



Special Needs Plan (SNP) Model of Care Training 2022



Important Note

SCAN's
Special Needs
Plan (SNP)
Model of Care
(MOC) Training

This applies to
all Medical
Groups who
provide care for
the SNP types:

Chronic Special Needs Plan (C-SNP)

- Balance
- Heart First
- VillageHealth

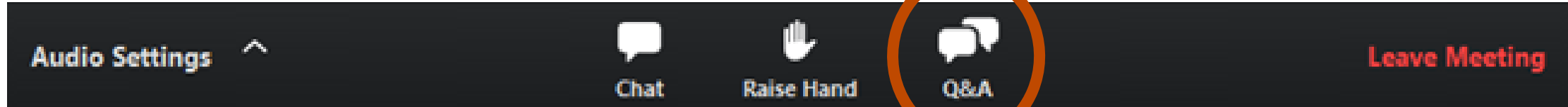
Dual Special Needs Plans (D-SNP)

- Connections
- Connections at Home

Institutional Special Needs Plan (I-SNP)

- Healthy at Home

Questions from the Audience – update with Zoom



Q & A

- Type question, hit send
- Questions may be answered out loud at the end of the webinar or via the Answer field

Agenda

Introduction and Training Objectives

SNP and SCAN's Mission

CMS SNP Guidelines

Provider Group Responsibilities

HRAs (Health Risk Assessments), Care Plans and Triggers

Interdisciplinary Care Team (ICT)

Individualized Care Plan (ICP)

Care Transitions

CM Referral Criteria

Audit and Oversight

SNP MOC Training

Meet the Presenters



Janelle Howe, VP Clinical Operation

- Introduction
- SNP MOC Training



Eve Gelb, MPH, SVP Duals

- SNP and SCAN's Mission



Lisa Roth, VP, Health Care Services Transformation

- CMS SNP Guidelines



Jeanette Despal, RN, Manager Network Compliance Clinical

- Provider Group Responsibilities
- Audit and Oversight



Amy Landers, Manager Care Coordination

- HRAs (Health Risk Assessments), Care Plans and Triggers



Maricris Tengco RN, Director Care Coordination

- Interdisciplinary Care Team (ICT)



Elizabeth Gomez, Director Social Support

- Individualized Care Plan (ICP)



David Tucker, Manager, Clinical Care

- Care Transitions
- CM Referral Criteria

Learning Objectives



Understand and Explain
Your Requirements as a
SNP Provider



Describe SNP Basics



Describe SNP Audit
Requirements



Our Mission



Eve Gelb, MPH, SVP
Duals
SNP and SCAN's Mission

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CMS SNP Guidelines



**Lisa Roth, VP,
Health Care Services
Transformation**



The 4 elements of the SNP Model of Care

- Chronic Disease SNP (**C-SNP**)
- Fully Integrated Dual Eligible SNP (**FIDE – SNP**)
- Institutional SNP (**I-SNP**)

SNP Population



- Health Risk Assessment (**HRA**)
- Individualized Care Plan (**ICP**)
- Interdisciplinary Care Team (**ICT**)
- Care Transitions (**CT**)

Care Coordination



- Staff/providers deliver care to SNP members

Provider Network



- Quality Measure Monitoring
- SNP model of care program evaluation process (annual)
- Quality Improvement Plan

Quality Measurement & Performance



CMS SNP Audit: Experience



HRA Timeliness



Review of Triggered Cases to Care Management



Care Transitions



Model of Care Training



Provider Group Responsibilities



**Jeanette Despal, RN,
Manager Network
Compliance Clinical**

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Provider Group Responsibilities - Delegation

Health Risk Assessment

Care Management and Coordination

Care Transitions

Interdisciplinary Care Team (ICT)

Model of Care Training

Individualized Care Plan

HRA, Trigger Report and ICP



**Amy
Landers, Manager
Care Coordination**



Accessing and Retrieving HRA, Trigger Reports, and ICPs

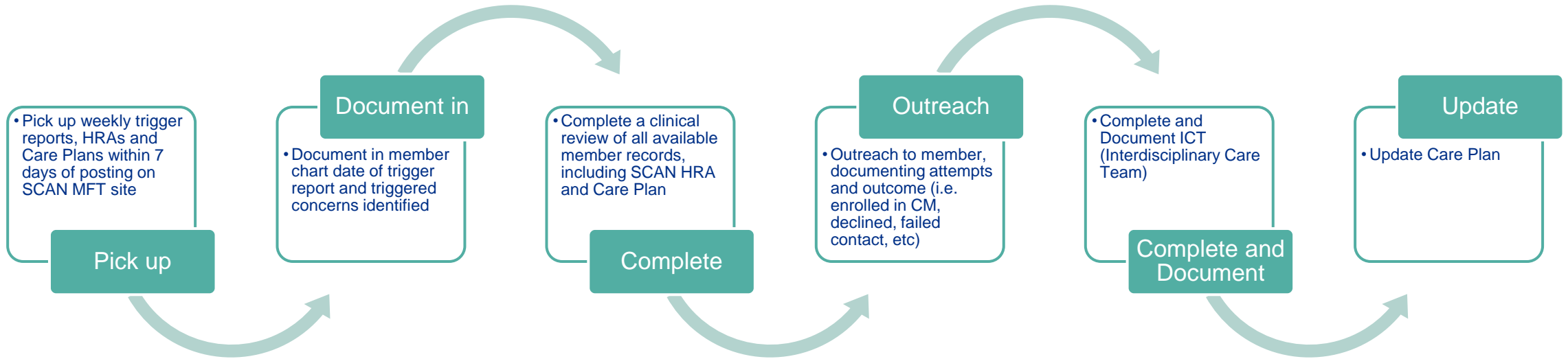
SCAN completes the HRA (NOT DELEGATED)

HRA used to triage members to low and high risk

High Risk members sent to delegated provider groups via a weekly trigger report on the mft site

All HRAs and Care Plans also sent to provider groups weekly via MFT site

Provider Group Requirements





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HRAs, Care Plans and Trigger Reports



Interdisciplinary Care Team (ICT)



Maricris Tengco
RN, Director Care
Coordination

Expectations

Define SNP ICT Requirements

Roles and Composition of ICT

Different Format of ICT

Communicate Between ICT Participants

Document the ICT

SNP ICT Requirements

	①	②	③
Requirements	<p>All SNP members received from HRA trigger report and via referral process</p>	<p>Composition of ICT (at minimum):</p> <ul style="list-style-type: none"> • CM assigned • Care Coordinator • Medical Expert (e.g. PCP, Specialist, Nurse Practitioner, Medical Director) • Member/Representative (if available) 	<p>ICT Format:</p> <ul style="list-style-type: none"> • In- person • Telephonically • Electronically
Operations and Documentation	<ol style="list-style-type: none"> 1. Complete within 30 days of receipt 2. Includes failed contact and declined 	<ol style="list-style-type: none"> 1. All ICT participants are required to complete MOC training (attestation is needed) 2. ICT recommendations and decisions are documented in the member's record (electronic or paper chart) 3. Evidence that copy of care plan was provided to/available to ICT participants and members 	<ol style="list-style-type: none"> 1. Date member trigger report/referral received 2. Member's acuity level 3. Date of ICT 4. ICT Participants 5. If member has seen their PCP or had any ER visits/ hospitalizations in the last year 6. Summary of case discussion and recommendations



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Interdisciplinary Care Team (ICT)



Individualized Care Plan (ICP)



Elizabeth Gomez,
Director Social
Support

ICP Overview



Provider expectations for creating a SNP Care Plan



When to update the Care Plan



Communicating the SNP Care Plan

Creating the SNP Care Plan

Review	Upon receipt of SCAN documents: Review HRA/ICP for triggered members
Complete	Complete a clinical review of all available member medical records to identify any new concerns and document
Outreach	Outreach to member, documenting attempts and outcome within 30 days of receipt of trigger report
Review	Review all triggers with the member on your outreach and assess for any other concerns, determine acuity level and need for case management.
Review	Review all findings in your Interdisciplinary Rounds
Send	Send the revised care plan to PCP and member

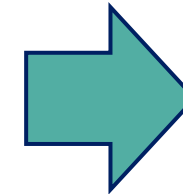
When to Update the Care Plan:

Clinical review identifies a change of health status not reflected on the SCAN care plan

During member outreach/assessment, a new concern is identified

As a result of Interdisciplinary Team review

A change of health status that occurs at any point during the member journey (e.g. admit/discharge from a facility)



Send the revised care plan to the member and PCP



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Interdisciplinary Care Plan (ICP)

Care Transitions



**David Tucker, LCSW,
CCM, Manager,
Clinical Care**



Care Transitions Overview

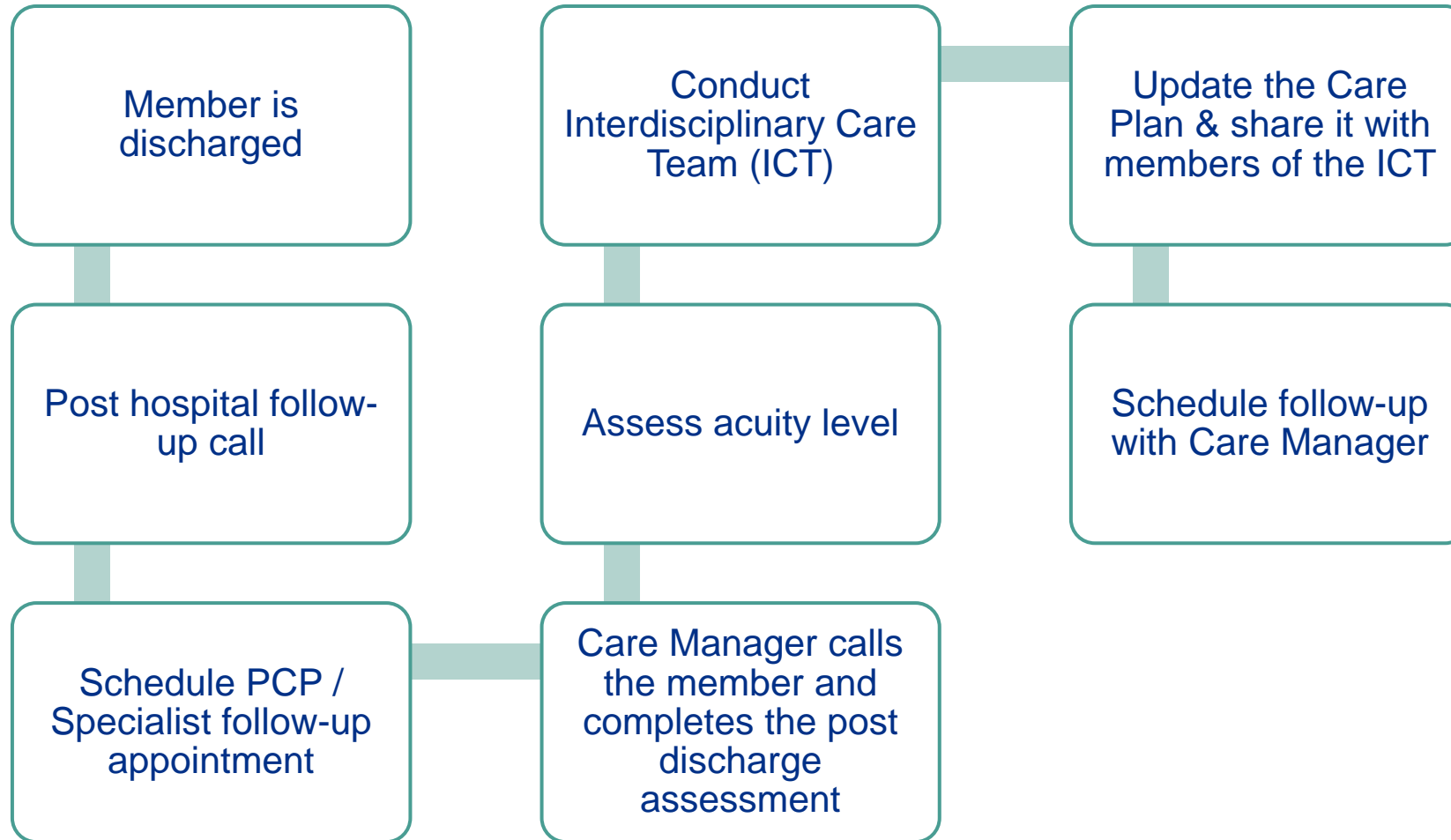


UNDERSTANDING CT



**PROVIDER
EXPECTATIONS**

Process.... SNP Care Transitions



Care Transitions (CT)

Delegated Medical Group Expectation

Care Transitions documentation must include:

- “Patient outreach was completed/attempted within 5 business days of discharge from one setting to another”.
- Notification to PCP within five business days of discharge
- Ensure follow-up services and appointments are scheduled within 5 business days of transition
- The team ensures there is an identified provider directing the member’s care and any other providers who need to be aware of the transition are notified.
- Care plan transferred between settings before, during, after transition of care
- Member coaching occurred
- Members of the ICT and members/caregivers have access to the plan of care



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Care Transitions



CM Referral Criteria



**David Tucker, LCSW,
CCM, Manager,
Clinical Care**

Care Management Referral Criteria

Two or more admissions or ER visits in the past 6 months

Change of health status/condition

- Hospital admission or readmission
- Additional chronic diagnosis since last review
- New high risk medication

Difficulty managing medications/non-adherence

End of life needs requiring palliative or hospice care

Have not seen their PCP in past 12 months despite need for ongoing monitoring

Access to care issues

Two or more incidents of falls and other related accidents in the past 6 months

Other concerns requiring ongoing follow up



Monitoring and Oversight



**Jeanette Despal, RN,
Manager Network
Compliance Clinical**

SNP Audit

1

Timely Submission of audit documents.

This includes MOC training for ICT participants of selected files.

2

Once CAP issued we cannot change audit results for untimely submission of documents.

3

Ensuring the right people are present during case walk through.

Corrective Action Plan – Creating a Successful Response



Corrective Action Plans

Root Cause Analysis- the “why” deficiency occurred.

Corrective Action Plan- Group plan for correcting deficiency

Implementation Date

Responsible Individual- Must be a person not a department



Repeat Deficiencies

Cannot accept same root cause or corrective action plan from previously submitted CAP



File Review Deficiencies (Case walk through)

Corrective Action Plan. Cannot cite that they will update a policy only.

SNP Model of Care Training



**Janelle Howe, VP
Clinical Operation**



SNP Model of Care Training



SCAN requires initial and annual SNP Model of Care training for network providers who see SNP members on a routine basis



CMS requires proof of completion of SNP Model of Care Training

SCAN keeps proof of your participation:

- When you attend one of the SCAN SNP MOC training webinars
- When you watch the recorded webinar (available on demand sometime in October)

Some Groups create their own SNP MOC Training:

- This training needs to be approved by SCAN
- Groups need to keep proof of staff completion of this training



CMS requested this proof during SCAN's recent audit

Questions?



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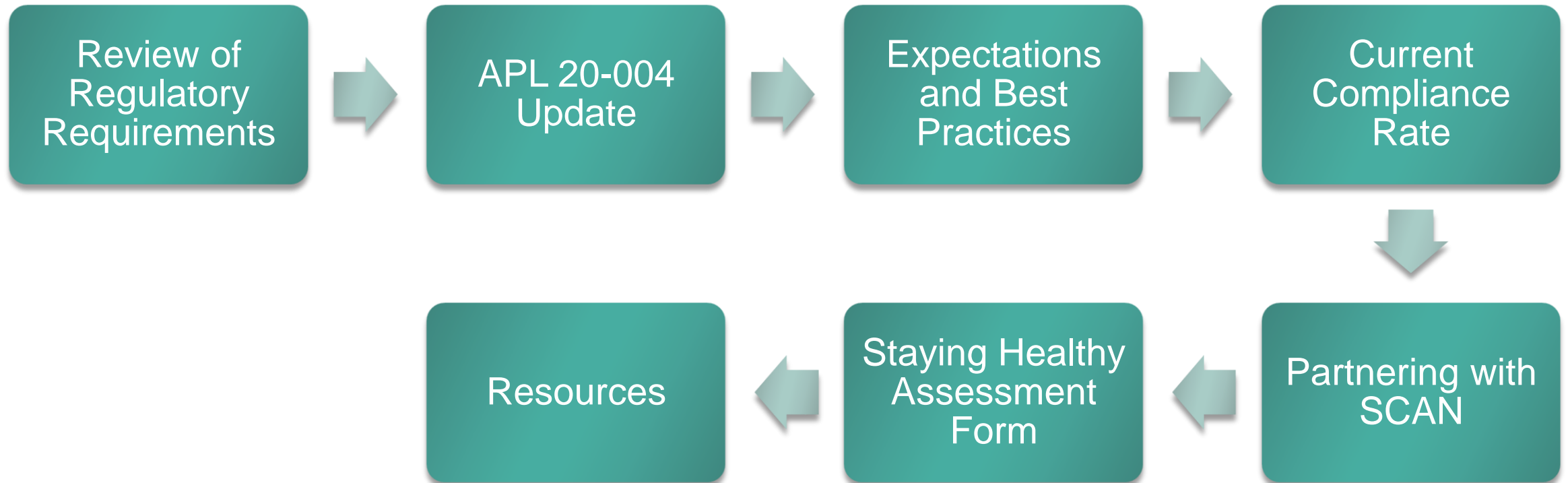
Thank you!



Initial Health Assessment/Staying Healthy Assessment and Annual Wellness Visits



Training Agenda



Regulatory Requirements

Medicare

Initial Medical Appointment / Assessment within 90 days of enrollment (Welcome to Medicare)

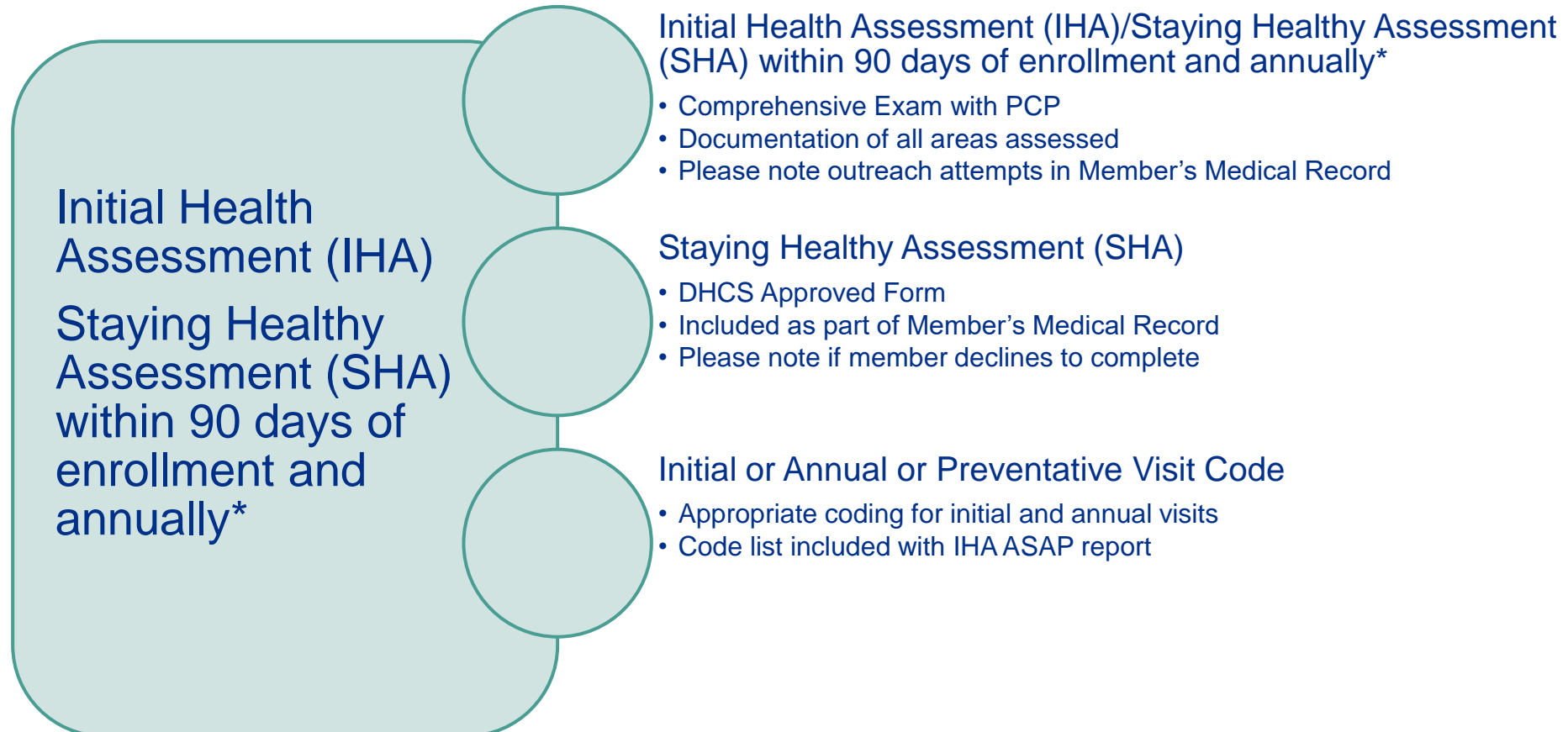
- Annual Appointment (Annual Wellness Visit or AWW) – once per year

Medi-Cal

- Initial Health Assessment (IHA) within 120 days of enrollment
- Must use Staying Healthy Assessment (SHA) Form (DHCS approved form)
- Annual Assessment - within 365 days of previous assessment

* SCAN Policy is for IHA/SHA to be completed within 90 days of enrollment.

Regulatory Requirements for Medi-Medi Members



*DHCS Requirement: Title 22, CCR, Section 53851 (b) (1)

APL 20-004 Update



**DHCS All Plan Letter
(APL) 20-004,
Emergency
Guidance for Medi-
Cal Managed Care
Health Plans in
Response to COVID-
19, was revised on
September 9, 2021**

Starting October 1, 2021, managed care plans must begin resumption of Initial Health Assessment (IHA) activities that were temporarily suspended December 1, 2019 – September 30, 2021.

Managed care plans are to coordinate access to providers as needed to facilitate primary care engagement.

For all members who are newly enrolled as of October 1, 2021, managed care plans are required to complete IHAs and coordinate care engagement within required contractual timeframes.

IHA Expectations and Reports

Medical Group should access IHA ASAP reports monthly from the SCAN Provider Portal

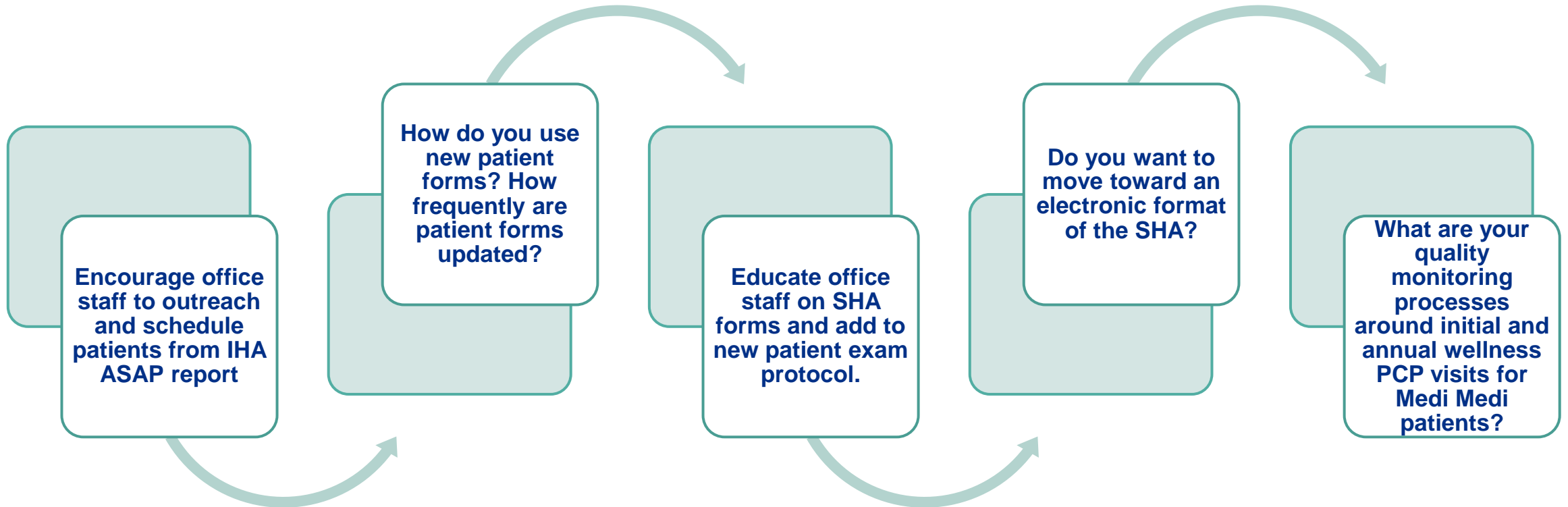
Medical Groups are expected to educate and support PCPs with facilitation of the IHA/SHA and Annual Wellness Visits

PCPs need to address risks (including social determinants of health) that are identified as part of screening and assessments

Facility Site Review audits will be conducted to review evidence that IHA/SHA were conducted

CAPs will be issued to non-compliant PCPs

Best Practices and Implementation

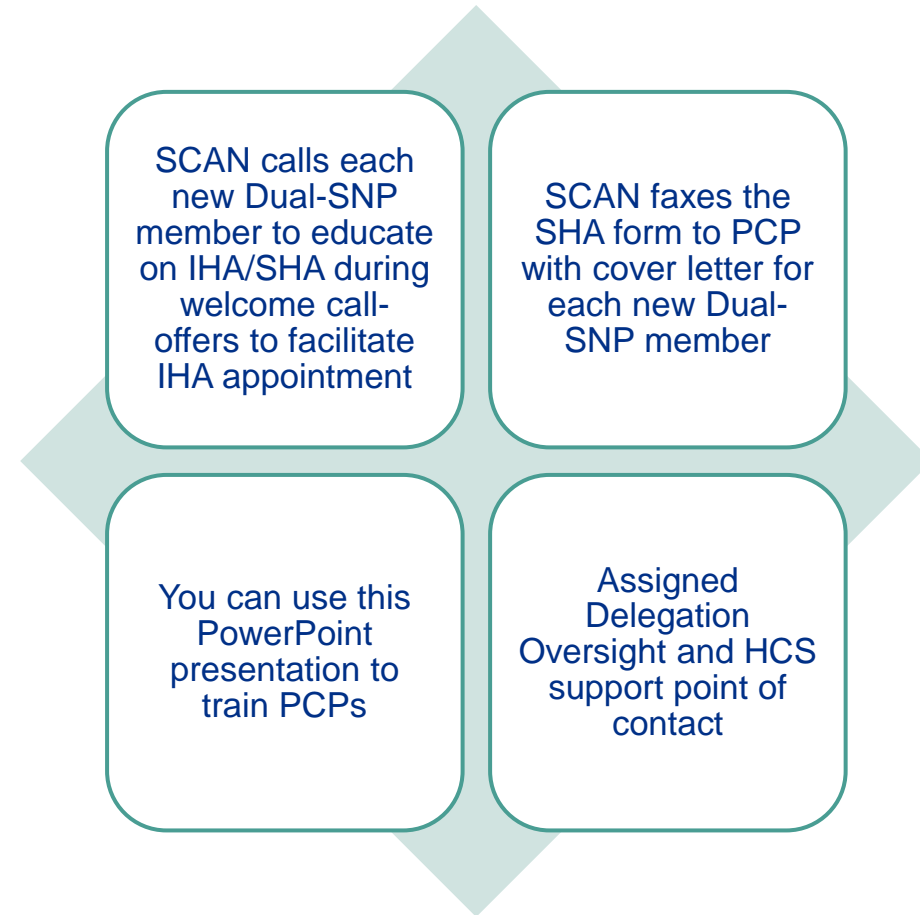


Compliance Rate



*Rates are from Aug 2022

Partnering with SCAN



DHCS Resources

DHCS Staying Healthy Assessment Questionnaires/Forms:

<http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx>

DHCS Staying Healthy Assessment FAQs:

http://www.dhcs.ca.gov/formsandpubs/forms/Documents/MMCD_SHA/GenDocs/SHA_FA_Qs.pdf

DHCS Policy Letter 13-001 (Revised):

<http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx>

DHCS All Plan Letter 20-004 (Revised) September 9, 2021:

<https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

Questions?

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Appendix – SNP MOC

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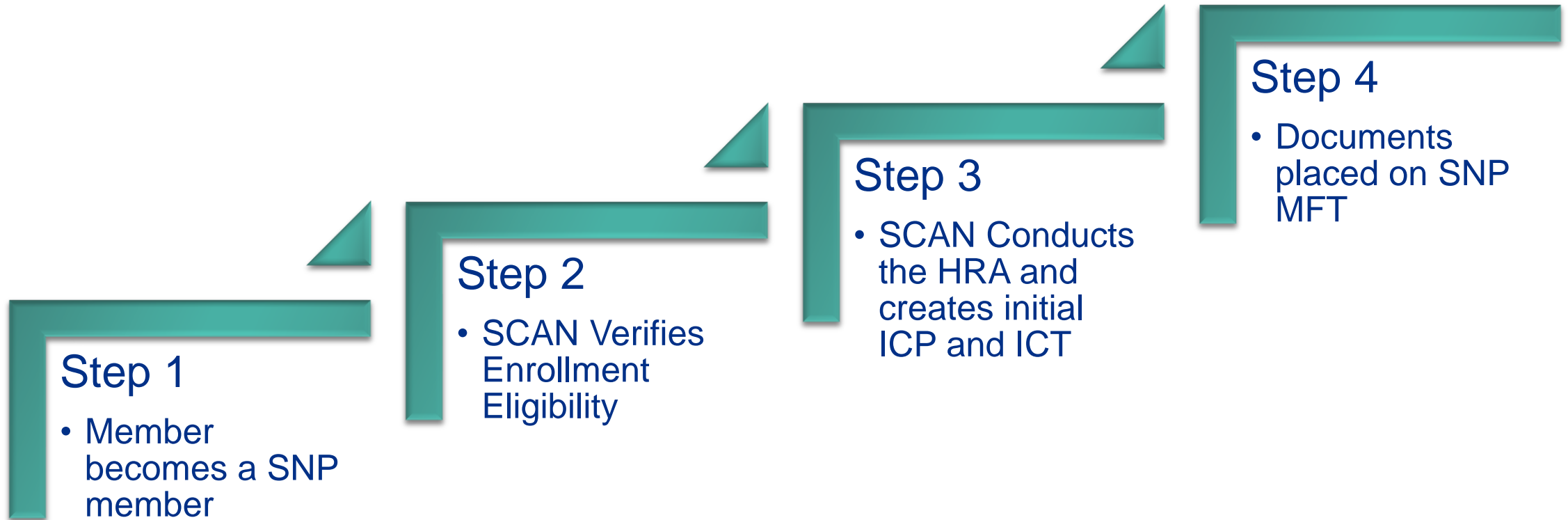
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SCAN's Mission

SCAN Health Plan (SCAN) is one of the nation's largest not-for-profit Medicare Advantage (MA) plan, serving over 200,000 members in California.

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

Journey of a Special Needs Plan Member (SCAN)



Journey Continues.... SNP Care Management (Medical Group)

Step 5

- Pick up documents from SNP MFT

Step 6

- Case Manager Assignment
- Review assessment, care plan and conduct clinical review
- Case Manager conduct member outreach
- Case Manager work with the member to decide on care management program goals
- Care Plan Implementation and Coordination of ICT
- Send revised care plan and any education material to member
- Re-evaluation of Care Plan and ongoing Follow-up

SNP types and eligibility

Chronic Special Needs Plan (C-SNP)

Eligibility verified 30 days post enrollment

- Balance Plan: Diabetes
- Heart First Plan: CHF, Arrhythmia, CAD, PVD, Chronic Venous Thromboembolic Disorder
- VillageHealth Plan: ESRD

Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP/D-SNP)

Eligibility verified monthly

- Designed for members who have both Medicare Part A and Part B, Full Medicaid benefits and FIDE SNP
- Connections and Connections at Home Plans

Institutional Special Needs Plan (I-SNP)

Eligibility verified by outside vendor

- Meet state criteria for Nursing Facility Level of Care (NFLOC)
- Healthy at Home Plan - Must reside in the community and not a facility (I-SNP is Institutional-Equivalent)

SNP Goals and Purpose of a SNP

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

SNP MFT Operations

SNP Report	Job Schedule	Day of the Week Report is Sent
Completed HRA and Care Plans	Weekly	Saturdays
Trigger Reports	Weekly	Mondays
SNP Membership	Monthly	5 th of Month

CMS SNP Resources

CMS Website

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

Presenter Contact Information

Section	2022 Facilitator	Presenter Email
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