Special Needs Plan (SNP) Model of Care 2024 Provider Training

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a member of MJHS Health System

OBJECTIVES

- Provide an overview of Elderplan's Special Needs Plans care structure for its members
- Understand the Care Management goals for its members
- Identify key roles and departments that support the model of care at Elderplan
- Understand the role of an interdisciplinary care team for Elderplan's Special Needs Plans members

INTRODUCTION

INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to have a **Model of Care (MOC)**

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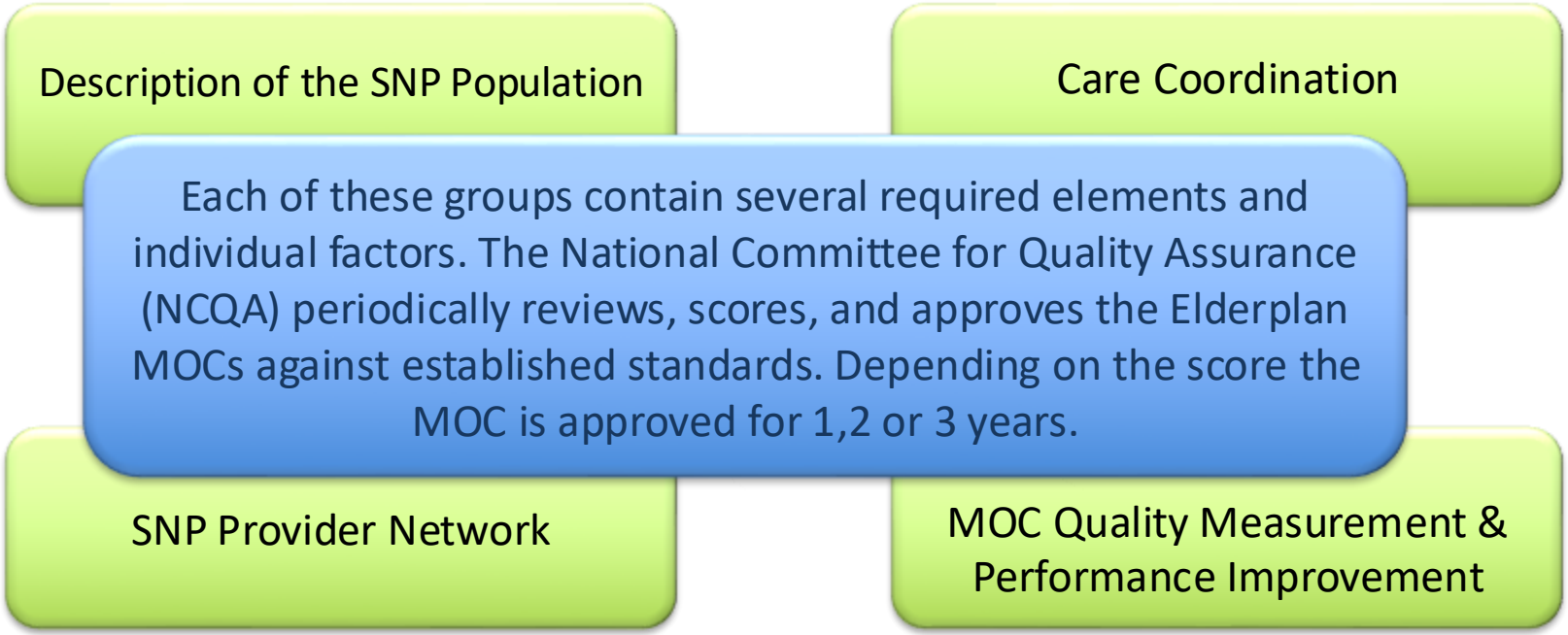
Elderplan is required to submit the following to CMS:

- Model of Care plan information
- Initial and annual training for employees and providers

INTRODUCTION

The SNP Model of Care (MOC) includes the following groups of clinical and non-clinical elements:



INTRODUCTION

The MOC includes specific elements and factors

MOC Elements

- Description of the SNP-specific target population
- Care management strategies for the most vulnerable subpopulation
- SNP staff structure and employee MOC training
- Health Risk Assessments (HRA)
- Individualized Care Plans (ICP)
- Interdisciplinary Care Teams (ICT)
- Provider network and provider MOC training
- Defined clinical practice guidelines and care transition protocols
- Measurable goals and health outcomes
- Communication of SNP quality performance outcomes and initiatives

DESCRIPTION OF SNP TARGET POPULATION

ELDERPLAN SPECIAL NEEDS PROGRAM (SNP)

Two (2) Dual-SNPs (D-SNP):

- Elderplan for Medicaid Beneficiaries (002)
- Elderplan Plus Long-Term Care (007)

Two (2) Institutionalized-SNP (I-SNP):

- Elderplan Advantage for Nursing Home Residents (003)
- Elderplan Select – ISNP/IESNP (018)

Eligibility Requirements

- Live in our geographic service area
- Entitled to Medicare Part A
- Enrolled in Medicare Part B
- Eligible for Part D

D-SNP

- Qualify for both Medicare and Medicaid (H3347-002) and Elderplan Plus Long-Term Care (H3347- 007)
- Eligible for nursing home level of care at time of enrollment (007)
- Expected to need at least one of the community based long-term care covered services for more than 120 days (007)

I-SNP

- Must reside in a contracted skilled nursing facility for greater than 90 days at time of enrollment
- (003)

ISNP/IESNP

- Must reside in a congregate care setting
- Elderplan Select (018)

GOALS & OBJECTIVES

Specific Care Management Goals for D-SNP

MOC Aspects of Care:

- Use of Health Risk Assessments to determine needs
- Facilitating access to essential services, affordable care, and health services
- Development of an individualized care plan
- Coordination of care through use of an interdisciplinary care team
- Transitional care across settings, providers, and health services
- Appropriate utilization of services
- Improving health outcomes

- Initial health risk assessment - 90 days before or after enrollment
- Interdisciplinary Care Team (ICT) with a Care Manager
- Meet care needs of dual eligible members
- Access to preventive health services and chronic disease management
- Care transitions support
- No racial or cultural disparities
- Improve health outcomes
- Coordination of Medicare and Medicaid benefits

D-SNP

- Initial health risk assessment – 30 - 90 days of enrollment
- Interdisciplinary Care Team (ICT) - Physician and Nurse Practitioner / Physician Assistant and RN Case Manager
- Meet care needs of institutional members
- Ensure preventive health measures and optimization of chronic disease management
- Care transitions support
- No racial or cultural disparities
- Improve health outcomes
- Collaborate with participating nursing facilities and assisted living facility

I-SNP, I-SNP / IE-SNP

Quality Improvement Committee (QIC) and subcommittee structure is the reporting vehicle for goals and outcomes.

Every quarter the QIC develops recommendations such as:

- Process changes
- Corrective actions
- Training for staff and/or providers
- Changes to MOCs

KEY STRUCTURE & STAFFING

Administrative Functions for D-SNP, I-SNP, I-SNP/IESNP

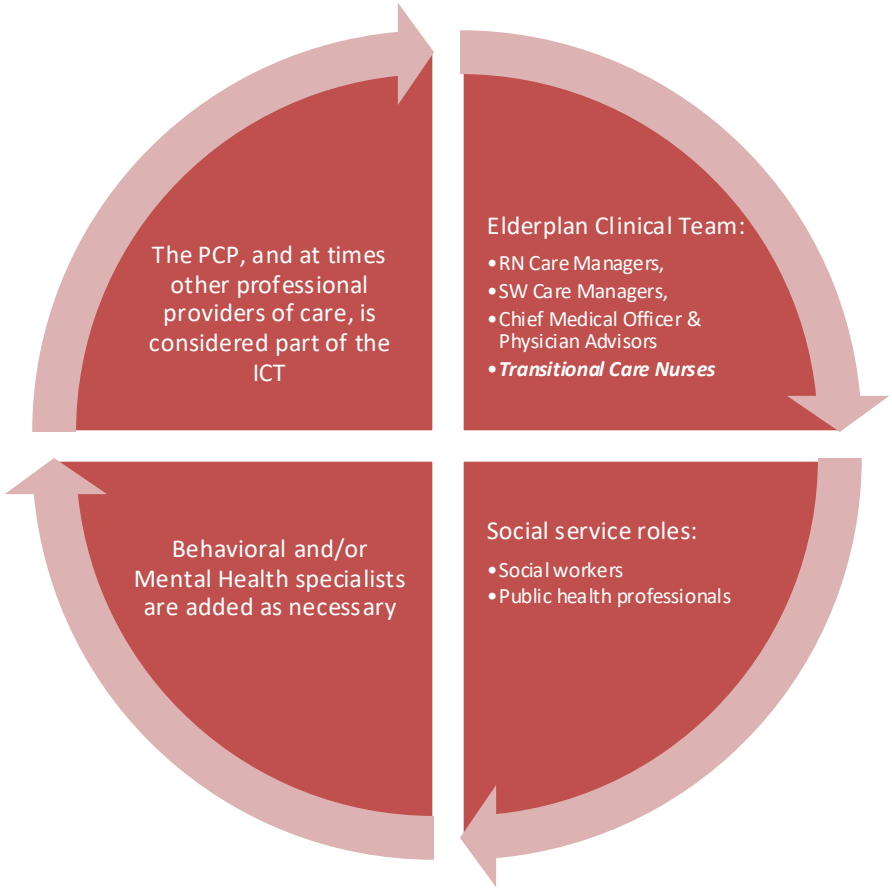
- Enrollment and Member Operations
- Sales and Marketing
- Member Services
- Claims
- Network Operations
- Regulatory Compliance
- Appeals & Grievances
- Facility Based Products

Clinical Functions for D-SNP, I-SNP, I-SNP/IESNP

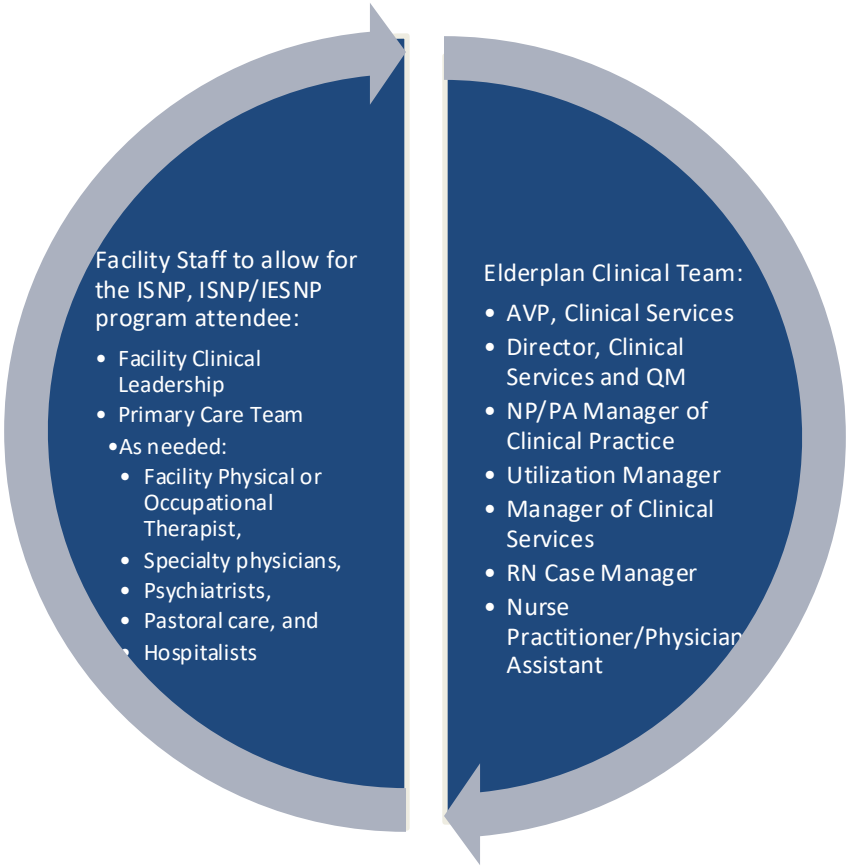
- Quality Management
- Coordinated Care
- Clinical Services
- MJHS Medical PC

Coordinated Interdisciplinary Care Team

D-SNP



I-SNP, I-SNP/ IE-SNP



Beneficiary Participation

D-SNP

- Member receives a “Welcome Letter” with assigned Care Manager
- Member and/or caregiver encouraged to inform the plan of new or changed condition
- Care Manager communicates with member to discuss the program and Individualized Care Plan

I-SNP, I-SNP/IE-SNP

- Member/designated representative receives “Introduction Communication” with assigned Care Team
- Member or designee is invited to attend Care Team Meeting, as necessary
- Assigned Practitioner/Care Manager communicates regularly with Member and/or designee

ICT Operations and Communications

Care Management Software System	Monthly Meeting	D-SNP	I-SNP, I-SNP/IE=SNP
• Member assessments • Care plan & Care transitions • Claims • Pharmacy data	• Coordinated Care Department and other departments • Issues relating to delivery of care model • Service issues or complaints	• Daily staff meetings • Ad-hoc meetings when there is a significant change to a member condition or needs	• Facility maintains clinical records • ICT members can access the member's clinical record • Regularly scheduled meetings at facility or conference call to discuss member issues and/or concerns

Provider Network & Clinical Practice Guidelines & Protocols

Practice Guidelines and Protocols

1. Licensing/Competency of Network Facilities and Providers

2. Coordination Among ICT, Network and Beneficiary to deliver services

3. Use Evidence-Based Clinical Practice Guidelines and Nationally Recognized Protocols

Practice Guidelines and Protocols

Licensing/Competency of Network Facilities and Providers

The Credentialing/Recredentialing Subcommittee (CRS) is responsible for ensuring that all participating providers, facilities and vendors meet Elderplan standards for credentialing and recredentialing.

- Chaired by the Executive Director, Medical Affairs the Subcommittee consists of participating physicians of various specialties, and representatives from the Plan's QM, G&A, Network Operations, and Credentialing
- Meet monthly for oversight of the Elderplan network
- Recommendations are reviewed to ensure that all applicable licensures and certifications are active from any governing or professional bodies, in compliance with CMS regulatory credentialing standards

Practice Guidelines and Protocols

Licensing/Competency of Network Facilities and Providers

The Board Certification expiration is reviewed on a yearly basis

- Credentialing database is maintained in CACTUS

Full re-credentialing occurs on a three-year cycle, however, if need arises, providers will be evaluated at any point in the cycle, i.e., when the Plan becomes aware of poor outcome from a regulatory survey or adverse events

- Substantiated concern or sanction with providers may result in actions such as corrective action plan from provider/vendor or recommendation of termination or non-renewal from participation with the Plan

Practice Guidelines and Protocols

Coordination among ICT, Network and Beneficiary to deliver services

The designated SNP Care Manager/Practitioner is responsible for identifying and coordinating needed services for the Member:

- Acts as liaison between the PCP and ICT;
- Updates and distributes revised Care Plan, as necessary;
- Documents activities in the electronic care management software and communicates (telephonically or electronically) to providers, Elderplan and member/caregiver, shares reports on hospitalizations, skilled services and any provider access issues
- Tracks progress towards established measurable goals and updates, as needed
- Encourages/supports the member in conversations with his/her PCP

Practice Guidelines and Protocols

Coordination among ICT, Network and Beneficiary to deliver services

- The PCP is electronically notified (via EMR) of member admissions and discharges to/from acute and subacute settings to facilitate post discharge follow-up and reconciliation of medication and treatment plan (I-SNP)
- During acute and subacute episodes, the ICM (Internal CM) coordinates transfers to facilities in collaboration with the Case Manager and facility designee (I-SNP)

Practice Guidelines and Protocols

Use Evidence-Based Clinical Practice Guidelines and Nationally Recognized Protocols

Clinical Practice Subcommittee

- Evaluates and adopts clinical practice guidelines applicable to the needs of the Plan's membership; these guidelines are then posted on the Plan's Provider Website along with news articles and updates in the Provider Magazine

Pharmacy and Therapeutics Subcommittee

- Offers valuable guidance on formulary development/maintenance and opportunities for enhancing member experience with the Plan

Practice Guidelines and Protocols

Use Evidence-Based Clinical Practice Guidelines and Nationally Recognized Protocols

Clinical Practice Committee

Utilize several additional tools/techniques to evaluate the use of evidence based clinical practice guidelines

- Distribution of provider scorecards outlining performance on nationally recognized standards of care
- Pharmacy data to identify potential care gaps or potential adverse events and compliance issues

Practice Guidelines and Protocols

Use Evidence-Based Clinical Practice Guidelines and Nationally Recognized Protocols

Clinical Practice Committee

Utilize several additional tools/techniques to evaluate the use of evidence based clinical practice guidelines

- Identify real and potential gaps in care and generates notice to physician and participant while sending quarterly reports to the Plan for review
- PCPs also receive monthly reports that identify gaps or opportunities for compliance with those clinical evidence-based practice guidelines used in HEDIS such as diabetes care, hypertension, cholesterol management and preventive care

Provider Network

The Provider network contains a sufficient number of services and facilities for the member's holistic care.

- Identifies and evaluates potential long term care facilities for participation
  - Facility must meet Plan's P&P for credentialing standards for participation in the network
- Evaluates provider adequacy with sufficient number of professionals to provide services directly on the premises of the long term care facility such as:
  - **Board Certified specialists** - Including Geriatrics, Cardiology, Neurology, Nephrology, Pulmonology, Endocrinology, Orthopedics, and Behavioral Health
  - **Clinicians** - Nurse Practitioners, Physical Therapists, Occupational Therapists, Respiratory Therapists

PROVIDER NETWORK

The Provider network contains a sufficient number of services and facilities for the participant's holistic care.

- **Facilities**
  - Including Inpatient Acute Hospitals, Psychiatric facilities and Skilled Nursing Facilities
- **Home Visits**
  - Conducted by qualified physicians and/or NPs
- **Community based services**
  - such as Radiology, Laboratory, Certified Home Health Agencies, Licensed Home Health Care Agencies, Transportation and DME vendors
- **Non-Par Providers**
  - An inventory of non-par providers to whom Clinical Services has authorized in the past is reviewed to identify providers to fill gaps

Training for Personnel & Provider Networks

Staff & Provider Training

Training is required for staff and providers annually

New Employee Training – Clinical Operating Areas

Mentored	• Observe processes • Enhance plan/member/provider interaction
Weekly Meeting	• Monitor activity • Provide direction and feedback
Monthly Meetings	• Provide updates and feedback • Regulation or Policy
Policies	• Stay in compliance with all new and revised policies via email and PPM

Provider Representatives distribute provider education materials, which include information on the MOC for the SNPs.

Providers are also able to access the training via our Provider Portal

HEALTH RISK ASSESSMENT

HEALTH RISK ASSESSMENT (HRA)

In this section, you will learn how and when we capture information about the member's health through health risk assessments.

- Care Managers administer D-SNP assessments for 002 plan members on an annual basis (In person, telehealth or telephonically) based on members' preferences.
- Members in the 007 plan are assessed in the home or via telehealth (video) for initial and ongoing re-assessment on an annual basis and if needed, using the UAS-NY tool.

HEALTH RISK ASSESSMENT (HRA)

D-SNP (002)

- All members enrolled in Elderplan for Medicaid Beneficiaries (002) will be assessed using a modified version of the Uniform Assessment System for NY (UAS-NY).
  - This assessment is electronically programmed, thus upon completion becomes a part of each member's clinical record within the Plan's care management software system.
  - This comprehensive assessment contains all necessary domains as outlined in the requirements: medical, functional, cognitive, psychosocial and mental health needs of each SNP member
  - This assessment can be completed in person, via telehealth and telephonically by a clinical professional, based on members' preferences, who is a member of the care team
  - Re-administered on annual basis, at minimum

HEALTH RISK ASSESSMENT (HRA)

D-SNP (007)

- All members enrolled in Elderplan Plus Long Term Care program (007) will be assessed using a NYSDOH Approved Assessment, which is the Uniform Assessment System for NY (UAS-NY). This comprehensive assessment includes the following domains:
  - social, functional, medical, behavioral, wellness and prevention domains,
  - caregiver status and capabilities,
  - as well as the member's preferences, strengths and goals.

HEALTH RISK ASSESSMENT (HRA)

D-SNP (007)

- UAS-NY identifies more detailed clinical information and specific/instrumental ADL assistance required.

This assessment is:

- Initially conducted by a New York Independent Assessor (NYIA)
- Reassessments are completed by a Registered Nurse, who is a member of the care team either face-to-face in member's home or via telehealth using video modality
- Re-administered on annual basis, at minimum

HEALTH RISK ASSESSMENT (HRA)

I-SNP, I-SNP/IE-SNP

- Naylor Risk of Acute Hospitalization tool includes questions to identify medical, psychosocial, functional and cognitive needs. It is completed by the designated clinician. HRA is completed during the member's initial evaluation and then annually
- Monthly monitoring tool, a health risk assessment developed by the plan to identify changes in condition and determine risk level

HEALTH RISK ASSESSMENT (HRA)

Personnel who review, analyze and stratify health care needs:

- Clinical Services, IT, and Quality Management departments analyze assessment data and set benchmarks for different SNP types
- Member-level data is reviewed by the ICT
- Plan-level data is reviewed in collaboration with Health Economics department
- Data is also reviewed by subcommittees of the Quality Improvement Committee consisting of Clinical Providers, Pharmacists and Quality Specialists
- **For I-SNP, I-SNP-IESNP only:** Manager of Clinical Services analyzes and presents Plan-and member-level data from the ongoing assessments to the ICT and the management team

HEALTH RISK ASSESSMENT (HRA)

Communication Mechanism(s)

- The ICT team is responsible for the development, implementation and oversight of an individualized Care Plan for each Member based on the assessment of medical, environmental, social and cognitive needs of the Member.

- The Care Plan is maintained in the case management system and is formulated based on Member health care needs and desired outcomes identified through telephonic initial assessment with the Member or Member's Designee or Representative using the internally modified assessment tool and/or regular contact between the Care/Case Manager and Member, the PCP or other Service Providers.

HEALTH RISK ASSESSMENT (HRA)

Communication Mechanism(s)

- This allows Elderplan to review Member progress and evaluate whether Member care and treatment goals are met or unmet and if changes are necessary to support Member's health outcomes.
- The team utilizes various evidence based clinical and functional assessments that address the unique medical, behavioral, cognitive, and social needs of Members who are dually eligible.

HEALTH RISK ASSESSMENT (HRA)

Communication Mechanism(s)

- Findings from the assessments can be documented in the case management and/or utilization management systems and used to update the Care Plan and maintain open communication with the Member regarding findings and the options for treatment and care.
- Designated Clinician (NP/PA/MD) discusses Individualized Care Plan with Member/Designated representative and Primary Care Physician along with instructions on how to contact the Member's Case Manager as needed.

HEALTH RISK ASSESSMENT (HRA)

Communication Mechanism(s)

I-SNP, I-SNP, IE-SNP

- Once the care plan is finalized, it is discussed/shared via phone, in person or via shared EMR with the member, as well as the PCP and ICT members (including designated clinician). Care Plan is maintained electronically in the Plan's case management database
  - Certain key responses allow the Plan’s databases to trigger electronic referrals for clinical intervention, such as disease or wellness education, to the appropriate care teams

INDIVIDUALIZED CARE PLAN

D-SNP Individualized Care Plan

Developing the member's Care Plan, the Care Manager does the following activities:

- Reviews assessments and other data
- Contacts the member in person, telehealth or telephonically to gather additional information and to develop individualized care plan based on member's preferences
- Reviews applicable clinical guidelines and criteria embedded in the Plan's case management database and Disease Monitoring software
- Member's answer and identification of preferences on the UAS-NY and/or D-SNP assessment will help Care Managers identify problems, set measurable goals and generate interventions that will address Member concerns and priorities.
- Member participates in the identification of interventions geared to addressing gaps in care (e.g., caregiver support and environmental or social issues)

D-SNP Individualized Care Plan

Developing the member's Care Plan. The Care Manager does the following activities:

- For members who require and receive personal care services administered and provided through the health plan, additional tools are used to determine the extent of the personal care needs
- Develops goals and identifies the appropriate interventions (e.g., home visiting physicians, telehealth monitoring, palliative care)
- Encourages PCP participation and solicits information when clinical concerns are identified
- Consults with other ICT members during care plan development

D-SNP Complete Care Plan

Once the Care Plan is complete, it is:

- Sent to the PCP via mail or fax
- Stored in the secure Plan's case management database, where it is accessible and can be updated by ICT
- Utilized as a valuable tool during care transitions (available to the Transitional Care RN for use in facilitating communication of key elements of the plan)
- Used as a reference to gauge progress towards goals in Care Manager interactions with the Member/Designee

D-SNP Complete Care Plan

Once the Care Plan is complete, it is:

- Evaluated and updated on an annual basis or when a significant change in condition or status is identified
  - Monthly inpatient admissions data, claims analysis, and other data triggers are used to revise Care Plan as necessary
  - Care Plan activity is monitored by the team supervisors and department management to ensure timeliness of updates, progress towards goals, and frequency/type of interventions

I-SNP, I-SNP/IE-SNP Care Plan

Upon effective date of enrollment, the member is assigned to a designated clinician who is on-site at the long-term care facility

- The designated clinician has access to the member's facility record, and along with initial utilizes various risk assessment tools and a as well as a full history and physical.

Individualized care plans include:

- The Case Manager working closely with the assigned designated clinician to develop Care Plan goals and interventions
- PCP participation is vital especially when clinical concerns are identified
- The member or representative is encouraged to be part of this development and voice preferences for clinical and social interventions

I-SNP, I-SNP/IE-SNP Care Plan

Individualized care plans also include:

- Monthly inpatient admissions data, claims analysis, and other data triggers are used to revise Care Plan as necessary
- Care Plan activity is monitored by the NP/PA Manager of Clinical Services to ensure timeliness of updates, progress towards goals, and frequency/type of interventions
- Data secure in the Plan's case management database

COMMUNICATION NETWORK

Communication Network

- ICT team's primary source of communication with members/caregivers and providers is telephonic
  - Member Services tracks and trends all incoming calls, call abandonment rates, and wait times
  - All incoming calls are recorded for quality control
  - SNP member/caregiver calls are forwarded to the appropriate Care Management Team or handled directly by the Member Service Representative
- I-SNP and IE-SNP members may also have face-to-face encounters with their assigned clinician
- Communication network for providers includes designated call center, secure web-portal, Plan website, and face-to-face meetings with Provider Reps

Communication Network

- The Plan provides additional resources in the form of print and electronic materials for both Members and Providers
- Communicates with regulatory agencies in the resolution of inquiries and complaints, such as through the CMS Complaint Tracking Modules, to ensure timely and adequate outcomes to member and provider concerns and issues

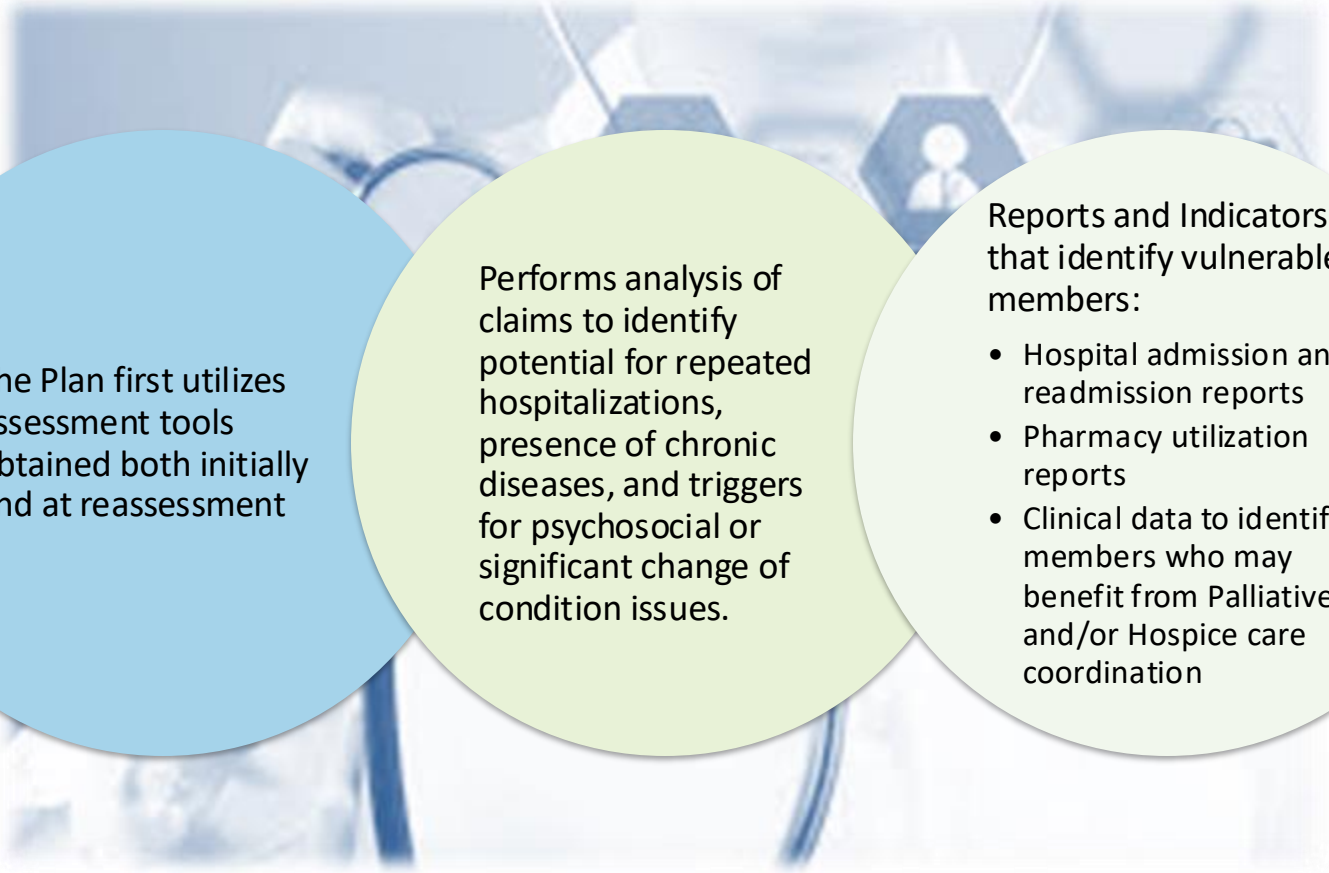
COMMUNICATION NETWORK

- The Quality Improvement Committee (QIC) has responsibility for identification and implementation of process changes or enhancements relating to communication activities
  - The Customer Service Subcommittee reports on volume, trends, and responsiveness with member calls
  - The A&G Subcommittee tracks and trends member complaints relating to access to plan and/or providers

COMMUNICATION NETWORK

- The DSNP also uses clinical rounds by the Integrated Member Engagement (IME) Committee.
  - One method employed by Elderplan to identify high risk members is the Integrated Member Engagement (IME) Committee. This multi-disciplinary team meets twice weekly to review inpatient hospital admissions, discuss initial discharge plans, and determine any special services members may need post-discharge. The stated objectives of the IME committee are to:
    - Proactively reduce readmissions to hospitals within 30 days
    - Holistically review high risk member's medical and social conditions to improve care
    - Enhance coordination amongst discharge and care planning teams
    - Ensure safe and effective use of medications
    - Reduce unnecessary medical expenses
    - Improve quality of care following acute care episodes

Care Management for Most Vulnerable Populations



The Plan first utilizes assessment tools obtained both initially and at reassessment

Performs analysis of claims to identify potential for repeated hospitalizations, presence of chronic diseases, and triggers for psychosocial or significant change of condition issues.

Reports and Indicators that identify vulnerable members:

- Hospital admission and readmission reports
- Pharmacy utilization reports
- Clinical data to identify members who may benefit from Palliative and/or Hospice care coordination

Performance & Health Outcome Measures

Data Collection & Analysis

- The Quality Management Department assist in all aspects of data collection and analysis
- HEDIS data and Part C&D reporting requirements are audited annually.

Evaluation & Monitoring

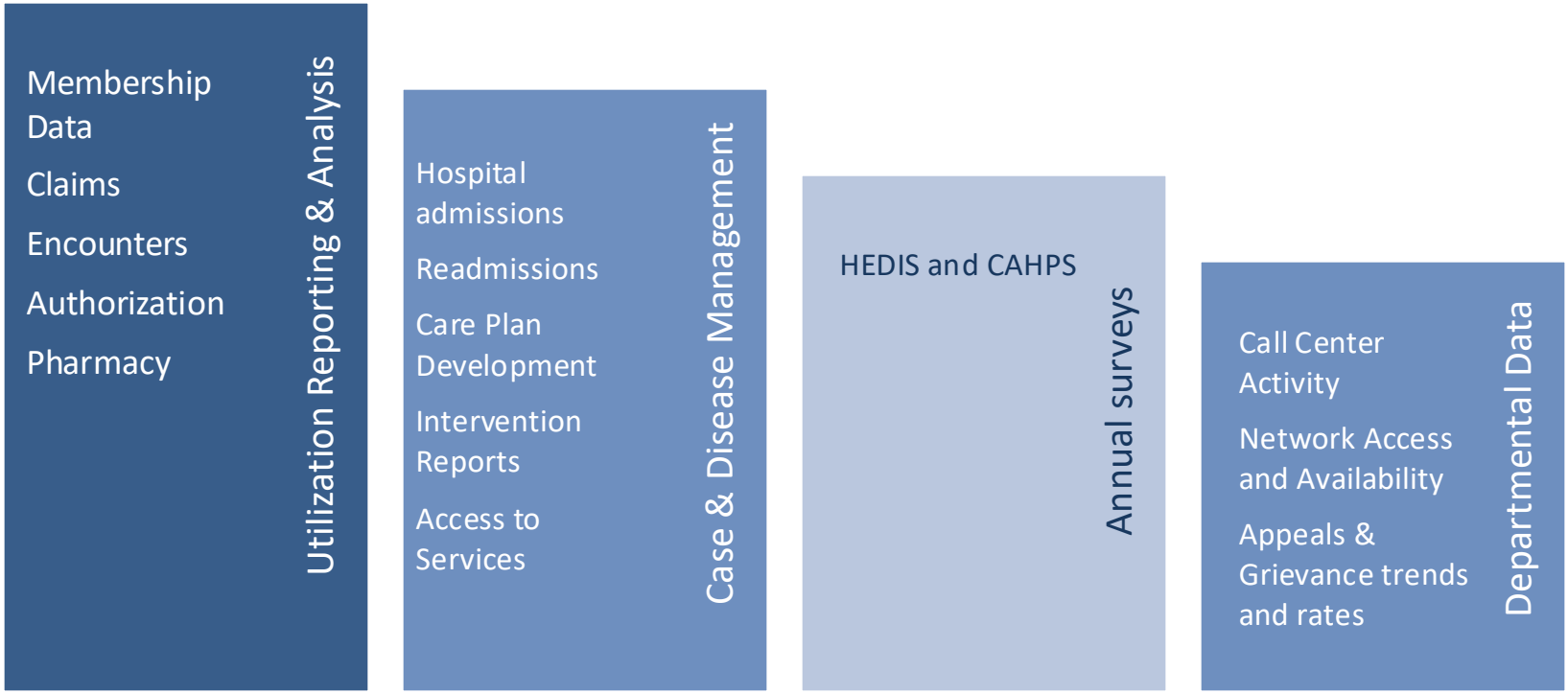
- Oversight of evaluation and monitoring activities include the Chief Clinical Officer, VP of Coordinated Care, VP of Quality and Performance Improvement, and the Executive Director, Medical Affairs.

Quality Improvement Committee

- Chaired by the VP of Quality Management and co-chaired by the Director of Performance Improvement.
- Follows all CMS requirements in development and participation in quality activities and reporting.

Annual Plan Quality Improvement Evaluation/Workplan	• All data analysis and standard reporting is used in the Annual Plan Quality Improvement Evaluation/Workplan, and along is presented to the Board of Directors for their review and approval
Performance & Education	• Plan performance is shared across the plan and key Providers • The plan educates its network and membership on performance measures through newsletters and on Elderplan's website

DATA SOURCES

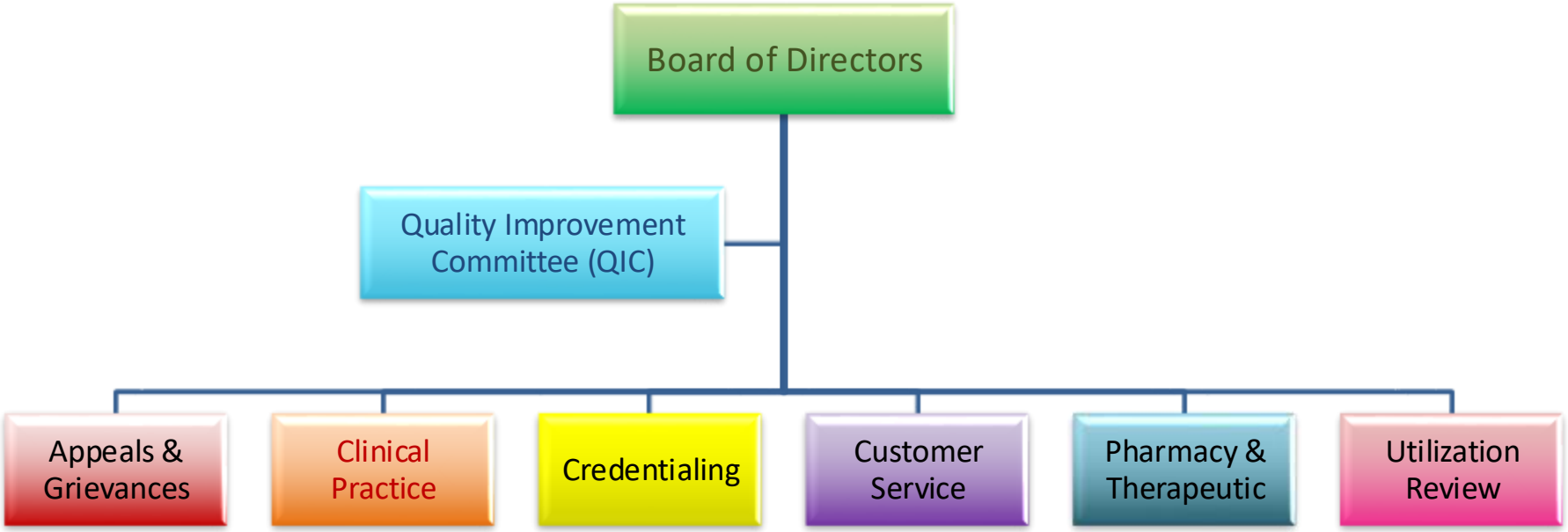


Performance And Health Outcome Measurements

The following will provide you additional information on:

- Hierarchy of accountability for the Elderplan Model of Care
- Subcommittee role in Quality Improvement
- Measurable Goals and Performance and Health Outcome Measurement

IMPLEMENTATION AND ACCOUNTABILITY



You have completed the
Model of Care Provider Training.

Please confirm that you have read and understood the material provided by completing the Model of Care Training attestation.

MODEL OF CARE TRAINING

Provider/Group Name: _____
Address: _____
NPI: _____
TIN: _____ License: _____

☐ PCP ☐ Specialist ☐ Multi-Specialty Group ☐ IPA

The Centers for Medicare & Medicaid Services (CMS) regulations require that health plans provide their Special Needs Plan provider network with information on their basic Model of Care. This applies to our Dual-Eligible Special Needs Plan (D-SNP) members who are eligible for both Medicare and Medicaid

The SNP MOC module covers metrics designed to improve Members' access to medical, social, and mental health services and transitions of care across health care settings. All personnel/entities that are part of Elderplan's provider network must receive this annual training

Once you have reviewed the Model of care training that outlines the basic Model of Care requirements for our providers, please confirm that you have read and understood the material provided by completing this attestation.

I, _____
(Name of the Provider/Administrator)
Hereby attest that

All employees (including Board Members, Directors, and Temporary employees) and the employees of downstream entities have completed D-SNP Model of Care training.