
# 2021 Dual Eligible Special Needs Plans (D-SNPs) and Chronic Condition Special Needs Plans (C-SNPs) Model Of Care Training

# Learning Objectives



| | |
|---|---|
| Describe | Describe Dual Eligible Special Needs Plans (D-SNPs) and Chronic Special Needs Plans (C-SNPs) |
| Describe | Describe what C-SNPs and D-SNPs offer |
| Describe | Describe D-SNP and C-SNP members qualify for this plan |
| Provide | Provide a description of Eon's Model of Care (MOC) |
| Describe | Describe our most vulnerable members |
| Benefit | Benefit Offerings |
| Provide | Provide a way to get answers to your questions |

# Training Requirements

- The Centers for Medicare & Medicaid Services (CMS) requires all care providers and staff who treat members in a SNP plan to complete an annual Model of Care (MOC) training.

- SNP's were created by Congress as part of the Medicare Modernization Act (MMA).

# Special Needs Plans

- Special Needs Plans (SNP's) are a type of Medicare Advantage plan that focus on Medicare Beneficiaries with special needs who would benefit from increase, focused coordination of care.

- There are 3 types of SNPs designed for specific groups of members with special health care needs:

    - Beneficiaries **dually eligible** for Medicare and Medicaid (D-SNP)
    - Beneficiaries with **Chronic conditions** (C-SNP)
    - Beneficiaries who are **institutionalized** or eligible for nursing home care (I-SNP)

# D-SNP Enrollment Requirements

❖ Reside in the plan service area (provide a proof of permanent residence)

❖Are entitled to Medicare Part A and are enrolled in Medicare Part B

❖Do not have End Stage Renal Disease (ESRD), unless member developed ESRD when he/she was already a member of a plan that we offer, or if he/she was a member of a different plan that was terminated.

❖Have Medicaid, with one of the following:

- Full benefit Dual Eligible (FBDE)
- Qualified Medicare Beneficiary (QMB)
- Qualified Medicare Beneficiary with Medicaid (QMB+)
- Specific Low Income Medicare Beneficiary (SLMB)
- Specific low Income Medicare Beneficiary Program with Medicaid (SLMB+)

# C-SNP Enrollment Requirements

- Reside in the plan service area (provide a proof of permanent residence)

- Are entitled to Medicare Part A and are enrolled in Medicare Part B

- Do not have End Stage Renal Disease (ESRD), unless member developed ESRD when he/she was already a member of a plan that we offer, or if he/she was a member of a different plan that was terminated.

- Must have one of the following CMS approved chronic conditions:
  - Diabetes Mellitus
  - Chronic Heart Failure
  - Cardiovascular Disorders

# Model of Care Includes

- Health Risk Assessment Tool (HRA)
- Interdisciplinary Care Team (ICT)
- Individualized Care Plan (ICP)
- Care Coordination
- D-SNP Benefits
- Provider Role
- Staff Role

# Health Risk Assessment (HRA)



The Health Risk Assessment Tool (HRAT) helps identify the members' most urgent needs by reviewing:

- Medical conditions
- Functional status (i.e. activities of daily living)
- Cognitive health
- Psychosocial, AND
- Mental health conditions

The HRAT is completed telephonically by the Health Services team:

- Within 90 days of member's enrollment
- Repeated within 365 days of initial HRAT completion
- When there is a charge in member's health condition

The results of the HRAT are used to create the individualized Care Plan (ICP)

# Categorizing Members

- HRAT results are reviewed and analyzed to categorize the members into Risk Groups based on established criteria.

- Members may fall into 3 Risk Groups:
- High Risk-the most vulnerable members, multiple chronic conditions and high utilization (ER visits, hospitalizations)
- Moderate- members with 2 or more chronic conditions and frequent utilization
- Low-members with 0 or 1 chronic condition, stable and able to self-manage

# Individualized Care Plan (ICP)



ICP is a plan developed for <u>each member that contains:</u>

- <u>Problems, Goals, Interventions, Barriers</u>

The ICP is developed by the Case Manager using:

- Results from the HRAT
- Claims data (laboratory results, pharmacy, hospital claims, ER claims)
- Member Preferences
- Interventions by the Case Manager
- Suggestions by the interdisciplinary Care Team (ICT)

The ICP is used to evaluate the member's health status and is updated every time there is a change in the member's health condition.

** Tool use to empower the members (identify member strengths, weakness)

# Interdisciplinary Care Team (ICT)

- All members are managed by the ICT to help achieve their goals
- Formal meetings takes place for the following:
    - Determine member's needs
    - Identify problems
    - Coordinate Care
    - Educate member
    - Determine if goals are "met" or "not met"
    - Refer member to community resources
    - Manage care transitions
    - Coordinate benefits

# Care Coordination



- Coordination of care for SNP members across various services through a central point of contact.
- Every member has a Case Manager, and he/she is responsible for all of the member's care.

How to improve care coordination

- Case Manager coordinates with PCP, specialist and other members of the ICT
- PCP is the "gatekeeper" and responsible for member's care and to identify what the member needs.

# Seamless Transition



- Transition of care occurs when members transitions from one care setting to another. For example:
  - Hospital to home
  - Hospital to Skilled Nursing Facility/Rehab
  - Nursing Home to Hospital
- Case Manager is responsible for ensuing a seamless transition of care between settings by;
  - Sharing the individualized Care Plan (ICP) with the PCP, hospitalist, facility and/or caregiver (as applicable);
  - Notifying the PCP of any member transition
  - Contacting the member of any planned transition to answer questions and provide educational material.

# Transition of Care Post-Hospitalization



- Members are called (48 hours) 2 days after hospital discharge and 14 days follow-up call
- A post-discharge or transitional assessment is conducted
- Medication reconciliation is performed
- ICP is updated with new information
- Meals form is completed SNP members and Meals are send to the home.

Case Manager assist the member with:

- Understanding the discharge diagnosis and hospital instructions
- Helps facilitate follow up appointments
- Assist with additional needed services (i.e. Home Health, DME, etc)
- Educate member on medical conditions

# C-SNP and D-SNP Benefits



- Case Management assistance and support
- End-of-life support
- Home delivered meals
- Non-emergency transportation
- After-hours nursing Hotline
- Mail order pharmacy
- Self-management activities
- Behavioral and community-based services
- Home and Community based services

# Provider Role



- Provider role:
  - Communicate with SNP care managers, ICT members, members and caregivers
  - Collaborate with CM in the ICP and maintain care plan within the member's medical record
  - Review and respond to patient-specific communication
  - Have member's ICP as part of the member's medical record
  - Participate in the interdisciplinary Care Team meetings
  - Educate the member on the importance of the HRA, which is essential in the development of the ICP.
  - Encourage the member to work with the CM team.
  - Complete the MOC training upon onboarding with Eon Health and annually thereafter.
    Direct Link:

# Eon's Staff Role

Staff roles in helping D-SNP members:

- Explain to the member the importance of the HRA
- Encourage member's to work with their Care Management Team
- Encourage our PCPs and other providers to participate in the ICT
- Remind PCP to access the SNP members Individualized Care Plan (ICP)
  ICP direct link:
- Perform annual MOC training, as required.
  Direct link:

# Contact us

If you have any questions about the Model of Care, Please do not hesitate to call:

- Provider Services at 1-866-788 3640
- Health Services Department at 1-866-689-8761

- You can access a copy of the MOC training at https://eonhealthplan.com/providers

# Thank you

**Eon Health Plan benefits are underwritten by Eon Health Plan**

Eon Health does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.