Alignment Health Plan
Provider Model of Care Training
Special Needs Plan (SNP)

2019/2020

ALIGNMENT
HEALTH PLAN

Special Needs Plan Overview

Special Needs Plan and Model of Care Background

- The Medicare Act of 2003 established a Medicare Advantage coordinated care plan that is designed to provide targeted care to individuals with special needs.
- Special Needs Plans (SNPs) are a type of Medicare Advantage plan that includes Part C (medical) and Part D (drug) coverage.
- SNP Model of Care (MOCs) are considered a vital quality improvement tool and integral component for ensuring that the unique needs of each member enrolled in a SNP are identified and addressed
- Provides coverage for vulnerable populations who have multiple conditions and barriers to participating in self-care management.
- Provides members with guidance and resources that help provide access to benefits and information.

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Special Needs Plan Overview

MOC Standard Requirements

- The SNP MOC requirements by NCQA® and CMS comprise the following clinical and non-clinical standards:
  - Description of the SNP Population
  - Care Coordination
  - Care Transition Protocols
  - Provider Network
  - MOC Quality Measurement and Performance Improvement
- Each standard contains several elements that are comprised of individual factors SNPs are assessed against.

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MOC Element 1

Summary Description of Alignment's SNP Eligibility Criteria

- Alignment currently offers a **Chronic SNP** plan for the following conditions:
  - Diabetes Mellitus
  - Chronic Heart Failure
  - Cardiovascular Diagnoses
    - Cardiac Arrhythmias
    - Coronary Artery Disease
    - Peripheral Vascular Disease
    - Chronic Venous Thromboembolic Disorder
- Alignment provides services to Special Needs Plan members in Los Angeles and Orange Counties under the Heart & Diabetes (HMO SNP) benefit plan.
- Members can not be currently undergoing treatment for End Stage Renal Disease (ESRD).

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MOC Element 1

Description of Overall SNP Population

- Alignment provides service to Special Needs Plan members in Los Angeles and Orange Counties who have a qualifying chronic condition (DM, CHF, CVD).
- A Population Assessment was conducted in order to build a Model of Care that will properly serve our member's needs. Factors we identified include but are not limited to:
  - Age of current Alignment C-SNP members range from 18-99 years old
  - There are slightly more males than females enrolled in the Alignment C-SNP plan
  - Caucasian, Hispanic and Asian are top 3 ethnicities within the Alignment C-SNP plan
  - Spanish is the preferred language followed by English

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Model of Care
Element 1

Description of Most Vulnerable Members

- Alignment SNP focuses on the vulnerable sub-population of members who are at highest risk of poor outcomes.
- The members are identified using Alignment Health Plan's proprietary software that is algorithm based and identifies census information, gaps in care, pharmacy information, HEDIS® information, and predicts risk scores for Alignment members.
- Reports are generated from the above-mentioned data to assist in the coordination of care for the most vulnerable population using criteria such as utilization, hospitalization, co-morbidities, predictive modeling data and program referrals.

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Model of Care Element 2A

Staff Structure and Care Coordination Roles

Administrative support is provided by Alignment staff with oversight of the various departments performed by the Alignment Compliance team

- Sales Department
- Enrollment Department
- Outreach and Member Engagement
- Claims

Clinical staff supporting the Alignment C-SNP Model of Care include:

- Utilization Management
- CareAnywhere Staff
- Nurse Practitioners, Physician Assistants, Social Workers and Physicians
- Clinical Operations
- Case Managers, Care Coordinators and Medical Assistants
- Quality Management for oversight of C-SNP QM activities and improvement

All staff are trained on the MOC upon hire and annually thereafter

Alignment does not delegate SNP Care Management

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Model of Care Element 2B

The Health Risk Assessment Tool (HRAT)

- A Health Risk Assessment (HRA) is required for all members enrolled in a SNP
- Alignment has a standardized HRA tool which can be completed telephonically, in person or on paper
- The HRA is a tool used to identify member risk levels including but not limited to Health, Functional, Cognitive, Psychosocial / Mental Health
- The HRA results are used to develop or update a member's Individualized Care Plan (ICP) and to stratify the member into risk categories for Care Management and Coordination

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Model of Care Element 2B

The Health Risk Assessment Tool (Cont.)

- All C-SNP members must have a completed Initial HRA within 90 calendar days of enrollment or with any change of Plan Benefit Package (PBP).
- Annually, members must have a reassessment HRA within 365 calendar days of their previous HRA or enrollment date.
- An HRA Reassessment may also occur if a member has a significant change in health status such as:
  - Hospital Or Skilled Nursing Facility (SNF) Admission
  - A Change In Care Setting
  - A Change In Behavioral Health Needs
  - A New Diagnoses Chronic Condition Such As CHF, DM, HTN Or CAD
  - When A Member, Family Or Provider Reports A Change In Condition

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Model of Care Element 2C

Individualized Care Plan (ICP)

- A Care Plan is a vehicle used to facilitate the nursing process.
- Care Plans are used as a communication tool to the member and the PCP and other providers.
- Care Plans address the gaps identified through the evaluation process and planned interventions.
- Essential Components of the ICP include:
  - Address gaps identified through the evaluation process
  - Planned interventions
  - Specific Goals and Objectives
  - Goals will be prioritized and tailored to the member's needs and preferences
  - Identification of goals met/not met

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Model of Care Element 2C

Individualized Care Plan (ICP) (Cont.)

- The Case Manager reassesses the member's progress toward goals periodically and if goals are not met
  - Barriers to achieving identified goals are re-defined and discussed with the member
  - Goals may be modified as desired by the member and/or caregiver
  - Alternative intervention actions are created to succeed in achieving the newly identified/re-defined goals
  - Progress, changes and revisions to the care plan are documented
- The Case Manager shares the initial ICP with the member, the PCP and other members of the Care Team and when the ICP is revised throughout the Care Management Process

Care Coordination

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Model of Care Element 2D

Interdisciplinary Care Team (ICT)

- The Interdisciplinary Care Team (ICT) is member-centric and based on a collaborative approach.
- The ICTs overall care management role includes member and caregiver evaluation, re-evaluation, care planning and plan implementation, member advocacy, health support, health education, support of the member's self-care management and ICP evaluation and modification as appropriate.
- All SNP Members must have an ICT that is based on the member's medical and psychosocial needs as determined by the HRA and ICP.
- The member, the Case Manager and the PCP make up the ICT, but might also include Social Workers, Pharmacists, Medical Director, Specialists and other treating Physicians.
- ICT information is communicated through various methods including:
  - the CM system documentation
  - telephonic communication with member/caregiver and provider
  - Written ICT meeting minutes
  - Documentation within the member's ICP

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Model of Care Element 2D

Interdisciplinary Care Team (ICT) - Member Responsibilities

As part of the SNP Program, members should be active participants in support of their healthcare

- Members are encouraged to complete a Health Risk Assessment initially upon enrollment and annually thereafter
- Members should participate in Alignment Case Management to develop an Individualized Care Plan, set and prioritize goals to improvement management of their chronic condition
- Communicate with primary provider as needed
- Work with their Interdisciplinary Care Team to work toward goals

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Model of Care Element 2D

Interdisciplinary Care Team (ICT) - Provider Responsibilities

- Primary Care Providers must be actively involved in the care of our C-SNP members
- Practitioners, Providers, Facilities and Ancillary Providers must always complete the credentialing and re-credentialing process ensuring active licenses and certifications
- Participate in the Interdisciplinary Care Team Meetings as requested to coordinate the SNP member's care
- Assess/re-assess C-SNP members to identify health status changes and update the Individualized Care Plan (ICP)
- Follow Transition of Care protocols
- Review and discuss care plans with members
- Refer members to Alignment Case Management as indicated
- Complete MOC training upon contracting with Alignment and annually thereafter
- Participate in Alignment's Quality Improvement Initiatives
- Participate in Provider Satisfaction Surveys

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Model of Care Element 2E

Care Transitions

- A Care Transition is movement of a member from one care setting to another when the member’s health status changes
- Care Transition settings include home, home health, acute care, skilled/ custodial nursing facilities, rehabilitation facility, outpatient/ambulatory care/surgery centers
- Care Transitions are addressed by the Case Manager for both planned and unplanned transitions in order to maximize member recovery and avoid preventable transitions
- All applicable ICT members are informed of the member’s needs pre, during and post transition from one care setting to another including the receiving facility

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Specialized Expertise

Model of Care Element 3A

- Alignment contracts with a network of Providers with specialized expertise to ensure that SNP members receive appropriate access to care necessary to manage their healthcare needs
- Alignment's existing provider networks are inherently designed to meet the specific needs of the SNP Program population as evidenced by
  - Contracted providers experienced in caring for our targeted population
  - A culturally-driven provider network
  - Providers, Facilities and Ancillaries located in geographic proximity to where the population resides
- Alignment's specialty network includes, but is not limited to, Internists, Endocrinologists, Cardiologists, Gastroenterologists, Oncologists, Pulmonologists, Surgeons and Behavioral Health Specialists

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Model of Care Element 3A

Specialized Expertise- Licensure & Credentials

- All Alignment Contracted Practitioners, Providers, Facilities and Ancillary Providers, undergo a Credentialing process to ensure they meet all Federal And State Credentialing Requirements
- All licensed practitioners and providers who have an independent relationship with Alignment Health Plan require credentialing
- Verification of credentialing information is performed by Alignment or its delegate initially prior to contracting and every 3 years after
- Alignment administers MOC training upon contracting and annually thereafter to all Providers seeing Alignment C-SNP members

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Model of Care Element 3B

Clinical Practice Guidelines (CPGs)

Alignment ensures all Practitioners, Providers, Facilities and Ancillary Providers use evidence-based nationally approved CPGs for making UM decisions

- The CPGs are approved annually
- Approved guidelines are shared with the network

Member education materials are reviewed annually to ensure consistency with approved CPGs

Alignment monitors how providers utilize CPGs and nationally-recognized protocols through annual review of utilization decisions, appeals process and HEDIS® reporting

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Model of Care Element 3B

Care Transition Protocols

- In addition to the Alignment contracted provider network, Alignment supports the member and the primary care provider through the Alignment Care Anywhere Program
- The Alignment's Care Anywhere Program is a physician led, Advance Practice Clinician (APC) driven model of care designed to support C-SNP members who have been identified as benefiting from a comprehensive in-home assessment to address immediate, chronic, and social health care needs
- The Care Anywhere Program delivers an extra layer of care services for targeted Members to not only reduce the unnecessary utilization of ER and inpatient services, but also to improve health outcomes and restore humanity in advanced care planning

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Model of Care Element 4

Performance Improvement Plan

- Alignment has a Quality Improvement Plan (QIP) that is specific to the MOC and designed to measure the effectiveness of the MOC
- Data is collected, analyzed and evaluated in order to report on the MOC quality performance improvement
- Specific HEDIS® health outcomes measures are identified in order to measure the impact the MOC has on SNP members
- SNP Member satisfaction surveys are utilized to assess overall satisfaction with the MOC
- The results of the surveys are used to modify the MOC QIP on an annual basis
- Each year, an annual evaluation of the MOC is performed and the results shared with the stakeholders through the Quality Improvement Committee (QIC)

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References

Regulatory References

- CMS Medicare Managed Care Manual- Chapter 16b- Special Needs Plans
- 42 C.F.R. §§ 422.2
- Social Security Act Section 1859 (b)(6)(B)(iii)
- CMS Medicare Managed Care Manual Chapter– Enrollment Guidelines
- CMS Medicare Managed Care Manual Chapter 3 – Marketing Guidelines
- CMS Medicare Managed Care Manual Chapter 4 – Beneficiary Protections
- CMS MMCM Chapter 8
- NCQA® Model of Care Scoring guidelines
- Medicare Part C Plan Reporting Requirements Technical Specifications Document

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2019 and 2020

Delegate Representative Attestation

Special Needs Plans (SNP) Model of Care Training Attestation 2019

I, ___________________________________, hereby attest that the attached listed providers have completed the **Special Needs Plan (SNP) Model of Care Training**.

The listed providers understand the Model of Care and the role in improving health outcomes for the most vulnerable population.

It is understood that the annual training is mandatory for all providers that care for SNP members and is required by the Centers for Medicare and Medicaid Services (CMS).

Name:____ Date:___________

Title:_______________________________ Signature: ________________________________

Contract Name: ____

Please return completed attestation and provider signature list to:

Alignment Quality Management Department

Email to QI@ahcusa.com

or send via fax 562-207-4617

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PROVIDER’S SIGNATURE LIST

Purpose: Special Needs (SNP) Model of Care (MOC) annual training is mandatory and is required by the Centers for Medicare and Medicaid Services (CMS) for all Medicare Advantage Special Needs Plan providers.

Instructions: Upon review of training, please provide your printed name, signature and training completion date. Submit this signature list of those who participated in the training along with the attestation

Print Name	Signature	Training Completion Date

Delegate Representative Attestation

Special Needs Plans (SNP) Model of Care Training Attestation 2020

I, ___________________________________, hereby attest that the attached listed providers have completed the **Special Needs Plan (SNP) Model of Care Training**.

The listed providers understand the Model of Care and the role in improving health outcomes for the most vulnerable population.

It is understood that the annual training is mandatory for all providers that care for SNP members and is required by the Centers for Medicare and Medicaid Services (CMS).

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