

# **Independent Health's Assure Advantage (HMO-SNP)**

## **Chronic Condition Special Needs Plan for those with Heart Failure and Diabetes**

**Model of Care Training  
2020**



# Topics Covered in This Training

- What is a Chronic Condition Special Needs Plan (C-SNP)
- Independent Health's C-SNP program
- Description of Target Population/Eligibility Requirements
- Benefit Structure
- Application Process/Provider Verification/Post Enrollment
- Model of Care
  - Health Risk Assessment (HRA)/Tool
  - Individualized Care Plan (ICP)
  - Interdisciplinary Care Team (ICT)
  - Provider Network
  - Quality Measurement and Performance Improvement

# What is a C-SNP Plan?

- “C-SNP” refers to “Chronic Condition Special Needs Plan”:
  - A C-SNP is a special needs plan designed for individuals who have certain chronic care conditions

# Independent Health's Background

- Independent Health's Chronic Condition Special Needs Plan is a C-SNP offered by Independent Health beginning January 1, 2019:
- The name of the plan is Independent Health's Assure Advantage (HMO-SNP)
- The goal of this plan is to administer a care model that enhances the quality of life for our members.
- This is a 'high-touch' managed care plan specifically for those with both diabetes and chronic heart failure which includes:
  - Telephonic and in-person support (home visits if necessary)
  - Member Education
  - Provider/lab testing coordination
  - Medication reconciliation & support

# Description of Target Population/Eligibility Requirements

- The targeted C-SNP population has a combination of geographic and disease specific criteria. The plan is designed for individuals who are currently diagnosed with two condition categories: diabetes and chronic heart failure.

The following are the disease states that is required to be eligible for the plan:

(Reference slide #11 for diagnosis codes to affirm member's disease state)

## CHF

- From any cause, including cardiomyopathy, diastolic dysfunction, pulmonary hypertension, lung disease, valve disease and more
- Compensated or unstable status
- Any combination of medications
- Normal or reduced ejection fraction
- Left- or right-sided

## Diabetes

- Type 1 or Type 2
- Using insulin or not
- Diet-controlled

# Eligibility Requirements Con't

- The individual can choose to enroll throughout the year (not just 1 time in the fall like “regular” Medicare Advantage)
- The beneficiary must be entitled to/or enrolled in Medicare Parts A and B
- The beneficiary must live in Erie County, NY (even if physicians are not in Erie County).
- The individual can be dual eligible (both Medicare and Medicaid)

# Benefit Structure – Specific to Population

- The 2021 benefit structure is designed to support needs of the C-SNP population:
  - \$0 copay for:
    - Diabetic monitors and supplies\*, therapeutic shoes & inserts
    - Medical and routine podiatry visits (unlimited routine visits)
  - Special Formulary - \$11 select care drugs used to treat heart failure and diabetes, including covered insulins and supplies for insulin administration
  - 12 one-way non-emergency transportation trips to a medically necessary destination
  - Competitive premium for plan with Part D benefits - \$60

# The Application Process

- The individual receives a sales kit from Independent Health to include:
  - An application
  - Pre-enrollment Qualification Assessment Tool (allows conditional enrollment if completed with the application)
  - Release of Information-Provider Verification Form (allows diagnoses confirmation from the primary care provider)
- Application Process:
  - Eligible individual chooses plan
  - Physician verifies inclusion criteria (signs verification form)



# The Application Process - Provider Verification

- Verification of Eligibility:
  - Verification of current diagnoses of diabetes and chronic heart failure is required for plan participation.
  - If the Provider Verification Form or telephonic attestation is not received by Independent Health by the end of the first month of enrollment, the member will be disenrolled from the plan at the end of the second month.

The next two slides provide you with an example of the Pre-enrollment Qualification Tool, Provider Verification Form and list of diagnosis codes designed to assist you in verifying eligibility requirements



# The Application Process - Provider Verification

Enrollment in Independent Health's Assure Advantage® (HMO C-SNP) requires a diagnosis of both Diabetes and Chronic Heart Failure. Patients may qualify for enrollment if currently diagnosed with the following ICD-10 codes. Due to the progressive nature of CHF, chronic disease management is required. Members who have early stage CHF (even if asymptomatic) also qualify for enrollment in Independent Health's Assure Advantage® (HMO C-SNP).

Diagnosis Code	Description	
<b>Specific enrollment criteria includes having at least one diagnosis from the Diabetic condition category and one from the Chronic Heart Failure condition category (diagnoses listed below)</b>		
E10.xx	Type 1 diabetes mellitus	<b>Diabetic Codes</b>
E11.xx	Type 2 diabetes mellitus	
E08.xx	Diabetes mellitus due to underlying condition	
E09.xx	Drug or chemical induced diabetes mellitus	
A3681	Diphtheritic cardiomyopathy	<b>Chronic Heart Failure Codes</b>
B3324	Viral cardiomyopathy	
I0981	Rheumatic heart failure	
I110	Hypertensive heart disease with heart failure	
I130	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	
I132	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	
I2601	Septic pulmonary embolism with acute cor pulmonale	
I2602	Saddle embolus of pulmonary artery with acute cor pulmonale	
I2609	Other pulmonary embolism with acute cor pulmonale	
I27.xx	Pulmonary heart conditions	
I28.x	Pulmonary vessel diseases	
I42.x	Cardiomyopathies	
I43	Cardiomyopathy in diseases classified elsewhere	
I50.xx	Heart failure	
I514	Myocarditis, unspecified	
I515	Myocardial degeneration	

**Note:** Please look for 3 digit prefix with either 4th (or 5th) digit qualifier in place of "x."



Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal.

H3362\_C7590\_C

© 2019 Independent Health Association, Inc. B427289

**Providers can reference the list of diagnosis codes on the back of the Provider Verification form to affirm the member's disease states.**



# The Application Process – Post Enrollment

- Once the member is enrolled, the member and the member's PCP will receive a letter to confirm enrollment into the Plan.
  - This is important because PCP's are part of the member's Interdisciplinary Care Team (ICT), as described in the MOC, and will coordinate with the Family Choice Care Manager (share information, actively support re: coordination needs, etc.)

# What is the Model of Care?

The Model of Care (MOC) is a comprehensive document developed by Independent Health and approved by CMS

- Provides the basic structure under which the Special Needs Plan (SNP) will meet the needs of its members
- Required by CMS for all Special Needs Plans
- Outlines the framework for promoting quality, care management and care coordination
- Describes how the unique needs of members are identified and addressed through the plan's care management practices

# Model of Care Con't

- The overall goal of the Independent Health MOC is to improve the quality of life for these members dealing with chronic heart failure and diabetes
- The MOC aims to assist these members with resources that may be available to meet their individual needs based on an individual plan of care.
- The C-SNP Care Coordination model of care includes an Interdisciplinary Care Team (ICT), Quality Measurements and Performance Improvement.
  - A collaborative process for improving the ability to deliver high-quality health care services and benefits to this population.
- The model, which includes care management and data analysis, is supported by one partner organization:
  - Family Choice of New York – Care Management Team

# Care Coordination: Health Risk Assessment (HRA)

- An individualized care plan is developed by a care manager to support the member's needs. This is a 'high-touch' managed care plan which includes:
  - Telephonic and in-person support (i.e., home visits if necessary)
  - Education
  - Provider/lab testing coordination
  - Medication reconciliation & support
- Each enrollee completes a Health Risk Assessment (HRA) to identify their unique needs (including medical, psychosocial, cognitive, functional and social aspects of care)
  - Member gets an HRA to evaluate needs (clinical, functional, environmental, social, mental health, etc.)
  - Family Choice personnel contacts member and creates an ICP with the member

# Health Risk Assessment Tool

- The Health Risk Assessment Tool:
  - A Health Risk Assessment Tool (HRAT) is completed by the member or conducted by a member of the Family Choice care manager team within 90 days of enrollment and annually thereafter. Additionally, reassessments occur if a member has a change in condition or a transition.
  - Responses on the HRAT are used by Family Choice care management team to populate information into the Individualized Care Plan (ICP).
  - The status in the answers shows the level of risk for various dimensions of the member's bio-psycho-social-functional-behavioral needs.



# Health Risk Assessment Tool Con't

- The Health Risk Assessment Tool:
  - Identified risks become the core of the Individualized Care Plan
  - HRAT information gets combined with other sources of information to stratify members and identify trigger points for outreach
  - Risk stratification results from the HRAT are used by Family Choice to:
    - Identify current and potential problems based on the assessment
    - Improve care coordination
    - Ensure members receive specialized medical and psychosocial care and related education through their Interdisciplinary Independent Team

# Care Coordination: Individualized Care Plan (ICP)

- The C-SNP Care Coordination model of care includes an Interdisciplinary Care Team (ICT), Quality Measurements and Performance Improvement.
- A collaborative process for improving the ability to deliver high-quality health care services and benefits to this population.

# Care Coordination: Individualized Care Plan (ICP)

- The Individualized Care Plan (ICP) may include the following essential components:
  - HRAT
  - Member's self management goals and objectives
  - Identified risks and goals for care and monitoring
  - Member's personal healthcare preferences
  - Specific interventions for diabetes
  - Specific interventions for chronic heart failure
  - Medications that might require close monitoring
  - Other medical problems that might affect the member's quality of life

# Care Coordination: Individualized Care Plan (ICP)

## Identification of Goals

- The care manager continually monitors the quality of care, services and products delivered to the member to determine if the goals are being met or if any new problems have developed.
- Through ongoing assessment, the care manager determines if the goals continue to be realistic and appropriate, and what interventions may be implemented to achieve or enhance positive outcomes.
- When progress toward goals is not being met, the care manager reassesses the case to identify and address known barriers.

# Care Coordination: Interdisciplinary Care Team (ICT)

- The member's Interdisciplinary Care Team (ICT) includes the following at a minimum:
  - Member/responsible party
  - Primary care physician
  - Family Choice care manager or Advanced Practice Provider (Nurse Practitioner or Physician Assistant)
  - Family Choice care coordinator
  - Other specialty providers as needed
- ICT members aim to improve the member's health by ensuring the following key areas are met:
  - Appropriate maintenance drugs are prescribed and taken for diabetes and chronic heart failure
  - Appropriate testing for disease control occurs
  - Identify barriers to care including functional, medical, social and behavioral
  - Coordinate transition of care needs and activity within the continuum of care

# Model of Care - Examples of Care Management Engagement with the Member

- Weekly/Monthly/Quarterly telephonic outreach by care manager:
  - Monitor of labs, weight, symptom management as necessary
- In-home visits by an NP, PA or MD depending on individual needs:
  - Fall Risk/Home Safety Assessment
  - Caregiver support
- Inpatient post-discharge follow up and transition of care management

# Model of Care - Examples of Care Management Engagement with the Member Con't

- Inpatient diversion programs (prevent need to go to emergency room)
- Access to 'Care Partners' – social work support
- Coordination and outreach for community services, including:
  - Scheduling in-home podiatry visits (important for diabetic)
  - Assistance in applying for HEAP
  - Meal delivery coordination (NOT a benefit)
  - Medicaid applications
  - Educational opportunities and material provided (i.e., diabetes self-management training)

# Provider Network

- Contracted providers with specialized clinical expertise pertinent to C-SNP population include:
  - Practitioners specializing in geriatric medicine
  - Internists/primary care physicians
  - Endocrinologists
  - Cardiologists
  - Nephrologists
  - Orthopedic surgeons



# Provider Network

- Facilities available to C-SNP members include:
  - Acute care hospitals
  - Tertiary medical centers
  - Dialysis centers
  - Acute care rehabilitation facilities
  - Skilled nursing facilities
  - Pharmacies
  - Outpatient diabetes management and cardiac rehabilitation centers
  - Wound care centers

# Quality Measurement and Performance Improvement

- The program uses specific outcome measures:
  - Identified for specified model of care goals.
  - The measures are tailored specifically to measure needs of those living with diabetes and chronic heart failure.
  - Measures are monitored at a specified frequency
  - The results of performance are compared with targeted thresholds.
    - Results of performance are reported to the Quality Improvement Committee and Independent Health leadership.
  - If targets are not met, management oversees the development and implementation of corrective actions, and they continue to monitor the outcomes until targets are met.

# C-SNP Model of Care Training Attestation

Thank you for completing the annual C-SNP Model of Care Training.

By completing the Attestation below you acknowledge:

- Participation in Independent Health's Assure Advantage (HMO-SNP) Chronic condition Special Needs Plan Annual MOC training
- Review and understanding of the course content provided
- Understanding of how your role and responsibilities support the MOC's implementation

[Click here to Start Attestation \(box - add link\)](#)  
[or exit and click on the link in the instruction page](#)