CCHP Health Plan

Special Needs Plan Model of Care (SNP - MOC)

2024 Model of Care Training for Providers

Learning Objectives

- To gain an understanding and comprehension of CCHP's Special Needs Plans (SNPs)
- To gain an understanding and comprehension of the Elements of the SNP Model of Care
- At the end of this training, you will be able to:
  - ❖ Describe the best practices for the SNP Model of Care
  - ❖ Describe how to improve coordination of care and member health outcomes

PROVIDER TRAINING STANDARDS

- *Chapter 42 of the Code of Federal Regulations, Part 422 (42 CFR 422.101 (f)(2)(ii)) mandates that Special Needs Plans (SNP) conduct SNP Model of Care (MOC) training for all employed and contracted providers.*

- All CCHP participating providers who routinely sees CCHP Medicare SNP members must receive training on the MOC initially and annually thereafter.
  - Initial training must be completed within 90 days from contract execution date and annually thereafter.
  - Annual training is provided via live webinar and attestation statement must be completed within 90 days from the live webinar.

What is SNP Model of Care?

- Special Needs Plans are specialized Medicare Advantage plans for beneficiary with special circumstances. A SNP can be one of 3 types:
  - Chronic SNP (C-SNP) for members with severe or disabling chronic conditions.
  - Institutional SNP (I-SNP) for members requiring an institutional level of care or equivalent living in the community.
  - Dual-Eligible SNP (D-SNP) for members eligible for Medicare and Medicaid.

- Model of Care is a comprehensive plan for delivering integrated care management program for special needs member.
  - It is the architecture for promoting quality, integrating benefits, coordination of care, and operation processes.

CCHP offers a Dual Eligible SNP (D-SNP)

- CCHP offers a D-SNP named "CCHP *Senior Select Program (HMO SNP)"*

  - Enrollees must have Medicare and Medicaid benefits
  - Offered in San Francisco
  - Enrollees in this D-SNP are responsible for $0 for covered medical services

D-SNP Benefits at CCHP

- CCHP offers specific benefits plans that meet the unique needs of our population which may include:
  - Walk in services at our Member Services
  - Medication Therapy Management
  - Disease management services
  - Non-emergency transportation services
  - Holistic and complementary health services
  - Community partnerships – Chinese Community Health Resource Center (CCHRC)
  - Over-the-counter allowance
  - Flex card benefits

D-SNP Model of Care

- Written documentation that describes the care management process and operations
- Required by Centers for Medicare and Medicaid Services (CMS)
- Must be NCQA accredited and renewal depends on scoring, ranges from every one (1) to three (3) years
- CCHP received three (3) years approval in 2022
- There are four (4) Model of Care Domains and fifteen (15) Elements

SNP MOC: 4 Domains, 15 Elements

DOMAIN 1: Description of the SNP Population

Element A. Description of Overall SNP Population

Element B. Sub-Population: Most Vulnerable Beneficiaries

DOMAIN 2: Care Coordination

Element A. SNP Staff Structure

Element B. Health Risk Assessment Tool

Element C. Face-to-Face Encounter (F2F)

Element D. Individualized Care Plan (ICP)

Element E. Interdisciplinary Care Team (ICT)

Element F. Care Transitions Protocols

SNP MOC: 4 Domains, 15 Elements (cont.)

DOMAIN 3: SNP Provider Network

Element A. Specialized Expertise

Element B. Use of Clinical Practice Guidelines and Care Transition Protocols

Element C. MOC Training for the Provider Network

DOMAIN 4: Quality Measurement / Performance Improvement

Element A. MOC Quality Performance Improvement Plan

Element B. Measurable Goals and Health Outcomes for the MOC

Element C. Measuring Patience Experience of Care (Satisfaction)

Element D. Ongoing Performance Improvement Evaluation of the MOC

Element E. Dissemination of SNP Quality Performance Related to the MOC

SNP MOC responds to our mission

Provide high-quality, affordable healthcare through culturally competent and linguistically appropriate services

- CCHP provides services to:
  - Frail elderly
  - High health risk individuals
  - Low-income and low socioeconomic population
  - Individuals with multiple chronic and acute health problems
  - Individuals with or at risk of medication and treatment plan non compliance
  - Individuals that lack family support
  - Limited English literacy individuals
  - Individuals with barriers to access community resources and support
  - Strive for quality outcomes
  - Support PCPs plan of care
  - Educate, guide, and support individuals to health and community resources

SNP MOC Goals

- Improve access to care
- Improve transitions of care to reduce unnecessary ED and hospital admissions
- Improve coordination of care through a single point of contact
- Improve access to preventive health services
- Improve appropriate utilization of services
- Improve quality scores
- Improve member satisfaction with providers and the plan
- Improve health outcomes

Description of the SNP Population

CCHP currently has 3,748 SNP beneficiaries in San Francisco.

- 96.6% of the SNP Population are Chinese
- 25-101+ years old is the age range of this population
- 64.9% of beneficiaries are between the ages of 65-80 years old
- 55.2% beneficiaries are women, 44.8% are men

What is Care Coordination?

- Facilitates effective use of resources to reduce the overall cost of care with overall goal of improved health outcomes
- Provides a single point of contact for the member across the continuum of care
- Coordination staff include registered nurses, social workers, and non-clinical coordinators
- Work collaboratively with the member, family/significant others, and providers of health care to implement a plan of care which meets the individual's needs

What are Care Coordination Activities?

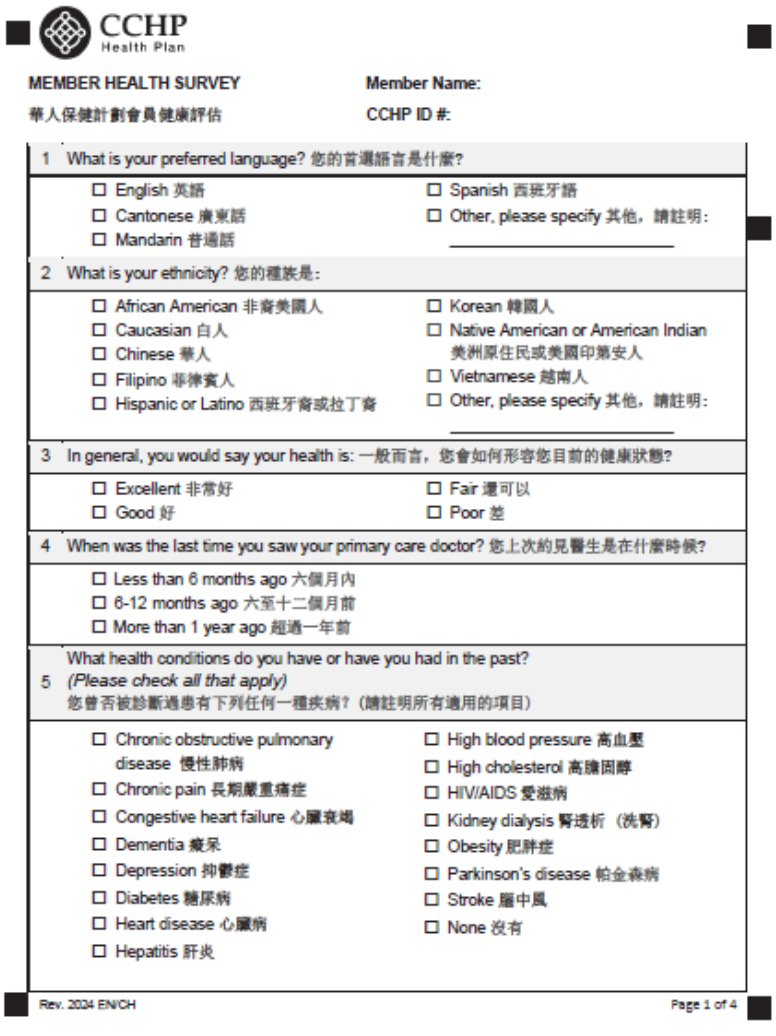
- Performs an assessment to identify individual health needs
- Develops a comprehensive individualized care plan (ICP)
- Identifies barriers to goals and strategies to address
- Provides personalized education for optimal wellness
- Encourages preventive care
- Post Discharge planning
- Reviews and educates on medication regimen
- Assists member to access community resources, Medicare, Medicaid benefits
- Assists caregiver when member is unable to participate

Health Risk Assessment

CMS regulation requires a Health Risk Assessment (HRA) is conducted for each member enrolled in SNP

- CCHP administers a health risk assessment (HRA) to all SNP members.
- Self-reported survey includes questions on medical, psychosocial, cognitive, functional and mental health.
- Consistent with CMS HRA regulation, CCHP updated HRA in 2024 to include questions regarding housing stability, food security, and access to transportation.
  - Initial HRA sent upon effective enrollment.
  - Annual reassessment sent upon 365 days of last HRA.
  - Telephonic outreach is conducted if no HRA is returned within 1 month of mailing date.
  - HRA provides the basis for the development of the plan of care.
  - Care Coordinators will review HRA and may contact member for follow up.

HRA Sample



CCHP Health Plan

MEMBER HEALTH SURVEY **Member Name:**

華人保健計劃會員健康評估 **CCHP ID #:**

1 What is your preferred language? 您的首選語言是什麼?

- ☐ English 英語
- ☐ Cantonese 廣東話
- ☐ Mandarin 普通話
- ☐ Spanish 西班牙語
- ☐ Other, please specify 其他，請註明: _____

2 What is your ethnicity? 您的種族是:

- ☐ African American 非裔美國人
- ☐ Caucasian 白人
- ☐ Chinese 華人
- ☐ Filipino 菲律賓人
- ☐ Hispanic or Latino 西班牙裔或拉丁裔
- ☐ Korean 韓國人
- ☐ Native American or American Indian 美洲原住民或美國印第安人
- ☐ Vietnamese 越南人
- ☐ Other, please specify 其他，請註明: _____

3 In general, you would say your health is: 一般而言，您會如何形容您目前的健康狀態?

- ☐ Excellent 非常好
- ☐ Good 好
- ☐ Fair 還可以
- ☐ Poor 差

4 When was the last time you saw your primary care doctor? 您上次約見醫生是在什麼時候?

- ☐ Less than 6 months ago 六個月內
- ☐ 6-12 months ago 六至十二個月前
- ☐ More than 1 year ago 超過一年前

5 What health conditions do you have or have you had in the past? *(Please check all that apply)* 您曾否被診斷過患有下列任何一種疾病?（請註明所有適用的項目）

- ☐ Chronic obstructive pulmonary disease 慢性肺病
- ☐ Chronic pain 長期嚴重痛症
- ☐ Congestive heart failure 心臟衰竭
- ☐ Dementia 癡呆
- ☐ Depression 抑鬱症
- ☐ Diabetes 糖尿病
- ☐ Heart disease 心臟病
- ☐ Hepatitis 肝炎
- ☐ High blood pressure 高血壓
- ☐ High cholesterol 高膽固醇
- ☐ HIV/AIDS 愛滋病
- ☐ Kidney dialysis 腎透析（洗腎）
- ☐ Obesity 肥胖症
- ☐ Parkinson's disease 帕金森病
- ☐ Stroke 腦中風
- ☐ None 沒有

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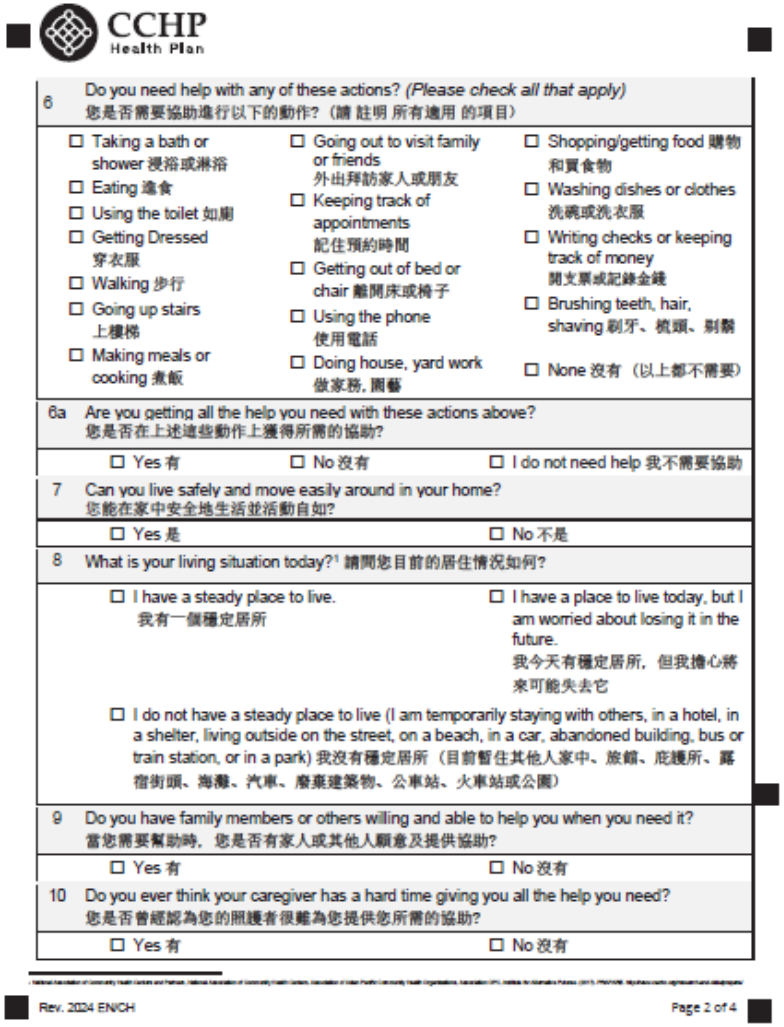

CCHP Health Plan

6 Do you need help with any of these actions? *(Please check all that apply)* 您是否需要協助進行以下的動作?（請 註明 所有適用 的項目）

- ☐ Taking a bath or shower 浸浴或淋浴
- ☐ Eating 進食
- ☐ Using the toilet 如廁
- ☐ Getting Dressed 穿衣服
- ☐ Walking 步行
- ☐ Going up stairs 上樓梯
- ☐ Making meals or cooking 煮飯
- ☐ Going out to visit family or friends 外出拜訪家人或朋友
- ☐ Keeping track of appointments 記住預約時間
- ☐ Getting out of bed or chair 離開床或椅子
- ☐ Using the phone 使用電話
- ☐ Doing house, yard work 做家務, 園藝
- ☐ Shopping/getting food 購物和買食物
- ☐ Washing dishes or clothes 洗碗或洗衣服
- ☐ Writing checks or keeping track of money 開支票或記錄金錢
- ☐ Brushing teeth, hair, shaving 刷牙、梳頭、剃鬍
- ☐ None 沒有 （以上都不需要）

6a Are you getting all the help you need with these actions above? 您是否在上述這些動作上獲得所需的協助?

- ☐ Yes 有
- ☐ No 沒有
- ☐ I do not need help 我不需要協助

7 Can you live safely and move easily around in your home? 您能在家中安全地生活並活動自如?

- ☐ Yes 是
- ☐ No 不是

8 What is your living situation today?[1] 請問您目前的居住情況如何?

- ☐ I have a steady place to live. 我有一個穩定居所
- ☐ I have a place to live today, but I am worried about losing it in the future. 我今天有穩定居所，但我擔心將來可能失去它
- ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) 我沒有穩定居所（目前暫住其他人家中、旅館、庇護所、露宿街頭、海灘、汽車、廢棄建築物、公車站、火車站或公園）

9 Do you have family members or others willing and able to help you when you need it? 當您需要幫助時，您是否有家人或其他人願意及提供協助?

- ☐ Yes 有
- ☐ No 沒有

10 Do you ever think your caregiver has a hard time giving you all the help you need? 您是否曾經認為您的照護者很難為您提供您所需的協助?

- ☐ Yes 有
- ☐ No 沒有

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Face-to-Face Encounter

CMS regulation requires require that all SNPs must provide for face-to-face encounters for the delivery of health care, care management or care coordination services as feasible on at least an annual basis

- The Care Coordination team may engage with the member in-person where possible and feasible and/or collaborate with a provider for the in-person contact such as a contracted home health, case manager, facility/office provider, community health worker
- May work with various providers or entities to coordinate the member's needs
- When in-person engagement is not available or appropriate such as when the member refuses, CCHP may utilize alternative communication methods such as telemedicine platforms, telephonic outreach, or mail to supplement the member contact

Development of Individualized Care Plans (ICP)

CMS regulation requires an individualized care plan (ICP) is developed for each member enrolled in SNP

- HRA responses used to develop/update the ICP
- Data such as claims and labs is used to develop the member's ICP when no HRA response is received
- ICP is maintained and stored to assure access by all care providers and meet HIPAA and professional standards
- ICP may include the following:
  - Member's health care preferences
  - Goals and objectives and targets with detailed tasks and self-management plans
  - Interventions and services tailored to member's unique and individual needs
  - Documentation if time-bound goals met or not met
- Utilize evidence-based guidelines such as InterQual Care Guidelines

Individualized Care Plan Goals Model

ICP goals based on the SMART Measurable Goal Model:

1. **Specific** – Exactly what is to be learned/accomplished by the member.
2. **Measurable** – A quantifiable goal and specific result that can be captured reported and documented in the ICP.
3. **Attainable** – Goal is achievable by the member.
4. **Relevant** – Goal is clearly linked to health status.
5. **Time-Bound** – The deadline or time period to motivate and evaluate is specific in terms of specific date, number of days/weeks/months or calendar year.

Individualized Care Plan…*cont*.

- ICP developed addresses HRA responses and member preventive care gaps.
- Members that do not respond to the HRA will receive an ICP based in part of claims or encounter data.
- ICP is documented in the care management tool and updated when a member's health status changes or at minimum annually.
- ICP updates and changes are communicated to the member, caregiver(s) and provider(s).

ICP Sample

CCHP 華人基層計劃

您報告稱您患有糖尿病。

甚麼是糖尿病?
糖尿病通常是一種慢性和終身疾病。糖尿病是因為身體沒有足夠的胰島素。胰島素是由胰臟分泌出來的。食物經消化後會分解成葡萄糖（Glucose）。胰島素將葡萄糖和澱粉分解成所需的能量。如果沒有足夠的胰島素，葡萄糖會累積在血液裡。當血液裡的葡萄糖過高時，就會在尿液裡排出。糖尿病能引發嚴重的健康問題，例如心臟，腎，眼睛，和神經系統。

有什麼症狀?
- 常感口渴
- 頻尿及尿量增加
- 食慾增加
- 體重下降
- 視力減低
- 傷口癒合緩慢
- 皮膚乾燥或發癢
- 容易疲倦
- 足部感到刺痛或麻木

我應該怎麼做?
以下是您的建議目標，除非您的醫生已經給予您不同的目標:
- 在未來的一年內，我的血糖血紅素HbA1c將維持在7%以下或在我醫生為我設定的目標範圍內，並避免低血糖
- 在未來的一年內，我會保持腳部健康，預防感染
- 在未來的一年內,我會去做眼睛檢查和保持我的眼睛健康
- 在未來的一年內，我目前的腎臟功能將會改善或者維持現狀
- 在未來的一年內，我目前的膽固醇指標將會改善或者維持現狀
- 在未來的一年內，每次的醫生看診，我的血壓將會保持在130 / 80 mmHg以下
- 在未來的一年內,我的體重將在健康的範圍或在醫生為我設定的個性化目標內

以下行動可能幫助您或您的醫生制定一個計劃，以預防或減少您患重病的機率:

You reported that you have Diabetes.

What is Diabetes?
Diabetes is usually a chronic and lifelong disease. Diabetes happens when there is not enough insulin in your body. Insulin is made by the pancreas. Food is broken down into sugar (glucose) during digestion. Insulin changes sugar and starches into energy that you need throughout the day. Without enough insulin, glucose builds up in your blood. When the level of glucose becomes too high, it spills into the urine. Diabetes can cause serious health problems, such as heart, kidney, eye, or nerve damage.

What are the symptoms?
- Being very thirsty
- Urinating a lot
- Feeling very hungry
- Losing weight without trying
- Blurry vision
- Having sores that are slow to heal
- Having dry, itchy skin
- Feeling very tired
- Losing feeling or having tingling in your feet

What should I do?
The following are your recommended goals, unless different goals have been given to you by your doctor:
- My HbA1c test will maintain under 7% or a personalized goal my doctor set for me and avoid low blood sugar over the next year
- My feet will be healthy and free from infections over the next year
- My eyes will stay healthy as possible as demonstrated during my eye exam over the next year
- My current kidney function will improve or stay the same over the next year
- My current cholesterol levels will improve or stay the same over the next year
- My blood pressure will be under 130/80 mmHg at every doctor's visit
- My weight will be in a healthy range or a personalized goal set by my doctor over the next year

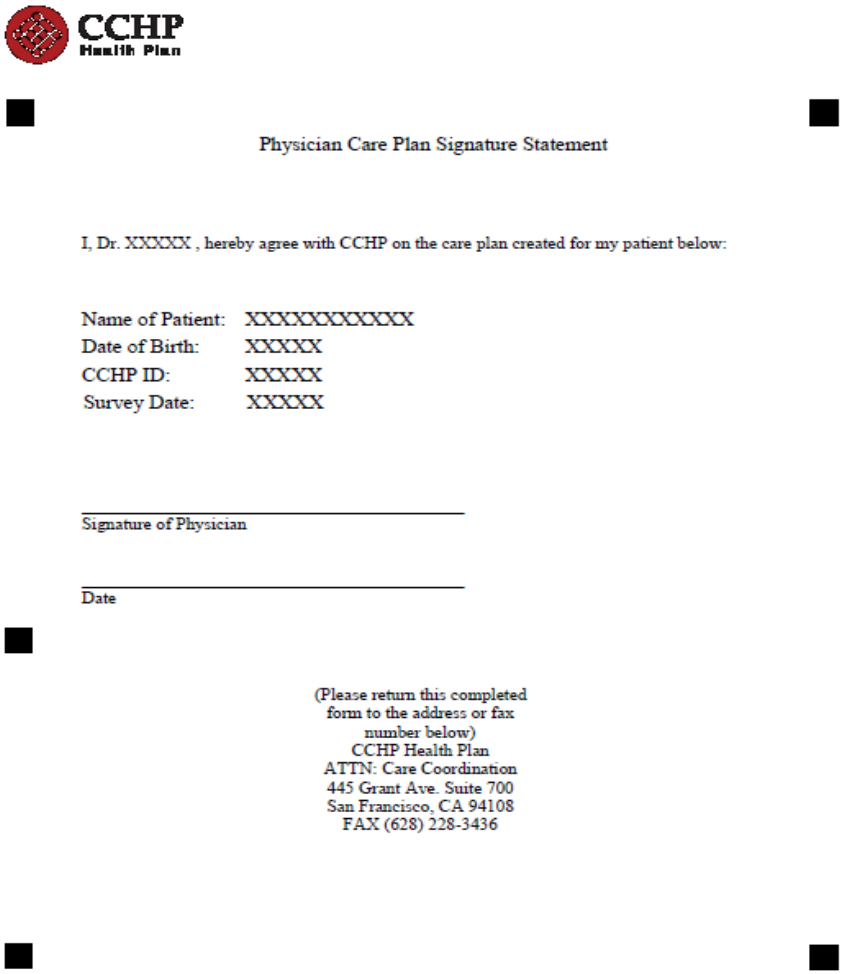
The following actions will help you and your doctor develop a plan to prevent or reduce your chances of serious health problems:
- I will make sure I see my doctor regularly (Last Visit: 11/09/2020)
- I will take diabetic medications if it is prescribed
- I will see an endocrinologist if recommended by my doctor (Last Visit: Data Not Available)
- I will do home blood sugar monitoring and keep records
- I will know what my blood sugar goal is after my next doctor's appointment
- I will know what my target blood pressure range is after my next doctor's appointment
- I recently completed my HbA1c test (Last Test: 5.70 05/04/2020)
- I will get my cholesterol blood test by06/07/2021
- I will get my kidney function blood test by12/31/2020
- I will follow the eating plan recommendations if given by my doctor
- I will know what my healthy weight goal is after my next doctor's appointment
- I will check and examine my feet daily

CCHP 華人基層計劃

- 我會定期約見醫生(上次見醫生日期: 11/09/2020)
- 如果我醫生給我開糖尿病藥，我會按照指示服藥
- 如果家庭醫生推薦,我會看內分泌科醫生（上次見醫生日期：沒有資料）
- 我會在家做血糖測試和記錄結果
- 在下一次看完醫生後，我會知道我的血糖目標是什麼
- 在下一次看完醫生後，我會知道我的血壓目標
- 我最近完成了血糖血紅素HbA1c測試（上次做測試日期：5. 70 05/04/2020）
- 我將會完成膽固醇血液測試 12/31/2020
- 我將會完成腎功能血液測試 12/31/2020）
- 我會遵守醫生提供的飲食建議
- 在下一次看完醫生後，我會知道我的體重目標是什麼
- 我會每天進行自我腳部檢查

ICP Distribution

- ICP are communicated via mail, fax, and secure email.
- Providers are asked to sign and return the *Physician Care Plan Signature Statement* to Care Coordination department.



CCHP Health Plan

Physician Care Plan Signature Statement

I, Dr. XXXXX , hereby agree with CCHP on the care plan created for my patient below:

Name of Patient: XXXXXXXXXXX
Date of Birth: XXXXX
CCHP ID: XXXXX
Survey Date: XXXXX

Signature of Physician

Date

(Please return this completed form to the address or fax number below)
CCHP Health Plan
ATTN: Care Coordination
445 Grant Ave. Suite 700
San Francisco, CA 94108
FAX (628) 228-3436

Interdisciplinary Care Team (ICT) and Staffing

- Participants of the ICT may include, but not limited to:
  - **Member/ Designated representative.** Provides input on health care preferences and plan of care.
  - **Primary Care Provider.** Acts as the member's gatekeeper. Works closely with the member to identify needs and ensure timely access to quality care.
  - **Chief Medical Officer.** Responsible for administrative performance compliance and care delivery services to ensure high quality of care for all beneficiaries
  - **Care Coordination Manager.** Oversees the day to day operations of the care coordination team.
  - **Care Coordination Nurses**. Contact communicate and coordinate care; post-discharge, disease and case management and health education.
  - **Medical Social Workers.** Address psychosocial issues access to low or no cost community resources, housing programs, appointments with network and out of network providers.
  - **MTM Pharmacist.** Address medication issues or concerns and refer to MTM program for medication review if deemed eligible.

Interdisciplinary Care Team (ICT)

- ICT composition is determined by member's needs.
- Provider and member participation in the ICT can better help address member's needs and achieve the plan of care.
- ICT may provide input and evaluate member's plan of care.
- CCHP holds ICT meetings regularly with clinical staff.

Transition of Care

Care transitions occur when a member moves from one health care provider or setting to another; for example, member was admitted to hospital and discharge to home, acute rehab, or skilled nursing facility.

- The member's plan of care is updated in the event of a health status changes or care transition.
- Primary care providers are notified when their patient has a transition of care.
- Our clinical staff will assist members to ensure appropriate follow up care is arranged after a transition of care.

Network Providers

- Incorporate relevant clinical information in the member's plan of care
- Follow transition of care protocols
- Utilize evidence-based care guidelines
- Annually review delegated group utilization decisions and member appeals process
- Review patient medication profiles in Medication Therapy Management (MTM) Program
- Contribute to improve the STAR and HEDIS outcomes reporting
- Help improve member experience through CAHPS and HOS data collection
- May participate in the Quality Improvement (QI) committee quarterly meeting

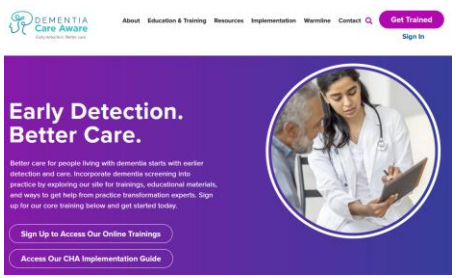
Role of the Provider

- Plays an integral part of the care team
- Encourage member to work with CCHP's care coordination team
- Take calls from the member's Care Coordinator
- Collaborate with the member's Care Coordinator to address needs
- Review the member's plan of care and send back the care plan attestation
- Participate in the ICT
- Complete the annual MOC training

Provider Dementia Care Aware Training

- Per DHCS- MOC 3c Factor 1A- Providers are encourage to complete training on initial screening and comprehensive assessment for dementia.
- The California Senate Bill 48 established an annual cognitive health assessment as a Medi-Cal benefit for beneficiaries age 65 and older if they are otherwise ineligible for a similar assessment as part of the Medicare Annual Wellness Visit.
- Providers can receive payment for this Medi-Cal benefit if providers complete cognitive assessment training approved by DHCS using validated tools recommended by DHCS.
- Dementia Care Aware training in the link below:

  https://www.dementiacareaware.org/



MOC Measurement

CCHP measures the effectiveness of its MOC by utilizing standardized measures to monitor performance such as:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Utilization measures (Admissions, ER visits, Length of Stay)
- Member experience (CAHPS, HOS surveys)
- Member satisfaction with Care Coordination

Summary

- CCHP SNP MOC needs to be YOUR model on managing care for your patients
- The model supports the mission of CCHP and its business objectives
- You are key to improving our members health outcomes

Training Attestation

To finalize completion of this training module, please click on the link below or scan the QR code to sign the attestation statement online.

I acknowledge that I have completed the **2024 SNP MOC Provider Training**.

Link to the SNP-MOC Attestation:

https://forms.office.com/r/NKbs5EJxby

QR Code for the Attestation:

Contacts and information

General Mailbox:

For Care Coordination needs:

- Care.management@cchphealthplan.com

For Provider needs:

- Provider.relations@cchphealthplan.com

References

- Centers for Medicare and Medicaid (2014). Medicare Managed Care Manual - Chapter 5 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf)
- Centers for Medicare and Medicaid (2023). Medicare Managed Care Manual - Chapter 16B (https://www.cms.gov/files/document/r129mcm.pdf)
- CMS Special Needs Plans (https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans)
- CCHP SNP MOC
- CCHP Policies and Procedures

THANK YOU

CCHP
Health Plan