TOP SNP TAKEAWAYS

"SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve."

Module 1 - Intro to SNP

1. The Centers for Medicare and Medicaid Services (CMS) has identified certain populations as having special needs that require enhanced or specialized standards of healthcare.
2. A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals.
3. SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.
4. The three types of SNPs include Dual-Eligible SNP (DSNP), Chronic Condition SNP (CSNP), and Institutional SNP (ISNP).
5. CSNP is for individuals that have one or more co-morbid and medically complex chronic conditions that are substantially disabling or life threatening; have a high risk of hospitalization or other significant adverse health outcomes; and require specialized delivery systems across domains of care.
6. ISNP is for an individual that will remain institutionalized for 90 days or longer who needs long-term care, skilled nursing, or intellectual disabilities services or inpatient psychiatric services.
7. DSNP is for individuals who is entitled to both Medicare and medical assistance from a state plan under Medicaid.
8. For an MA organization to offer a CSNP or DSNP plan, they must have a contract with CMS that will cover all Medicare Part A, B & D benefits, offer supplemental benefits and have an approved DSNP contract and an approved Model of Care (MOC) document.
9. The MOC provides a member-centric continuum of care model that demonstrates that the plan is ensuring access and availability to coordinated care to all eligible SNP members.
10. DSNPs are the most complex of the 3 types of SNPs because members may have a combination of chronic medical and behavioral health conditions, disabilities, and significant social and financial challenges.

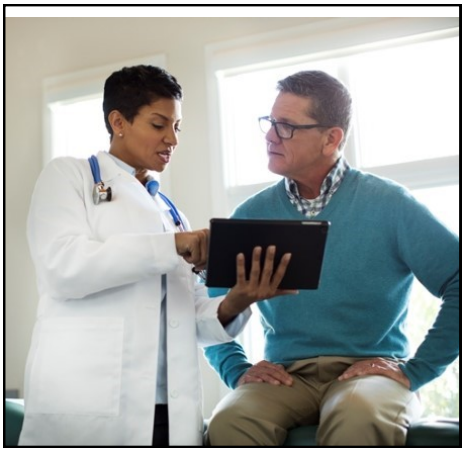
Contents:

Module 2 - Health Risk Assessment

1. The Health Risk Assessment (HRA) is a member-completed questionnaire designed to assess medical, functional, cognitive, psychosocial, and mental health needs of each member.
2. The results of the HRA are used to develop an ICP, otherwise known as the Plan of Care (POC), for the member, and for the ongoing coordination of Interdisciplinary Care Team (ICT) activities.
3. CMS has requirements and compliance standards for the administration of the HRA and its results.
4. The HRA must be completed for all new members within 90 days before or after the enrollment effective date.
5. Reassessments are required annually and if there is a health status change and/or a care transition (e.g., hospital discharge, Skilled Nursing Facility, Long term Acute Care, Acute Inpatient Rehab, change in medication, multiple falls).

"Every issue and health problem that is identified through the completion of the HRA is to be addressed in the ICP."

6. The HRA identifies members at a higher risk for adverse health events, indicating a need for additional screening for Case Management and/or Behavioral Health Management.
7. Some health plans have delegated the HRA process to provider groups and other health care organizations; other health plans retain ownership of the initial and annual HRA process.
8. Every issue and health problem that is identified through the completion of the HRA is to be addressed in the ICP.
9. In addition to being used for the development of the ICP, the HRA results must be reviewed, analyzed and stratified (if applicable to the health plan or organization delegated for the HRA) for each member.
10. Completion of the HRA is an element in the STARS program, which was created by CMS to provide quality and performance information to Medicare beneficiaries in order to assist them in choosing their health plan.



Module 3 - Individual Care Plan

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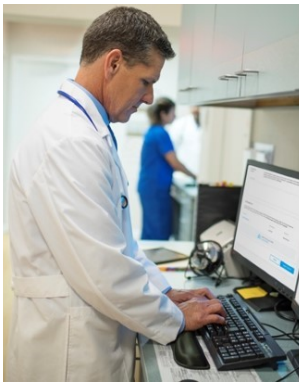
1. The ICP summarizes the member's medical conditions, functional abilities, psychiatric and social history with goals that are unique to the member.
2. CMS has requirements and compliance standards for the development and management of the ICP.
3. The ICP begins with the completion of the HRA, which identifies issues and health problems that must be addressed in the ICP.

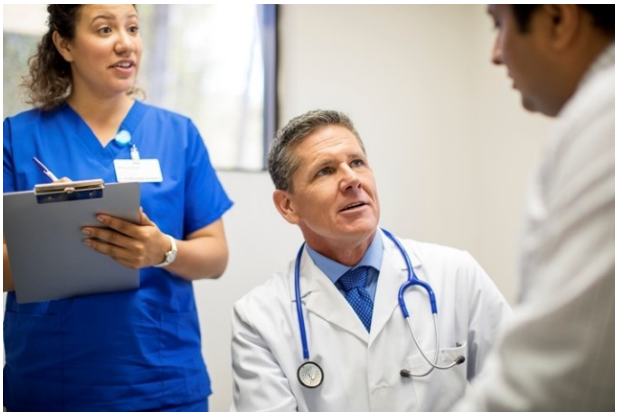
Having goals for each identified issue from an HRA or other assessment is often referred to as a "one-to-one." match"

4. The ICP is a MOC element and must include, but is not limited to, the following components: needs, preferences, services, and goals.
5. The ICP should be developed with the member and/or caregiver to ensure that it includes the member's preferences and individual needs.
6. A goal must be established for each identified issue and each goal must be Specific, Measurable, Attainable, Relevant and Timebound ("SMART" goals).
7. Having goals for each identified issue from an HRA or other assessment is often referred to as a "one-to-one match" during internal monitoring and/or external audits, and is a critical compliance element.
8. Once the ICP is completed, it is shared with the member and the ICT via mail, email, facsimile electronically, or in person.
9. If a member is identified as high risk and/or having multiple chronic conditions, they are often enrolled in a complex case management or disease management program and assigned a case manager to review the ICP with the member.
10. During reassessment of the ICP, unmet goals are reviewed by ICT members to identify barriers and determine alternative actions. The ICP is updated to reflect the changes and shared with the ICT members.



Module 4 - Accessing HRA/ICP in ICEU

1. ICUE is used as a care management platform to house a collection of tools and capabilities, including the HRA and ICP.
2. The HRA, also known as the Risk Stratification Assessment (RSA) by some health plans such as UnitedHealthcare, is a self-assessment questionnaire completed by a SNP member.
3. Although your role may not be delegated to complete the HRA, you will need to access a completed HRA and/or the POC in the ICUE platform.
4. If you are a Care Delivery Organization (CDO) provider who documents in a different platform other than ICUE, it is your responsibility to look at the current HRA and also the previous HRA, to ensure that all appropriate updates have been made to the problems, goals, and interventions in the POC.
5. The POC must be current and address all previously identified issues that still apply to the member, as well as all new issues discovered during care management outreaches, changes to a member's condition, and during transitions of care assessments.
6. In ICUE, the Member tab is where you can access member specific information and various tabs such as Eligibility, the Plan of Care, Assessments, Medications, and Providers.
7. Under the Assessments tab, look under the completed section to locate the RSA and click the hyperlink to open the assessment.
8. The date inside the assessment is the actual date of completion and should be the date that is used for documentation purposes.
9. To access a problem, click on the hyperlink to a specific problem and you will then have access to various tabs within the problems.
10. CMS requires the member's POC to address all identified health issues or conditions in the HRA/RSA.



"The HRA is a self-assessment questionnaire completed by a SNP member."

Module 5 - Transition of Care (TOC)

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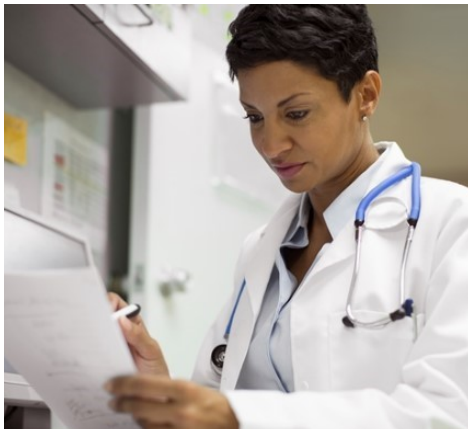
1. A Transition of Care (TOC) is the movement of a member from one care setting to another as the member's health status changes.

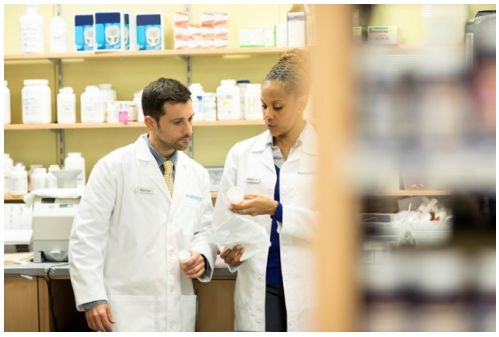


2. CMS developed Care Transition Protocols (CTP), which are outlined in the SNP POC requirements.
3. The key focus areas for management of care transitions include medication reconciliation, follow-up appointment, discharge plan, status change, and personal health information.
4. A member can decline case management while remaining eligible for transitions of care and outreach.
5. CTPs must be in place to provide for continuity and coordination of care as members transition between different health care settings.
6. The six factors of CTPs include continuity of care, care transition personnel, applicable transitions, personal health information, self-management activities, and notification of point of contact.
7. The goal of care transitions management is to avoid readmissions and improve health outcomes by providing members with the tools and support to promote knowledge and self-management skills.
8. Interventions to manage transitions to the home setting vary depending on each member's needs regarding understanding of discharge plans and condition management, reconciliation of discharge medications, follow-up appointments with appropriate providers and referral to appropriate case management programs, if applicable.
9. The ICP that is developed or revised during a TOC is shared with members, caregivers, and providers, and all are encouraged to share the ICP with others to support communication of health information.
10. Education is focused on the member and caregivers to promote self-management and participation in health care interventions and outcomes.

"CTPs must be in place to provide for continuity and coordination of care."

Module 6 - Interdisciplinary Care Team (ICT)

1. Each SNP will have an ICT, to work collaboratively to develop and implement care plans to meet the member's medical, behavioral, long-term care, and social service needs.
2. At minimum, the ICT will consist of the member and/or their caregiver and the Primary Care Provider (PCP) but can also include other support professionals and family



members/caregivers.
3. The ICT uses measurable goals within the ICP to manage services provided to meet health care needs and evaluate progress towards desired outcomes.
4. The member is encouraged to take an active role regarding their care, contribute to their self-management goals that are reflected in the ICP, and provide feedback to the ICT regarding their ICP.
5. The care manager will facilitate continuity and appropriateness of care and services to meet the member's healthcare need via member assessments, ICP management, measurable goal establishment, and outcomes evaluation.
6. PCPs and specialists have the clinical expertise and capability to make clinical decisions and treatment recommendations to address needs of a member.
7. A Pharmacist may participate in ICT activities as requested and makes recommendations regarding pharmacy issues.
8. Per CMS guidelines, there should be a detailed and comprehensive description of the composition of the ICT and a clear explanation for how the ICT members contribute to improving the health status of the SNP members.
9. The HRA and ICP are used to determine the composition of the ICT; including those cases where additional team members are needed to meet the unique needs of the individual member.
10. Per CMS requirements, organizations are must show evidence of an established communication plan that is overseen by SNP personnel who are knowledgeable and connected to multiple facets of the SNP MOC.

"A Pharmacist may participate in ICT activities as requested and makes recommendations regarding pharmacy issues."

Module 7 - Complex Case Management

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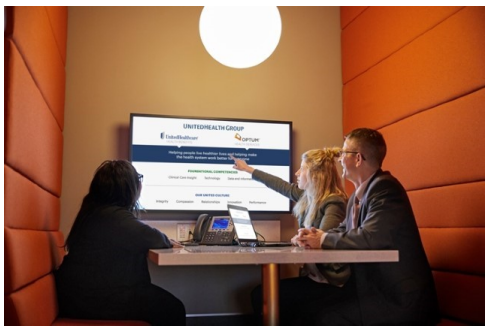
1. According to the 2021 National Committee for Quality Assurance (NCQA) requirements, Complex Case Management (CCM) requires that the organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.
2. A CDO may be delegated to specifically manage a CCM program, and therefore must follow the requirements set forth by NCQA.
3. CCM involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.
4. All eligible members have the right to participate or to decline to participate in a variety of programs and eligibility is not limited to one complex condition or to members already enrolled in other plan programs.
5. Referrals for CCM can be from other medical management programs, a discharge planner, directly from the member, caregiver or provider.
6. CCM programs if accredited through NCQA must meet certain requirements, such as the presence of a formal case management plan.
7. Certain states may have additional requirements for CCM programs, especially when dealing with DSNP programs because the member is eligible for both Medicare (federal) and Medicaid (state).
8. The CCM care team consists of case managers who use specific assessments and clinical guidelines, algorithms, or evidence-based materials to create a personalized case management plan that meets their assigned members' needs.
9. CCM involves having a cohesive plan of action for addressing member needs across the continuum of care.
10. Members enrolled in a formal CCM program may utilize other programs as needed based on the organization's hierarchy.

"CCM involves having a cohesive plan of action for addressing member needs across the continuum of care."

Module 8 - Auditing and Monitoring

1. The health plan is responsible to ensure that the Model of Care (MOC) and CMS Standards are part of the Care Coordination Process.
2. To ensure delegated processes are in compliance with CMS requirements, internal monitoring activities are expected by delegates and should be anticipated with health plan personnel.
3. Internal monitoring activities include a review of policies and procedures, as well as a process for the handling of member cases, specifically around timeliness and appropriateness of care management interventions (e.g., transitions of care assessments and development of individualized care plans).
4. All business partners who perform any work related to SNP membership must assure that their work supports and meets the compliance of the MOC and CMS standards.
5. It is important to establish an internal review process at the delegated organization level as well at the health plan level, to be prepared for official CMS-health plan audits of SNP performance.
6. The purpose of CMS SNP audits is to evaluate health plans and their delegated entities who manage SNP membership, and how they implement and work toward meeting requirements to specific protocol related to the SNP MOC.
7. CMS will sample all case file documentation for Health Plans implementation of care coordination in relation to its MOC in the following areas: HRA administration; ICP appropriateness and implementation; ICT appropriateness, development and implementation of enrollee's ICPs; and coordination of members transitions across care settings.
8. Issues identified by internal monitoring need to be associated with applicable corrective action plans, including but not limited to training and education, revision of processes and team handoffs, assessment and care plan changes, system enhancements, staff counseling/education, staffing model changes, reporting, and other operational improvements in order to meet requirements.
9. The intent of internal monitoring is to ensure ongoing compliance with the rules and approved policies, identify risks as they occur, and create process improvement strategies to improve overall compliance.
10. Successful external CMS audits are made possible by internal preparation and oversight of SNP MOC requirements, and compliant outcomes are typically aligned with the best care management outcomes for SNP members.

"Issues identified by internal monitoring need to be associated with applicable corrective action plans."



CMS Compliance Standards

2.1 Health Risk Assessment

2.1.1: Did the health plan conduct an initial HRA?
2.1.2: Did the health plan conduct the initial HRA either 90 days before or after the enrollment effective date?
2.1.3: Did the completed HRA include a comprehensive initial assessment and reassessment(s) of the needs of the beneficiary?
2.1.4: Did the Health plan conduct the annual HRA within 1 year of the initial assessment/1year of the previous HRA?

2.2 Individual Care Plan

2.2.1 Was the individualized care plan (ICP) completed according to the organization's MOC?
2.2.2 Was a comprehensive ICP developed and designed to address needs identified in the HRA, consistent with the MOC?
2.2.3 Did the ICP include measurable outcomes in accordance with the MOC?
2.2.4 Was the ICP reviewed/revised based on the member's health condition and in accordance with the SNP's most recently approved MOC?
2.2.5 Was documentation provided to verify the implementation of the ICP, such as proof of claims and/or documentation of social services provided?
2.2.6 Was member and/or caregiver participation facilitated when developing the ICP?
2.2.7 For the ICP, was communication coordinated among personnel, providers, and members?

2.3 Interdisciplinary Care Team

2.3.1 Does documentation demonstrate that member care was managed by an ICT comprised of appropriate clinical disciplines according to the SNP's approved MOC?

2.4 Care Transitions

2.4.1 Did the (e.g., health plan or delegated organization) implement care transition protocols to maintain member's continuity of care as defined in the MOC?
2.4.1.1. Did the member have a transition of care assessment (TOC)?
2.4.1.2. Was the member contacted?
2.4.1.2a For members who are unable to be reached (UTR), was the applicable process to contact member followed?
2.4.1.3 Did the Care Manager provide a single point of contact (SPOC) for the member through the first month of transition following discharge home and communicate this to the member and/or responsible party verbally via phone or face to face?
2.4.1.4 Was a Discharge Plan created post TOC, as evidenced by the following? (2.4.1.4.1 through 2.4.1.4.7)
2.4.1.4.1 Completion of an assessment by a Care Manager for this TOC.
2.4.1.4.2 Member is knowledgeable about indications that their condition is worsening and how to respond to changing conditions to include when to notify the PCP or specialist.
2.4.1.4.4 Was a Follow Up Appointment scheduled? (All Components 2.4.1.4.4a - 2.4.1.4.4b)
2.4.1.4.4a Has the member scheduled or completed a follow-up appointment(s) with appropriate providers?
2.4.1.8 Is the member knowledgeable regarding their medications?
2.4.1.9 Did clinical staff serve as the case manager and clinical resource for the member? CM is defined as: RNs, CHWs, social workers and clinical administrative coordinators (CACs), LPN/LVN, Telephonic Care Coordinators, Care Team Associates and BHA (Behavioral Health Advocate)
2.4.1.10 Was the ICP created / modified for management of the transition in collaboration with the member to determine goals and timeframe for follow-up?
2.4.1.11 Was the ICP updated and recommunicated to the ICT?
2.4.1.12 Was the member educated about their personal health information to facilitate communication related to prescriptions, providers and treatment? Personal Health Record: Member portal, notebook, personal notes - (e.g.: found in PHA, goal created…)
2.4.1.13 Was the member and/or responsible party educated (encouraged to be an active participant in their care) regarding achieving optimal health through engaging in self-management skills?

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