Dual Eligible-Special Needs Plan (D-SNP) Model of Care Overview

Training

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CMS requirements

- The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff receive basic training about our Dual-Eligible Special Needs Plan (D-SNP) Model of Care.
- The D-SNP Model of Care is a plan for delivering coordinated care and care management to individuals with special needs.
- This course will describe how McLaren Health Plan and their contracted providers can work together to successfully deliver a D-SNP Model of Care.

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Our mission

- McLaren Health Plan's D-SNP program is designed to maximize the quality of care, access to care and health outcomes of our special needs members.

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Training objectives

- Define what a Dual Eligible-Special Needs Plan (D-SNP) is and what it offers
- Identify the population that qualifies for this plan
- Outline McLaren Health Plan's Model of Care
- Identify requirements to participate in D-SNP Provider Network, guidelines and protocols and network training opportunities
- Explain Model of Care Quality Measurement and Performance Improvement

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What is a D-SNP?

- A D-SNP is a special type of Medicare Advantage plan that provides health benefits for people who are “dual eligible,” meaning they are entitled to both Medicare and Medicaid.
- These individuals have complex health care needs. Lack of coordination between the Medicare and Medicaid programs makes it difficult for them to navigate these systems of care and adds to the cost of both programs.
- D-SNPs were developed to address this group.
- All D-SNPs are required to have an executed contract with applicable State Medicaid Agencies.

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What is a D-SNP?

- In a D-SNP, Medicare is always primary; Medicaid is the payer of last resort and supplements Medicare coverage.
- D-SNPs follow existing Medicare Advantage program rules.
- Eligible individuals can enroll in a D-SNP during the regular Medicare Advantage enrollment period (October 15 through December 7) or during a Special Enrollment Period.
- Effective January 2019, eligible individuals are also permitted to make a coverage change one time per quarter during the first nine months of the year with an effective date of enrollment into the new plan being the first of the month.

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Who qualifies for a D-SNP?

- To be eligible for a D-SNP, an individual must meet the dual eligibility requirements for both Medicare and Medicaid.
  - Must be eligible/enrolled in Medicare Part A and/or B
  - Receive full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through a Medicare Savings Program.
- Qualified individuals must also live in the McLaren Health Plan service area.

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Who qualifies for a D-SNP?

- These individuals:
  - Are a more vulnerable subgroup of Medicare beneficiaries
  - Are a mix of over 65 and under 65 who qualified based on a disability
  - Are typically more costly based on health care needs
  - Tend to have a lower income and report lower health status than other beneficiaries

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Who qualifies for a D-SNP?

- Members must reside within McLaren Health Plan's service area.

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McLaren Health Plan's Model of Care

- McLaren Health Plan's D-SNP Model of Care is a plan for delivering care management and care coordination to:
  - Improve quality
  - Increase access
  - Create affordability
  - Integrate and coordinate care across specialties
  - Provide seamless transitions of care
  - Improve use of preventive health services
  - Encourage appropriate utilization and cost effectiveness
  - Improve member health

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McLaren Health Plan's Model of Care

- McLaren Health Plan's D-SNP Model of Care design includes the following:
  - Completion of an annual Health Risk Assessment (HRA)
  - Development and coordination of an Interdisciplinary Care Team (ICT)
  - Development of an Individualized Care Plan (ICP)
  - Annual health exam with Primary Care Provider (PCP)
  - Care coordination
  - D-SNP benefits
  - Provider participation
  - Provider network guidelines and protocols
  - Quality Measurement and Performance Improvement

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Health risk assessment (HRA)

- The HRA:
  - Helps identify members with the most urgent needs
  - Is an important part of a member's care coordination
  - Contains member self-reported information
  - Helps create the member's individualized care plan
  - Assesses the following needs of each member:
    - Medical
    - Functional
    - Cognitive
    - Psychosocial
    - Mental Health

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HRA process

Attempt to reach member

Three attempts

Unable to Reach Letter is issued (includes Care Coordinator contact information)

If member or legal representative refuses care coordination, this is documented in the member's record

Care Manager conducts HRA

Completed within 90 days of member enrollment into DSNP

Includes a comprehensive assessment of member needs, including medical, behavioral, cognitive, functional and social needs

Must be completed annually within one year of the Initial Assessment or previous HRA

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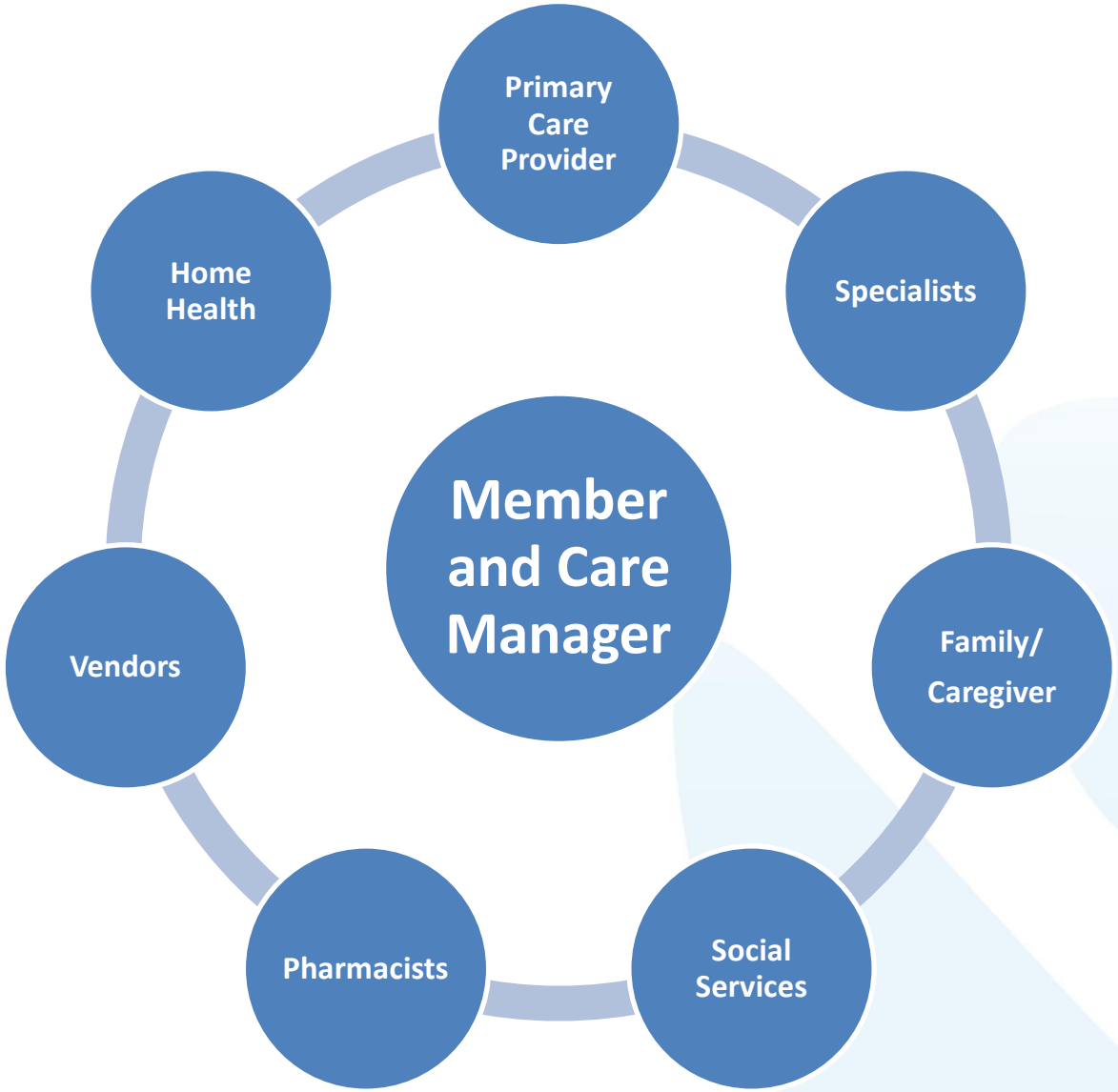
Interdisciplinary Care Team (ICT)



- Each member is managed by a care team
- Care team participants are based on the member's needs
- Care Managers will keep the team updated with information involving the member's care plan
- Team meets formally
- Smaller meetings occur, as needed

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ICT participation

- Determine each member's goals and needs
- Coordinate member care
- Identify problems and anticipate member crisis
- Educate members about conditions and medications
- Coach members to use their ICP
- Refer members to community resources
- Manage transitions
  - Identify problems that could cause transitions
  - Try to prevent unplanned transitions
- Coordinate Medicare and Medicaid benefits for members
- Identify and assist members with changes in the Medicaid eligibility

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ICT process

- Each member will have an ICT meeting at least annually and when there is a change in condition, as required
- Care Manager coordinates the ICT
- Care Manager meets with the member, caregivers, PCP and other member supports (e.g., Behavioral Health, Home Care Nurses, DME)
- Internal monthly ICT rounds occur for care coordination as indicated per the member's plan of care

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Individualized care plan (ICP)

- The ICP is the mechanism for evaluating a member's current health status. It is the ongoing action plan to address a 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.
- This is a living document that changes as the member changes.
- The Member Profile section of the ICP:
  - Summarizes the ICP
  - Captures HEDIS gaps in care
  - Contains medication review notes from McLaren Health Plan pharmacists
  - Includes diagnoses from claims data, certain lab results and a list of current medications filled by member

An ICP is developed and maintained for each D-SNP member using:
HRA results
Laboratory results, pharmacy, emergency department and hospital claims data
Care Manager interaction
ICT input
Member preferences and goals
Annual health exam with PCP

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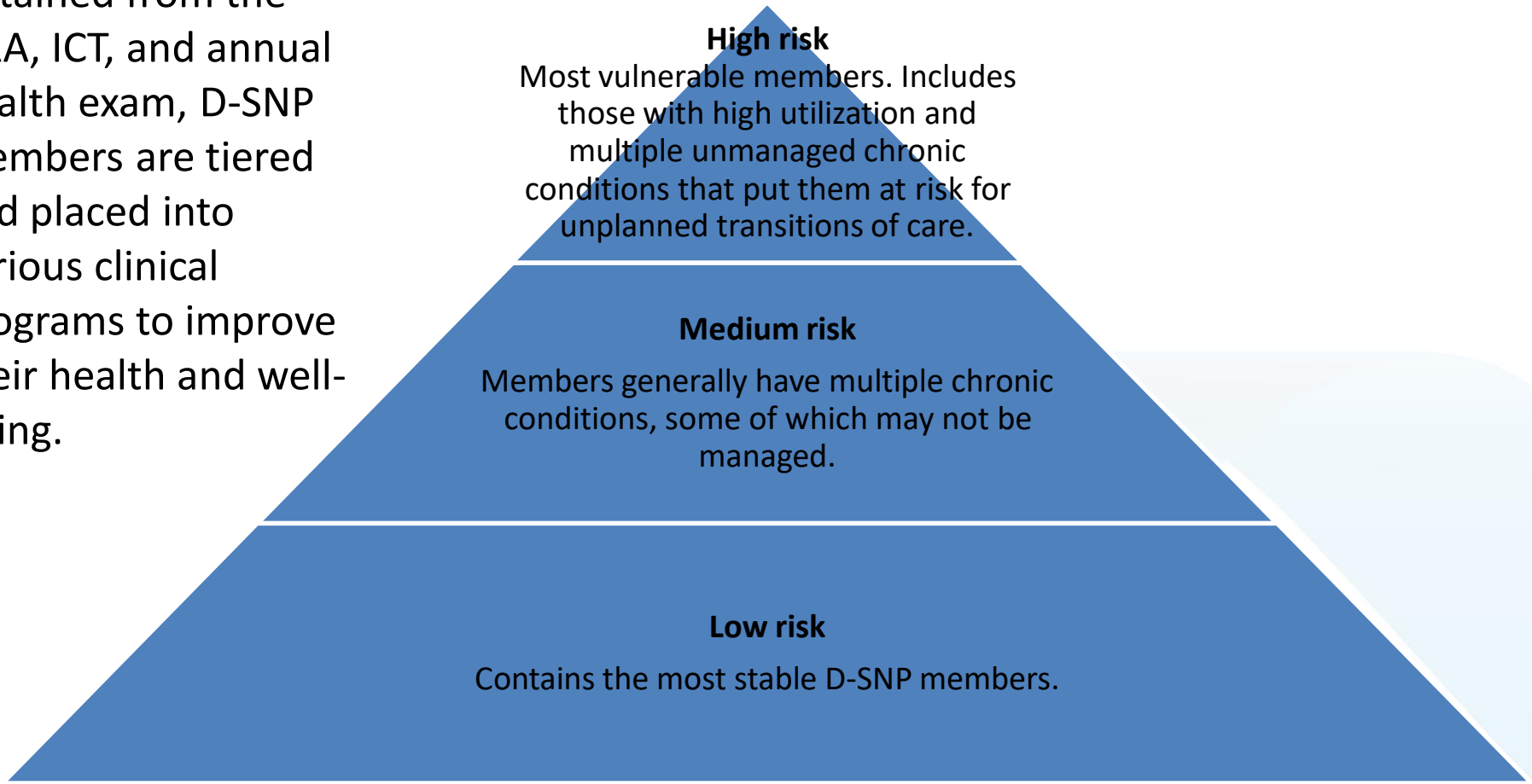
ICP Tiers

Using the information obtained from the HRA, ICT, and annual health exam, D-SNP members are tiered and placed into various clinical programs to improve their health and well-being.



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ICP Process

- Care Manager completes the ICP within 14 days of the HRA
- ICP must include interventions specifically designed to meet the needs identified in the HRA
- ICP must have 3-5 long- and short-term goals and include measurable outcomes
- ICP must address any barriers to care, plus any education, social/community and cultural/language needs
- ICP must have input from the member or legal representative; must obtain a copy of a member-signed ICP
- Care Manager must send the ICP to the PCP's office to add to the member's record
- If member refuses care coordination, it's documented in the medical record
- If member refuses care coordination, member is kept at "low risk" status and an ICP is created
- ICP is issued to the ICT, member and providers via mail, fax or secure email

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Annual Health Exam with Primary Care Provider (PCP)

- Goal is to have preventive and annual exams performed within six months of enrollment
- Results from the exam contribute to the ICP
- The PCP monitors and schedules appropriate screenings – Care Manager can help schedule visits
- The PCP monitors all chronic conditions and schedules any appropriate tests and/or screenings, referrals and medications
- Member HRA and ICP is always available to the PCP through our secure member/provider portal,

https://www.mclarenhealthplan.org/mhp/mclaren-connect

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Care coordination

- Staff structure
  - **Administrative staff:** Customer service, Appeals and Grievances, claims, enrollment
  - **Clinical staff:** Care managers, social workers, nurses, behavioral health/substance abuse clinicians
  - **Oversight staff:** Quality improvement, credentialing, provider services, Medical Director

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Care coordination

- Integrate and coordinate care across specialties
  - McLaren Health Plan integrates and coordinates care for D-SNP members across the care continuum through a central point of contact. The Care Manager functions as this central contact across all settings and providers.
- To improve coordination of care:
  - PCP is the gatekeeper and is responsible for identifying the needs of the beneficiary
  - Care Manager coordinates care with the member, the member's PCP and other participants of the member's ICT
  - All D-SNP members have a PCP and Care Manager

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Care coordination

- For seamless transitions between care settings :
  - Notify the member's PCP of a transition
  - Share the member's ICP with the PCP, the hospitalist, the facility, and/or the member/caregiver
  - Contact the member prior to a planned transition to provide educational materials and answer questions related to the upcoming transition

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Care coordination

- Post-hospitalization transition of care:
  - Includes phone calls after being discharged home from the hospital (3-day post-hospital call/14-day follow-up call)
    - Helps member understand discharge diagnosis and instructions
    - Facilitates follow-up appointments
    - Helps schedule transportation
    - Assists with needed home health care and medical equipment
    - Resolves barriers to obtaining medications
    - Educates member on new or continuing medical conditions

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D-SNP benefits

- A D-SNP includes coverage for hospital services (Medicare Part A), medical health care needs (Medicare Part B) and prescription drugs (Medicare Part D).
- The plan goes beyond either Medicaid or Original Medicare alone with extra benefits and features at no extra cost. Additional benefits may include:

No or low cost sharing	Care coordination
Vision and hearing benefits	Over-the-counter quarterly allowance
Transportation benefits	Telehealth services
Gym memberships	Medication therapy management
Diet and nutritional education	Behavioral health services
End-of-life support services	Social work support
Home and community-based services partnerships	Meal programs

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Provider participation

- Provider partners are an invaluable part of the ICP. Our D-SNP Model of Care offers an opportunity for us to work together for the benefit of our member, your patient, by:
  - Enhancing communication
  - Focusing on each member's special needs
  - Delivering care management programs to assist with the patient's medical and non-medical needs
  - Supporting the member's plan of care

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Provider participation

- You can help by:
  - Communicating with D-SNP Care Managers, ICT members, members and caregivers
  - Collaborating with McLaren Health Plan on ICPs
  - Reviewing and responding to patient-specific communication
  - Maintaining ICPs in member medical records
  - Participating in ICTs
  - Reminding members of the importance of the HRA, which is essential in the development of the ICP
  - Encouraging members to work with their ICT
  - Completing the Model of Care training upon onboarding and again annually

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Provider participation

- The D-SNP network must meet the needs of the dual-eligible population served. A participating provider must be certified as a Michigan Medicaid provider and have a Medicaid ID number.
- Specialized expertise to manage the special needs population and monitor the use of clinical practice guidelines
- Ability to manage transitions, advocate, inform and educate members, perform assessments, diagnose and treat
- D-SNP members are protected from balance billing. Providers cannot balance bill and must accept the Medicare and Medicaid payments as payment in full.
  - Dual members should show their McLaren Health Plan ID to all providers to assist with billing and service issues.

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Provider network guidelines and protocols

- The D-SNP provider network:
  - Requires specialized expertise that supports the target population
  - Is made up of providers and facilities that go through a rigorous credentialing process
  - Is monitored to ensure provider utilization of clinical practice guidelines and protocols
  - Incorporates annual Model of Care training provided for all staff and providers
  - Includes communication activities between McLaren Health Plan, the member, the provider network and all agencies involved in member's care

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Quality Measurement and Performance Improvement

- Performance, quality and health outcome measurements are collected, analyzed and reported to evaluate the effectiveness of the model of care.
- These measurements are used by our Quality Management team and include the following measures:
  - Healthcare Effectiveness Data and Information Set (HEDIS) – used to measure performance on dimensions of care and service
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
  - Health Outcomes Survey (HOS) member survey – used to compute physician and mental component scores to measure health status
  - CMS Part C Reporting Elements – includes benefit utilization, adverse events, organizational determinations and procedure frequency
  - Medication therapy measurement
  - Clinical and administrative/service quality improvement projects

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Quality Measurement and Performance Improvement

- Measurable goals are in place to evaluate the performance of our D-SNP plan in the following areas:
  - Improve access and affordability of healthcare needs
  - Improve coordination of care and delivery of services
  - Improve transitions of care across health care settings
  - Ensure appropriate utilization of services for preventive health and chronic conditions

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Quality Measurement and Performance Improvement

- The goals we have in place address the following:
  - Adequacy of our network
  - Our rates of completion of the HRAs, developing ICPs and completing an ICT review
  - Rates on certain preventive care services and chronic condition management
  - Frequency of follow-up care post discharge
  - Visits to the PCP
  - Utilization rates of emergency room and inpatient admissions

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Thank you!

- Thank you for your participation in this annual Model of Care training.
- Please complete the attestation form on the last slide and return to the fax number provided to receive credit for this training.
- If you have questions, please feel free to contact us at:
  - Provider portal address
  - Provider relations phone number

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McLaren Health Plan D-SNP Model of Care Attestation

- I attest that my practice has reviewed the D-SNP Model of Care presentation.
- I understand the goals of the program and the requirements of the Model of Care.
  - Plan of care feedback
  - Clinical coordination for the member
  - Participation in ICT
  - Responsive and cooperative with the plan clinical representatives
  - Referring member to medically necessary services in accordance with plan benefits
  - Appropriate communication with the member's family or legal representative
  - Timely submission of documentation
- I understand how to obtain additional information or resources.
- I understand that this presentation and attestation are yearly requirements.

Provider Name: _____ ID #: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

Please sign and fax to: _____

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