Special Needs Plan

Model of Care Annual Training 2024

Model of Care Training

Purpose

- Chapter 42 of the Code of Federal Regulations, Part 422 (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

- Understand characteristics and needs of the chronic, dual eligible, and institutional Special Needs Plans (SNP)
- Be able to identify the components of care planning and the role of the Interdisciplinary Care Team (ICT) in care coordination for SNP members
- Be familiar with key principles for improving transitional care management and the case management referral process
- Recognize measurement outcomes used to evaluate Carelon Health's compliance with the Model of Care
- Review changes for 2024 related to D-SNPs in California

What is a Special Needs Plan (SNP)?

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care.

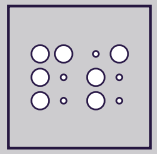
SNP enrollment is limited to people with specific diseases, certain healthcare needs, or who also have Medicaid.

SNPs are only available to those beneficiaries who have an additional qualifying condition.

SNPS combine the benefits of Original Medicare (Parts A and B) with prescription drug coverage (Part D).

SNPs tailor their benefits, provider choices, and list of covered drugs (formularies) to best meet the specific needs of the groups they serve.

Types of Special Needs Plans (SNPs)



C-SNP – people living with severe or disabling chronic conditions

D-SNP – people who have both Medicare and Medicaid

I-SNP – people who live in a skilled nursing facility or require long-term or resident care in a healthcare institution for at least 90 days

SNP Goals

All SNPs have the following overarching goals:

1. Improve access to medical, behavioral, and social services
2. Improve access to preventive health services and affordable care
3. Improve outcomes by identifying baselines, benchmarking, and evaluating results
4. Improve coordination of care, including transitions of care across health care settings

Minimum Eligibility Requirements

All members must:

- Have both Medicare Part A & Medicare Part B
- Live in the approved service area

C-SNP

Members must be clinically diagnosed with the specific chronic medical disorder(s) covered under the C-SNP, such as:

- Diabetes, cardiovascular disorders, chronic lung disorders, and/or end stage renal disease

D-SNP

- Members must be eligible for both Medicare and Medicaid benefits

I-SNP

- Members must currently reside in a nursing home, or at a home in the community and require an institutional level of care

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SNP Population

General and Vulnerable Populations

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
    - Alzheimer's or other dementia-related disorders

The Carelon Health Model

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

Carelon Health Care Coordination

Health Risk Assessment

- Carelon Health uses a Health Risk Assessment (HRA) for all SNP members to assess for various chronic conditions.
- The HRA Tool is integrated into the Electronic Health Record (EHR) to capture the member's conditions and aid in the development of the Individualized Care Plan (ICP).
    - HRAs allow Carelon Health to assess the medical, cognitive, functional, psychosocial and behavioral health needs of each beneficiary
    - The Initial HRA is to be completed within 90 days for all newly enrolled SNP Members.
    - Annual HRAs are to be completed within 364 days of last HRA, or as the member's health care status changes

Individualized Care Plan

Individualized Care Plan (ICP) is…

- Developed by the care manager, with input from the patient and ICT, based on information obtained from the member's assessment and issues identified on the HRA.
- Reviewed and updated by the care manager during the annual reassessment process, upon significant change in patient's health status, upon patient's request, or when deemed necessary by the care manager.
- 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.
- A general ICP will be created for members who are unreachable or unwilling to participate. All members will have an ICP, regardless of their participation status.

Individualized Care Plan

The ICP...

- Includes the member's self-management and goals
- Identifies measurable outcomes and progress
- Recognizes potential barriers and progress towards goals

Goals

- The member is involved in the development of the ICP and agrees with the care plan and goals
- Goals are prioritized considering the member's healthcare needs and personal preferences

Interdisciplinary Care Team

Interdisciplinary Care Team (ICT) involves:

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

ICT Communication

- Methods of communication
  - Telephonic
  - Virtual
  - Face-to-face
  - Electronic data transfer record keeping

ICT Communication (Face-to-Face)

Regulations at 42 CFR § 422.101 (f) (1) (iv) require that all SNPs 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

D-SNP California

*New for 2024 from Cal-Aim DSNP Policy Guide

Dementia/Alzheimer's Care

- For patients with dementia care needs, the Interdisciplinary Care Team (ICT) must include the patient's caregiver and a trained dementia care specialist to the extent possible and as consistent with the patient's preferences.

- D-SNPs must have trained dementia care specialists on ICTs, as needed.

Resources

- Providers are encouraged to leverage "Dementia Care Aware" resources to detect cognitive impairment.

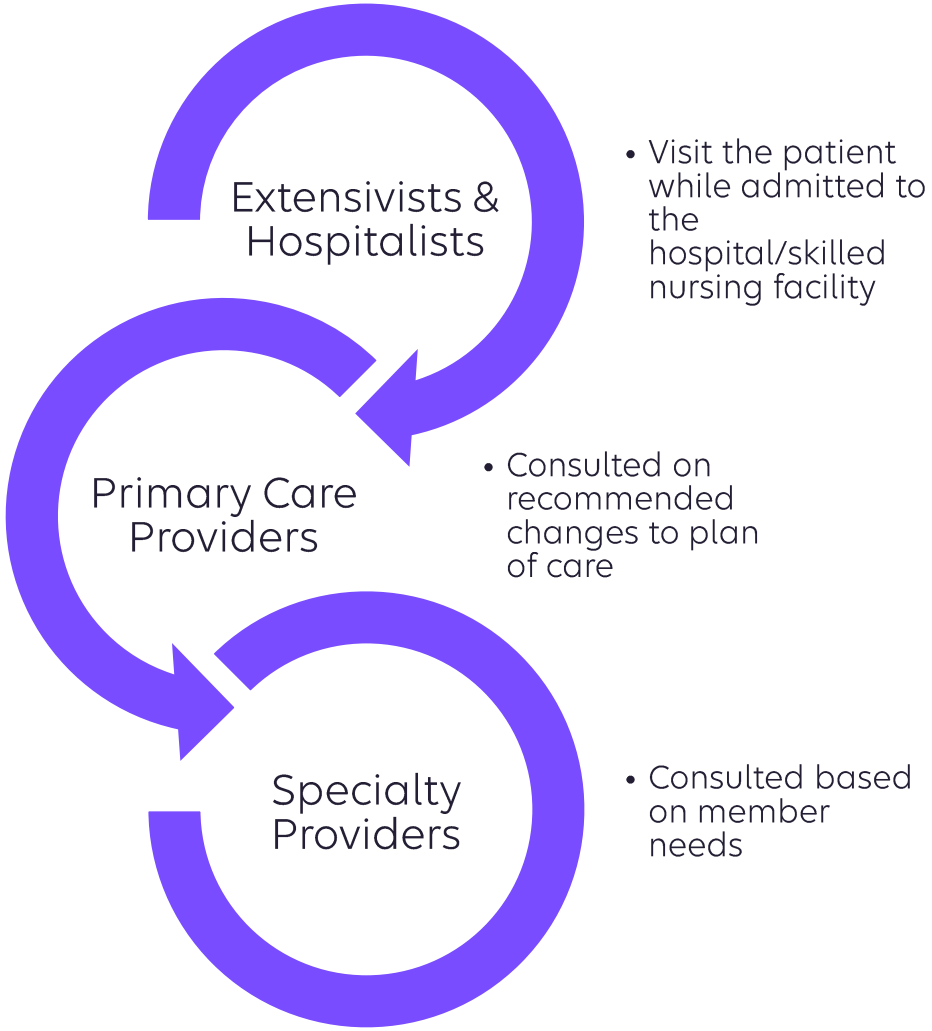
  The website is https://www.dementiacareaware.org/

- The Dementia Care Aware Warmline is available to health care providers at 1-800-933-1789, from Monday to Friday between 9 a.m. and 5 p.m.

  - The warmline offers education and decision-making consultation for clinicians and primary care teams in California, covering topics related to dementia screening, assessment, diagnosis, management, and care planning.

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



Care Transitions

Care transitions can be a challenging time for members

- One objective of the model of care is to ease the transition process by:
  - Helping members plan and prepare for care transitions
  - Ensure care continues after transitions are complete
  - Communicate and coordinate with treating providers

This objective is accomplished by:

- Utilizing interdisciplinary care transition protocols
- Updating, communicating (to patient, PCP, authorized representative, ICT) 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

Care Managers provide outreach and discharge planning support

Care Managers schedule post-hospital follow-up with PCPs

Care Managers continue communication with the member, based on post-discharge risks

Care Managers complete a comprehensive assessment upon discharge to ensure the member has all discharge needs met

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 Carelon Health patients.

Care Management Referrals (Common Referrals)

Palliative Services

- Specialized care for people living with a serious or terminal illness
- Provide relief from the symptoms, stress and discomfort of the illness

Hospice Services

- Focus is on supportive comfort and quality of life, rather than cure
- Goal is to enable members to be comfortable and free of pain, so that they live each day as fully as possible.

Social Determinants of Health (SDoH)

- Economic stability, education access, health care access, community/social

Complex Case Management

- Ensures timely access to and coordination of medical and psychosocial services
- Includes: assessment of needs, care plan creation/implementation, care coordination, monitoring, reassessment, follow-up and case conferences

Hospice Services

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.

Hospice services are provided by external vendors as the patient’s primary provider.

- Carelon Health Care Management continues to provide non-Hospice care through coordination of care with the patient’s hospice agency.
    - This support occurs through telephonic communication and by conducting face-to-face visits.

Social Services

The need for a Social Service referral is determined by the requesting clinician.

Common scenarios include:

- Social Determinants of Health (SDoH)
- Member experiencing social isolation
- Declining ability to care for self
- Discussing alternative living arrangements
- Elder abuse (financial, physical, and/or emotional)
- Self neglect
- Substantial need for community resources support
- End-of-life and advance care planning discussion and assistance
- Behavioral health needs, including conservatorship discussions
- Member's health and safety are in jeopardy due to inability to manage personal care or activities of daily living (i.e.: getting dressed, going to bed, personal hygiene, continence management, eating and daily routines)

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Provider Network

Specialized Network

Provider Network

Carelon Health 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
- Oncology
- Pulmonology
- Behavioral health
- Orthopedics
- Ophthalmology

Provider Network Requirements

Carelon Health tracks all treating providers to ensure they:

- Have active licensure/certifications that are necessary to participate in the patients' care
- Have access to Clinical Practice Guidelines/Provider Portal
- Actively participate in the interdisciplinary care team (ICT), based on needs
- Participate in 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 healthcare settings

Improve Outcomes

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

SNP Performance

Carelon Health monitors and evaluates each SNP regarding performance and outcomes, including:

- Model of Care goals and progress towards 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 Carelon Health's public website.

Resources

- 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
- Carelon Health Model of Care Policy
  - CHS-MOC-06 & CHS-CLC-04
- Palliative Care Definition
  - Palliative Care Definition | What is Palliative Care | Center to Advance Palliative Care (capc.org)
- Medicare: Special Needs Plans (SNP)
  - Special Needs Plans (SNP) | Medicare
- CMS
  - Special Needs Plans | CMS
- What are Medicare Special Needs Plans (SNPs)?
  - What are Medicare Special Needs plans (SNPs)? | UnitedHealthcare (uhc.com)
- What You Need to Know
  - Special Needs Plans: C-SNP, I-SNP, D-SNP...What You Need to Know - Colonial Penn Insights

THE ACADEMY