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

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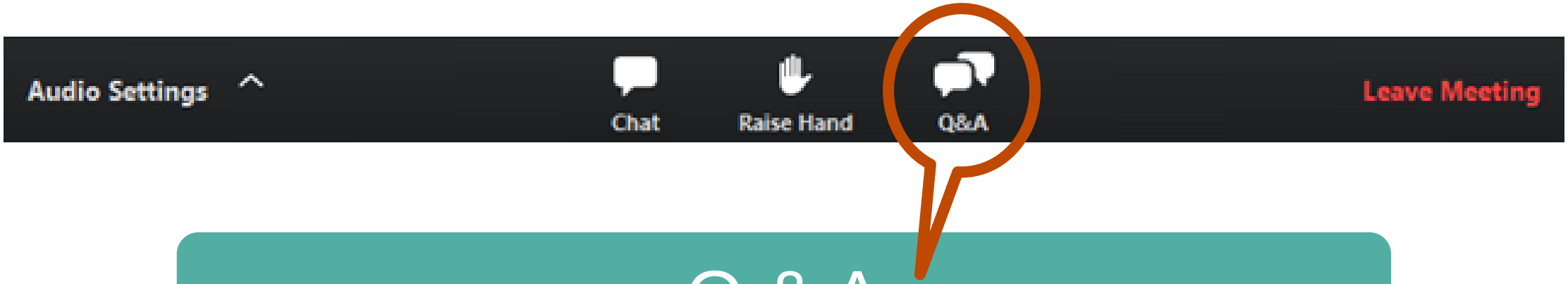
Questions from the Audience – update with Zoom



Q & A

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

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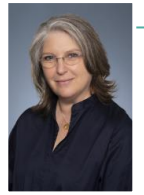
Agenda

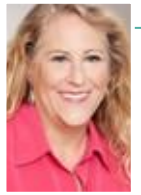
- Introduction and Training Objectives
- SNP and SCAN's Mission
- CMS SNP Guidelines
- Provider Group Responsibilities
- HRAs (Health Risk Assessments), Care Plans and Triggers
- Interdisciplinary Care Team (ICT)
- Individualized Care Plan (ICP)
- Care Transitions
- CM Referral Criteria
- Audit and Oversight
- 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

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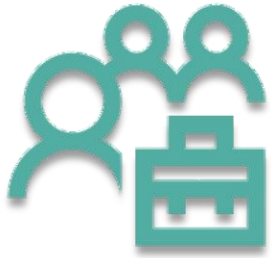
Learning Objectives



Understand and Explain Your Requirements as a SNP Provider

Describe SNP Basics

Describe SNP Audit Requirements

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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

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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

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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

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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

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Provider Group Requirements

Pick up
- Pick up weekly trigger reports, HRAs and Care Plans within 7 days of posting on SCAN MFT site

Document in
- Document in member chart date of trigger report and triggered concerns identified

Complete
- Complete a clinical review of all available member records, including SCAN HRA and Care Plan

Outreach
- Outreach to member, documenting attempts and outcome (i.e. enrolled in CM, declined, failed contact, etc)

Complete and Document
- Complete and Document ICT (Interdisciplinary Care Team)

Update
- Update Care Plan

Poll

HRAs, Care Plans and Trigger Reports

Interdisciplinary Care Team (ICT)

Maricris Tengco
RN, Director Care Coordination

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Expectations

- Define SNP ICT Requirements
- Roles and Composition of ICT
- Different Format of ICT
- Communicate Between ICT Participants
- Document the ICT

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SNP ICT Requirements

	1	2	3
Requirements	**All SNP members received from HRA trigger report and via referral process**	**Composition of ICT (at minimum):** • CM assigned • Care Coordinator • Medical Expert (e.g. PCP, Specialist, Nurse Practitioner, Medical Director) • Member/Representative (if available)	**ICT Format:** • In- person • Telephonically • Electronically
Operations and Documentation	1. Complete within 30 days of receipt 2. Includes failed contact and declined	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	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

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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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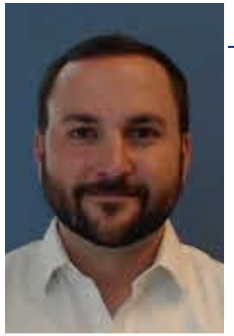
Interdisciplinary Care Plan (ICP)

Care Transitions



David Tucker, LCSW, CCM, Manager, Clinical Care

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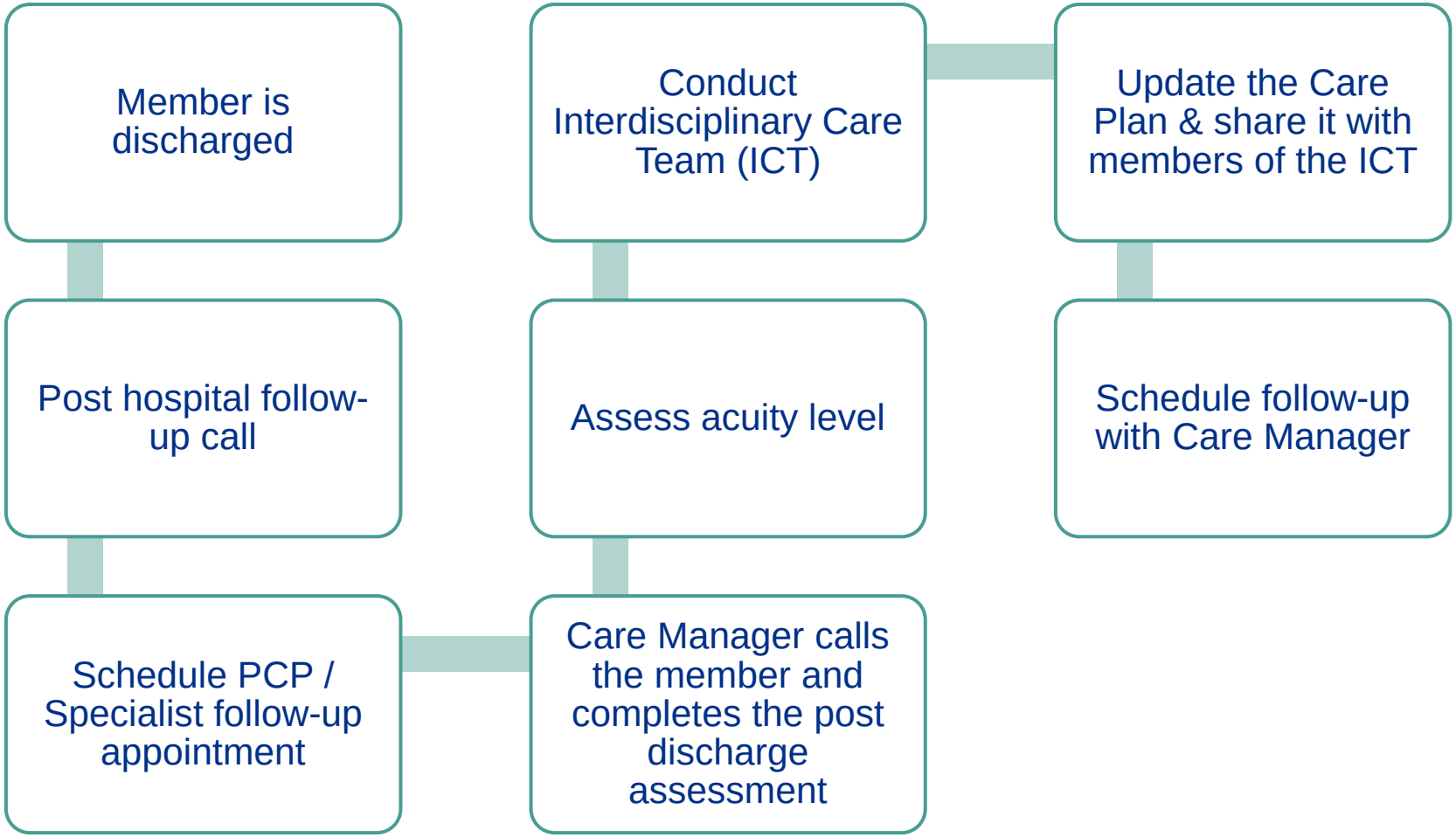
Care Transitions Overview

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

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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

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Monitoring and Oversight

Jeanette Despal, RN, Manager Network Compliance Clinical

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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.

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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.

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SNP Model of Care Training

Janelle Howe, VP
Clinical Operation

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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

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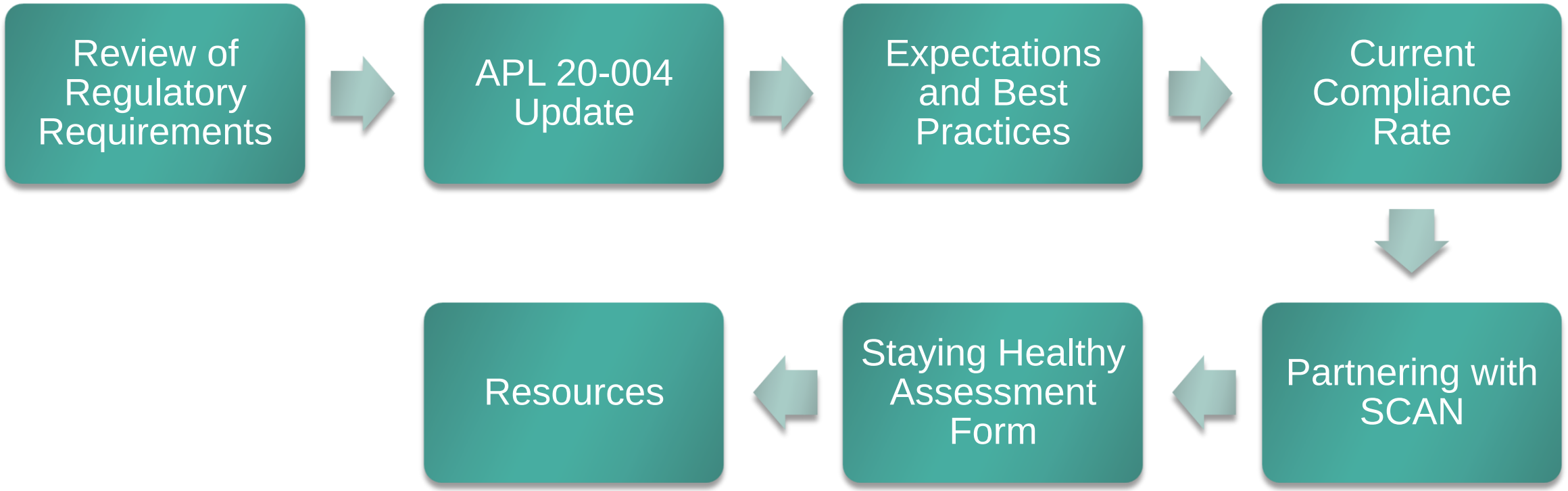
Questions?

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 AWV) – 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.**

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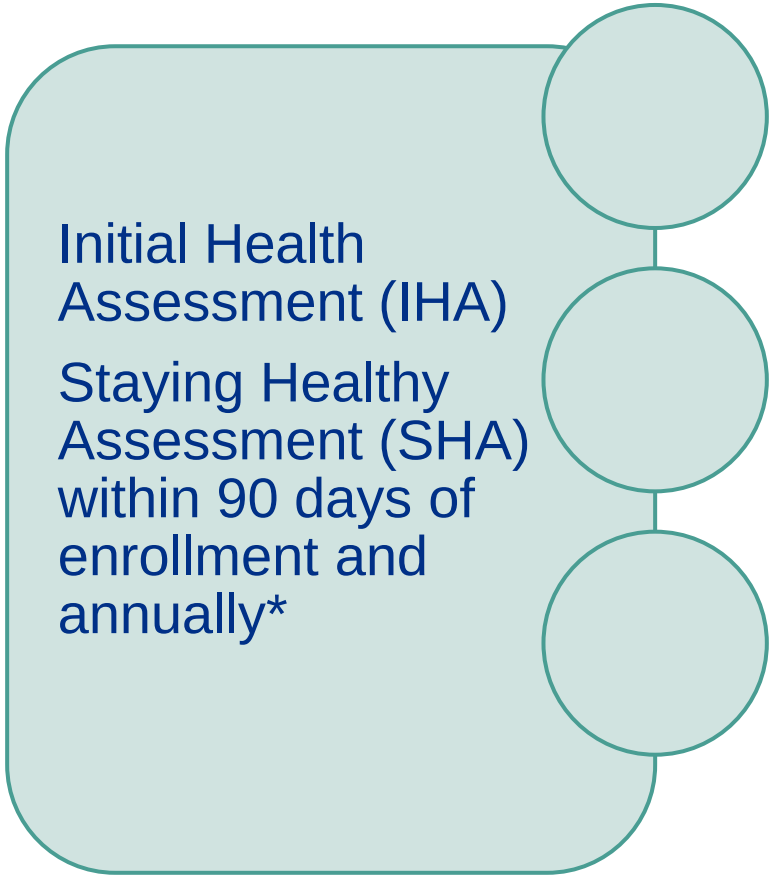
Regulatory Requirements for Medi-Medi Members



Initial Health Assessment (IHA)/Staying Healthy Assessment (SHA) within 90 days of enrollment and annually*

- Comprehensive Exam with PCP
- Documentation of all areas assessed
- Please note outreach attempts in Member's Medical Record

Staying Healthy Assessment (SHA)

- DHCS Approved Form
- Included as part of Member's Medical Record
- Please note if member declines to complete

Initial or Annual or Preventative Visit Code

- Appropriate coding for initial and annual visits
- Code list included with IHA ASAP report

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

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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.

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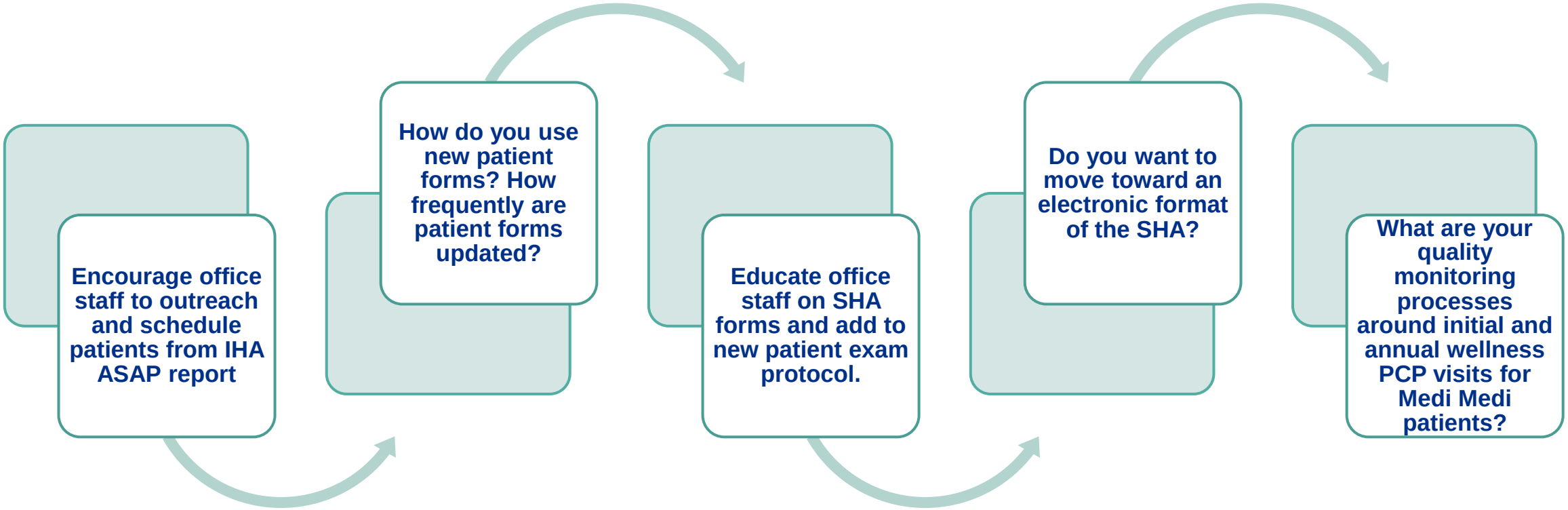
IHA Expectations and Reports

- 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

IHA ASAP posted on SCAN Provider Portal

+

Do you know who from your group is pulling the report?

+

SCAN network average completion rate =

=

34.4%*

*Rates are from Aug 2022

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Partnering with SCAN

- SCAN calls each new Dual-SNP member to educate on IHA/SHA during welcome call- offers to facilitate IHA appointment
- SCAN faxes the SHA form to PCP with cover letter for each new Dual-SNP member
- You can use this PowerPoint presentation to train PCPs
- Assigned Delegation Oversight and HCS support point of contact

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_FAQs.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?

Jeanette Despal, Manager
Network Compliance-Clinical
Delegation Oversight Quality
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jdespal@scanhealthplan.com

Appendix – SNP MOC

Appendix Table of Contents – SNP MOC

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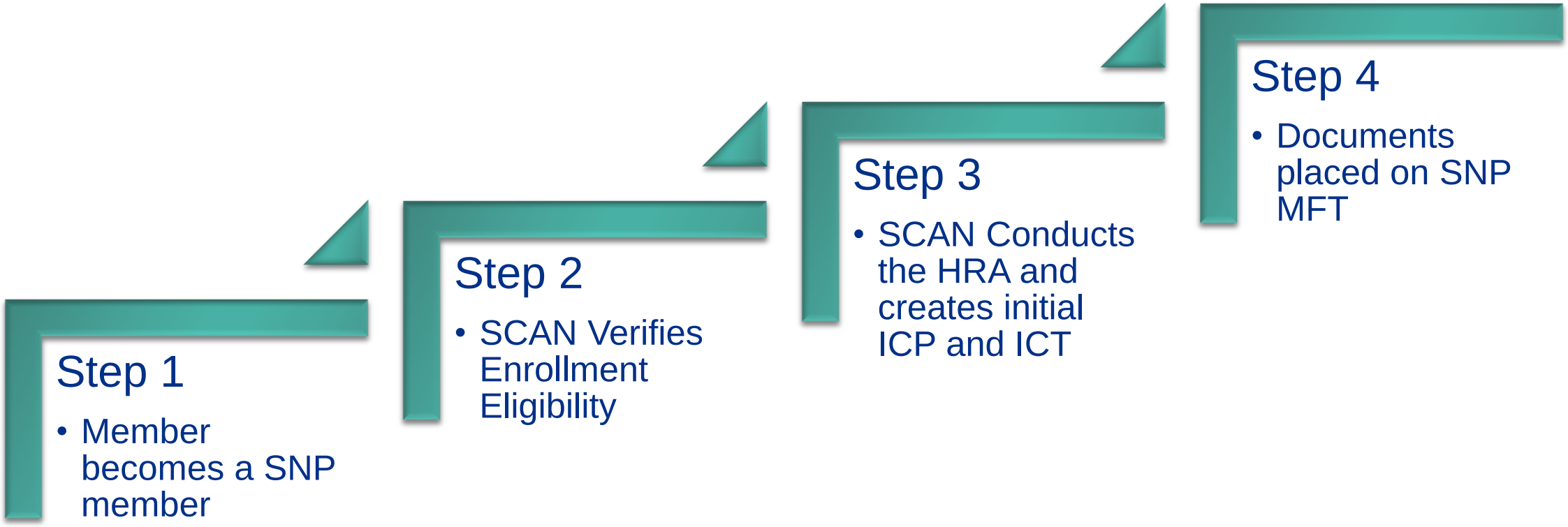
SCAN's Mission

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)

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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	5th of Month

CMS SNP Resources

CMS Website

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

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Presenter Contact Information

Section	2022 Facilitator	Presenter Email
Introduction and Training Objectives	**Janelle Howe,** VP Clinical Operations • Complex Care Management	jhowe@scanhealthplan.com
SNP and SCAN's Mission	**Dr. Payam Parvinchiha**, Corporate VP, Network Quality and Innovation	PParvinchila@scanhealthplan.com
CMS SNP Guidelines	**Lisa Roth**, VP, Health Care Services Transformation	LRoth@scanhealthplan.com
Provider Group Responsibilities	**Jeanette Despal, RN,** Manager Network Compliance Clinical	JDespal@scanhealthplan.com
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CM Referral Criteria	**David Tucker**, Manager, Clinical Care	dtucker@scanhealthplan.com
Audit and Oversight	**Jeanette Despal, RN,** Manager Network Compliance Clinical	JDespal@scanhealthplan.com
SNP MOC Training	**Janelle Howe,** VP Clinical Operations • Complex Care Management	jhowe@scanhealthplan.com

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