CSNP/ISNP Model of Care Training - Provider Training

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**CommuniCare Advantage is the OBA for the legal entity OH CHS SNP, Inc.*

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Overview

- The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care (MOC) as part of the enhanced care coordination and service model expected to serve the needs of a SNP population.
- The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.
- All providers must undergo MOC training annually.
- The training will identify how you, as a provider of care, will support the Special Needs Plan Model of Care, while understanding CMS requirements for managing those members.
- Through distribution of this training and an attestation, we ensure all employees who serve our members develop an understanding of the MOC and the specialized needs of each member.

Learning Objectives

- This training describes CommuniCare Advantage's (CCA's) SNP population and ensures that the participant has a thorough understanding of the MOC.
- Upon completion, participants will be able to explain the basic components of the SNP MOC including the following:
  - Understand SNP eligibility
  - Understand the MOC
  - Explain the elements of the MOC

What is a Special Needs Plan (SNP)

Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs. They are administered by a health payer like CommuniCare Advantage.

CMS had defined three types of SNPs that serve the following types of members:

- A CSNP (Chronic Care Special Needs Plan) is for members with a specific chronic illness or illnesses.
- An ISNP (Institutional Special Needs Plan) is for members who live in an institution such as nursing homes or long-term care facilities.
- A DSNP (Dual Special Needs Plan) is for members who have both Medicare and Medicaid benefits.

All CommuniCare Advantage Medicare SNP plans consist of CSNPs and ISNPs. CommuniCare Advantage Health Plans presently do not have DNSPs.

CommuniCare Advantage ISNP and CSNP

CommuniCare Advantage (CCA) is part of the CommuniCare Family of Companies, an integrated healthcare system with a 40-year history of providing post-acute care and other healthcare services.

- CCA offers an ISNP for individuals living in a nursing home or long-term care facility.
- CCA offers a CSNP for individuals with diabetes mellitus, cardiovascular disease, and/or chronic heart failure. It offers the same benefits as Original Medicare, with additional benefits such as pharmacy benefits and supplemental benefits like dental and vision.
- Member eligibility is tracked and confirmed monthly and can be verified through the Provider Portal.
- ISNP members may lose eligibility when one or all of the following occurs:
  - They lose full Part A or Part B eligibility.
  - They move out of the CCA-contracted facility.
- CSNP members may lose eligibility when one or all of the following occurs:
  - They lose full Part A or Part B eligibility.
  - They move out of the service area.
  - They no longer have the qualifying condition.

We believe in partnering with our provider network to support the unique needs of each member and to promote high-quality care and services.

What Makes an Effective MOC

An effective MOC describes the framework, processes, and systems used to coordinate care for our members. The MOC includes these four elements:

- Description of the SNP population
- Care coordination
- Care provider overview
- Quality measurement and performance goals

MOC 1: SNP Member Population

MOC Element 1 includes characteristics related to the membership that CCA and providers serve including demographics, social factors, cognitive factors, environmental factors, living conditions, and comorbidities.

This element also includes:

- Description of most vulnerable population
- Determining and tracking eligibility
- Economically diverse, including individuals that are dually eligible for Medicare and Medicaid
- Some may have inadequate support systems
- Varying levels of ability, function, and independence
- Most members will speak the English language
- Many may have hearing and/or vision impairments

MOC 2: Care Coordination – Staffing

- Our Care Coordination Model is founded on a collaborative approach within our integrated care system.
- The Plan utilizes a flexible case management model to address the varying needs of the population, including utilizing nurse practitioners and nurses or social workers.
- Utilization Management (UM) Nurse collaborates with the Case Managers (CM) to facilitate hospital discharge planning and other care transitions and coordinates member's needs.
- CM and UM staffing is evaluated from time to time based on membership needs, growth, and other factors.
- Staff undergo rigorous training including compliance and systems training that begins at hire and is ongoing.
- In addition, CommuniCare Advantage partners with other providers to facilitate key services, such as:
  - Pharmacy Benefit Management (PBM)
  - Claims
  - Dental, hearing, and vision
  - Analytics – data mining and dashboards (split between in-house data analytics and sub-contracted vendor)
  - PHP (Personalized Health Partners) who provide case management for highly complex members
  - Call Center after hours/overflow
  - Telehealth

MOC 2: Care Coordination – Health Risk Assessment (HRA)

- The Plan utilizes a **Health Risk Assessment (HRA)** that is comprehensive and specialized for a community-based population (CSNP) with diabetes, heart failure, and/or cardiovascular disease or who reside in one of our ISNP facilities.
- ISNP and CSNP members are encouraged to complete a health screening online or over the phone to identify individuals at risk and most in need of a care management visit.
- Once completed, the screening is used to triage the urgency of an in-person Health Risk Assessment completed with a care manager for CSNP or with a Personalized Health Partner (PHP) Nurse Practitioner (NP) for ISNP.
- All HRAs for all plans are conducted within 90 days of enrollment and, at minimum, again within one year of completion of the last HRA.
- The main objective of the HRA is to assess the members' current health status, estimate their level of health risk, and facilitate the development of their **Individualized Care Plan (ICP).**
- The Plan utilizes a predictive model that rates each member's acuity and risk based on the HRA findings:
  - Low risk
  - Moderate risk
  - High risk
- HRA results are maintained in the integrated clinical database and disseminated to the **Interdisciplinary Care Team (ICT)** participants in a variety of ways.
- The CSNP member's Case Manager and the ISNP member's PHP NP are responsible for providing pertinent HRA and related ICP changes to the member's Primary Care Physician (PCP) and other care providers participating in the member's ICT.

MOC 2: Care Coordination – Individualized Care Plan (ICP)

- In collaboration with the member, the Case Manager develops an Individualized Care Plan (ICP) to address the member's health goals including medical, social, behavioral, and other health care needs.
- The ICP includes the following:
  - Self-management goals developed from the HRA including interventions and outcomes
  - Risk score as generated by HRA
  - Providers and other clinical specialists responsible for delivering care and services for the member
  - Health care directive information
  - Barriers to achieving goals and timeline for goal completion
  - Member-identified disability, cultural, religious, linguistic, and social determinants impacting care and services

MOC 2: Care Coordination – Interdisciplinary Care Team (ICT)

- Interdisciplinary Care Team works collaboratively to develop and implement care plans to meet the member's needs.
- The ICT members are based on member preferences and needs, such as:
  - Member
  - Case Manager
  - PCP
  - Specialists as applicable
  - Other participants as indicated
- The ICT works to empower the member in self-management efforts.
- The CSNP Case Manager and the ISNP PHP NP are responsible for scheduling ICT meetings, informing ICT members of meeting logistics, and updating Care Plan changes.
- ICT collaboration is documented in the member's record in the integrated clinical database.

MOC 2: Care Coordination – Care Transition Protocol

- Transitions of Care (TOC) occur when a member moves from one setting of care to another, such as from acute hospital inpatient care to home. Documentation of the TOC includes but is not limited to:
  - Care plan
  - Medication list
  - Advanced directives, if applicable
  - Up-to-date medical notes and other pertinent information, for example:
    - Discharge instructions from the acute care setting
    - Follow-up appointments needed after an outpatient procedure
- The Case Manager is responsible for communicating with the member, their caregiver/family and Primary Care Physician (PCP), and others during care transitions. This includes ensuring that essential information is provided to the receiving provider when a transition is planned.
- The Case Manager will collaborate with the UM staff when the member is inpatient.
- UM staff will coordinate discharge planning with the Case Manager to ensure that the member will receive the necessary care and services upon discharge.
- Upon return home, the Case Manager initiates follow up with the member to review discharge plan, complete an updated HRA and medication reconciliation. This will allow for an update to the ICP as applicable and initiate further ICTs as appropriate.

MOC 3: Provider Network – Specialized Expertise

- CommuniCare Advantage offers a network of providers, specialists, and facilities with the expertise necessary to facilitate the care and treatment of each member.
- The Provider Network team is responsible for ensuring network adequacy covering all services.
- Network adequacy is assessed at least quarterly to ensure that the Plan has the requisite number of providers to facilitate timely, high-quality care.
- Each provider undergoes formal credentialing to ensure that they are eligible to participate in Medicare programs and meet the professional standards applicable to the provider.

MOC 3: Network – Use of Clinical Practice Guidelines Compliance

- CCA utilizes Clinical Practice Guidelines (CPGs) to guide the care and treatment of members.
- The Medical Policy Committee evaluates and adopts clinical practice guidelines applicable to the needs of CCA's membership (e.g., ASG Clinical Practice Guidelines (CPGs) and the Institute of Medicine(IOM)).
- Annually, CCA validates compliance with selected clinical practice guidelines through data analysis.
- When individual network providers do not adhere to specific CPGs, CCA conducts outreach and offers education and resources.
- If a systemic problem is identified, CCA undertakes broader analysis to evaluate the efficacy of the CPG.

MOC 4: Quality Measurement and Performance Improvement

- CCA has implemented a quality improvement program that will ensure all CMS Model of Care requirements and member care coordination are met.
- CCA's Quality Improvement Program (QIP) monitors, evaluates, and facilitates quality improvement in the quality of healthcare services provided to CCA members through outcome measures such as HEDIS and STARs.
- In addition, the QIP covers a number of different domains including medical care, patient safety, member satisfaction, and the delivery of services.
- CCA utilizes a QIP to develop the annual quality plan, conduct evaluations, and manage the overall quality activities of CCA.
- Providers and other stakeholders have the opportunity to participate in CCA quality workgroups such as the Credentialing Committee.
- Information regarding CCA's performance is shared annually with key stakeholders including the provider network.
- CCA educates its network and membership with updates regarding performance measures and/or changes in the MOC.

MOC Goals Focus

- CCA has chosen seven focus areas for MOC goals:
  - Improve access to care
  - Improve affordability of care
  - Improve coordination of care and appropriate delivery of service
  - Enhance care transitions across healthcare setting and providers
  - Ensure appropriate utilization of previous services
  - Ensure appropriate utilization of service for chronic conditions
  - Beneficiary health outcomes

MOC Compliance

- All Providers who care for CCA members are responsible for compliance with the MOC.
- This includes compliance with all CMS requirements and the ethical administration of the Plan's SNP MOC, which is an enterprise-wide shared responsibility.
- All Providers are required to sign an attestation stating that they have completed and understand the annual CCA MOC Training.

Thank you!

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