Chronic Condition – Special Needs Plan

Annual Provider Model of Care Training 2020

COURSE OBJECTIVES

GOLDEN STATE MEDICARE HEALTH PLAN

- Special Needs Plans (SNPs) Overview
- Chronic Condition Special Needs Plans (C-SNPs) Background
- Describe Golden State Medicare Health Plan (GSMHP) C-SNP Target Population
- Describe the goals of GSMHP C-SNP Model of Care (MOC)
- Describe the key components of the C-SNP MOC
- Understand your role in the C-SNP MOC
- Explain how to get answers to your questions

SPECIAL NEEDS PLANS OVERVIEW

GOLDEN STATE
MEDICARE HEALTH PLAN

- The Centers for Medicare & Medicaid Services (CMS) requires all staff and contracted medical providers receive basic training about the Special Needs Plans (SNPs) Model of Care (MOC)
- Golden State Medicare Health Plan (GSMHP) Chronic Condition Special Needs Plan (C-SNP) MOC is the roadmap for delivering coordinated care and care management to eligible C-SNP beneficiaries
- This provider training will describe how GSMHP's C-SNP staff and contracted providers can work together to successfully deliver the C-SNPs MOC

SPECIAL NEEDS PLANS OVERVIEW

GOLDEN STATE MEDICARE HEALTH PLAN

- The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage Coordinated Care Plan (MA CCP) designed to provide targeted care to individuals with special needs
- <u>In the MMA, Congress identified "special needs individuals" as:</u>
  1. Institutionalized individuals
  2. Dual eligibles
  3. Individuals with severe or disabling chronic conditions, as specified by CMS
- <u>Types of Special Needs Plans (SNPs):</u>
  - ✓Institutional Special Needs Plans (I-SNPs)
  - ✓Dual eligible Special Needs Plans (D-SNPs)
  - ✓***Chronic condition Special Need Plans (C-SNPs)***

CHRONIC CONDITION SPECIAL NEEDS PLANS

GOLDEN STATE MEDICARE HEALTH PLAN

Chronic Condition Special Needs Plans (C-SNPs): Background

- For individuals with specific severe or disabling chronic conditions. The Medicare beneficiary must have one (1) or more of the following chronic conditions:

✓Chronic alcohol and other drug dependence
✓Autoimmune disorders
✓Cancer (excluding pre-cancer conditions)
✓Cardiovascular disorders
✓Chronic heart failure
✓Dementia
✓Diabetes mellitus
✓End-stage liver disease
✓End-Stage Renal Disease (ESRD) requiring any mode of dialysis
✓Severe hematologic disorders
✓HIV/AIDS
✓Chronic lung disorders
✓Chronic and disabling mental health conditions
✓Neurologic disorders
✓Stroke

GSMHP C-SNP TARGET POPULATION

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- C-SNPs are permitted by CMS to target a group of commonly co-morbid and clinically linked chronic conditions
- GSMHP has identified a unique and complex population of Medicare beneficiaries within its service area who have extensive health care needs related to:

✓ ***Diabetes Mellitus (DM)***

✓ ***Chronic Heart Failure***

and/or

✓ ***Cardiovascular Disorders***

- GSMHP has created a C-SNP to address the needs of this unique population, within the service areas of Los Angeles, Orange, Riverside, San Luis Obispo, and Stanislaus counties

GSMHP C-SNP MOC GOALS

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- Improve ***ACCESS*** to medical, mental health, social services, affordable care and preventive health services
- Improve ***COORDINATION OF CARE*** through an identified point of contact (i.e., Primary Care Physician)
- Improve seamless ***TRANSITIONS OF CARE*** across healthcare settings, providers, and health services
- Assure ***APPROPRIATE UTILIZATION*** of services
- Assure ***COST-EFFECTIVE HEALTH SERVICES*** delivery
- Improve ***HEALTH OUTCOMES*** for beneficiaries with ***DM, chronic heart failure, and/or cardiovascular disorders***

GSMHP C-SNP MOC KEY COMPONENTS

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- The key components of GSMHP's Model of Care (MOC) include:

1. A comprehensive Health Risk Assessment (HRA): initial and annual
2. The development of an Individualized Care Plan (ICP) with member input
3. The Participation of the member (and family member or caregiver) and their Primary Care Provider (PCP) in an Interdisciplinary Care Team (ICT)
4. Care coordination
5. GSMHP C-SNP Staff and Provider role

HEALTH RISK ASSESSMENT

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- Health Risk Assessment (HRAs):
  1. Helps identify beneficiaries with the most urgent needs
  2. Integral part of the member's care coordination
  3. Contains member self-reported information
  4. Helps develop the members' Individualized Care Plan (ICP)
  5. Assess the following needs of each member:
     - ✓ Medical
     - ✓ Functional
     - ✓ Cognitive
     - ✓ Psychosocial
     - ✓ Mental Health
  6. Completed by the case management team within 90 days of enrollment, and annually

INTERDISCIPLINARY CARE TEAM

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- Interdisciplinary Care Team (ICT):
  - Each member is managed by an ICT
  - A member's Primary Care Physician (PCP) is an integral part of their Interdisciplinary Care Team (ICT)
  - The Case Manager is the key point of communication for the PCP and the member with the rest of the ICT
  - The ICT membership includes, but is not limited to:
    - ✓ Member (family or caregiver)
    - ✓ PCP
    - ✓ GSMHP's C-SNP Case Manager
    - ✓ GSMHP's C-SNP Chief Medical Officer
    - ✓ GSMHP's Clinical Behavioral Health Team Member
    - ✓ GSMHP's Director of Pharmacy

INTERDISCIPLINARY CARE TEAM

GOLDEN STATE MEDICARE HEALTH PLAN

- ICT Role:
  - ✓ Determines member goals and needs
  - ✓ Coordinates member care
  - ✓ Identifies problems and anticipates crises
  - ✓ Educates members about their chronic conditions and medications
  - ✓ Coaches members to use their Individualized Care Plans (ICPs)
  - ✓ Refers members to community resources
  - ✓ Manages transitions

INDIVIDUALIZED CARE PLAN

GOLDEN STATE MEDICARE HEALTH PLAN

- Individualized Care Plan (ICP):
  - ✓ Mechanism for evaluating the member's current health status
  - ✓ Ongoing action plan to address the member's care needs with member and ICT
  - ✓ ICP contains member-specific problems, goals, and interventions
  - ✓ A living document that changes as the member changes
  - ✓ ICP is developed and maintained for each C-SNP member using:
    1. Health risk assessment results
    2. Lab results, pharmacy, emergency department, hospital claims data
    3. Case manager interaction(s)
    4. ICT input
    5. Member preferences and personal goals

CARE COORDINATION

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- GSMHP's C-SNP coordinates care for C-SNP members across the care continuum through a central point of contact: ***GSMHP's C-SNP Case Manager***
- <u>To improve the coordination of care:</u>
  - ✓ The PCP is the gatekeeper
  - ✓ The GSMHP C-SNP Case Manager coordinates care with the member, the member's PCP, specialists (i.e., endocrinologists, cardiovascular specialists, etc.), and other participants of the member's ICT
  - ✓ The member's PCP is notified of any transition
  - ✓ The member's ICP is shared with applicable providers, such as their PCP, the hospitalist, the facility, and the member/family/caregiver
  - ✓Members are contact prior to any planned transitions to provide educational materials and answer any questions related to the transition

UNDERSTANDING YOUR ROLE IN THE C-SNP MOC

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- The GSMHP's C-SNP staff and provider partner relationship is an instrumental part of the ICT
- GSMHP's C-SNP allows us to work together for the benefit of the Medicare beneficiary by:
  - ✓ Enhancing communication
  - ✓ Focusing of each individual member's special needs
  - ✓ Delivering care management to assist with the member's chronic medical and non-medical needs
  - ✓ Supporting the member's ICP

UNDERSTANDING YOUR ROLE IN THE C-SNP MOC

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- <u>What you can do as GSMHP's C-SNP Provider to help C-SNP members:</u>
  - ✓ Communicate with GSMHP's C-SNP Case Managers, ICT, and members
  - ✓ Collaborate with GSMHP's C-SNP on the ICP
  - ✓ Maintain the C-SNP member's ICP in their medical record
  - ✓ Actively participate in the ICT
  - ✓ Review and respond to member-specific communication
  - ✓ Remind C-SNP members of the importance of the HRA
  - ✓ Encourage member to work with their GSMHP C-SNP Case Manager and ICT
  - ✓ Complete GSMHP C-SNP MOC Training upon hire and annually

Don’t Forget to Submit Your Attestation

I acknowledge that I am the authorized representative for the delegated entity to which the acknowledgement form was issued. I am acknowledging that all applicable personnel within the provider network have completed the 2020 annual SNP Model of Care Training.

Delegated Entity:

Signature:

Print Name: **Title:**

Date:

Thank You!

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MEDICARE HEALTH PLAN

For Questions

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