Providence
Medicare Advantage Plan

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

Optum Provider Training – Behavioral Health
December 2017

Learning Objectives

After this training, you will be able to:

- Recognize the Providence Medicare Dual Plus (HMO SNP) as Special Needs Plan (D-SNP)
- Describe the four domains of the SNP Model of Care (MOC)
- Describe your role as a provider in relation to the corresponding domains of the Model of Care
- Describe your role as an Optum provider in the transition process under the Providence Medicare Advantage Care Coordination Program

D-SNP Background

- The Medicare Modernization Act of 2003 established Special Needs Plans to provide Medicare Advantage Organizations the flexibility to offer special plan benefit packages, for beneficiaries with distinct health care needs, that focus on providing coordinated care to decrease costs and improve health outcomes for vulnerable populations. There are three types of SNPs:
  - Dual Eligible or D-SNP for members eligible for both Medicare and Medicaid
  - Chronic Disease or C-SNPs for members with severe or disabling chronic conditions
  - Institutional or I-SNP for members requiring institutional (nursing facility) level of care
- Providence Medicare Dual Plus (HMO SNP) is a D-SNP

D-SNP Background

- To offer a SNP, a Medicare Advantage Organization must have a CMS approved Model of Care (MOC)
- The Centers for Medicare and Medicaid Services (CMS) requires all SNP providers to receive basic training about Dual-Special Needs Plan Model of Care (D-SNP MOC)
- Providence Medicare Advantage Plans will offer Providence Medicare Dual Plus (HMO SNP) to Dual Eligible members beginning January 1, 2018. To be eligible, members must be eligible for both Medicare and Full Benefit Medicaid

D-SNP Frequently Asked Questions

- Q. Is a D-SNP an integrated Medicare-Medicaid plan?
  - A. No, a D-SNP is a Medicare Advantage plan type that limits enrollment to dual eligible members only. However, it only covers the Medicare and Part D benefits, and not Medicaid benefits. Medicaid benefits are still administered through the State's Oregon Health Plan program.

- Q. Who can enroll in Providence Medicare Dual Plus (HMO SNP)?
  - A. Enrollment is limited to Medicare beneficiaries with full Medicaid benefits who reside in Clackamas, Multnomah, and Washington Counties. Usual Medicare requirements apply.

- Q. What is the Providence Medicare Dual Plus (HMO SNP) enrollment process and how does it differ from the enrollment of non-SNP Providence Medicare plans?
  - A. Generally, the enrollment process is the same. However, since Providence Medicare Dual Plus (HMO SNP) may only enroll full benefit dual eligible members, an additional eligibility step is required. Our Membership Accounting team will need to verify Medicaid eligibility status in Oregon's Medicaid Management Information System (MMIS) prior to enrollment.

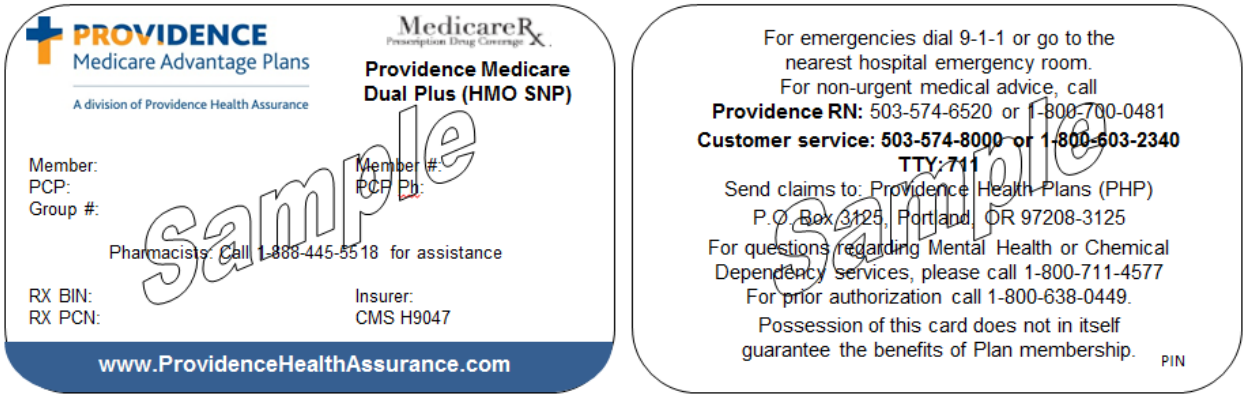
- Q. When can a member join Providence Medicare Dual Plus (HMO SNP)?
  - A. Full benefit eligible dual beneficiaries qualify for Special Election Period (SEP) and are able to enroll and/or switch plans not only during the annual enrollment period, but also at the start of every month.

D-SNP Frequently Asked Questions - Continued

- Q. How can a member join the Providence Medicare Dual Plus (HMO SNP) D-SNP?
  - A. A member can join the Providence Medicare Dual Plus (HMO SNP) in the same ways that a member can join other Medicare Advantage plans. For example, an individual can enroll via an agent/broker, a direct paper application, a telephonic application, or any other methods we use to enroll Medicare Advantage members. Additionally, their State case worker can assist with enrollment.
- Q. Does Providence Medicare Dual Plus (HMO SNP) only enroll "in-house" duals (those enrolled in PHP Medicaid as well?)
  - A. No, Providence Medicare Dual Plus (HMO SNP) is open to any Full Benefit Dual Eligible members residing in the tri-county area regardless of Coordinated Care Organization (CCO) or Health Share physical health plan managing their OHP coverage.
- Q. Are prescription drugs for Providence Medicare Dual Plus (HMO SNP) covered by Medicare or Medicaid?
  - A. Dual eligible members are enrolled in limited drug plans through Medicaid. Providence Medicare Dual Plus (HMO SNP) includes Medicare Part D and is the primary prescription drug coverage.
- Q. Which drugs are covered by Medicaid?
  - A. Over-the-counter drugs on the OHP formulary only.

D-SNP Frequently Asked Questions - Continued

- Q. How can my staff tell if one of my patients has Providence Medicare Dual Plus (HMO SNP)?
  - A. The patient will have a Providence Medicare Dual Plus (HMO SNP) member ID card. It will look like this:



  - Please also ask for their Oregon Health Plan ID card to identify the appropriate Medicaid carrier.

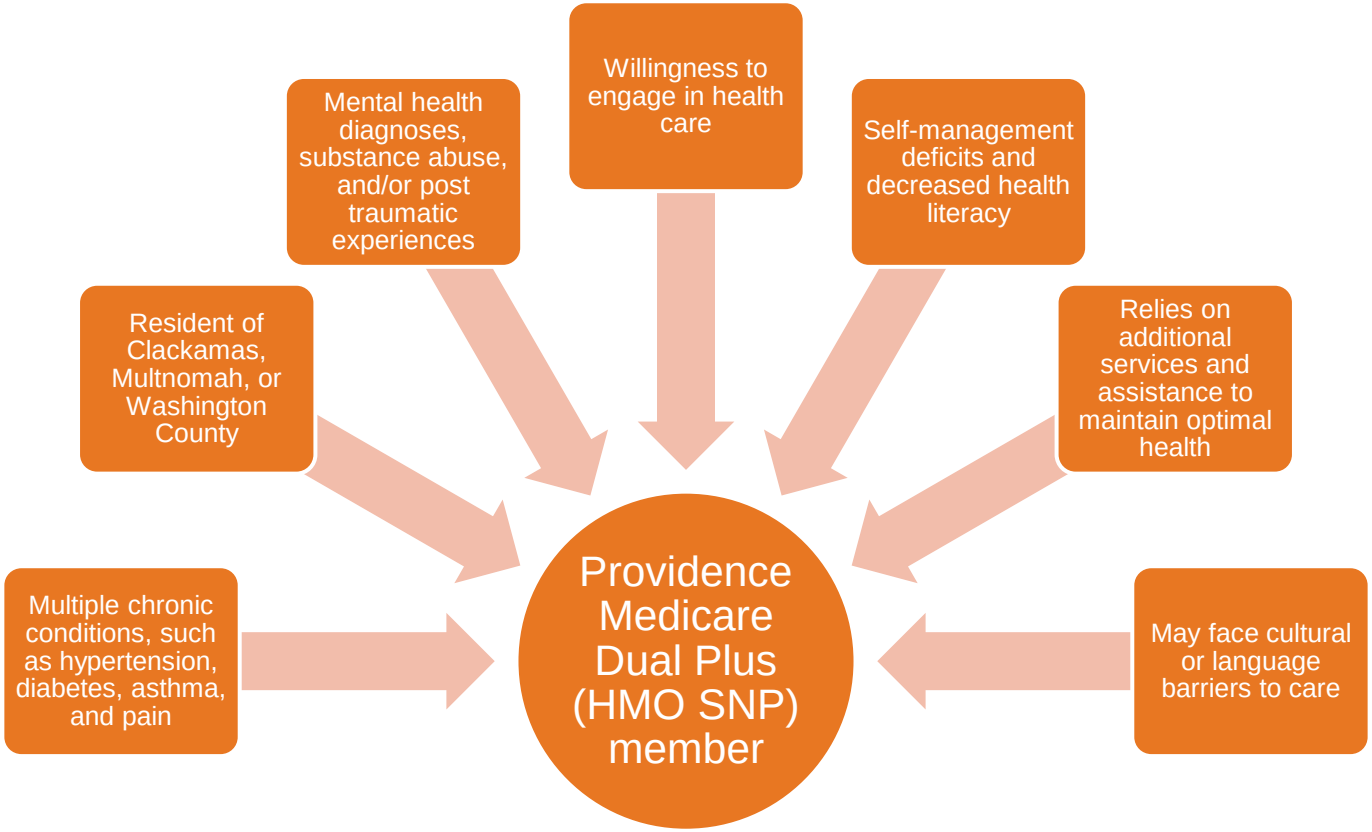
What is the Dual Special Needs Model of Care (MOC)?

The Dual Special Needs Plan Model of Care is a mandated service by CMS.

D-SNP MOC contains the following four (4) domains:

- Description of the SNP Population
- Care Coordination
- SNP Provider Network
- Quality Measurement & Performance Improvement

Domain 1: D-SNP Population



Domain 1: D-SNP Population (cont.)

- Low income
  - Under approx. $14,000 per year single or $30,000 per year family of 4
  - Under approx. $8,000 in assets

- High instances of chronic conditions

	Alzheimer's	Asthma	Chronic Bronchitis	Congestive Heart Failure	Dementia	ESRD
PHA Dual Plus Members	5.18%	14.86%	4.05%	15.32%	10.14%	1.13%

- High instances of behavioral health conditions

	Bi-Polar Disorder	Chemical Dependency	Depression	PTSD	Schizophrenia	Tobacco Use
PHA Dual Plus Members	3.15%	15.54%	21.62%	5.63%	4.28%	15.09%

- High rate of long term care – institutional and home-and-community-based

- High barriers due to social determinants of health

All Providence Medicare Dual Plus (HMO SNP) Members:

- Receive care coordination services upon enrollment
- Are assigned a Providence Health Plan “Plan” RN Care Manager
  - Optum works in conjunction with Providence for members requiring behavioral health care management
- Are supported by a member-specific Interdisciplinary Care Team (ICT). Membership may include, but is not limited to the member/member representative, the PCP (or medical home team), Plan Care Management team (RN Care Coordinator, LCSW, Clinical Support Coordinator, Pharmacist), Behavioral Health Provider, community partner, care advocate, clinic based staff, and other ancillary disciplines (physical therapy, dietician, specialty provider, etc.)

The Plan RN Care Coordinator will:

- Conduct an initial and annual **Health Risk Assessment** (HRA) with the member. The initial member HRA must be completed within 90 days of the member's enrollment date; annually thereafter (within 365 days of last assessment) or when the member's health status changes.
- Develop an **Individualized Care Plan** (ICP) based on the HRA or change in the member's health care status
- Notify the **Individualized Care Team** (ICT) of the ICP and coordinate ongoing updates and changes to align with the treatment plan and health status changes
- Coordinate the delivery of services
- Coordinate care conferences at least annually and ICT collaboration when appropriate

Components of the HRA:

- The Health Risk Assessment (HRA) is a member questionnaire that includes medical (including preventive), psychosocial, cognitive, cultural and functional questions that help identify gaps in care, chronic conditions, safety concerns, and access to care.
- The HRA guides care management options based on opportunities, available interventions, and the member's goals, priorities and preferences.

Provider Role:

- Review and discuss the HRA with member
- Identify immediate health risks
- Take necessary interventions
- Collaborate with the Care Management team

Individualized Care Plan (ICP)

- Using the HRA, an ICP is developed for each Providence Medicare Dual Plus (HMO SNP) plan member by the assigned Plan RN Care Coordinator, with input from the Interdisciplinary Care Team (ICT).
- The ICP goals and interventions are based on the member's specific health care needs and personal healthcare preferences.
- Modification to goals, motivation, or priority in the ICP may occur as health needs change; this is assessed with each contact.
- The initial ICP and all changes or adjustments are shared (faxed/ emailed/mailed) with the member and/or caregiver, PCP, and the ICT.

Provider's Role in the Individualized Care Plan (ICP)

- Collaborate in the development of the member's ICP.
- Review and discuss the Individualized Care Plan with the member upon initial ICP development, if significant changes are made to the ICP, and/or annually.
- Support and encourage the member to continue the treatment established in the care plan.
- Contribute, update, and give input when changes in member's health occur.

Interdisciplinary Care Team (ICT)

- All D-SNPs must have an Interdisciplinary Care Team (ICT) to identify care interventions, provide expertise, and coordinate the delivery of services and benefits to members.
- The Plan created an ICT Committee composed of a team of health and administrative professionals to help address the overall needs of the individual member, as well as our overall Providence Medicare Dual Plus (HMO SNP) population.

Provider's Role in Interdisciplinary Care Team (ICT)

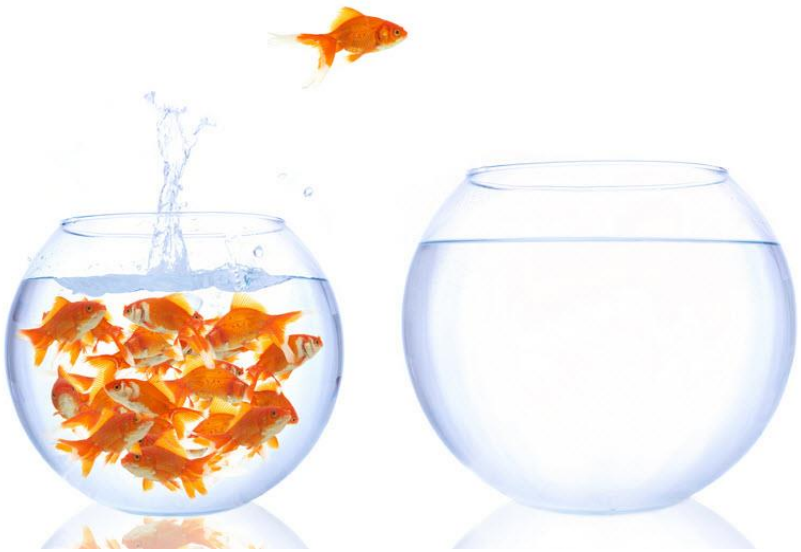
- Participate and provide clinical expertise in the development of the member's ICP and promote use of clinical practice guidelines.
- Collaborate with the Plan RN Care Coordinator and Care Management Team in member goal setting and follow-up.
- Engage members in self management and health education.
- Coordinate delivery of appropriate quality services and benefits that meet the member's needs and improve outcomes.
- Promote access and integrate other physicians and providers into the member's health care management as needed.
- Communicate changes in the member's health status to the ICT.
- Participate in ICT care conference(s) annually or as needed.

Transition of Care Protocols

Plan RN Care Managers facilitate the coordination and continuity of medical care by:

- Sharing pertinent information with all practitioners.
- Organizing and/or participating in case conferences.
- Collaborating with practitioners to ensure treatment plan alignment.
- Reporting identified gaps in care.
- Assisting practitioners and members with transition of care.
- Providing members with educational materials to cover their specific healthcare needs.
- Working with the ICT and ancillary partners to ensure all resources and services are provided to the member in a timely manner.
- Review of the ICP, implementing changes to support the member's goals.
- Documenting all interventions in the electronic charting system so that it is readily available to the health care team.

Provider's Role in Care Transitions



- Include the admission or discharge notification made by the Plan in the member record.
- Evaluate the member as soon as possible after an inpatient discharge (i.e., follow-up office visit, medication reconciliation).
- Review, update and discuss the care plan with the member, particularly any revisions resulting from health status changes.
- Work with the Plan Care Coordinator to facilitate provision of needed services.

Provider Network Focus

Optum works with our Providers to:

- Ensure member timely access to care.
- Engage providers with specialized expertise and experience to address the health care needs of the D-SNP population, such as Cardiology, Endocrinology, and Mental Health Specialists.
- Promote the use of evidence-based clinical practice guidelines and protocols when caring for members.
- Improve collaboration and active communication with the ICT and care coordinators.
- Enhance participation in developing, reviewing and updating member care plans.
- Assure that network providers are licensed through a formal credentialing process.

D-SNP MOC Training for Personnel and Provider Network

Provider Role:

- Take the Providence Medicare Dual Plus (HMO SNP) MOC training annually
- Complete the MOC Training Acknowledgement of Receipt Form
- Keep the Providence Medicare Dual Plus (HMO SNP) MOC training as a reference source

Performance and Health Outcome Measurement Process

The Plan will:

- Regularly conduct performance and outcomes monitoring of the D-SNP-MOC program and report to the internal Quality Improvement Team.
- Evaluate effectiveness of the D-SNP-MOC annually.
- Communicate D-SNP plan performance annually.
- Establish new measures and interventions to continually improve care and health services provided to our members.

Provider's Role in Quality Improvement

- **Focus on D-SNP performance in specifically measured areas:**
  - Increase use of Primary Care
  - Decrease ED Utilization
  - Ensure HRA Completion
  - Ensure Colorectal Cancer Screening
  - Reduce/Prevent Readmissions
  - Complete annual Diabetes HbA1c testing
  - Encourage participation in PHA Care Management Programs

- **Participate and support quality initiatives**
- **Ensure proper documentation in member record to support quality care performance monitoring (**i.e., HEDIS**)**
- **Respond to PHA requests for information**
- **Review annual program evaluation summary**

Provider's Role in Quality Improvement

Complete Annual Care Assessments – Care for Older Adults (COA)

- Pain Assessment (pain screening or pain management plan)
- Functional Status Assessment (Activities of Daily Living)
- Medication Review

HEDIS Measure (COA)	Eligible Codes
Pain Assessment	90863, 99605, 99606, 1160F TCM codes: 99495, 99496
Functional Status Assessment	1170F
Medication Review	1125F, 1126F

Thank you!

- Thank you for partnering with Optum, on behalf of PHA, in improving the health of our members and our community.
- Please acknowledge completion of this training by following the attestation instructions outlined in the cover letter.

For questions or concerns please contact us at:

Optum Network Services

503-603-7398