ALIGNMENT
HEALTH PLAN

Special Needs Plan (SNP)
Provider Model of Care Training
2020/2021

1. Special Needs Plan Model of Care Overview

SNP Overview

- 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
- SNPs provide coverage for at-risk populations who have multiple conditions and barriers to participating in self-care management
- SNPs provide members with guidance and resources that help provide access to benefits and information

What is a Model of Care?

- A SNP Model of Care (MOC) is considered a vital quality improvement tool and integral component for ensuring that the unique needs of each member enrolled in a SNP plan is identified and addressed

- The MOC is a fundamental component of SNP Quality Improvement so CMS requires the National Committee for Quality Assurance (NCQA) to review and approve all SNP MOCs based on standards and scoring criteria established by CMS

- A MOC is required for each SNP type

Overall Model of Care Goals

- **Improve Access**
  - Improving access to medical and mental health and social services
  - Improving access to affordable care, long-term supports and services (LTSS) and preventive health services

- **Improve Coordination**
  - Improving coordination of care through an identified point of contact
  - Improving transitions of care across health care settings, provider and health services
  - Assuring appropriate utilization of services

- **Improve Health Status**
  - Improving patient health outcomes

Special Needs Plan Types

- **Chronic Condition (C-SNP)**
  - Beneficiaries with targeted chronic conditions such as cardiovascular disease, diabetes, congestive heart failure, osteoarthritis, mental disorders, end-stage renal disease (ESRD), or HIV/AIDS

- **Dual Eligible (D-SNP or DE-SNP)**
  - Beneficiaries who qualify for both Medicare and Medicaid coverage

- **Institutional (I-SNP)**
  - Beneficiaries who reside, or are expected to reside, for 90 days or longer in a long-term care facility – defined as a 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

ALIGNMENT HEALTH PLAN
CHRONIC SPECIAL NEEDS PLAN (C-SNP)

Heart & Diabetes (HMO C-SNP) 010

Alignment Health Plan C-SNP

Alignment Health Plan's Chronic Condition SNP provides services under the Heart & Diabetes (HMO C-SNP) 010 benefit plan, available to eligible members who:

1. Reside within the program's service area: **Los Angeles County or Orange County, California**

2. Is not currently undergoing treatment for end-stage renal disease (ESRD)

3. Have a **qualifying chronic condition** confirmed by their provider. Qualifying conditions for this C-SNP must include at least one following confirmed conditions:
   - ❑ Diabetes Mellitus
   - ❑ Chronic Heart Failure
   - ❑ Cardiovascular Diagnoses
     - Cardiac Arrhythmias
     - Coronary Artery Disease
     - Peripheral Vascular Disease
     - Chronic Venous Thromboembolic Disorder

Description of the Alignment C-SNP Population

Overall SNP Population

- A population assessment was conducted to build a Model of Care that will properly serve our members' 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
  - The Top 3 ethnicities within the Alignment C-SNP plan are Caucasian, Hispanic and Asian
  - Spanish is the preferred language, followed by English

Most Vulnerable Members

- The Alignment C-SNP focuses on the vulnerable sub-population of members who are at highest risk of poor outcomes
- C-SNP members are identified using Alignment'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, comorbidities, predictive modeling data and program referrals

Alignment C-SNP Membership Distribution

- Los Angeles County, CA
- Orange County, CA

ALIGNMENT HEALTH PLAN
DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)

CalPlusDuals (HMO D-SNP) 030

Alignment Health Plan D-SNP

Alignment Health Plan's Dual Eligible SNP will provide services in 2021 under the CalPlusDuals (HMO D-SNP) 030 benefit plan, available to qualified seniors and individuals with disabilities who meet the qualifying criteria below:

1. Meet dual-eligibility status requirements
   - ❑ Enrollment in a federally administered Medicare program based on age and/or disability status
   - ❑ Enrollment in the state-administered Medi-Cal program based on low income and assets

2. Reside within the program's service area: **San Joaquin, Stanislaus or Marin counties in California**

3. Qualify for **BOTH** Medicare and California Medi-Cal benefits

D-SNP Benefits & Goals

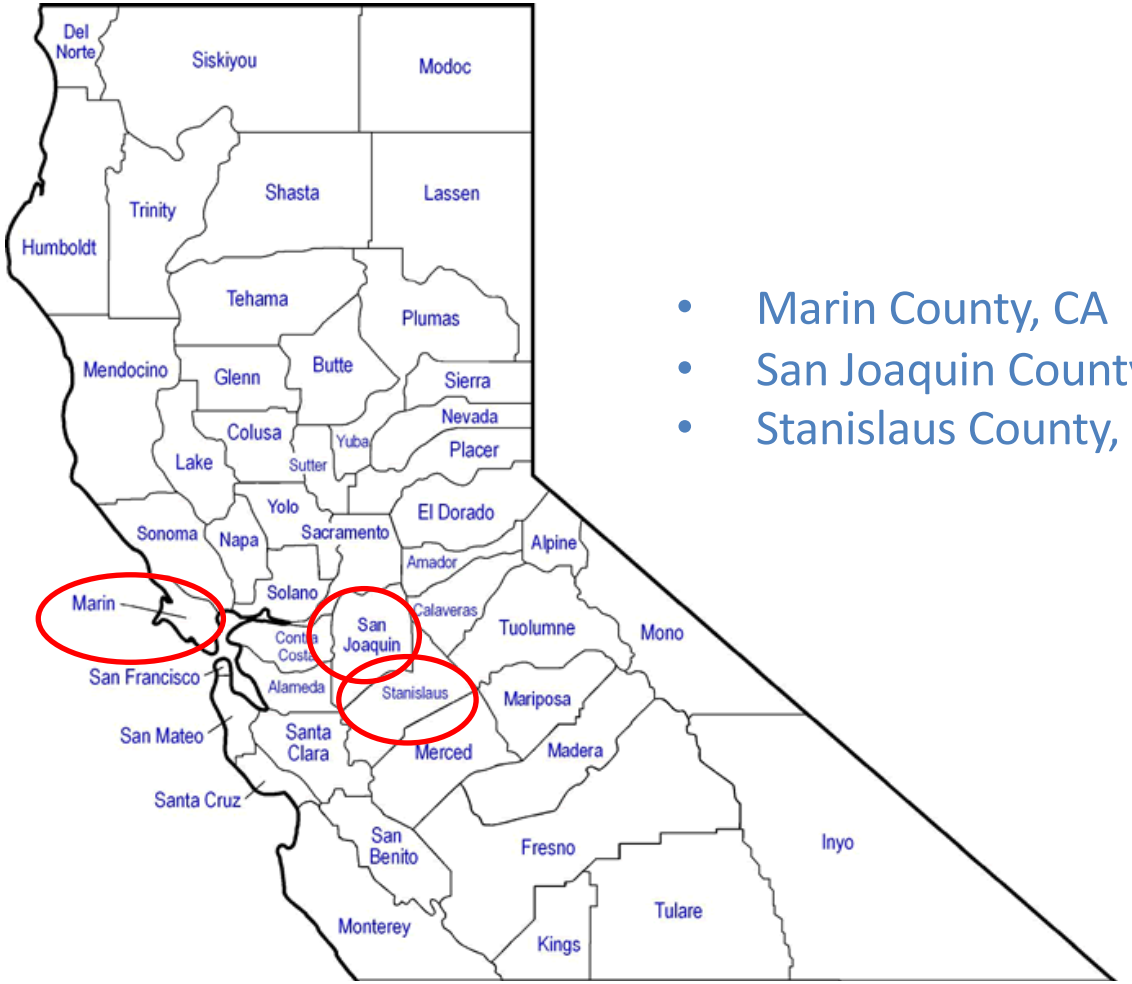
- Medicare is **first** payor with cost-share covered by Medicaid
- Care coordination is provided to all D-SNP members, providing Medicare- and Medicaid-covered benefits in a non-duplicative, synergistic manner
- Care coordination outreach to the member within 90-days of enrollment and immediately with transitions in care
- Outreach and completion of an **Annual** Health Risk Assessment (HRA)
- Development of an Individualized Care Plan (ICP)
- Development and coordination of, an Interdisciplinary Care Team (ICT) and meeting(s)
- Quality Improvement (QI) Process and Health Quality Outcomes are monitored and must be met

Description of the Alignment D-SNP Population

Populations at greatest risk are identified in order to direct resources towards those with increased need for care management services:

- Complex and multiple chronic conditions – patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems
- Disabled – patients unable to perform key functional activities (walking, eating, toileting) independently such as those with amputation and/or blindness due to diabetes
- Frail – may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF)
- Dementia – patients at risk due to moderate/severe memory loss or forgetfulness
- End-of-life – patients with terminal diagnosis such as end-stage cancers, heart or lung disease

Alignment D-SNP Eligible Counties 2021



- Marin County, CA
- San Joaquin County, CA
- Stanislaus County, CA

2. Model of Care Requirements

Elements of a SNP Model of Care (MOC)

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

Care Management – MOC Requirements

CMS requires all C- SNP and D-SNP members to have the following:

HRA	• Initial and Annual Health Risk Assessment
ICP	• Individualized Care Plan
ICT	• Interdisciplinary Care Team Meetings

MOC – Benefits to Meet Specialized Needs

- **Disease Management** – whole person approach to wellness with comprehensive online and written educational and interactive health materials
- **Medication Therapy Management** – a pharmacist reviews medication profile and communicates with patient and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** – the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP
- **Additional Benefits** – vary by type of SNP but may include dental, vision, podiatry, meals, telehealth, over-the-counter, grocery, pet care or social needs

3. Care Management (CM)

About Care Management (CM)

Care Management

Care Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the patient and their caregiver's comprehensive health needs through communication and available resources to promote patient safety, quality of care and cost-effective outcomes.

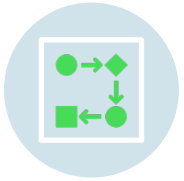
What is a Care Manager?

Care Managers are health care professionals like nurses and social workers trained to meet health care needs by assisting the patient to navigate the health care system and collaborating with providers, their social support system, their community and other professionals associated with their care.

Care Management Process Overview

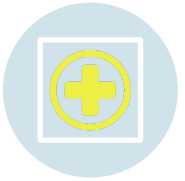
Patient identification

Care plan development with HRA/patient



Assessment and problem/ opportunity identification

Care plan implementation and coordination with ICT



Patient agreement with care plan

Re-evaluation of care plan and follow-up

4. Health Risk Assessment (HRA)

The Health Risk Assessment (HRA)

- A Health Risk Assessment (HRA) is required for **all** members enrolled in either C-SNP or D-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
- Alignment attempts to complete the HRA within 90 days of initial enrollment and annually, or when there is a change in the patient's condition
- Results of the HRA are communicated to the member and member's provider
- Clinical review of the HRA must be reviewed, analyzed and stratified by the Care Manager within 30-calendar days of the HRA completion
- Patients have the right to refuse to complete the HRA
- HRA completion rates are CMS STAR Measures!

Health Risk Assessment Tool (HRAT)

Alignment has several ways to complete an HRA in order to accommodate the member's preference

Health Risk Assessment Key Elements

- **<u>The HRA is a Medicare requirement for all C-SNP and D-SNP members</u>**
- HRA assessment must include:
  - Demographic data (e.g., age, gender, race)
  - Self-assessment of health status and activities of daily living (ADLs)
  - Functional status and pain assessment
  - Medical diseases/conditions and history
  - Biometric values (e.g., BMI, BP, glucose)
  - Psychosocial risks (e.g., depression, stress, fatigue)
  - Behavioral risks (e.g., tobacco use, nutrition, physical activity)

5. Individualized Care Plan (ICP)

Individualized Care Plan (ICP)

- An ICP is the mechanism for evaluating the member's current health status. It is the ongoing action plan to address the member's care needs in conjunction with the ICT and member.
- These plans contain member-specific problems, goals and interventions, addressing issues found during the HRA and any team interactions.
- An ICP is developed and maintained for each C-SNP and D-SNP member using:
    - Health risk assessment results
    - Laboratory results, pharmacy, emergency department and hospital claims data
    - Care manager interaction
    - Interdisciplinary care team input
    - Member preferences and personal goals
- This is a living document that changes as the member changes.

ICP – Member-Centered Goals

Measurable goals provide a clear description for the patient and care manager on how and when the goals have been achieved, patient behavior and improvement in health outcomes.

Goals and outcomes reflect patient behaviors and responses expected as a result of nursing interventions. Write a goal or outcome to reflect a **patient's** specific behavior, not to reflect the **care manager's** goals or interventions.

Each goal should address only **one behavior or response**. The outcome should be **measurable** and **evidence-based**.

Goals can be short term or long term.

ICP – Building Individualized Care Plans

Member-Centered Care Plan

Problems	Communicated by the patient regarding their life, health, worries and behaviors
Goals	What the patient hopes to achieve regarding their health
Barriers	Lack of transportation, finances, housing, treatment side effects
Interventions	Actions to support problem resolution and support goal decrease stress

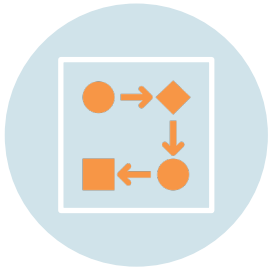
Note: ICP needs to be completed and updated by a licensed person.

The Care Plan is an Active, Dynamic Document

DOCUMENT EFFECTIVENESS OF CARE PLAN

PROBLEM SOLVE INEFFECTIVE INTERVENTIONS

DOCUMENT ALL CARE PLAN ACTIVITY



RE-EVALUATE AND RE-ASSESS

ICP – Updating the Care Plan

- Update the patient's care plan when changes in condition or transitions of care (TOC) occur

- Close problems, goals and interventions accurately using:
  - Claims data
  - Prescription drug event (PDE)
  - Lab, radiology etc.

- All updates are documented and communicated as needed

6. Interdisciplinary Care Team (ICT)

Interdisciplinary Care Team (ICT)

- The Interdisciplinary Care Team (ICT) is member-centric and based on a collaborative approach.
- The ICT's 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.
- Both C-SNP and D-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 care manager and the PCP make up the ICT,** but might also include social workers, pharmacists, medical director, specialists or 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

Interdisciplinary Care Team- ICT

The Interdisciplinary Care Team is developed based on patient needs/requests and facilitate:

- Access to appropriate and person-centered care
- Multidisciplinary approach to support Integrated Care Management
- Development of a comprehensive plan of care
- Communication regarding individualized care plan

The care manager* leads and determines ICT membership with the patient and can include:

- Patient/Caregiver*
- Medical Expertise*
- Social Services Expertise
- Behavioral Health as indicated
- Pharmacist
- Nursing Facility Representative
- Discharge Planner
- PT/OT/ST
- Community agencies
- Other health care professionals

*Indicates minimum required

ICT – Regular Meetings

ICT meetings are conducted at least annually and more frequently based on the patient's needs. They can be in the form of:

- Virtual/Conference calls
- In-person meetings (Grand Rounds)
- Inpatient facility care conference
- Exchange of care plan via fax/mail when member is non-participatory

ICT Participants

7. Care Transition

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 Care 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

Post-Discharge Transition of Care

- The **post-discharge** program for C-SNP and D-SNP members, includes phone calls or visits after being discharged home from the hospital. Members receive a post-hospital call within 10 days of discharge.
- During these calls, the CM or Provider
  - Helps the member understand discharge diagnosis and instructions
  - Facilitates follow-up appointments
  - Assists with needed home health and equipment
  - Resolves barriers to obtaining medications
  - Educates the member on new or continuing medical conditions

8. Provider Network

Clinical Practice Guidelines (CPGS)

- Alignment ensures all providers and IPA/medical groups 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, annual chart reviews, appeals process or HEDIS® reporting

Provider Network

- Specialized Expertise
- Alignment and its delegated IPAs/Medical Groups contract with a network of providers with specialized expertise to ensure that all SNP program members receive appropriate access to care necessary to manage their health care 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 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

Provider Network (cont.)

- In addition to the Alignment contracted provider network, Alignment supports the member and the primary care provider through the Alignment Care Anywhere program
- Alignment's Care Anywhere program is a physician-led, Advance Practice Clinician (APC)-driven model of care designed to support C-SNP and D-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

Provider Network (cont.)

Provider Network Oversight

- All Alignment contracted 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 or sooner based on state requirements
- Alignment administers MOC training upon contracting and annually thereafter to all providers seeing Alignment C-SNP or D-SNP members

9. Plan Performance and Quality Outcomes

Quality Measurement and Performance Improvement

- Alignment has a Quality Improvement Plan (QIP) that is specific to the C-SNP or D-SNP MOCs and designed to measure the effectiveness of each 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 all SNP members
- All SNP program 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)

Process Measures

Measure	Description
Initial HRA Completed On Time (Initial HRA and Annual HRA)	Initial HRA must be completed within +/- 90 days of effective enrollment
Annual HRA Completed On Time	Annual HRA completed within 365 days of previous HRA
HRA Completed On Time (Initial HRA and Annual HRA)	Combined total of Initial and Annual HRA rates above
Individualized Care Plan Completion	Percent of members with ICPs created within 30 days post HRA or UTC call cycle or Refusal or within 365 days
Interdisciplinary Care Team Participation	Engaged members will be managed by an Interdisciplinary Care Team
Member Engagement	Engaged members participating in a Care Management Program
Member Experience	Members' overall satisfaction with Care Management based on annual Member Satisfaction Survey Results
Social Services Participation	D-SNP engaged members participating with Social Services or accessing Community Resources

Health Outcomes Measures

Measure	Description
Hospitalizations/1000 members per year	Number of inpatient hospitalizations per member month (annualized)
30-Day All Cause Readmissions	Reduce the rate of readmissions after 30-days post-discharge
Emergency Room Rate/1000 members per year	Number of ED visits per member month (annualized)
Diabetics with controlled HbA1c	Diabetic members who had evidence of controlled blood sugar (Hba1c ≤ 9)
Care of Older Adult (66+): Functional Assessment (annually)	Members with documented evidence of being evaluated by the provider with a functional assessment; note that ADLs and IADLs were assessed **(must be in the medical record).**
Care of Older Adult (66+): Pain Assessment (annually)	Members with documented evidence of being evaluated by the provider with a Pain Assessment **(must be in the medical record)**
Care of Older Adult (66+): Medication Review (annually)	Members with documented review by **prescribing provider or clinical pharmacist** of ALL member's medications, prescription, OTC and herbal therapies. **Medication list must be in the record (must be documented in the medical record)**
Post-Discharge Outreach	Number of members receiving post-discharge contact within 10 business days of discharge

10. Roles and Responsibilities

Member Responsibilities

As part of a SNP Program, members should be active participants in support of their health care

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

Provider Responsibilities

- Communicate with C-SNP or D-SNP care managers, ICT members, members and caregivers
- Collaborate with Alignment on the ICP
- Review and respond to patient-specific communication
- Maintain ICP in member's medical record
- Participate in the ICT
- Follow Transition of Care protocols
- Complete MOC training upon contracting with Alignment and annually thereafter
- Participate in Alignment's Quality Improvement Initiatives
- Participate in Provider Satisfaction Surveys
- Always complete the credentialing and re-credentialing process ensuring active licenses and certifications

ALIGNMENT HEALTH PLAN

Special Needs Plan (SNP) Provider Model of Care Training

2020/2021