Special Needs Plan Model of Care Annual Training 2023

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CareMore HEALTH

Chapter 42 of the Code of Federal Regulations, Part422 (42CFR422.101(f)(2)(ii)

mandates that Special Needs Plans(SNPs) conduct SNP Model of Care(MOC) training for all contracted providers.

Model of Care is the evidence-based process by which we integrate benefits and coordinate care for beneficiaries enrolled in a Special Needs Plan.

Objectives

At end of the course, program participants will:

- Understand characteristics and needs of the chronic, dual eligible, institutional Special Needs Plans (SNP)

- Know the important components of care planning and the role of the Interdisciplinary Care Team (ICT) in care coordination for SNP Members

- Understand CareMore's patient-centric Model of Care approach

- Be familiar with key principles for improving transitional care management and the case management referral process

- Recognize measurement outcomes used to evaluate CareMore's compliance with the Model of Care

What is a Special Needs Plan (SNP)

Medicare and Medicaid Legislation

The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage (MA) coordinated care plan (CCP) that was specifically designed to provide extra benefits to groups with special health care needs, with the goal of improving care and decreasing costs for the frail and elderly through improved coordination.

Definitions

There are 3 types of Special Needs Plans (SNPs)

I-SNP – Involving institutionalized beneficiaries

C-SNP – Involving beneficiaries with severe or disabling chronic conditions

D-SNP – Involving dually eligible for both Medicare/Medicaid

SNP Goals

All SNPs have the following overarching goals:

Improve Access to medical, behavioral and social services

Improve Access to preventive health services and affordable care

Improve Coordination of care including transitions of care across health care settings

Improve Outcomes by identifying baselines, benchmarking and evaluating results

Minimal Eligibility Requirements

Members must:

• Have both Medicare Part A and Medicare Part B

• Live in the approved service area

• <u>Not</u> have End-Stage Renal Disease (ESRD), with limited exceptions, at initial enrollment

For C-SNP

• Clinically diagnosed with the specific chronic medical disorders covered under the C-SNP such as diabetes, chronic lung disorders, or coronary heart disease, and end stage renal disease.

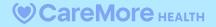For D-SNP

• Eligible for both Medicare and Medicaid benefits

For I-SNP

• Currently reside in a nursing home or at home in the community and needing an institutional level of care

SNP Population

General and Vulnerable Populations

CareMore's Vulnerable Populations

Intensive management of frail and chronically ill members, identified through predictive models, data scans, pharmacy utilization reports, PCP referrals, and/or member self-identification.

SNP population encounters multiple co- morbidities such as high blood pressure, high cholesterol, heart disease, depression, poor nutritional status and Alzheimer's or other dementia related disorders.

The CareMore Model

The patient is at the center of all that we do.

Regional Medical Officer (RMO)

Advanced Practice Clinicians (NP)

Primary Care Physician (PCP)

Patient

Community Staff

Case Manager/ Mobile Coordinator (CM/UM)

Shared Services: Pharmacy, BH, SW, Specialist

CareMore Care Coordination

Health Risk Assessment

Individual Care Plan

Inter-disciplinary Care Team

Care Transition

Care Management Referrals

Health Risk Assessment

CareMore uses a Health Risk Assessment (HRA) for all SNP members to assess for various chronic conditions.

HRAs conducted include:

- Initial HRA completed within 90 days for all newly enrolled SNP Members.

- Annual HRAs are to be completed no less than 365 days of last HRA, or as the member's health care status changes

HRAs allow CareMore the opportunity to assess the medical, cognitive, functional, psychosocial and behavioral health needs of each beneficiary

The HRA Tool is integrated into our Electronic Health Records (EHR) to capture the member's conditions and aid in the development of the Individualized Care Plan (ICP).

Individual Care Plan

The Individual Care Plan (ICP) is created by CareMore's care team based on information obtained from the member's assessment and issues identified on the HRA.

- The member is involved in the development of the ICP and is in agreement with the care plan and goals
- Goals are prioritized considering the member's health care needs and personal preferences
- The ICP includes member's self-management and goals
- The ICP identifies measurable outcomes and progress
- The ICP recognizes potential barriers and progress towards goals
- The ICP is shared with members of the Interdisciplinary Care Team (ICT) as well as the member and other network providers/stakeholders as needed to ensure comprehensive coordination of care
- ICP is reviewed and/or updated annually (at a minimum), or as the member's healthcare needs change

Interdisciplinary Care Team

CareMore's Interdisciplinary Care Team (ICT) involves the following:

- A multi-disciplinary team that evaluate the needs of beneficiaries based on their risk levels and severity of their chronic conditions as provided for in the ICP.

- Coordination of special needs of the beneficiaries with input from the beneficiary, Advanced Practice Clinicians (APC), Case Managers, Social Workers, Behavioral Health, Specialists, and Primary Care Physicians.

- Methods of communication include telephonic, virtual, and face-to face meetings as well as electronic data transfer record keeping

- New for 2023: ICT must include providers with expertise and training (in a defined role appropriate to their licensure).

Interdisciplinary Care Team (cont)

New regulations for 2023:

Regulations at 42 CFR § 422.101 (f) (1) (iv) require that all SNPs must provide for face to face encounters for the delivery of health care, care management, or care coordination services.

- At least annually
- Beginning within the first 12 months of enrollment
- As feasible, with the enrollee's consent

Care Transitions

Care Transitions can be a challenging time for members.

One objective of the model of care is to help member's to plan and prepare for care transitions, ensure care continues after transitions are complete and communicate and coordinate with treating providers

This is accomplished by:

- Utilizing interdisciplinary care transition protocols

- Updating, communicating, and implementing ICPs

- Providing clear communication and education to members and caregivers

- Periodic monitoring of health status (progression or decline)

Care Transitions / Health Status Changes

When the health status of a SNP member changes, the ICT is mobilized to provide the unique care that is needed.

- Extensivists visit the patient in hospital/skilled nursing facility
- Primary Care Providers are consulted on recommended changes to plan of care
- Specialty providers are consulted based on member needs

Care Managers provide outreach and discharge planning support

- Schedule post-hospital follow up with Extensivists
- Continue communication with member based on post-discharge risks
- Coordinate with Extensivist/APC to update the ICP and communicate with the Primary Care Provider

Care Management Referrals

The Care Management Team helps ensure members receive personalized care coordination across the entire delivery of care. The Care Managers focus on clinical, behavioral and social needs of CareMore patients. This includes referrals for the following:

- **Palliative Services**

- **Social Determinants of Health (SDoH):** Economic Stability, Education Access, Health Care Access, Community/Social

- **Hospice Services**

- **Complex Case Management** - a process to ensure timely access to and coordination of medical and psychosocial services for patients and their care/support system. This includes assessment of needs, care plan creation/implementation, care coordination, monitoring, reassessment, follow-up and case conferences.

Hospice Services

While Hospice services are provided by external vendors as the patient's primary provider, CareMore Care Management department continues to provide non-Hospice care through coordination of care with the patient's Hospice agency by providing support through telephonic communication, and conducting face to face visits. The focus of Hospice is supportive comfort and quality of life, rather than cure.

The goal is to enable members to be comfortable and free of pain, so that they live each day as fully as possible.

Hospice Services (cont)

The philosophy of hospice is to provide support for the member's emotional, social, and spiritual needs as well as medical symptoms as part of treating the whole person. Hospice may be provided at home, skilled nursing facility or acute facility.

Hospice works with the member, family and caregiver to support the individual care needs and wishes of the member in final stages of life.

Palliative Services

CareMore uses a Integrated Palliative Care Program focused on providing care to the most at risk fragile, medically complex elderly patients and others with chronic debilitating medical conditions. This program is designed to provide comprehensive care management to the patient and their family/caregiver(s). The program also assists patients with a more supportive, less invasive treatment plan in their transition to hospice care.

The mission is to improve quality and efficiency of care to maximize quality of life and reduce redundant or unnecessary services.
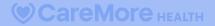
Social Services

The need for a Social Service referral is determined by the requesting clinician, examples include:

- Social Determinants of Health (SDOH) (Economic Stability, Education Access, Health Care Access, Community/Social)
- The member's health and safety are in jeopardy due to inability to manage personal care for things such as getting up and dressed, going to bed, personal hygiene, continence management, eating and daily routines
- Member is experiencing social isolation
- Declining ability to care for self
- Discussing alternative living arrangements
- Elder abuse - financial, physical, emotional
- Self Neglect
- Substantial need for Community resources support
- End of life and advanced planning discussion and assistance
- Behavioral health needs including conservatorship discussions

Provider Network

Specialized Network

CareMore's Provider Network

CareMore contracts with providers in all geographic service areas to ensure the healthcare needs of the SNP patients are met. This includes, but is not limited to:

Internal Medicine

Endocrinology

Cardiology

Behavioral Health

Orthopedics

Oncology

Pulmonology

Ophthalmology

Provider Network Requirements

CareMore ensures and tracks all treating providers for the following:

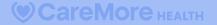Active necessary licensure/certifications

Access to Clinical Practice Guidelines/Provider Portal

Participation in ICT based on needs

Annual Model of Care training

Quality Measures

SNP Goals and Performance

SNP Goals

All SNPs have the following goals:

Improve Access

- To affordable care and preventative health services

- To medical, behavioral health and social services

Improve Coordination

- Coordination of care and transitions of care across health care settings

Improve Outcomes

- Use baselines, benchmarks and metrics to assess patient health outcomes for improvements

SNP Performance

CareMore monitors/evaluates each SNP regarding performance and outcomes, including:

- Model of Care goals and progress toward the goals

- SNP specific HEDIS measures

- Patient Satisfaction Surveys

- Improvement projects for SNP, chronic care or disease management

SNP performance evaluation is communicated with executive leadership and submitted annually to the QM Committee.

A summary is shared with key stakeholders such as members and providers and is available on CareMore's public website.

References

NCQA Special Needs Plans Model of Care Approvals

https://snpmoc.ncqa.org/wp-content/uploads/CY2023SNPModelofCareTrngFAQs.pdf

Special Needs Plans, Medicare Managed Care Manual

https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

CareMore Model of Care Policy

CHS-MOC-06 & CHS-MOC-03

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