Special Needs Plan
Model of Care Provider Training
Agenda

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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.
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.
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)
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.
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.
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.
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.
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
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
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.
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.
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
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
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
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
Resources
Contact

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