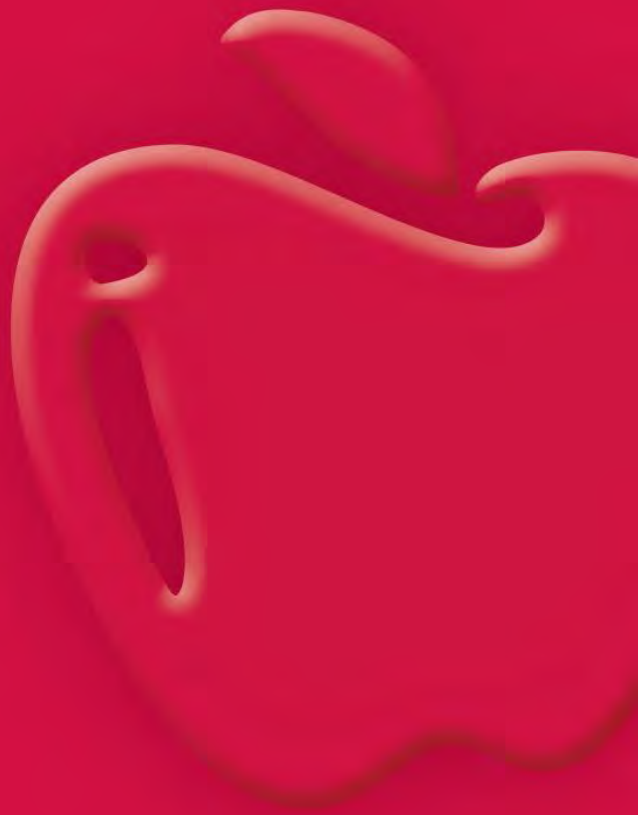
Independent Health's Assure Advantage (HMO-SNP) Chronic Condition Special Needs Plan for those with Chronic Heart Conditions

Model of Care Training
2026



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Special Needs Plans (SNP) – Medicare Advantage plan designed to attract and enroll Medicare beneficiaries who fall into a certain special needs demographic.

Independent Health currently offers two Special Needs Plans (SNP)

Institutional Special Needs Plan (I-SNP)

- Designed for individuals who require long-term care in a facility like a nursing home, skilled nursing facility and live in that setting for at least 90 days or more.
- Independent Health's Medicare Family Choice (HMO I-SNP) provides tailored healthcare coverage for those residing in institutional settings.
- Care coordination: Aim to coordinate care between the facility and provider, ensuring beneficiaries receive necessary medical services within the institution including specific medical treatments, therapies, and support services.

Chronic Condition Special Needs Plan (C-SNP)

- Designed to meet the unique needs of individuals living with certain chronic care conditions.
- Independent Health's Assure Advantage (HMO C-SNP) is tailored for those members with heart disease, conditions.
- Let's begin learning more about our CSNP plan through our Annual Model of Care Training.

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Topics Covered in This Training

- Intent of 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 – Care Coordination
  - Health Risk Assessment (HRA)
  - Individualized Care Plan (ICP)
  - Interdisciplinary Care Team (ICT)
  - Provider Network
  - Quality Measurement and Performance
- Conclusion of Training
- Questions? – Email: Jeremy.Laubacker@independenthealth.com

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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 heart disease conditions.

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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 chronic heart failure conditions which includes:
  - Telephonic and in-person support (home visits if necessary)
  - Member Education
  - Provider/lab testing coordination
  - Medication reconciliation & support.

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Description of Target Population/Eligibility Requirements

The following is the disease state 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

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Eligibility Requirements Con't

- The individual can choose to enroll anytime 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).

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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)

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The Application Process - Provider Verification

- Verification of Eligibility:
  - Verification of current diagnoses of chronic heart failure conditions is required for plan participation.
  - If Independent Health does not receive the Provider Verification Form or telephonic attestation 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 provides an example of the Pre-enrollment Qualification Tool, Provider Verification Form and list of diagnosis codes designed to assist you in verifying eligibility requirements.

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Independent Health's Assure Advantage (HMO C-SNP)

Pre-Enrollment Qualification Assessment Tool

Independent Health's Assure Advantage (HMO C-SNP) is a Medicare Advantage Special Needs Plan (SNP) designed for people currently diagnosed with a chronic heart failure condition category. To enroll in this plan, a provider must have diagnosed you with this health condition.

IMPORTANT - Please complete this form and submit this form with your enrollment application

If you can answer "Yes" or "Not sure" to any of the following questions, you may be eligible to join our chronic condition SNP. When this form is completed and submitted along with an enrollment application, you will be enrolled into Independent Health's Assure Advantage (HMO C-SNP). We will attempt to verify your chronic condition with your provider during the first month of enrollment. If we are unable to verify your chronic condition, we are required to disenroll you from the Special Needs Plan.

Enrollee Information

Last name:	First Name:	Middle Initial:
Medicare ID Number:	Phone (xxx-xxx-xxxx):	
Birth date (MM/DD/YYYY):		

Chronic Condition Questions

1. Have you been diagnosed with chronic (or congestive) heart failure (CHF) or related condition (see page 3)? ☐ Yes ☐ No ☐ Not Sure
2. Have you had problems with fluid retention in your lungs or swelling in your legs due to a heart problem? ☐ Yes ☐ No ☐ Not Sure
3. Do you take medication to prevent fluid retention? ☐ Yes ☐ No ☐ Not Sure

Provider Verification Form

Release of Information. By joining Independent Health's Assure Advantage (HMO C-SNP), a Medicare Advantage Special Needs Plan for chronically ill Medicare beneficiaries, I acknowledge that I have the chronic condition listed below. I authorize and direct the provider/provider representatives listed below to confirm my chronic condition if so requested by the health plan and to disclose my medical records to the health plan. The authorization shall be effective until I am no longer enrolled in the health plan. I understand that the health plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I do, however, understand that enrollment is contingent upon confirmation of my chronic condition by my provider's (or provider's representative) signature below. I further understand that I may revoke this authorization at any time in a signed, written communication, although the health plan may continue to maintain information obtained while this authorization was effective. Any disclosure made pursuant to this authorization that is redisclosed by the health plan is then no longer subject to the protections of the HIPAA Privacy Rule. I also acknowledge that the health plan may use, disclose, or obtain my personal health information with Medicare, any provider involved in my health care, or any other health plan as is necessary for treatment, payment and other health care operations.

ENROLLEE AUTHORIZATION: Please sign, complete and identify at least one provider who can confirm your current diagnosis of chronic heart failure:

1. **Enrollee Name:** _____
   First *Middle* *Last*
   Address: _____ City: _____
   State: _____ Zip: _____ Phone: _____ DOB: _____
2. **Provider Name:** _____ Phone: _____
   Address (if available): _____

Enrollee/Authorized Legal Representative Signature: _____ **Date:** _____

PROVIDER/PROVIDER REPRESENTATIVE, please complete and return this form to Independent Health within 48 hours of receipt. This section must be completed in full to process the application.

I, _____ (PROVIDER/PROVIDER REPRESENTATIVE), here by certify that _____ (Prospective Member) has the following health condition(s):
___**has a Chronic Heart Failure Condition Category** (See the back of this pamphlet for a list of ICD-10 codes)

Provider/Provider Representative Signature: **Date:**

For Office Use Only

Telephonic Attestation completed by: _____ CSNP
Full Name *Department* *Job Title*

Telephonic Attestation: Date: _____ Time: _____

Representative signature: _____ date: _____

Provider mail this form to: Independent Health, PO Box 610, Williamsville, NY 14231

Fax this form to: 716-250-7162

If you have any questions about this form, please call 1-800-958-4405 (TTY: 711) between October 1 - March 31: Monday - Sunday, 8 a.m. to 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. to 8 p.m.

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The Application Process - Provider Verification

Enrollment in Independent Health's Assure Advantage® (HMO C-SNP) requires a diagnosis of a Chronic Heart Failure condition. 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 Specific enrollment criteria includes having at least one diagnosis from the Chronic Heart Failure condition category (diagnoses listed below)
A3681	Diphtheritic cardiomyopathy
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."

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

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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 PCPs are part of the member's Interdisciplinary Care Team (ICT), as described in the MOC, and will coordinate with the Family Choice Care Manager/Care Coordinator (share information, actively support re: coordination needs, etc.).

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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.

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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.

- 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 model, which includes care management, is supported by the Care Management Team of our partner Family Choice of New York.

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Care Management

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Care Coordination

- Independent Health contracts with Family Choice of New York Medical, PC, (FC) to provide care management services as part of the Model of Care.

- This is a ‘high-touch’ managed care plan which includes:
  - Telephonic and in-person support (i.e., home visits if necessary)
  - Education
  - Assessments
  - Self management education
  - Medication management
  - Coordination of services
  - Care Coordination
  - HRATs/Care plan oversight
  - Transitions assistance
  - Provider/lab testing coordination
  - Medication reconciliation & support

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Staffing

Care Coordinator	• Assigned to Care Management Service Levels 0, 1, 2
	  • Level 0- members who have declined care management.
	  • Levels 1-2- members who are clinically stable and oftentimes independent or have excellent support systems in place. These members receive telephonic engagement routinely with our Care Coordinators and may have a periodic visit by a nurse.
	• Conducts HRA and reviews ICP with RN/APP Care Manager for approval and reports new onset or persistent symptoms to clinical team.
	• Communicates with other health care providers on behalf of the member.

RN Care Manager & Advanced Practice Provider (APP) Care Manager	• Assigned to Care Management Levels 3 and 4 • These members are more clinically complex members and benefit from closer follow up and engagement. These members receive in person home visits by our Registered Nurses or APP. • Ongoing assessment and monitoring with ICP review. • Communicates with other health care providers who are involved in the member's care.

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Care Coordination: Health Risk Assessment (HRA)

- The Health Risk Assessment Tool:
  - Completed within 90 days before or after enrollment, after an inpatient admission, and annually within 365 days of the last HRAT. Assesses the member's status and identifies possible risk factors.
  - Provides data that assists with the member's medical management
  - Questions are focused on five elements related to the member's needs:
    - Medical
    - Functional
    - Cognitive
    - Psychosocial/social determinants of health
    - Mental health

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Care Coordination: Health Risk Assessment (HRA) Cont.

- Each enrollee completes a Health Risk Assessment (HRA) to identify their unique needs (including medical, psychosocial, cognitive, functional, mental health and SDoH aspects of care).

- HRAT information gets combined with other sources of information to identify the predicted intensity and frequency of care management services and identify points for outreach. Results are then used to develop and update an Individualized Care Plan by to support the member's needs.

- 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 mental/psychosocial/SDoH care and related education through their Interdisciplinary Care Team.

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Care Coordination: Individualized Care Plan (ICP)

- The Individualized Care Plan (ICP) is a living document that outlines identified self-management goals and personal health care preferences and/or identified needs.

- The ICP has individualized goals with specific interventions and timeframes for goal evaluation and modification. Goals are clearly identified, measurable, and change as conditions/needs change.

- Care Managers and Care Coordinators review, confirm and update the ICP using HRAT and other available information. All ICPs are reviewed and signed by the APP or RN Care Manager.

- Identified risks become the core of the ICP– this plan includes explicitly stated member goals of care from the HRAT.

- The ICP is shared with the PCP for review and feedback after enrollment, annually, and after a hospital admission/observation.

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Care Coordination: Individual Care Plan (ICP)

The Individualized Care Plan (ICP) essential components:

- Member's self management goals and objectives
- Identified risks and goals for care and monitoring
- Member's personal healthcare preferences
- Specific interventions for chronic heart failure conditions
- Other medical problems that might affect the member's quality of life

Identification of Goals

- The Care Manager/Care Coordinator 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/Care Coordinator 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/Care Coordinator reassesses the case to identify and address known barriers.

Interdisciplinary Care Team

- **The Interdisciplinary Care Team (ICT)** is a member-centered group that collaboratively addresses and discusses the member's care plan, health status, and interventions. The ICT is comprised of:
  - Member/Member's Caregivers/Representatives
  - Care Coordinator
  - Care Manager RN or APP
  - Primary Care Provider
  - Social Worker
  - Additional members such as specialists, pharmacists, behavioral health specialists and social workers can be added.

- Care Managers and Care Coordinators are the primary source of facilitation for communication with the members of the ICT.

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Transitions of Care

- Continuity of care is an integral part of the C-SNP. For members who are in the hospital, the care team is alerted to the hospitalization via an available admission/discharge / transfer data feed available in Erie County through the health exchange, HEALTHeLINK.

- The members of the ICT, including the Care Manager and Care Coordinator are responsible for coordinating the care transition process and for ensuring that follow-up services and appointments are scheduled and performed.

- Member ICP information is made available to the hospital team.

- Upon discharge, the Care Manager or Care Coordinator calls the member upon discharge from the inpatient setting to schedule a follow up home visit with his/her Care Manager. A medication reconciliation is completed ensuring member has appropriate medication.

- The post-discharge contact may include communicating information related to community services available to assist with ongoing care and services such as Meal Delivery services provided under the Independent Health C-SNP benefit.

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

- Weekly/Monthly/Quarterly/Biannual telephonic outreach by Care Manager or care coordinator:
  - Monitor of labs, weight, symptom management as necessary

- In-home visits by an RN/APP (NP & PA) depending on individual needs:
  - Fall Risk/Home Safety Assessment
  - Caregiver support

- Social Worker support- Conducts psychosocial and social determinants of health (SDoH) assessments as needed.

- Provides psychosocial interventions as needed or refers member to a community resource.

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

- Communicates with the family/responsible party about the member's psychosocial and SDoH needs.
- Inpatient post-discharge follow up and transition of care management.
- Inpatient diversion programs (prevent need to go to emergency room).
- Coordination and outreach for community services, including:
  - Assistance in applying for HEAP
  - Meal delivery coordination (NOT a benefit)
  - Medicaid applications
  - Educational opportunities and material provided

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Provider Network

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

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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 cardiac rehabilitation centers
  - Wound care centers

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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 chronic heart failure.
  - Measures are monitored at a specified frequency

- The program uses specific outcome measures:
  - 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.

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C-SNP Model of Care Training Attestation

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

Completing the training acknowledges:

- 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 Model of Care

Click here to complete attestation: https://independenthealth.az1.qualtrics.com/jfe/form/SV_4Mjux1fcW6luMMm

Or, you may exit this presentation and fill out the attestation from the instruction page.

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