COURSE NOTES

INTRODUCTION

The goal of this course is to explain the Model of Care requirements that must be met by a Special Needs Plan (SNP). These requirements, outlined in federal regulations and in the Centers for Medicare & Medicaid (CMS) guidance, provide the framework to help us deliver high-quality and coordinated care to our SNP members.

As you will learn in this course, to comply with the SNP requirements, you need to:

- Learn about the CMS SNP Model of Care requirements.
- Learn about your region's SNP Model of Care.
- Complete SNP Model of Care training every year.

WHY IS SNP COMPLIANCE IMPORTANT?

SNP compliance is important because:

- To operate a SNP, CMS — in partnership with National Committee for Quality Assurance (NCQA) — must approve each SNP's Model of Care.
- The SNP Model of Care is one of the functional areas included in the CMS Program Audit.

MODULE 1: WHAT IS THE SNP MODEL OF CARE?

WHAT IS A SPECIAL NEEDS PLAN (SNP)?

In the Medicare Modernization Act of 2003 (MMA), the Federal Government created a new type of Medicare Advantage (MA) plan, called a Special Needs Plan (SNP), for individuals with complex, high cost, and high medical needs.

Three types of SNPs were authorized for specific populations:

- Dual Eligible SNP (D-SNP) — for individuals with both Medicare and Medicaid
- Chronic Care SNP (C-SNP) — for individuals with severe or disabling chronic conditions (qualifying conditions are determined by CMS)
- Institutional SNP (I-SNP) — for individuals who meet an institutional level of care, and either reside in an institution or receive these services in a home setting

Of these three, Kaiser Permanente offers only the D-SNP, which targets the dual eligible population.

COURSE NOTES

The SNP goals are to improve member care and quality in the following areas:

- Health outcomes
- Access to medical, mental health, and social services
- Access to affordable care
- Coordination of care through an identified point of contact
- Transitions of care across health care settings
- Access to preventive health services
- Appropriate use of services

WHAT IS THE SNP MODEL OF CARE?

The SNP Model of Care (MOC) is a set of requirements established by the Centers for Medicare & Medicaid Services (CMS) to define the administrative, care delivery, and quality improvement requirements for a SNP.

To operate a SNP, every health plan must submit a MOC narrative to CMS/NCQA (National Committee for Quality Assurance) for approval. The narrative explains how the SNP will comply with the SNP MOC requirements and coordinate care for its members.

MOC ELEMENTS

To understand the SNP MOC, the modules in this course will explain these four elements of the MOC:

1. Description of the SNP Population
2. Care Coordination
3. SNP Provider Network
4. MOC Quality Measurement and Performance Improvement

WHY IS THE MODEL OF CARE IMPORTANT?

The MOC is important because:

- Each SNP must maintain a MOC narrative approved by CMS/NCQA.
- Each SNP's MOC narrative must describe how it will address the specific needs of its members and comply with CMS requirements.
- CMS audits SNPs against their approved MOC narrative.

COURSE NOTES

MODULE 2: SNP POPULATION REQUIREMENTS

The SNP population description lays the foundation for all of the other MOC elements. At Kaiser Permanente, we offer the dual eligible SNP, which means the eligible population must have both Medicare AND Medicaid.

In addition to eligibility, the MOC population description includes socio-demographic, medical and health characteristics, and related challenges. For example, low health literacy may contribute to adverse health care outcomes. Understanding these unique characteristics allows us to better care for these SNP members.

CMS requires that member eligibility is verified before enrollment and on an ongoing basis. When members lose their Medicaid eligibility, they must be involuntarily disenrolled from the SNP, unless they requalify during an established grace period.

POPULATION REQUIREMENTS IN THE MOC

In the MOC, the SNP must describe their target population which includes, but is not limited to, the following:

- Population demographics
  - Average age, gender, and ethnicity
  - Language barriers
  - Socioeconomic status
  - Environmental and/or living conditions
  - Cultural beliefs and/or barriers
- A detailed profile of the status of the members (medical, social, and cognitive) including:
  - The incidence and prevalence of major diseases and chronic conditions
  - Other significant barriers faced by the target population
  - Comorbidities
  - Deficits in health literacy
  - Caregiver considerations

THE MOST VULNERABLE BENEFICIARIES

The MOC must also identify the most vulnerable beneficiaries it serves. Vulnerable beneficiaries are those with the greatest needs, such as frailty, disability, severe and persistent mental illness, end-of-life, or complex chronic conditions.

For this group, the MOC must explain:

- How this sub-population is identified
- Their demographic characteristics (average age, gender, ethnicity, language barriers, deficits in health literacy, socioeconomic status) and how their health outcomes are affected
- Their need for unique clinical intervention
- What services and/or resources are provided to address their medical and/or social factors
- The specially tailored services that are provided
- How community-based partnerships are established to provide needed resources and/or services

MODULE 3: CARE COORDINATION REQUIREMENTS

Care coordination helps ensure that the needs of SNP members are met, such as:

- Health care needs
- Preferences for health services
- Information sharing across health care staff and facilities

Care coordination also maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved health care outcomes.

CARE COORDINATION IN THE MODEL OF CARE

In the MOC, the SNP must explain the care coordination process, including:

- How staff roles and responsibilities, both indirectly and directly, support the D-SNP population
- How the Health Risk Assessment (HRA) process is conducted
- How the Individual Care Plans (ICP) are created and updated
- How the Interdisciplinary Care Team (ICT) develops the ICP and coordinates member care
- How patient transitions between care settings are managed

COURSE NOTES

D-SNP STAFF STRUCTURE

Describe staff roles and responsibilities for the following:

- Care coordination
- Direct enrollee care and education of self-management techniques
- Pharmacy consultation
- Behavioral counseling
- Annual MOC training processes and policies

THE HEALTH RISK ASSESSMENT PROCESS (HRA)

Every SNP member must receive an initial HRA within 90 days pre or post enrollment in SNP.

The SNP must use the HRA to assess the member's:

- Medical status
- Functional status
- Mental health status
- Cognitive status
- Psychosocial status

Reassessments must be completed within 365 days from the last assessment, or more frequently as needed. For example, if there's a change in the member's health status or a care transition.

HRA PROCESS IN THE MOC

In the MOC, the SNP must describe how the HRA process works:

- How the initial and annual HRA assessments are conducted
- Who conducts the HRA
- How the results are analyzed and stratification process
- How the HRA information is disseminated to:
  - The ICT
  - The member and caregivers
  - Other SNP personnel who oversee the member's ICP
- How the HRA results are used to inform the development of an ICP
- How the plan outreaches to members that are unable to reach

THE INDIVIDUALIZED CARE PLAN (ICP)

Each SNP member must have an ICP that contains:

- The member's self-management goals and objectives
- The member's personal healthcare preferences
- A description of the specific services for the member
- A description of the SNP's goals and objectives for the member
- Identification of goals (met or not met)

- If the enrollee's goals are not met, the MOC must describe the plan's process for reassessing the current ICP and determining the appropriate alternative actions as well as providing the update(s).

The ICP drives the care the member receives. Development of comprehensive ICPs includes identifying goals and objectives, including measurable outcomes, considering all results from the HRAs, while focused on conditions a member chooses to pursue.

ICP REQUIREMENTS IN THE MOC

In the MOC, the SNP must explain how the ICP is developed and maintained:

- Which staff uses the HRA results to develop the member's ICP
- How the member and/or caregiver is involved in developing the ICP
- How the ICP is reviewed and updated (at least annually, or more frequently when a member experiences a change in health status or health setting)
- Where the ICP is documented, maintained, and made accessible to the ICT, provider network, and members and/or their caregivers
- How updates to the ICP are communicated to the member, caregiver, and providers
- When ICP goals are met or not met, how the ICP is revisited and actions documented

THE INTERDISCIPLINARY CARE TEAM (ICT)

Each SNP member must be assigned to an ICT. The ICT is responsible for:

- Analyzing and incorporating the member's HRA results into the ICP
- Facilitating member and caregiver participation in the ICT
- Collaborating to develop, and update at least annually, an ICP for each member
- Continuously using health care outcomes to evaluate processes and to manage changes to the ICP
- Coordinating and communicating care and services based on the ICP

ICT REQUIREMENTS IN THE MOC

In the MOC narrative, the SNP must explain how the ICT works:

- How the ICT is staffed (must align with the member's needs, as identified through the HRA and ICP)
- How the ICT facilitates the participation of members and/or caregivers
- How the ICT contributes to

improving the health status of SNP members

- How member information is communicated regularly within the ICT (between SNP personnel and with members and/or caregivers) and how this communication is documented
- How the stratified HRA results are used to determine the composition of the ICT

The composition of the ICT changes in response to changes in the member's needs. For example, when new healthcare needs or conditions are identified, additional specialists might be added to the team.

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CARE TRANSITION

When a SNP member transitions from one care setting to another, the ICT ensures that care transition protocols are followed to maintain the member's continuity of care.

In the MOC, the SNP must explain how the care transition process works:

- How members and caregivers are notified of their point of contact
- How the member's individual care plan is transferred between care settings
- How members and caregivers can send their protected health information (PHI) to providers
- How follow-up services and appointments are scheduled and completed
- How members are educated about their condition and appropriate self-management activities

FACE-TO-FACE ENCOUNTERS

All SNPs must provide for face-to-face encounters for the delivery of health care, care management or care coordination services.

Face-to-face encounters must occur, as feasible and with the individual's consent, on at least an annual basis beginning within the first 12 months of enrollment.

A face-to-face encounter must be either in-person or through a visual, real-time, interactive telehealth encounter.

The face-to-face encounter must be between each enrollee and a member of the enrollee's ICT, the plan's case management and coordination staff or contracted plan healthcare providers

such as: the enrollee's regular primary care physician, a specialist related to the enrollee's chronic condition, a behavioral health provider, health educator, social worker and Managed Long-Term Services and Support (MLTSS) plan staff or related MLTSS health care provider.

The plan must address the consent process for both in-person and virtual face-to-face encounters. If the enrollee refuses an annual face-to-face encounter or if the SNP was unable to reach the enrollee after a reasonable number of attempts, the plan would be considered to have complied with the requirement despite the lack of a qualified encounter. However, plans should document the basis or reason that a face-to-face encounter is not feasible.

Examples of the necessary services or engagement during the face-to-face encounter include but are not limited to:

- Engaging with the enrollee to manage, treat and oversee or coordinate their health care, e.g., furnishing preventive care included in the ICP.
- Annual wellness visits and/or physicals.
- Completion of a health risk assessment, e.g., initial health risk assessment, reassessment.
- Care plan review or other similar care coordination activities.
- Health related education whereby the enrollee receives information or instructions critical to the maintenance of their health or implementing processes for maintaining the enrollee's health, such as the administration of a medication.

MODULE 4: PROVIDER NETWORK REQUIREMENTS

SNP PROVIDER NETWORK IN THE MOC

The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP members. In the MOC, the SNP must fully describe the following about the provider network:

- Specialized expertise provided
- Clinical practice guidelines
- SNP MOC training

Let's look at what each of these contains.

PROVIDER EXPERTISE

CMS requires that providers have the expertise that SNP members need and be qualified and appropriately credentialed. For example, if a SNP population has a high prevalence of cancer, the SNP must ensure its network has an adequate

number of oncologists to address the needs of these members. In the MOC, the SNP must explain the expertise of their providers, including areas of specialization and how their providers:

- Collaborate with the Interdisciplinary Care Team (ICT) and the member.
- Contribute to the Individual Care Plan (ICP).
- Ensure services are effective and delivered in a timely manner.

At Kaiser Permanente, our provider network includes licensed and competent providers with specialized expertise to address the needs identified in the MOC population description and the most vulnerable population.

CLINICAL PRACTICE GUIDELINES

CMS requires that SNPs have clinical practice guidelines (CPGs) and that nationally recognized protocols are used to provide care, when appropriate.

While the expectation is that providers refer to established CPGs, the guidelines do not take into account individual patient characteristics (such as past medical history and comorbidities) and therefore may not be appropriate in all cases. Accordingly, a provider ultimately determines the treatment and the best plan of care for the member.

MODEL OF CARE (MOC) TRAINING

CMS requires annual MOC training for providers to ensure they understand what the MOC is and why it's important.

At Kaiser Permanente, we provide annual training to all providers seen on a routine basis by SNP members, and we are required to document MOC training completions and address any challenges with completion of this training.

MODULE 5: QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT REQUIREMENTS

MOC QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

To effectively deliver high-quality health care services to SNP members, CMS requires that each SNP be actively involved in measuring, analyzing, evaluating, reporting, and improving the MOC's quality and performance.

In the MOC, the SNP must identify and define its measurable goals and health outcomes. Each SNP must also describe the process used to continuously assess and evaluate quality and performance improvement.

COURSE NOTES

THE QUALITY PERFORMANCE IMPROVEMENT PLAN

Each SNP must have a Quality Performance Improvement Plan to ensure the MOC effectively meets the needs of the SNP population. In this plan, the SNP must explain:

- How the Quality Performance Improvement Plan is developed and regularly monitored
- How specific measurable goals and health outcome measures are identified and used to assess the impact of the MOC
- How data is continuously collected and analyzed to evaluate the Quality and Performance Improvement Plan
- How actions to improve the MOC are documented and communicated

At Kaiser Permanente, each region has a comprehensive quality improvement program that measures quality and performance improvement to determine if systems and processes need to be modified.

QUALITY PERFORMANCE IMPROVEMENT PLAN REQUIREMENTS

In the MOC, the SNP must explain its ongoing plan for quality and performance improvement.

These five areas must be addressed:

1. Quality Performance Improvement Plan
2. Measureable goals and health outcomes
3. Measuring patient experience of care
4. Ongoing performance improvement evaluation of MOC
5. Dissemination of SNP quality performance related to the MOC

HEALTH CARE OUTCOMES

CMS requires that the Quality Performance Improvement Plan address four areas:

1. Improvement of healthcare access and affordability of the healthcare needs identified for the SNP population
2. Improvement of coordination of care and appropriate delivery of services through direct alignment of the HRA, ICP, and ICT
3. Enhanced care transitions across healthcare settings and providers
4. Appropriate use of services for preventive health and chronic conditions

Each of these areas must be linked to measurable goals with baselines, targets, time frames, and an indication of whether the goals were met.

HEALTH CARE OUTCOME REQUIREMENTS IN THE MOC

In the MOC, the SNP must describe:

- What specific data source(s) are used
- How the MOC's impact on the health outcomes of SNP members is assessed and tracked
- What processes and procedures are used to determine if the health outcomes/goals are met
- What specific steps are taken if goals are not met in the expected time frame

MEMBER SATISFACTION FEEDBACK

Including member satisfaction feedback is an important part of quality and performance improvement. CMS requires that each SNP describes how member satisfaction feedback is integrated into the SNP's overall Quality Performance Improvement Plan.

MEMBER SATISFACTION FEEDBACK REQUIREMENTS IN THE MOC

In the MOC, each SNP must explain:

- What tool is used to collect member satisfaction feedback
- How member satisfaction feedback is analyzed
- How frequently member satisfaction feedback is collected
- How the results are communicated and used to improve the MOC

EVALUATION AND COMMUNICATION

CMS expects each SNP to use the results from the health outcome and member satisfaction feedback analysis to regularly improve the MOC. This involves actively documenting the results (including when goals are not met), communicating them in a timely manner to key stakeholders, and modifying the MOC based on the results.

EVALUATION AND COMMUNICATION REQUIREMENTS IN THE MOC

In the MOC, the SNP must explain how the following stakeholders are informed about the results from the ongoing quality performance improvement process:

- SNP leadership and management groups
- SNP personnel and staff
- SNP provider network