Special Needs Plan
Model of Care Provider Training

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Agenda

- Training Overview
- Special Needs Plans
- Model of Care
- Resources

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Training Overview

Training Overview

- The Centers for Medicare & Medicaid Services (CMS) requires UnitedHealthcare to provide Model of Care (MOC) training for all care providers in-network for a Special Needs Plan (SNP) and out-of-network care providers seen by SNP members routinely.
- Today's training will help you understand:
  - CMS requirements for the SNP MOC
  - MOC key components
  - Your role in supporting the MOC
- Because the care coordination process described in the MOC can vary across insurers, you may be asked to complete multiple SNP MOC trainings.

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Doc#: PCA-1-013512-01152019_02192019

MOC Training Procedure

- You may complete the training individually.
- You may also complete the training as a group representative and share it with care providers in your group.
- Please use the attestation form at the end of this training to attest to your training completion.

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Special Needs Plans
(SNPs)

SNP Overview

- SNPs are Medicare Advantage coordinated care plans that are required to have a MOC.
- SNPs help identify and address members' unique health care needs.
- SNPs can help improve care continuity and coordination.
- A SNP can be a:
  - Health maintenance organization (HMO)
  - HMO point of service (HMO-POS)
  - Local or regional preferred provider organization (PPO or RPPO)

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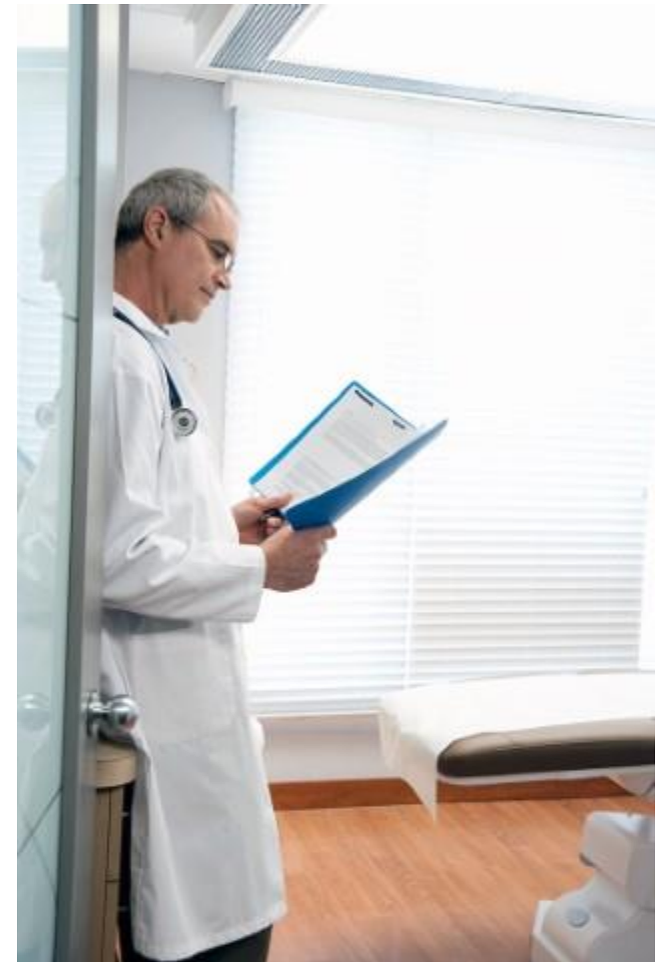
SNP Care Providers

- SNP care providers are contracted to offer health care services to SNP members.
- We notify care providers about our SNP MOC training through emails, online notifications, our *Network Bulletin* newsletter and other messages.



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Who are SNP Members?

- SNP members often have comorbidities such as diabetes, chronic heart failure, cardiovascular disease or chronic lung diseases.
- They may reside in their homes, skilled facilities or in the community while receiving skilled care.
- They may be affected by language barriers, health literacy challenges, poor socioeconomic status, cultural barriers, limited resources, limited access to health resources and caregiver limitations.

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SNP Member Eligibility

Members must qualify for one of the following Medicare Advantage SNPs:

- **Dual SNPs (DSNPs):** Members are eligible for both Medicare and Medicaid.
- **Fully Integrated Dual Eligible (FIDE) SNP:** This DSNP provides members with access to Medicare and Medicaid benefits managed under one health plan.
- **Institutional SNPs (ISNPs):** Members have an actual or expected stay of 90 days or longer in a nursing facility or skilled nursing facility.
- **Institutional Equivalent SNPs (IESNPs):** These members live in an assisted living facility or community and require an institutional level of care.
- **Chronic Special Needs Plan (CSNP)*:*** Members have specific severe or disabling chronic conditions specified by CMS.

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Chronic Conditions

- CSNPs can enroll members who have one of the following **15 chronic conditions**:
  - Alcohol and drug dependence
  - Autoimmune disorders
  - Cancer
  - Cardiovascular disorders
  - Chronic and disabling mental health conditions
  - Chronic heart failure
  - Chronic lung disorders
  - Dementia
  - Diabetes
  - End-stage liver disease
  - End-stage renal disease requiring any mode of dialysis
  - HIV/AIDS
  - Neurological disorders
  - Severe hematological disorders
  - Stroke
- UnitedHealthcare doesn't currently offer plans for all 15 conditions.

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Model of Care

Model of Care

- CMS requires all SNPs to have a MOC.
- The MOC describes **the structure for care management and coordination.**
- **The MOC includes four elements:**
  - SNP population description
  - Care coordination elements
  - Care provider network overview
  - Quality measurement and performance improvement

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Care Coordination

The MOC describes the essential components of care coordination:

- Structure and oversight
- Administration of the health risk assessment tool (HRAT)
- The member's individualized care plan (ICP), based on their HRAT results
- The interdisciplinary care team (ICT) contributing to the member's care
- Transition protocols for members

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The HRAT

- The HRAT is a screening assessment tool used to identify:
  - Medical conditions
  - Psychosocial and functional status
  - Cognitive ability and mental health
- An HRAT must be completed within **90 days** of member enrollment and within **365 days** from the previous assessment.
- HRAT results are used to create or update the member's ICP.

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ICP

- The ICP includes:
  - The member's self-management goals and health care preferences
  - A description of services tailored to the member's needs
  - Measurable goals – and actions taken if goals aren't met
- To encourage care coordination, we share ICPs with the member's primary care provider (PCP) verbally, online or by fax, mail or email.
- We also share member HRAT results and ICPs with the member, authorized family members and caregivers.
- You can view your patient's ICP online and add comments by using the Care Conductor tool on Link. To access the tool, go to **UHCprovider.com** and click on the Link button in the top right corner.

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The ICT

- The ICT uses **measurable goals** to manage services, help meet the member's health care needs and evaluate their progress.
- The ICT can evolve based on the member's health care needs and outcomes.
- We encourage members and their caregivers to actively participate in their ICT. The ICT can also include:
  - Behavioral health clinicians
  - Pharmacists
  - PCPs
  - Nurses and social workers
  - Other health care professionals

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Care Transition Protocols

Transition protocols provide **continuity of care** through:

- Appropriate follow-up appointments and services
- Plan member education on health indicators
- Assistance with transitional care such as:
    - Medication reconciliation
    - Review and communication of ICPs with appropriate caregivers
    - Self-managed health skills and activities

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SNP Care Providers

The MOC describes:

- The care provider’s expertise for the special needs population
- Oversight of the care provider network and collaboration with the ICT through the ICP process
- The use of Clinical Practice Guidelines (CPGs) and care transition protocols
- Initial and annual MOC training for care providers

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Performance Measurement

- We measure **MOC performance goals** and share our results.
- Our ongoing performance monitoring and annual evaluation focuses on:
  - Improving member access to health care, based on SNP population needs
  - Improving care coordination and service delivery by aligning the member's **HRAT, ICP** and **ICT**
  - Enhancing care transitions across health care settings and care providers
  - Helping members utilize services for preventive health and chronic conditions

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Resources

Contact

If you have questions about this training, please contact our SNP MOC training team at **snp_moc_providertraining@uhc.com** or **877-842-3210.**

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Thank you.

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