking, and reporting assists to address any barriers to care.
- Strategies for effectively addressing individual barriers is a collaborative engagement with providers to improve care coordination.
- Understanding the factors that motivate healthcare decision-making for your primary member groups helps improve outcomes in health.

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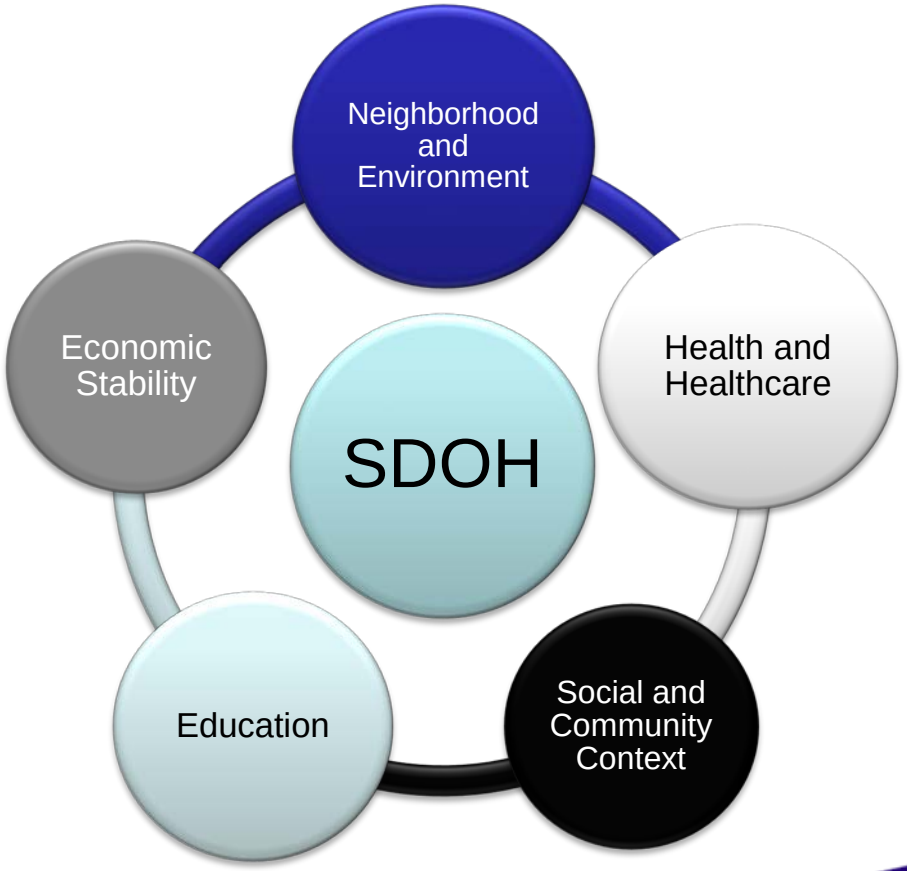
III. Description of Target Population: Social Determinants of Health (SDOH)



SOURCE: Healthy People 2020

IV. D-SNP Benefits

What services does Medicare cover, and what services does Medicaid cover?

- **Types of services under Medicare include**: Inpatient Hospital Care (Medical and Psychiatric), Outpatient Care (Medical and Psychiatric), Physician and Specialists Services, SNF Care, Home Health Care, Hospice Care, Prescription Drugs, Durable Medical Equipment, etc.
- **Types of services under Medicaid (CCC Plus) include:** Medicare copayments, hospital and skilled nursing when Medicare benefits are exhausted, long-term nursing facility care (custodial), community-based long-term services and supports, Medicare non-covered services such as some over-the-counter medicines, incontinence products, etc.

V. Care Coordination

Role of Care Coordinator

Health Risk Assessments

Individualized Care Plan

Interdisciplinary Care Team

Person-centered Approach

V. Care Coordination
Role of Care Coordinator

- **Care coordination** involves deliberately organizing member care activities and sharing information among the **ICT to achieve safer and more effective patient-centered care.**
- This requires effective communication between **providers, members, and caregivers** using an interoperable infrastructure to enable the transfer of clinical information between care providers.

V. Care Coordination
Role of Care Coordinator

Specific activities include the following mandated services:

- Conducting health risk assessments
- Leading ICT review of proposed care needs
- Developing an ICP
- Planning and initiation of services identified by ICP
- Monitoring of services and member's condition
- Reassessment and ICP review

V. Care Coordination
Role of Care Coordinator

The role includes areas to support the providers in caring for their members, and they look to collaborate in areas such as:

- Plan of Care feedback and consensus
- Clinical coordination for the member
- Participation in ICT
- Responsive and cooperative with Optima Health staff
- Referring member to medically necessary services
- Communication with the member's family or legal representative
- Timely submission of documentation
- Obtaining informed consent from member or legal representative
- Access and use of our evidence-based Clinical Practice Guidelines

V. Care Coordination
Health Risk Assessments

If a change in health status occurs, the member's data is updated as available.

If your members experience a significant change in health, you can reach Optima Health to ensure timely information results are reflected in an enhanced ICP and access to care coordination services.

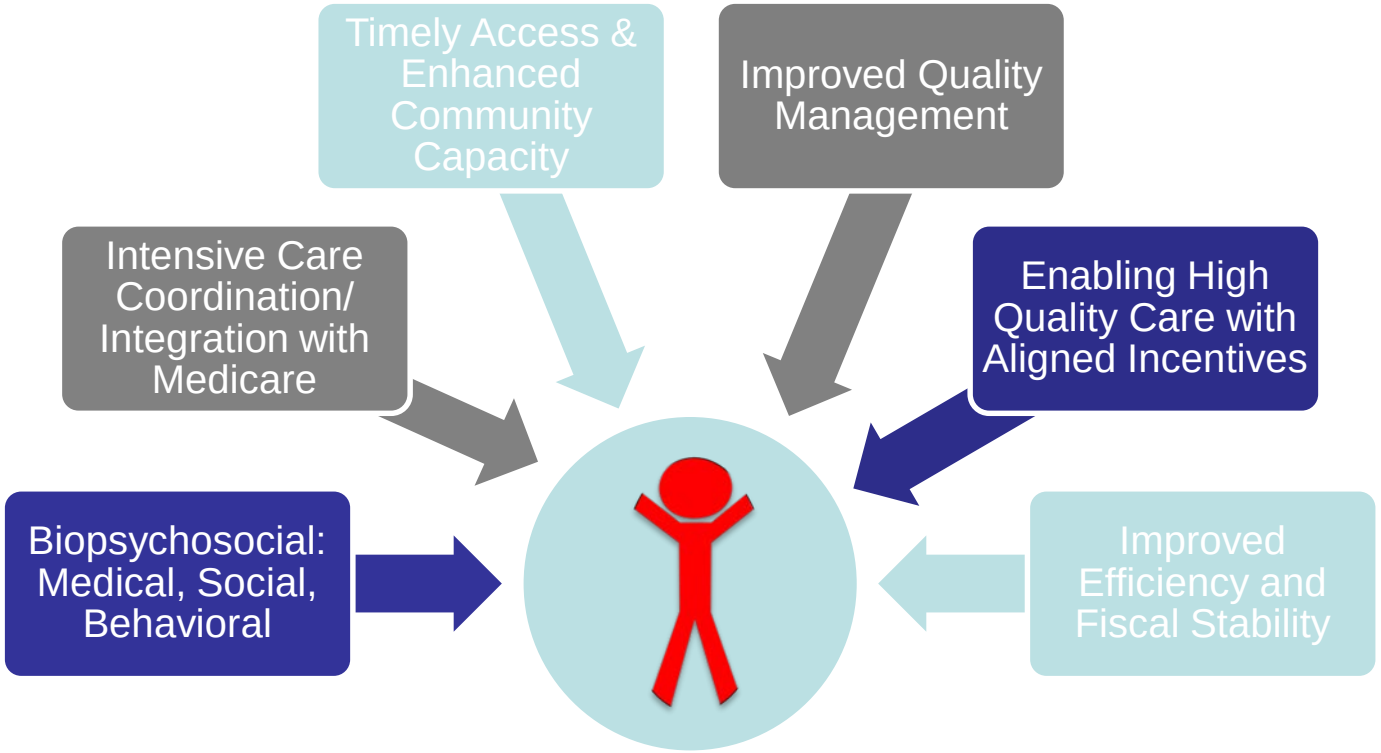
V. Care Coordination
Individual Care Plan (ICP)

- The ICP is developed by the Optima Health clinical staff to address issues the member may be facing within these areas:
  - Medical, Psychosocial, Behavioral, Cognitive, Functional, Pharmaceutical
- The ICP is formulated based on: HRA assessment, MD feedback, disease or general assessments, and any additional findings or needs that may be reported by the member/caregiver or ICT.

V. Care Coordination Interdisciplinary Care Team (ICT)

- Composition of the ICT includes but not limited to: member/family/caregiver (as appropriate) and those providers/specialists significantly involved in the member's care (PCP, specialist(s), care manager, and others as needed) to provide a member-centered approach to care and collaborate in care planning.
- This includes discussions concerning the individual's health status, current/possible interventions, and goals for the member.

V. Care Coordination
Person-Centered Delivery Model



Fully Integrated and Person-Centered Model

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VI. Utilization Management

- Service Authorizations
- Transitions of Care
- Continuity of Care
- Out-of-Network Services

VI. Utilization Management

Also called Medical Care Services (for prior authorization and utilization management) in the provider manual online:

https://providers.optimahealth.com/SiteCollectionDocuments/plan-management-plan-ref-provider-manual.pdf

VI. Utilization Management

Optima Health has mechanisms in place to detect and correct potential under- and over-utilization of services. As such:

- UM decision-making is based only on appropriateness of care and service.
- The Managed Care Organization does not compensate practitioners or others individuals conducting utilization review for denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage denials of coverage or service.

VI. Utilization Management Service Authorization

The preferred method to obtain prior authorization is through the Optima Health secure provider portal, Provider Connection. Providers must register to access Provider Connection. Forms and instructions are on the website:

https://www.optimahealth.com/providers/medical-authorizations/

VI. Utilization Management Service Authorization

- Optima Health primarily uses Milliman Clinical Guidelines (MCG), DMAS's service authorization criteria, American Society for Addiction Medicine (ASAM), Addiction and Recovery Treatment Services (ARTS), Coleman's Transitions Model or other national standard(s) in making medical necessity determinations.
- In addition, proprietary guidelines are developed and utilized to augment these nationally accepted standards.

VI. Utilization Management Transitions of Care

- Members transitioning from one care setting to another are at high risk of complications and often access costly, but avoidable, reuse of services. Optima Health's Transitional Care Program (TCP) is based on the Coleman Care Transition Model.

VI. Utilization Management: Out of Network

- Physicians may not refer to out-of-network providers unless authorized by the plan.
- Physicians must obtain a prior-authorization from the plan **prior** to recommending the member obtain care out of network.
- HMO plans will not pay if the services are provided to the member by a non-participating provider.
- PCPs or Specialists **may not** authorize non-covered benefits or out-of-network services unless medically necessary and prior authorized by the plan.

VI. Utilization Management: Out of Network

Prior Authorization Procedures and Requirements

Prior authorization is based on medical necessity as supported by medical criteria and standards of care. Optima Health does not provide incentives to influence authorization decisions, promote denials of coverage of care, or encourage under-utilization of services.

***Requests for elective admissions must be submitted for prior authorization 10 days prior to scheduling an admission or procedure. Treatment by non-participating providers must receive prior authorization from Optima Health in the same time frame as above*.**

VII. Performance and Health Outcomes Measurement

- The goal of performance improvement and quality measurement is to improve the SNP's ability to deliver high-quality healthcare services and benefits to its SNP beneficiaries.
- Achievement of this goal may be the result of increased organizational effectiveness and efficiency through incorporation of quality measurement and performance improvement concepts that drive organizational change.
- As a provider, your services directly impact high-quality healthcare services and benefits to its SNP beneficiaries.

VII. Performance and Health Outcome Measurement

Quality Improvement

- Is it Time to Give Statins a Try?
- Follow-Up Care for Children Prescribed ADHD Medication
- World Mental Health Awareness
- October is Breast Cancer Awareness Month
- November is Diabetes Awareness Month
- Get Off Your Butt: Stay Smokeless for Life
- New Measures for HEDIS® 2018
- Clinical Guidelines

VIII. Marketing and Outreach Process

Providers need to understand marketing and outreach processes. These processes have many requirements that protect the beneficiaries.

The provider's role is to know the requirements exist and to contact Optima Health if they have questions or need to support a beneficiary in his/her care.

VIII. Marketing and Outreach Process

D-SNPs may choose to send the ANOC for member receipt by September 30 and the EOC for member receipt by December 31; however, D-SNPs that choose this option must also send an SB with the ANOC on September 30.

VIII. Marketing and Outreach Process

The SB must include the elements described below:

- The benefits and cost-sharing protections the individual is entitled to under the State Medicaid program; and
- The specific benefits and cost-sharing protections that are covered under the D-SNP for dual-eligible individuals.

IX. Cultural Competency

Delivery of culturally competent care allows healthcare providers to appropriately care for and address healthcare concerns, to include belief and value systems, of patients with diverse cultural and linguistic needs.

IX. Cultural Competency

Providers are encouraged to:

- Build rapport by providing respectful care
- Determine if the member needs an interpreter or translation services
- Remember that some cultures have specific beliefs surrounding health and wellness
- Ensure the member understands diagnosis, procedures, and follow-up requirements

IX. Cultural Competency

Providers are encouraged to (continued):

- Offer health education materials in languages that are common to your patient population
- Be aware of the tendency to unknowingly stereotype certain cultures
- Ensure staff is receiving continued education in providing culturally competent care

IX. Cultural Competency

More information regarding cultural competency and CME opportunities are available at:

https://www.optimahealth.com/providers/education/

- Under Cultural Competency Training
  - "Cultural Diversity" by Optima Health

Optima Health's Cultural Diversity Course (CME):

http://sentara.articulate-online.com/9094660812

IX. Cultural Competency

Cultural Competency Training Now Available

Cultural competence and effective communication are keys to understanding a patient's concerns and help to ensure they understand their healthcare plan.

Cultural competency training courses are now available for all Optima Health providers on the Education page of optimahealth.com/providers.

When you have completed training, please complete the Provider Acknowledgement Form for Cultural Competency so that you can be credited for this education. Your provider profile in the Optima Health provider directory will be updated to reflect that you have participated in cultural competency training.

Access to this training does not require secure login. If you have questions, please contact your Network Educator.

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X. Claims Processing Requirements

The preferred method for claim submission to Optima Health is electronic claim submission. Claims can be submitted through a clearinghouse, AllScripts/PayerPath, or can be submitted directly by a provider or vendor.

X. Claims Processing Requirements

- All claims must be submitted within the guidelines of the product (see the “Timely Filing” section in this chapter), or they will be denied as a late claim submission.
- Claims submitted must be for participating providers within the practice.

X. Claims Processing Requirements

Submit paper claims on the standard CMS 1500 form for professional providers or UB-04 form for facilities. All claims must be “clean claims” or “complete claims.”

- These are claims that are properly completed claims for payment for covered services that require no further information, documentation, adjustment, or alteration by the participating provider in order to be processed or paid.

X. Claims Processing Requirements

Electronic Funds Transfer (EFT)

- EFT is safe, secure, efficient, and less expensive than paper check payments. Funds are typically deposited 24 hours after payments are processed. Clean claims are processed and paid by Optima Health within an average of 7 days when submitted electronically and when payment is made through EFT.
- Providers are encouraged to enroll for EFT by completing the Electronic Payment/Remittance Authorization Agreement on the provider web portal.

X. Claims Processing Requirements

Timely Filing Policy

- The filing deadline for all plans is **365 days** from the date of service.
- Any claim received more than 365 days from the date of service will be denied as a late claim submission unless documentation supporting an acceptable reason for the delay or proof of timely filing is included. Acceptable reasons for delayed filing include coordination of benefits with a primary carrier or inaccurate carrier information provided by the member.

XI. Appeals and Grievances Policies & Procedures

Claim Appeals

- Optima Health attempts to resolve issues presented by providers informally whenever possible. An internal provider appeals process is available to reconcile issues if an issue cannot be resolved informally.

XI. Appeals and Grievances Policies & Procedures

- An appeal is a formal request to reconsider and change a previous adverse decision when Optima Health has determined the original payment was properly adjudicated and the provider continues to dispute the payment.
- Optima Health will not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

XI. Appeals and Grievances Policies & Procedures

Hold Harmless Policy

- For all Optima Health products, if Optima Health denies a claim for service due to failure of the contracted providers to follow any rule or procedure, or based on retrospective review the service was not medically necessary, the provider **must** hold the member harmless and not bill the member.

XI. Appeals and Grievances Policies & Procedures

Adverse Benefit Determination – Provider Appeals on Behalf of a Member

- Providers may appeal adverse benefit determinations on behalf of the member; however, they must indicate they are appealing on behalf of the member. These member appeals may be filed pre-service, concurrent to, or following services being rendered. Appeals on behalf of the member are processed according to the member appeal process and must include a completed Authorized Designation Form signed by the member. Expedited Appeals do not require the Authorized Designation Form.

XI. Appeals and Grievances Policies & Procedures

Access the Policies for Provider Appeals, Expedited Appeals, and Member Appeals:

https://www.optimahealth.com/documents/provider-manuals/optima-health-community-care-provider-manual-supplement.pdf

Grievance and Appeals for Optima Health Comm Care Class:

https://www.optimahealth.com/providers/education/

- Under Optima Health Community Care
  - Click on: Grievance and Appeals for Optima Health Community Care

XII. Provider Portal

The Provider Manual also provides directions to locate detailed lists, contact information, and policies on the provider web portal.

Utilization Management for Optima Health Community Care Class:

http://sentara.articulate-online.com/9094636148

XII. Provider Portal

Web-based access to Optima Health medical plan information including:

- Member eligibility
- Authorization status and OB authorization submission
- Detailed claim status
- PCP membership reports
- Ability to view remits and pend reports
- Access to C3 Clear Claim Connection

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XII. Provider Portal

How Do I Get Started?

Set up your internet access. For optimum performance, high-speed internet access is desired (DSL, cable or network).

All authorized users must agree to Sentara's Statement of Responsibility and Confidentiality.

Complete the online Provider Connection Enrollment form.

You will be contacted by Network Management with your sign-on ID and password.

XIII. Communication and Plan Contact Information

Optima Health has many resources on the website and portal to communicate:

- Optima Health News
- Provider Resources
- Authorizations and Medical Policies
- Pharmacy
- Quality Improvement
- Important Numbers
- Newsletters
- https://www.optimahealth.com/providers/updates/

XIV. Member Rights & Responsibilities

Each type of Optima Health product has a specific Member Rights and Responsibilities document that is provided to members at the time of enrollment.

XIV. Member Rights & Responsibilities

Optima Health will:

- Use all reasonable means to facilitate healthcare services for members with physical, mental, language, and cultural barriers.
- Ensure the needs of members with physical, mental, language, and/or cultural barriers are properly accommodated.

XIV. Member Rights & Responsibilities

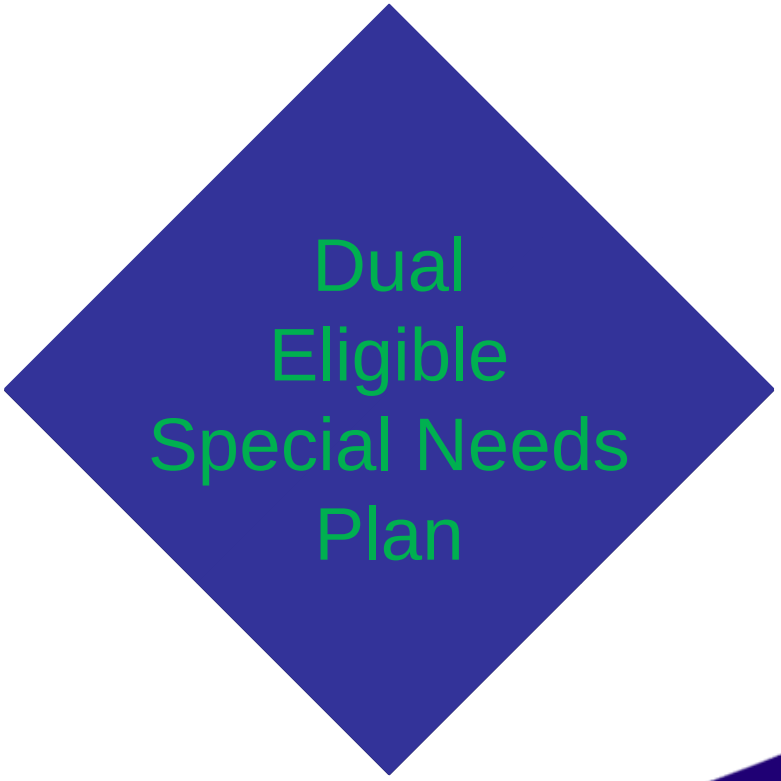
Members with special needs should be instructed to call Member Services at the number on the back of their Member ID card. Members are notified of these services in their member materials (handbook).

XIV. Member Rights & Responsibilities

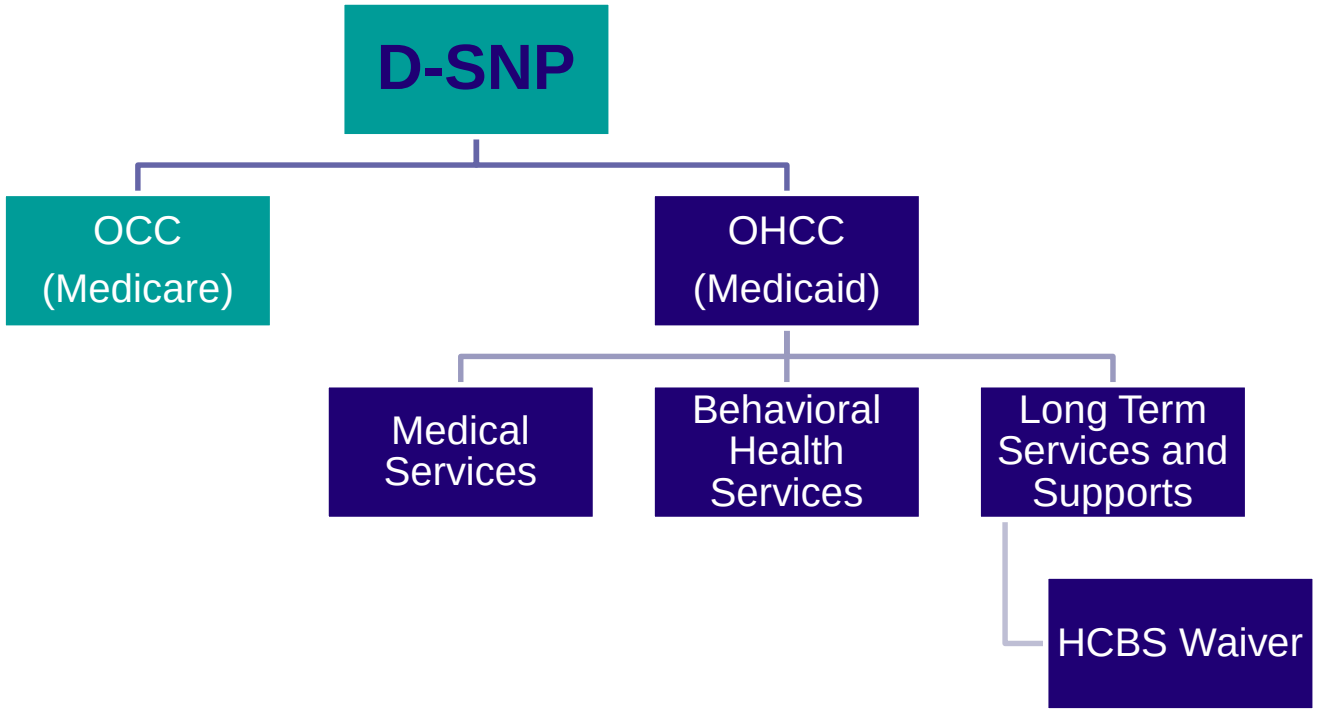
The Member Rights and Responsibilities document assures all Optima Health members are treated in a manner consistent with the mission, goals, and objectives of Optima Health and assures members are aware of their obligations and responsibilities upon joining the plan and throughout their membership with the plan.

Dual Eligible Special Needs Plan

- A special type of Medicare Advantage plan
  - Includes Parts A, B, and D
  - State-wide HMO
- Recipients with both Medicare and Medicaid
- Note: both plans may or may not be through Optima Health



XV. Comparisons Between SNP & CCC Plus Programs



XV. Comparisons Between SNP & CCC Plus Programs

SNP and CCC Plus Common Goals

- Benefits offered, provider choices, and drug formularies are designed to best meet the specific needs of the member
- Serve members with complex needs
- Focus on improving quality, access, and efficient through care coordination services
- Improve health outcomes
- Integrated delivery model

XV. Comparisons Between SNP & CCC Plus Programs: Medicare and Medicaid Coordination of Benefits

SNP members may select the same health plan for their Medicare and Medicaid services (D-SNP). The plan must coordinate benefits including:

Medicare Benefits

- Hospital Care
- Physician & Ancillary Services
- Skilled Nursing Facility (SNF)
- Home Health Care
- Hospital Care
- Prescription Drugs
- Durable Medical Equipment (DME)

Medicaid Benefits

- Medicare Cost Sharing
- Hospital and SNP (when Medicare benefits are exhausted)
- Nursing Facility (custodial)
- HCBS Waiver Services
- Community Behavioral Health and Substance Disorder Services
- Medicare non-covered services like OTC drugs, some DME and Supplies, etc.

Thank you

for completing the Provider SNP & CCC Plus Training!

OptimaHealth