HealthTeam Advantage Chronic Special Needs Plan Education

Learning Goals

- Brief background of Medicare Advantage and HTA
- What is a Chronic Special Needs Plan (CSNP) and how does it differ from traditional Medicare Advantage plans?
- How do beneficiaries qualify for the plan?
- What is a Special Needs Plan (SNP) Model of Care (MOC)?
- Understanding the care coordination for SNP members and the development of an individual care plan (ICP)
- The membership and function of the interdisciplinary care team (ICT)

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Thank you for taking time to review the training material on the HealthTeam Advantage Chronic Special Needs Plan Model of Care. The goals of the training are to explain the differences between a Special Needs Plan and standard Medicare Advantage and how Special Needs Plans tailor additional services and benefits to Medicare beneficiaries who are considered more vulnerable. This training will include information of how beneficiaries qualify for a Special Needs Plan, what a Special Needs Plan Model of Care encompasses, and detail the critical importance of care coordination for a Special Needs Plan member through the development of an individual care plan and the interdisciplinary care team.

Medicare Advantage and HealthTeam Advantage

- HealthTeam Advantage launched as new Medicare Advantage plan in 2016
  - Guilford, Alamance, Randolph, and Rockingham
  - Now in 7 NC Counties (Alamance, Davidson, Davie, Guilford, Forsyth, Randolph, Rockingham)
- Cone Health owns 100% of HTA
- Two PPO products with 6,200 initial lives
- Current membership is around 15,000
- The HTA vision is to be the insurer of choice! And, thoughtfully explore geographic expansion, other product lines and continued evaluation of other opportunities.

HealthTeam Advantage is 100% owned by Cone Health. It was launched as a new Medicare Advantage insurance plan in 2016, initially serving beneficiaries in Guilford, Alamance, Randolph, and Rockingham counties. Initial enrollment was a little more than 6,000 lives. It has subsequently expanded to 7 counties in North Carolina and provides Medicare Advantage coverage to more than 15,000 beneficiaries. The HMO CSNP plan is a new offering in 2020 to provide additional coverage options for members with special needs.

Medicare Advantage and Medicare Special Needs Plans

- Congress created Special Needs Plans (SNPs) as a new Medicare Advantage (MA) plan type in 2003
- The Center for Medicare & Medicaid Services (CMS) approves three types of SNPs:
  - **Dual-eligible SNPs:** enroll only beneficiaries dually entitled to Medicare and Medicaid
  - **Chronic SNPs:** enroll only beneficiaries who have certain chronic or disabling conditions
  - **Institutional SNPs:** enroll only beneficiaries who reside in institutions or are nursing-home certified

When a person qualifies for Medicare, they have several choices. They may remain in the traditional Medicare program or they can choose a Medicare Advantage plan. In addition to these choices, Medicare beneficiaries with certain qualified conditions or qualifying situations may be able to enroll within a Medicare Advantage Special Needs Plan. CMS has approved three types of Special Needs Plans. The first is designed for beneficiaries who have dual eligibility for both Medicare and Medicaid. The second type is designed for beneficiaries with certain chronic or disabling conditions. Finally, institutional Special Needs Plans enroll beneficiaries who reside in institutions or are nursing home certified.

Characteristics of Special Needs Plans

- Limited enrollment: Members must have a qualifying condition
- The members tend to have multiple comorbid conditions and are more challenging, complicated, and costly to manage
- Plan benefits are customized to better meet the needs of the chosen population
- Enrollment options are year-round for those with qualifying conditions
- There must be a comprehensive SNP Model of Care (MOC) that provides a detailed road map for care management, policies, and clinical operations (The MOC must be approved by NCQA)

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In general, Special Needs Plans have limited enrollment as potential members must have a qualified condition. Most Special Needs Plan beneficiaries have multiple comorbid conditions and are more challenging, complicated, and costly to manage. Special Needs Plan benefits are generally customized to better meet the needs of the select population. For each of the Special Needs Plans, a comprehensive Model of Care that provides a detailed roadmap for the care management, policies, and clinical operations must be developed.

The CMS List of 15 SNP-specific Chronic Conditions

Medicare Advantage plan targeting benefits for persons with one or more of the following severe or disabling chronic conditions:

- Chronic alcohol and other drug dependence
- Autoimmune disorders
- Cancer (excluding pre-cancer conditions)
- Cardiovascular disorders
- Chronic heart failure
- Dementia
- Diabetes mellitus
- End-stage liver disease
- End-Stage Renal Disease (ESRD) requiring any mode of dialysis
- Severe hematologic disorders
- HIV/AIDS
- Chronic lung disorders
- Chronic and disabling mental health conditions
- Neurologic disorders
- Stroke

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When Chronic Special Needs Plans were originally developed, a panel was tasked with creating a list of eligible conditions. This ranges from issues with alcohol and drug dependence all the way through neurologic disorders. Most commonly, Chronic Special Needs Plans focus on diabetes mellitus and heart conditions.

HTA's Diabetes & Heart Care HMO CSNP

HealthTeam Advantage has expanded its existing Medicare Advantage product line by offering a Chronic Special Needs Plan (CSNP) for Medicare eligible beneficiaries who have diabetes and/or chronic heart failure.

Eligibility requirements:

- Eligible beneficiaries must be entitled to Medicare Part A and enrolled in Part B as of the effective date of coverage
- Prospective members must have a verified diagnosis of diabetes and/or congestive heart failure
- Prospective members must reside in Guilford County
- Prospective members must not have a diagnosis of End Stage Renal Disease (this restriction will be waived if the prospective member is a current member of an HTA PPO plan)

Eligibility will be verified by the following:

- At the point of enrollment, enrollees must attest to having the chronic condition. Verification of a member's diagnoses for enrollment in the CSNP will be confirmed through a provider verification form.

Given the integration HealthTeam Advantage enjoys with a successful ACO (THN) and a strong health system, HTA leadership felt the plan was well positioned to offer the expanded comprehensive services needed for a special needs population. Analysis of the existing HTA population indicated a strong need for additional services to manage diabetes and heart failure. Given the increased resources required to manage these more venerable members, enrollment was limited to a single county (Guilford) with plans to expand as we gain experience. The HTA Diabetes & Heart Care HMO CSNP was first offered January 1st, 2020.

Eligibility for a Chronic Special Needs Plans requires first and foremost that potential members be entitled to Medicare benefits. The members will also need to attest that they have diabetes, congestive heart failure, or both conditions at the time of their enrollment. Members will only be eligible if they reside in Guilford County. A simple chronic condition verification form will need to be completed by their identified PCP to remain enrolled within the CSNP.

Customer Value Proposition

"To partner with beneficiaries in management of their chronic conditions, reduce acute exacerbations of heart failure, improve diabetic control and generally improve care, outcomes and the experience of care."

- Individualized member care plan
- Care coordination between primary care and specialty services
- Concierge model for personalized customer service
- Integrated pharmacist support
- Disease specific education
- Specially tailored formularies ($0 copays for key meds)
- Care plans directed by local expert physicians
- Latest technologic advances to improve monitoring and compliance

For potential members with diabetes and/or heart failure, a Special Needs Plan provides an opportunity to have insurance coverage designed around their chronic condition. Each member has an assigned care manager who develops an individualized care plan. That care plan is built around national guidelines for the management of diabetes and heart failure but also considers an individual's unique situation and personal health goals. The benefits are designed to make it easier and more affordable to obtain needed services. There are $0 copays for key specialty visits in addition to the $0 copays for primary care appointments. The medication formulary is tailored specifically to improve affordability and therefore compliance with the medication necessary to improve diabetic control and stabilize heart failure. These plans are designed to partner with Medicare beneficiaries to better manage their chronic conditions, improve their outcomes as well as their experience of care.

Effect of CSNP Enrollment on Outcomes for Medicare Beneficiaries with Diabetes

Diabetic Medicare beneficiaries who are enrolled in CSNPs experience better outcomes than they would in non-specialized Medicare Advantage plans. Using a claims-based approach to compare beneficiary outcomes on five clinical and utilization measures, Avalere found that enrollees in a diabetes-focused CSNP were:

- 22% more likely to have a primary care visit
- 10% more likely to receive appropriate diabetes testing
- 38% less likely to have an inpatient hospital admission
- 32% less likely to have a readmission
- 6% more likely to fill (and refill) a prescription for an antidiabetic medication

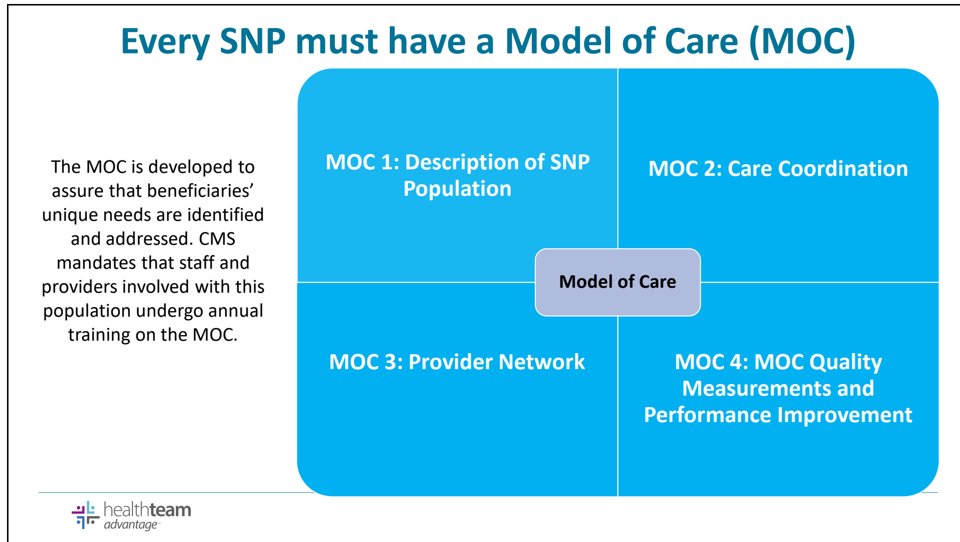
These findings held true when controlling for expected differences in enrollees' demographics and health status. The analysis suggests that CSNPs can improve outcomes for beneficiaries with diabetes compared to non-SNPs.

There is evidence that Special Needs Plans can provide beneficiaries with improved outcomes for their chronic conditions. For example, one study by Avalere demonstrated that Medicare beneficiaries with diabetes who were enrolled in a CSNP were significantly more likely to have appropriate testing and improved compliance and less likely to have hospital admissions and/or readmissions compared to similar diabetic members in traditional Medicare Advantage plans.

CMS Model of Care (MOC) Training Requirements

HealthTeam Advantage is required to conduct initial and annual training for in-network and out-of-network providers seen by members on a routine basis

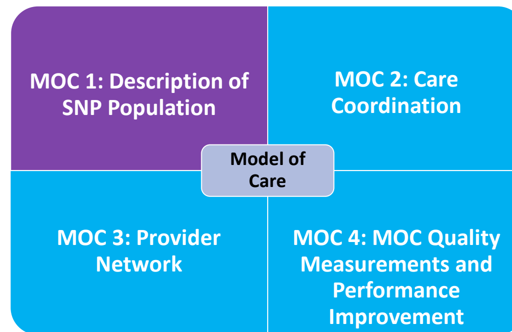
Special Needs Plans are required to conduct initial and then annual Model of Care training for both in-network and out-of-network providers who see CSNP members on a routine basis. The plan is required to document evidence that the organization makes Model of Care trainings available to these providers and performs outreach when necessary to encourage their completion of this training.



What really differentiates a Special Needs Plan from a traditional Medicare Advantage plan is the Model of Care. The Model of Care provides the road map for promoting quality, care management as well as the policies and procedures that will be deployed to deliver on the unique needs of enrollees. CMS considers the Model of Care to be a vital quality improvement tool and an integral component for ensuring that the unique needs of each member are identified and addressed. The Model of Care has approximately 75 sections divided into four major elements.

MOC Element #1

Understanding of the intended population with methods to identify the most vulnerable members of this population.



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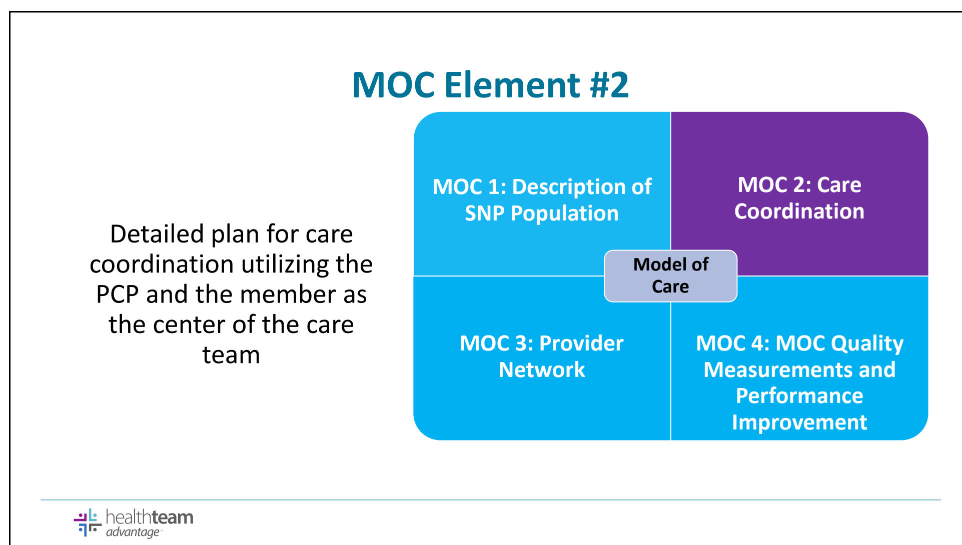
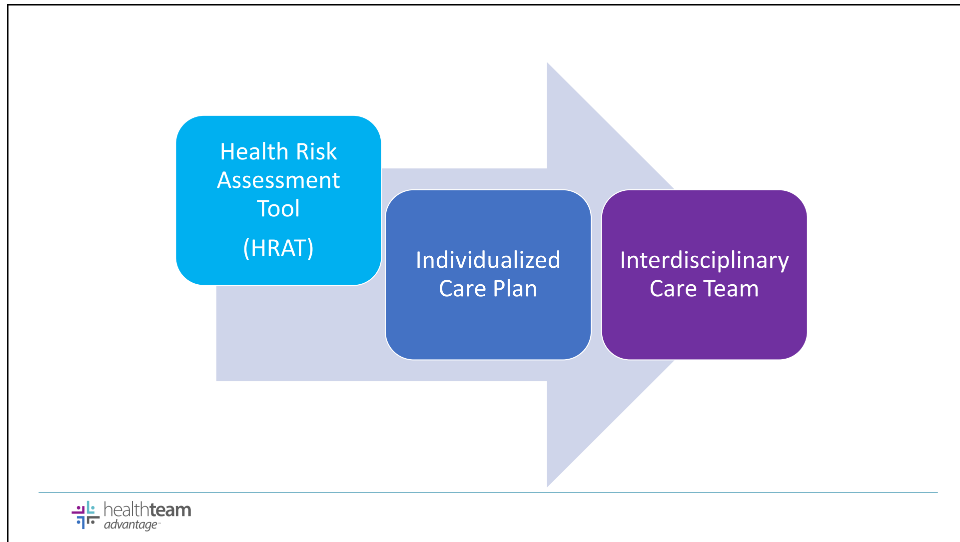
The first element of the Model of Care requires that a plan uses analytic, utilization, and cost data to understand the intended population so the most needy and vulnerable members can be identified. The expectation is that the cohort population is evaluated not only for its medical requirements but also social economic needs as well as potential barriers to receiving needed care and services. We analyzed our current Guilford county membership who have diabetes and/or heart failure to access not only their medical status but utilization patterns, social factors, cognitive challenges, and medical comorbidities to understand the most vulnerable sub-groups that require the most comprehensive care management and ancillary services.



The second element of the Model of Care focuses on care coordination. This requires a very detailed description of how the health plan will coordinate the healthcare needs and preferences of the member and share that information with the interdisciplinary care team (IDT). This element includes descriptions of the health risk assessment tool (HRAT), development of the individualized care plan (ICP), and membership of the interdisciplinary care team (ICT).

This element also includes how information will be shared during the care transitions or with other significant changes in the individual care plan.



HTA member's special needs assessment and care coordination development begins with a comprehensive health risk assessment tool. It is a CMS requirement that each member enrolled in a Special Needs Plan completes a health risk assessment that addresses not only their medical status but also helps determine social economic needs, barriers to getting care, impediments to activities of daily living, as well as self-reported concerns and personalized health goals.

Health Risk Assessment Tool

Sample Questions

14. Are you overwhelmed by managing a health condition?
- ☐ No
- ☐ Yes Which condition? ______________

15. Do you have trouble obtaining food on a frequent basis?
- ☐ No
- ☐ Yes

16. Do you need assistance with the following? Check one response for each task.

Task	Able to do this without help	I have some help with these	I need help and I have no one to help me.
Bathing			
Dressing			
Eating			
Using the restroom			
Walking			
Taking medications			
Meal preparation			
Housekeeping chores			
Shopping and errands			
Transportation			
Money management			

17. If you smoke, are you thinking about quitting smoking and interested in receiving some information?
- ☐ No
- ☐ Yes

18. Do you take more than eight medications?
- ☐ No
- ☐ Yes

19. Do you sometimes go without your medications due to cost?
- ☐ No
- ☐ Yes

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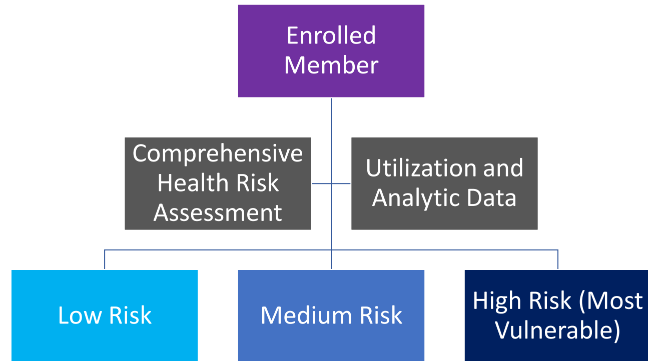
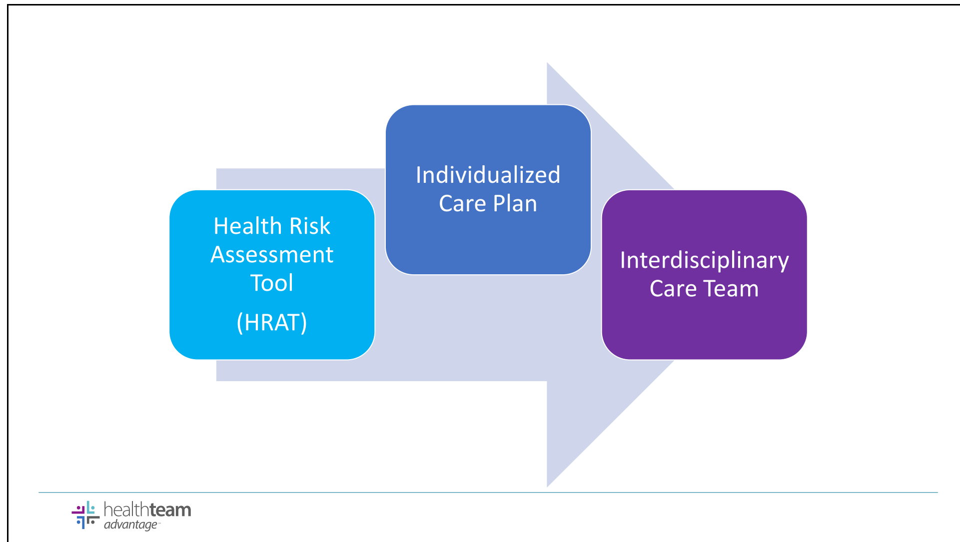
This slide shows some sample questions from the HealthTeam Advantage health risk assessment tool. The assessment is available to members online or in print. Assistance is available for members who have difficulty completing the form either through the member's personal HealthTeam Advantage Healthcare Concierge or their assigned THN Care Manager.



Responses from the health risk assessment, along with any available utilization data, is then used to risk stratify each member into a low-risk, medium-risk or a high-risk cohort. The high-risk group represents our most vulnerable membership.



Each unique member of the HTA CSNP will have their own Individual Care Plan (ICP) developed by their assigned Care Manager with input from the interdisciplinary care team as needed. This is created from the HRAT responses along with prior utilization data. Important components will include the member's own self-stated management goals and health objectives. The ICPs will include disease specific goals based on approved national guidelines. Care plans are reviewed and updated on a regular schedule based on the member's risk level. Additional reviews and updates are performed as needed during care transitions or based on IDT discussions.

Individualized Care Plans (ICPs)

High Risk

Moderate Risk

Low Risk

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DIABETES CARE PLAN

PROBLEMS

1. Member identified as diabetic through attestation and HbA1c value

INTERVENTIONS

1. Educational outreach via member newsletter and mailings
    a. Medication adherence
    b. Annual eye(retinal)exam
    c. Foot care
    d. Appropriate lab testing
    e. Dietary compliance
2. Recommended Guidelines and Physician Monitoring for Compliance
    a. 2019 American Diabetes Association Guidelines: https://professional.diabetes.org/content-page/practice-guidelines-resources
    b. Monitor gap closure of annual HEDIS diabetic measurement set
    c. Appropriate lab testing for monitoring including: HgbA1c, LDL-C and renal function panels
    d. Monitoring of utilization metrics including annual wellness visits, emergency room utilization and hospital admissions
    e. Monitoring of abnormal results for further interventions
3. Additional monitoring
    a. Medication reconciliation
    b. Functional status assessment

GOALS

1. HgbA1c < 7%
2. Monitor HgbA1c at least 2 times per 12 months
3. Medication adherence of 90% +
4. Annual wellness visit annually
5. At least one additional PCP visit/ year
6. Annual retinal exam
7. Annual foot exam
8. Annual lipid profile

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An example diabetes care plan for a low-risk member.

Member Education and Outreach

What Zone are you in today?

GREEN Zone	• No shortness of breath • No weight gain • No swelling in legs, feet, ankles, belly or hands • No chest discomfort, heaviness or pain	This is your goal every day
Yellow Zone	Do you have one or more of the following: • Weight gain of 3 pounds in one day or 5 pound in a week • Swelling in feet, ankles, belly or hands • Did you miss any of your medications • It is harder for you to breath lying down, you need to sit up • Chest discomfort, heaviness or pain • New or worse dizziness • Dry hacking cough • You feel uneasy and just don't feel right	Call your Doctor or 336-x xx-xxxx
Red Zone	• It is hard to breathe and does not help when you sit up • Stronger or more chest discomfort, heaviness or pain • Fainting, nearly fainting or passing out • New confusion or can't think clearly • Coughing up frothy or pink sputum (mucous)	Call 911

Diabetes care checklist

Keep track of your diabetes treatment

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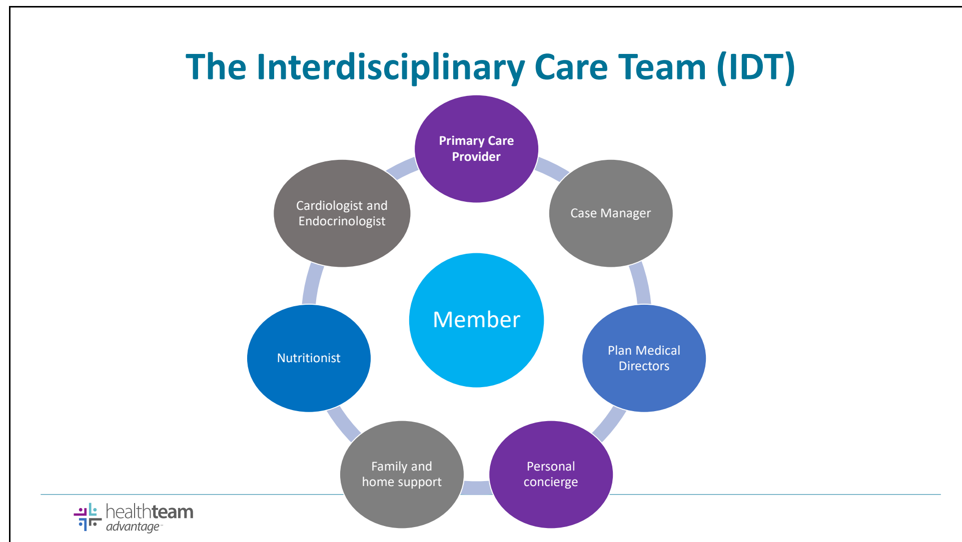
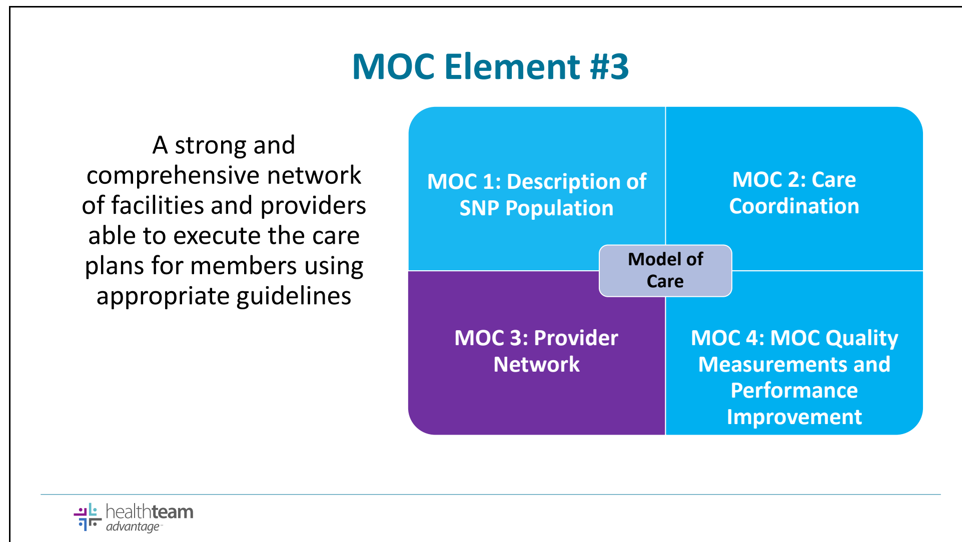
Member outreach and education efforts are a large component of the ICPs. These are some examples:

Left: Heart failure zone guide

Right: Personal checklist to track needed care



The member and their caregiver(s) are at the center of the Interdisciplinary Care Team (IDT) with their participation being encouraged through self-help strategies and personal health goals established at the time of the HRA. The member's primary care physician (PCP) is the IDT member who ultimately determines which services the member will receive and should drive clinical decision making. The member's care manager acts as the coordinator of services and is the single point of contact for all IDT members involved in the member's care. The other IDT members contribute to care planning and utilization as the members care needs change over time. Additional members may include: specialty physicians, pharmacist, nutritionist, personal health plan concierge, or social worker.



The third element of the Model of Care centers around the provider network. CMS requires that Special Needs Plans demonstrate that the provider network has specialized clinical expertise necessary to deliver the needed care to beneficiaries and processes are in places to oversee that the providers have appropriate credentialing and active licenses.
Provider responsibilities include:

Accepting invitations to participate in member's IDT meetings whenever possible
Provide feedback to THN care managers on the ICP
Maintaining copies of the ICP and transition of care notifications in the member's medical record when received
Collaborating and actively communicating with THN care managers assigned to the CSNP membership

HTA Clinical Practice Guidelines

- HealthTeam Advantage has adopted the following nationally accepted and locally vetted evidence-based guidelines:
  - **Diabetes:**
    - American Diabetes Association: Standards of Medical Care in Diabetes-2019
      https://care.diabetesjournals.org/content/42/Supplement_1/S1
      https://clinical.diabetesjournals.org/content/37/1/11 (abridged version for Primary Care)
  - **Congestive Heart Failure:**
    - 2017 ACC/AHA/HFSA Focused Update Guideline for the Management of Heart Failure
      https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/04/27/15/50/2017-acc-aha-hfsa-focused-update-of-hf-guideline

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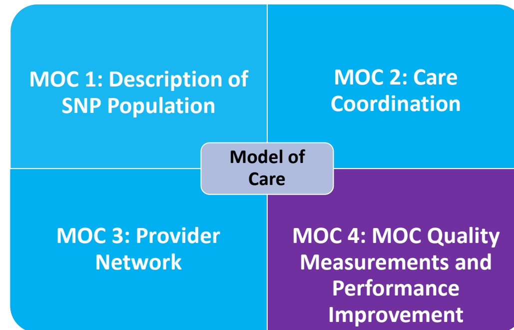
HTA has adapted several nationally accepted guidelines for management of members with diabetes and or heart failure. These guidelines have been vetted by local experts as well as the HTA medical management committee. HTA is expected to monitor performance in the use of these guidelines and to have policies and procedures in place to adjust, modify, or alter these guidelines when they are not appropriate for specific vulnerable members

MOC Element #4

Continuous monitoring of process, performance and quality outcomes with detailed reporting and improvement strategies



HTA employs a comprehensive quality performance and improvement plan. This plan ensures that HTA can monitor and evaluate the effectiveness of the MOC program and make necessary changes to meet and exceed stated goals. This is accomplished in collaboration with its provider network.

Measurable Goal Examples

Process Measures

- HRA completion rate
- ICT meeting rates
- Percentage of members with ICPs
- Complaints about the plan
- Percentage of staff that completes annual MOC training
- CAHPs survey results around getting needed care and care quickly

Outcome measures

- HEDIS scores for diabetes and hypertension measures
- Medication adherence rates
- Plan’s all-cause readmission rate
- ED utilization rates
- Generic medication dispensing rate
- Percentage of members with an assigned PCP

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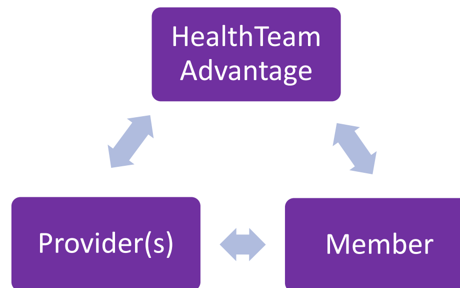
These are some of the processes and outcomes HTA measures, appraises, and reports that help gauge the effectiveness of the MOC objectives. These results are shared with leadership as well as representatives of the local medical community through the HTA Medical Management and Quality Committee.

Communication Plan

- Provider Portal
- Provider Manual
- Provider Phone Line
- Faxes and Emails
- HTA and THN Websites
- THN Beacon
- THN Performance Specialists
- Plan and THN Websites
- Member Newsletters
- Provider Division Meetings and Town Halls
- Committee Meetings



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The final sections of the MOC describe how HTA communicates its quality improvement plan and performance to various stakeholders.

If you have questions or concerns please reach out!

David Grapey, MD, MHA, FACS
Chief Medical Officer
HealthTeam Advantage
Cell: 336.706.0030
Email: dgrapey@healthteamadvantage.com

In summary, The CMS MOC and MOC guidelines require that HTA and its provider network work together for the benefit of our special needs members. This is done through:

- Enhanced communication with members, HTA, and the providers
- Interdisciplinary approach to meeting medical as well as social needs
- Comprehensive coordinated care across the entire care journey
- Consideration for an individual member's care plan preferences and self-care goals
- Strategic quality improvement plan with monitoring and adjustments as needed to maximize effectiveness

If you have concerns or comments, please reach out to HealthTeam Advantage

Thank you!

You have completed the Model of Care Training Please complete the attestation.

Open Form

https://healthteamadvantage.com/required-annual-model-of-care-training-for-csnp-providers/attestation/

Thank you for taking care of our members and for participating in this MOC training!
Please complete the attestation