ALIGNMENT
HEALTH PLAN

Alignment Health Plan
Provider Model of Care Training
Special Needs Plan (SNP) 2019

SNP Overview

The Medicare Act of 2003 established a Medicare Advantage coordinated care plan that is designed to provide targeted care to individuals with special needs.

Special Needs Plans (SNPs) are a type of Medicare Advantage plan that includes Part C (medical) and Part D (drug) coverage.

Provides coverage for vulnerable populations who have multiple conditions and barriers to participating in self-care management.

Provides members with guidance and resources that help provide access to benefits and information.

Elements of Alignment Health Plan's (AHP) SNP Model of Care (MOC)

The SNP MOC requirements by NCQA® and CMS comprise the following clinical and non-clinical standards:

- Description of the SNP Population
- Care Coordination
- Care Transition Protocols
- Provider Network
- MOC Quality Measurement and Performance Improvement

Summary of AHP's SNP

AHP currently offers a **Chronic SNP** plan for the following conditions:

- Diabetes Mellitus
- Chronic Heart Failure
- Cardiovascular Diagnoses
  - Cardiac Arrhythmias
  - Coronary Artery Disease
  - Peripheral Vascular Disease
  - Chronic Venous Thromboembolic Disorder

AHP provides services to Special Needs Plan members in Los Angeles and Orange Counties under the Platinum (HMO) and Heart & Diabetes (HMO SNP) benefit plan.

Members can not be currently undergoing treatment for End Stage Renal Disease (ESRD).

Description of SNP Population

Overall SNP Population

- AHP provides service to Special Needs Plan members in Los Angeles and Orange Counties who have a qualifying chronic condition (DM, CHF, CVD).

- A Population Assessment was conducted in order to build a Model of Care that will properly serve our member's needs. Factors we identified include but are not limited to:
  - Age of current AHP C-SNP members range from 18-99 years old
  - There are slightly more Males than females enrolled in the AHP C-SNP plan
  - Caucasian, Hispanic and Asian are top 3 ethnicities within the AHP C-SNP plan
  - Spanish is the preferred language followed by English

Description of SNP Population (Cont'.)

Most Vulnerable Members

- Alignment SNP focuses on the vulnerable sub-population of members who are at highest risk of poor outcomes.

- The members are identified using Alignment Health Plan's proprietary software that is algorithm based and identifies census information, gaps in care, pharmacy information, HEDIS® information, and predicts risk scores for AHP members.

- Reports are generated from the above-mentioned data to assist in the coordination of care for the most vulnerable population using criteria such as utilization, hospitalization, co-morbidities, Predictive modeling data and program referrals.

Staff Structure and Care Coordination Roles

- Administrative support is provided by AHP staff with oversight of the various departments performed by the AHP Compliance team
  - Sales Department
  - Enrollment Department
  - Outreach and Member Engagement
  - Claims
- Clinical staff supporting the AHP C-SNP Model of Care include:
  - Utilization Management
  - CareAnywhere Staff
  - Nurse Practitioners, Physician Assistants, Social Workers and Physicians
  - Clinical Operations
  - Case Managers, Care Coordinators and Medical Assistants
  - Quality Management for oversight of C-SNP QM activities and improvement
- All staff are trained on the MOC upon hire and annually thereafter.
- AHP does not delegate SNP Care Management.

The Health Risk Assessment (HRA)

- A Health Risk Assessment (HRA) is required for all members enrolled in a SNP.
- Alignment has a standardized HRA tool which can be completed telephonically, in person or on paper.
- The HRA is a tool used to identify member risk levels including but not limited to Health, Functional, Cognitive, Psychosocial / Mental Health.
- The HRA results are used to develop or update a member's Individualized Care Plan (ICP) and to stratify the member into risk categories for Care Management and Coordination.

The Health Risk Assessment (HRA) (Cont'.)

- All C-SNP members must have a completed Initial HRA within 90 calendar days of enrollment or with any change of Plan Benefit Package (PBP).
- Annually, members must have a reassessment HRA within 365 calendar days of their previous HRA or enrollment date.
- An HRA Reassessment may also occur if a member has a significant change in health status such as
  - Hospital Or Skilled Nursing Facility (SNF) Admission
  - A Change In Care Setting
  - A Change In Behavioral Health Needs
  - A New Diagnoses Chronic Condition Such As CHF, DM, HTN Or CAD
  - When A Member, Family Or Provider Reports A Change In Condition

Individualized Care Plan (ICP)

- A Care Plan is a vehicle used to facilitate the nursing process.
- Care Plans are used as a communication tool to the member and the PCP and other providers.
- Care Plans address the gaps identified through the evaluation process and planned interventions.
- Essential Components of the ICP include:
  - Address gaps identified through the evaluation process
  - Planned interventions
  - Specific Goals and Objectives
  - Goals will be prioritized and tailored to the member's needs and preferences
  - Identification of goals met/not met

Individualized Care Plan (ICP) (Cont'.)

- The Case Manager reassesses the member's progress toward goals periodically and if goals are not met
  - Barriers to achieving identified goals are re-defined and discussed with the member
  - Goals may be modified as desired by the member and/or caregiver
  - Alternative intervention actions are created to succeed in achieving the newly identified/re-defined goals
  - Progress, changes and revisions to the care plan are documented

- The Case Manager shares the initial ICP with the member, the PCP and other members of the Care Team and when the ICP is revised throughout the Care Management Process.

Interdisciplinary Care Team (ICT)

- The Interdisciplinary Care Team (ICT) is member-centric and based on a collaborative approach.
- The ICTs overall care management role includes member and caregiver evaluation, re-evaluation, care planning and plan implementation, member advocacy, health support, health education, support of the member's self-care management and ICP evaluation and modification as appropriate.
- All SNP Members must have an ICT that is based on the member's medical and psychosocial needs as determined by the HRA and ICP.
- The member, the Case Manager and the PCP make up the ICT, but might also include Social Workers, Pharmacists, Medical Director, Specialists and other treating Physicians.
- ICT information is communicated through various methods including:
    - the CM system documentation
    - telephonic communication with member/caregiver and provider
    - Written ICT meeting minutes
    - Documentation within the member's ICP

Care Transitions

- A Care Transition is movement of a member from one care setting to another when the member's health status changes.
- Care Transition settings include home, home health, acute care, skilled/ custodial nursing facilities, rehabilitation facility, outpatient/ambulatory care/surgery centers.
- Care Transitions are addressed by the Case Manager for both planned and unplanned transitions in order to maximize member recovery and avoid preventable transitions.
- All applicable ICT members are informed of the member's needs pre, during and post transition from one care setting to another including the receiving facility.

Clinical Practice Guidelines (CPGs)

- AHP ensures all providers and IPA/medical groups use evidence-based nationally approved CPGs for making UM decisions
  - The CPGs are approved annually
  - Approved guidelines are shared with the network
- Member education materials are reviewed annually to ensure consistency with approved CPGs.
- AHP monitors how providers utilize CPGs and nationally-recognized protocols through annual review of utilization decisions, appeals process and HEDIS® reporting.

Provider Network

Specialized Expertise

- Alignment and it's delegated IPA/Medical Groups contract with a network of providers with specialized expertise to ensure that SNP members receive appropriate access to care necessary to manage their healthcare needs.
- AHP's existing provider networks are inherently designed to meet the specific needs of the SNP Program population as evidenced by
  - Contracted providers experienced in caring for our targeted population
  - A culturally-driven provider network
  - Providers located in geographic proximity to where the population resides
- AHP's specialty network includes, but is not limited to, Internists, Endocrinologists, Cardiologists, Gastroenterologists, Oncologists, Pulmonologists, Surgeons and Behavioral Health Specialists.

Provider Network (Cont’.)

- In addition to the AHP contracted provider network, AHP supports the member and the primary care provider through the AHP Care Anywhere Program.
- The Alignment’s Care Anywhere Program is a physician led, Advance Practice Clinician (APC) driven model of care designed to support C-SNP members who have been identified as benefiting from a comprehensive in-home assessment to address immediate, chronic, and social health care needs.
- The Care Anywhere Program delivers an extra layer of care services for targeted Members to not only reduce the unnecessary utilization of ER and inpatient services, but also to improve health outcomes and restore humanity in advanced care planning.

Provider Network (Cont’.)

Provider Network Oversight

- All AHC Contracted Providers, Facilities and Ancillary Providers, undergo a Credentialing process to ensure they meet all Federal And State Credentialing Requirements.
- All licensed practitioners and providers who have an independent relationship with Alignment Health Plan require credentialing.
- Verification of credentialing information is performed by AHP or its delegate initially prior to contracting and every 3 years after.
- AHP administers MOC training upon contracting and annually thereafter to all Providers seeing AHP C-SNP members.

AHP MOC Quality Measurement and Performance Improvement

- AHP has a Quality Improvement Plan (QIP) that is specific to the MOC and designed to measure the effectiveness of the MOC.
- Data is collected, analyzed and evaluated in order to report on the MOC quality performance improvement.
- Specific HEDIS® health outcomes measures are identified in order to measure the impact the MOC has on SNP members.
- SNP Member satisfaction surveys are utilized to assess overall satisfaction with the MOC.
- The results of the surveys are used to modify the MOC QIP on an annual basis.
- Each year, an annual evaluation of the MOC is performed and the results shared with the stakeholders through the Quality Improvement Committee (QIC).

Member Responsibilities

As part of the SNP Program, members should be active participants in support of their healthcare

- Members are encouraged to complete a Health Risk Assessment initially upon enrollment and annually thereafter
- Members should participate in AHP Case Management to develop an Individualized Care Plan, set and prioritize goals to improvement management of their chronic condition
- Communicate with primary provider as needed
- Work with their Interdisciplinary Care Team to work toward goals

Provider Responsibilities

- Primary Care Providers must be actively involved in the care of our C-SNP members
- Providers must complete the credentialing and re-credentialing process ensuring active licenses and certifications at all times
- Assess/re-assess C-SNP members to identify health status changes and update the Individualized Care Plan (ICP)
- Collaborate with members of the Interdisciplinary Care Team (ICT) to ensure coordination of care and transition of care for our member
- Follow Transition of Care protocols
- Review and discuss care plans with members
- Refer members to AHP Case Management as indicated
- Complete MOC training upon contracting with AHP and annually thereafter
- Participate in AHP's Quality Improvement Initiatives
- Participate in Provider Satisfaction Surveys

Regulatory References

CMS Medicare Managed Care Manual- Chapter 16b- Special Needs Plans

42 C.F.R. §§ 422.2

Social Security Act Section 1859 (b)(6)(B)(iii)

CMS Medicare Managed Care Manual Chapter– Enrollment Guidelines

CMS Medicare Managed Care Manual Chapter 3 – Marketing Guidelines

CMS Medicare Managed Care Manual Chapter 4 – Beneficiary Protections

CMS MMCM Chapter 8

NCQA® Model of Care Scoring guidelines

Medicare Part C Plan Reporting Requirements Technical Specifications Document Number 13 for “SNP Care Management”

Model of Care Attestation