Special Needs Plan Model of Care

2020 Provider Training

HealthCare Partners, IPA
HealthCare Partners, MSO

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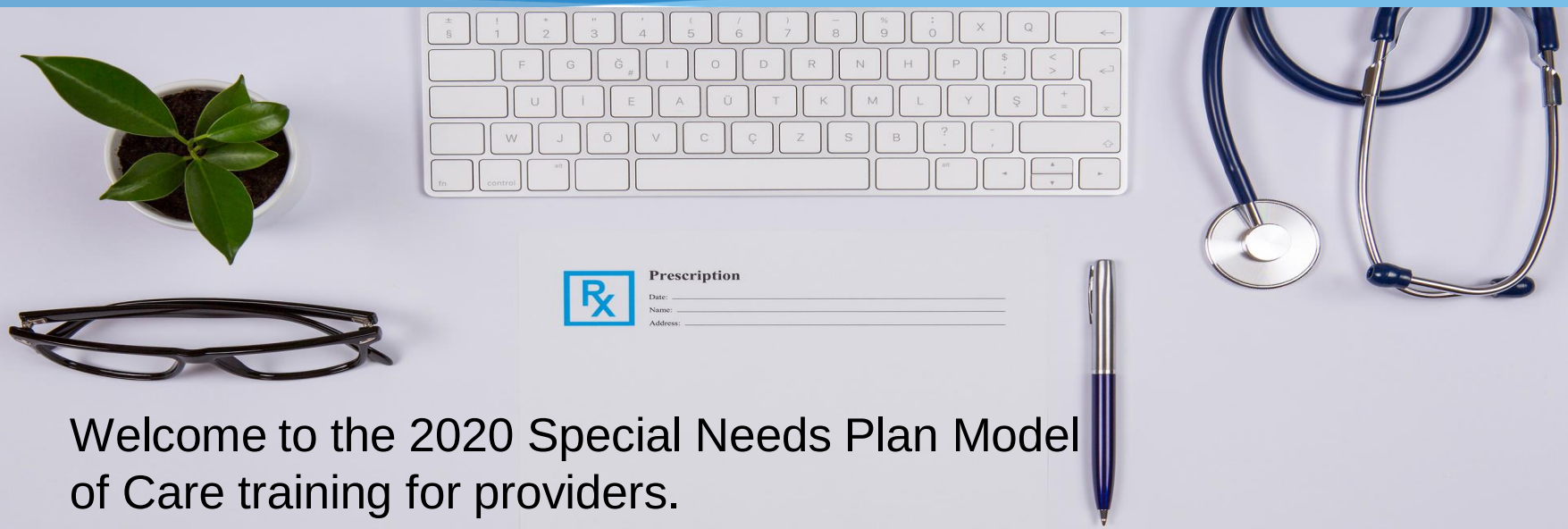


Welcome to the 2020 Special Needs Plan Model of Care training for providers.

We value your partnership in caring for our members.

This year's course is designed to help you provide coordinated and appropriate care for your patients.

Introduction

This training will provide you with an overview of the Special Needs Plan Model of Care.

By the end of this course, you will understand:

- The definition of an SNP and characteristics of the SNP population.
- The objectives and components of the model of care.
- Your responsibilities as a network provider.
- The importance of your active participation in the model of care.
- How you can improve patient satisfaction and health outcomes.

Special Needs Plan (SNP) Model of Care (MOC)

Let's start by defining SNP MOC

- SNP is a type of Medicare Advantage coordinated care plan that limits enrollment to Medicare beneficiaries with special needs (i.e., live in an institution, have Medicare and Medicaid benefits, or have a chronic condition).
- SNPs designed to provide targeted care to individuals who have both Medicare and Medicaid benefits (also known as "dual eligible") are Dual Eligible SNPs (D-SNPs).
- SNP model of care is a comprehensive program through which care is efficiently delivered and well-coordinated by integrating all Medicare and Medicaid physical health, behavioral health, pharmacy, and community-based services through an interdisciplinary team.
- The Centers for Medicare & Medicaid Services regulate all SNPs. CMS reviews and approves each SNP's model of care.

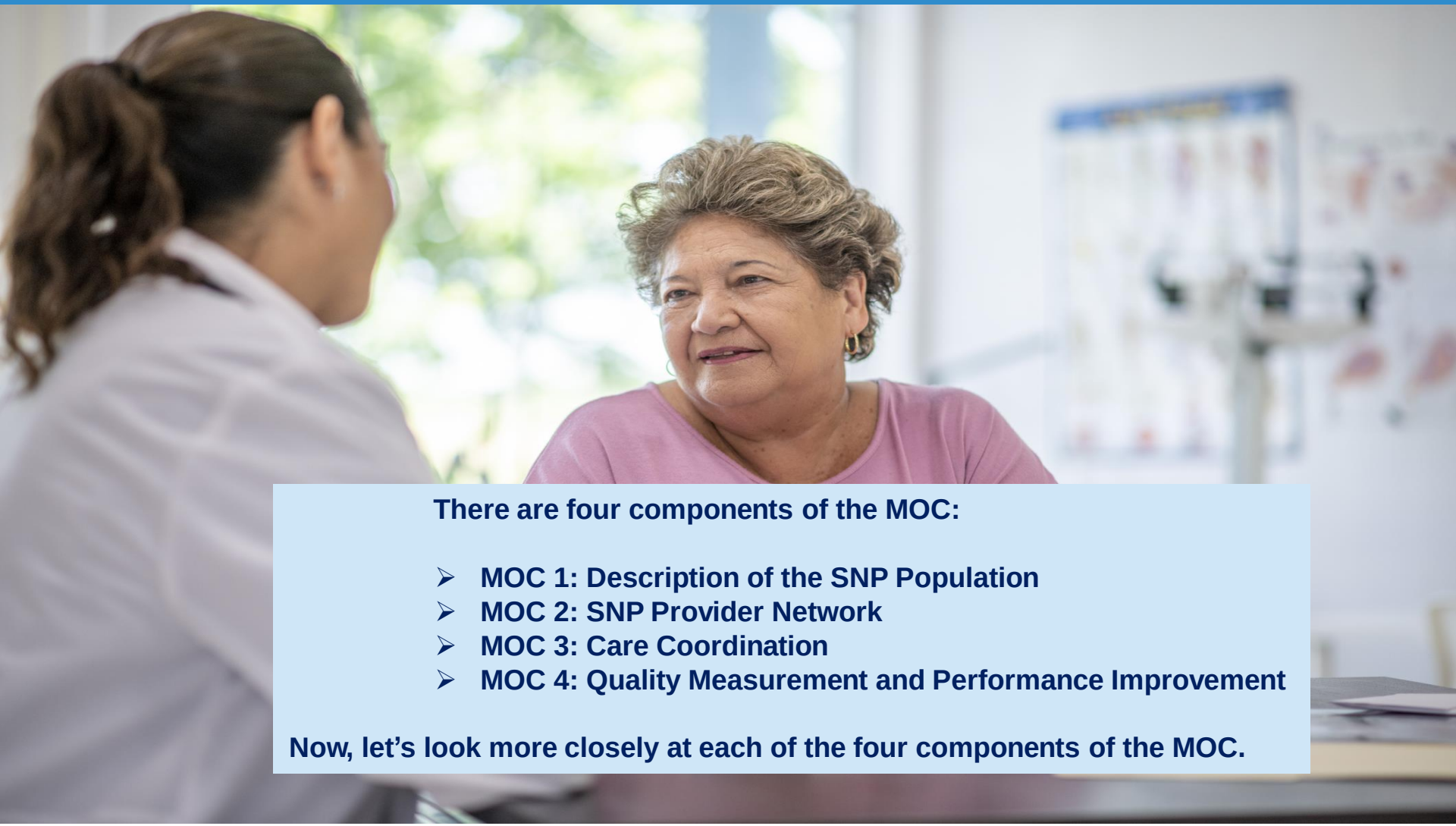
Special Needs Plan (SNP) Model of Care (MOC)

The Model of Care is the structure of the care management processes and systems to provide coordinated and appropriate care for our special needs members.

The key MOC objectives specific to the unique needs of the SNP population are to:

- **Evaluate and improve members' access to clinical and administrative services.**
- **Monitor continuity and coordination of health care.**
- **Review and evaluate the current status of care and service against regional and national requirements and benchmarks such as NCQA's Quality Compass Accreditation/90th percentile, and CMS Medicare 5 Star Ratings.**
- **Ensure members' access to safe medical and behavioral health care.**
- **Measure and address member satisfaction with care and services.**

Special Needs Plan Model of Care



There are four components of the MOC:

- **MOC 1: Description of the SNP Population**
- **MOC 2: SNP Provider Network**
- **MOC 3: Care Coordination**
- **MOC 4: Quality Measurement and Performance Improvement**

Now, let's look more closely at each of the four components of the MOC.

MOC 1: Description of the SNP Population

Characteristics of the SNP population:

- **Healthy living with chronic conditions**
- **Violent crime neighborhoods**
- **Poor housing conditions**
- **Food insecurity**
- **Lower levels of education**
- **Limited language and health proficiency**
- **Social isolation**

MOC 1 is the SNP population. This component describes some of the health and economic characteristics of the SNP population, and the resources you and plans can make available to them.

SNP members are a highly vulnerable population. They have a high incidence of chronic conditions and behavioral health conditions including substance use disorders. Many SNP members have more than one chronic condition, which leads to higher risk of poor health. They need access to home and community-based services, intensive care coordination, and proactive monitoring of their health status.

The SNP population may live in neighborhoods with violent crime, have significant housing problems, and experience food scarcity. Limitations, such as lower levels of education, English language proficiency, health literacy, social isolation, and transportation issues, lead to barriers in our members' ability to effectively communicate with their health care professionals and receive the care they need at the right time.

For assistance with services for the visually impaired, providers may contact Lighthouse Guild at 800-284-4422.

MOC 1: SNP Population
Characteristics of the SNP population:

SNP Member Benefit Plan for 2020

HCP supports four SNP benefit plans with two provider networks.

Our plans include a wide range of benefits designed to meet our members' needs in a personal way. Please make sure your patients know about these benefits and take advantage of them.

HCP administers the Medicare portion of the benefits for their members. CMS requires all Medicare providers to complete MOC training for each of the SNPs with which they participate.

Nondiscrimination Rule

YOU CANNOT DISCRIMINATE BECAUSE OF:

- **Age**
- **Amount of payment**
- **Claims experience**
- **Color**
- **Creed**
- **Disability**
- **Ethnicity**
- **Evidence of insurability**
- **Gender**
- **Genetic information**
- **Health literacy**
- **Health needs**
- **Health status**
- **HIV status**
- **Language**
- **Marital status**
- **Medical history**
- **Medication history**
- **Mental or physical disability or medical condition**
- **National origin**
- **Need for health services**
- **Place of residence**
- **Plan membership**
- **Race**
- **Religion**
- **Sex**
- **Sexual orientation**
- **Source of payment**
- **Type of illness or conditions**
- **Veteran status**

Providers must comply with all applicable laws prohibiting discrimination against any member and in accordance with the same standards and priority as the provider treats his/her/its other patients regardless of any of these factors.

In addition, our providers must comply with:

- Terms of HCP's contracts with the New York State Department of Health and/or CMS
- Laws that apply to recipients of federal funds, and all other applicable laws or regulations
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Title VI of the Civil Rights Act of 1964
- HIPAA – the Health Insurance Portability and Accountability Act
- HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law
- Section 1557 of the Affordable Care Act of 2010

MOC 2: SNP Provider Network

Do not "Balance Bill" dual eligible members:

- **Medicare providers must not collect Medicare cost-sharing from Medicare-Medicaid dual eligible individuals**
- **Providers may bill state Medicaid programs for these costs, but states can limit Medicare cost-sharing payments**
- **Medicare and Medicaid payments, if any, must generally be accepted as payment in full**

MOC 2 is the SNP Provider Network. This component provides you with tools to help you care for your SNP patients, like MOC training, access standards, medical policies, and practice guidelines.

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from Medicare-Medicaid dual-eligible individuals.

Providers may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by federal law, New York state can limit Medicare cost-sharing payments, under certain circumstances.

Medicare and Medicaid payments, if any, must generally be accepted as payment in full. Medicare-Medicaid dual-eligible individuals are exempt from Medicare cost-sharing liability

MOC 2: SNP Provider Network

Access to Care Standards:

- Follow standards of appointment availability
- Make sure members can access a live voice after hours
- Prevent audit failures - conduct your own secret shoppers calls

It's important for our members to get the right care at the right time.
It's part of your commitment to quality patient care.

Providers are expected to adhere to HCP's appointment availability and 24-hour access standards such as: non-urgent sick visit within 48 to 72 hours, routine care visit within four weeks, and oncology specialist visit within three business days.

For after-hours coverage, make sure members can access a live voice direct to the practitioner or covering practitioner, or via an answering service that can reach the practitioner or covering practitioner.

MOC 3: Care Coordination

HCP uses preventive and condition-specific Clinical Practice Guidelines related to the treatment of acute, chronic, and behavioral health issues. These evidence-based guidelines are based on nationally recognized protocols for the assessment, care, and maintenance of health.

Paper copies of Clinical Practice Guidelines are available upon request. Updates are included in the provider newsletter. **Please make sure we have your current email on file so you can receive timely updates.**

MOC 3 is Care Coordination. Working together to care for your SNP patients' special health needs is important. Your role is essential to ensure the model of care is a success for optimal coordination of care.

There are four elements in care coordination:

- **Health Risk Assessment (HRA)**
- **Interdisciplinary Care Team (ICT)**
- **Individualized Care Plan**
- **Care Transitions Protocol**

Let's look more closely at each of these elements.

MOC 3: Care Coordination

Health Risk Assessments (HRAs)

- Administered to all SNP members
- Responses reviewed by HCP to determine outreach, evaluation and development of an individualized care plan
- Assessments identify members “at risk” and members needing condition specific services

CMS requires all SNPs to conduct an HRA for each individual enrolled in the SNP. The quality and content of the HRA should identify the medical, functional, cognitive, psychosocial, and mental health needs of each SNP beneficiary.

You can assist in this process by encouraging your HCP members to complete the HRA survey. The information provided in the HRA helps the HCP Care Management Department determine the types of services and supports they may need as part of their care plan. The Care Management Department refers HRA responses to other departments and/or programs for outreach as appropriate.

Case Sample

Here's a case sample of the importance of an HRA.

A member's daughter called Care Management and requested assistance for her mother – a 62-year-old female, alert, oriented to name, time and place, but forgetful, and lives with her daughter. The member was an HRA non-responder – our team was able to complete the HRA. Based on the responses, we learned the member had a recent post-hospital discharge due to tachycardia, bilateral leg swelling, diagnosed to have diabetes, and abnormal lab results.

The daughter reported the member's blood pressure and fasting blood glucose level as always high. HealthCare Partners' care manager immediately contacted the member's PCP office for care coordination. The PCP's office scheduled a same-day appointment. The care manager followed up with the PCP, who indicated the member was seen and needed changes to her medication regime.

MOC 3: Care Coordination

Interdisciplinary Care Team (ICT)

Regulations require all SNPs to use an Interdisciplinary Care Team in the management of care for each individual enrolled in the SNP.

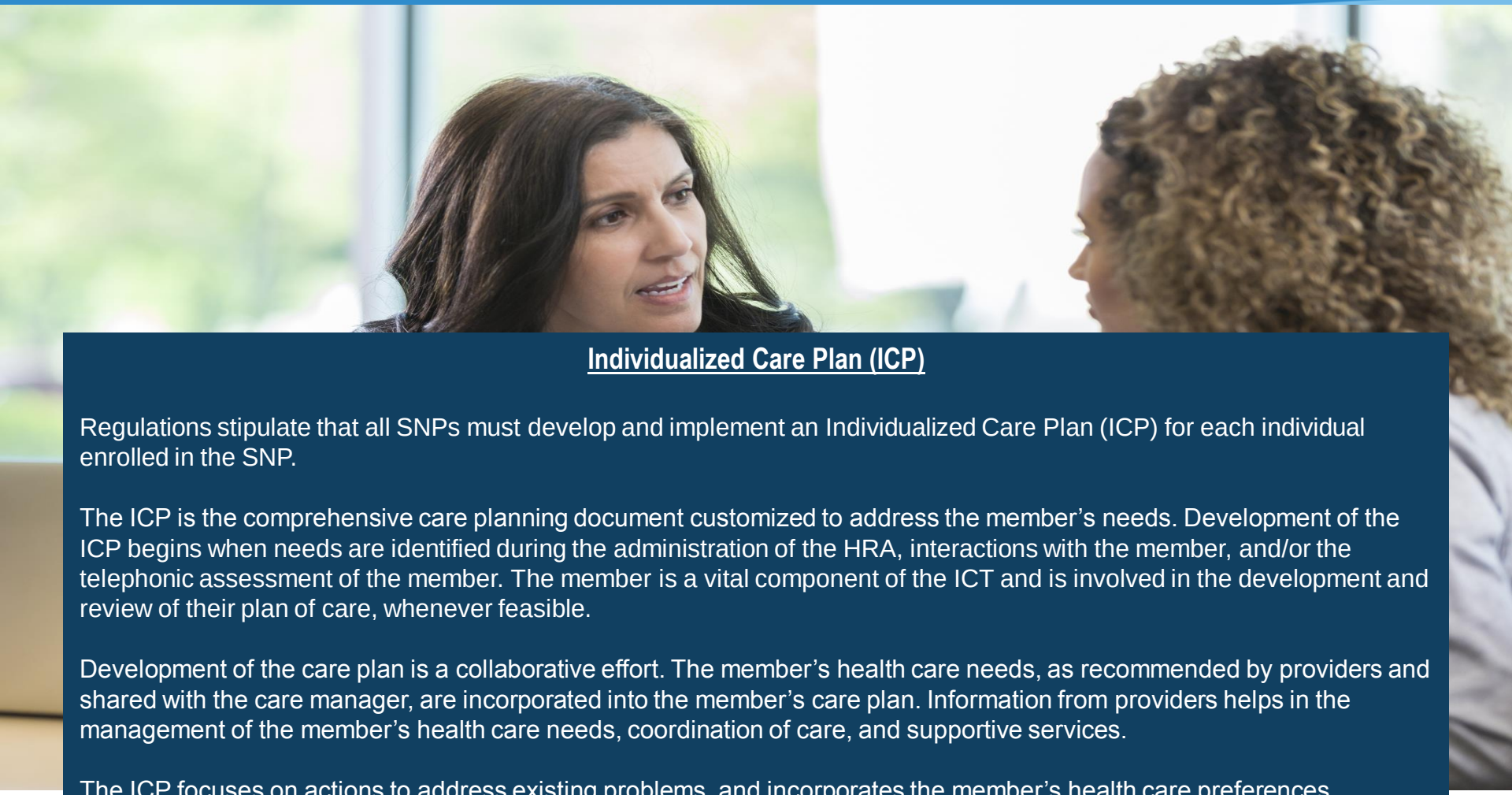
This multidisciplinary team structure supports a member-centric approach to ensuring all areas of the member's health spectrum are maintained. In addition to the member or the designated family/caregivers, the ICT is comprised of clinicians representing various disciplines based on the member's specific clinical needs. The ICT meets Bi-weekly for 1 hour with selected SNP cases for presentation. Meetings are held telephonically or in person with telephonic options for members, caregivers, and providers. The ICT assists in the care plan development and implementation, and enables the member to have access to care coordination. The care management team proactively contacts the appropriate providers to identify the specific needs and services the member requires.

Here’s a success story with a member and daughter who participated in the ICT meeting.

A widowed, disabled, non-English-speaking male member who lives with his 15-year-old daughter was experiencing a housing problem and wanted a two-bedroom apartment for both of them. He was saving money to be able to move, but had financial struggles. His daughter, translating for him during the ICT meeting, stated that she was also in need of school supplies and clothing.

The social worker informed and connected them to a church activity within their area. The daughter was able to get free school supplies and clothing. In addition, the social worker addressed the housing concern by linking the member to available housing resources, and he was able to get an apartment within his budget.

MOC 3: Care Coordination



Individualized Care Plan (ICP)

Regulations stipulate that all SNPs must develop and implement an Individualized Care Plan (ICP) for each individual enrolled in the SNP.

The ICP is the comprehensive care planning document customized to address the member's needs. Development of the ICP begins when needs are identified during the administration of the HRA, interactions with the member, and/or the telephonic assessment of the member. The member is a vital component of the ICT and is involved in the development and review of their plan of care, whenever feasible.

Development of the care plan is a collaborative effort. The member's health care needs, as recommended by providers and shared with the care manager, are incorporated into the member's care plan. Information from providers helps in the management of the member's health care needs, coordination of care, and supportive services.

The ICP focuses on actions to address existing problems, and incorporates the member's health care preferences. Revisions are based on the member's changing health needs, and feedback from providers.

MOC 3: Care Coordination

Transitional Care

Transitional care is essential for persons with complex care needs. Examples of transition between settings include: in or out of hospital, skilled or custodial nursing, rehabilitation center, outpatient surgery centers, or home health.

Based on a comprehensive plan of care, transitional care is the special effort to coordinate care, and as a result, reduce the risk of poor quality care, ensure patient safety, and maximize health outcomes. HealthCare Partners provides transitional care services for SNP members discharged from the hospital with Inpatient Post-Acute Care Services or Home Care Services. Members are managed by the HealthCare Partners Transitional Care Program for 90 days post hospital discharge.

Utilizing a multidisciplinary team approach to support SNP members' medical, behavioral, pharmaceutical, social and financial needs, case managers work with the member, provider, and community delivery system to coordinate care and services. Transitional care includes logistical arrangements, education of the member and family, and coordination among health professionals involved in both the sending and receiving aspects of the transfer.

The care manager ensures that the member's assessment and care plan are updated with any applicable changes and sets appropriate interventions in coordination with providers and the ICT.

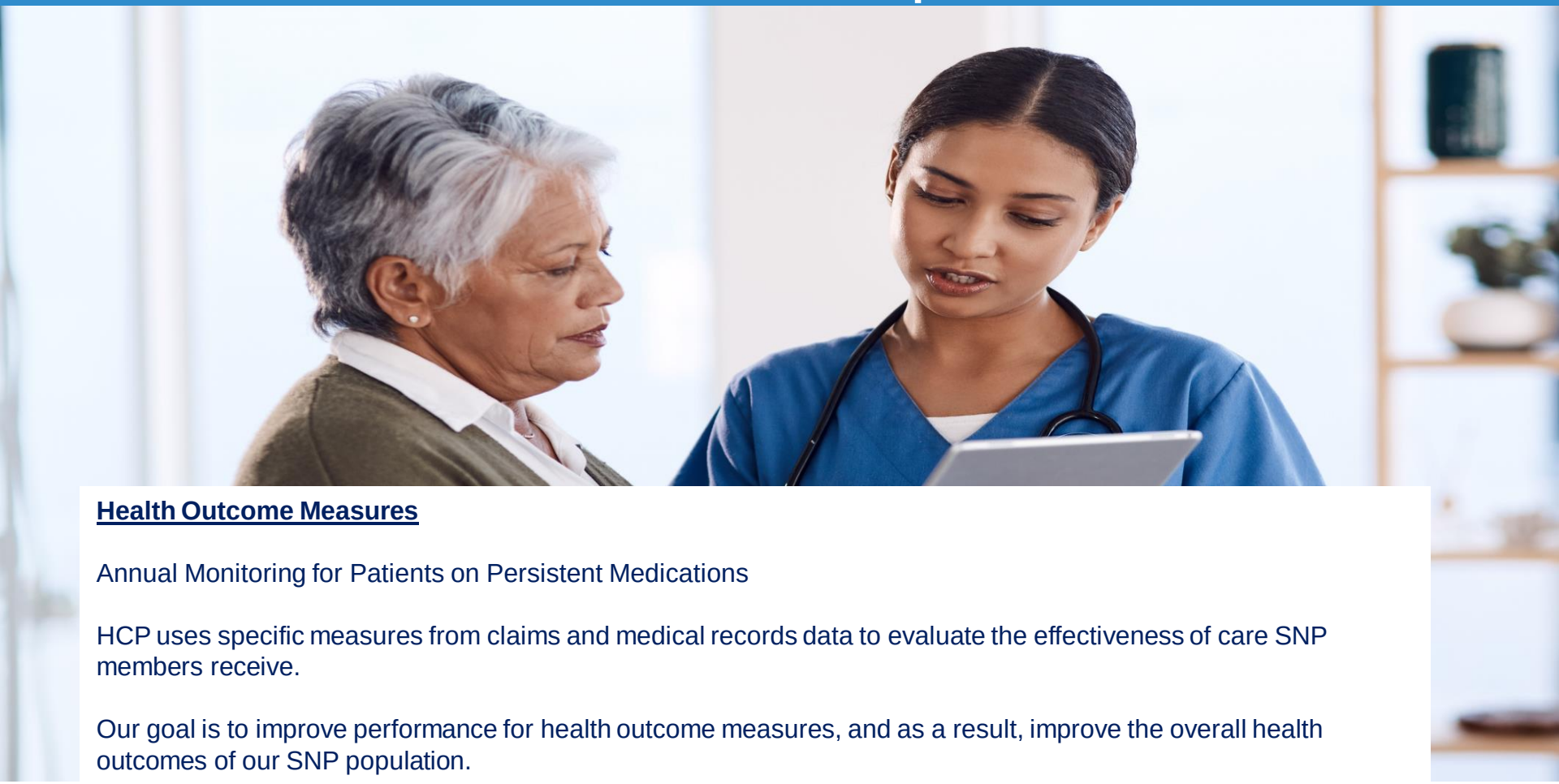
Members are encouraged to complete and maintain their Personal Health Record, which contains member goals, a medication list, allergies, questions for providers, member conditions, and "red flags" to share with the member's doctor or the treating facility.

MOC 4: Quality Measurement and Performance Improvement

At HCP, our goals for SNP members are to improve and ensure receipt of:

- **Essential medical, mental health, and social services.**
- **Affordable care and preventive health services.**
- **Coordinated care through the direct alignment of the HRA, ICT, and ICP.**
- **Seamless transition of care across health care settings, providers, and health services.**
- **Appropriate utilization of services.**
- **Beneficial health outcomes.**

MOC 4: Quality Measurement and Performance Improvement



Health Outcome Measures

Annual Monitoring for Patients on Persistent Medications

HCP uses specific measures from claims and medical records data to evaluate the effectiveness of care SNP members receive.

Our goal is to improve performance for health outcome measures, and as a result, improve the overall health outcomes of our SNP population.

As you care for SNP members, consider these measures and implement strategies in your practice to enhance health outcomes.

MOC 4: Quality Measurement and Performance Improvement

Recommendations to guide discussions with patients during office visits and help better manage their health:

Physical activity in older adults:
- Ask patients about overall physical and mental well-being and quality of life.
- Ask patients about level of exercise and physical activity and make recommendations.
- Emphasize the benefits of exercise on improved physical functioning.

Management of urinary incontinence:
- Ask patients about urinary incontinence.
- Ask if patients are currently receiving any treatment.
- Educate patients on potential treatment options based on severity.

Fall risk management:
- Ask patients about falls, feeling dizzy, problems with balance or walking, blurry vision, eye exams, and updated eye prescriptions.
- Discuss risk factors and consequences of falls.
- Educate patients on how to prevent falls.

MOC 4: Quality Measurement and Performance Improvement

Measuring Patient Experience

SNP member satisfaction

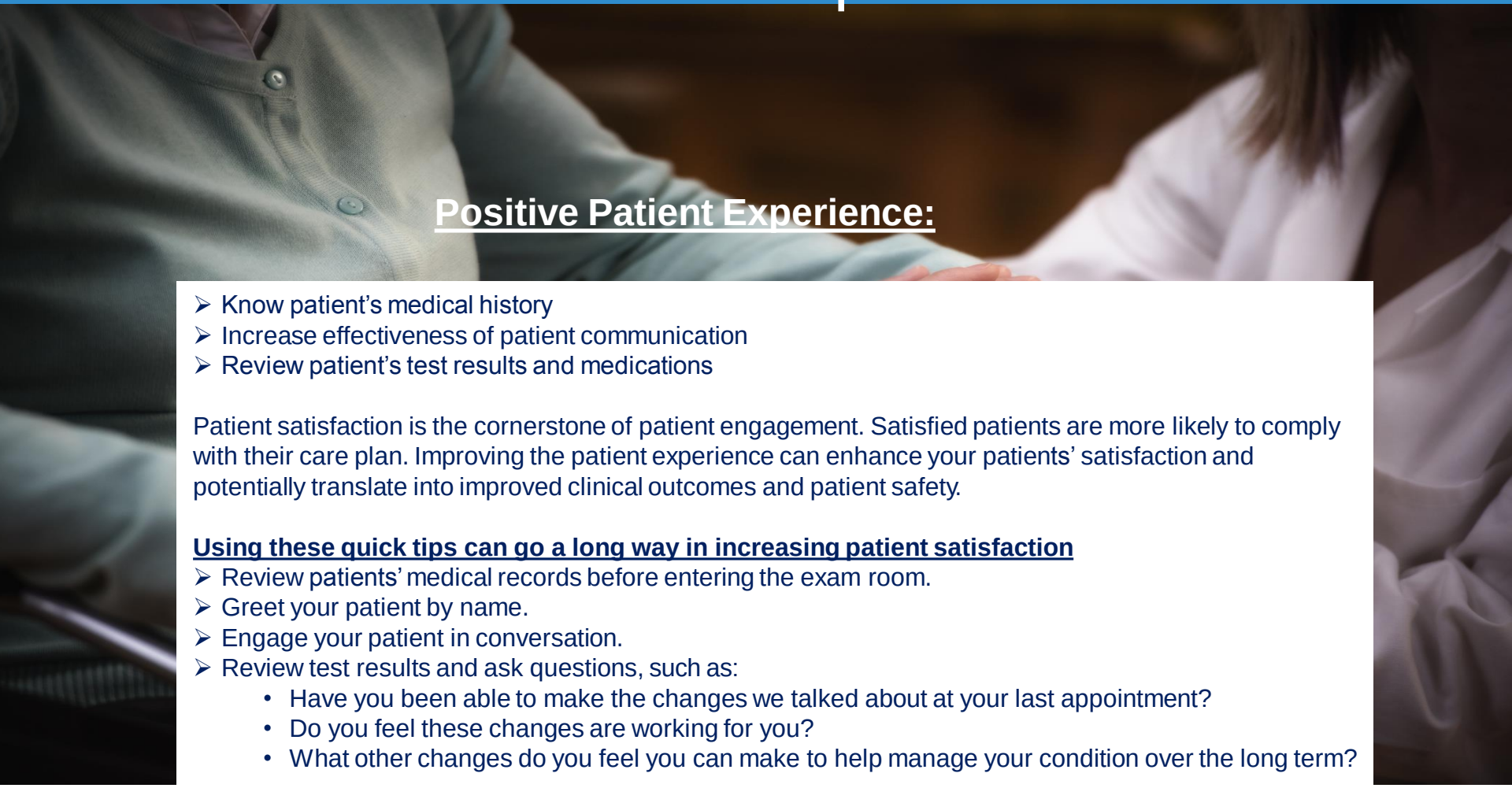
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey (HOS)

HCP uses the CAHPS and HOS tools to measure member satisfaction. CAHPS and HOS are fielded yearly per CMS requirements.

You and your staff can encourage your patients to take these surveys, but do not influence their responses. The surveys ask them about their experience with you, their health plan, and the care they receive. Results of the surveys tell us how well we're meeting their needs and where we may improve.

Based on these results, underperforming measures are identified, and interventions are planned accordingly as part of HCP's performance improvement plan. Results of the surveys are used to establish future threshold goals in order to improve performance and member satisfaction.

MOC 4: Quality Measurement and Performance Improvement



Positive Patient Experience:

- Know patient's medical history
- Increase effectiveness of patient communication
- Review patient's test results and medications

Patient satisfaction is the cornerstone of patient engagement. Satisfied patients are more likely to comply with their care plan. Improving the patient experience can enhance your patients' satisfaction and potentially translate into improved clinical outcomes and patient safety.

Using these quick tips can go a long way in increasing patient satisfaction

- Review patients' medical records before entering the exam room.
- Greet your patient by name.
- Engage your patient in conversation.
- Review test results and ask questions, such as:
  - Have you been able to make the changes we talked about at your last appointment?
  - Do you feel these changes are working for you?
  - What other changes do you feel you can make to help manage your condition over the long term?

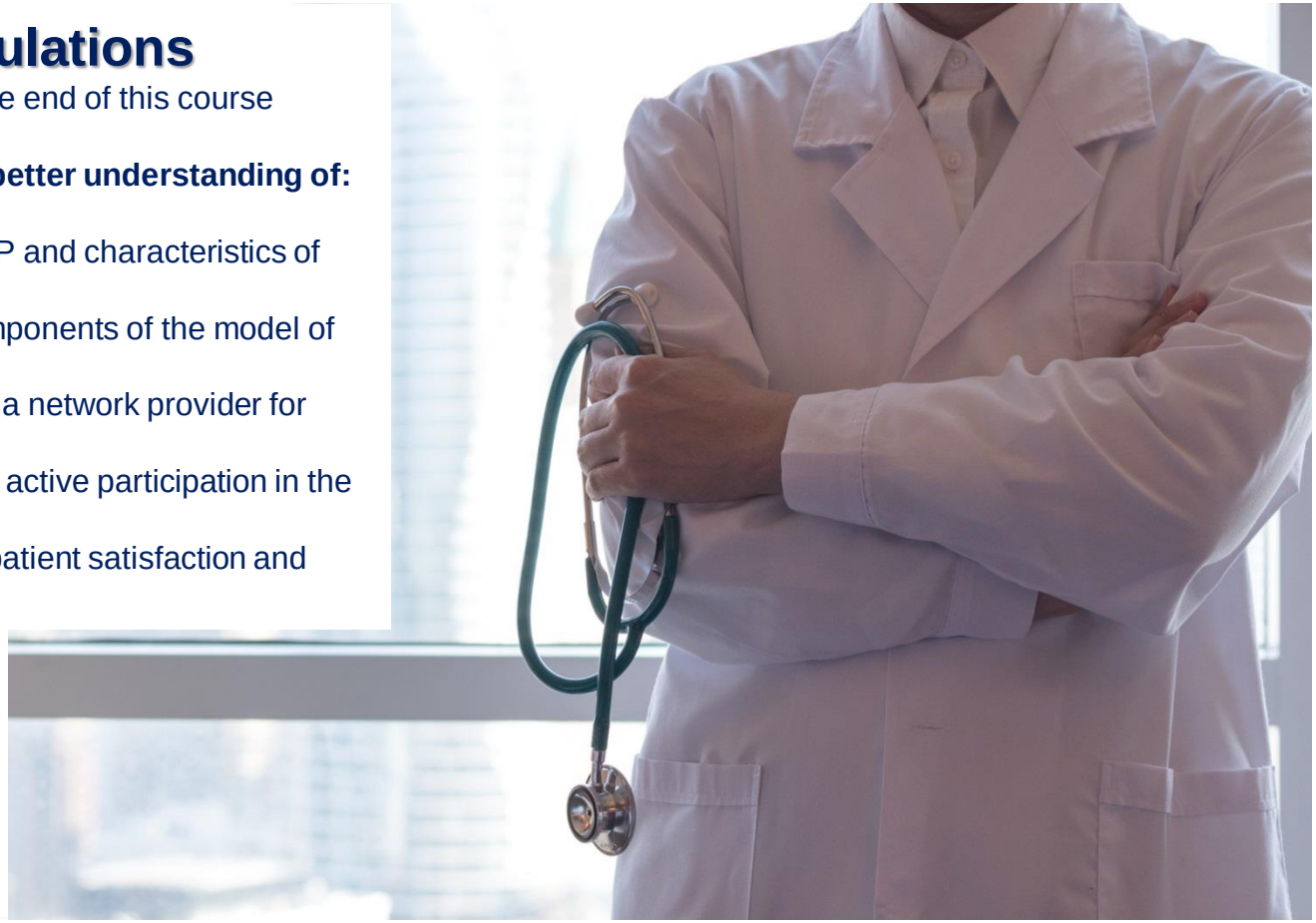
Continue these best practices so your patients feel well cared for and commit to follow-up care.

Congratulations

You have reached the end of this course

You should now have a better understanding of:

- ❑ The definition of an SNP and characteristics of the SNP population.
- ❑ The objectives and components of the model of care.
- ❑ Your responsibilities as a network provider for SNP members.
- ❑ The importance of your active participation in the model of care.
- ❑ How you can improve patient satisfaction and health outcomes.




Thank
you