Provider Manual

Dual Eligible Special Needs Plan (D-SNP)

Align DUALPartnership (HMO D-SNP)

SANFORD HEALTH PLAN

Dual Eligible Special Needs Plan (D-SNP)

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Program Description

The D-SNP covers members in North Dakota beginning January 1, 2025. D-SNPs are designed for individuals who are dually enrolled in Medicare and Medicaid. The D-SNP is a coordination-only model which requires coordination of benefits only and is not a Managed Care Plan. These individuals are often referred to as "dual eligibles" or "dually eligible individuals."

All the member's care (medical, behavioral, and social services) is coordinated seamlessly and may not carry extra costs for the member. D-SNPs offer joint coverage from both Medicare and Medicaid, which means members typically have lower out-of-pocket costs. D-SNPs may also cover premiums, deductibles, and copays that would otherwise be paid separately under Medicare and Medicaid.

Member Eligibility

Those eligible for D-SNP include members who:

- Qualify for Medicare because of age (65 or older) or due to disability;
- **AND** are eligible for Medicaid because they meet the requirements to qualify for Medicaid in North Dakota
- Live in the SHP D-SNP service area

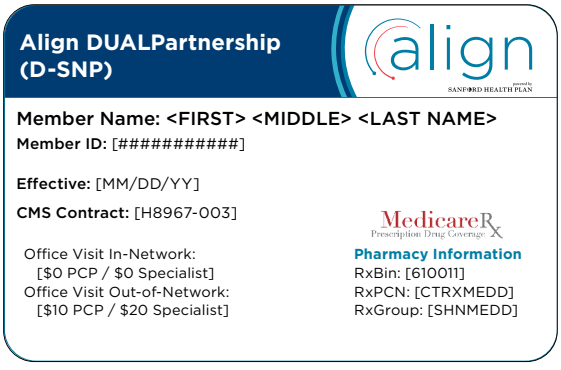
D-SNP is designed to help dual-eligible members more easily get the care they need. The D-SNP plan streamlines access to care by coordinating:

- Medicare and Medicaid benefits, such as professional, acute care, ancillary and pharmaceutical services that are covered by Medicare and Medicaid
- Medicaid waiver services such as cost-sharing, transportation, attendant care, assisted living and other services.

D-SNP care coordination model addresses social determinants of health by identifying members who may benefit from housing and food support services, and then connecting them with community agencies. Each member is connected to a care coordinator. See Model of Care section for additional information on how our D-SNP members are served.

- Verifying eligibility
  - Member ID Card. ***Note that changes do occur and the card alone does not guarantee member eligibility***.
  - Verify eligibility online using our eHealthsuite provider portal at **ehsprd-shp300hs.healthsuiteadvantage.com**
  - Call the Customer Service Department at (844) 637-4760

ID Card



Member Benefits and Services

All Medicare Advantage members receive benefits and services as defined in their Evidence of Coverage (EOC). Benefits and services are subject to change on January 1st of each year. Providers may contact customer service for information on covered services and verification of applicable member copayments and/or cost-sharing owed by the member to the provider for the provision of services.

All participating providers are obligated to bill and collect applicable member copayments and/or cost-sharing as permitted under the Plan or by law. Participating providers of Medicare Advantage are, however, prohibited from balance-billing members' copayments and/or cost-sharing when members are determined qualified and eligible for benefits under the state Medicaid program. For more information, go to: **cms.gov/MLNMattersArticles/Downloads/SE1128.pdf**.

Emergent and Urgent Services

Medicare Advantage follows the Medicare definitions of "emergency medical condition," "emergency services" and "urgently-needed services" as defined in the Medicare Managed Care Manual, Chapter 4 Section 20.2:

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or treat an emergency medical condition.

Urgently-Needed Services: Covered services that are not emergency services as defined above but:

- Are medically necessary and immediately required as a result of an unforeseen illness, injury or condition.
- Are provided when the member is temporarily absent from the plan's service area or under unusual and extraordinary circumstances when the member is in the service area, and the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services through the Plan network.

The Plan's provider network includes multiple hospitals, emergency rooms and providers able to treat the emergent conditions of our members twenty-four (24) hours a day, seven (7) days a week. Emergent services should be obtained from the closest facility that can provide the service. All emergency and urgently needed services may occur without prior authorization or referrals.

Member Supplemental Benefits

In addition to medical benefits within the D-SNP, members also have supplemental benefits providing additional benefits such as dental, vision, hearing and other services. Complete details on supplemental benefits can be found at **sanfordhealthplan.com/align/lp/dsnp/dual-eligible-special-needs-plans**.

Billing Requirements

D-SNP provider agrees to accept SHP's D-SNP Medicare reimbursement as payment in full for services rendered to Dual Eligible Members, or to bill North Dakota Medicaid as applicable for any additional Medicare payments that may be reimbursed by Medicaid.

Claim Submission: Electronic claims submitted for Medicare Advantage should use Payor ID RP035. If you do not wish to file claims electronically, paper claims can be mailed to:

Medicare Advantage
Sanford Health Plan/RAM
P.O. Box 31041
Tampa, FL 33631-3041

After the Sanford Health Plan/RAM processes the D-SNP claim, the provider must submit any remaining balance to North Dakota Medicaid as a Medicare Crossover Claim. ND Medicaid would be billed for any remaining deductible, copay and/or coinsurance. The provider should follow their normal process for submitting the remaining balance of the D-SNP claim to ND Medicaid.

Medical Management

Notification of Inpatient Admissions

Medicare Advantage requires providers to notify the plan of an inpatient admission. For notification, providers should call (800) 805-7938. Emergent admission notification must be received within one business day of admission. For observation stays, Medicare Advantage expects hospitals (including critical access hospitals) to furnish the Medicare Outpatient Observation Notice (MOON) as required by law. This obligation exists even though Medicare Advantage waives the three-day stay requirement.

Prior Authorization

Requests for prior authorizations of services should be made before or at the time of scheduling the service. Plan PCPs, practitioners and specialists are responsible for requesting prior authorization for the services they order. Facilities may also request prior authorizations for scheduled admissions, elective admissions, procedures and outpatient services ordered by the PCP or advanced practice provider. Medicare Advantage recommends calling at least fourteen (14) days in advance of an elective admission, procedure or service. For prior authorizations, providers can fax a Request Prior Authorization form to (605) 312-8219 or call our Utilization Management department at (800) 805-7938.

NOTE: Oncology treatment and services must be entered and authorized through Eviti Connect online at eviti.com.

Services Requiring Prior Authorization: Providers should refer to the provider section of the plan's website for the listing of services typically requiring authorization. The presence or absence of a service or procedure on the list does not determine coverage or benefit.

Please visit **sanfordhealthplan.com/align/help** and refer to the Prior Authorizations section.

Documentation for Prior Authorizations: The Utilization Management department evaluates requests using CMS guidelines as well as nationally accepted criteria to process prior authorization requests and notifies the provider and member of the determination.

Decisions and Time Frames

- **Expedited:** When you as a provider believe waiting for a decision under the routine time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you may request an expedited request. Expedited requests will be determined within 72 hours or as soon as the member's health requires.
- **Routine:** If all required information is submitted at the time of the request, CMS generally mandates a health plan determination within 14 calendar days.

Once the Utilization Management department receives the request for authorization, Medicare Advantage will review the request using national coverage determinations (NCDs) or local coverage determinations (LCDs) or nationally recognized industry standard criteria. If the request for authorization is approved, Medicare Advantage will assign an authorization number and enter the information in the Plan's medical management system.

The authorization number is only used for reference, it does not signify approval. **Claims for services requiring prior authorization must be submitted with the assigned authorization numbers.** This authorization number can be used to reference the admission, service or procedure.

Special Needs Plans Model of Care

The Centers for Medicare and Medicaid Services (CMS) require all special needs plans (SNPs) to provide initial and annual Model of Care (MOC) training to network providers that are contracted to see SNP members and out-of-network providers who routinely see SNP members. Sanford Health Plan offers SNPs and therefore required by CMS to make training available. This training should be completed upon hiring and annually thereafter. Training should be done by providers and other staff who may participate in an SNP member Interdisciplinary Care Team, responsible for implementation of the member's Care Plan, or manage planned or unplanned transitions of care.

Document and maintain MOC training completion records and provide such records upon request to validate that the training has been completed. Records must include the provider's or staff person's name, their department or title, and the date the training was completed. If a provider fails to complete the CMS-required training and remains non-compliant, they may be required to develop a Corrective Action Plan or be subject to other remediation activities

Sanford Health Plan's Model of Care

D-SNPs are required to have a Model of Care (MOC). The MOC provides members with a patient-centered, primary care-driven care experience. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, the MOC is designed to improve the quality of life for members while providing access to the same services covered by Original Medicare. Goals of the MOC include:

- Improve coordination of care through an identified point of contact
- Improve transitions of care across health care settings and providers
- Improve access to preventive health services
- Improve member health outcomes

SHP's policy, Model of Care Training for Provider Network, details our obligation to provide high quality coordinated care consistent with the Centers for Medicare and Medicaid Services (CMS) rules and regulations as provided under section 1859(f)(7) of the Social Security Act related to developing and operationalizing a Model of Care approved by the National Committee for Quality Assurance (NCQA) on behalf of CMS. CMS requires Medicare Advantage Special Needs Plans to establish an MOC to provide the foundation and structure for implementing and operating a Special Needs Plan (SNP).

The MOC has four focus areas to address member needs:

- Description of the Special Needs Population
- Care Coordination
- Provider Network
- Quality Measurement and Performance Improvement

SHP performs training for providers (both contracted and out-of-network providers who routinely see members). This training is provided as part of the initial enrollment and annually thereafter. Providers are required to attest each year that MOC training for their staff was completed. The complete MOC can be viewed in the Medicare Advantage Provider Portal.

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