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

Initial and Annual Training

2018

Learning Objectives

Program participants will be able to:

- List the three overall goals of the SNP Model of Care
- Describe the three qualifying medical conditions for patients in the Health Net Jade C-SNPs
- Understand the important components of the care plan and team based care to improve care coordination for SNP patients
- Name two principles important to improve transition care management
- Identify three outcomes being measured to evaluate the Model of Care

Special Needs Plan (SNP) Background

SNPs are Medicare Advantage plans with special benefit packages for populations with distinct health care needs. Goal is to provide extra benefits and team-based care to improve outcomes and decrease costs for special need population through improved coordination. There are 3 SNP types:

- Dual Eligible or D-SNP for those eligible for Medicare and Medicaid
- Chronic Disease or C-SNP for those with severe or disabling chronic conditions – provider attestation of condition required
- Institutional or I-SNP for those requiring institutional level of care or equivalent living in the community (*Health Net does not have this type)*

Goals of Special Needs Plans

Improve Access

- Improving access to medical and mental health and social services
- Improving access to affordable care and preventive health services

Improve Coordination

- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, providers and health services
- Assuring appropriate utilization of services

Improve Outcomes

- Improving patient health outcomes

Section 2

Model of Care 1

SNP Population

General Population

Vulnerable Subpopulations

Health Net SNPs

Health Net has two types of SNPs:

- D-SNPs for patients that are dually eligible for Medicare and Medicaid known as the Amber SNPs
- C-SNPs for patients with chronic and disabling disorders known as the Jade SNPs - one or more of the following chronic diseases is required and must be documented/attested to depending on specific SNP:

1. Diabetes
2. Chronic Heart Failure
3. Cardiovascular Disorders (CV):
   - Cardiac Arrhythmias
   - Coronary Artery Disease
   - Peripheral Vascular Disease
   - Chronic Venous Thromboembolic Disorder

Vulnerable SNP Sub-Populations

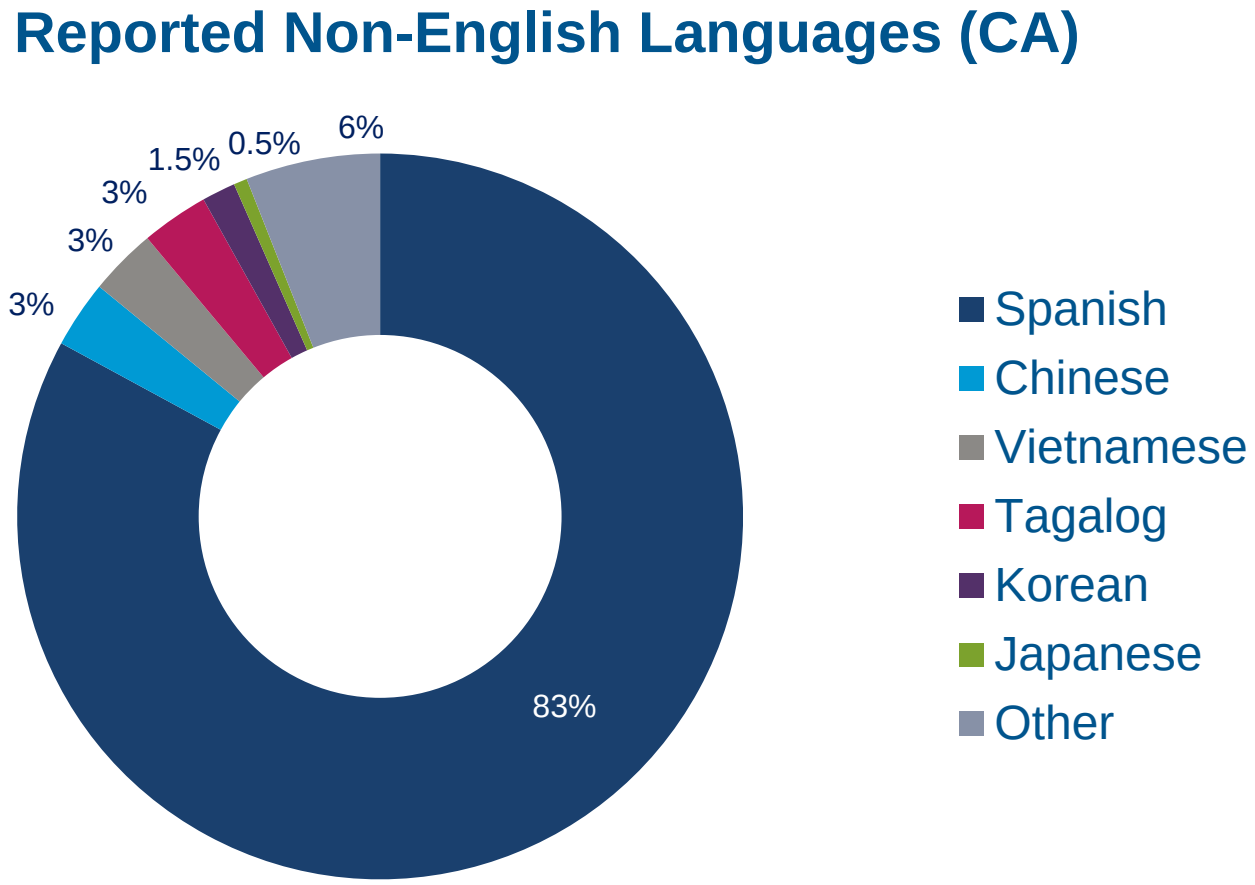
Populations at greatest risk are identified to direct resources towards patients with increased need for team based care:

- Complex/multiple chronic conditions – require assistance with disease management and navigating health care systems
- Disabled - unable to perform key functional activities independently
- Frail – over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF
- Cognitively Impaired – at risk due to moderate/severe memory loss
- End-of-Life – those with terminal diagnosis

Benefits to Meet Specialized Needs

- **Decision Power Disease Management** – whole person approach to wellness with comprehensive in-person, online and written educational and interactive health resources
- **Medication Therapy Management** – pharmacist review of medication profile quarterly and communication with member/ doctor when issues identified: duplications, interactions, gaps in treatment, adherence
- **Transportation** – covers medically related trips up to unlimited under the health plan or Medicaid benefit and vary according to the specific SNP and region
- In addition, SNP may have benefits for **Dental, Vision, Podiatry, Gym Membership, Hearing Aides, OTC allowance or lower costs for items such as Diabetic Monitoring supplies, Cardiac Rehabilitation** – these benefits vary by region/SNP type

SNP Member Diversity



Language/Communication Resources

SNP patients may have greater incidence of limited English proficiency, health literacy issues and disabilities that affect communication and impact health outcomes.

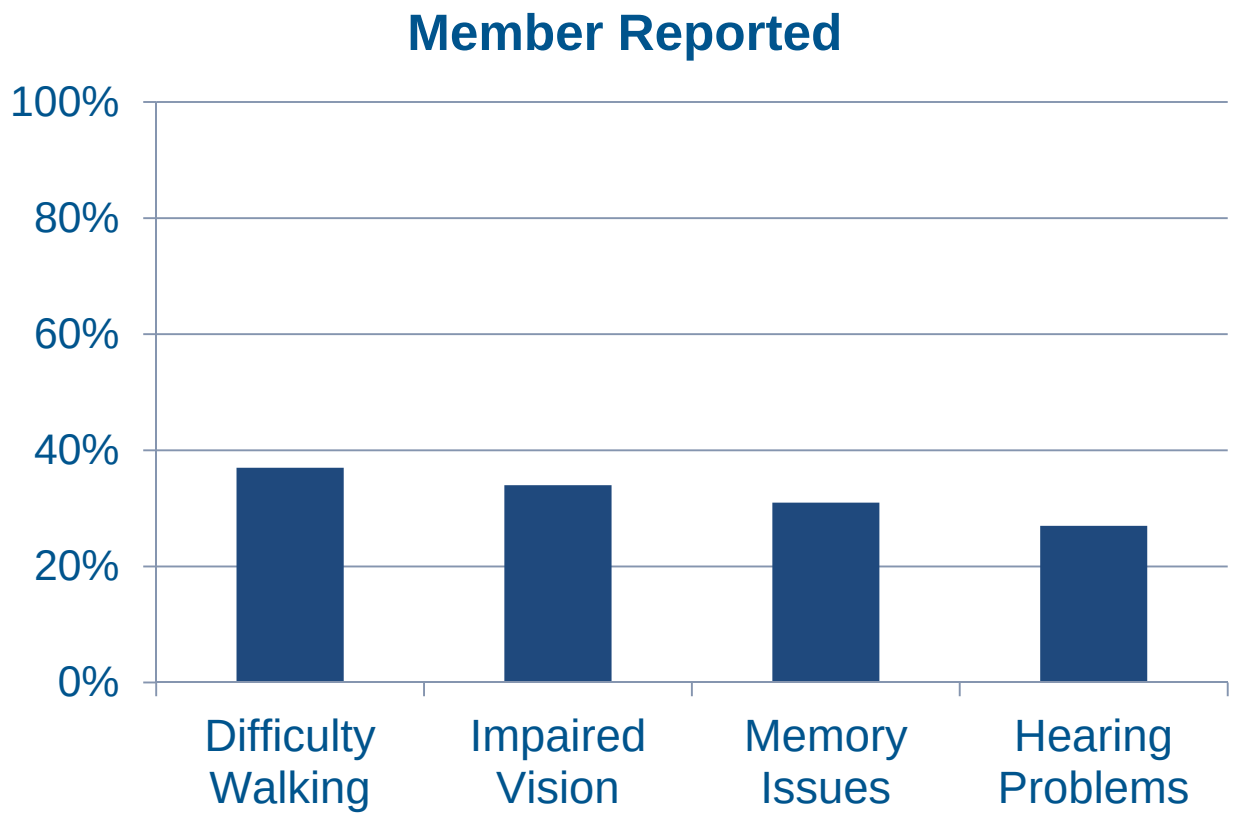
- Office interpretation services- in-person and sign-language with minimum of 3-5 days notice
- Health Literacy - training materials and in-person training available
- Cultural Engagement – training materials and in-person training available
- Vital documents translated or alternate format provided
- 711 relay number for hearing impaired

Communication Systems

Multiple communication systems to implement the SNP care coordination requirements:

- An **Electronic Medical Management System** for documentation of case management, care planning, input from the interdisciplinary team, transitions, assessments and authorizations
- A **Customer Call Center** to assist with enrollment, eligibility and coordination of benefit questions and meet individual communication needs (language or hearing impairment)
- A secure **Provider Portal** to communicate member information to SNP delegated medical groups
- A **Member Portal** for access to online health education, interactive programs and the ability to create a personal health record
- **Member and Provider Communications** such as member and provider newsletters and educational outreach may be distributed by mail, phone, fax or online

SNP Population Special Needs



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Section 3

Model of Care 2

Care Coordination:

Case Management

Health Risk Assessments

Individualized Care Plan

Interdisciplinary Care Team

Care Transitions

Patient Centric

- Patient is informed of and consents to Case Management
- Patient participates in development of their Care Plan
- Patient agrees to the goals and interventions of their Care Plan
- Patient informed of Interdisciplinary Care Team (ICT) members and meetings
- Patient either participates in the ICT meeting or provides input through the Case Manager and informed of outcomes
- Patient satisfaction with the SNP Program is measured annually

Evidence Based Case Management (CM)

- All SNP patients enrolled in case management and notified of CM single point of contact by letter/follow-up phone call
- Patients may opt out of active case management but Case Manager continues to attempt an annual contact or when change in status or transition in care.
- Patients are stratified according to their risk profile and/or Health Risk Assessment (HRA) to focus resources on most vulnerable
- Patients with only a behavioral health diagnosis (drug/alcohol, schizophrenia, major depressive, bipolar/paranoid) receive primary case management from MHN, the Behavioral Health provider
- Contingency planning is in place to avoid disruption of services for events such as disasters

Roles of the Case Manager:

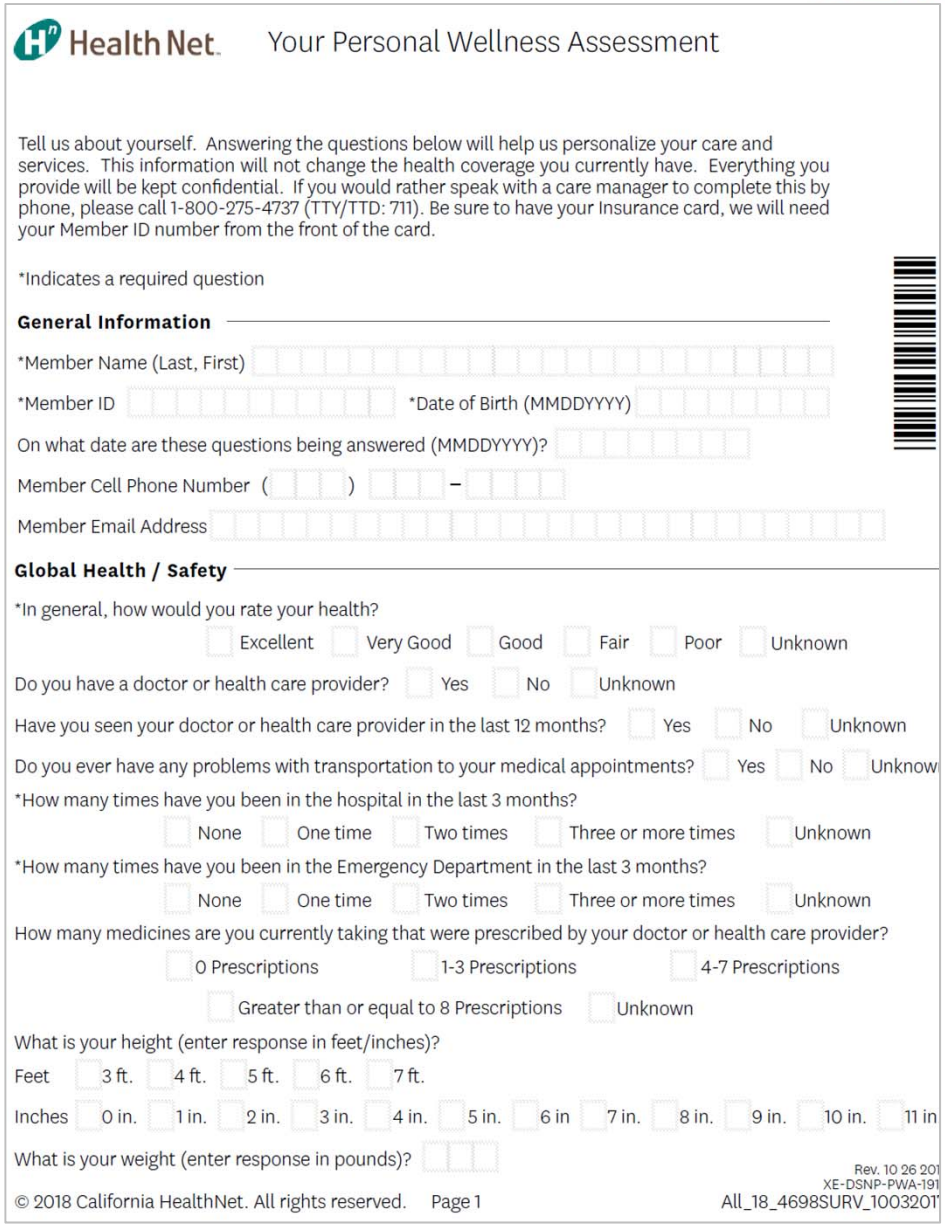
94% of members report overall satisfaction with CM

- Performs a health risk assessment of medical, psychosocial, cognitive and functional status
- Develops a comprehensive individualized care plan with member input
- Identifies barriers to goals and strategies to address
- Discusses member care at Interdisciplinary Care Team (ICT) meetings.
- Provides personalized education for optimal wellness
- Encourages preventive care and closure of care gaps such as cancer screening, vaccines
- Reviews and educates on medication regimen
- Promotes appropriate utilization of benefits
- Assists member to access community resources
- Assists caregiver when member is unable to participate
- Assesses cultural and linguistic needs and preference
- Coordinates care with primary care physician

Health Risk Assessment (HRA)

- An HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks
- Health Net attempts to complete initial HRA telephonically within 90 days of enrollment and annually or if there is a significant change or transition of care
- Multiple attempts are made to complete HRA including mailed surveys and e-mail reminders
- The HRA responses are used to identify needs, incorporated into the care plan and communicated to the care team
- Reassessments when there is a change in health condition and and annual updates are used to update the care plan

- Encourage patients to complete HRA over telephone or by mail
- Explain the information helps the Case Manager and ICT to meet their healthcare needs
- Register for and check the provider portal regularly for new HRAs
- Use the HRA responses to stratify patient outreach
- HRA is mailed to non-delegated provider groups



Health Net. Your Personal Wellness Assessment

Tell us about yourself. Answering the questions below will help us personalize your care and services. This information will not change the health coverage you currently have. Everything you provide will be kept confidential. If you would rather speak with a care manager to complete this by phone, please call 1-800-275-4737 (TTY/TTD: 711). Be sure to have your Insurance card, we will need your Member ID number from the front of the card.

*Indicates a required question

General Information

*Member Name (Last, First)

*Member ID *Date of Birth (MMDDYYYY)

On what date are these questions being answered (MMDDYYYY)?

Member Cell Phone Number ( ) –

Member Email Address

Global Health / Safety

*In general, how would you rate your health?
Excellent Very Good Good Fair Poor Unknown

Do you have a doctor or health care provider? Yes No Unknown

Have you seen your doctor or health care provider in the last 12 months? Yes No Unknown

Do you ever have any problems with transportation to your medical appointments? Yes No Unknow

*How many times have you been in the hospital in the last 3 months?
None One time Two times Three or more times Unknown

*How many times have you been in the Emergency Department in the last 3 months?
None One time Two times Three or more times Unknown

How many medicines are you currently taking that were prescribed by your doctor or health care provider?
0 Prescriptions 1-3 Prescriptions 4-7 Prescriptions
Greater than or equal to 8 Prescriptions Unknown

What is your height (enter response in feet/inches)?
Feet 3 ft. 4 ft. 5 ft. 6 ft. 7 ft.
Inches 0 in. 1 in. 2 in. 3 in. 4 in. 5 in. 6 in 7 in. 8 in. 9 in. 10 in. 11 in

What is your weight (enter response in pounds)?

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Individualized Care Plan (ICP)

Created for each patient by the Case Manager with input from the care team. The patient and/or caregiver is involved in and agrees with the care plan and goals:

- Based on the patient's assessment and identified problems
- Goals are prioritized considering patient's personal preferences and desired level of involvement in the process
- Updated when change such as new diagnosis/hospitalization or at least annually and communicated to ICT and patient
- Accessible/shared with members of the ICT including patient and provider
- Includes patient's self-management plans and goals
- Includes description of services tailored to patient's needs
- Includes barriers and progress towards goals

ICP **Must** Address All Risks Identified in HRA and/or Other Sources

HRA/Assessment/ Claims	Risks
Medical History Gap Reports Utilization Reports	Diabetes Obesity Lack of medication adherence Recent ER visit for fall
Labwork/ biometrics	HgA1c - 9 BMI – 31
Mental Health	Positive depression screen
Health Behaviors	Does not get annual Flu vaccine
Psychosocial	No transportation to Dr. appts

ICP Goals for Each Risk **Must** be Specific, Measureable and Include Date to be Achieved

Risk	Specific and Measurable Goal Established with Patient
Poor Medication Adherence	Patient will report taking diabetes medications daily at each monthly call and will not be on care gap list by March.
Positive Depression Screen	Patient will report discussing emotional health with PCP at next doctor appointment on April 20th.
Obesity – BMI	Patient will lose 5 pounds over next 6 months
Fall Risk	Patient will report going to gym once per week during monthly calls
Lack of Annual Flu vaccine	Patient will get flu vaccine by November 1.
Lack of transportation	Patient will successfully utilize transportation benefit for next doctor appointment on April 20th

ICP **Must** Include Actions to Achieve Goals

Risks	Actions to Achieve Goals
Poor control of Diabetes Obesity Poor medication adherence Recent ER visit for fall	Provide Diabetes and diet education. Set exercise and weight loss goals with patient Review medication regime and provide adherence tips to address individual barriers Fall prevention education and to discuss with doctor
HgA1c - 9 BMI – 31	Monitor lab work and weight for improvement
Positive depression screen	Referral to MHN
Does not get annual Flu vaccine	Educate on importance of vaccine, address barriers to obtaining vaccine
No transportation to Dr. appts	Educate on benefit and provide contact information

Must Document Care Plan Implementation

Risk	Case Manager Notes
Poor Control of Diabetes	2/15/XX *Reviewed diet with patient – she reports eating smaller portions since last call and diet education.*
Poor Medication Adherence	1/15/XX *Review of diabetes medications and proper admin– patient verbalizes understanding. Encouraged to use pill box.*
Positive Depression Screen	3/21/XX *Patient refused referral to MHN – states she will discuss with her doctor at April visit.*
Obesity – BMI	4/21/XX *Patient states she only lost 2 lbs at Doctor visit yesterday. Reviewed concept of steady and slow weight loss.*
Fall Risk	2/15/XX *Patient reports she is taking 15 minute walk once a day and will increase to 20 minutes next week*.
Lack of Annual Flu vaccine	9/15/XX *Review of importance of Flu vaccine – patient still concerned it will make her sick. Addressed barriers.*
Lack of transportation	3/21/XX *Patient has contacted transportation company and arranged ride to 4/20 Dr. appointment*

Interdisciplinary Care Team (ICT)

The Health Net, MHN or delegated Case Manager coordinates the ICT with regular communication to manage the patient's medical, cognitive, psychosocial and functional needs. The patient and/or caregiver is included on the ICT whenever possible:

- Required Team Members:
  - Medical Expert
  - Social Services Expert
  - Mental/Behavioral Health Expert – when indicated
- Additional Team Members could be:
  - Pharmacist
  - Health Educator/Disease Management
  - Restorative Therapist
  - Nutrition Specialist
- Communication plan for regular ICT exchange of information including accommodations for patients with sensory, language or cognitive barriers

Care Transition Protocols

Patients are at risk of adverse outcomes when transitioning between settings (hospital, nursing home, rehabilitation center, outpatient surgery centers or home health).

- Patients experiencing an inpatient transition are identified and managed (pre-authorization, facility notification, census)
- Important elements (diagnoses, medication reconciliation, treatments, providers and contacts) of the care plan transferred between care settings before, during and after a transition
- Patient able to communicate their health information to healthcare providers in different settings
- Patient informed of health status and self-management skills: discharge needs, meds, follow-up care, signs of change and how to respond (discharge instructions, post-discharge calls)

Section 4

Model of Care 3

Provider Network:

Specialized Provider Network

Clinical Practice Guidelines

Model of Care Training

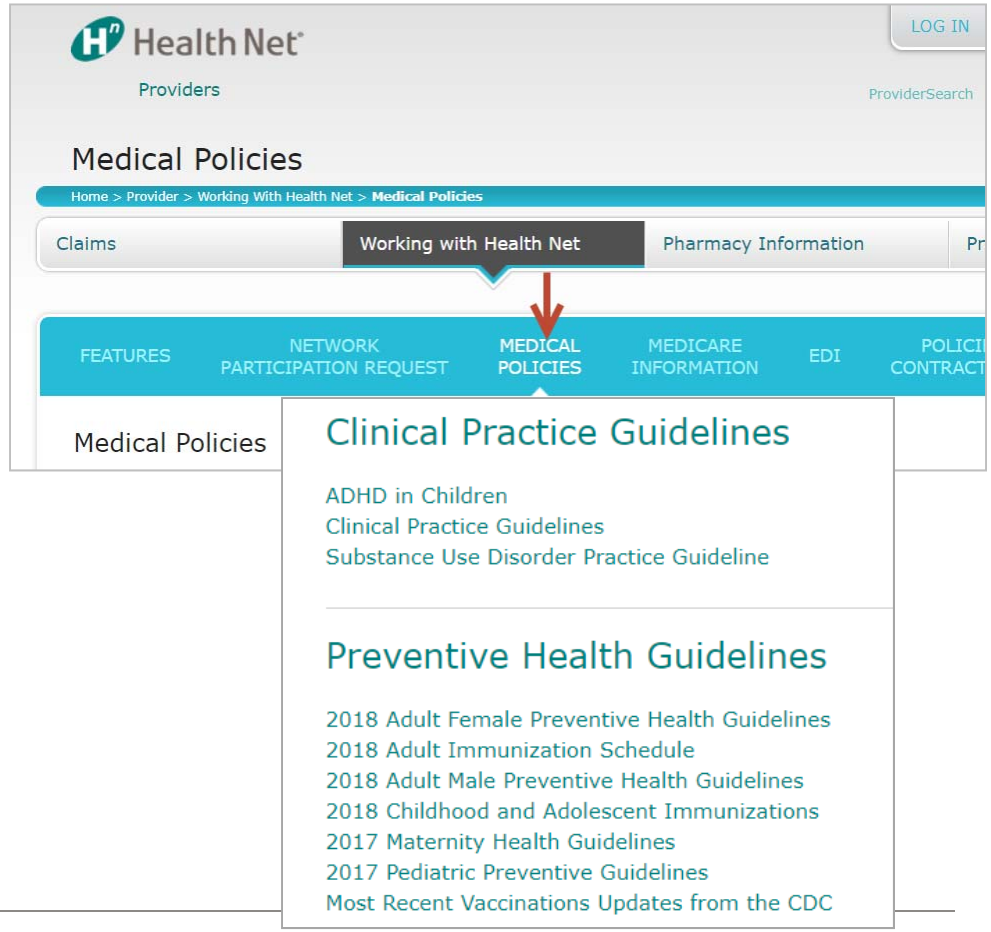
Specialized Provider Network

- Health Net maintains a comprehensive network of primary care providers and specialists such as cardiologists, neurologists and behavioral health practitioners to meet the health needs of chronically ill, frail and disabled SNP patients
- Team based case management is provided by Health Net when it is not delegated to the patient's primary care provider and medical group
- Delegated medical groups must demonstrate capability to meet the team based care requirements
- The Delegation Oversight team conducts regular audits to monitor that delegated medical groups meet the SNP Model of Care requirements

Jade C-SNPs – Chronic Heart Failure and Cardiovascular Disease

In addition to a Provider Network with practitioners and specialists skilled in managing patients with Cardiovascular Disease, the program has available:

- Disease Management to assist patients to manage their Cardiovascular disease
- Additional benefits (vary by plan) can include zero cost cardiac rehab services
- Clinical Practice Guidelines for Chronic Heart Failure located on the Provider Portal



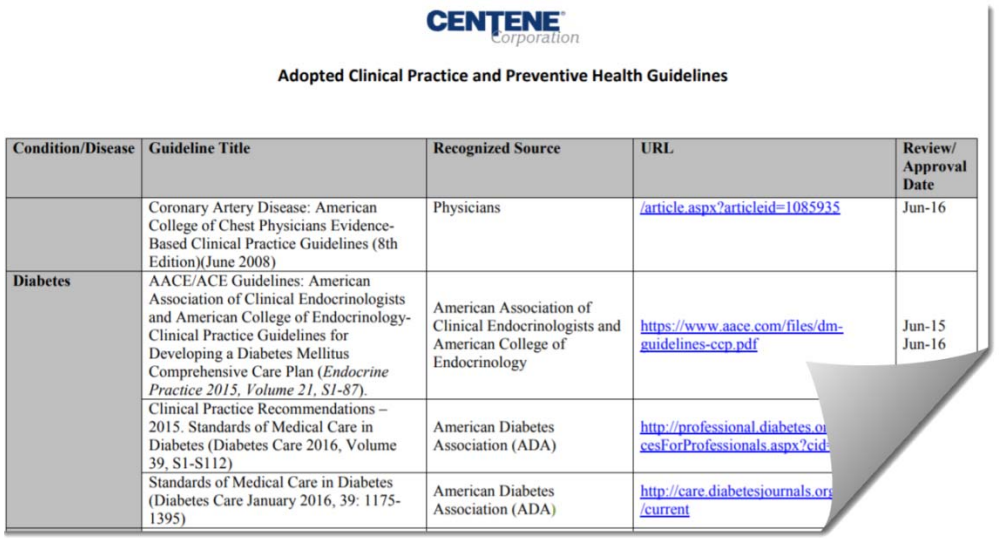
Jade C-SNPs – Diabetes

In addition to a Provider Network with practitioners and specialists skilled in managing patients with Diabetes, the program has:

- Disease Management to assist patients to manage their Diabetes
- Interactive programs for healthy activity and weight control
- Additional benefits (vary by plan) can include zero cost for Diabetic monitoring supplies, low cost Podiatrist visits
- Clinical Practice Guidelines for Diabetes and other chronic diseases located on the Provider Portal

Click below to see the to Health Net/Centene:

Clinical Practice Guidelines



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Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Approval Date
	Coronary Artery Disease: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition)(June 2008)	Physicians	/article.aspx?articleid=1085935	Jun-16
Diabetes	AACE/ACE Guidelines: American Association of Clinical Endocrinologists and American College of Endocrinology-Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan (*Endocrine Practice 2015, Volume 21, S1-87*).	American Association of Clinical Endocrinologists and American College of Endocrinology	https://www.aace.com/files/dm-guidelines-ccp.pdf	Jun-15 Jun-16
	Clinical Practice Recommendations – 2015. Standards of Medical Care in Diabetes (Diabetes Care 2016, Volume 39, S1-S112)	American Diabetes Association (ADA)	http://professional.diabetes.o cesForProfessionals.aspx?cid	
	Standards of Medical Care in Diabetes (Diabetes Care January 2016, 39: 1175-1395)	American Diabetes Association (ADA)	http://care.diabetesjournals.or /current	

D-SNPs -Coordinating Medicare and Medicaid

The goals of coordination of Medicare and Medicaid benefits for members that are dual-eligible:

- Members informed of benefits offered by both programs
- Members assisted to maintain Medicaid eligibility
- Member access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and Medicaid claims when Health Net is contractually responsible
- Members informed of rights to pursue appeals and grievances through both programs
- Members assisted to access providers that accept Medicare and Medicaid

Section 5

Model of Care 4

Quality Improvement:

Measureable Goals

Evaluation of Performance

Communicates Progress Towards Goals

Quality Improvement Program

Health Plans offering a SNP must conduct a Quality Improvement program to monitor health outcomes and implementation of the Model of Care by:

- Identifying and defining measurable Model of Care goals and collecting data to evaluate annually if measurable goals are met
- Collecting SNP specific HEDIS® measures
- Conducting a Quality Improvement Project (QIP) annually that focuses on improving a clinical or service aspect that is relevant to the SNP population (Diabetes Prevention)
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness (Osteoporosis Management)
- Communicating goal outcomes to stakeholders

Data Collection

Data is collected, analyzed and evaluated from multiple domains of care to monitor performance and identify areas for improvement:

- Health Outcomes
- Access To Care
- Improved Health Status
- Implementation Of MOC
- Health Risk Assessment
- Implementation Of Care Plan
- Provider Network
- Continuum Of Care
- Delivery Of Extra Services
- Communication Systems

SNP HEDIS® Measures

- Colorectal Cancer Screening
- Spirometry Testing for COPD Pharmacotherapy
- Management of COPD Exacerbations
- Controlling High Blood Pressure
- Persistence of Beta-Blockers after Heart Attack
- Osteoporosis Management Older Women with Fracture
- Medication Reconciliation Post-Discharge
- All Cause Readmission
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental illness
- Annual Monitoring for Persistent Medications
- Potentially Harmful Drug Disease Interactions
- Use of High Risk Medications in the Elderly
- Care for Older Adults
- Board Certification

Questions? Best Practices?

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Section 6

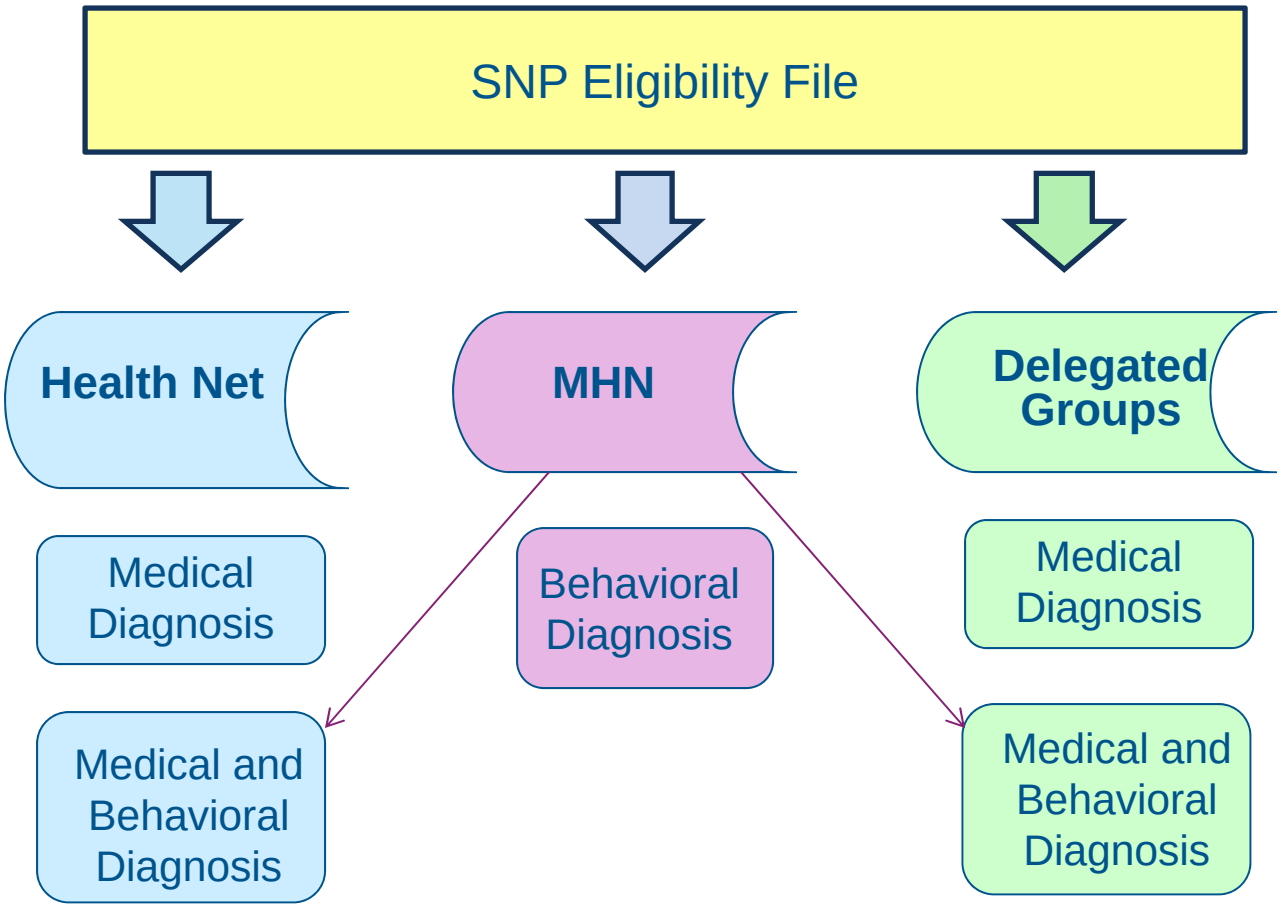
Appendix:

Flow Charts

Types of Case Management

References

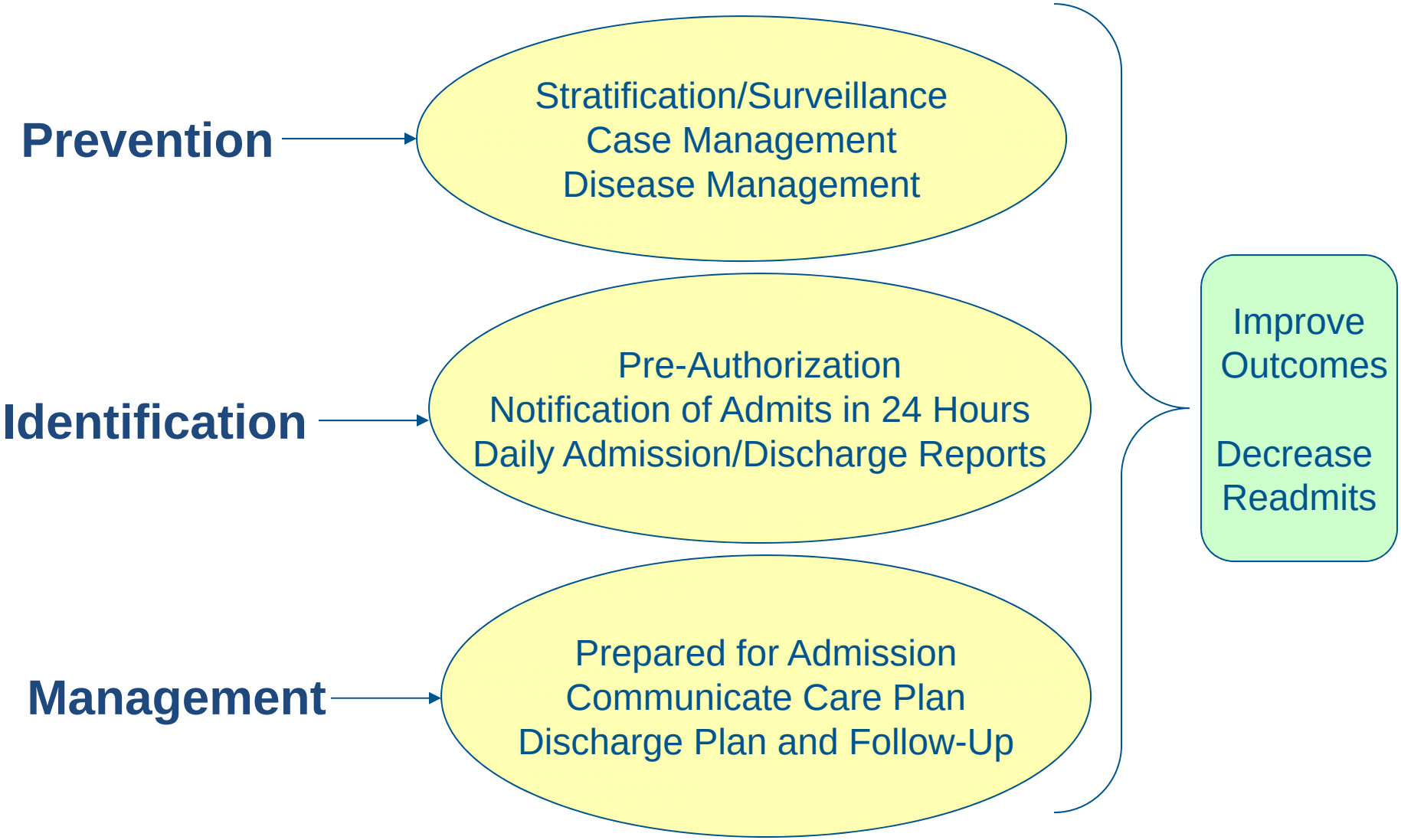
SNP Case Management Flowchart



Health Net Types of Case Management

	SNP Complex Case Management	Complex Case Management	Ambulatory Case Management
Length of Enrollment	Continuous for all SNP members	Short-term for catastrophic or terminal diagnosis	Short-term to meet coordination of care needs
Components	Annual HRA Assessment Care Plan ICT Coordination of Care	Assessment Care Plan Home Visits Coordination of Care	Assessment Care Plan Coordination of Care
Identification	Referral/Predictive modeling to move members between care levels per need	Referral/Predictive modeling – less than 1% of members	Referral/Predictive modeling – ex. transplants, maternity, hi-risk
Membership	SNP Members	All lines of business	All lines except SNP

Care Transitions Process



References

- Chapter 5 of the Medicare Managed Care Manual
- Title 42, Part 422, Subpart D, 422.152
- Model of Care Scoring Guidelines CY 2018 (2/10/17)
- Chapter 16B Special Needs Plans of the Medicare Managed Care Manual