CONE HEALTH

SPECIAL NEEDS PLAN (SNP) TRAINING

In keeping with the Affordable Care Act, the Department of Health and Human Services (HHS) developed the National Quality Strategy (NQS) and the National Prevention Strategy (NPS) which culminated in the "Medicare Advantage and Prescription Drug Plan Quality Strategy. As a result, all Medicare Advantage Organization (MAOs) are required, as a condition of their contract with CMS, to develop a Quality Improvement program that is based on care coordination for enrollees. Among quality improvement program requirements provided in CFR §422.101(f) and 422.152(g) for Special Needs Plans (SNPs), all MAOs must develop Model of Care (MOC) plan to provide coordinated care for special needs individuals. The Model of Care elements required for the plan are described in detailed in the CMS Medicare Managed Care Manual Chapter 5 – Quality Assessment 20.2.1. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf

Model of Care Measurable Goals and Health Outcomes include:

- Quality Improvement
- Improving access and affordability
- Coordination of care and appropriate delivery of services
- Enhancing care transitions across all healthcare settings
- Ensuring appropriate utilization of services for preventive health
- Describing, in detail methods to assess and track health outcomes
    - Processes used to determine outcomes met or not met
    - Steps to be taken if goals are not met in the expected timeframe.

Aspects of the Model of Care scoring criteria to be used to assess the MAO plan includes:

MOC 1 Description of overall SNP population

1. Describe how the health plan staff will determine, verify and track eligibility of SNP beneficiaries.
2. Describe the social, cognitive and environmental factors, living conditions and co-morbidities associated with the SNP population.
3. Identify and describe the medical and health conditions impacting SNP beneficiaries.
4. Define the unique characteristics of the SNP population served.

Contributing Factors:

- ✓ **Determine, verify and track eligibility**
- ✓ **Identify health conditions**
    - ➢ **Medical**
    - ➢ **Cognitive**
    - ➢ **Other conditions effecting SNP beneficiaries**
- ✓ **Define unique characteristics of the SNP**

C-SNPs: – Describe chronic conditions, incidence and prevalence as related to the target population covered by this SNP

• The description must include information on limitations and barriers that pose potential challenges for beneficiaries (e.g., multiple comorbidities, lack of care coordination between multiple providers)

D-SNPs: – Describe dual-eligible members, such as full duals or partial duals.

• The description must include information on limitations and barriers that pose potential challenges for beneficiaries (e.g., gaps in coordination of benefits between Medicare and Medicaid, poor health literacy).

In summary, "Dual eligible beneficiaries", as the term describes, identifies those enrolled in Medicare Part A and/or Part B getting full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of the following Medicare Savings Program (MSP):

- Qualified Medicare Beneficiary (QMB) Program
  - Helps pay Part A, Part B of both Program premiums, deductibles, coinsurance and copayments
- Specified Low-Income Medicare Beneficiary (SLMB) Program
  - Helps pay Part B premiums
- Qualifying Individual (QI) Program
  - Helps pay Part B premiums on a first- come, first-served basis
- Qualified Disabled Working Individual (QDWI) Program
  - Pays Part A premiums for certain disabled and working beneficiaries under 65 not getting Medicaid and who meet certain income and resource limits set by their State

I-SNPs: – Specify the facility type and provide information about facilities where SNP beneficiaries reside (e.g., long term care facility, home or community-based services). – Include information about the types of services, as well as about the providers of specialized services

• The description must include information on limitations and barriers that pose potential challenges for beneficiaries (e.g., dementia, frailty, lack of family/caregiver resources or support).

Who pays primary coverage for "dual eligible beneficiaries"?

- Medicare always pays dual eligible beneficiaries first
- Medicaid is generally the payer of last resort
- Medicaid may cover cost not covered or partially covered by Medicare (such as nursing home care, personal care, and home- and community-based services)

MOC 2: Care Coordination

1. Staff Structure
   a. Administrative roles and responsibilities
   b. Clinical roles and responsibilities
   c. Coordination of staff and responsibilities and job title
   d. Contingency plan
   e. Maintaining training records
   f. Actions if training is not completed
2. Health Risk Assessment Tool (HRAT)
   a. Use and dissemination of HRAT information
   b. Initial assessment – 90 days
   c. Reassessment – Annual assessment is conducted 365 days after initial
   d. Plan and rationale for reviewing, analyzing and stratifying results
3. Individualized Care Plan (ICP)
   a. Components
      i. Beneficiary's self-management goals and objectives
      ii. Beneficiary's personal healthcare preferences
      iii. Descriptions of services tailored to beneficiary's needs
      iv. Identification of goals met or not met

4. Interdisciplinary Care Team (ICT)
    a. How does the organization determine the ICT membership
    b. How do the roles and responsibilities of the ICT members, beneficiaries and caregivers contribute to the development and implementation of an effective interdisciplinary process
    c. How the ICT members contribute to the beneficiaries improving health status
5. Care Transition Protocols
    a. How are protocols used to maintain continuity of care for SNP beneficiaries
    b. How organization transfers beneficiaries ICP between health care settings
    c. How beneficiaries have access to personal health information to facilitate communication with healthcare providers in other settings
    d. How are beneficiaries and/or caregivers educated regarding heath status to foster appropriate self-management activities
    e. How are beneficiaries and caregivers informed about the point of contact throughout the transition process

MOC 3: Provider Network

The MAO must establish a provider network with specialized expertise that describes:

1. How providers with specialized expertise correspond to target populations identified in MOC 1.
2. How SNP overseas its provider network facilities and oversees its providers are competent and have active licenses
3. How the SNP documents updates and maintains accurate provider information
4. How providers collaborate with the ICT and contribute to a beneficiary's ICP to provide necessary specialized services.

MOC 4: MOC Quality Measurement and Performance Improvement

The organization must develop a MOC quality performance improvement plan describing:

1. Overall quality improvement plan and how the organization delivers or provides the appropriate services to SNP beneficiaries based on their unique needs
2. Specific data sources and performance and outcome measures used to continuously analyze, evaluate and report MOC quality performance
3. How leadership, management groups and other SNP personnel and stakeholders are involved with the internal quality performance process
4. How SNP-specific measurable goals and healthcare outcomes objectives are integrated in the overall performance improvement plan

FDR Defined

First Tier Entity – A party that enters into a written arrangement with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare-eligible individual.

Downstream Entity – A party that enters into a written arrangement with a First Tier entity for the provision of administrative services or health care services to a Medicare eligible individual.

Related Entity – An entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and 1) performs management functions under contract or delegation, 2) furnishes services to Medicare enrollees under an oral or written agreement, or 3) leases real property or sells materials to the Medicare Advantage Organization or Part D plan sponsor at a cost of more than $2,500 during a contract period. [4]

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See 42 CFR §§ 422.500 and 423.501.

References:

1. Center for Medicare and Medicaid Services. Medicare Managed Care Manual. Chapter 5: Quality Assessment.

   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf

2. Center for Medicare and Medicaid Services. Dual Eligibility Needs Plans (D-SNPs)

   https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/D-SNPs

3. Center for Medicare and Medicaid Services. Model of Care Plan
   https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

4. Chan, Denny and Christ, Amber. Justice in Aging Chapter Summary. "Legal Basics: Dual Eligibiles". May 2019.
   https://ncler.acl.gov/getattachment/Legal-Training/Dual-Eligibles-Ch-Summary.pdf.aspx?lang=en-US

5. Center for Medicare and Medicaid Services. MedLearn Matters. " Dual Eligible Beneficiaries Under Medicare and Medicaid. February 2020.
   https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

6. Medicare Advantage. "Medicare and Medicaid Dual Eligibility: Medicare D-SNP (Dual Eligible Special Needs Plan) Eligibility & Enrollment"

   https://www.medicareadvantage.com/resources/dual-eligible-medicare-medicaid-plans

Example of other Payor Model of Care Plans:

1. Allwell – Sunshine Health
   https://www.sunshinehealth.com/content/dam/centene/Sunshine/pdfs/SH-MOC-Training-2018.pdf