# Leon Health Plan (HMO-D-SNP)

## 2024 Model Of Care Training

(Last approved 01/12/2024)

# Training Overview- Objectives & Agenda

- At the conclusion of this training, the following learning objectives will be addressed:
- Describe the characteristics of the D-SNP and Medicare Advantage requirements
- Describe the SNP Population
- Understand the Care Coordination Model ( Components)
  - Health Risk Assessment
  - Individualized Care Plan
  - Interdisciplinary Care Team
  - Care Transitions
- Understanding your responsibilities as a network provider
- Describe the role of the Plan and the contracted providers in the delivery of the MOC
- Describe how the Plan Measures performance and evaluates the success of the MOC

# Dual Special Needs Plan (SNP) Requirements

**A dual Special needs plan:**

- May only enroll members that have both Medicare and Medicaid; Members who are dually eligible typically cannot be balanced billed for cost sharing and may have additional benefits covered by Medicaid once their Medicare benefits provided by the Plan have been exhausted.
- Is a Medicare Advantage Prescription Drug Plan ( MA-PD) with additional requirements, primarily surrounding care coordination
- Covers all Original Medicare (FFS) benefits, including A/B and D ( prescription drugs), as well as any supplemental benefits approved by CMS as part of the annual bid process
- Must comply with:
  - SNP application
  - MOC approved by NCQA
  - Health Risk Assessment (HRA)
  - 100% of members with care management activities
  - Additional Star (quality) measures
  - Additional Part C Required Reporting related to HRA
  - Executive contracted with the State Medicaid agency to either provide or coordinate some Medicaid Benefits

**The Plan contracts with CMS to provide Medicare benefits for their members; care coordination requirements is the major difference between MA Plans and a SNP**

# Model of Care: Section 1

**Description of the Special Needs Plan (SNP)**

**Population**

# Leon Health Plan's D-SNP Population

- Eligible for Medicaid benefits ( may or may not have cost sharing requirements) at time of enrollment and ongoing; Plan must involuntarily disenroll members that lose Medicaid eligibility after a prescribed time ( up to six months)
- Resides with the service area ( Miami-Dade County)
- Selects primary care provider from Leon Medical Centers roster
- Can enroll members residing in the community, as well as those within an institutional setting

# D-SNP Demographics

**Based on excising data available to the Plan for those dually eligible, Leon Health Plan anticipates the following demographics:**

- 60% female
- Approximately 95% of the population is 65 years and older
- Spanish as the primary language for approximately 98% of the population

# Anticipated Prevalent Diagnoses

**Based on existing data available to the Plan for those dually eligible, Leon Health Plan anticipates the following prevalent diagnoses.**

- Cardiovascular Disease
- Diabetes
- COPD
- CHF
- Depression
- Anxiety

# Vulnerable Subpopulations

| Population | Description |
| --- | --- |
| Multiple hospitalizations within 6 months | 3 or more overnight stays within 6 months, including medical or behavioral health |
| Readmission within 30 days of prior inpatient discharge | Within 30 days of prior inpatient discharge |
| Poly Pharmacy | 10 or more prescription medications |
| End of Life or Advanced Illness | Palliative care |
| Fall within past 6 months | Fall with injury and/or fracture within past 6 months |
| Patient Health Questionnaire – 9 (PHQ-9) | Score of 15 or greater on PHQ-9 survey tool |
| Rating of overall health on HRA | Rating of "poor" on HRA question |

# Model of Care: Section 2

**Care Coordination**

# Care Coordination Model

**The Model of Care Requires a Plan to conduct care coordination activities for all members**

The  Plan uses primarily clinical staff to conduct care coordination activities, including:

- Chief Medical Officer
- Behavioral Health Practitioner ( Masters or Doctoral Degree in BH field)
- RN Case Managers( Medical and behavioral health experience)
- Case Coordinators ( RN, LPN, LVN)
- Social Worker (LCSW)
- Clinical Support Associate ( non-clinical staff providing administrative support to the case management team)

# Health Risk Assessment

- Conducted within 90 days of enrollment and then minimally every 365 days
- Drives stratification and subsequently frequency of care management activities by plans case management team

**Members receive care coordination activities through a dedicated case manager approach**

# Individualized Care Plan ( ICP)

Created for every member:

- Includes a member's self-management goal and objectives; personal healthcare preferences; services and benefits specifically tailored to needs; identification of goals ( met/ not met/ barriers)
- The ICO is generated at the conclusion of the initial HRA and updated based on the availability of ongoing information, such as medical or pharmacy claims
- The ICP is updated based on a member's stratification
  - Low- ICP reviewed/ updated minimally annually
  - Moderate- ICP reviewed/ updated minimally every six months
  - High/ most vulnerable- OCP reviewed/ updated minimally quarterly

The ICP is shared with the member and/ or caregiver, PCP and other interdisciplinary care team participants

# Interdisciplinary Care Team (ICT)

- The ICT is a multidisciplinary approach to care coordination and may include internal and external resources coordinated by the Plan's case management team
- ICT participants are identified based on the unique needs of each member and may include, in additional to the RN case Manager, the member and/or caregiver, CMO, clinical pharmacist, LCSW, UM staff, PCP, other specialists, ect.
- The ICT meets based on a member's stratification:
  - Low-minimally annually
  - Moderate- Minimally every six months
  - High/most vulnerable- minimally quarterly
- ICT meeting are documented, including attendance and participant credentials, and the ICP updated by the case management team, as relevant

# Care Transitions

- The case management team actively participates in both planned and unplanned care transitions, defined as movement between "home" and an inpatient setting (hospital, rehab, LTAC, SNF)
- The case management team shares the members ICP with the receiving facility and serves as a resource throughout the care transition for both the facility and member and/ or their caregiver
- The RN Case manager assesses for any change to the members ICP and coordinates follow up assessment and care

# Model of Care: Section 3

**Provider Network**

# Specialized Network

- Network contracting focused on partnership with Leon Medical Centers for primary and specialty care to align objectives of entities; additional contracting to meet CMS time and distance standards
- Credentialing activities that meet NCQA requirements
- Practitioner collaboration with a members Individualized Care Plan (ICP) and Interdisciplinary Care Team ( ICT)
- Use of evidence based clinical practice guidelines for utilization of services and address gaps in care; documentation of any exception to guidelines in the members medical record
- Contracted providers must meet plan access and availability and medical record documentation standards
- Support care transition protocols and coordinating continuity of care

# Model of Care: Section 4

**Quality Measurement and Performance Improvement**

# Quality Improvement Plan

**CMS requires Medicare Advantage Plans to have a documented Quality Improvement (QI) Plan that includes, but is not limited to :**

- QI Plan Description
- QI Work Plan
- QI/ MOC Evaluation (annually); results disseminated to internal staff,
- Committees, board of directors <BOD), members and providers
- Chronic Care Improvement Program (CCIP) relevant to the SNP population
- Quality Improvement Project(s)

**Progress to goals, including root cause analysis, is monitored and reviewed by the QI Committee, as specified in the QI work plan**

# Measurable Goals & Health Outcomes

**Goals and health outcomes draw upon nationally developed guidelines, such as HEDIS, CAHPS, CMS Star rating, etc. and have been established relevant to the dual population that address:**

- Access
- Affordability
- Improvements in care coordination and appropriate delivery of services through alignment with the HRA, individualized care plan, and interdisciplinary care team
- Enhanced care transitions across impatient settings
- Ensuring appropriate utilization of services for preventive health and chronic conditions; and
- Improving health outcome