Senior Care Plus

A Medicare Advantage Plan from Hometown Health.

Dual Eligible Special Needs Plan (D-SNP)
Model of Care Training

Model of Care Elements

- MOC 1: Description of SNP Population
- MOC 2: Care Coordination
- MOC 3: Provider Network
- MOC 4: MOC Quality Measurement and Performance Improvement

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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 (SNP's), with the goal of improving care and decreasing costs for the frail and elderly through improved coordination.
- The Bipartisan Budget Act of 2018 provides continued access to Medicare Advantage special needs plans for vulnerable populations and expanded supplemental benefits and expanding the use of telehealth.
- SNP's are identified by 3 specific types:
  - Institutionalized beneficiaries (I-SNP)
  - Beneficiaries with severe or disabling chronic conditions (C-SNP)
  - Dual eligible for both Medicare and Medicaid (D-SNP)

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Eligibility Requirements

SNP minimum eligibility requirements:

- Medicare Part A and Medicare Part B
- Reside in the service area
- Do not have End-Stage Renal Disease, ESRD, at the time of enrollment (with limited exceptions)
- C-SNP
  - Clinically diagnosed with the specific chronic medical disorders covered under the C-SNP including diabetes, ESRD, chronic lung disorders, or coronary heart disease
- D-SNP
  - Eligible for both Medicare and Medicaid benefits
- I-SNP
  - Reside in a nursing home
  - Reside in the community or at home and certified as needing an institutional level of care

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MOC 1: Description of SNP Population

SCP D-SNP Population

- Average age: 69 years old
- Gender: 70% female, 30% male
- Ethnicity: 78% Caucasian, 10% Hispanic, 12% other
- Language: 84% English, 6% Spanish, 10% other
- Socioeconomic: average income of $31,500 a year
- Access to health care or services: over 50% could benefit from transportation services
- Over 80% have multiple co-morbidities such as high blood pressure, high cholesterol, heart disease, depression, poor nutritional status and Alzheimer's or other dementia related disorders.

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Most Vulnerable Enrollees

- Additional benefits for D-SNP members:
  - Post-Discharge meals
  - Personal Emergency Response System (PERS)
  - Transportation

- D-SNP member unique health needs:
  - Gaps in care coordination
  - Coordination of Medicare and Medicaid benefits
  - Poor health literacy

- Senior Care Plus considers those members who are frail, chronically ill, and have multiple co-morbidities the most vulnerable of the D-SNP population. These members require intensive case management and are identified through pharmacy and medical service utilization, claim reporting, PCP referrals and member self-identification.

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Community Partners

Senior Care Plus is part of the Renown Health system and partners with contracted providers and facilities to provide the following services for our D-SNP members

Two acute care hospitals with 946 licensed beds and the region's only level II trauma center
Acute rehabilitation facility
Multiple skilled nursing facilities
Renown home health and hospice
Geriatric Specialty Care transitional care program which offers in home primary care
Identified High Quality Community Providers: Alpine Family Medicine, Reno Family Physicians and Virginia Family Care Center

Renown Health Primary Care, Specialty Care, Behavioral Health Care and Urgent Care providers

Transitional care navigator, chronic care management, case management, social work and community health worker teams, in addition to the prior authorization and concurrent review teams who ensure appropriate placement, authorization and coordination of services to meet the needs of the D-SNP membership.

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MOC 2: Care Coordination

- SCP D-SNP Staff Structure
- Health Risk Assessment Tool (HRAT)
- Face to Face Encounter
- Individualized Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- Care Transition Protocols (CTP)

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D-SNP Staff Structure

- Medical Director and Chief Medical Officer
- RN Case Manager assigned all DSNP members
- Social Worker as support when needed
- Concurrent Review and Prior authorization RN’s
- Transitional Care Navigators
- Quality management
- Primary Care, Geriatric Specialty Care, Behavioral Care, Urgent Care, Home Health and Hospice

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Initial and Annual MOC Training

- MOC Training
  - MOC annual training is mandatory for all Renown Health staff to include Senior Care Plus and Hometown Health staff, in addition to the providers, hospital staff, home health and hospice providers.
  - MOC Training is made available to the community provider network
  - Training records are maintained in the e-learning system for all Renown providers staff.

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Health Risk Assessment (HRA)

SCP utilizes a Health Risk Assessment (HRA) for all its DSNP members in order to assess members for their chronic conditions and Social Determinants of Health (SDoH).

- HRAs are completed via the Hometown Health website, or
- Telephonically, or
- Face to face
  - Occur at least yearly, with member's consent
  - Between the member and provider or Case Manager
  - In person or via interactive telehealth

HRAs allow SCP to assess the medical, cognitive, functional, psychosocial and mental health of the DSNP members

- Completed within 90 days of enrollment
- Annual reassessment completed within one year of initial assessment

HRA allows capture of member conditions and development of the Individualized Care Plan (ICP)

All encounters are documented in the EMR: Epic

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Individual Care Plan (ICP)

Created by the Case Manager
Based upon information obtained from the member and the member's HRA

Developed with the member

- Individualized based upon member's needs
- Includes measurable goals and outcomes
- Includes the member's self-management goals and objectives
- Includes the member's personal healthcare preferences

Shared with the Interdisciplinary Care Team (ICT) including the member and other network providers as necessary to ensure comprehensive coordination of care

Reviewed and updated to evaluate progress and goals (at minimum once per year) or as the member's healthcare needs change and after each inpatient admission

If goals and objectives are not met, the Case Manager will reassess the ICP and modify or create a new ICP with the member

Documented in the EMR: Epic

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Interdisciplinary Care Team (ICT)

The ICT is comprised of multiple interdisciplinary team members that evaluate the needs of DSNP members based on their risk levels and severity of their chronic conditions as provided for in the ICP.

- Coordinates the special needs of the members with input from the member, Case Managers, Social Workers, Medical Director, Concurrent Review nurses, Transitional Care Coordinators, and providers, as necessary.

- Communication structures within the ICT include telephonic and electronic data transfer record keeping

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Care Transition Protocols (CTP)

Care Transitions are one of the most vulnerable episodes for members.

A main objective of SCP's model of care is to assist the member in obtaining optimum health or improved capacity by:

- Planning and preparing for care transitions
- Ensuring care after transitions are completed
- Communication with and coordination of treating providers

This is accomplished by:

- Interdisciplinary care transition protocols
- Updating, communicating, and implementing ICPs
- Providing clear communication and needed educations to members and caregivers
- Periodic evaluations based upon monitoring of progress or decline in health status

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Care Transitions (continued)

When the health status of a D-SNP member changes, an ICT meeting is held to provide the unique care that is needed.

- TCN or concurrent review RN notifies D-SNP case manager (CM) of member admission
- CM Follows member and participates in facility rounds, ICT and IDT meetings.
- Ensures follow up with primary care provider within 3 days, and that discharge paperwork includes follow up appointments
- CM discusses member IDT meetings

Case Managers provide outreach and discharge planning support

- Outreaches member upon discharge
- Provides contact information to member
- Updates ICP with member collaboration
- Review goals and updates
- Re-evaluate risk stratification and updates as needed
- If member is not scheduled with primary care provider within 1-21 days post discharge, also complete Discharge Education and Med Reconciliation in EPIC via phone
- Admissions are submitted to the State of Nevada as required

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Case Management

The Case Management team ensures members receive personalized care coordination across the entire delivery of care continuum and is focused on the clinical, behavioral, and social needs of D-SNP members

Complex Case Management: A multi-step process to ensure timely access to and coordination of medical and psychosocial services for members and their family/support system. This includes intake, assessment of needs, care planning, care plan implementation, care coordination, monitoring and follow-up, reassessment, and case conferencing.

Social Worker Services: The need for a Social Service evaluation is determined by the requesting clinician by prioritizing based on need.
For example:

- Elder abuse: financial, physical, emotional
- Self Neglect
- End of Life: Advanced Planning discussion/assistance
- Mental health issues: Conservatorship needs
- Declining ability to care for self possibly needing discussion on alternative living arrangements

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MOC 3: Provider Network

- Primary Access to Renown Medical Group, Geriatric Specialty Clinics, Alpine Family Medicine, Reno Family Physicians, and Virginia Family Care Center
- Specialized Expertise
- Clinical Practice Guidelines (CPG) and Care Transition Protocols (CTP)
- Model of Care Training for the Provider Network

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Specialized Expertise

- Senior Care Plus Contracts with an extensive number of providers within each of its geographic service areas to ensure the healthcare needs of our SNP
- These providers are selected for inclusion into the network based on their expertise in areas such as, but not limited to:
  - Internal Medicine, Endocrinology, Cardiology, Oncology, Ophthalmology, Orthopedics, Pulmonology, Behavioral Health
- Senior Care Plus ensures all providers are reviewed for the following:
  - Active license and certifications as necessary
  - Have access to established Clinical Practice Guidelines
  - Participation in ICT as D-SNP member needs dictate and can be conducted in face-to-face, virtual or telephonic meetings

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Clinical Practice Guidelines (CPG) and Care Transition Protocols (CTP)

- Reliable and Exact Care Pathways
  - Diabetes
  - Prevention
  - Coronary Artery Disease (In Progress)
- Complex Case Management Program
  - COPD
  - CHF

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Model of Care Training for the Provider Network

- Model of Care Training for the Provider Network
  - Annual training is mandatory for all Renown Health staff to include Senior Care Plus and Hometown Health staff, in addition to the providers, hospital staff, home health and hospice providers
  - MOC Training is made available to the community provider network
  - Training records are maintained in the e-learning system for all Renown providers
- All newly added and existing providers receive annual Model of Care Training

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MOC 4: Quality Measurement and Performance Improvement

- MOC Quality Performance Improvement Plan
- Measurable Goals and Health Outcomes for the MOC
- Measuring Patient Experience of Care (SNP Enrollee Satisfaction)
- Ongoing Performance Improvement Evaluation of the MOC
- Dissemination of SNP Quality Performance Related to the MOC

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MOC Quality Performance Improvement Plan

Senior Care Plus's Quality Improvement Plan monitors each of its SNPs for performance and effective outcomes for each individual SNP. This can include:

- Identifying and defining Model of Care goals and collection of data to evaluate timely to see if goals are on track or met
- Collecting SNP specific HEDIS measures
- Conducting Patient Satisfaction Surveys
- Conducting and evaluating improvement projects to improving a SNP population clinical or service
- Conducting and evaluating Chronic Care improvement projects to improve disease management

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Measurable Goals and Health Outcomes for the MOC

- Improve Access
  - Medical, mental health and social services
  - Affordable care and preventative health services
- Improve Coordination
  - Coordination of care and transitions of care
- Improve Outcomes
  - Identify baselines and benchmarks for patient health outcomes

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Measuring SNP Performance

GOAL FOCUS	MEASURED BY
Improve Access and Affordability	
• Improving access to medical and mental health and social services • Improving access to affordable care and preventive health services	• Network Adequacy • Provider Network Complaints • Inpatient & ER Visits
Improve Coordination of Care and Care Transitions	
• Improving coordination of care and transitions of care across health settings	• HRA/ICP/ICT Completion Reports • Program Participation • Post Discharge Follow up Status
Improve Outcomes	
• Identifying baselines and benchmarks for marked patient health outcomes	• SNP HEDIS collection • Part D Stars Collection

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Goals

Goal	Beneficiary health outcome	Measure Description	Benchmark	Re-Measurement	Data Source	Reporting Frequency
Improve access and affordability	Provider Availability	Meet CMS network adequacy requirement of 90% of members able to access (time and distance) each HSD required specialty.	90%	Semi- annual	Provider Services	Annual
	Member Complaints	Complaints related to provider network access will not exceed 10 per 10,000 members	10/10,000	Semi-annual	Grievance and Appeals Data	Annual
	Inpatient (IP) Admissions	Admits per member per year	Annually based on membership and experience	Quarterly	UM Data	Annual
	Emergency Dept. (ED) utilization	ED Visits/1000	Annually based on membership and experience	Quarterly	UM Data	Semi-annual

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Goals

Goal	Beneficiary health outcome	Measure Description	Benchmark	Re-Measurement	Data Source	Reporting Frequency
Improve Care Transitions across all healthcare settings and providers	Follow up visit with practitioner post medical hospitalization	Members discharged from the hospital will have a follow up visit within 30 days which includes either with the PCP, Specialist or home health provider	Percent based on annual review and reporting will reflect Benchmark average 50-75% will have follow up visit within 30 days	Quarterly	Claims	Semi-annual
	Follow up visit with BH practitioner post BH hospitalization	Members will have a follow up visit post discharge from a mental health facility within 30 days	35% will have follow up visit within 30 days (actual benchmark determined during annual review)	Quarterly	Claims	Semi-Annual

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Goals

Goal	Beneficiary health outcome	Measure Description	Benchmark	Re-Measurement	Data Source	Reporting Frequency
Ensuring appropriate utilization for condition specific services	Comprehensive medication review for members with chronic conditions (DM, HTN, CHF, dyslipidemia, RA)	Part D Stars	Meet or Exceed CMS 3 Star rating with 68% of members in SNP contracts receiving a CMR	Annually	CMS	Annual
	Statin Therapy for Patients with Cardiovascular Disease (SPC)	HEDIS	Meet or Exceed CMS 4 STAR Rating.	Annually/ Monthly HEDIS Admin Review	HEDIS	Annual
	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	HEDIS	Meet or Exceed CMS 4 STAR Rating.	Annually/ Monthly HEDIS Admin Review	HEDIS	Annual
	Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9.0%)	HEDIS	Meet or Exceed CMS 4 STAR Rating.	Annually/ Monthly HEDIS Admin Review	HEDIS	Annual

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Goals

Goal	Beneficiary health outcome	Measure Description	Benchmark	Re-Measurement	Data Source	Reporting Frequency
Improve Coordination of Care and appropriate delivery of services	Completion of the HRA	Complete the HRA within 90 days of member's enrollment date. OR documentation of member or caregiver refusal	100% new members	Monthly	Internal Specification	Annual
	Completion of the annual reassessment	Completed reassessment (HRA) within 365 days of the previous HRA OR documentation of refusal by member or caregiver	100% existing members	Monthly	Internal Specification	Annual
	Completed care plan	Completed care plan OR documentation to show refusal to participate	100% new members	Monthly	Internal Specifications	Semi-annual
	Documented ICT	Minimal annual documentation of an ICT until documentation of refusal to participate	100% eligible members	Monthly	Internal Specifications	Semi-annual
	PCP Visit	Members who have been in the program one (1) years will have at least one (1) PCP visit	10-75% eligible members	Quarterly	Claims	Semi-annual

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Measuring Patient Experience of Care (SNP Enrollee Satisfaction)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- Conducted Annually
- Measures:
  - Rating of the Health Plan
  - Rating of the Drug Plan
  - Rating of Healthcare Quality
  - Care Coordination
  - Access to Routine Care
  - Access to Specialist Care
  - Getting Needed Drugs

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Ongoing Performance Improvement Evaluation of the MOC

- Quality Improvement projects are reviewed by the Quality Improvement Committee at least annually for approval and quarterly to review performance
- Interventions are approved and prioritized by the committee

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Dissemination of SNP Quality Performance Related to the MOC

- Clinical leadership monitors performance and serves as the oversight monitor to ensure progress on goals have been made
- Results are communicated with the executive leadership and submitted annually to the QM committee as part of end of year evaluations for SNP MOC Improvement
- Summary Analysis is also shared with additional key stakeholders such as members and providers

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References

- Chapter 5 Quality Assessment, Medicare Managed Care Manual
  - Medicare Managed Care Manual (cms.gov)
- Chapter 16-B Special Needs Plans, Medicare Managed Care Manual
  - Medicare Managed Care Manual Chapter 16B (cms.gov)
- H.R. 1982 – Bipartisan Budget Act of 2018
  - Text - H.R.1892 - 115th Congress (2017-2018): Bipartisan Budget Act of 2018 | Congress.gov | Library of Congress
- NCQA Special Needs Plan Model of Care Approvals
  - Special Needs Plan | Model of Care Approvals (ncqa.org)
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  - CFR-2000-title42-vol2-sec422-152.pdf (govinfo.gov)

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Questions


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