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HEALTH PLAN®

SPECIAL NEEDS PLANS (SNP)

Model of Care Training

04/12/2017

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ACCREDITATION STATEMENT

RN: SCAN Health Plan (SCAN) is a provider approved by the California Board of Registered Nursing (Provider #CEP-13453). This activity has been approved for up to 2 contact hour(s).

BBS: Course meets the qualifications for 2 hours of continuing education credit for LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences. SCAN Health Plan is a CAMFT-approved continuing education provider. Provider No. 127226

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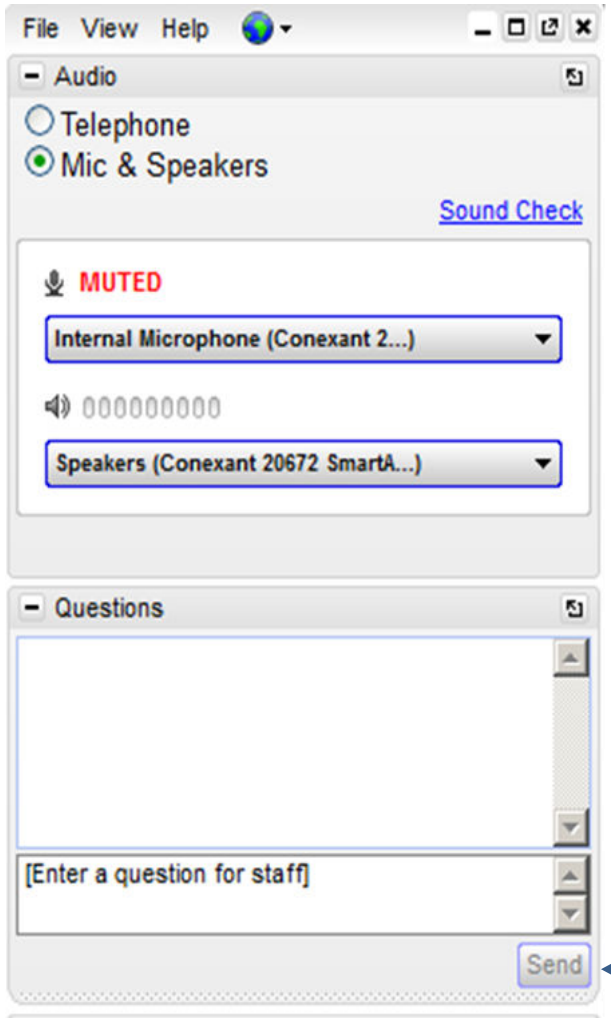
Questions from the Audience



Learning Objectives

- Special Needs Plan Overview
- CMS Special Needs Plan Model of Care Requirements
- CMS Audit Readiness
- Resources and Reference Materials

Special Needs Plan Overview

SCAN Health Plan

SCAN Health Plan (SCAN) is the nation's fourth largest not-for-profit Medicare Advantage (MA) plan, serving over 180,000 members in California.

SCAN's mission is to keep seniors healthy and independent. One way we do this is by providing comprehensive medical coverage, prescription benefits, and support services specifically designed to meet the unique needs of seniors.

Special Needs Plan (SNP) Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) authorized the creation of a type of Medicare Advantage (MA) plan referred to as a Special Needs Plan (SNP), to address the unique needs of certain Medicare populations.

SNPs have been reauthorized several times since their establishment. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Patient Protection and Affordable Care Act (PPACA – effective January 1, 2012) both contain provisions reauthorizing and modifying SNPS.

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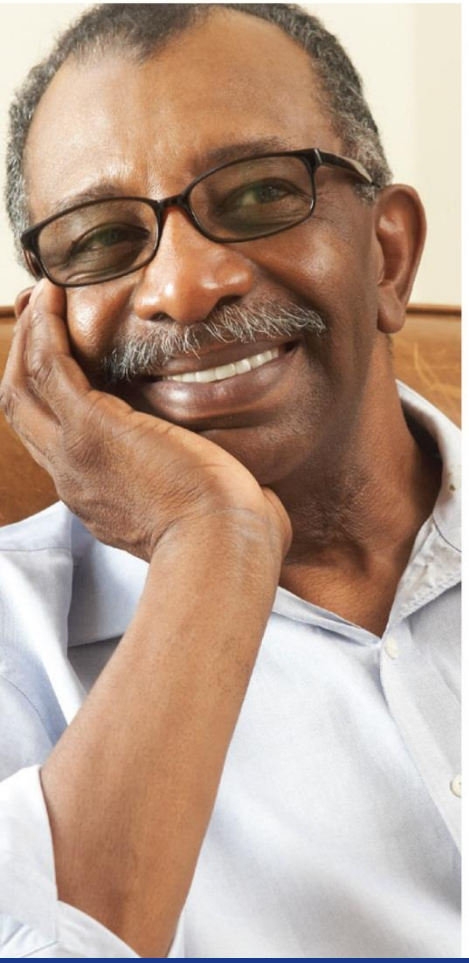
Goals of Special Needs Plans

- Improve access and affordability to member healthcare needs
- Improve coordination of care and ensure appropriate delivery of services through the alignment of the HRA, ICP and ICT
- Enhance care transitions across all healthcare settings
- Ensure appropriate utilization of services for preventative health and chronic conditions
- Improve member health outcomes

Types of SNPS and Eligibility



I-SNP (Institutional – eligibility verified by outside vendor)

- Members who live in the community but require the same level of support provided at a nursing home (Institutional-Equivalent)
- Nursing Facility Level of Care (NFLOC)
- **Healthy at Home**

D-SNP (Dual Eligible – eligibility verified monthly)

- Members who have both Medicare Part A and Part B, full Medicaid benefits
- **Connections/Connections at Home**: Dually enrolled with SCAN in SoCal (FIDE-SNP)
- **Connections**: Medicare only enrolled with SCAN in NorCal
- **Connections at Home:** Must also meet NFLOC

C-SNP (Chronic – eligibility verified 30 days post enrollment)

- Members with severe chronic conditions:
- **Balance**: Diabetes
- **Heart First:** CHF, Arrhythmia, CAD, PVD, Chronic Venous Thromboembolic Disorder
- **VillageHealth:** ESRD

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CMS Special Needs Plan Model of Care Requirements

Model of Care (MOC)

MODEL OF CARE (MOC)

CMS requires SNP Plans to develop a MOC that describes their approach to caring for their target population. The SNP MOC is a working framework indicating how the SNP proposes to coordinate the care of the SNP enrollees.

REQUIRED TRAINING

CMS requires all employed and contracted staff, who provide direct and indirect care coordination services to SNP members, to complete initial SNP MOC training and annually thereafter. SCAN delegates this requirement to each medical group to provide initial and annual training for all employed and contracted staff and maintain the documentation of that training.

For more information, please refer to your Delineation of Responsibilities (DOR)

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CMS Special Needs Plan

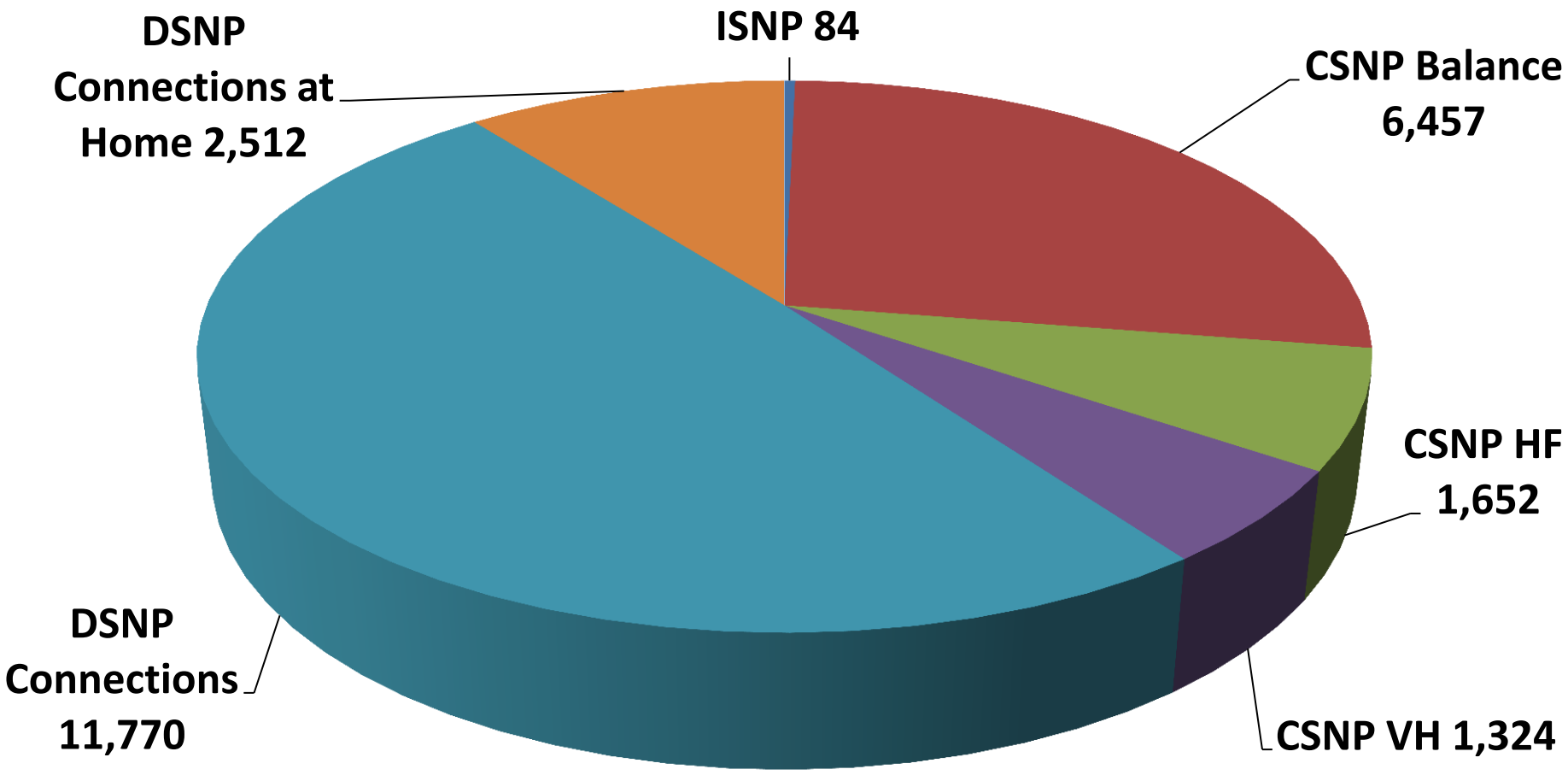
Model of Care Requirements

MOC 1	• SNP Population
MOC 2	• Care Coordination
MOC 3	• Additional Provider Network Requirements
MOC 4	• Audit Readiness

SNP Model of Care (MOC) - Process

- CMS allows MA plans to file for 3 types of SNP's (I-SNP, D-SNP, C-SNP)
- In February Plans are required to submit a MOC to CMS for approval
- In April Plans are notified of MOC scores (must receive 70% to pass)
- In January plans implement their approved MOC

MOC 1: SCAN's SNP Population



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SCAN SNPs by County

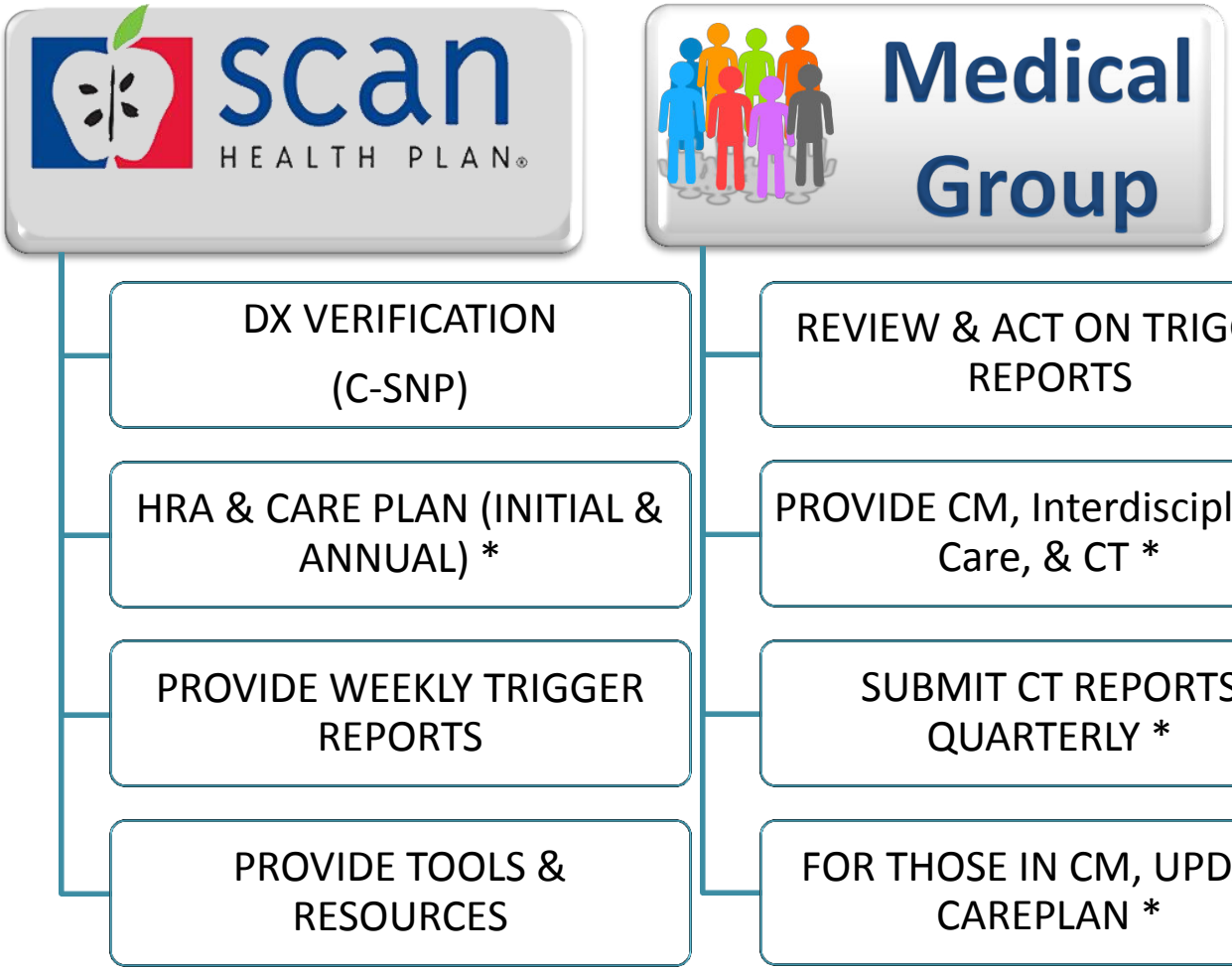
2017 Special Needs Plans by County

Plan Name	Type of Product	LA	OC	RV	SB	SD	MA	NAP/ SON	SJ
Heart First	Chronic SNP		x	x	x	x	x	x	
Balance	Chronic SNP	x	x				x	x	
VillageHealth	Chronic SNP	x	x	x	x				
Healthy at Home	Institutional SNP	x	x	x	x				
SCAN Connections	Dual SNP	x		x	x				x
Connections at Home	Dual SNP	x		x	x				
FIDE SNP	Dual SNP	x		x	x				

SCAN SNP Characteristics

CHARACTERISTICS OF SCAN SPECIAL NEEDS PLAN POPULATIONS	
Demographic	SCAN SNP members are more ethnically diverse than the Medicare population.
General health	SCAN SNP members were more likely to view their health as fair or poor when compared to the Medicare population (35% vs. 27%).
Depression	Eight percent (8%) of the SCAN SNP members had a positive depression screen, compared to 13% of the Medicare population.
Pain	About 16% of the SCAN SNP members and Medicare population reported that pain interfered with their day to day activities quite a bit/very much/all the time.
Chronic Conditions	Ninety percent (90%) of the SCAN C-SNP members, 71% of the SCAN D-SNP members, 85% of the H5425 SNP members, and 76% of the Medicare population reported having two or more chronic conditions.
ADL	Eighteen percent (18%) of SCAN SNP members have 3 or more activities of daily living (ADL) impairment; compared to 14% among the Medicare population.
Urinary/Bladder Problems	Over a third of the SCAN SNP members aged 85 or above reported urinary or bladder problems in the past 6 months.
Falls	About 28% of the SCAN SNP members reported falling to the ground within the past year.

MOC 2: Care Coordination Responsibilities



**VillageHealth Responsibility for ESRD*

Care Coordination Requirements

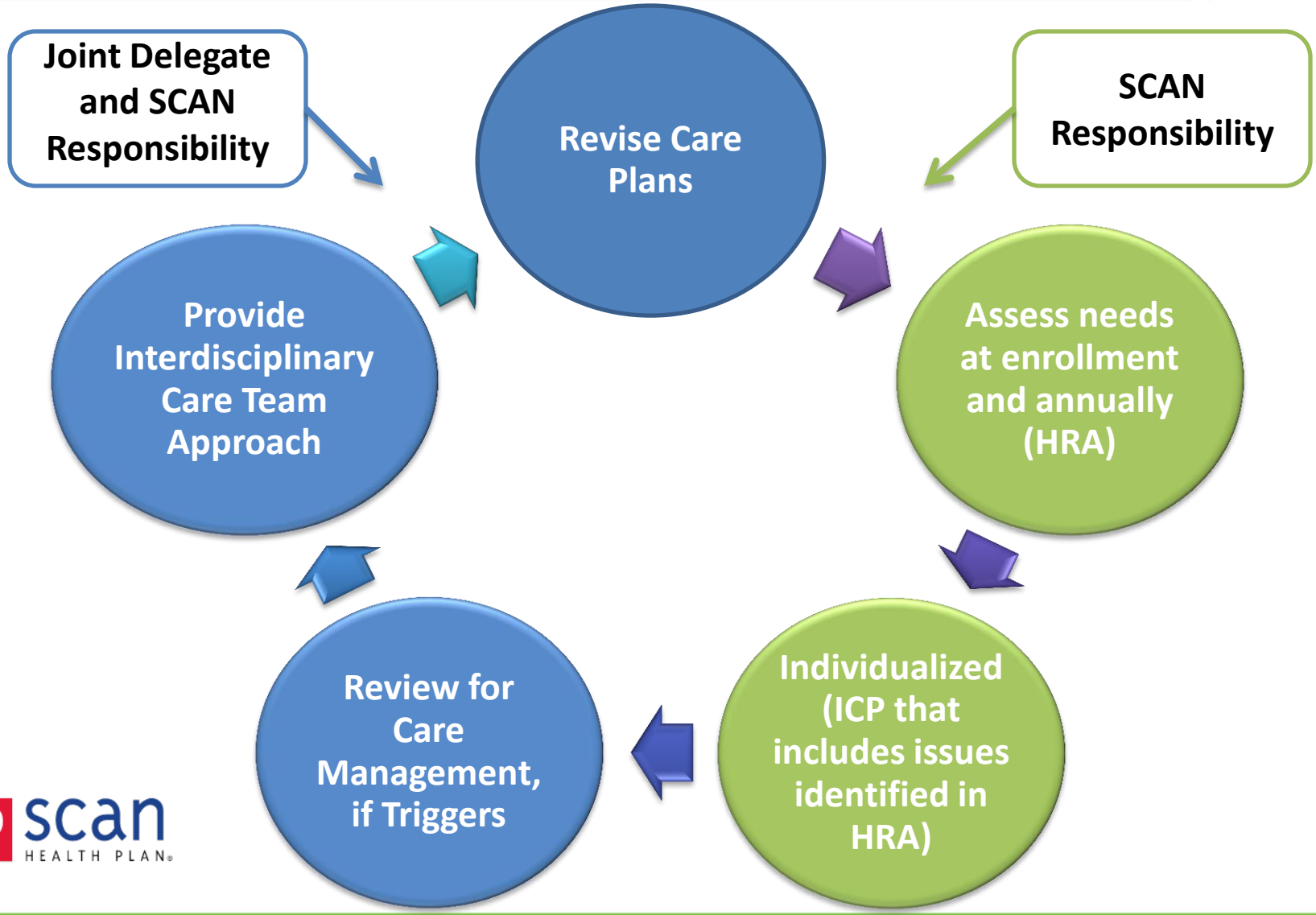
- **Health Risk Assessment (HRA)**
- All SNP Members must have an Initial and Annual Reassessment

- **Individualized Care Plan (ICP)**
- All SNP Members must have a care plan based on results of HRA

- **Interdisciplinary Care Team (ICT)**
- All SNP Members must have interdisciplinary care




Care Coordination Process



HRA Care Management Triggers

Members who complete an HRA either trigger or do not trigger.

Below are examples of why a member would trigger:

"Poor" self-rated health	**3+ SNF admissions in the last year**
8 or more medications	**3+ ER visits in the last year**
Moderate to Severe Depression (PHQ-2)	**Report difficulty managing health condition**
Difficulty with ADLs (Bathing, Eating & Toileting)	**3+ falls in the last year**
3+ hospital admissions in the last year	**Requests a Case Manager**

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Trigger Report

3422 - SNP HRA CM Trigger Report to

Row Count: 12

Member ID	Member Name	Date of Birth	Division ID/Plan Code	Division Name/SNP Plan Type	Network	Assessment Accepted Date	Trigger Report Reason
123456789	Last, Name	4/29/1939	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/6/2017	Depression
123456789	Last, Name	4/29/1937	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/10/2017	ADL: bathing
123456789	Last, Name	4/29/1939	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/6/2017	8+ meds
123456789	Last, Name	4/29/1937	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/10/2017	8+ meds, 3+ ER visits, 3+ Hospital Admits
123456789	Last, Name	5/26/1950	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/6/2017	8+ meds, ADL: bathing, ADL: toilet
123456789	Last, Name	4/29/1937	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/10/2017	ADL: bathing; falls, Depression, 8 +meds
123456789	Last, Name	5/26/1950	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/6/2017	ADL: bathing, ADL: eating, ADL: toilet, ER, Self ID poor health
123456789	Last, Name	4/29/1937	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/10/2017	ADL: bathing
123456789	Last, Name	5/26/1950	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/6/2017	8+ meds, ADL: bathing, ADL: toilet
123456789	Last, Name	4/29/1937	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/10/2017	ADL: bathing
123456789	Last, Name	5/26/1950	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/6/2017	8+ meds, ADL: bathing, ADL: toilet
123456789	Last, Name	4/29/1937	010LACFULL	SCAN Connections (HMO SNP), Los Angeles FULL	Medical Group	3/10/2017	ADL: bathing

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Secure File Transfer Protocol (sFTP)

SCAN uses the SNP sFTP to share SNP member information

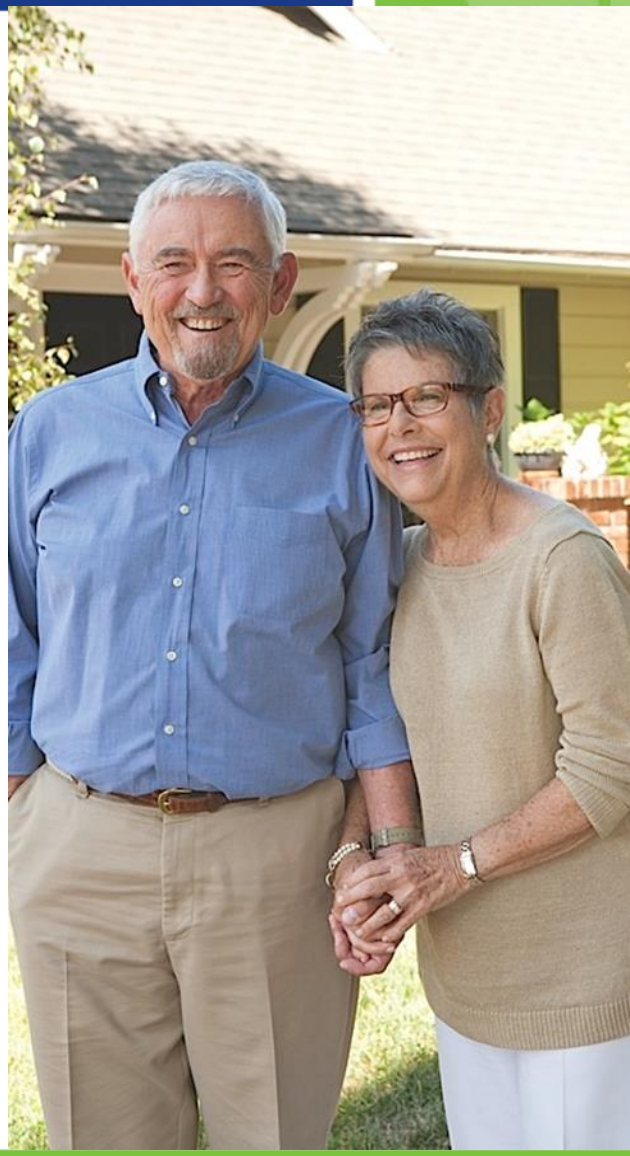
SNP Report	Job Schedule	Day of the Week Report is sent
Completed HRA and Care Plans	Weekly	Saturdays
Trigger Reports	Weekly	Mondays
SNP Census	Monthly	2nd of Month

Review for Care Management Based on Triggers and **Document**

Complete Clinical Review within 30 days of notification of HRA Care Management Trigger:
• Review available clinical records that may include the following: utilization data, lab results, chronic conditions and pharmacy
• Analyze findings from the HRA and other assessments and inputs
• Utilize evidence based guidelines to support treatment decisions
• Determine the need for referral to care management based on the members acuity level
• If you are unable to reach the member or the member declines to participate, complete the activities above based on information available in your system

Care Management Programs

- Programs for Advanced Illness (PAI)
- Complex Care Management
- Disease Management
- Care Coordination
- Population Health Management



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Interdisciplinary Care Requirements – Care Management Responsibility

CMS Requirements

Define the roles and composition of the interdisciplinary care team

Define the use of clinical care managers and others who play critical roles in ensuring an effective interdisciplinary care process is being conducted

Provide a clear and comprehensive description of the communication plan that ensures exchanges of beneficiary information occurs regularly

SCAN ICT Composition Requirement

All SNP Members require Interdisciplinary Care

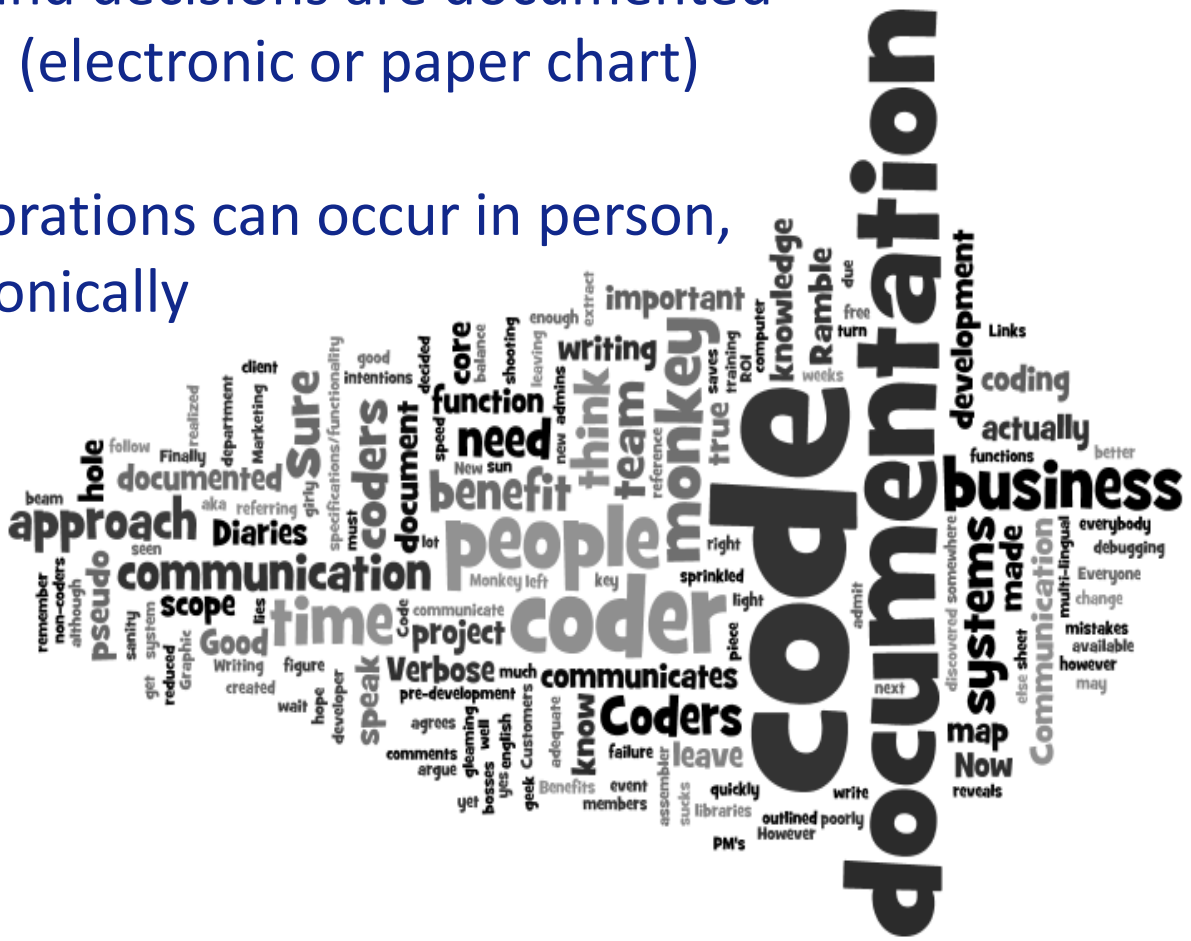
At minimum, the collaboration between any of the following:

- CM assigned to member
- Care Coordinator
- Medical expert (e.g. PCP, Specialists, Nurse, Medical Director)

**Include the member/caregiver if available*

Interdisciplinary Care Documentation

- ICT recommendations and decisions are documented in the member's record (electronic or paper chart)
- Interactions and collaborations can occur in person, telephonically or electronically



Documentation Elements

At minimum, interdisciplinary care should include…

- ❑ Date member Trigger Report received
- ❑ Member's acuity level
- ❑ Date of Interdisciplinary Care
- ❑ Interdisciplinary Care participants
- ❑ Interdisciplinary Care participants attestation of SNP MOC Training
- ❑ If member has seen their PCP or had any ER visits/ hospitalizations in the last year
- ❑ Date of last Care Plan update
- ❑ Summary of case discussion and recommendations

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Care Transitions

Care Transitions is evidence-based, short-term process with specific interventions designed to minimize unnecessary hospital admissions/readmissions and ensure safe and coordinated transitions across the care continuum.

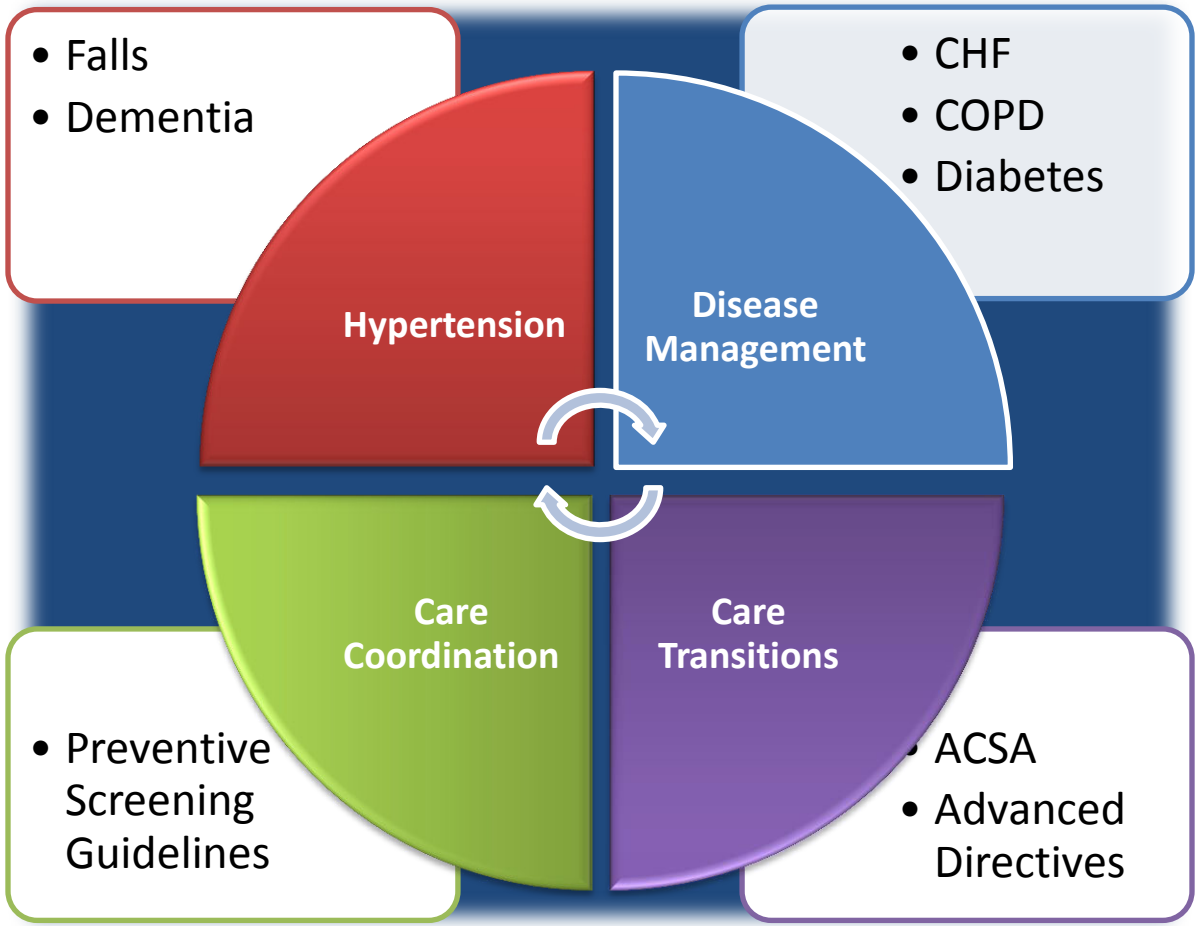
Protocols focus on:

- Medication reconciliation across care settings
- How and when to respond to warning signs/symptoms
- Ensuring post discharge MD follow up visits are scheduled and occur
- A Personal Health Record (PHR) to convey information between settings
- Advanced care planning to assist end of life discussion and decision making

Care Transitions Requirements

- Contact the member within 3 business days post notification of discharge
- Documentation that there are Personnel responsible for coordinating the care transition process
- Process to ensure the ICP is transferred between healthcare settings before, during and after a transition in care has occurred.
- Documentation that the member/caregiver have access to and can adequately utilize the personal health information
- Documentation that the member was coached regarding care transitions

MOC 3: Provider Network Clinical Guidelines



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Model of Care Training Requirement

Who

- Staff/Providers delivering the MOC must complete annually

Format

- Written materials, face-to-face, web, audio/video conference

Content

- Use your own, or draw from SCAN's

https://www.scanhealthplan.com/providers/clinical-guidelines-and-practice-tools/snp-model-of-care-training

Common Issues or Questions

1.
   - Who has access to the SCAN SNP sFTP?
   - What information can you find there?
2.
   - Do all SNP members have to be assessed for Case Management?
   - How would an auditor know when this happens?
3.
   - What if a member indicated they do NOT want CM on the HRA?
4.
   - How do we complete a Care Plan if we're unable to contact the member?
5.
   - Who should be part of the ICT?
   - How does ICT happen?
   - How is it documented?

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CMS Audit Readiness

MOC 4: CMS Audit Readiness

Bulletin

Annual Delegation Oversight Audit

- The Network Compliance Team audits the medical group's who are responsible for SNP care management
- SCAN also has internal controls and audits to ensure compliance (on the plan side)

CMS MOC Compliance Audit

- The CMS program audit of the SNP MOC evaluates implementation and performance
- CMS Audit cycles generally run about 4 years

Delegation Oversight (DO) Audits

DO audit nurses review files to ensure compliance in four critical areas. Lack of evidence in any of these areas result in a corrective action plan.

Predominately FILE REVIEW vs P&P REVIEW

Trigger Report

- Documentation to demonstrate the trigger report reviewed w/in 30 days of receipt.

Care Transitions

- Documentation indicating member was contacted/attempted w/in 3 business days of notification of discharge?

SNP Care Management

- Documentation of a clinical care mgmt. plan and an updated ICP
- ICT recommendations documented and incorporated in the care plan as appropriate.

MOC Training

- Evidence MOC Training was offered to employees and providers w/in the last 12 months

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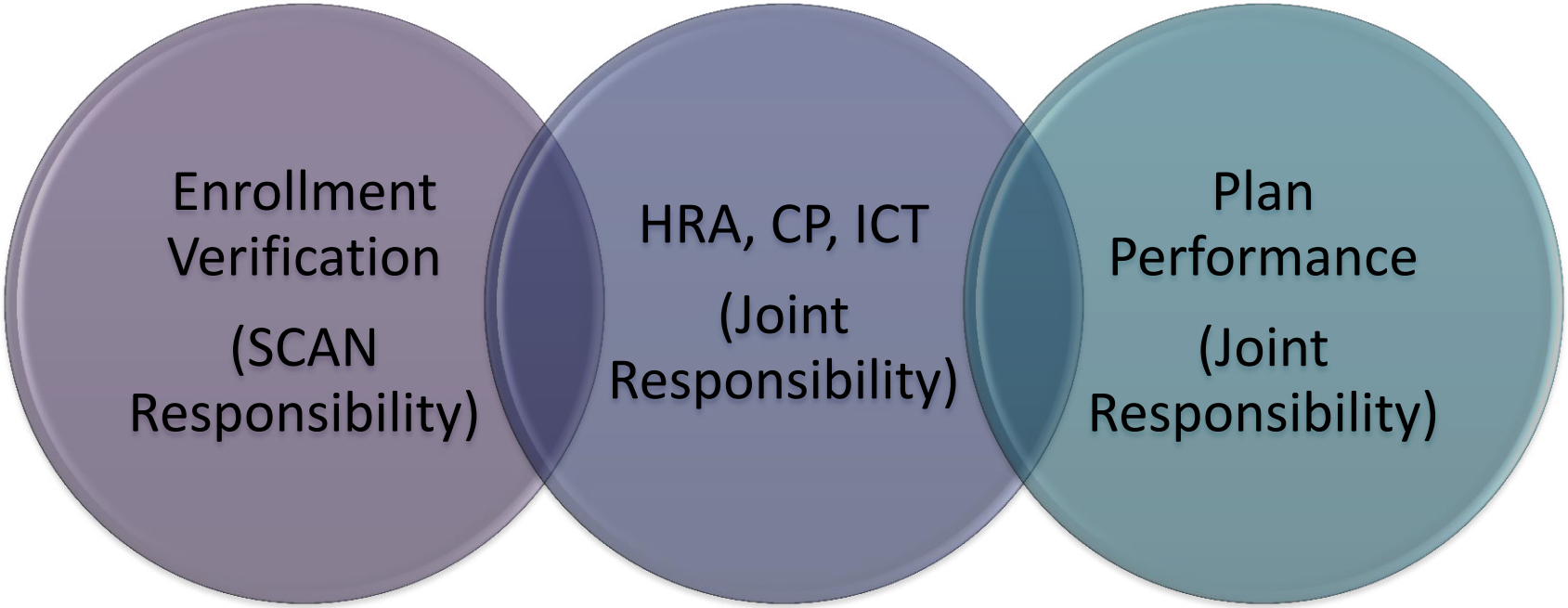
CMS Audit Elements

The purpose of the CMS SNP audit is to evaluate the implementation of the SNP Model of Care (MOC)



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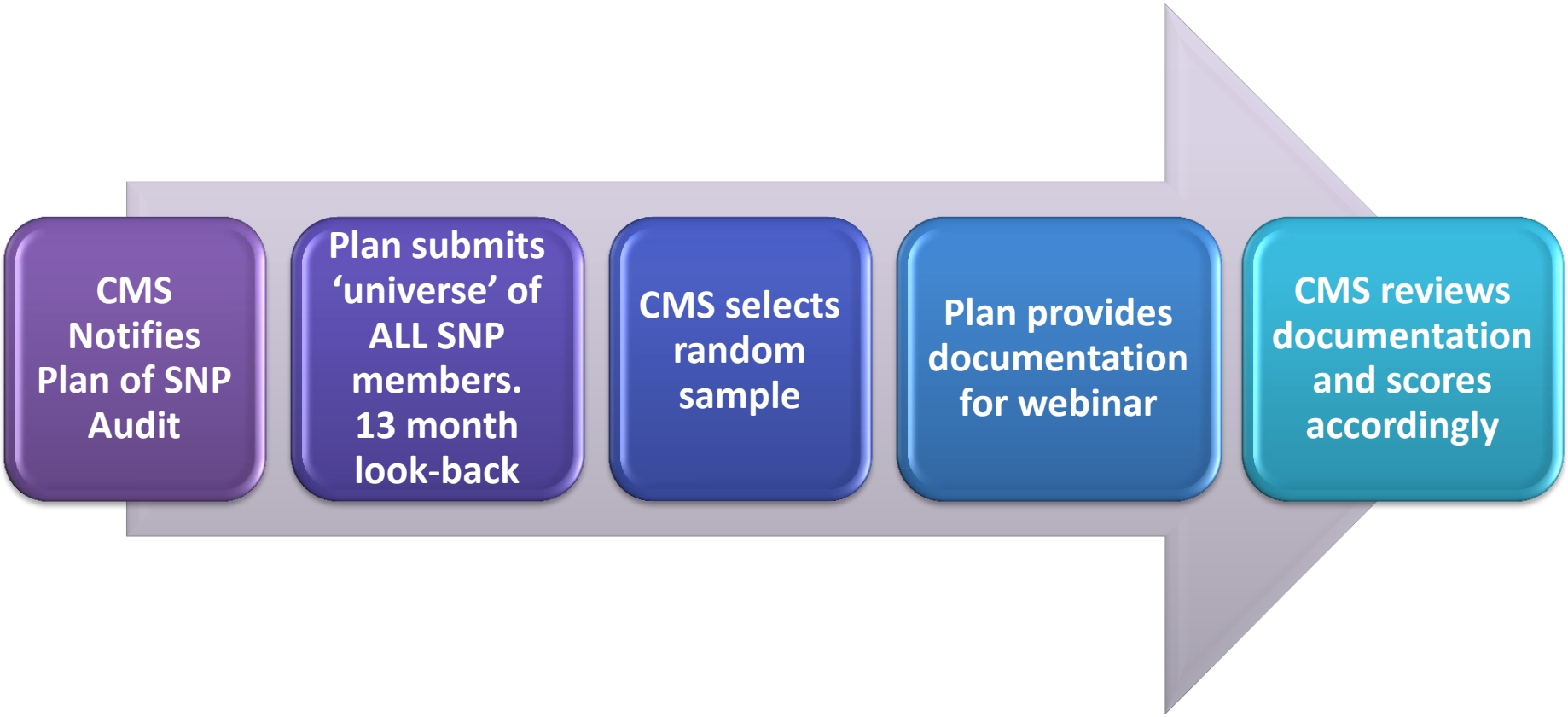
CMS Audit Process



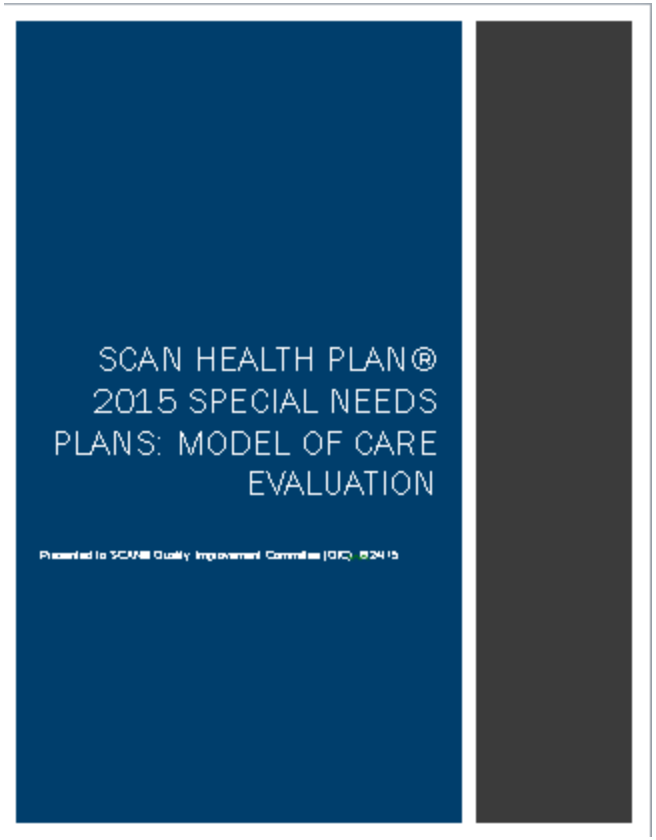
I. Enrollment Verification

SNP	ELIGIBILITY
I-SNP Institutional	• Must meet Nursing Facility Level of Care (NFLOC) • Initial eligibility is verified by outside vendor • Annual eligibility is verified by Care Manager
D-SNP Dual-Eligible	• Must have Medicare and Medi-Cal • Eligibility is verified monthly
C-SNP Chronic	• Qualifying diagnosis verified 30 days post enrollment • Balance: Diabetes • Heart: CHF, Arrhythmia, CAD, PVD, Chronic Venous Thromboembolic Disorder • VillageHealth: ESRD

II. Implementation of HRA, ICP and ICT

HRA	*ICP's*	*ICT*
• *Timely HRA's* • *Assess members needs – medical, psychosocial, cognitive, functional and mental health*	• *Include Measurable Goals & Outcomes* • *Reviewed & Revised for members enrolled in CM*	• *Documentation including recommendations, participants* • *MOC Training*

III. Plan Performance Monitoring & Evaluation



- Methodology for collecting, analyzing, reporting and evaluating their MOC's performance
- Annual SNP Audit
- Use the analysis of performance measures to improve the MOC and develop Corrective Action Plans

Understand CMS Audit Outcomes

- SNP Universe Submission
  - ☑No CMS Findings
- Populations to be Served—Enrollment Verification
  - ☑No CMS Findings
- Care Coordination
  - × 8 Corrective Actions Required
- Plan Performance Monitoring & Evaluation of MOC
  - ☑No CMS Findings

Independent Audit Validation Process

- SCAN is required to hire an independent auditor
- SCAN and delegates will implement corrective actions
- Independent auditor will retest the conditions identified during the 2016 CMS Program Audit for SNP MOC
- SCAN and delegates will have to demonstrate a **clean period—currently planned for June**
- Independent auditor will generate a report with three possible outcomes:
  - Pass
  - Additional monitoring required by CMS
  - Fail

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SCAN SNP Outreach Objectives

Understand SCAN's 2016 CMS SNP MOC Audit Outcomes

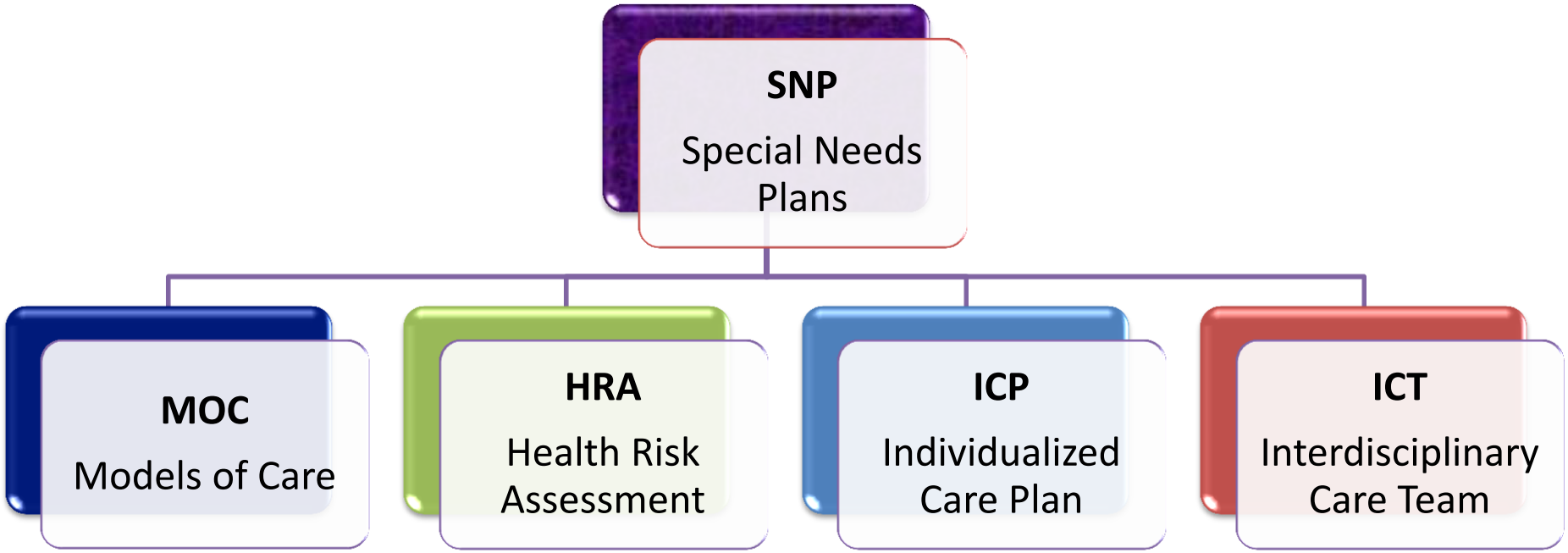
Understand SCAN's Next Steps – Independent Validation Audit

Collaborate on Ways to Implement Corrective Actions and Pass Validation Audit

Develop Follow Up Plan and Process

Resources and Reference Materials

SNP Abbreviations



CMS and SCAN SNP Resources

SCAN's Annual SNP Provider Training

- Webinar provided during 2nd Quarter – *April 12, 2017*

SCAN Health Plan Website

- For Providers
- Clinical Guidelines & Practice Tools Link
- "SNP MOC Self Paced Training"
- *https://www.scanhealthplan.com/providers/clinical-guidelines-and-practice-tools/snp-model-of-care-training*

CMS Website

- Medicare Managed Care Manual Chapter 5
- Medicare Managed Care Manual Chapter 16b
- *https://www.cms.gov*

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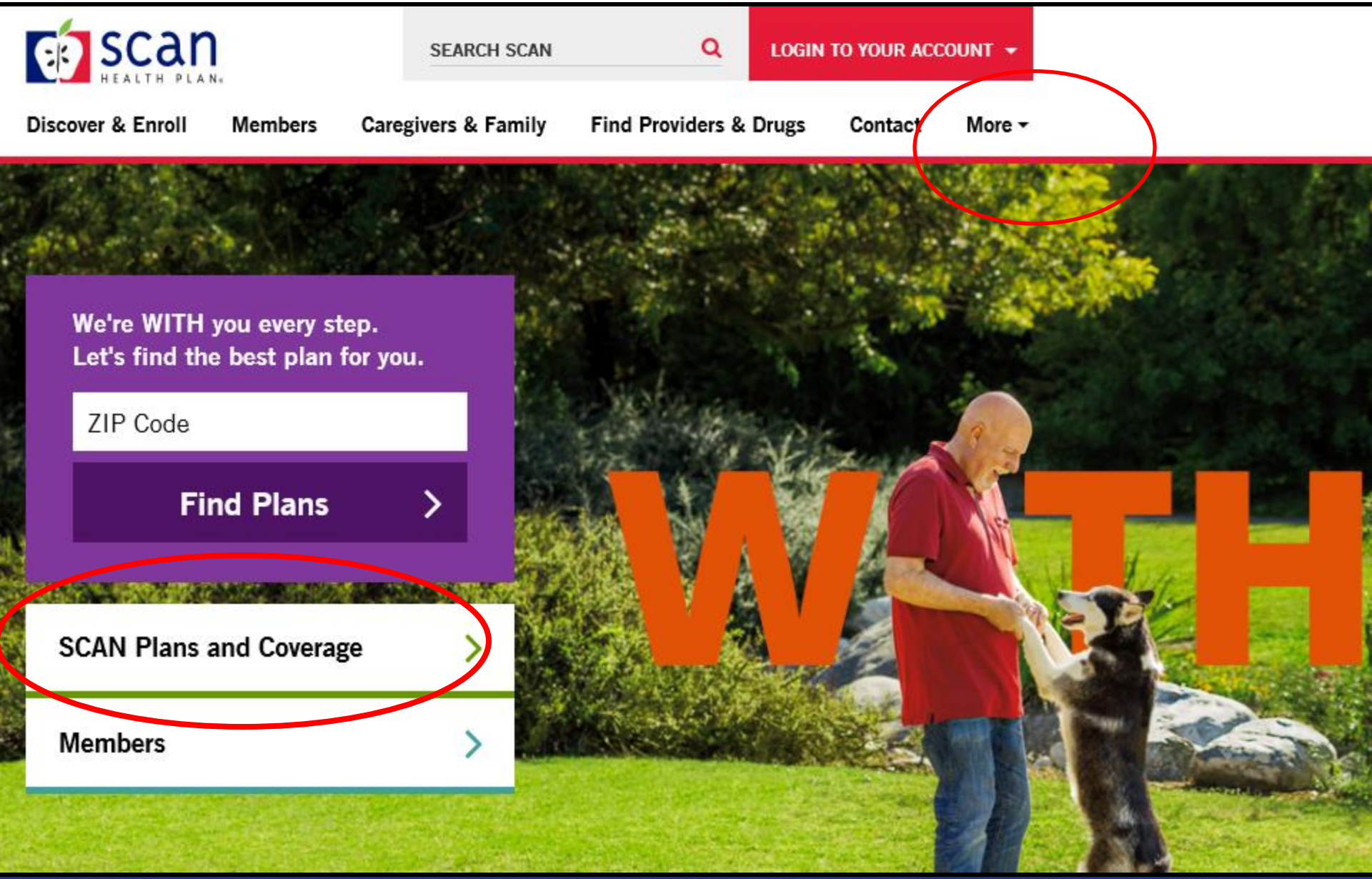
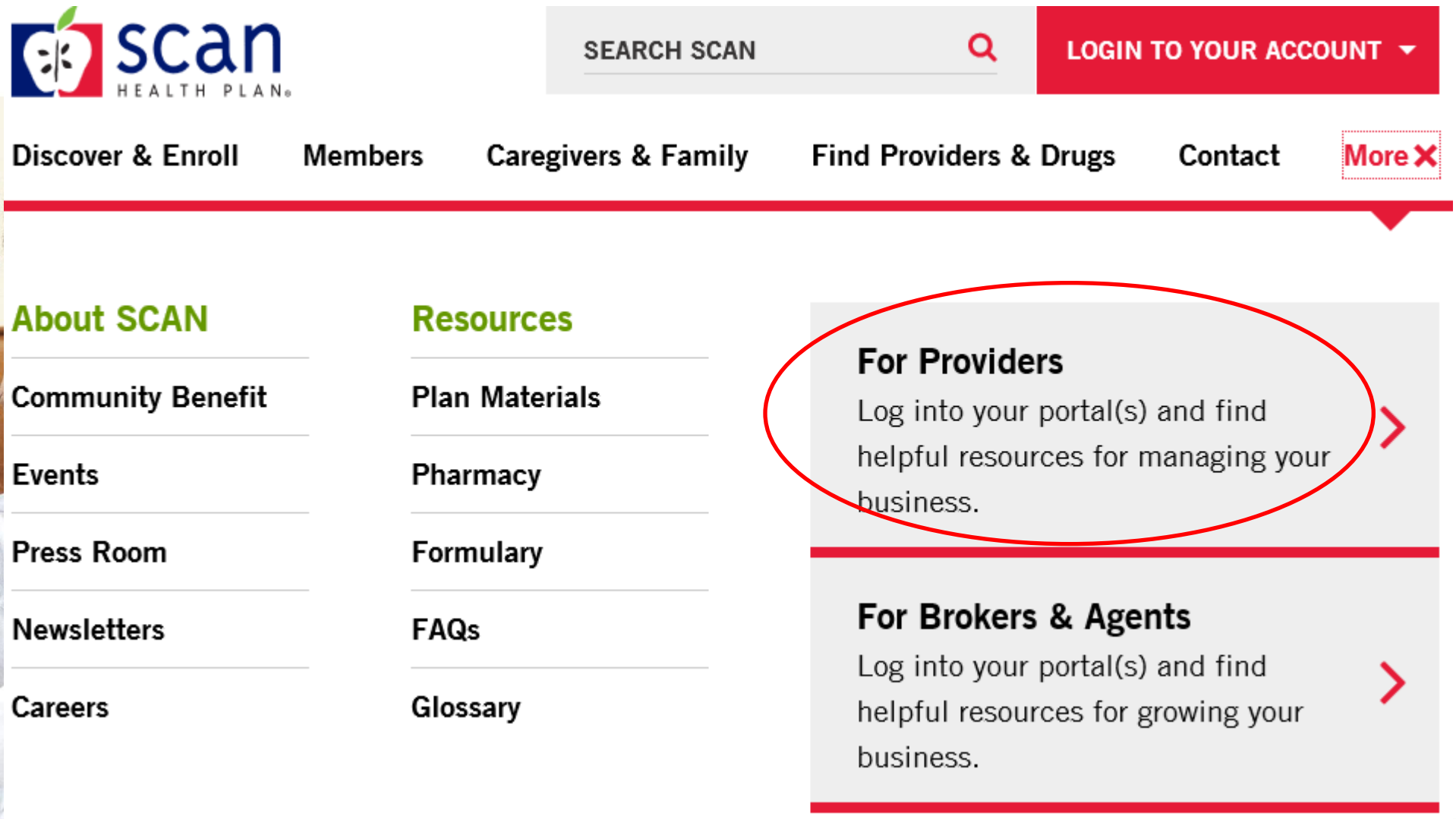
Coordination of Medicare & Medi-Cal

Medi-Cal (LA, RV, SB) FIDE- DSNP	Medi-Cal (SJ) D-SNP	*Plus Plan* *Non-SNP*
PAL 866-722-6725 • Acupuncture/Chiropractor • Dental • Hearing/Vision • Routine Podiatry	Dual Eligible, but only Medicare is with SCAN	*Dual Eligible, but only Medicare is with SCAN*
Medical Management 800-250-9048 • Long Term Care • Inpatient Mental Health • Non-Medicare covered DME & Supplies	Subject to all SNP requirements (HRA, Care Plan, Care Transitions, etc.)	*Not subject to SNP requirements*
Care Coordinator 800-887-8695 • Community Based Adult Services (CBAS) • Incontinence Supplies • Nutritional Supplements • Personal Care • DME (Bathroom)	Contact SCAN for 1 page guide on coordinating benefits with Medi-Cal Managed Care Plans or FFS	*If you'd like, contact SCAN for 1 page guide on coordinating benefits with Medi-Cal Managed Care Plans*

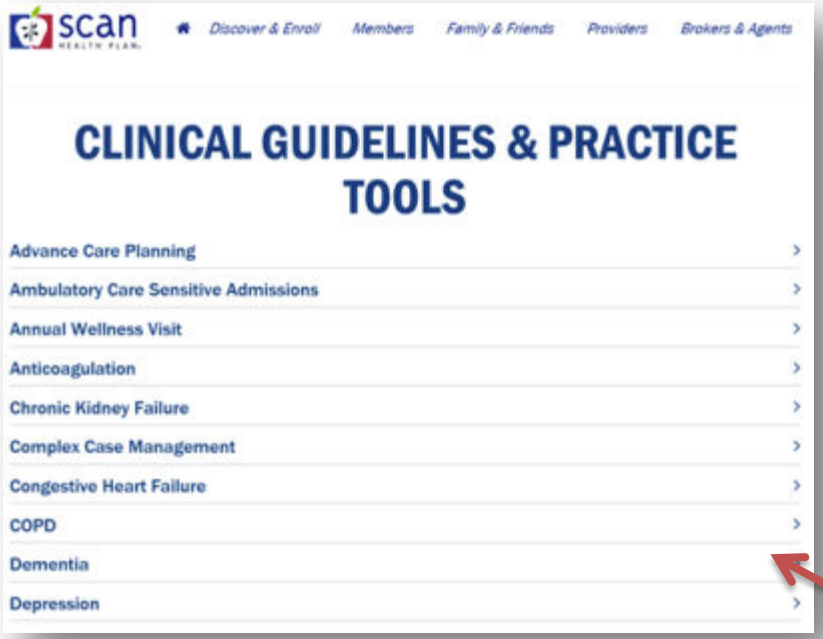
https://www.scanhealthplan.com/

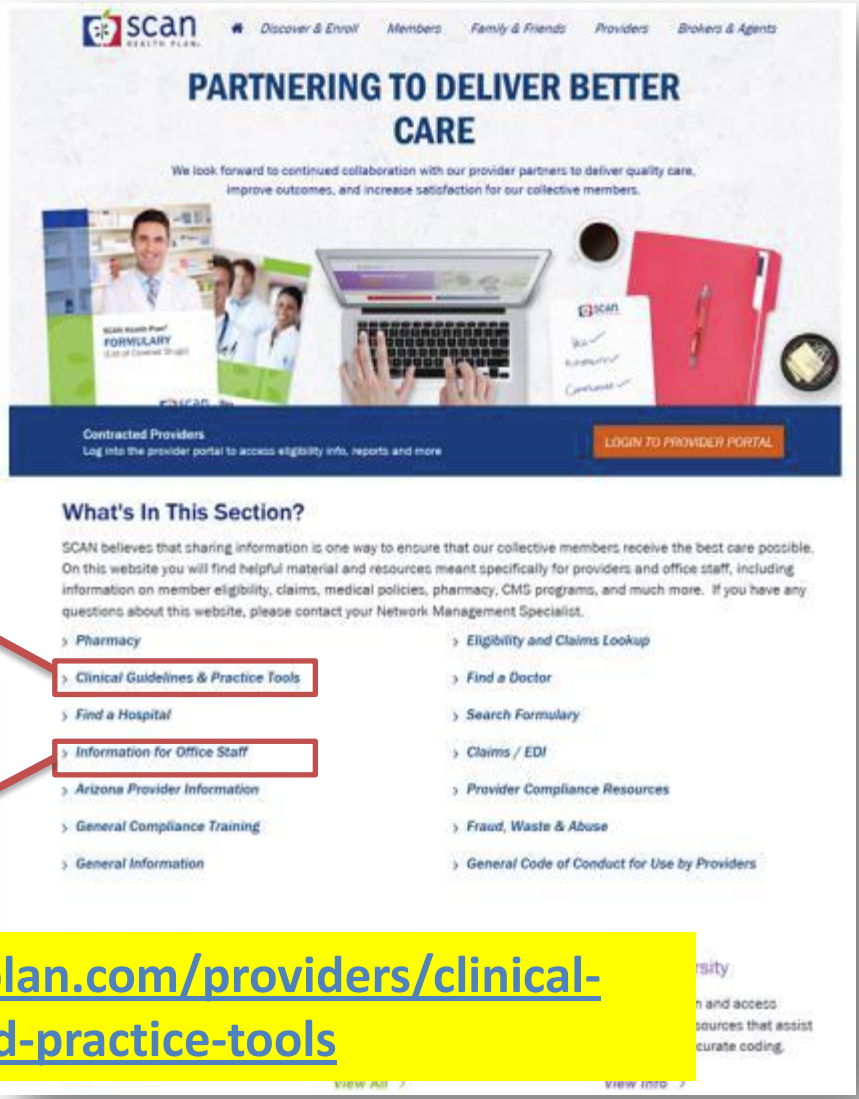


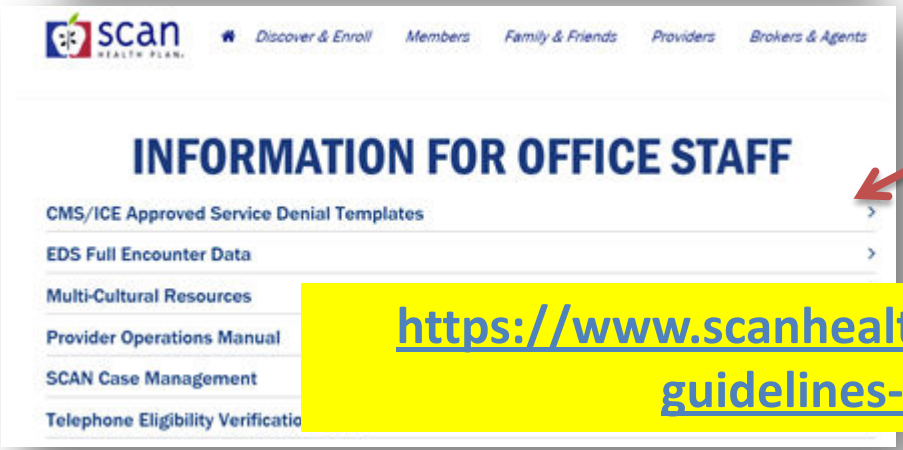
Information on member Clinical Guidelines, eligibility, claims, medical policies, pharmacy, CMS programs and more!



Clinical Guidelines & Tools







https://www.scanhealthplan.com/providers/clinical-guidelines-and-practice-tools

Questions?