# MODEL OF CARE

INSTITUTIONAL EQUIVALENT SPECIAL NEEDS PLAN (IE-SNP)
DUAL-ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)

*Training for network providers and out-of-network providers routinely seen by enrollees*

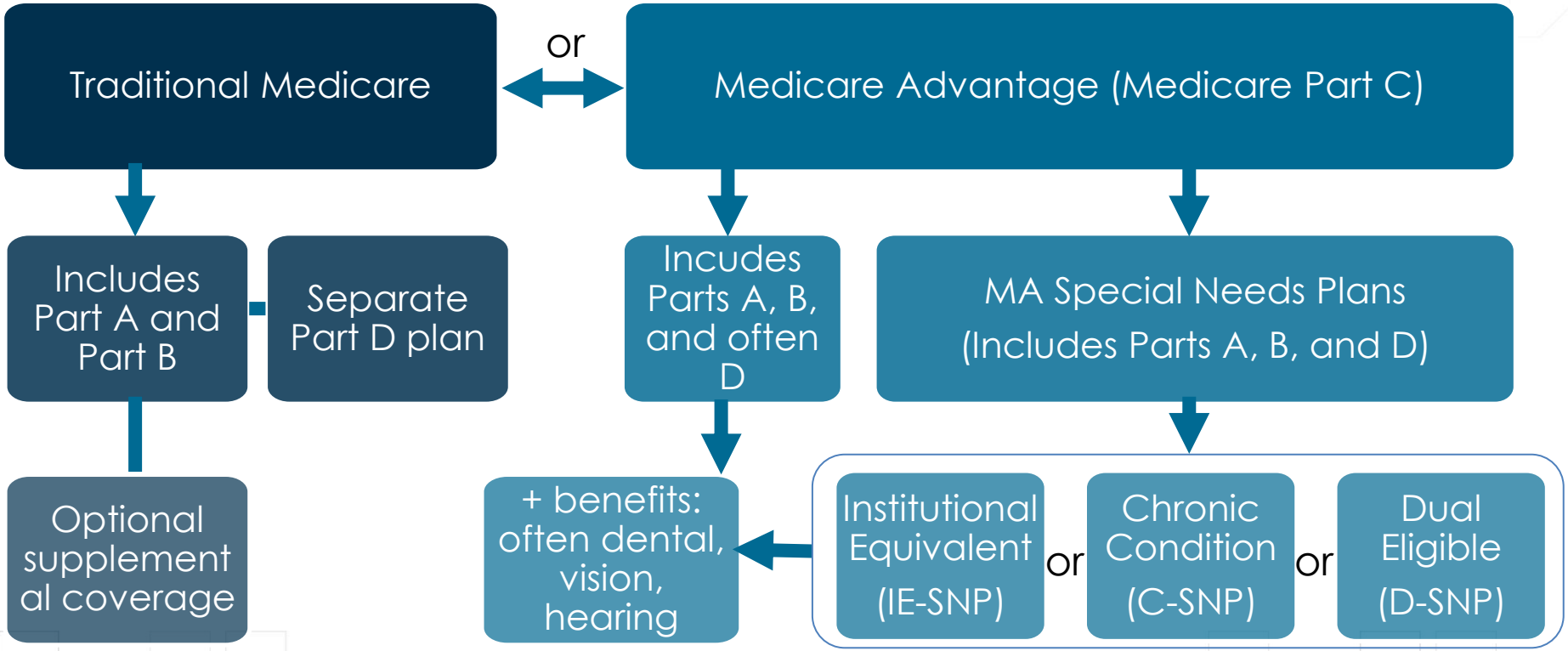
SANFORD HEALTH PLAN

# Objective

*Educating providers with a comprehensive overview of all D-SNP program requirements, expectations, and provider roles and responsibilities for the Plan's Model of Care*

- Medicare 101
- About Institutional Equivalent Special Needs Plan (IE-SNP) and Dual-Eligible Special Needs Plans (D-SNP)
- Model of Care Overview
- Care Coordination: Health Risk Assessment, Individualized Care Plan, Interdisciplinary Care Team, Face-to-Face Encounters, Care Transitions
- Provider Network
- Quality Measurement and Performance

# Medicare 101




Part A: hospital insurance, Part B: medical insurance, Part D: drug plan

# Special Needs Plans (SNPs)

## Medicare Advantage SNPs

Provide benefits and services to

- People with specific diseases: chronic condition plans, or C-SNPs
- Those who need nursing home levels of care: institutional plans, or IE-SNPs
- Those who qualify for Medicare and Medicaid: dual-eligible plans, or D-SNPs

SNPs include care coordination and design special benefits, provider networks, and drug formularies around the populations they serve.

**Plan D-SNP**

Sanford Health Plan offers a D-SNP, providing care to those who qualify in Burleigh County, Cass County, and Morton County. The Plan features a broad provider network, special benefits, and heavy emphasis on care coordination to support Member needs.

**Plan IE-SNP**

Sanford Health Plan offers an IE-SNP, providing care to those who qualify in our ND, SD or NE service area. The Plan features a broad provider network, special benefits, and heavy emphasis on care coordination to support Member needs.

# Who can join the I-SNP?

## Eligibility

To be eligible, an individual must

- Be enrolled in Medicare Part A and B
- Live in the Plan's service area (specific counties within the States of SD, ND, and NE)
- Be a citizen or lawfully present in US
- Have resided or are expected to reside in a contracted LTC facility for 90 or more days

Sanford Health Plan has a thorough process for determining, verifying, and tracking eligibility for enrollment.

**Profile**

I-SNP eligible beneficiaries tend to have average age 80+, chronic medical, cognitive, and behavioral health issues, and polypharmacy versus other Medicare Advantage enrollees.

All members reside in a long-term care facility (LTC).

# Who can join the IE-SNP?

## Eligibility

- To be eligible, an individual must
- Be enrolled in Medicare Part A and B
- Live in the Plan's service area (specific counties within the States of SD, ND, and NE)
- Be a citizen or lawfully present in US
- Reside at home or in a participating Assisted Living or Basic Care Facility but require an equivalent level of care as a Skilled Nursing Facility
- A determination that the individual has institutional Level of Care (LOC) needs

Sanford Health Plan has a thorough process for determining, verifying, and tracking eligibility for enrollment.

**Profile**

IE-SNP eligible beneficiaries tend to have average age 80+, chronic medical, cognitive, and behavioral health issues, and polypharmacy versus other Medicare Advantage enrollees.

IE-SNP plan is designed for individuals living in the community, but requiring an institutional level of care

# Who can join the D-SNP?

## Eligibility

To be eligible, an individual must

- Be enrolled in Medicare Parts A & B
- Live in Burleigh, Cass, or Morton County
- Be a citizen or lawfully present
- Be eligible for North Dakota Medicaid

Sanford Health Plan D-SNP has a thorough process for determining, verifying, and tracking eligibility for enrollment.

**Profile**

D-SNP-eligible beneficiaries tend to have low incomes and limited savings, but they have greater variation in age, physical health, and mental health than other Medicare Advantage enrollees.

Some may be age 65+ and in relatively good health despite poverty; others may have life-long disabilities or have significant physical or mental impairments that are barriers to employment.

# Model of Care Overview

SNPs are required to submit a Model of Care (MOC) for scoring and approval by the National Committee for Quality Assurance (NCQA) that outlines the covered population, care coordination, provider network, and quality management/performance improvement approach.

# MOC 1: The IE-SNP Population

Characteristics of Sanford Health Plan's IE-SNP population:

- Predominantly Caucasian
- Predominantly Female
- Predominantly English speaking
- Average age of 80+
- Multiple co-morbidities and conditions
- Cognitive impairments and mental illness
- Frailty
- Affected by disabling conditions. Examples:
  - Severe depression and mental illness
  - Cardiac arrythmias, heart failure, vascular disease
  - Diabetes with complications
  - COPD
  - Dementia with complications
  - Chronic kidney disease
  - Morbid Obesity

IE-SNP Members are expected to require highly coordinated care and ongoing support.

# MOC 1: The D-SNP Population

Characteristics of Sanford Health Plan's D-SNP population:

- Predominantly Caucasian
- Predominantly Female
- Predominantly English speaking
- Average age of 66
- Very low income
- Multiple co-morbidities and/or co-occurring conditions
- Affected by disabling conditions. Examples:
  - Severe depression and mental illness
  - Cardiac arrythmias, heart failure, vascular disease
  - Diabetes with complications
  - COPD
  - RA, inflammatory and connective tissue disorders
  - Chronic kidney disease

D-SNP Members are expected to require highly coordinated care and ongoing support.

# MOC 2: Care Coordination

*Care coordination is a pivotal element of the IE-SNP and D-SNP Model of Care.*

The **Health Risk Assessmen**t is a comprehensive tool used in the first 90 days and then annually to:

1. Collect member self-reported health status, conditions, and treatments
2. Identify potential gaps (medical, functional, cognitive, psychosocial, and mental health) in existing care and immediate care needs
3. Monitor changes in self-reported health status

*The Plan uses this information to stratify Member needs and risk as High, Medium, or Low for care planning.*

| HRA Tool Question Domains |
|---|
| Medical/Physical Health |
| Behavioral Health/ Substance Use Disorder |
| Cognitive |
| Psychosocial |
| Social Determinants of Health |
| Functional: ADLs/IADLs |
| Existing Services and Supports |

# MOC 2: Care Coordination

An **Individualized Care Plan (ICP)** organizes care around Member needs identified in the HRA.

The Advanced Plan Provider (APP) for IE-SNP and Care Coordinator for D-SNP drafts the plan with the following essential components:

1. Members individualized problems, goals, interventions, and provides a guide for member's care
2. Member self-management goals and objectives
3. The Member's personal healthcare preferences
4. Service needs tailored to the Member's medical, behavioral health or substance abuse, psychosocial, functional, and cognitive needs
5. Roles of the Member's natural supports and/or authorized person
6. Identification of goals met or not met

# MOC 2: Care Coordination

An **Interdisciplinary Care Team (ICT)** ensures effective coordination of care and optimal outcomes by leveraging different disciplines, training, and background of engaged care and service providers

- The APP/Care Coordinator proposes ICT members based on their expertise, role and/or established relationship with the Member.
- The core team typically includes the Member, caregiver, APP/Care Coordinator, and PCP and may be supplemented based on Member needs.
- The ICT refines the ICP as needed.
- ICT members collaborate and communicate, respecting Member goals and preferences. ***This is an essential provider expectation.***

# MOC 2: Care Coordination

## Roles & Responsibilities of Providers, Physicians & Clinicians

- **Communication**
  - Communicate relevant information with plan regarding member's care
  - Respond to communication form Plan regarding member's care
  - This includes communicating with multiple people
    - Members
    - Care Givers
    - Care Management teams
    - Other members of the Interdisciplinary Care Team
- **Participating in the development of the ICP**
- **Maintain ICP and transition of care notices from the Plan**
- **Complete Model of Care training annually and complete the attestation**

# MOC 2: Care Coordination

**Face-to-face encounters** are critical to coordinating care with IE-SNP and D-SNP Members.

The requirement for at least one face-to-face encounter (with the Member's permission) within the first 12 months of enrollment and annually thereafter will be satisfied through the APP/Care Coordinators.

Examples:

- Completion of the initial or annual HRA
- Care Planning discussions related to the overall ICP or specific interventions
- Care Transition planning
- Health and preventive care education and disease management information

*After a visit, the APP/Care Coordinator will update the ICT, if needed, with proposed changes to existing services, new care and services, appointments needed with PCP or specialists, other interventions, and any ICP updates.*

# MOC 2: Care Coordination

Members experiencing **Care Transitions** require particular support.

The Plan's transitional care model will support all those changing care setting or level of care  regardless of provider network affiliation or Member's low, medium, or high stratification level.

To reduce the incidence of inappropriate care transitions, particularly those resulting in unnecessary ED visits, hospital admission, and re-hospitalizations and to promote continuity of care, the Plan will focus on Member-centered care, communication, and Member safety.

*The APP/Care Coordinator will be the point of contact for communication with the Member, caregiver, ICT, and other members of the extended care team. After a transition, the APP/Care Coordinator will update the HRA and communicate proposed changes to the ICP.*

# MOC 3: Provider Network

The Plan's credentialed providers provide the full scope of covered services Members need.

- Actively licensed, credentialed
- Collaborate with the ICT and contribute to a beneficiary's ICP
- Plan confirms access, availability, and provider data accuracy regularly

| Provider Category | Examples of Provider Types |
|---|---|
| Primary Care Providers | Internal Medicine, Family Practice, General Practice, FQHCs, RHCs, and advance practice professionals including nurse practitioners and physician assistants. |
| Specialists | Cardiology, Endocrinology, Neurology, Orthopedics, Pulmonology, OB/GYN, Surgeons, Oncology, Pulmonology; Psychiatry, Addiction Medicine, Psychologists, Clinical Social Work, Clinical Psychology and advance practice professionals |
| Medication | Pharmacies, Pharmacists |
| Outpatient and Ancillary Services | Laboratory, radiology, diagnostic imaging, mammography, rehabilitation services (PT, OT, ST), SUD |
| In-Home Services | Home Health, DME, and therapeutic oxygen. |
| Nursing Facilities | Skilled and custodial care facilities. |
| Hospitals | Acute medical care, behavioral health, rehabilitation, transplant centers, LTACH. |
| Behavioral Health | Psychiatrists, Psychologist, Licensed Professional Counselors, Social Workers |

# MOC 4: Quality Measurement and Performance Improvement

The Quality Improvement (QI) Program supports and promotes the mission, vision, and values of Sanford Health Plan through continuous improvement and monitoring.

The QI Program is a systemwide program implemented and delivered through the integration and coordination of services. Patient safety is an integral component of providing quality care to all Members.

The Program enables oversight of Plan activities, such as policies and procedures, scheduled and ad hoc audits, reporting requirements, identification of responsibility, timelines, consequences for noncompliance, committee involvement, transparency, board quality committee approval, staffing requirements, project descriptions, etc.

# Questions?

You will be asked to confirm completion of training with an attestation that the Compliance Department will retain.

*It is important to understand the full Model of Care and the IE-SNP and D-SNP populations and to recognize the important role you, as a provider, play in safe, effective, and Member-focused care.*

Please let us know if you have questions or suggestions or would like further information.