Alignment Healthcare

Special Needs Program Training

Quality Management Department

Special Needs Plan (SNP) Overview

SNP Overview

- Medicare Advantage (MA) plans were created by the Medicare Modernization Act of 2003 (MMA)
- Special Needs Plans (SNPs) are a type of Medicare Advantage plan that includes Part C (medical) and Part D (drug) coverage
- Provide coverage for vulnerable populations who have multiple conditions and barriers to participating in self-care management
- Provide members with guidance and resources that help provide access to benefits and information

CMS Goal for Special Needs Plans (SNPs)

SNPs should emphasize monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping members maintain or improve their health status

Types of SNP

There are 3 types of SNP programs that CMS offers:

- *Institutional*
- *Dual Eligible*
- *Chronic*

Institutional (I-SNP)- Beneficiaries who reside, or are expected to reside, for 90 days or longer in a long term care facility – defined as skilled nursing facility (SNF) nursing facility (NF), intermediate care facility (ICF) or inpatient psychiatric facility OR those who live in the community but require an equivalent level of care to those who reside in a long term care facility.

Dually Eligible (D-SNP or DE-SNP)- Beneficiaries who qualify for both Medicare and Medicaid coverage.

Chronic Condition (C-SNP)- Beneficiaries with targeted chronic conditions such as cardiovascular disease, diabetes, congestive heart failure, osteoarthritis, mental disorders, ESRD, or HIV/AID

SNP Participation

Why participate in a SNP Program?

- AHC's clinical model is established in a way that we are already catering to the chronically ill and those with special needs
- Establishing a formal SNP plan allows for opportunities to open enrollment to the population in need throughout the year, provide greater benefits to the population and receive rates in line with the member's condition

What Makes a SNP Product Unique?

- Plan benefit packages are developed with the SNP populations in mind
  - Example – C-SNP packages are developed with generally richer benefits than standard MAPD plans in areas that help support the health maintenance of the plan members such as $0 to low cost diabetic supplies

How Do Members Enroll in a C-SNP?

Qualifying Condition

- Members who have been diagnosed with a qualifying condition have a continuous Special Enrollment Period (SEP) to join a C-SNP at any time, but are locked in to the C-SNP after selection, like any other MAPD plan, until the next Annual Enrollment period (AEP).

Verification of Chronic Condition

- Verification of a chronic condition is required by the end of their effective month per CMS and must be signed by the provider or an authorized employee of the provider's office
- Attempts to obtain eligibility verification information from an enrollee's existing provider using methods other than telephone contact (CMS 40.2.1)

Termination from C-SNP

- If verification is not completed by the last day of the 2nd month of enrollment, the member will be terminated from the C-SNP plan and transitioned to a regular MAPD plan

Verification of Enrollment Form

ALIGNMENT HEALTH PLAN

Verification of Chronic Condition

(IMPORTANT: PLEASE RETURN WITHIN 10 DAYS OF ORIGINAL RECEIPT)

The applicant listed below has applied for a special needs Medicare plan through Alignment Health Plan. For the applicant to qualify, a **physician or physician's office** must confirm his or her diagnosis by completing this form. We appreciate your assistance. For questions, please call (323) 728-7232, ext 5558, TTY 711, Monday- Friday 8:00 am -5:00 pm, except Holidays.

To be completed by the Applicant

Applicant's Full Name: _____ Applicant's Date of Birth: _____

Applicant's Address: _____ City: _____ State: ___ Zip: _____

Medicare ID Number (HIC#): _____ Proposed Effective Date: _____

Physician Name & Address: _____

Physician Phone Number: _____ Physician Fax Number: _____

To be completed by the Physician / Physician's Office

By signing this form, you confirm the patient has been diagnosed with:

☐ None ☐ Diabetes ☐ Chronic Heart Failure ☐ Cardiovascular Disease: Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Chronic Venous Thromboembolic Disorder

Confirmation provided by:

_____ _____

Signature *Date*

_____ _____

Printed Name or Stamp *Title*

_____ _____

Practice Name and Address *Phone Number*

Please return to: Alignment Health Plan
1100 W Town and Country Rd, Suite 300
Orange, Ca. 92868

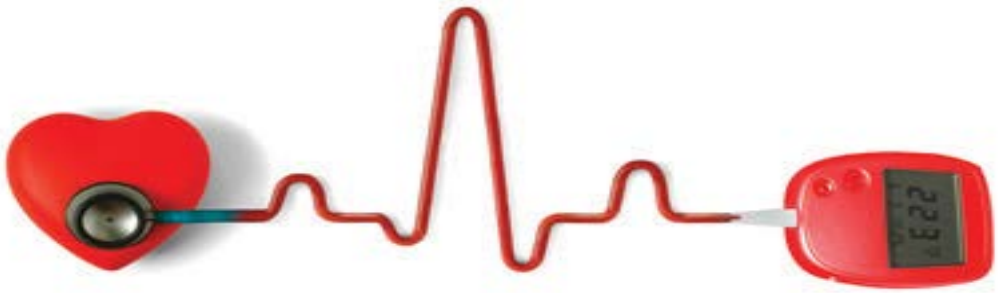
Or fax to: (562) 207-4623

Alignment Health Plan is an HMO and HMO SNP plan with a Medicare contract. Enrollment in Alignment Health Plan depends on contract renewal.

Alignment Health Plan Model of Care

Alignment Health Plan (CA)
Model of Care

- Offered in Los Angeles County and Orange County only
- Chronic Conditions SNP (C-SNP)
  - Diabetes, Chronic Heart Failure, Cardiovascular Disease
- Plan Benefit Package– H3815-010
- Product Name: Heart & Diabetes (HMO SNP)
- C-SNP Case Management is <u>NOT</u> Delegated to MSOs or IPAs



California (AHP) SNP Plans

LA County

Orange County

Model of Care Overview

What is a Model of Care?

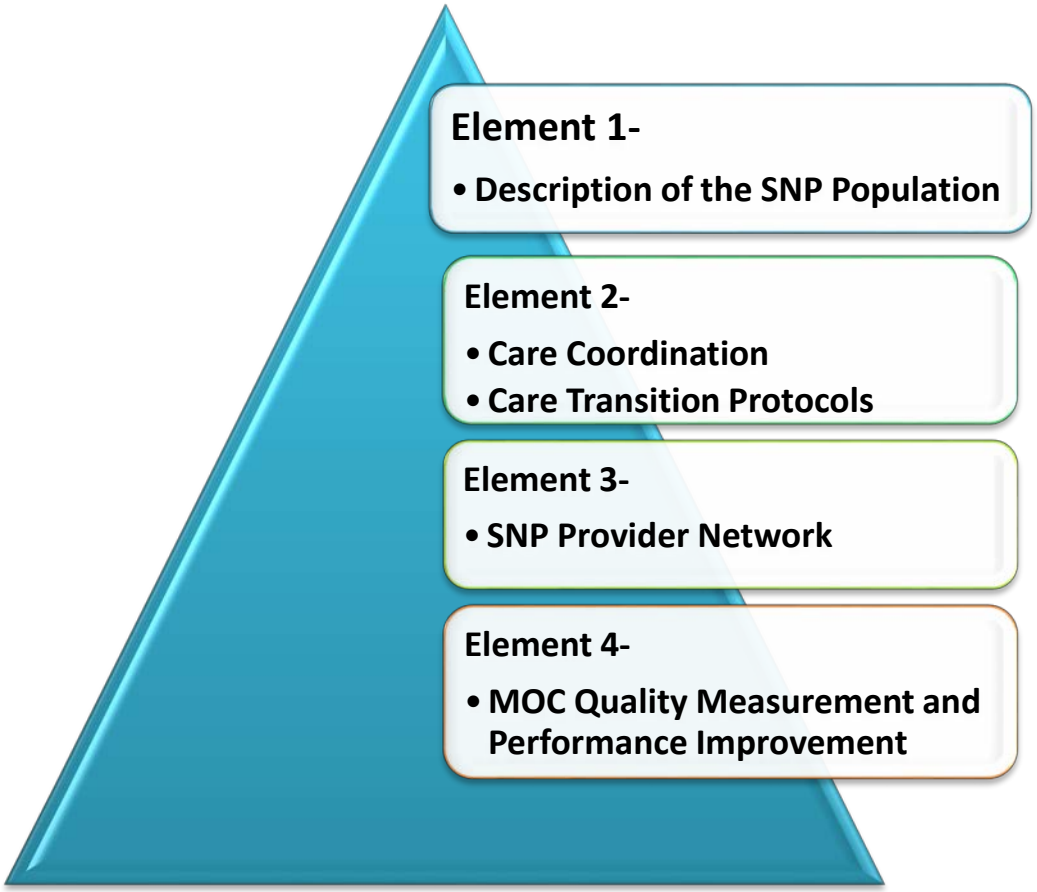
- A SNP Model of Care (MOC) is considered a vital quality improvement tool and integral component for ensuring that the unique needs of each member enrolled in a SNP are identified and addressed.
- The MOC is a fundamental component of SNP quality improvement so CMS requires the National Committee for Quality Assurance (NCQA) to review and approve SNPs' MOC based on standards and scoring criteria established by CMS.
- A MOC is required for each SNP type

Model of Care Goals

- To **improve access to affordable** medical, mental health and social services
- To **improve coordination** of care through an identified point of contact
- To create seamless **transitions across the health care setting**, health care providers and health services
- To **improve access to preventive** care services
- To improve the **appropriate utilization** of services
- To facilitate delivery of **cost-effective** health services
- To **improve members' health outcomes** through reduction of admissions, improved self-management, functional status, improved pain management and improved quality of life

MOC Elements

The MOC requirements comprise the following clinical and non-clinical standards:



MOC Element 1- Description of SNP Population

MOC Element 1: Description of SNP Population

- Element A- Overall SNP Population
  - Identify and describe the target population, including health and social factors, and unique characteristics of each SNP Type
  - Describe how the staff will determine, verify and track eligibility of SNP members
  - Describe the social, cognitive and environmental factors, living conditions and co-morbidities associated with the SNP population
  - Identify and escribe the medical and health conditions impacting SNP members
  - Define the unique characteristics of the SNP population served
- Element B- Most Vulnerable Members
  - Defines and identifies the most vulnerable members within the SNP population and provides a complete description of specially tailored services
  - Explains how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, affect the health outcomes of the most vulnerable
  - Correlates between demographic and the unique clinical requirements
  - Identifies and escribes established relationships with partners in the community to provide needed services

MOC Element 2-
Care Coordination
Health Risk Assessment

MOC Element 2: Care Coordination

- Element A- SNP Staff Structure
  - Administrative and clinical staff roles and responsibilities
  - How care coordination occurs
- Element B- Health Risk Assessment Tool
  - How the HRAT is used to develop the ICP
  - Dissemination of information to the ICT
  - Process for conducting initial and annual assessments
  - Methodology used to review, analyze and stratify HRA results
- Element C- Individualized Care Plans (ICPs)
  - Describe elements of the ICP
  - Process for Development/Modification
  - Documentation, Mantainence and Communication
- Element D- Interdisciplinary Care Team (ICT)
  - Key Members of ICT
  - Roles/responsibilities
  - How the ICT contributes to improving member health status
  - Communications within the ICT
- Element E- Care Transition Protocols
  - Type of health care settings and personnel responsible for care transitions
  - How the elements of the member's ICP is shared between settings and who has access
  - Describe the point of contact throughout the transition process

The Health Risk Assessment (**HRA**)

A Health Risk Assessment (HRA) is required for all members enrolled in a SNP

- The HRA is a tool used to identify member risk levels including but not limited to: Health, Functional, Cognitive, Psychosocial / Mental Health
- All SNP members must have a completed Initial HRA within 90 calendar days of enrollment or with any change of Plan Benefit Package (PBP).
- Annually, members require an HRA within 365 calendar days of their previous HRA or enrollment date
- HRAs should be repeated when there is a major health status change or care transition.
- The HRA may be completed face-to-face, telephonically or written
- CMS requires a minimum 3 outreach attempts and a letter within 30 calendar days in the first 90 calendar days for initial and 90 calendar days prior to the annual HRA due date when an HRA is not completed
- The HRA must be reviewed, analyzed and stratified by the Case Manager within 30 calendar days of administering the HRA.
- HRA completion rates are CMS STAR Measures!

Health Risk Assessment Tool (HRAT)

To accommodate member preferences, AHC has several ways to complete an HRA

Jump Start Assessment

- The Jump Start Assessment (JSA) is performed in person at either a Care Center or as an in home assessment
- The JSA meets the HRA requirements of the MOC and Star measures
- The JSA consists of the following:
    - 120+ point assessment
    - A head to toe physical
    - Lab work - blood and urine collection.
    - Review of current and past medical history.
    - Review of medications, to include any over the counter (OTC) drugs.
    - Assessment to determine other health needs or screenings as needed to address individual health concerns.
    - Referrals for further testing and chronic disease management clinics.
    - Results are shared with member's PCP and we work together to coordinate and manage care.
    - Referrals for specialty care and disease management programs as necessary
    - Assist in completing HEDIS measures
    - Review of advanced directives

Telephonic Health Risk Assessment

- Subset of the Jumpstart Visit Assessment questions
- Can be asked over the telephone by non-clinical staff- JSA Outreach Team
- Questions include:
  - Self reported health status
  - Tobacco and Alcohol usage
  - Marital Status
  - Living situation
  - Caregiver support
  - ADLs (Barthel Index)
  - Fall history
  - PHQ-2
  - Community Assessment Risk Screen (CARS)
    - Hospitalizations
    - Emergency Room or Urgent Care Visits
    - Chronic conditions
    - > 5 Medications
  - Advance Directives
  - Medical Supplies or Home care services
  - Dialysis service
  - Specialist Care

Paper Health Risk Assessment

- Used when unable to contact a member or member refuses
- Sent at the member's request
- Includes same questions as the Telephonic HRA
- Sent for annual reassessments

The Comprehensive Assessment

This is an Assessment of the Member's health status based on NCQA® standards

This is a stand alone assessment which should be used for all members engaged in Case Management

The Comprehensive Assessment consists of the following :

- Member health status including condition-specific issues
- Member's clinical history; including medications
- Activities of daily living
- Behavioral health status, including cognitive functions
- Psychosocial issues
- Cultural and linguistic needs, preferences, or limitations
- Visual and hearing needs, preferences, or limitations
- Caregiver resources and involvement
- Available benefits (Value-added services such as in-home survey, social services, pharmacy, education, dietitian and behavioral health)
- Available community resources
- Life-planning activities including advanced directives, living wills, and hospice

MOC Element 2- Care Coordination Individualized Care Plan

Care Plan Basics

- A Care Plan is a vehicle used to facilitate the nursing process
- Allows us to clarify most urgent or priority interventions
- A Care Plan serves as written blueprint to carry out nursing actions
- Care Plans are used as a communication tool to the member and the PCP

The Individualized Care Plan (**ICP**)

- An Individualized Care Plan (ICP) outlines health related goals and is developed by the Case Manager with the member and is communicated to the member's PCP to contribute relevant clinical information.
- The ICP must be initiated or updated within 30 calendar days from the referral to CM or from the initial or most recent HRA
- If a member is unable to contact or refuses to complete an HRA, a care plan is created using available information such as Command Center, Utilization or claims data
- Goals must be individualized and prioritized based on the member's identified needs
    - Include both short and long term goals
    - Include time frame for evaluation
- The CP must include interventions for all needs identified from the Health Risk Assessment and Comprehensive Assessment
- The CP is required to be updated and reviewed with the member throughout the calendar year or until all goals are met

MOC Element 2- Care Coordination Care Transition

Care Transitions

Members who experience a care transition are vulnerable to receiving fragmented and unsafe care when they move from one setting to another

- Care transition settings include home, home health, acute care, skilled/custodial nursing facilities, rehabilitation facility, outpatient/ambulatory care/surgery centers
- Care Transition support needs are addressed by the Case Manager in order to maximize member recovery and avoid preventable transitions
- During any transition of care, it is the responsibility of the Case Manager to share the members individualized care plan with the receiving setting.
- As the member's primary point of contact during a transition, the case manager should:
    - Provide the member with educational materials and ensure member has understanding of health changes.
    - Verify physician appointments are made
    - Ensure the member has an understanding of post-discharge plan and instructions
    - Verify ordered Home Health and Durable Medical Equipment supplies are in place
    - Provider member and caregiver support/training
    - Reconcile medications
- All applicable ICT members are informed of the member's needs pre, during and post transition from one care setting to another including the receiving facility

MOC Element 3- Provider Network

MOC Element 3: Provider Network

- Element A- Special Expertise
  - The specialized expertise in the provider network addresses the needs of the target population as described in MOC 1
  - How the SNP oversees the licensure and certification of providers
  - Documentation of provider information
  - Collaboration between the providers and ICT to provide necessary specialized services
- Element B- Use of Clinical Practice Guidelines and Care Transition Protocols
  - Monitoring how providers utilize CPG and nationally-recognized protocols appropriately
  - Identify challenges where CPG and protocols need to be modified
  - Decisions to modify CPGs and acted upon by the ICT
  - Oversees the use of care transition protocols to maintain continuity of care
- Element C- Provider Network Training
  - Initial and annual trainings for network and out-of-network providers seen by members on a routine basis
  - Offering MOC trainings to all network providers
  - Challenges associated with completion of MOC trainings
  - Actions taken when training is not complete

MOC Element 4- Quality Measurement and Performance Improvement

MOC Element 4-
Quality Measurement and Performance Improvement

- Element A- Quality Performance Improvement Plan
  - Plan-level information focusing on goals that measure overall pl performance related to all aspects of the MOC
- Element B- Measureable Goals and Health Outcomes for the MOC
  - Plan-level measures and goals for the target population
  - Health/clinical goals (e.g., controlling diabetes, mental health screening)

- Element C- Measuring Patient Experience of Care
  - Plans may use wide variety of patient experience/satisfaction surveys—CAHPS/HOS are acceptable, as are other alternatives
  - Provide details of surveys and methodology for data collection
  - Describe how results of patient experience surveys are integrated into the overall MOC performance improvement plan
  - Describe steps taken by the SNP to address issues identified in survey responses
- Element D- MOC Ongoing Performance Improvement Evaluation of the MOC
  - How the SNP uses the results from its performance indicators/measures to support its ongoing quality improvement plan including lessons learned and challenges in obtaining timely data.
- Element E- Dissemination of SNP Quality Performance
  - Detail who receives the information, how often they receive it, and what communication methods are used

Responsibilities

Member Requirements

- As part of the SNP Program, members should be **active participants** in support of their healthcare.
  - Members should participate in AHP Case Management to develop their care plan
  - Work with their Interdisciplinary Care Team to work toward goals

Provider Responsibilities- Participation and Communication

- PCPs will receive a copy of the member care plans throughout the year for all new C-SNP patients and existing patients.

- You will receive updates to the care plan if there is a change in condition, after a care transition or annually.

- Your participation ensures your patient understands their care plan and receives needed care

Provider Responsibilities- Participation and Communication

- Assess/re-assess your patient to identify health status changes and update the Individualized Care Plan (ICP)
- Discuss the care plan with your patient
- Communicate with the Interdisciplinary Care Team (ICT) to ensure coordination of care and transition of care for your patient
- Refer your patients to the Alignment Case Management Program
- Participate and support Alignment Health Plan's quality improvement initiatives
- Participate in Alignment Health Plan's provider satisfaction survey

Who is Responsible For Compliance With The SNP Model Of Care?

Compliance with CMS requirements and the ethical administration of the Alignment Health Plan and Alignment Healthcare SNP MOCs is a enterprise-wide, shared responsibility.

If processes, process changes, meetings, trainings and communications are not documented they do not exist with CMS!

Regulatory References

- CMS Medicare Managed Care Manual- Chapter 16b- Special Needs Plans
- 42 C.F.R. §§ 422.2
- Social Security Act Section 1859 (b)(6)(B)(iii)
- CMS Medicare Managed Care Manual Chapter– Enrollment Guidelines
- CMS Medicare Managed Care Manual Chapter 3 – Marketing Guidelines
- CMS Medicare Managed Care Manual Chapter 4 – Beneficiary Protections
- MMCM Chapter 8
- NCQA® Model of Care Scoring guidelines
- Medicare Part C Plan Reporting Requirements Technical Specifications Document Number 13 for “SNP Care Management”

Model of Care Attestation Page

Delegate Representative Attestation

Special Needs Plans (SNP) Model of Care Training Attestation

I, _____, hereby attest that the attached listed providers have completed the **Special Needs Plan (SNP) Model of Care Training**.

The listed providers understand the Model of Care and the role in improving health outcomes for the most vulnerable population.

It is understood that the annual training is mandatory for all providers that care for SNP members and is required by the Centers for Medicare and Medicaid Services (CMS).

Name:_____ Date:_____

Signature_____

IPA: _____

Please return completed attestation and provider signature list to:

AHP Quality Department

Email to QI@ahcusa.com

or send via fax 562-207-4617

PROVIDERS SIGNATURE LIST

Purpose: Special Needs (SNP) Model of Care (MOC) annual training is mandatory and is required by the Centers for Medicare and Medicaid Services (CMS) for all Medicare Advantage Special Needs Plan providers.

Instructions: Upon review of training, please provide your printed name, signature and training completion date.

Print Name:	Signature:	Training Completion Date: