



Special Needs Plan Model Of Care

Dual Eligible Special Needs Plan
Provider Training



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Quality health coverage. It's our Mission.

Introduction

- The Centers for Medicare and Medicaid Services (CMS) require that providers receive Special Needs Plan (SNP) Model of Care (MOC) Training annually.
- The Medicare Improvements for Patients and Providers Act (MIPPA), signed into law on July 15, 2008, added new requirements pertaining to a SNP MOC.
- This training describes how Fidelis Care, its network providers, and providers who routinely see SNP members can work to ensure a successful Model of Care that complies with regulations and benefits their Fidelis Care members.
- We hope you find this training of value, and we thank you in advance for your ongoing work to ensure access, quality of care, and quality of service to our members.



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Dual Eligible Special Needs Plans

- Dual Eligible Special Needs Plans (D-SNPs) are specialized Medicare Advantage plans for individuals with special needs. They are specifically designed for low-income elderly and low-income disabled individuals.
- Fidelis Care SNP members are eligible for Medicare and Medicaid because they are among the most vulnerable populations in New York State and are often disabled and/or live with persistent medical conditions.



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Special Needs Plan (SNP)

Model of Care (MOC) Components

The Special Needs Plan (SNP) Model of Care (MOC) is a service delivery mechanism that contains the following 11 elements:

1. Description of SNP-specific Target Population
2. Measurable Goals
3. Staff Structure and Care Management Roles
4. Interdisciplinary Care Team (ICT)
5. Provider Network Special Expertise and Use of Clinical Practice Guidelines
6. Model of Care Training (plan staff and provider network)
7. Health Risk Assessment (HRA)
8. Individualized Care Plan (ICP)
9. Communication Network
10. Care Management for the Most Vulnerable Subpopulation
11. Performance and Health Outcome Measurements



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The SNP Population

The Model of Care is based upon the description of Fidelis Care's Special Needs Plan population:

- The medical, social, cognitive, environmental, living conditions, and comorbidities associated with the SNP population in their geographic service area.
- Including other characteristics that affect health such as, population demographics (e.g., age, gender, ethnicity) and potential health disparities associated with specific groups (e.g., language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, and caregiver considerations).



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SNP Model of Care Services

Fidelis Care's SNP Model of Care (MOC) offers the opportunity for the Plan to work with providers for the benefit of members.

- It includes delivery of specialized services and benefits to Special Needs Plan members who are:
 - Mentally Complex.
 - Have Multiple Chronic Conditions.
 - Frail and Disabled.
 - Are Near the End of Life.
- Add-on services include but are not limited to:
 - Non-emergency Transportation.
 - Private Duty Nursing.
 - Home Health Aide.
 - Inpatient Mental Health Services.



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Fidelis Care Provider Network

All Lines of Business*

- ✓ **69,913** Providers serving **1,524,017** Members, of which **31,794** are **Dual SNP Members**
- ✓ **13,827** Primary Care Providers
- ✓ **52,480** Specialists
- ✓ **209** Hospitals
- ✓ **3,397** Other

Vendor Network*

- ✓ **4,335** Dental
- ✓ **1,305** Vision
- ✓ **4,936** Pharmacy

Fidelis Care contracts with providers who have expertise specific to the SNP population.



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*Based on September 2016 Contracting data.

Provider Network By Region

Buffalo Region

All Lines of Business

10,824 Providers

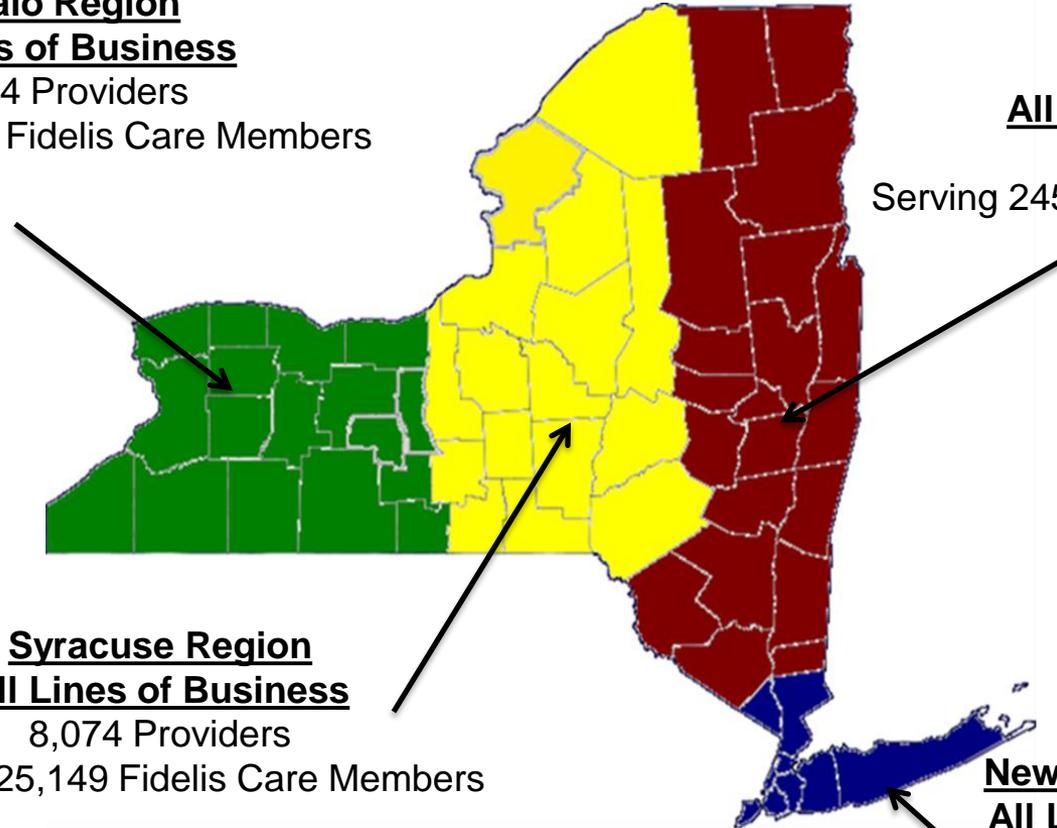
Serving 224,344 Fidelis Care Members

Albany Region

All Lines of Business

10,122 Providers

Serving 245,047 Fidelis Care Members



Syracuse Region

All Lines of Business

8,074 Providers

Serving 225,149 Fidelis Care Members

New York City Region

All Lines of Business

42,138 Providers

Serving 829,477 Fidelis Care Members



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Interdisciplinary Care Team (ICT)

All SNPs must have an Interdisciplinary Care Team (ICT) to coordinate the delivery of services and benefits to members.

Purpose of the ICT:

- Review each member's Individualized Care Plan and re-evaluate as needed.

The ICT consists of:

- Individuals who have experience with the SNP population and the unique care needs of the member, including:
 - Member and or Designee(s).
 - Physician.
 - Registered Nurse.
 - Behavioral Health Specialist.
 - Medical Social Worker.
 - Other individuals or clinicians as indicated by the member's situation



Provider's Role in the ICT

The provider's role in the ICT is essential to ensure quality in the delivery of health services. Providers are expected to:

- Communicate and collaborate with health plan care managers, members of the ICT, and members and caregivers on developing and updating the Individualized Care Plan for each SNP member.
- Identify available alternatives to manage the special needs of the members and improve their health outcomes.
- Review Individualized Care Plan with members and assist them with referral processes as needed.
- Perform ongoing analysis and reassessment of members health care status.
- Participate in the ICT as requested to ensure optimal coordination of care and transition of care.



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Provider Network — Specialized Expertise

Fidelis Care is committed to maintaining a network of quality providers in compliance with CMS to ensure members can select providers from a range of specialties and facility types.

- All providers must meet credentialing requirements.
- PCP contracts require 24/7 availability or designated coverage.
- Wait time is to be a maximum of one (1) hour over 90% of the time.
- Geomapping assessments of provider locations are conducted.
- Routine assessments of providers are performed to ensure all standards are met.



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Provider's Role in Provider Network — Specialized Expertise

- Complete the Fidelis Care credentialing and re-credentialing process.
- Keep updated credentials.
- Notify Fidelis Care of credentialing changes and status as a Fidelis Care provider.
- Comply with the Clinical and Preventive Health Practice Guidelines.



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Health Risk Assessment (HRA)

The Health Risk Assessment (HRA) is a standardized instrument that is part of the assessment of every SNP member.

Fidelis Care provides outreach to our members to collect information about their health in an effort to gain as much initial information as possible when individuals join the SNP, at least annually thereafter, and any time there is a significant change in the member's health status.

Fidelis Care completes a HRA within 90 days of a member's enrollment, with reassessments performed as often as necessary, but no later than one year after the member's last documented HRA.



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Individualized Care Plan (ICP)

Individualized Care Plans (ICP) are developed as a guide for care delivery in conjunction with the member/caregiver, primary care provider, and other appropriate specialists.

The Care Plans include:

- Resource-specific services and benefits to be utilized, including appropriate level of care.
- Identification of measurable outcomes.
- Short- and long-term goals.
- Provision of educational materials and one-on-one education.
- Collaborative approaches to be used, including community and family participation.
- Coordination of Medicare and Medicaid benefits to maximize service delivery and increase cost efficiency.
- Identification of, and strategies to overcome, potential barriers to achieving identified goals, including but not limited to financial, cultural, language, or family/community support issues.
- Planning for continuity of care, including transitions in care.



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Provider's Role in the ICP

- Review and discuss the Individualized Care Plan sent by Fidelis Care with the member.
- Work with member to continue treatment established in the Individualized Care Plan.
- Update the Individualized Care Plan as member's health status changes.
- Coordinate care with our Care Managers.



Care Coordination

Fidelis Care staff ensures the delivery of specialized services to SNP members through Care Coordination activities.

- Conduct Health Risk Assessment.
- Schedule Interdisciplinary Care Team Meetings.
- Assign Dedicated Care Manager.
- Develop Individualized Care Plan.
- Enact Care Transition Protocols.



Care Transition Protocols

Care Managers at Fidelis Care ensure:

- A point of contact as members move between levels of care.
- Continuity of care for SNP members.
- Contact members within 3 business days of an inpatient discharge.
- Assistance with scheduling follow-up services and appointments.
- Facilitation of information sharing between providers as members move between levels of care.
- Measurement of changes in the member's health status.
- Assistance to members with appropriate self-management activities.



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Provider's Role in Care Transition Protocols

- Assist Care Manager and hospital with inpatient discharge planning.
- Include the admission or discharge notification sent by Fidelis Care in the member record for reassessment and medication reconciliation.
- Conduct a medication reconciliation within 30 calendar days of discharge.
- Schedule more frequent appointments with members when they are undergoing transitions between levels of care.
- Review and discuss the updated care plan as result of health status changes.
- Comply with the pre-authorization process established by Fidelis Care.



Care for the Most Vulnerable Population

Fidelis Care identifies its most vulnerable SNP members for additional case management intervention through daily and quarterly reports.

These reports include:

- High utilization patterns.
- Transitions in care settings.

Our most vulnerable members typically exhibit 5-7 risk factors, identified from the member's chronic health care conditions, utilization patterns, and other complex needs, care gaps, and concerns.

Examples of Most Vulnerable Population includes Members with:

- Behavioral health diagnosis in addition to one or more chronic medical conditions or social circumstances of concern
- Need for social services interventions such as housing, food, heat, financial assistance
- 2 or more non-elective inpatient stays in the previous year
- 5 or more medications
- Cancer
- HIV



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Care for the Most Vulnerable Population

Additional intervention for these vulnerable members may include:

- Collaboration and coordination with other health care and community organizations when needed such as in-home meals.
- Providing in-home supportive services such as personal care aide.



Provider's Role in the Care for the Most Vulnerable Population

- Become familiar with the benefits that Fidelis Care Special Needs Plans provide members, so you can better serve your patients.
- Review Fidelis Care's Individualized Care Plans to ensure alignment with your Treatment Plan.
- Review test results with members, their medication adherence, and their adherence to primary care and specialty appointments.



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Communication Network

Fidelis Care communicates with stakeholders using:

- Face-to-face meetings.
- Telephone (to discuss care needs).
- Mail (to provide a copy of the Individualized Care Plan).
- Email (to provide non-PHI printed materials).
- Secure email (to provide PHI and other sensitive material outside the Fidelis Care network firewall).
- Fidelis Care website (to notify of changes to the MOC).
- Member Newsletter (both mail and web version).
- Secure file transfer protocol and other secure protocols via the Internet (exchanging data with regulatory agencies).
- Video conference (interoffice meetings, including visiting officials, providers, and members).



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Provider's Role in the Communication Network

- Communicate availability to participate in meetings and conference calls with the ICT.
- Access the Fidelis Care Provider Portal site on a regular basis to obtain our communications.
- Check mails and emails regularly for Fidelis Care communications.
- Maintain regular contact with the Care Management staff at Fidelis Care.



Quality Measurement and Performance Improvement

- The goal is to improve the SNP's ability to deliver health care services and benefits to SNP members in a high-quality manner.
- Quality measurement and performance improvement concepts are used to drive organizational change.
- Fidelis Care's Executive and Senior Leadership provide oversight to ensure a comprehensive quality improvement program is in place to measure current level of performance and determine if organizational systems and processes must be modified based on performance.



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Quality Measurement and Performance Improvement

Measures, Goals, and Health Outcomes, including:

- Ensuring access to and affordability of health care.
- Improving coordination of care and appropriate delivery of services.
- Enhancing care transitions across all health care settings and providers.
- Engaging members and providers to improve health outcomes.
- Ensuring appropriate utilization of services for preventive health and chronic conditions (including some HEDIS measures).
- Measuring SNP Member Satisfaction and Health Outcomes.



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Provider's Role in Quality Measurement and Performance Improvement

- Reassess the member to identify health status changes and update the Individualized Care Plan.
- Analyze reports communicated by Fidelis Care.
- Keep proper communication in the member record to support HEDIS data collection process.
- Participate and support Fidelis Care quality improvement initiatives.
- Participate in Fidelis Care provider satisfaction surveys.
- Respond timely to requests for information from Fidelis Care.



How Does SNP Model of Care Benefit Providers?

- Better manage transition of care process.
- Identify problems and anticipate potential crises.
- Help coordinate Medicare/Medicaid benefits for members.
- Reinforces the Provider's Treatment Plan.
 - Ensure medications are obtained and taken appropriately.
 - Encourage members to follow their physician's plan of care.
 - Encourage appropriate follow-up with providers.
 - Ensure understanding of provider instructions.
 - Obtain community resources for non-medical needs.
- When possible, prevent unplanned transitions and adverse outcomes.



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Questions?

If you have any questions, please call the
Provider Call Center at:

1-888-FIDELIS (1-888-343-3547)



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Thank you

- We hope you found this Medicare Special Needs Plan (SNP) Model of Care (MOC) Training helpful. Your access to this presentation has been recorded.
- Please download this presentation and share it with others at your practice as appropriate.

