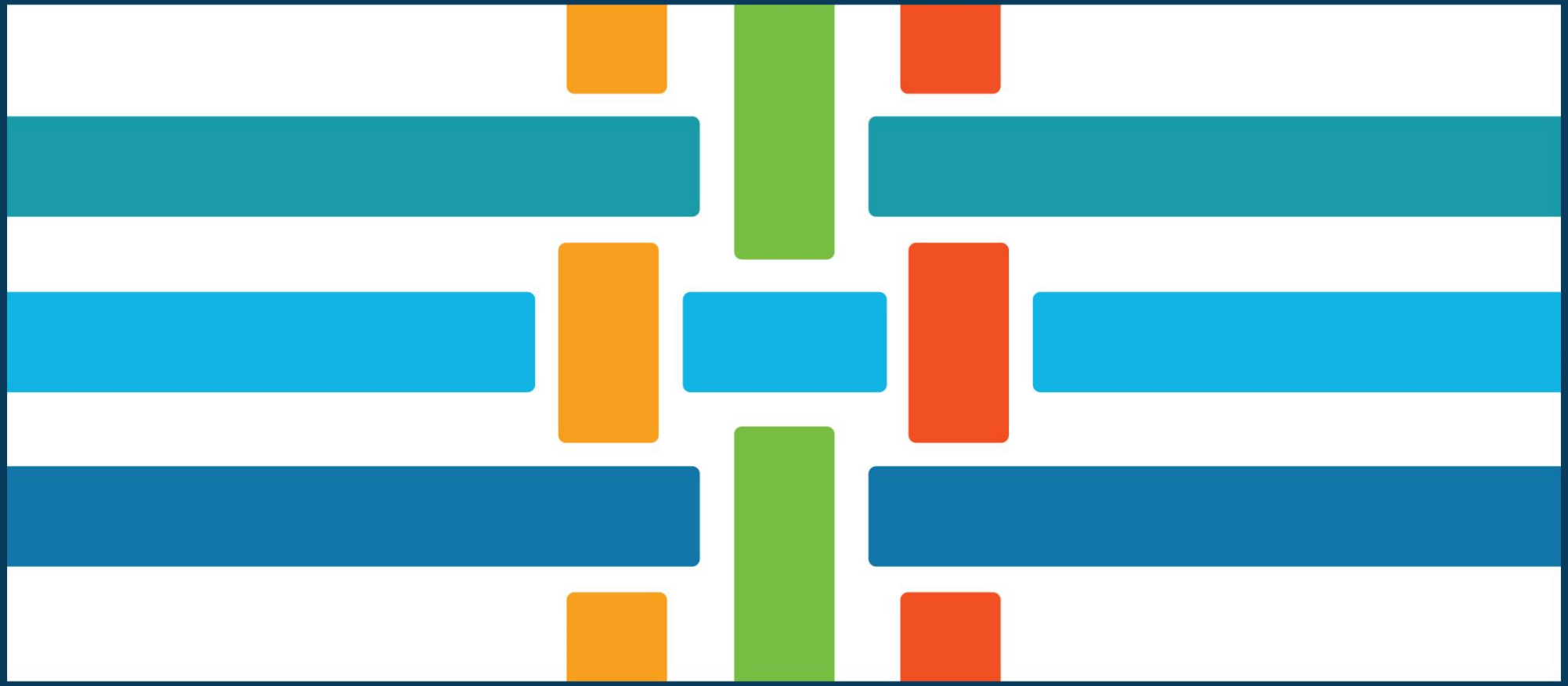
ALIGNMENT HEALTHCARE MODEL OF CARE TRAINING



Agenda

- Overview of the MOC
- SNP Products
- Alignment Model of Care & partnerships

Note: In CA, LA & OC have a C-SNP

SNPs and MOCs

1. What are Special Needs Plans (SNPs)?
2. What is a SNP Model of Care (MOC)?
3. Why is a SNP MOC Important?
4. What are the Elements of a SNP MOC?
5. Who is responsible for compliance with the SNP MOC?

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WHAT ARE SPECIAL NEED PLANS?

Special Needs Plans (SNPs) were created by Congress in the Medicare Modernization Act (MMA) of 2003 as a type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries: The institutionalized, dual-eligible and individuals with severe or disabling chronic conditions.

These beneficiaries are typically older, with multiple co-morbid conditions, and therefore more challenging and costly to treat.

TYPES OF SNPs

INSTITUTIONAL (I-SNP)

Beneficiaries who reside, or are expected to reside, for 90 days or longer in a long term care facility – defined as skilled nursing facility (SNF) nursing facility (NF), intermediate care facility (ICF) or inpatient psychiatric facility OR those who live in the community but require an equivalent level of care to those who reside in a long term care facility.

DUALLY ELIGIBLE (D-SNP / DE-SNP)

Beneficiaries who qualify for both Medicare and Medicaid coverage.

CHRONIC CONDITIONS (C-SNP)

Beneficiaries with targeted chronic conditions such as cardiovascular disease, diabetes, congestive heart failure, osteoarthritis, mental disorders, ESRD, or HIV/AIDS.

Overview (con't)

WHAT IS A MODEL OF CARE?

The Model of Care (MOC) is the Plan's guide to how we care for our members; monitor effectiveness, improve quality of care and communicate with stakeholders

Model of Care Approval Process

- Plans apply for SNPs during the CMS annual MA application process. MOC submissions are required for SNP applications. Each SNP type requires a separate MOCs developed at the contract level.
- The MOC must be evaluated and accepted by NCQA, in order for the SNP to begin and continue to provide services.
- MOCs are approved on a 1, 2 or 3 year basis.
- Plans that apply for SNP service area expansions must resubmit the MOC during the CMS Medicare Application process regardless of current approval time period.
- MOCs are required to be redlined on an annual basis and submitted to CMS, current MOCs are used for CMS audits.

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Model of Care GOALS

- To **improve access to affordable** medical, mental health and social services
- To **improve coordination** of care through an identified point of contact
- To create seamless **transitions across the health care setting**, health care providers and health services
- To **improve access to preventive** care services
- To improve the **appropriate utilization** of services
- To facilitate delivery of **cost-effective** health services
- To **improve members' health outcomes** through reduction of admissions, improved self-management, functional status, improved pain management and improved quality of life

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Elements of a Model of Care (4 main elements)

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1. Description of SNP population
2. Care Coordination
3. Provider Network
4. Quality Measurement and Performance Improvement

Elements of a Model of Care (4 main elements)

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1

Description of SNP population

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MOC Element 1: Description of the SNP Population

1

This element includes a detailed narrative of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with the SNP population in the plan's geographic service area. Average age, gender, ethnicity, language barriers, deficits in health literacy, low socioeconomic status and other factor(s) affect the health outcomes of the most vulnerable beneficiaries.

For Alignment's MOC we were able to contribute current member statistics to describe the potential SNP population.

Elements of a Model of Care (4 main elements)

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2 Care Coordination

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MOC Element 2: Care Coordination

2

This element fully defines **SNP staff roles and responsibilities** across all health plan functions that directly or indirectly affect the care coordination of SNP beneficiaries. (Org Charts, Job Descriptions)

It includes a detailed explanation of how the initial **Health Risk Assessment Tool (HRAT)** and annual reassessment are conducted for each beneficiary. At Alignment the initial HRAT is called a "Jump Start". The HRAT is submitted to CMS and auditable.

It explains the processes for developing the member's **Individualized Care Plan (ICP)**, how the beneficiary and caregiver(s) are involved in its development, how often the ICP is reviewed, how it is modified as the beneficiary's healthcare needs change.

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MOC Element 2: Care Coordination, cont'd

2

It describes the composition of the **Interdisciplinary Care Team (ICT)**, the roles/responsibilities of team members, how the expertise and capabilities of ICT members align with the identified clinical and social needs of SNP beneficiaries, and how ICT members contribute to improving the health status of SNP beneficiaries.

This element also explains how **Care Transitions Protocols** are used to maintain continuity of care for SNP beneficiaries and specifies the process and rationale for connecting the beneficiary to appropriate providers.

2

HEALTH RISK ASSESSMENTS

Alignment Healthcare's Health Risk Assessment (HRA) =

JUMP START

2

- Initial assessments will be conducted within 30 days of member's eligibility
- Care Plan development after JSA
- 120+ point assessment
- A head to toe physical.
- Lab work - blood and urine collection.
- Review of current and past medical history.
- Review of medications, to include any over the counter (OTC) drugs.
- Assessment to determine other health needs or screenings as needed to address individual health concerns.
- Referrals for further testing and chronic disease management clinics.
- Results are shared with member's PCP and we work together to coordinate and manage care.
- Referrals for specialty care and disease management programs as necessary
- Assist in completing HEDIS measures
- Review of advanced directives

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Jump Start Assessments (HRA / JSA's) [con't]

2

- Annual assessments will be conducted within 365 days of the initial assessment
- Outbound outreach attempts after enrollment is processed to encourage members to participate in their Jump Start Appointments
- Homebound visits will be conducted if necessary
- Members are stratified by acuity level
- Individualized Care Plans will be developed and provided to the member following their JSA
- Members unable to be contacted will receive a general care plan and relevant educational materials

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2

INDIVIDUALIZED CARE PLAN

Individualized Care Plan (ICP)

2

- Following their Jump Start Assessment, members will be provided an Individualized Care Plan (ICP)– complete with Assessment outcomes and goals.
- ICPs will be developed with the member, case manager, PCP and shared with the Interdisciplinary Care Team (ICT).
- Care plans will also be created for transitions to/from hospital, home and SNF and shared with those facilities.
- A Case Manager will be assigned to each member who will function as the hub of the member's care needs and serve as the member's point of contact.
- Members may be referred to specialists or specific services or enrolled in disease management programs.
- ICPs will be updated following a change in condition or transition in care.
- ICP review will be conducted during Alignment Daily Rounds.

2

INDIVIDUALIZED CARE TEAM

Individualized Care Team (ICT)

2

- The ICT is a team comprised of different professional disciplines within the provider network who work together to optimize quality of life and outcomes and to support the member and/or family meet health goals in ICP.
- The ICT core team includes the member, PCP, and case manager.
- Other health professionals selected may include AHC Practitioner; Specialists; Care coordinator and/or Case manager; Social worker; Behavioral health provider; Nutritionist; or other practitioners as necessary.
- All applicable ICT members are informed of the member's needs pre, during, and post transition from one care setting to another or a change in condition
- ICT meetings may be scheduled or ad hoc and may be held face-to-face, telephonic, web-based, or accomplished through written communication to review progress and identify additional interventions for example rounds, meetings with the member and/or member's caregiver

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Elements of a Model of Care (4 main elements)

3

Provider Network

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MOC Element 3: Provider Network

3

This element includes a complete and detailed description of the **specialized expertise available to SNP beneficiaries in the provider network** that corresponds to the SNP population.

It explains the processes for ensuring that network providers utilize appropriate **clinical practice guidelines** and nationally-recognized protocols.

It details how the SNP conducts **initial and annual Model of Care training** for network providers and out-of-network providers seen by beneficiaries on a routine basis.

Elements of a Model of Care (4 main elements)

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4 Quality Measurement and Performance Improvement

ELEMENTS OF A SNP MOC, *cont'd*

MOC Element 4: MOC Quality Measurement & Performance Improvement

4

This element narrates the SNP **quality performance improvement plan**, how we ensure services are delivered to SNP beneficiaries to effectively meet their unique healthcare needs.

It describes specific **surveys tools used to measure SNP beneficiary satisfaction, quality measures** to continually evaluate and improve the SNP, and **communication of SNP quality performance results** to multiple stakeholders on a routine basis. **Development and adherence to measureable goals and outcomes.**

Quality Improvement Plans are required to be submitted to CMS as a part of the MOC. Ongoing evaluation and updates of the MOC.

Impacts to HEDIS, Quality Reporting & **STARS**

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Chronic Condition SNPs Enrollment

- Sales agents must be specifically trained using materials and processes compliant with CMS
- Emphasis is on supplying applicants with comprehensive plan information
- Special Election Period
  - Beneficiaries who have been **diagnosed with a qualifying condition have a continuous Special Enrollment Period (SEP) to join a C-SNP at any time.** If the member has any questions about their enrollment, please refer them to member/customer service.

- Applicant must be diagnosed with the condition by a physician and complete the following forms within 30 days of enrollment:
- Prequalification Form
  - Completed at time of sale
  - Includes disease-specific questions
  - Must be received with the application to process enrollment
- Verification of Chronic Condition (VCC) Form / Documentation
  - May be sent to member as attachment to the acknowledgement of enrollment letter, or other mailed method determined by the plan
  - Must be signed by physician or an authorized full-time employee of the physician's office
  - Must be received within the first month of coverage
  - VCC form cannot be provided to member at time of sale
  - Plans may obtain documented telephone contact with the provider or provider's office confirming that the individual has the condition
  - Plans are required to verify condition by the last day of the member's effective month or member will be disenrolled at the end of the following month.

ALIGNMENT HEALTH PLAN
MODEL OF CARE PARTICIPATION

What makes SNP products unique?

Plan benefit packages are developed with the SNP populations in mind

Example – C-SNP packages are developed with generally richer benefits than standard MAPD plans in areas that help support the health maintenance of the plan members such as $0 to low cost diabetic supplies

MEMBER and PROVIDER REQUIREMENTS

Active Participation

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

- Primary Care Providers must be **actively involved** in the care of their patients.

ALIGNMENT HEALTH PLAN
CALIFORNIA MODEL OF CARE

FOUR MODELS OF CARE APPROVED

- *California (through Alignment Health Plan f/k/a CCHP):*
- Market: Los Angeles & Orange County
  - Chronic Conditions **SNP (C-SNP)**
  - **Diabetes, Chronic Heart Failure, Cardiovascular Disease**
- MOC Approval 3 years through 12/31/18: Score 98.33%
- Plan Benefit Package H3815-010
- Product Name: Heart & Diabetes (HMO SNP)

Unique Requirements Contract #H3815

Alignment Health Plan (AHP) (f/k/a Citizens Choice Health Plan)

1. AHP developed and is responsible for the complete MOC for the Plan
2. AHP Quality Improvement Plan
3. AHP HRA (Jump Start) documentation submitted

AHP / AHC MOC (con't)

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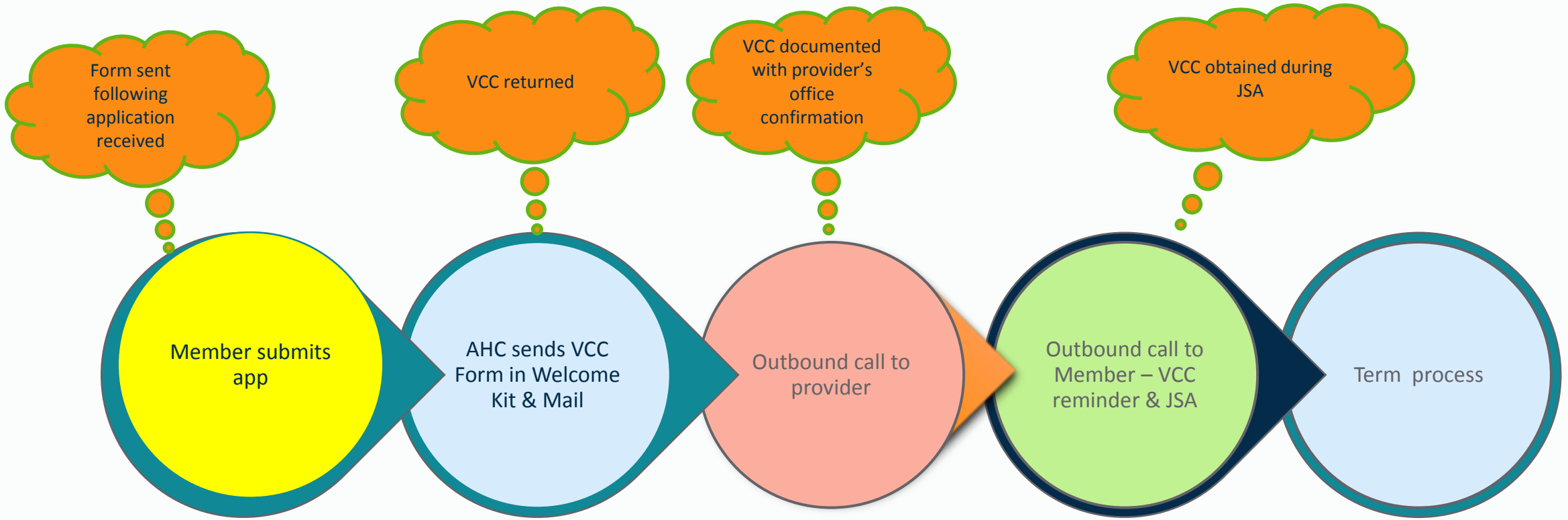
Verification of Chronic Condition Process C-SNP



Members are active for two months prior to being disenrolled for not confirming CSNP eligibility

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WHO IS RESPONSIBLE FOR COMPLIANCE WITH THE SNP MODEL OF CARE?

Everyone!

Compliance with CMS requirements and the ethical administration of the Alignment Health Plan and Alignment Healthcare SNP MOCs is a enterprise-wide, shared responsibility.

If processes, process changes, meetings, trainings and communications are not documented they do not exist with CMS!

CMS Regulatory Requirements

MODEL OF CARE IS - **AUDITABLE**

CMS regularly conduct model of care AUDITS at the contract level. CMS releases: audit protocols, best practices and lessons learned documentations.

Remember - If processes, meetings, trainings and communications are not documented, they do not exist with CMS.

MODEL OF CARE IS - **REPORTABLE**

Part C Reporting – New reportable element *"SNP Care Management"*
Subject to Data Validation Audits

SNP CARE MANAGEMENT **AFFECTS STARS!**

SNP specific elements are part of the Star Ratings.

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Regulatory References

1. Medicare Managed Care Manual:
   a) Chapter # 2 – enrollment guidelines
   b) Chapter # 3 – marketing guidelines
   c) Chapter # 4 – beneficiary protections
   d) Chapter # 16-b – SNP Chapter of the MMG
2. CMS – SNP MOC audit process
3. CMS – MOC Scoring guidelines – MOC is developed based on the structure, factors and elements required in the scoring guidelines
4. CMS – Part C Tech Specs –contains CMS reporting requirements – see report # 13 for "SNP Care Management"

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Questions?
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