Special Needs Plans (SNPs)

2019 SNP Model of Care (MOC) Training for Providers
COURSE OBJECTIVES

After completing this course, you will be able to:

› List 3 types of Special Needs Plans (SNPs) and how they are targeted to the SNP populations.
› Explain how SNPs improve care coordination and health outcomes.
› Describe what a Model of Care (MOC) is and its benefits.
› Provide detail about how doctors play important roles in obtaining higher Centers for Medicare & Medicaid Services (CMS) Star Ratings.
› Describe SNP MOC resources available to you from Cigna-HealthSpring.
In 2008, CMS issued the final regulation *Medicare Improvements for Patients and Providers Act of 2008*, known as **MIPPA**.

This regulation mandated that all Medicare Advantage plans that wanted to offer an SNP:

- Have an approved **MOC**.
- Create a SNP that provides additional services and benefits that meet the needs of the most vulnerable and frail population.
The Patient Protection and Affordable Care Act (PPACA) reinforced the importance of the SNP MOC as a fundamental component to the SNP program and requires that the National Committee for Quality Assurance (NCQA) perform a review that ensures the MOC meets the CMS SNP requirements.

NCQA will score and approve or deny a plan’s MOC.
Chapter 42 of the Code of Federal Regulations, Part 422 (42 CFR 422.101 (f)(2)(ii)) mandates that SNPs conduct annual SNP MOC training for all employed and contracted providers.
CMS created three SNP types: C-SNP, D-SNP, and I-SNP. A distinct MOC tailored to the targeted SNP population needs and conditions is required for each type of SNP.

<table>
<thead>
<tr>
<th>Chronic Condition SNP (C-SNP)</th>
<th>Dual Eligible SNP (D-SNP)</th>
<th>Institutional SNP (I-SNP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-SNPs are designed for Medicare beneficiaries with a specific medical condition, like diabetes.</td>
<td>D-SNPs are designed for Medicare beneficiaries who are eligible for Medicare and Medicaid.</td>
<td>I-SNPs are designed for Medicare beneficiaries who reside, or are expected to reside, in a long-term care facility for 90 days or longer.</td>
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| Cigna offers two C-SNPs:  
  • Cigna-HealthSpring Achieve  
  • Cigna-HealthSpring Achieve Plus | Cigna offers a single D-SNP: Cigna-HealthSpring TotalCare. | Cigna offers one I-SNP: Cigna-HealthSpring Traditions. |
What is a Model of Care (MOC)?

A MOC is the evidence-based process by which Cigna-HealthSpring integrates benefits and coordinates care for customers enrolled in SNPs.
Why is a MOC Important?

- MOCs **facilitate early assessment**, and identify health risks and major changes in the health statuses of customers. MOCs facilitate coordination of care to improve the overall health of our customers, and describe the care management program for SNP customers.

- **Evidence-based guidelines** serve as the foundation of the care management program and are the evidence-based process (Clinical Core Model) by which we integrate benefits and coordinate care for customers enrolled in Cigna-HealthSpring’s SNPs.
Cigna-HealthSpring’s approved clinical practice guidelines can be found in your Provider manual on the Cigna-HealthSpring website:

http://www.cigna.com/medicare/healthcare-professionals/
SNP MOC KEY FEATURES

Domain 1: SNP Population
- Sub-Population: Most Vulnerable Beneficiaries
- SNP Staff Structure
- Health Risk Assessment Tool
- Individualized Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- Care Transitions Protocols

Domain 2: Care Coordination
- Specialized Expertise
- Use of Clinical Practice Guideline, Care Transition Protocol
- MOC Training for the Provider Network

Domain 3: Provider Network
- MOC Quality Performance Improvement Plan
- Measureable Goals and Health Outcomes for the MOC
- Measuring Patient Care Experience (Satisfaction)
- Ongoing MOC Performance Improvement Evaluation
- Dissemination of SNP MOC Quality Performance

Domain 4: Quality Measurement, Performance Improvement

*Determined and required by the CMS
SNP MOC Goals are to...

- Improve access to medical, mental health, and social services.
- Improve access to affordable care.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health care settings and providers.
- Improve access to preventive health services.
- Ensure appropriate utilization of services.
- Improve beneficiary health outcomes.

* Determined and required by the CMS
Each SNP offers a distinct MOC specific to the population served:

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<td>Focuses on diabetes management</td>
<td>Offers a wide variety of services</td>
<td>Customers are most often the frail elderly who are no longer able to care for themselves.</td>
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<td>Services include routine diabetes monitoring, preventive screenings, and customer outreach with an A1c greater than or equal to 8. Diabetes programs include chronic disease management, blood sugar control, diabetes supplies (blood sugar monitors, strips, etc.), diabetes education and coaching, and medication.</td>
<td>Services include, chronic-condition disease management, low to no copayment for monthly premiums, primary care physician (PCP) office visits, dental coverage, routine eye and hearing examinations, preventive screenings, and customer outreach. Benefits vary based on the plan selected.</td>
<td>Patients’ inability to manage their health independently or in the community may be due to a cognitive or functional decline or a medical or mental illness. Unique services are designed to meet their complex needs.</td>
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SNP MOC CLINICAL CARE MANAGEMENT MODEL

Benefits of a SNP: Improved Care Coordination and Health Outcomes

1. Health Risk Assessment (HRA)
   - The HRA is a comprehensive assessment of a customer’s medical, psychosocial, cognitive, and functional needs.

2. Risk Stratification
   - HRA responses and other data are used to identify a customer’s care needs.

3. Individualized Care Plan (ICP)
   - HRA responses are used to create an ICP. The ICP may be revised with health status changes.

4. Interdisciplinary Care Team (ICT)
   - The ICT supports SNP customers and ICP goal development.

5. Care Transition Protocols
   - Care transitions can result in a health status change, therefore we coordinate care.

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HOW WE SUPPORT YOU

We help by:

- **Participating** in your patient’s Interdisciplinary Care Team (ICT) meeting
- **Collaborating** with ICT case managers and members of the ICT committee
- **Encouraging** patients and/or their caregivers to participate in the ICT
- **Helping** your patients achieve their health goals through ICP goal management
- **Informing** the PCP of transitions of care
The ICT includes:

- Member or his/her caregiver
- Member’s PCP
- Nurse Care Managers
- Others based on the customer’s individual health care needs

Need help?

Reach out to Case Management – we’re here to help!
YOU ARE THE KEY ELEMENT TO IMPROVING CUSTOMERS’ HEALTH OUTCOMES

Did you know that SNP and CMS Star Ratings have similar metrics?
YOU ARE THE KEY ELEMENT TO IMPROVING CUSTOMERS’ HEALTH OUTCOMES

Doctors: You play an important and critical role!

Assisting with Health Risk Assessment (HRA) completions improves Star Ratings.
YOU ARE THE KEY ELEMENT TO IMPROVING CUSTOMERS’ HEALTH OUTCOMES

Doctors: You play an important and critical role!

Assisting with Health Risk Assessment (HRA) completions improves Star Ratings.

Reviewing care plans with patients improves Care Coordination Star metrics.
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Doctors: You play an important and critical role!

Assisting with Health Risk Assessment (HRA) completions improves Star Ratings.

Reviewing care plans with patients improves Care Coordination Star metrics.

Addressing care plan goals not met...

Preventive Screenings are Star Ratings.
YOU ARE THE KEY ELEMENT TO IMPROVING CUSTOMERS’ HEALTH OUTCOMES

Doctors: You play an important and critical role!

Assisting with **Health Risk Assessment (HRA) completions** improves Star Ratings.

Reviewing **care plans** with patients improves **Care Coordination** Star metrics.

Addressing care plan goals not met... **Preventive Screenings** are Star Ratings.

**Reviewing** transition of care notifications and placing them in your patients’ medical records.
YOU ARE THE KEY ELEMENT TO IMPROVING CUSTOMERS’ HEALTH OUTCOMES

Doctors: You play an important and critical role!

Assisting with **Health Risk Assessment (HRA) completions** improves Star Ratings.

Reviewing **care plans** with patients improves **Care Coordination** Star metrics.

Addressing care plan goals not met...**Preventive Screenings** are Star Ratings.

Reviewing **transition of care notifications** and placing them in your patients’ medical records

Scheduling **follow-up appointments** within seven days of discharge improves Star Ratings.
YOU ARE THE KEY ELEMENT TO IMPROVING CUSTOMERS’ HEALTH OUTCOMES

Doctors: You play an important and critical role!

Assisting with **Health Reimbursement Account (HRA) completions** improves Star Ratings.

Reviewing **care plans** with patients improves **Care Coordination** Star metrics.

Addressing care plan goals not met... **Preventive Screenings** are Star Ratings.

Reviewing **transition of care notifications** and placing them in your patients’ medical records

Scheduling **follow-up appointments** within seven days of discharge improves Star Ratings.

**Encouraging Medication Adherence.**

Medication Adherence improves Star Ratings.
YOU ARE THE KEY ELEMENT TO IMPROVING CUSTOMERS’ HEALTH OUTCOMES

Doctors: You play an important and critical role!

Assisting with **Health Reimbursement Account (HRA) completions** improves Star Ratings.

Reviewing **care plans** with patients improves **Care Coordination** Star metrics.

Addressing care plan goals not met... **Preventive Screenings** are Star Ratings.

Reviewing **transition of care notifications** and placing them in your patients’ medical records

Scheduling **follow-up appointments** within seven days of discharge improves Star Ratings.

Encouraging **Medication Adherence**. Medication Adherence improves Star Ratings.

Attending **ICT meetings**. If you’re unable to attend, review the care plan you received.
YOU ARE THE KEY ELEMENT TO IMPROVING CUSTOMERS’ HEALTH OUTCOMES

Doctors: You play an important and critical role!

Together, through our communication and collaboration, we will improve your patient’s health outcome and you’ll achieve improved Star Ratings!
WE’RE HERE TO HELP!

SNP Resource Contact Information

Dual and Chronic SNP Customers:

› For HRA questions, call our team at: 1-800-331-6769.

› For ICP or ICT questions, call our Case Management team at: 1-866-952-7593. The telephone number can also be found in your Cigna Provider Manual.

Institutional SNP Customers:

› For HRA, ICP, or ICT questions, call our Care Coordination team at: 1-866-487-3004.
WRAP-UP

Thank you for participating in Cigna’s 2019 SNP MOC Training!