Special Needs Plan (SNP) Model of Care Training 2021

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Important Note

SCAN's Special Needs Plan (SNP) Model of Care (MOC)Training

This applies to all Medical Groups who provide care for the SNP types below:

- Chronic Special Needs Plan (C-SNP) – Balance, Heart First, VillageHealth
- Dual Special Needs Plans (D-SNP) - Connections, Connections at Home
- Institutional Special Needs Plan (I-SNP) – Healthy at Home

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Questions from the Audience – update with Zoom

Chat

- Send chat to host or panelists
- Use the chat for comments or questions you don't want shared with everyone

Q & A

- Type question, hit send
- Questions may be answered out loud at the end of the webinar or via the Answer field

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Agenda and Presenters

Section	Presenter	Presenter Email
Introduction and Training Objectives	**Debbie Ong**, HCS Project Principal	debong@scanhealthplan.com
SNP and SCAN's Mission	**Dr. Payam Parvinchiha**, Corporate VP, Network Quality and Innovation	PParvinchila@scanhealthplan.com
CMS SNP Guidelines	**Lisa Roth**, VP Care Management and Social Support	LRoth@scanhealthplan.com
Provider Group Responsibilities	**Lisa Desai**, Director Provider Delegation Oversight	LDesai@scanhealthplan.com
HRAs (Health Risk Assessments), Care Plans and Triggers	**Amy Landers,** Manager Care Coordination	ALanders@scanhealthplan.com
Interdisciplinary Care Team (ICT)	**Maricris Tengco RN**, Director Care Coordination	mtengco@scanhealthplan.com
Individualized Care Plan (ICP)	**Jeanette Despal,** HCS Clinical Trainer	JDespal@scanhealthplan.com
Care Transitions	**Jeanette Despal,** HCS Clinical Trainer	JDespal@scanhealthplan.com
CM Referral Criteria	**Elizabeth Gomez**, Manager Care Coordination	EGomez2@scanhealthplan.com
Audit and Oversight	**Eliot Kreun**, Senior Network Compliance Auditor	EKreun@scanhealthplan.com
SNP MOC Training	**Debbie Ong**, HCS Project Principal	debong@scanhealthplan.com

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Learning Objectives

- Explain Your Requirements as a SNP Provider
- Describe SNP Basics
- Describe SNP Audit Requirements

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SNP and SCAN's Mission

CMS SNP Guidelines

The 4 elements of the SNP Model of Care

SNP Population

- Chronic Disease SNP (**C-SNP**)
- Fully Integrated Dual Eligible SNP (**FIDE –SNP)**
- Institutional SNP (**I-SNP**)

Care Coordination

- Health Risk Assessment (**HRA**)
- Individualized Care Plan (**ICP**)
- Interdisciplinary Care Team (**ICT**)
- Care Transitions (**CT**)

Provider Network

- Staff/providers deliver care to SNP members

Quality Measurement & Performance

- Quality Measure Monitoring
- SNP model of care program evaluation process (annual)
- Quality Improvement Plan

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SNP CMS Audit Findings

SCAN was audited by CMS in June, 2021

The audit followed 30 SNP member cases from HRA and Individualized Care Plan (ICP) development to Care Transitions

CMS Reviewed:

HRAs (initial and annual) creation and timeliness

Integrated Care Plans and their distribution

Anticipate follow-up audit within the next 6 months

Emphasis was on:

- Initial and annual HRA completion and timeliness
- Care Transitions and associated Individualized Care Plan updates and distribution
- SNP Care Management team proof of SNP Model of Care training (SCAN and Group personnel)

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Provider Group Responsibilities

Provider Group Responsibilities - Delegation

- Initial Health Assessment
- Care Management and Coordination
- Care Transitions
- Interdisciplinary Care Team (ICT)
- Model of Care Training
- Individualized Care Plan

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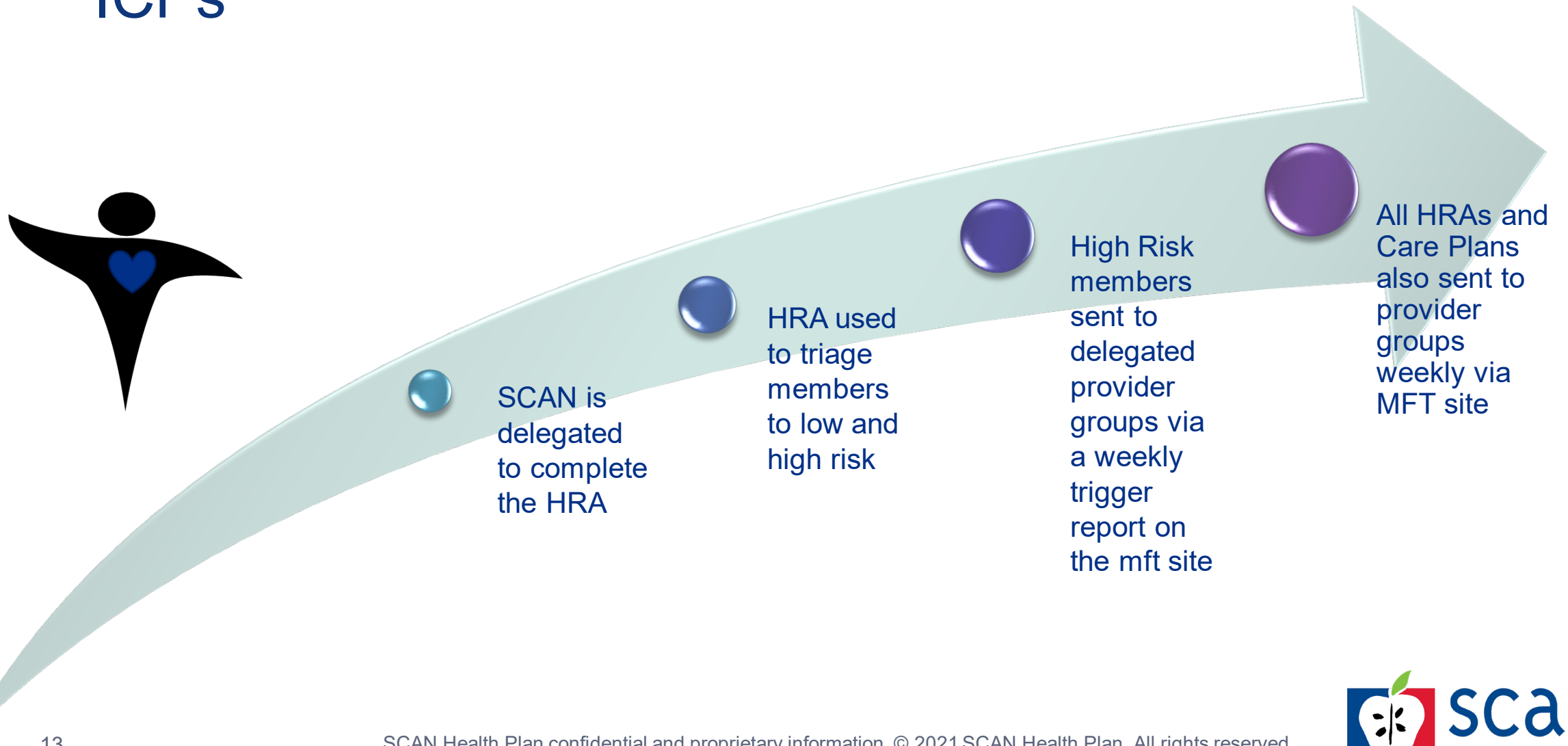
HRA, Trigger Report and ICP

Accessing and Retrieving HRA, Trigger Reports, and ICPs



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Provider Group Requirements

Pick up weekly trigger reports, HRAs and Care Plans within 7 days of posting on SCAN MFT site

Document in member chart date of trigger report and triggered concerns identified

Complete a clinical review of all available member records, including SCAN HRA and Care Plan

Outreach to member, documenting attempts and outcome (i.e. enrolled in CM, declined, failed contact, etc)

Complete and Document ICT (Interdisciplinary Care Team)

Update Care Plan

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HRAs, Care Plans and Trigger Reports

Interdisciplinary Care Team (ICT)

Maricris Tengco

Director of Care Coordination

Expectations

- Define SNP ICT Requirements
- Roles and Composition of ICT
- Different Format of ICT
- Communicate Between ICT Participants
- Document the ICT

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SNP ICT Requirements

	1	2	3
Requirements	**All SNP members received from HRA trigger report and via referral process**	**Composition of ICT (at minimum):** • **CM assigned** • **Care Coordinator** • **Medical Expert (e.g. PCP, Specialist, Nurse Practitioner, Medical Director)** • **Member/Representative (if available)**	**ICT Format:** • **In- person** • **Telephonically** • **Electronically** 
Operations and Documentation	1. Complete within 30 days of receipt 2. Includes failed contact and declined	1. All ICT participants are required to complete MOC training (attestation is needed) 2. ICT recommendations and decisions are documented in the member's record (electronic or paper chart) 3. Evidence that copy of care plan was provided to/available to ICT participants and members	1. Date member trigger report/referral received 2. Member's acuity level 3. Date of ICT 4. ICT Participants 5. If member has seen their PCP or had any ER visits/ hospitalizations in the last year 6. Summary of case discussion and recommendations

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Interdisciplinary Care Team (ICT)

Individualized Care Plan (ICP)

Jeanette Despal, Clinical Trainer

Learning Objectives

Provider expectations for creating a SNP Care Plan

When to update the Care Plan

Communicating the SNP Care Plan

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Creating the SNP Care Plan

Upon receipt of SCAN documents: Review HRA/ICP for triggered members

Complete a clinical review of all available member medical records to identify any new concerns and document

Outreach to member, documenting attempts and outcome within 30 days of receipt of trigger report

Review all triggers with the member on your outreach and assess for any other concerns, determine acuity level and need for case management.

Review all findings in your Interdisciplinary Rounds

Send the revised care plan to PCP and member

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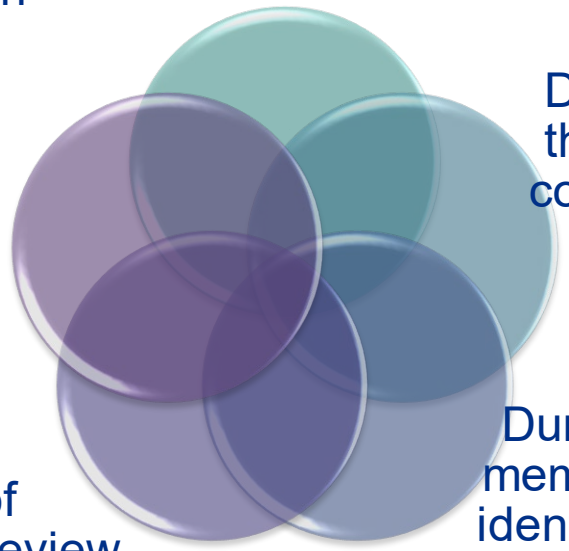
When to Update the Care Plan:

Clinical review identifies a change of health status not reflected on the SCAN care plan

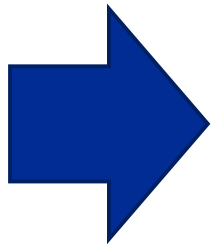
A change of health status occurs at any point during the member journey e.g. admit/discharge from a facility



During outreach to the member a new concern is identified

As a result of Interdisciplinary review

During outreach a member denies any identified concern or your records indicate it has been addressed



Send the revised care plan to the member and PCP

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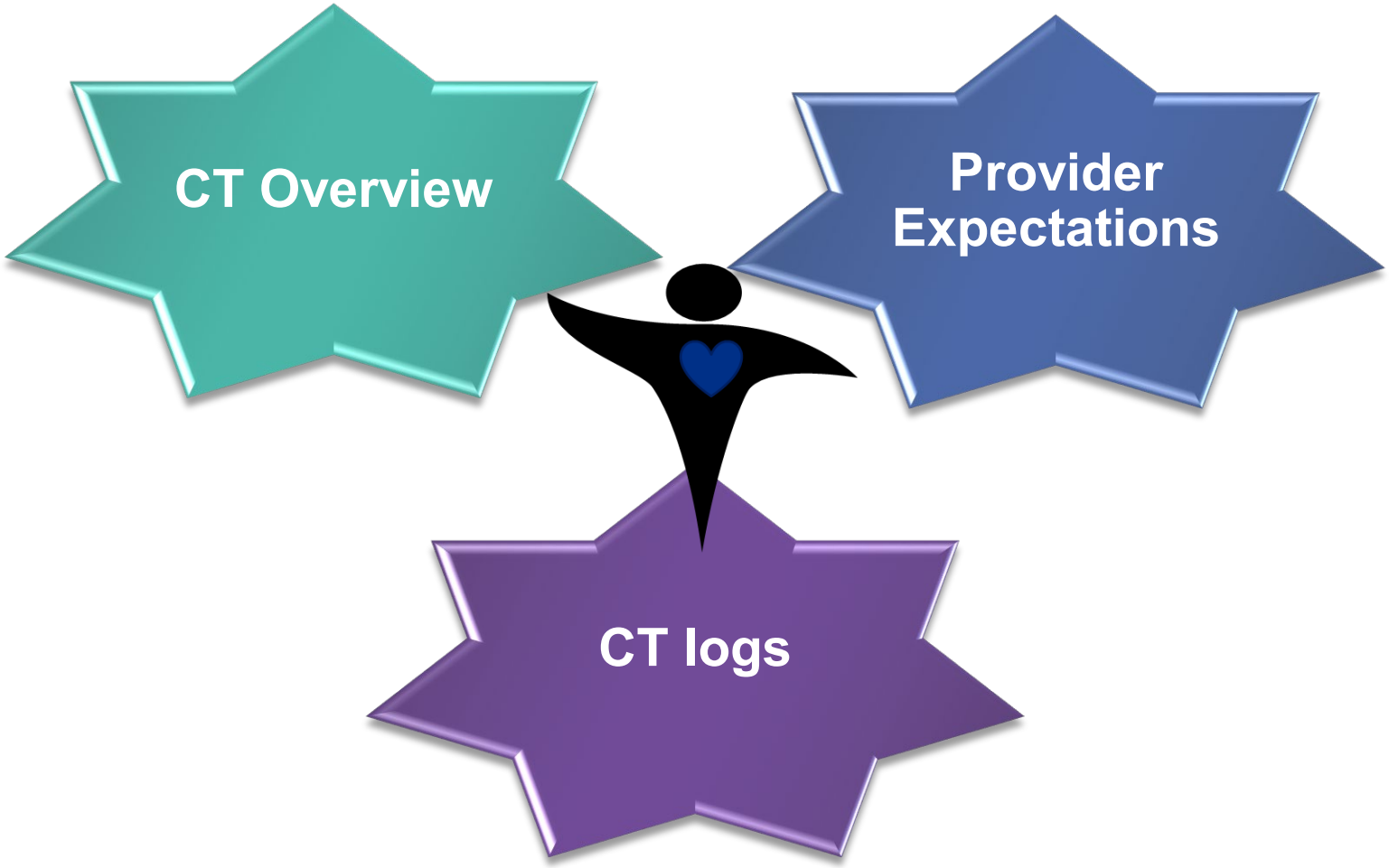
Interdisciplinary Care Plan (ICP)

Care Transitions

Jeanette Despal, Clinical Trainer

Care Transitions Objectives



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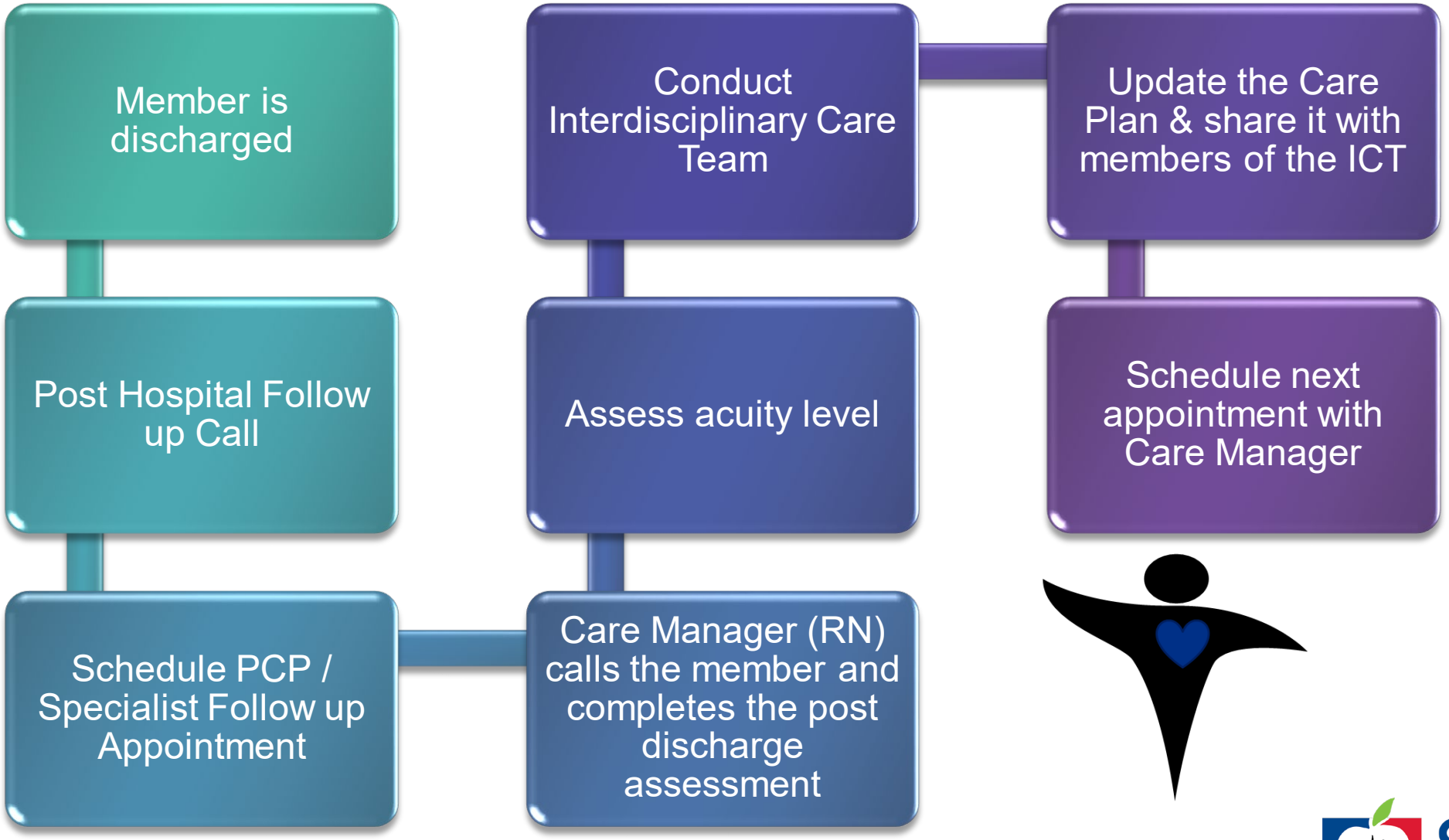
Journey Continues…. SNP Care Transitions



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Care Transitions (CT)

Delegated Medical Group Expectation

Care Transitions documentation must include:

- "Patient outreach was completed/attempted within 5 business days of discharge from one setting to another".
- Notification to PCP within five business days of discharge
- Ensure follow-up services and appointments are scheduled within 5 business days of transition
- The team ensures there is an identified provider directing the member's care and any other providers who need to be aware of the transition are notified.
- Care plan transferred between settings before, during, after transition of care
- Member coaching occurred
- Members of the ICT and members/caregivers have access to the plan of care

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2021 SCAN CT Log Due Dates

SCAN provides oversight to ensure regulatory and compliance requirements are met

CT logs are to be submitted on a quarterly basis

Upload to the MFT site into CT Logs should be placed in the SNP To SCAN SNPMisc folder

Reports fed through compliance tool and group results are posted

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2021 SCAN CT Log Data Elements

SCAN provides CT log 2 weeks prior to due date

Review the "instruction page"

All SNP members receive the CT intervention!

Contact the SNP Project Principal for support

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Care Transitions

CM Referral Criteria

Elizabeth Gomez

Manager of Care Coordination

Care Management Referral Criteria

Two or more admissions or ER visits in the past 6 months

Change of health status/condition

- Hospital admission or readmission
- Additional chronic diagnosis since last review
- New high risk medication

End of life needs requiring palliative or hospice care

Have not seen their PCP in past 12 months despite need for ongoing monitoring

Access to care issues

Difficulty managing medications/non-adherence

Two or more incidents of falls and other related accidents in the past 6 months

Other concerns requiring ongoing follow up

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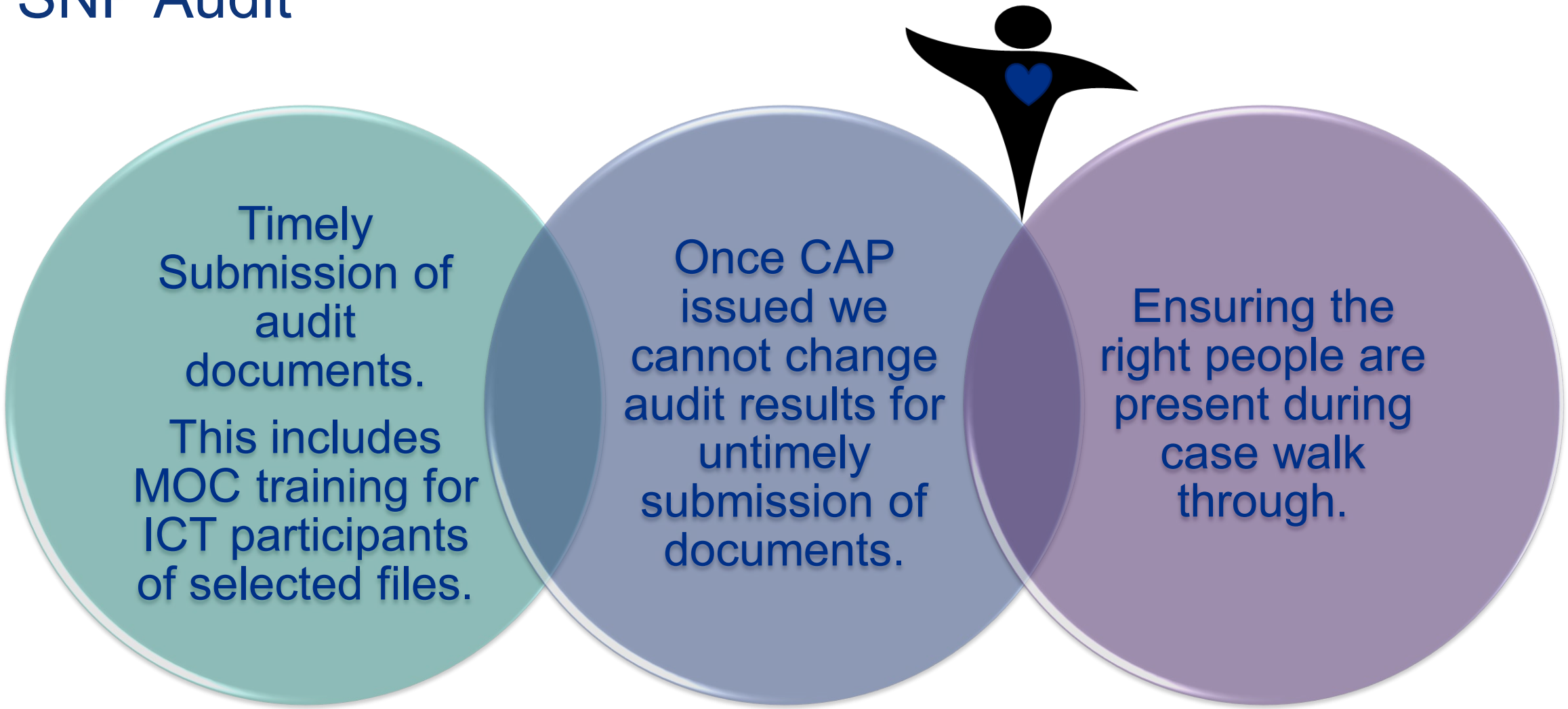
Monitoring and Oversight

SNP Audit



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Corrective Action Plan

Corrective Action Plans

- Root Cause Analysis- the “why” deficiency occurred.
- Corrective Action Plan- Group plan for correcting deficiency
- Implementation Date
- Responsible Individual- Must be a person not a department

Repeat Deficiencies

- Cannot accept same root cause or corrective action plan from previously submitted CAP

File Review Deficiencies (Case walk through)

- Corrective Action Plan. Cannot site that they will update a policy only.

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SNP Model of Care Training

SNP Model of Care Training

SCAN requires initial and annual SNP Model of Care training for network providers who see SNP members on a routine basis

CMS requires proof of completion of SNP Model of Care Training

SCAN keeps proof of your participation:

- When you attend one of the SCAN SNP MOC training webinars
- When you watch the recorded webinar (available on demand sometime in October)

Some Groups create their own SNP MOC Training:

- This training needs to be approved by SCAN
- Groups need to keep proof of staff completion of this training

CMS requested this proof during SCAN's recent audit

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Questions?

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Thank you!

Appendix – SNP MOC

Appendix Table of Contents – SNP MOC

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SCAN's Mission

- SCAN Health Plan (SCAN) is one of the nation's largest not-for-profit Medicare Advantage (MA) plan, serving over 200,000 members in California.
- SCAN's mission is to keep seniors healthy and independent. We do this is by providing comprehensive medical coverage, prescription benefits, and support services specifically designed to meet the unique needs of Seniors.

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Journey of a Special Needs Plan Member (SCAN)

Step 1

Member becomes a SNP member

Step 2

SCAN Verifies Enrollment Eligibility

- Duals – confirm eligibility in Medicare and Medi-Cal
- CSNP – confirm diagnosis

Step 3

SCAN Conducts the HRA and creates initial ICP and ICT

- HRA - Health Risk Assessment
- ICP – Individualized Care Plan

Step 4

Documents placed on SNP MFT

- Health Risk Assessment (HRA)
- Individualized Care Plan (ICP)
- Trigger Report with identified triggers from HRA responses

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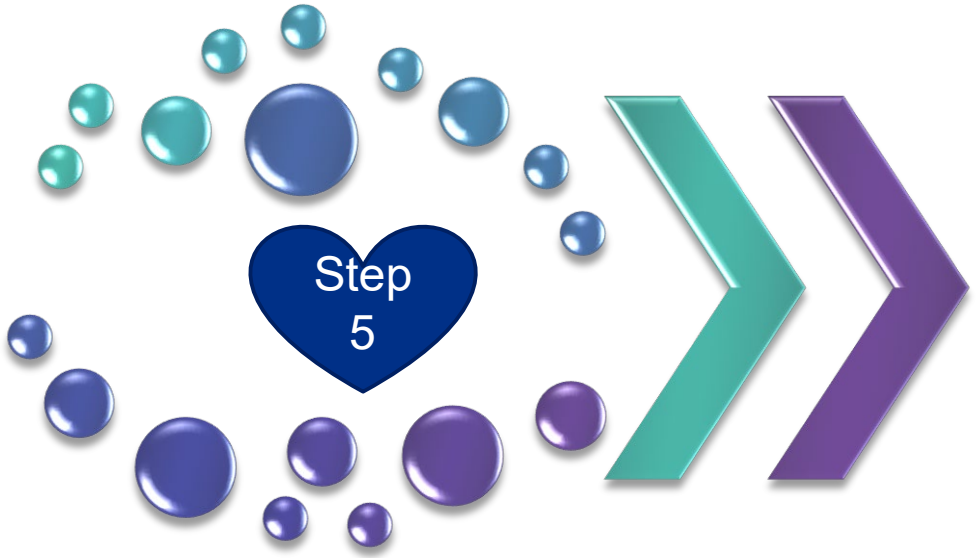
Journey Continues…. SNP Care Management (Medical Group)



Pick up documents from SNP MFT

- **Case Manager Assignment**
- **Review assessment, care plan and conduct clinical review**
- **Case Manager conduct member outreach**
- **Case Manager work with the member to decide on care management program goals**
- **Care Plan Implementation and Coordination of ICT**
- **Send revised care plan and any education material to member**
- **Re-evaluation of Care Plan and ongoing Follow-up**

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SNP types and eligibility

Chronic Special Needs Plan (C-SNP)

Eligibility verified 30 days post enrollment

- Balance Plan: Diabetes
- Heart First Plan: CHF, Arrhythmia, CAD, PVD, Chronic Venous Thromboembolic Disorder
- VillageHealth Plan: ESRD

Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP/D-SNP)

Eligibility verified monthly

- Designed for members who have both Medicare Part A and Part B, Full Medicaid benefits and FIDE SNP
- Connections and Connections at Home Plans

Institutional Special Needs Plan (I-SNP)

Eligibility verified by outside vendor

- Meet state criteria for Nursing Facility Level of Care (NFLOC)
- Healthy at Home Plan - Must reside in the community and not a facility (I-SNP is Institutional-Equivalent)

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SNP Goals and Purpose of a SNP

Improve access and affordability to member healthcare needs

Improve coordination of care and ensure appropriate delivery of services through the alignment of the HRA, ICP and ICT

Enhance care transitions across all healthcare settings

Ensure appropriate utilization of services for preventative health and chronic conditions

Improve member health outcomes

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SNP MFT Operations

SNP Report	Job Schedule	Day of the Week Report is Sent
Completed HRA and Care Plans	Weekly	Saturdays
Trigger Reports	Weekly	Mondays
SNP Membership	Monthly	2nd of Month

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CMS SNP Resources

CMS Website

- https://www.cms.gov
  - Medicare Managed Care Manual Chapter 5
  - Medicare Managed Care Manual Chapter 16b

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SCAN SNP Resources

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