Special Needs Plans (SNPs) Model of Care

Annual Training

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Health Net

Presentation For:
Provider Webinar
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Learning Objectives

Program participants will be able to:

- List the three overall goals of the SNP Model of Care
- Describe the three qualifying medical conditions for patients in the Health Net Jade C-SNPs
- Name two actions providers can take to assist patients in the Dual Eligible Amber D-SNPs to access care
- Understand the important components of the care plan and team based care to improve care coordination for SNP patients
- Name two principles important to improve transition care management
- Identify three outcomes being measured to evaluate the Model of Care

Special Needs Plan (SNP) Background

SNPs were created as part of the Medicare Modernization Act in 2003. Medicare Advantage plans must design special benefit packages for groups with distinct health care needs, providing extra benefits, improving care and decreasing costs for the frail and elderly through improved coordination. A SNP can be for one of 3 distinct types:

- Dual Eligible or D-SNP for patients eligible for Medicare and Medicaid
- Chronic Disease or C-SNP for patients with severe or disabling chronic conditions – an initial attestation that patient has specific condition is required from provider
- Institutional or I-SNP for patients requiring an institutional level of care or equivalent living in the community (*Health Net does not have this type of SNP*)

Goals of Special Needs Plans

Improve Access

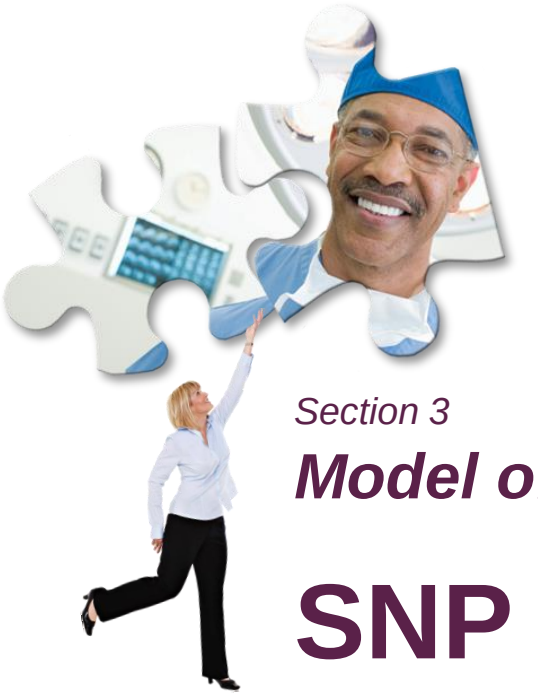
- Improving access to medical and mental health and social services
- Improving access to affordable care and preventive health services

Improve Coordination

- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, providers and health services
- Assuring appropriate utilization of services

Improve Outcomes

- Improving patient health outcomes



Section 3

Model of Care 1

SNP Population

General Population

Vulnerable Subpopulations

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Health Net SNPs

Health Net has two types of SNPs:

- D-SNPs for patients that are dually eligible for Medicare and Medicaid known as the Amber SNPs
- C-SNPs for patients with chronic and disabling disorders known as the Jade SNPs - one or more of the following chronic diseases is required depending on the specific plan:

1. Diabetes
2. Chronic Heart Failure
3. Cardiovascular Disorders:
   - Cardiac Arrhythmias
   - Coronary Artery Disease
   - Peripheral Vascular Disease
   - Chronic Venous Thromboembolic Disorder

Health Net SNPs 2017

D-SNPs for patients that are dually eligible for Medicare and Medicaid:

- *Amber I (CA)*
- *Amber II (CA)*
- *Amber II Premier (CA)*
- *Amber (AZ)*

C-SNPs for patients with chronic and disabling disorders:

- *Jade (CA) for Chronic Heart Failure, Diabetes, CV Disorders*
- *Jade (AZ) for Diabetes, Chronic Heart Failure*
- *Jade Cardio (AZ) for CV Disorders*
- *Jade (OR) for Chronic Heart Failure, Diabetes, CV Disorders*

Health Net SNPs
Jan 2017

HNCA	Enrollment
Jade	6.919
Amber I	1,074
Amber II	8,513
Amber II Premier	113
HNAZ	
Amber	745
Jade	2,249
Jade Cardio	343
HNOR	
Jade	3,958

SNP Plans by State and County

HNCA	
Jade	Kern, Los Angeles, Orange
Amber I	Kern, Los Angeles, Orange, Riverside, San Bernardino
Amber II	Kern, Los Angeles, Orange, Riverside, San Bernardino, San Francisco, San Diego, Fresno, Tulare
Amber II Premier	Fresno
HNAZ	
Amber	Maricopa
Jade and Jade Cardiovascular	Maricopa, Pinal
HNOR	
Jade	Clackamas, Multnomah, Polk, Washington, Yamhill, Linn, Benton

Vulnerable SNP Sub-Populations

Populations at greatest risk are identified in order to direct resources towards the patients with increased need for case management services.

- Complex and multiple chronic conditions – patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems
- Disabled- patients who are unable to perform key functional activities independently such as ambulation, eating or toileting, such as members who have suffered an amputation and blindness due to their diabetes
- Frail – may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF that increase frailty
- Dementia – patients at risk due to moderate/severe memory loss or forgetfulness
- End-of Life- patients with terminal diagnosis such as end-stage cancers, heart or lung disease

Benefits to Meet Specialized Needs

- **Decision Power Disease Management** – whole person approach to wellness with comprehensive online and written educational and interactive health materials
- **Medication Therapy Management** – a pharmacist reviews medication profile quarterly and communicates with member and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** – the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP and region
- In addition, SNP plans may have benefits for **Dental, Vision, Podiatry, Gym Membership, Hearing Aides or lower costs for items such as Diabetic Monitoring supplies, Cardiac Rehabilitation** – these benefits vary by region and type of SNP

Language/Communication Resources

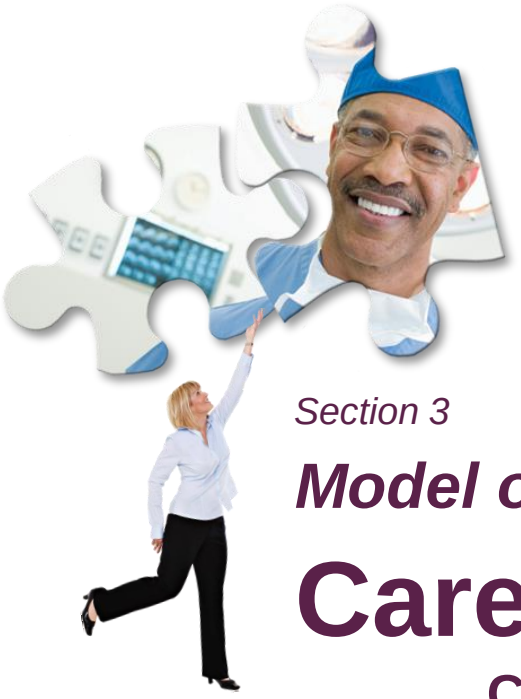
SNP patients may have greater incidence of limited English proficiency, health literacy issues and disabilities that affect communication and have negative impact on health outcomes.

- Office interpretation services- in-person and sign-language with minimum of 3-5 days notice
- Health Literacy - training materials and in-person training available)
- Cultural Engagement – training materials and in-person training available
- Health Net translates vital documents
- 711 relay number for hearing impaired

Communication Systems

Multiple communication systems are necessary to implement the SNP care coordination requirements:

- An **Electronic Medical Management System** for documentation of case management, care planning, input from the interdisciplinary team, transitions, assessments and authorizations
- A **Customer Call Center** to assist with enrollment, eligibility and coordination of benefit questions and able to meet individual communication needs (language or hearing impairment)
- A secure **Provider Portal** to communicate HRA results and new member information to SNP delegated medical groups
- A **Member Portal** for access to online health education, interactive programs and the ability to create a personal health record
- **Member and Provider Communications** such as member and provider newsletters and educational outreach may be distributed by mail, phone, fax or online



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Section 3

Model of Care 2

Care Coordination

Case Management
Health Risk Assessments
Individualized Care Plan
Interdisciplinary Care Team
Care Transitions

Patient Centric

- Patient is informed of and consents to Case Management
- Patient participates in development of their Care Plan
- Patient agrees to the goals and interventions of their Care Plan
- Patient informed of Interdisciplinary Care Team (ICT) members and meetings
- Patient either participates in the ICT meeting or provides input through the Case Manager and is informed of the outcomes
- Patient satisfaction with the SNP Program is measured annually

Evidence Based Case Management (CM)

- All SNP patients ~~enrolled in~~ case management and notified of CM single point of contact by letter/follow-up phone call
- Patients may opt out of active case management but Case Manager continues to attempt an annual contact or when change in status or transition in care.
- Patients are stratified according to their risk profile and Health Risk Assessment (HRA) to focus resources on most vulnerable (frail, disabled, chronic diseases)
- Patients with only a behavioral health diagnosis (drug/alcohol, schizophrenia, major depressive, bipolar/paranoid) receive primary case management from MHN, Health Net's Behavioral Health provider
- Contingency planning is in place to avoid disruption of services for events such as disasters

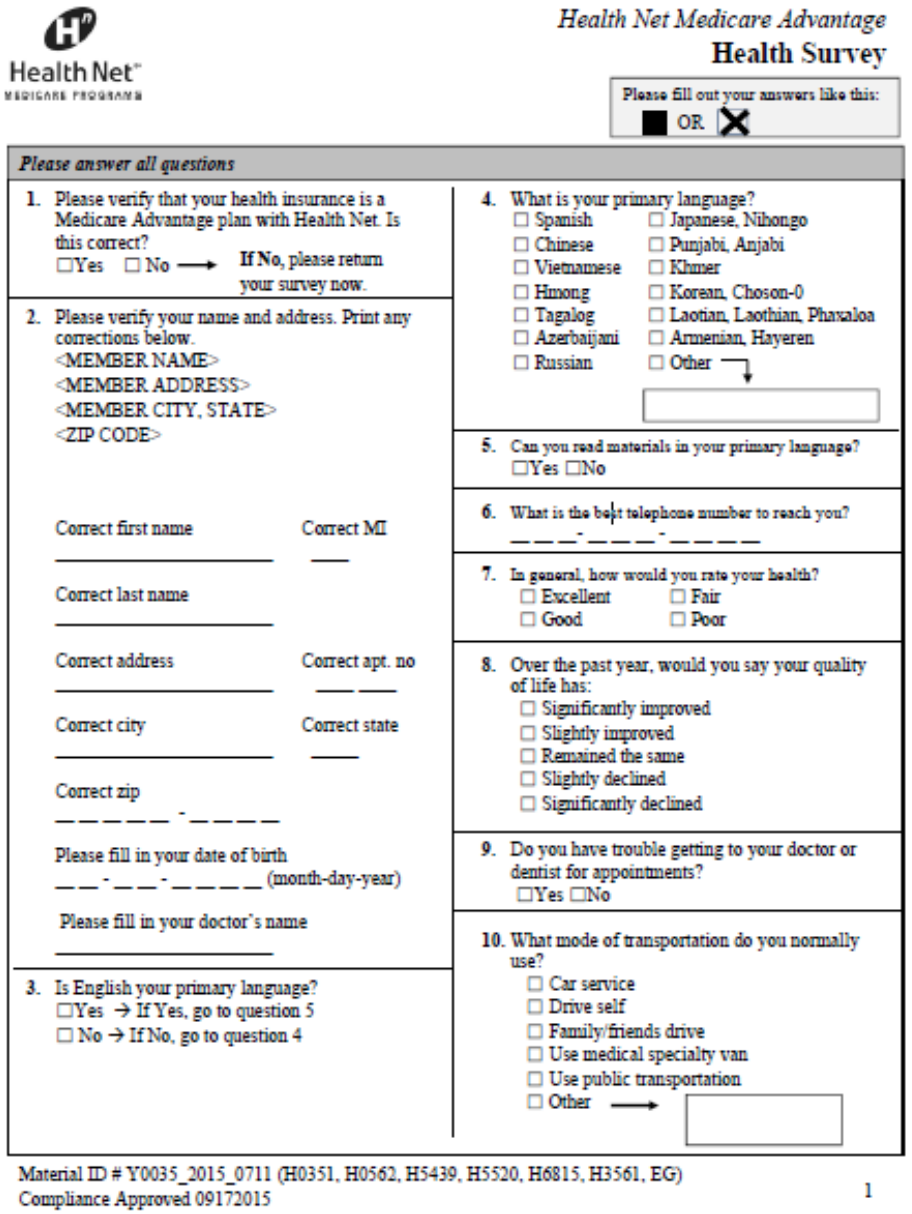
Roles of the Case Manager:

- Performs a health risk assessment of medical, psychosocial, cognitive and functional status
- Develops a comprehensive individualized care plan with member input
- Identifies barriers to goals and strategies to address
- Discusses member care at Interdisciplinary Care Team (ICT) meetings.
- Provides personalized education for optimal wellness
- Encourages preventive care such as flu vaccines and mammograms
- Reviews and educates on medication regimen
- Promotes appropriate utilization of benefits
- Assists member to access community resources
- Assists caregiver when member is unable to participate
- Assesses cultural and linguistic needs and preference
- Coordinates care with primary care physician

Health Risk Assessment (HRA)

- An HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks
- Health Net attempts to complete initial HRA telephonically within 90 days of enrollment and annually or if there is a change in the patients condition or transition of care
- Multiple attempts are made to contact the patient including mailed surveys and e-mail reminders
- The patient's HRA responses are used to identify needs, incorporated into the member's care plan and communicated to care team via electronic medical management system, the provider portal or by mail
- Patient is reassessed if there is a change in health condition and these and annual updates are used to update the care plan

- Encourage patients to complete HRA when they are called or it is mailed to them
- Explain the information helps the Case Manager and ICT to meet their healthcare needs
- Register for and check the provider portal regularly for new HRAs
- Use the HRA responses to stratify patient outreach
- HRA is mailed to non-delegated provider groups



Health Net
MEDICARE PROGRAMS

Health Net Medicare Advantage
Health Survey

Please fill out your answers like this: ■ OR ☒

Please answer all questions

1. Please verify that your health insurance is a Medicare Advantage plan with Health Net. Is this correct?
   ☐Yes ☐No → **If No**, please return your survey now.

2. Please verify your name and address. Print any corrections below.
   <MEMBER NAME>
   <MEMBER ADDRESS>
   <MEMBER CITY, STATE>
   <ZIP CODE>

   Correct first name _____ Correct MI ___
   Correct last name _____
   Correct address _____ Correct apt. no ___ ___
   Correct city _____ Correct state ___
   Correct zip _____-_____
   Please fill in your date of birth ___-___-_____ (month-day-year)
   Please fill in your doctor's name _____

3. Is English your primary language?
   ☐Yes → If Yes, go to question 5
   ☐No → If No, go to question 4

4. What is your primary language?
   ☐ Spanish ☐ Japanese, Nihongo
   ☐ Chinese ☐ Punjabi, Anjabi
   ☐ Vietnamese ☐ Khmer
   ☐ Hmong ☐ Korean, Choson-0
   ☐ Tagalog ☐ Laotian, Laothian, Phaxaloa
   ☐ Azerbaijani ☐ Armenian, Hayeren
   ☐ Russian ☐ Other →

5. Can you read materials in your primary language?
   ☐Yes ☐No

6. What is the best telephone number to reach you?
   ___-___-____

7. In general, how would you rate your health?
   ☐ Excellent ☐ Fair
   ☐ Good ☐ Poor

8. Over the past year, would you say your quality of life has:
   ☐ Significantly improved
   ☐ Slightly improved
   ☐ Remained the same
   ☐ Slightly declined
   ☐ Significantly declined

9. Do you have trouble getting to your doctor or dentist for appointments?
   ☐Yes ☐No

10. What mode of transportation do you normally use?
    ☐ Car service
    ☐ Drive self
    ☐ Family/friends drive
    ☐ Use medical specialty van
    ☐ Use public transportation
    ☐ Other →

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Individualized Care Plan (ICP)

Created for each patient by the Case Manager with input from the care team. The patient and/or caregiver is involved in development of and agrees with the care plan and goals:

- Based on the patient's assessment and identified problems
- Goals are prioritized considering patient's personal preferences and desired level of involvement in the process
- Updated when change such as new diagnosis/hospitalization or at least annually and communicated to ICT and patient
- Accessible/shared with members of the ICT including patient and provider
- Includes patient's self-management plans and goals
- Includes description of services tailored to patient's needs
- Includes barriers and progress towards goals

ICP **Must** Address All Risks Identified in HRA and/or Other Sources

HRA/Assessment/Claims	Risks
Medical History Gap Reports Utilization Reports	Diabetes Obesity Lack of medication adherence Recent ER visit for fall
Labwork/ biometrics	HgA1c - 9 BMI – 31
Mental Health	Positive depression screen
Health Behaviors	Does not get annual Flu vaccine
Psychosocial	No transportation to Dr. appts

Goals for Each Risk Identified **Must** be Specific, Measureable and Include Date to be Achieved

Risk	Specific and Measurable Goal Established with Patient
Poor Medication Adherence	Patient will report taking diabetes medications daily at each monthly call and will not be on care gap list by March.
Positive Depression Screen	Patient will report discussing emotional health with PCP at next doctor appointment on April 20th.
Obesity – BMI	Patient will lose 5 pounds over next 6 months
Fall Risk	Patient will report going to gym once per week during monthly calls
Lack of Annual Flu vaccine	Patient will get flu vaccine by November 1.
Lack of transportation	Patient will successfully utilize transportation benefit for next doctor appointment on April 20th

ICP **Must** Include Actions to Achieve Goals

Risks	Actions to Achieve Goals
Poor control of Diabetes Obesity Poor medication adherence Recent ER visit for fall	Provide Diabetes and diet education. Set exercise and weight loss goals with patient Review medication regime and provide adherence tips to address individual barriers Fall prevention education and to discuss with doctor
HgA1c - 9 BMI – 31	Monitor lab work and weight for improvement
Positive depression screen	Referral to MHN
Does not get annual Flu vaccine	Educate on importance of vaccine, address barriers to obtaining vaccine
No transportation to Dr. appts	Educate on benefit and provide contact information

Must Document Care Plan Implementation

Goal	Case Manager Notes
Poor Control of Diabetes	2/15/16 *Reviewed diet with patient – she reports eating smaller portions since last call and diet education.*
Poor Medication Adherence	1/15/16 *Review of diabetes medications and proper admin– patient verbalizes understanding. Encouraged to use pill box.*
Positive Depression Screen	3/21/16 *Patient refused referral to MHN – states she will discuss with her doctor at April visit.*
Obesity – BMI	4/21/16 *Patient states she only lost 2 lbs at Doctor visit yesterday. Reviewed concept of steady and slow weight loss.*
Fall Risk	2/15/16 *Patient reports she is taking 15 minute walk once a day and will increase to 20 minutes next week*.
Lack of Annual Flu vaccine	9/15/16 *Review of importance of Flu vaccine – patient still concerned it will make her sick. Addressed barriers.*
Lack of transportation	3/21/16 *Patient has contacted transportation company and arranged ride to 4/20 Dr. appointment*

Interdisciplinary Care Team (ICT)

The Health Net, MHN or delegated Case Manager coordinates the ICT which communicates regularly to manage the patient's medical, cognitive, psychosocial and functional needs. The patient and/or caregiver is included on the ICT whenever possible:

- Required Team Members

Medical Expert
Social Services Expert
Mental/Behavioral Health Expert – when indicated

- Additional Team Members could be

Pharmacist
Health Educator
Restorative Therapist
Nutrition Specialist
Nursing/Disease Management

- Communication plan for regular exchange of information within the ICT including accommodations for members with sensory, language or cognitive barriers

Care Transition Protocols

Patients are at risk of adverse outcomes when there is transition between settings (in or out of hospital, skilled or custodial nursing, rehabilitation center, outpatient surgery centers or home health)

- Patients experiencing an inpatient transition are identified and managed (pre-authorization, facility notification, census)
- Important elements (diagnoses, medications, treatments, providers and contacts) of the patient's care plan transferred between care settings before, during and after a transition
- Patient knowledgeable of health information to communicate care to other healthcare providers in different settings
- Patient is educated about health status and self-management skills: discharge needs, meds, follow-up care, signs of change and how to respond (discharge instructions, post-discharge calls)

Patient Understanding of Instructions is Verified

- Studies show 40-80% of medical information is forgotten immediately
- Of the retained information, 50% is remembered incorrectly
- Especially important for telephonic case management
- "Teach Back" confirms the "teacher" has provided the essential information in a manner understandable to the patient

Examples:

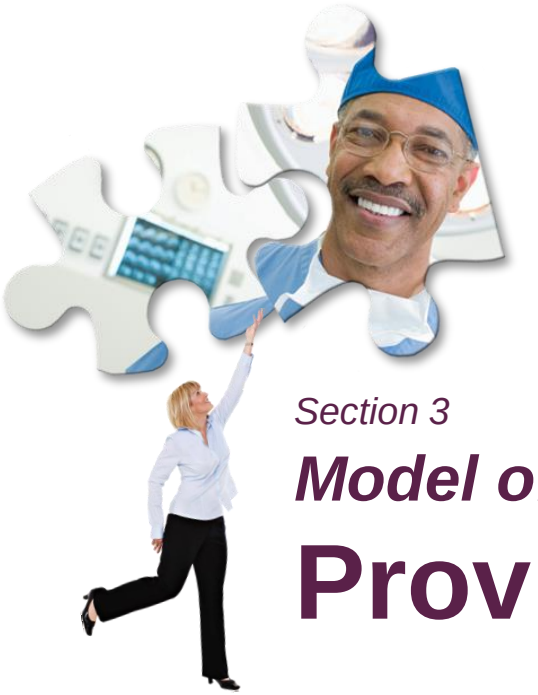
"I want to make sure I explained your medication correctly – can you tell me how you are going to take the ____?"

"I gave you a lot of information about Diabetes – can you tell me three things you are going to do today to improve control of your Diabetes?

- Provide clarification as needed until the patient is able to correctly describe **in their own words** what they are going to do

Specific Model of Care Survey Outcomes for Coordination of Care Goals

Goals	AZ	CA	OR
85% report they have medication and treatment information needed at discharge	91%	88%	93%
85% report they get needed help to coordinate care from doctor office	92%	98%	96%
59% have Health Risk Assessments completed within time frames	50%	48%	75%
90% report overall satisfaction with Case Management services	95%	90%	96%



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Section 3

Model of Care 3

Provider Network

Specialized Provider Network

Clinical Practice Guidelines

Model of Care Training

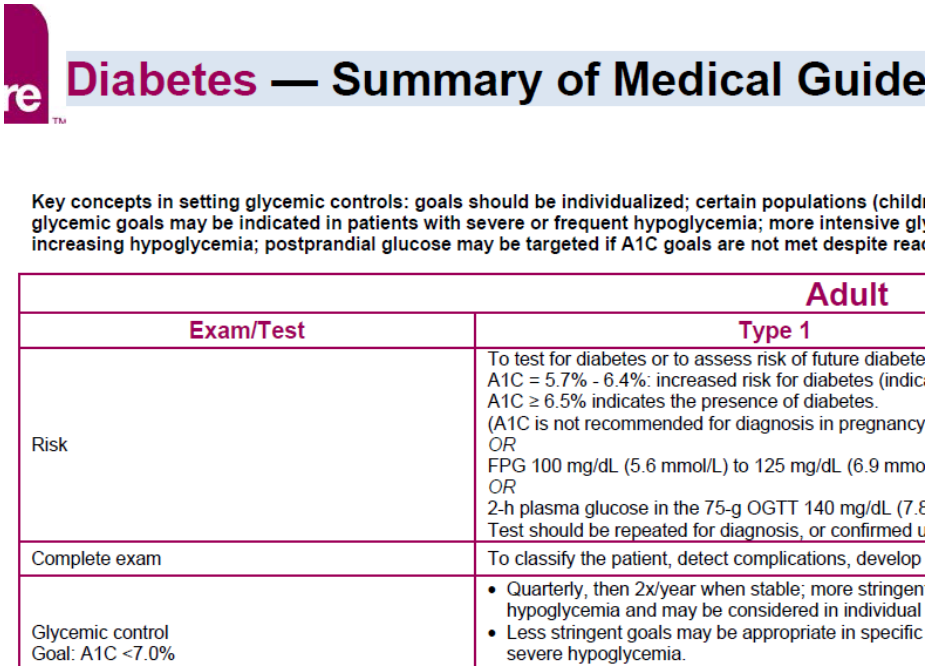
Specialized Provider Network

- Health Net maintains a comprehensive network of primary care providers and specialists such as cardiologists, neurologists and behavioral health practitioners to meet the health needs of chronically ill, frail and disabled SNP patients
- Team based case management is provided by Health Net when it is not delegated to the patient's primary care provider and medical group
- Delegated medical groups must demonstrate capability to meet the team based care requirements
- The Delegation Oversight team conducts audits to monitor that delegated medical groups meet the SNP Model of Care requirements

Jade C-SNPs – Diabetes

In addition to a Provider Network with practitioners and specialists skilled in managing patients with Diabetes, the program has:

- Disease Management to assist patients to manage their Diabetes
- Interactive programs for healthy activity and weight control
- Additional benefits (vary by plan) can include zero cost for Diabetic monitoring supplies, low cost Podiatrist visits
- Clinical Practice Guidelines for Diabetes and other chronic diseases located on the Provider Portal



re Diabetes — Summary of Medical Guide

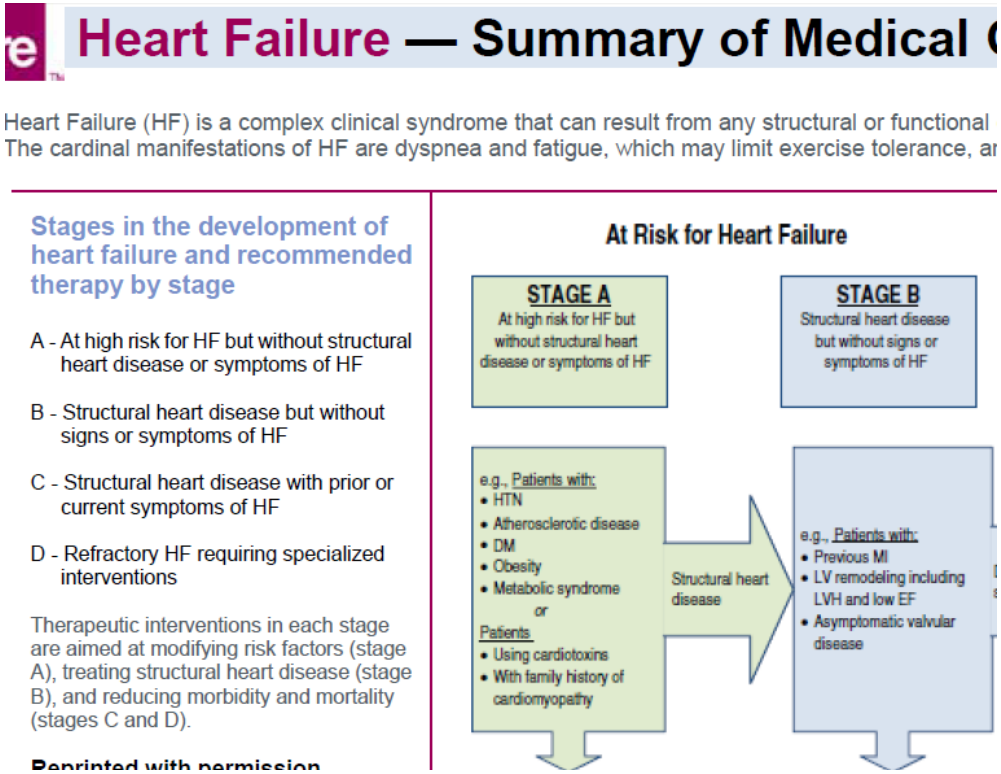
Key concepts in setting glycemic controls: goals should be individualized; certain populations (childr glycemic goals may be indicated in patients with severe or frequent hypoglycemia; more intensive gly increasing hypoglycemia; postprandial glucose may be targeted if A1C goals are not met despite reac

	Adult
Exam/Test	Type 1
Risk	To test for diabetes or to assess risk of future diabete A1C = 5.7% - 6.4%: increased risk for diabetes (indic A1C ≥ 6.5% indicates the presence of diabetes. (A1C is not recommended for diagnosis in pregnancy *OR* FPG 100 mg/dL (5.6 mmol/L) to 125 mg/dL (6.9 mmo *OR* 2-h plasma glucose in the 75-g OGTT 140 mg/dL (7.8 Test should be repeated for diagnosis, or confirmed u
Complete exam	To classify the patient, detect complications, develop
Glycemic control Goal: A1C <7.0%	• Quarterly, then 2x/year when stable; more stringen hypoglycemia and may be considered in individual • Less stringent goals may be appropriate in specific severe hypoglycemia.

Jade C-SNPs – Chronic Heart Failure and Cardiovascular Disease

In addition to a Provider Network with practitioners and specialists skilled in managing patients with Cardiovascular Disease, the program has available:

- Disease Management to assist patients to manage their Cardiovascular disease
- Additional benefits (vary by plan) can include zero cost cardiac rehab services
- Clinical Practice Guidelines for Chronic Heart Failure located on the Provider Portal



Heart Failure — Summary of Medical

Heart Failure (HF) is a complex clinical syndrome that can result from any structural or functional
The cardinal manifestations of HF are dyspnea and fatigue, which may limit exercise tolerance, ar

Stages in the development of heart failure and recommended therapy by stage

A - At high risk for HF but without structural heart disease or symptoms of HF

B - Structural heart disease but without signs or symptoms of HF

C - Structural heart disease with prior or current symptoms of HF

D - Refractory HF requiring specialized interventions

Therapeutic interventions in each stage are aimed at modifying risk factors (stage A), treating structural heart disease (stage B), and reducing morbidity and mortality (stages C and D).

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At Risk for Heart Failure

STAGE A
At high risk for HF but without structural heart disease or symptoms of HF

STAGE B
Structural heart disease but without signs or symptoms of HF

e.g., Patients with:
- HTN
- Atherosclerotic disease
- DM
- Obesity
- Metabolic syndrome

or

Patients
- Using cardiotoxins
- With family history of cardiomyopathy

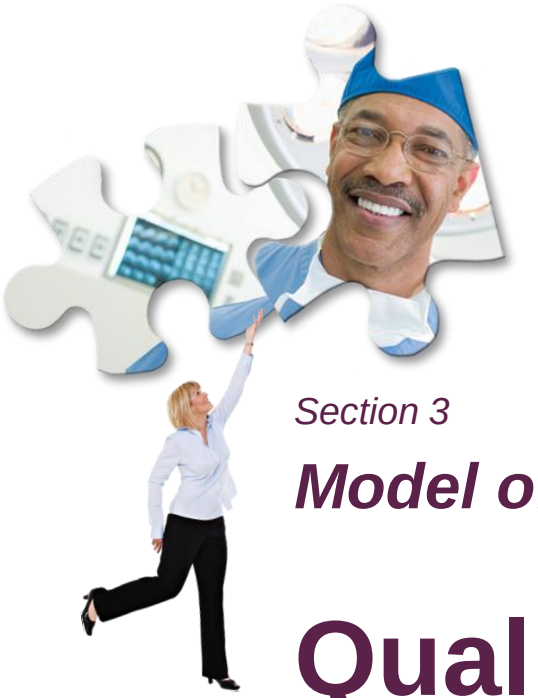
Structural heart disease

e.g., Patients with:
- Previous MI
- LV remodeling including LVH and low EF
- Asymptomatic valvular disease

D-SNPs -Coordinating Medicare and Medicaid

The goals of coordination of Medicare and Medicaid benefits for members that are dual-eligible:

- Members informed of benefits offered by both programs
- Members assisted to maintain Medicaid eligibility
- Member access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and Medicaid claims when Health Net is contractually responsible
- Members informed of rights to pursue appeals and grievances through both programs
- Members assisted to access providers that accept Medicare and Medicaid



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Section 3

Model of Care 4

Quality Improvement

Measureable Goals

Evaluation of Performance

Communicate Progress Towards Goals

Quality Improvement Program

Health Plans offering a SNP must conduct a Quality Improvement program to monitor health outcomes and implementation of the Model of Care by:

- Identifying and defining measurable Model of Care goals and collecting data to evaluate annually if measurable goals are met
- Collecting SNP specific HEDIS® measures (appendix)
- Conducting a Quality Improvement Project (QIP) annually that focuses on improving a clinical or service aspect that is relevant to the SNP population (Preventing Readmissions) (Osteoporosis Management)
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness (Adherence to Cardiovascular Medications)
- Communicating goal outcomes to stakeholders

Data Collection

Data is collected, analyzed and evaluated from multiple domains of care to monitor performance and identify areas for improvement:

- Health Outcomes
- Access To Care
- Improved Health Status
- Implementation Of MOC
- Health Risk Assessment
- Implementation Of Care Plan
- Provider Network
- Continuum Of Care
- Delivery Of Extra Services
- Communication Systems

Questions? Best Practices?

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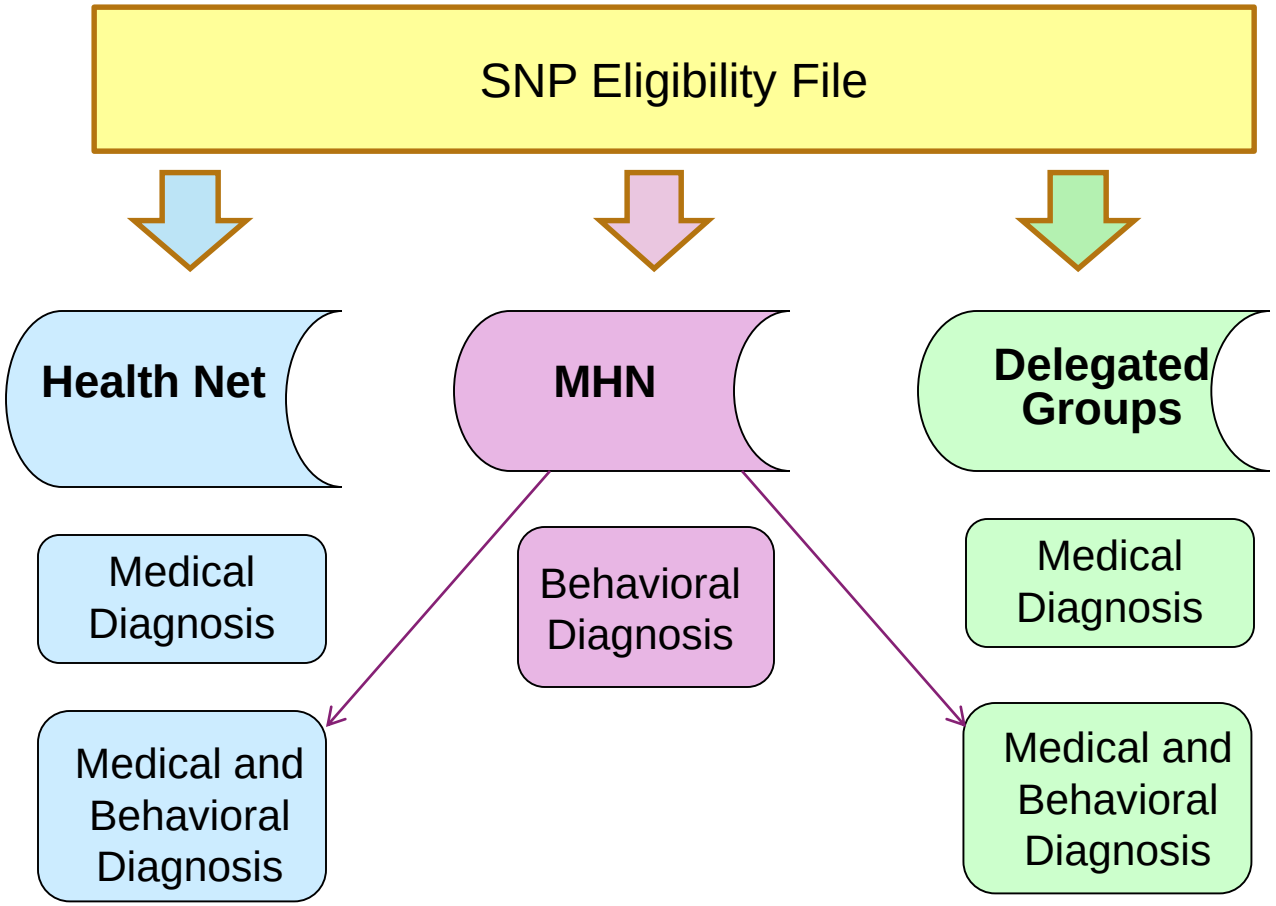
Section 4

Appendix

Flow Charts
Types of Case Management
HEDIS Measures
References

SNP Case Management Flowchart



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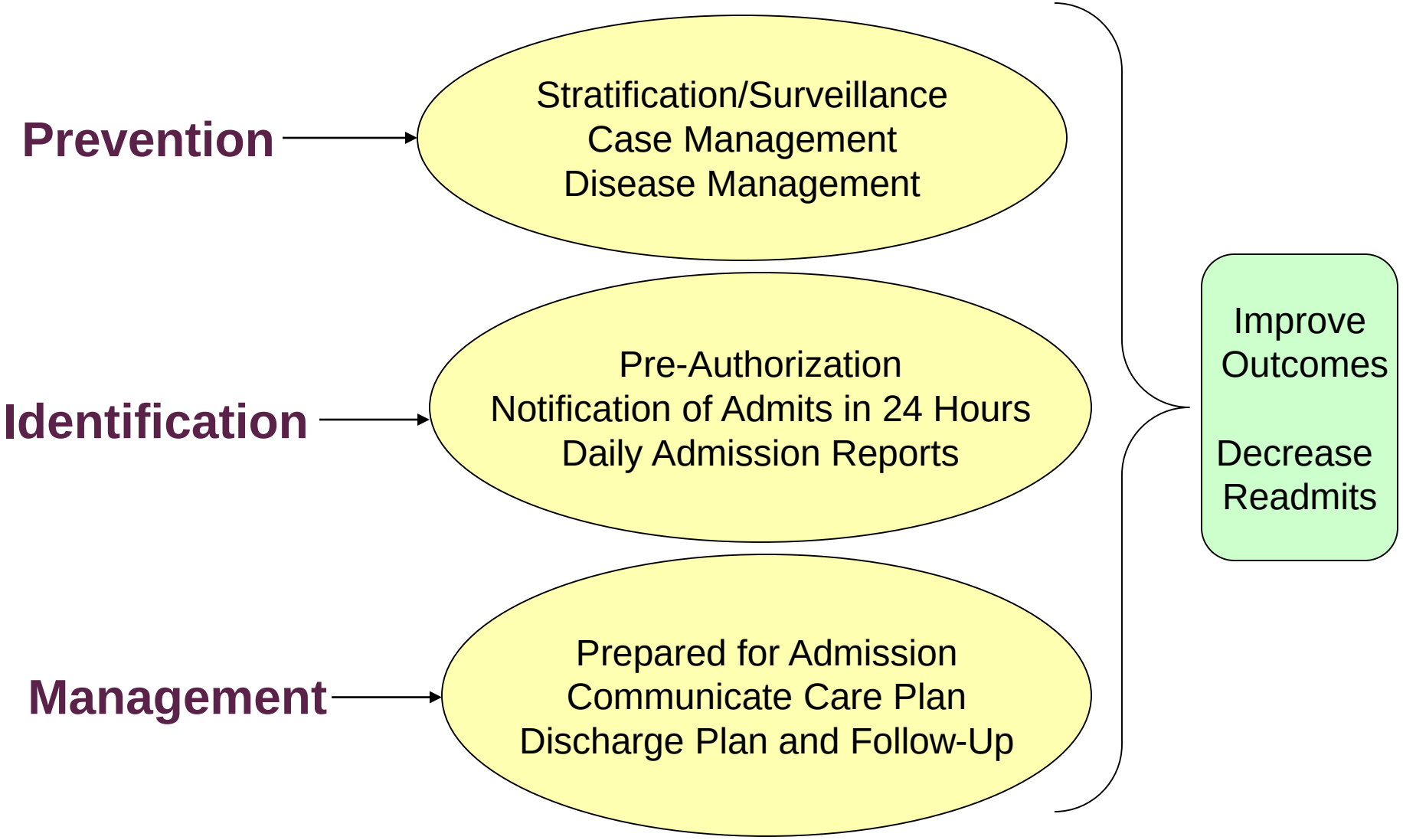
Health Net Types of Case Management

	SNP Complex Case Management	Complex Case Management	Ambulatory Case Management
Length of Enrollment	Continuous for all SNP members	Short-term for catastrophic or terminal diagnosis	Short-term to meet coordination of care needs
Components	Annual HRA Assessment Care Plan ICT Coordination of Care	Assessment Care Plan Home Visits Coordination of Care	Assessment Care Plan Coordination of Care
Identification	Referral/Predictive modeling to move members between care levels per need	Referral/Predictive modeling – less than 1% of members	Referral/Predictive modeling – ex. transplants, maternity, hi-risk
Membership	SNP Members	All lines of business	All lines except SNP

Care Transitions Process



SNP HEDIS® Measures

- Colorectal Cancer Screening
- Spirometry Testing for COPD Pharmacotherapy
- Management of COPD Exacerbations
- Controlling High Blood Pressure
- Persistence of Beta-Blockers after Heart Attack
- Osteoporosis Management Older Women with Fracture
- Medication Reconciliation Post-Discharge
- All Cause Readmission
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental illness
- Annual Monitoring for Persistent Medications
- Potentially Harmful Drug Disease Interactions
- Use of High Risk Medications in the Elderly
- Care for Older Adults
- Board Certification

References

- Chapter 5 of the Medicare Managed Care Manual
- Title 42, Part 422, Subpart D, 422.152
- www.cms.gov/Medicare/HealthPlans/SpecialNeedsPlans
- Model of Care Scoring Guidelines CY 2018 (2/10/17)
- Chapter 16B Special Needs Plans of the Medicare Managed Care Manual

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