2022

Model of Care

Training

LEARNING OBJECTIVES

Define and Describe

- Training requirement
- D-SNPs and C-SNPs
- Special Needs Plan's offerings
- Member qualification requirements
- Describe Clear Spring Health's MOC
- Identify plans most vulnerable members
- Detail Benefit Offerings

Resources

- Where to go for Answers to your questions

Training Requirements

The Centers for Medicare & Medicaid Services (CMS) requires all contracted Medicare providers and staff to receive basic training about the Special Needs Plans (SNP) Model of Care. Clear Spring is required to provide training to providers to ensure its enrolled dual eligible and chronic condition SNP members receive appropriate benefits and services.

Special Needs Plans

- Special Needs Plans (SNPs) are a type of Medicare Advantage plan that focus on Medicare Beneficiaries with special needs who would benefit from increased, focused coordination of care.

- There are three types of SNPs designed for specific groups of members with special health care needs:
  - Beneficiaries with **Dual Eligibility** who qualify for both Medicare and Medicaid (**D-SNP**)
  - Beneficiaries with **Chronic Conditions** (**C-SNP**)
  - Beneficiaries who are **Institutionalized** or eligible for Nursing Home Care (**I-SNP**)

D-SNP Eligibility Requirements

1. Must reside in the plan service area and provide proof of permanent residence
2. Must be entitled to Medicare Part A and be enrolled in Medicare Part B
3. Does not have End Stage Renal Disease (ESRD), unless member developed ESRD when he/she was already a member of a plan that we offer, or if he/she was a member of a different plan that was terminated
4. Have Medicaid: one of the following:
    - Full Medicaid (only)
    - Qualified Medicare Beneficiary without other Medicaid (QMB Only)
    - QMB Plus
    - Specific Low-Income Medicare Beneficiary without other Medicaid (SLMB Only)
    - SLMB Plus
    - Qualifying Individual (QI)
    - Qualified Disabled and Working Individual (QDWI)

C-SNP Eligibility Requirements

1. Must be eligible for Medicare
2. Must reside in the Plan service area and provide proof of residence
3. Must be entitled to Medicare Part A and be enrolled in Medicare Part B
4. Must have one of the following:
    - Diabetes Mellitus
    - Chronic Heart Failure
    - Cardiovascular Disorders

Clear Spring Health's Special Needs Plans (SNPs)

Clear Spring Health offers two Special Needs Plans for 2022

- **Medicare-Medicaid Dual Eligible Program (D-SNP):**

  Available for Plans

  - H6672 001 - Georgia
  - H9403 001 – South Carolina

  Plan has received accreditation by NCQA for 3 years which will expire in 2023.

- **Medicare-Medicaid Chronic Condition Program (C-SNP):**

  Available for Plans

  - H6672 003 – Georgia
  - H9403 003 – South Carolina

- Accreditation for C-SNP Programs is granted annually by NCQA. The Plan was accredited for 2021 and will submit for accreditation for 2022.

The Model of Care includes:

Health Risk Assessment Tool (HRA) – A health risk assessment (HRA) is sometimes known as a health risk appraisal. This is a questionnaire that evaluates lifestyle factors and the health risk of a member.

Interdisciplinary Care Team (ICT) – A group of health care professionals with various areas of expertise that work together to help members reach their desired goals.

Individualized Care Plan (ICP) – Document that is prepared by nursing personnel to coordinate care, improve healthcare services and help members achieve their individual goals and objectives.

Care Coordination – Care coordination is performed by the Case Management team and involves the organization of member care activities and information sharing among all participating providers concerned with member's care to achieve a more effective healthcare outcome.

SNP Benefits – Benefits for SNP population that combines all the benefits of original Medicare plus additional benefits available to those members who qualify.

Provider Role – The role and contribution of individual providers in the health care of the SNP membership.

Staff Role - The role of the plan's staff in the management and implementation of the support work needed to assist the SNP membership

Health Risk Assessment Tool

- The **Health Risk Assessment Tool (HRAT)** helps identify a member's most urgent needs by reviewing:
    - Medical conditions
    - Functional status (i.e., activities of daily living)
    - Cognitive health
    - Psychosocial health
    - Mental health conditions
- The HRAT is completed over the phone by the Health Services team:
    - Within 90 days of member's enrollment
    - Repeated within 365 days of initial HRAT completion
    - When there is a change in member's health condition
- The results of the HRAT are used to create the **Individualized Care Plan (ICP)**

Categorizing Members At Risk

- HRAT results are reviewed and analyzed to categorize the members into Risk Groups based on established criteria.

- Members may fall into **3 Risk Groups:**

  High Risk: The most vulnerable members with multiple chronic conditions and high utilization (ER visits, hospitalizations)

  Moderate Risk: Members with two or more chronic conditions and frequent utilization

  Low Risk: Members with no chronic conditions or just one, and who are stable and able to self-manage

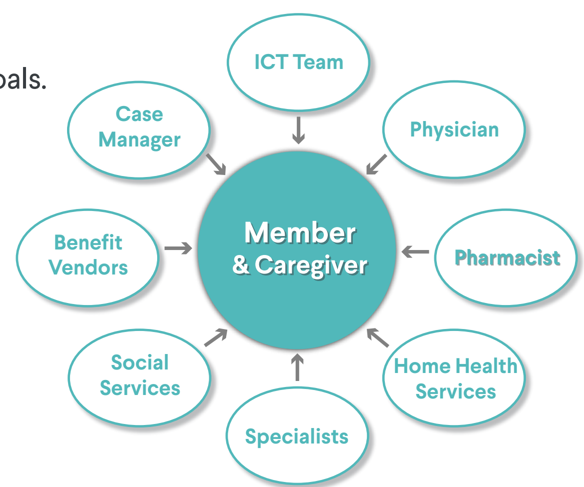
An ICP is developed for each member

- The ICP includes:
  - Problems
  - Goals
  - Interventions

- The ICP is developed by the Case Manager using:
  - Results from the HRAT
  - Claims data (laboratory results, pharmacy, hospital claims, ER claims)
  - Member desired goals
  - Interventions by the Case Manager
  - Suggestions by the interdisciplinary Care Team (ICT)

- The ICP is used to continuously evaluate the member's health status and is updated every time there is a change in the member's health condition. An individualized care plan enables members to actively participate in their healthcare program.

The ICP and Provider Partners



- All members are managed by the ICT to help achieve the plan goals.
- Formal meetings take place for the following:
  - To determine member's needs
  - Identifying problems
  - For member education
  - To determine if goals have been "met" or "not met"
  - To refer/inform member of community resources
  - To manage care transitions
  - To coordinate benefits

Care Coordination: The Care Manager

- Coordination of care for SNP members is completed across various services through a central point of contact, the Case Manager. Every member is assigned to a Case Manager, and he/she is responsible for all the member's care.
- How to improve care:
  - The Case Manager coordinates the care provided by the PCP, specialists and other members of the ICT.
  - The PCP is responsible for member care and identifying member needs.

Providing Transition of Care

- Transition of care occurs when members move from one care setting to another. For example:
  - Hospital to home
  - Hospital to a Skilled Nursing facility or Rehab
  - Nursing home to hospital
- The Case Manager is responsible for ensuring a seamless transition of care between settings by:
  - Sharing the Individualized Care Plan (ICP) with the PCP, hospitalist, facility and/or caregiver as applicable
  - Notifying the PCP of any member transition
  - Contacting the member of any planned transition and answering any questions and to provide educational materials

Transition of Care: Post-Hospitalization

- Contact with member after hospitalization:
  - Members are called 48 hours (2 days) after hospital discharge and 14 days after in a follow-up call
  - A post-discharge or transitional assessment is conducted
  - Medication reconciliation is conducted
  - ICP is updated with new information
  - A Meals Form (SNP) is completed, and meals are delivered to member's home

- Case Manager assists member with:
  - Understanding the discharge diagnosis and hospital instructions
  - Scheduling follow-up appointments
  - Any additional needed services: Home Health, DME etc.
  - Understanding and learning about relevant medical conditions

BENEFITS
PROVIDER ROLE / STAFF ROLE

D-SNP and C-SNP Benefits:

- Case management assistance and support
- End-of-life support
- Home delivered meals
- Non-emergency transportation
- After-hours Nursing Hotline
- Mail order pharmacy
- Self-management activities including medication management, medication adherence, lifestyle changes and self-education
- Behavioral and community-based services

Provider Role:

- Communicate with SNP care managers, ICT members, members and caregivers
- Collaborate with care managers and in maintaining the member's medical records
- Reviews and responds to patient-specific communications
- Maintain ICP information within member's medical records
- Participate in the interdisciplinary care team meetings
- Educate member on the importance of the HRA which is essential in the development of the ICP
- Encourage the member to work with the CM team
- Complete the MOC training upon onboarding with Clear Spring Health and annually thereafter:

Clear Spring Staff Roles:

- Explain to the member the importance of the HRA
- Encourage members to work with their Care Management Team
- Encourage our PCPs and other providers to participate in the ICT
- Remind PCP to access the SNP members Individualized Care Plan (ICP) ICP direct link:
- Conduct annual MOC training as required:
- Complete attestation after completing MOC training

  MOC Training Attestation Form:
  http://csh2022/mapd/wp-content/uploads/sites/3/2021/12/Model-of-Care-Training-Attestation-2022-Fillable.pdf

If you have any questions about the Model of Care, please don't hesitate to call

Provider Services at 1-866-788 3640

Health Services Department at 1-866-689-8761

You can access a copy of the MOC training at in our website:
https://2022clearspringhealthcare.com/mapd/providers/quality-improvement/