El Paso Health+
Advantage Dual SNP

Dual Eligible Special Needs Plans (DSNP) Model of Care Training

Mission & Vision

Our **Mission**

To **build relationships** with our Members, Providers, and Partners that strengthen the delivery of healthcare in our community and **promotes access to quality healthcare** for children, families, and individuals.

Our **Vision**

We will be the region's **trusted** community health plan.

Introduction

- The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff receive basic training about the Dual Special Needs Plans (DSNPs) Model of Care (MOC).

- The DSNPs Model of Care is the plan for delivering coordinated care and care management to special needs members.

- This course will describe how El Paso Health and our contracted providers can work together to successfully deliver the DSNPs Model of Care.

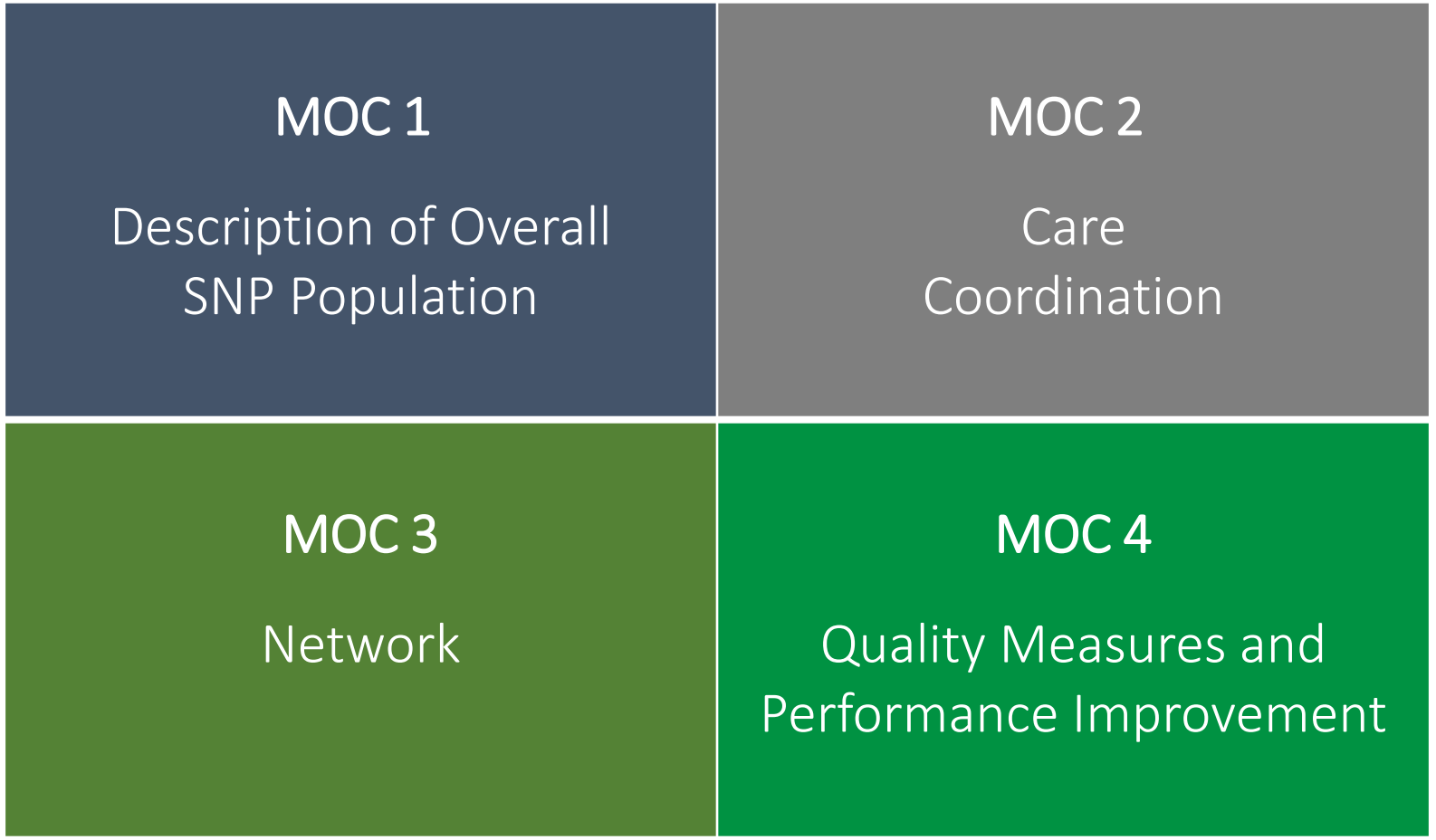
Training Plan Content
D-SNP Model of Care

Learning Objectives

- EPH employed and contracted staff who directly or indirectly affect Care Coordination services for DSNP Members are required to complete DSNP MOC training initially - within 30 days of start date or execution of contract

- Program participants will be able to:
  - List the three overall goals of the D-SNP Model of Care
  - Describe the three vulnerable subpopulations
  - Understand the purpose of the Health Risk Assessment
  - Understand the key components of the Individualized Care Plan and how it impacts Care Coordination
  - Understand the purpose of the Interdisciplinary Care Team and how it impacts Care Coordination
  - Name two principles important to improve transitions of care
  - Identify three Performance indicators being measured to evaluate the Model of Care

Model of Care Elements



MOC 1: Description of the Overall D-SNP Population

- **D-SNP Background:** A general description of D-SNP and its Membership
- **Goals of Special Needs Plans**: Describes goals to improve access, Care Coordination and outcomes
- **SNP Population:** Outlines the basic qualification requirements and the three most vulnerable groups of Members
- **Benefits to Meet Specialized Needs:** Describes health plan benefits to meet the needs of the vulnerable subpopulations
- **D-SNP Member Diversity:** Identifies cultural make-up of the population
- **Language/Communication Resources:** Identifies resources to assist Members with language and communication needs
- **Communication Systems:** Identifies ways in which communication takes place

MOC 2-Care Coordination

- **Case Management:** Description of how Care Coordination takes place and the roles of the Case Manager
- **Health Risk Assessments (HRA):** Description of how, when, and why the HRA is completed
- **Individualized Care Plan (ICP):** Description of how, when, and why the ICP is completed
- **Interdisciplinary Care Team (ICT):** Describes team Member selection, role, and how information is shared
- **Care Transitions Protocol:** Describes the process for managing transitions, how requirements are met, and information is shared

MOC 3 Provider Network

- **Specialized Provider Network:** Description of the Provider Network composition and how interactions occur
- **Clinical Practice Guidelines:** Description of Clinical Practice Guidelines appropriate to vulnerable subpopulations
- **Model of Care Training:** Outlined the methods, timelines, content, and attestation of completion

MOC 4 Quality Improvement

- Measureable Goals: Identifies D-SNP goals, how performance is evaluated and communicated to stakeholders
  - EPH D-SNP Goals and impact on vulnerable subpopulations
  - Evaluation of performance
  - Communication of results

MOC 1
Description of Overall SNP Population

MOC 1: Description of Overall SNP Population

SNP Plan Overview

- A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan specifically designed to provide targeted care and limit enrollment to special needs individuals.

- **Dual Eligible Special Needs Plans (DSNPs)** enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

MOC 1: Description of Overall SNP Population

D-SNP Background

2003	**SNPs** were created as part of the Medicare Modernization Act.
2008	**CMS** contracted with the National Committee for Quality Assurance (NCQA) to develop a strategy to **evaluate the quality** of care provided by SNPs.
2011	• The **Patient Protection** and **Affordable Care Act (ACA)** mandated further SNPs program changes: – submit **Models of Care** (MOCs) that comply with CMS standards – **NCQA** must **review and approve** these MOCs
2015	CMS published The **Equity Plan for Improving Quality in Medicare**
2018	**SNPs became permanent** in 2018 with the signing of **H.R. 1982, the "Bipartisan Budget Act of 2018**
2020	El Paso Health launches Medicare

MOC 1: Description of Overall SNP Population

Dual Special Needs Plans Eligibility & Features

Eligible members:

- Reside within the program's service area
  El Paso and Hudspeth Counties
- Meet dual eligibility status requirements
  QMB and QMB+
- Benefit plans are **custom designed** to meet the needs of the target population

Primary coverage for dual eligible members:

- Medicare is always primary
- Medicaid is the payer of last resort and supplements Medicare coverage
- Members are eligible for special election period to change health plans quarterly throughout the year

MOC 1: Description of Overall SNP Population

QMB and QMB+ Medicaid Eligibility Categories

- *EPH's D-SNP is open to beneficiaries in QMB and QMB+ Medicaid eligibility categories*

Medicaid Eligibility Category	Description
Qualified Medicare Beneficiary without other Medicaid (QMB only)	An individual entitled to Medicare Part A, with an income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplementary Social Security Income (SSI) eligibility, and who is not otherwise eligible for full Medicaid benefits through the State. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan.
QMB+	An individual who meets the standards for QMB eligibility, and who also meets the criteria for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance, and provides full Medicaid benefits to the extent consistent with the State Plan. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically needy level.

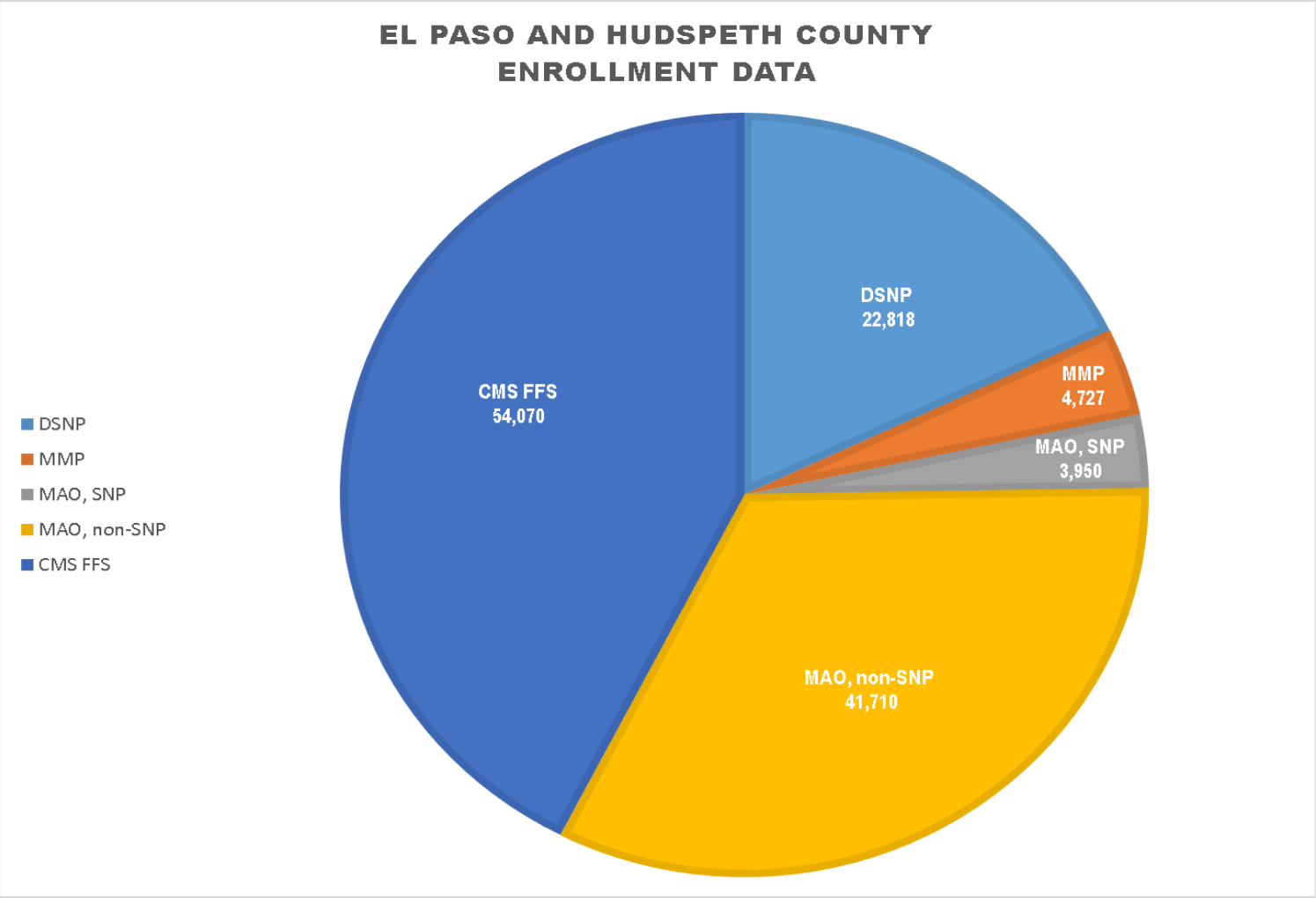
MOC 1: Description of Overall SNP Population

Goals of Special Needs Plans

Goal One	Goal Two	Goal Three
Improve Access	Provide Seamless Care Coordination	Improve Outcomes
• To safer, higher quality, equitable, and affordable healthcare	• ensure that the patient's need and preferences for health services and information sharing across people, functions, and sites are met over time	• Social, Behavioral and Medical outcomes for vulnerable populations • HEDIS measures
(CMAG 2012)	*(NQF 2006)*	

MOC 1: Description of Overall SNP Population

Overall Population



	El Paso County	Hudspeth County
Total Population	827,398	4053
Medicare Pop. (May 2017)	20,077	142
Spanish Spoken at Home	71.0%	77.7%
Population Aged 65+	15%	10.5%

MOC 1: Description of Overall SNP Population

Vulnerable Subpopulations

- **Diagnosis of Diabetes**
- **Diagnosis of Alzheimer's Disease or other dementia; Indication of forgetfulness**
- **And age of 80 years or older who live in the community and have three or more chronic illnesses (Frail Individuals)**

MOC 1: Description of Overall SNP Population

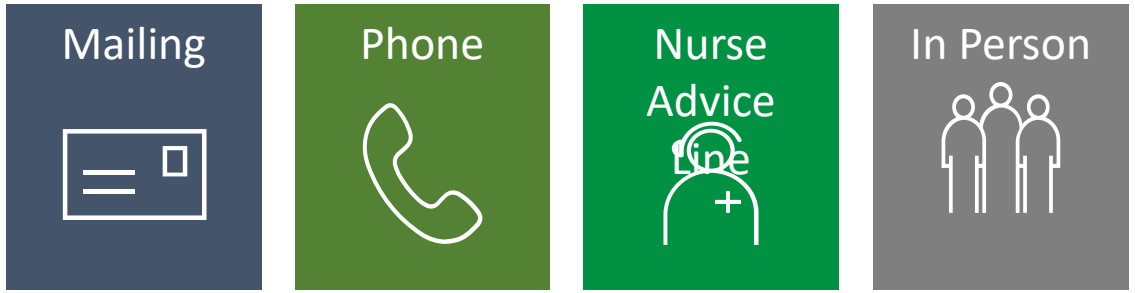
Language and Communication Resources

- In 2015, EPH adopted National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care standards to ensure that all Members entering the health care system receive equitable and effective treatment.
  - Identifies resources to assist Members with language and communication needs
- Language and Cultural
  - EPH Member Services Representatives, Outreach Associates, and Case Managers and after hours Nurse line are bilingual in English and Spanish or arrange Interpretation Services for other languages. EPH staff participate in cultural competency training as well as live locally, among DSNP members
- Literacy and Impairment (hearing, vision, self-care, and independent living difficulties)
  - Materials provided in preferred language and form (e.g., larger print, Braille, and versions in other languages)
  - Sign language interpretation, or Telecommunications Device for the Deaf (TDD) access.

MOC 1: Description of Overall SNP Population

Language and Communication Systems

- Ways in which communication takes place



- Multiple systems to implement the D-SNP Care Coordination requirements
  - Customer Service Hotline
  - Member Portal, website
  - Provider Portal
  - Internal database of Community Resources
  - Electronic Management Information System – case management documentation system
  - Member and Provider Communications such as member and provider newsletters and educational outreach

MOC 2
Care Coordination

MOC 2: Care Coordination

Case Management

Description of how Care Coordination takes place and the roles of the Case Manager

- **Member centric, evidence based Care Coordination** is provided through an integrated staff structure in which the Dual Special Needs Plan (DSNP) **Members' health care needs are met and health services are delivered in the preferred setting.**
- EPH administrative and clinical staff roles support Care Coordination to **maximize the use of effective, efficient, safe and high-quality Member services** provided by network Providers as well as Community Partners.
- Case Managers core functions **promote the highest level of physical, psychological, and social functioning possible** for Members and their families.

MOC 2: Care Coordination

Health Risk Assessment

The Health Risk Assessment Tool (HRAT) is a series of questions designed to best identify a Member's state of health, risk for exacerbation of acute or chronic conditions, functional decline, and social issues likely to impact the Member's ability to achieve personal health and well-being goals.

Purpose:

- Assess the medical, functional, cognitive, psychosocial and mental health needs of each SNP beneficiary.
- Contributes to development of the ICP
- Supports ICT composition and activities

MOC 2: Care Coordination

Health Risk Assessment

Process:

- EPH employs a collaborative team approach to ensure completion of the HRAT. Member Services and Health Services work together to perform outreach, generate mailings, and coordinate with Providers to facilitate Member engagement.
- HRAT mailing
- Member Services Outreach
- Case Manager Outreach

Each DSNP Member will have an HRAT and ICP completed initially within 90 days of enrollment effective date and within 365 days of the last HRAT.

MOC 2: Care Coordination

Health Risk Assessment Continued

Additional assessments will be conducted as indicated

- Diagnoses of Diabetes,
- Diagnosis of Alzheimer's Disease or other dementia; Indication of forgetfulness
- Age of 80 years or older who live in the community and have three or more chronic illnesses (Frail Individuals)

Quality Improvement supports Health Services in the review and analysis of HRAT results through tracking vulnerable subpopulation indicators through other sources to stratify Members as high or medium risk, dependent upon the condition that caused the following:

- Potentially Preventable Admissions;
- Potentially Preventable Emergency Department Visits;
- Potentially Preventable Readmissions;
- Comprehensive Diabetes Control;
- And Immunizations Adherence
- Members with no indication of the above will be deemed low risk

MOC 2: Care Coordination

Individualized Care Plan

Each D-SNP Member will have an Individualized Care Plan completed initially and updated at least annually, or with a change in health care needs, per CMS regulations.

Purpose:

- Identify gaps in care, at risk areas, knowledge deficits, and self-management issues.
- Develop individualized, member centric opportunities and associated goal with correlating health care professional interventions

Process:

- Identify opportunities based on HRAT
- Member prioritizes individualized goals
- Linguistic and cultural preferences are included
- Updated as changes occur

MOC 2: Care Coordination

Individualized Care Plan Continued

The ICP will be individualized based on the initial HRAT results, the Case Manager assessment, the Member's medical history, health care, cultural and linguistic preferences, pharmacy utilization, and input from all active Members of the ICT.

MOC requirements:

- Each D-SNP Member will receive an Individualized Care Plan within 30 days of completion of the HRAT. The ICP is shared in the manner that the Member has requested.
- When the Member cannot be reached, or opts-out of service coordination,
  - EPH uses available clinical data to develop an ICP
  - includes a wellness and self-management plan
  - The ICP is mailed to the address of record accompanied by a letter with request for a call to Member Services to complete the HRAT and participate in development of the ICP.

MOC 2: Care Coordination

The key components of the ICP

- The ICP includes the following essential elements:
  - HRAT Results;
  - Case Manager disease specific assessment (asthma, diabetes, depression, etc.);
  - Gaps in care;
  - Opportunities which are defined as a need to improve health outcomes;
  - Identification of goals met and not met, including self-management goals;
  - Interventions, including a description of services tailored to meet the Member's needs;
  - Actions;
  - Progress toward goals, interventions, and actions;
  - If goals are not met, the CM staff, in coordination with the ICT, will reassess the current ICP and determine appropriate alternative actions
  - Outcomes;
  - Barriers to care;
  - Author of elements or Staff responsible for that portion of the ICP;
  - Member's personal health care preferences;
  - And identification of caregiver and caregiver contact information.

MOC 2: Care Coordination

Interdisciplinary Care Team

Team Member selection, role, and how information is shared

Purpose: The Interdisciplinary Care Team (ICT) is a group of health care professionals from diverse fields who work together consistently toward a common goal for the Member, to improve care.

Composition of the Interdisciplinary Care Team:

- Core team: Member or representative, Primary Care Provider (PCP) or designee, and Case Manager.
- Expanded ICT: Core team and others to address specific needs at a point in time.
  - Caregiver, Member Services Representative, Medical Director, Specialists, Clinical Supervisor, Pharmacy Technician, Pharmacist, Utilization Review Nurse Coordinator, and partners such as a Case Manager with the Local Mental Health Authority.
  - Any person/Provider who has an impact on the health and wellbeing of the Member.

MOC 2: Care Coordination

Interdisciplinary Care Team Continued

Roles:

- Member and/or caregiver: identify and prioritize goals, indicates cultural, linguistic and other preferences
- Case Manager: primary contact for ICT members, schedules, leads and documents findings of ICT case conference, shares updates to ICP
- PCP: provides insight on primary care and treatment, makes recommendations
- Expanded ICT members: provide insight on specialty care and treatment, make recommendations

Communication Plan:

- The Case Manager acts as the single point of contact for members of the ICT
- A meeting summary of each case review by the ICT is documented in the Member's record
- The updated ICP is shared with members of the ICT

MOC 2: Care Coordination

Interdisciplinary Care Team Continued

MOC requirements:

- All DSNP members are assigned an ICT
- Special accommodations will be made for Members with hearing or visual impairments, language and literacy barriers, and cognitive deficiencies.
- Case review meetings will occur weekly
- **Each Member will be reviewed no less than annually**
- Criteria for review includes
  - unplanned hospitalized for anticipated length of stay of 7-10 days
  - all cause readmission
  - Risk of admission
  - Pharmacotherapy non-adherence
  - Inadequate progress toward goals
  - Member, Caregiver or ICT Member Request
  - And other as approved by Director of Health Services

MOC 2: Care Coordination

Care Transitions Protocol

EPH engages the DNSP Member, caregiver and ICT in planning and preparation for a transition, works actively to coordinate the transition, and ensures follow-up through support provided by appropriate Care Coordination personnel.

Identification and Management of transitions across health care settings:

- Communication of a facility admission or discharge is conveyed to the PCP, the Case Manager, and other Members of the ICT within one business day of notification by prior authorization, concurrent review, facility notification or census reports
  - Case management team initiates member education at the onset of a transition
  - UM team initiates discussion with facility case management team
  - UM team enters authorizations which alert EPH case manager
  - UM team and EPH case manager collaborate on discharge plan
  - EPH case manager completes Transition of Care 2 Assessment within 7 days of discharge
  - ICT is convened
  - ICP is updated and shared with ICT
- Communication Plan
  - To maintain continuity of care, the existing ICP is shared with the Provider or facility within five business days of notification of transition.
  - In planned transition, the ICP will be shared before the transition occurs.
  - ICP is shared with ICT as updates occur

MOC 3
Provider Network

MOC 3: Provider Network

Training Plan Content Final MF

El Paso Health maintains a specialized provider network that is designed to provide access to medical, behavioral and psycho-social services for the dual population.

El Paso Health provider partners are an invaluable part of the interdisciplinary care team. Our D-SNP Model of Care offers an opportunity for us to work together for the benefit of our members by enhancing communication, focusing on each individual member's special needs and delivering care management programs to assist with the patient's medical and non-medical needs.

The provider role

- Communicate with D-SNP care managers, ICT members and caregivers
- Collaborate with our organization on the ICP
- Participate in the ICT
- Complete MOC training upon onboarding and again annually.

MOC 4
Quality Improvement

MOC 4: Quality Improvement

Goals

- Measureable Goals: Identifies D-SNP goals, how performance is evaluated, and communicated to stakeholders
  - EPH utilizes a wide array of data sources, performance and outcome measures to analyze, evaluate, and report on MOC implementation and effectiveness
    - medical and pharmacy utilization reports
    - call center utilization reports
    - complaints and appeal reports
    - network adequacy reports
    - quality of life indicators
    - clinical health outcome metrics (HEDIS)
    - Member satisfaction survey results
    - internal MOC implementation audit tool
    - CAHPS survey

MOC 4: Quality Improvement

Goals Continued

EPH D-SNP Goals and impact on vulnerable subpopulations

- Health outcome measures specific to the identified vulnerable populations will be monitored regularly and assessed annually
- All Vulnerable D-SNP Populations
  - Potentially Preventable Admissions, ED Visits and Re-admissions
- Diabetes Population
  - Comprehensive Diabetes Control

MOC 4: Quality Improvement

Goals Continued

- Alzheimer's Disease and other Dementias Population
  - Inappropriate use of antipsychotic medications for Members with Alzheimer's and other dementia-related conditions (Potentially Harmful Drug-Disease Interactions in the Elderly)
  - Hospitalization following discharge from a skilled nursing facility
  - Rate of individuals who move to a long term facility
- Frail Population - 80 years or older who live in the community and have three or more chronic illnesses
  - Flu Shot Rate
  - Incidence of Osteoporosis
  - Pneumonia Vaccine
  - Hospitalization following discharge from a skilled nursing facility
  - Rate of individuals who move to a long term facility

MOC 4: Quality Improvement

Evaluation of Performance and Communication of Results

Performance indicators tracked quarterly through the MOC audit tool:

- Percent of associates who directly or indirectly affect care coordination services who receive DNSP Model of Care training annually
- Percent of network providers who receive initial DNSP MOC training within 30 days of inclusion in EPH Network
- Percent of network providers who receive DNSP MOC training annually
- Percent of DNSP members who complete initial HRAT within 90 days of enrollment
- Percent of DNSP members who complete HRAT annually
- Percent of DNSP members who receive an ICP within 30 days of completing HRAT
- Percent of admissions or discharges that are communicated to the ICT within 1 business day of notification
- Percent of transitions of care where Member's ICP is shared with provider or facility within 5 business days of notification

Communication of results: If goals are not met the PDSA method is applied to determine the root cause of the deficiency. The Medical Director, Director of Health Services, and/or Providers are notified about deficiencies. Interventions are put in place. The results are reported to the OIC, QIC and applicable departments and the BOD in quarterly and/or ad hoc reports.

DSNP Model of Care Post Test

- Please remember to complete and return the MOC Attestation once the training has been completed. The following options are available.

Fax form to: 915-225-6762

Email Form: ProviderServicesDG@elpasohealth.com

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