2017 Special Needs Plan Model of Care

UnitedHealthcare
This training is designed to comply with the regulatory requirement that all staff (employed and contracted) who affect the care coordination either directly or indirectly of Special Needs Plan (SNP) beneficiaries receive initial and annual Model of Care (MOC) training.

Because of your role, you are required to take this training.
Objectives

At the conclusion of this training, you will be able to:

- Define the following concepts:
  - SNP
  - MOC
  - Measurable goals and outcomes

- Understand the Centers for Medicare & Medicaid Services (CMS) requirements for SNP Models of Care
CMS defines those affecting the care coordination *directly or indirectly* of SNP beneficiaries as anyone associated with their care, such as:

- Claims
- Clinical
- Network
- Sales
- Communication
- Enrollment
- Marketing
SNP plans were established by the Medicare Modernization Act of 2003.

SNPs are designed to provide targeted care to beneficiaries with special needs, such as improved coordination and continuity of care.

UnitedHealthcare SNPs do not exclusively treat individuals with developmental delays.

The population may have one or more chronic diseases, which often include diabetes, chronic heart failure, cardiovascular disease, and chronic lung diseases.

In addition, beneficiaries may have functional cognitive limitations, financial challenges and may reside in a geographic area with limited resources.
Types of Special Needs Plans

Each Medicare Advantage SNP limits its membership to individuals in one of the following groups, or a subset of them:

- **Dual SNPs and Medicare-Medicaid Plans**: are health plans for individuals eligible for Medicare and Medicaid
  - A Fully Integrated Dual Eligible (FIDE) SNP is a special type of DSNP for high-risk Medicare-enrolled beneficiaries.

- **Institutional/Institutional Equivalent SNPs**: are health plans for individuals residing in nursing homes or equivalent settings, such as assisted living facilities, for 90 days or longer

- **Chronic SNPs**: are health plans for individuals with one or more identified chronic condition, such as diabetes or congestive heart failure

Please continue for more detailed information about each SNP type.
Dual Eligible Special Needs (DSNPs) and Medicare Medicaid Plans (MMPs)

Dual Eligible and FIDE SNPs

• Enroll beneficiaries who are entitled to both Medicare and Medical Assistance from a State Plan under Title XIX (Medicaid).

• These plans offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

Medicare-Medicaid Plans

• This population includes those individuals with dual enrollment in Medicare (Part A and/or Part B) and Medicaid managed under one health insurance plan.
Institutional/Institutional Equivalent Special Needs Plans (ISNPs/IESNPs)

**Institutional SNPs**
- These plans restrict enrollment to MA eligible individuals who, for 90 days or longer, require the level of services provided in a long-term care (LTC) skilled nursing facility, (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility (ICF) for the intellectually disabled, inpatient psychiatric facility, or an assisted living facility (ALF).

**Institutional Equivalent SNPs**
- These plans enroll MA eligible individuals living in the community (such as assisted living facilities), but requiring an institutional level of care.
Chronic Special Needs Plans (CSNPs)

Chronic SNPs

• These plans restrict enrollment to special needs individuals with specific severe or disabling chronic conditions.

• CSNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations, and helping beneficiaries move from high-risk to lower risk on the care continuum.

• CMS has approved fifteen SNP specific chronic conditions for which CSNPs can target enrollment, although UnitedHealthcare does not currently offer plans for all fifteen conditions.

• Alcohol and drug dependence
• Autoimmune disorders
• Cancer (excluding pre-cancer conditions)
• Cardiovascular disorders
• HIV/AIDS
• Chronic lung disorders
• Chronic and disabling mental health conditions
• Severe hematological disorders
• Neurological disorders
• Stroke
• End-stage liver disease
• Chronic heart failure
• Dementia
• Diabetes Mellitus
• End-stage renal disease requiring any mode of dialysis
What is a Model of Care?

CMS requires that all SNPs have an approved Model of Care, a comprehensive document that describes the:

- Services provided to members in the SNP
- Framework to support the SNP in meeting the needs of each of its enrolled members
- Infrastructure to promote and evaluate quality, care management, and care coordination processes for the SNP

MOCs are reviewed and scored by the National Committee for Quality Assurance (NCQA) on behalf of CMS.
1. Description of Special Needs Plan Population
Contains a description of the overall SNP population, including geographical and demographical information.
Describes services provided to the most vulnerable members within the SNP population.

2. Care Coordination
Describes the staff involved in SNP.
Contains how the SNP administers the Health Risk Assessment Tool (HRAT), creates and updates the Individualized Care Plan (ICP), and discusses the makeup of the Interdisciplinary Care Team (ICT).
Describes Care Transition Protocols.

3. SNP Provider Network
Demonstrates specialized expertise of the SNP providers.
Describes the use of Clinical Practice Guidelines and Care Transitions Protocols.
Establishes MOC Training for the Provider Network.

4. Quality Measurement and Performance Improvement
Establishes the MOC Quality Performance Improvement Plan, Measurable Goals & Health Outcomes for the MOC.
Describes how the SNP measures Patient Experience of Care (SNP Member Satisfaction), the ongoing Performance Improvement Evaluation of the MOC, and the dissemination of SNP Quality Performance related to the MOC.
The HRAT is a screening assessment focused on:
- medical,
- psychosocial,
- functional,
- cognitive, and
- mental health.

The SNP must conduct the initial assessment within 90 days of enrollment and must conduct annual reassessment within one year of the initial assessment. The HRAT may be reassessed if warranted by health status change or care transition (e.g., hospitalization, fall, or change in medication).

Multiple attempts must be made to complete the HRAT, including at least 3 telephonic outreaches and 3 mailings. For beneficiaries who refuse telephonic contact twice, those who have requested to be placed on the Do Not Call list, or beneficiaries residing in a group home setting, a mailing is sent. **Documentation is key for both attempted and completed HRATs.**
Individualized Care Plan (ICP)

The Health Risk Assessment Tools are used to create the beneficiary’s ICP.

The organization must develop an ICP for each beneficiary, to deliver appropriate care to the beneficiary. The organization’s ICP must include, but is not limited to:

• The beneficiary’s self-management goals and objectives.
• The beneficiary’s personal healthcare preferences.
• A description of services specifically tailored to the beneficiary’s needs.
• The identification of goals (met or not met).

ICP communication is required between beneficiary, provider and staff.
• The beneficiary is encouraged to share the ICP with his or her Primary Care Provider (PCP).
• The health plan must send a copy of the ICP to the PCP via fax, mail, email, or provider portal.
• The ICP is housed in the health plan’s clinical documentation system.
• The plan is updated as needed according to changes in beneficiaries’ health status, care transitions, and new diagnoses.
Measurable Goals

The ICP must address every item, need, or concern identified from the HRAT using measurable goals.

A measurable goal consists of five parts (SMART), known as the Measurable Goal Model:

- **Specific** – Exactly what is to be learned/accomplished
- **Measurable** – A quantifiable goal, results can be seen and documented
- **Attainable** – Goal is member achievable
- **Relevant** – Goal is clearly linked to health status
- **Time-Bound** – Deadline or time period to motivate and evaluate

If the beneficiary’s goals are not met, the organization’s MOC must describe the process for reassessing the current ICP and determining the appropriate alternative actions.
• Every beneficiary has access to an Interdisciplinary Care Team (ICT) to promote collaborative care and coordination of services

• Each beneficiary’s ICT includes, at a minimum, the PCP, the member, family and caregivers, and the assigned case manager, if enrolled in a case management/care coordination program
Care Transitions

A care transition is defined as a beneficiary moving from one care setting to another, whether planned or unplanned as the beneficiary’s health changes. There are seven care transition settings addressed with Transitional Case Management.

- Outpatient Centers (ambulatory care/surgery centers)
- Home (usual source of care or usual practitioner)
- Home Health Care
- Rehab Facility
- Acute Care
- Custodial Nursing Facility
- Skilled Nursing Facility
Care Transitions

Roles of Transitional Case Management:

• Provide post hospital and transition management assessment and support for up to 30 days post discharge

• Develop interventions to meet beneficiary transition needs, including medication reconciliation

• Review and update the ICP with the beneficiary

• Conduct follow-up call to reinforce the value and importance of a PCP visit within 7 days of discharge
SNP Provider Network

The Model of Care includes a detailed description of the specialized expertise available to SNP beneficiaries in the provider network.

- It explains the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols.

- It details how the SNP conducts initial and annual Model of Care training for network providers and out-of-network providers seen by beneficiaries on a routine basis.
Quality Measurement and Performance

The Model of Care also details the specific survey tools used to measure SNP member satisfaction, quality measures to continually evaluate and improve the SNP, and communication of SNP quality performance results on a routine basis.

UnitedHealthcare is committed to identifying and measuring specific goals related to its Model of Care and the needs of the SNP populations. We employ a wide range of data to evaluate the effectiveness of the Model of Care. We also track SNP-specific measurable goals and health outcomes objectives are based on member health status and priorities.
Congratulations!

You have reached the end of the 2017 Special Needs Plans Model of Care Staff Training.

If you would like further information about SNPs:
• Visit the CMS website: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/

If you would like further information about MOCs:
• Visit the CMS website: http://SNPmoc.ncqa.org/