healthteam advantage℠

Provider Chronic Special Needs Plan Education

2024

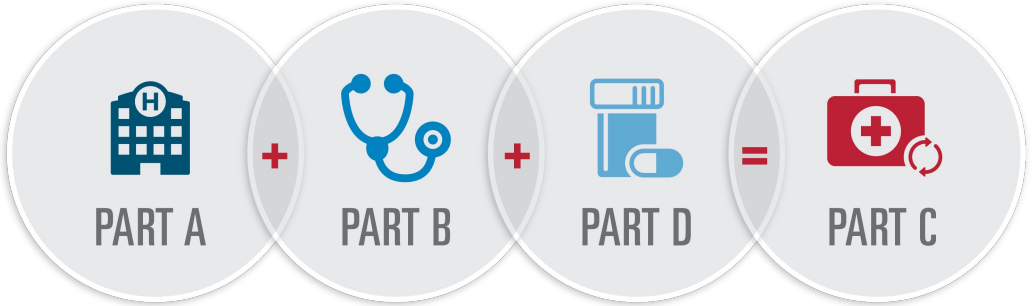
Learning Goals

- 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)
- We are in seven counties

Medicare Advantage and HealthTeam Advantage

- HealthTeam Advantage launched as new Medicare Advantage plan in 2016
  - Guilford, Alamance, Randolph, and Rockingham
  - Currently In seven NC counties (Alamance, Davidson, Davie, Forsyth, Guilford, Randolph, and Rockingham)
- HTA is co-owned by Cone (51%) and Novant (49%)
- Three PPO and two HMO including the CSNP Plan
- The current total membership is around 17,000 (~1500 members in CSNP)
- The HTA vision is to be the insurer of choice with the best patient outcomes!
- And thoughtfully explore geographic expansion, other product lines, and continued evaluation of other opportunities.

Ownership & Operations



- 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

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)

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

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 (CHF).

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 chronic heart failure
- Prospective members must reside in one of seven counties

Eligibility will be <u>verified</u> by the following:

- Enrollees must attest to having the chronic condition at the point of enrollment. Verification of a member's diagnosis for enrollment in the CSNP will be confirmed through a provider verification form.

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)
- Senior Savings Model for insulin coverage
- Care plans directed by local expert physicians
- Latest technologic advances to improve monitoring and compliance

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

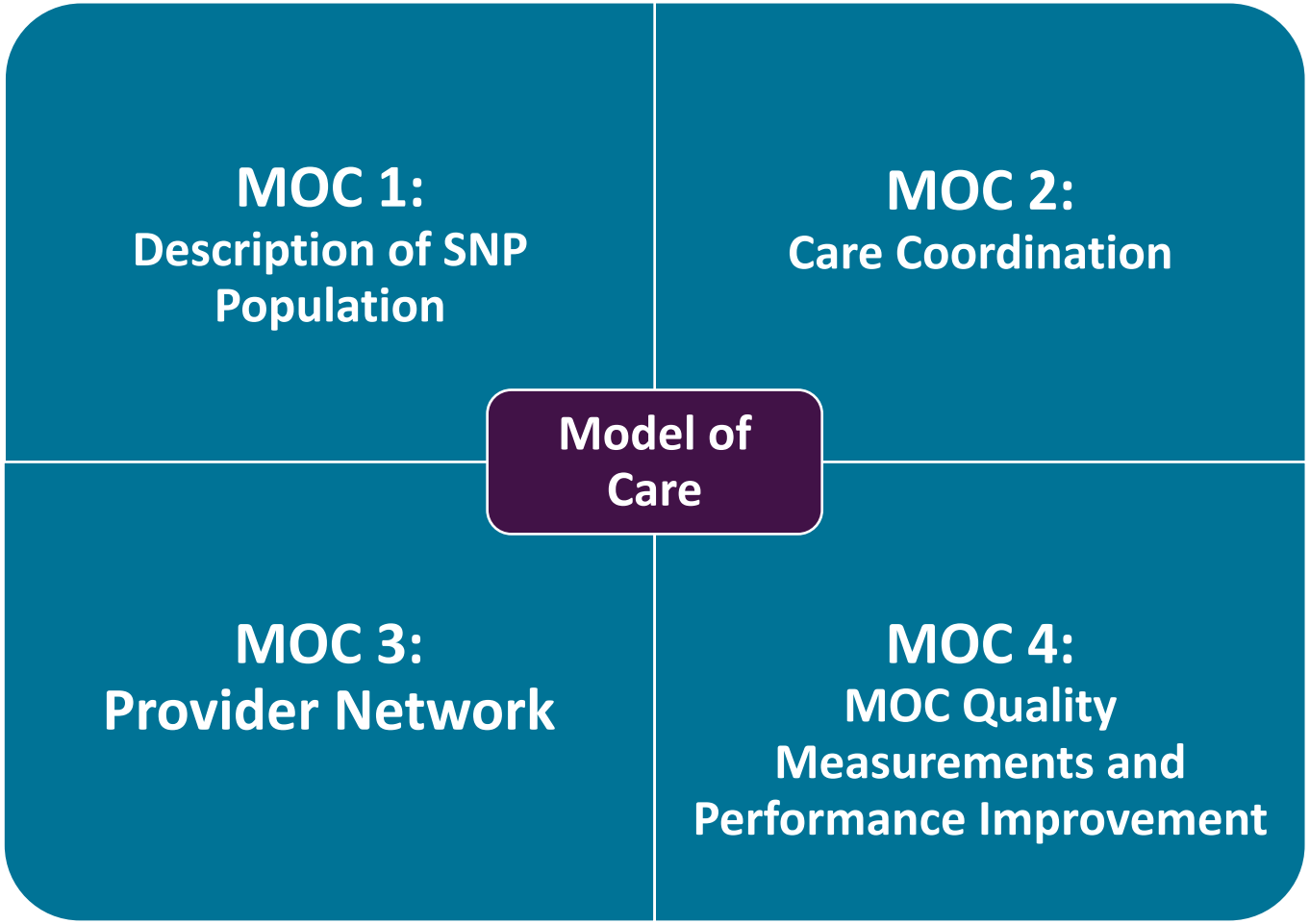
These findings held true when controlling for expected differences in enrollees' demographics and health status. The analysis suggests that CSNPs can improve outcomes for beneficiaries with diabetes compared to non-SNPs.

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.

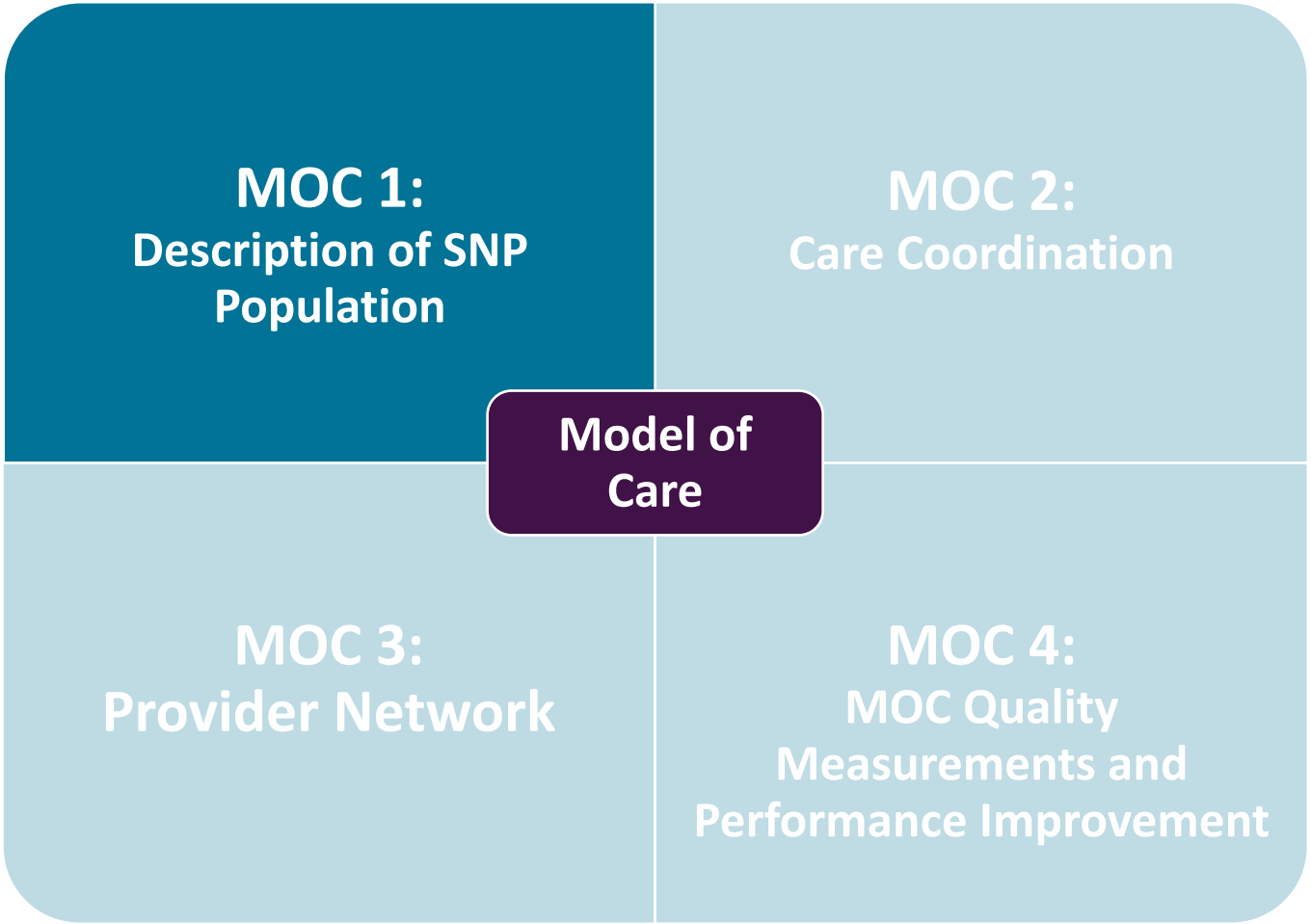
Every SNP must have a Model of Care (MOC)

The MOC is developed to assure that beneficiaries' unique needs are identified and addressed. CMS mandates that staff and providers involved with this population undergo annual training on the MOC.



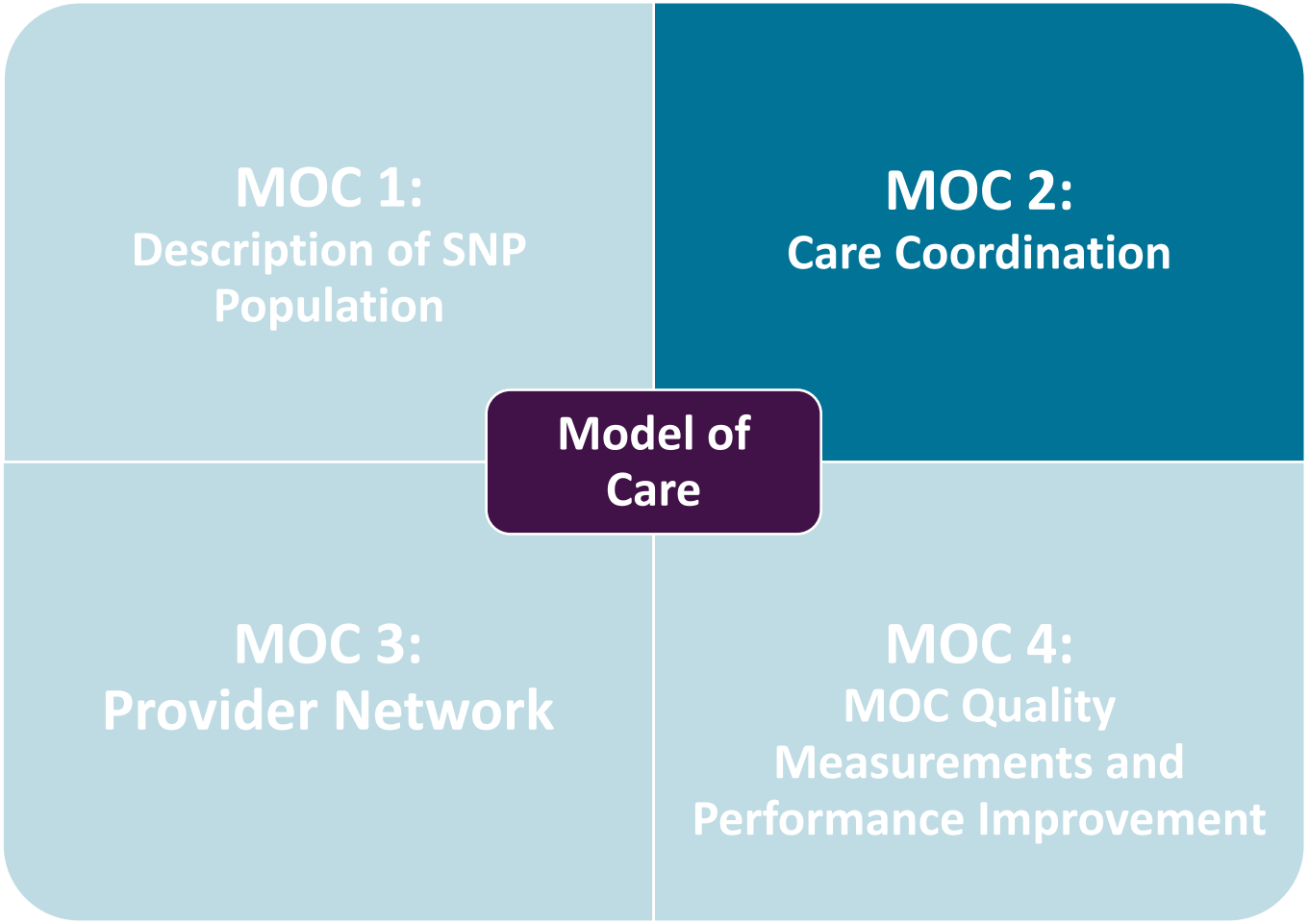
MOC Element #1

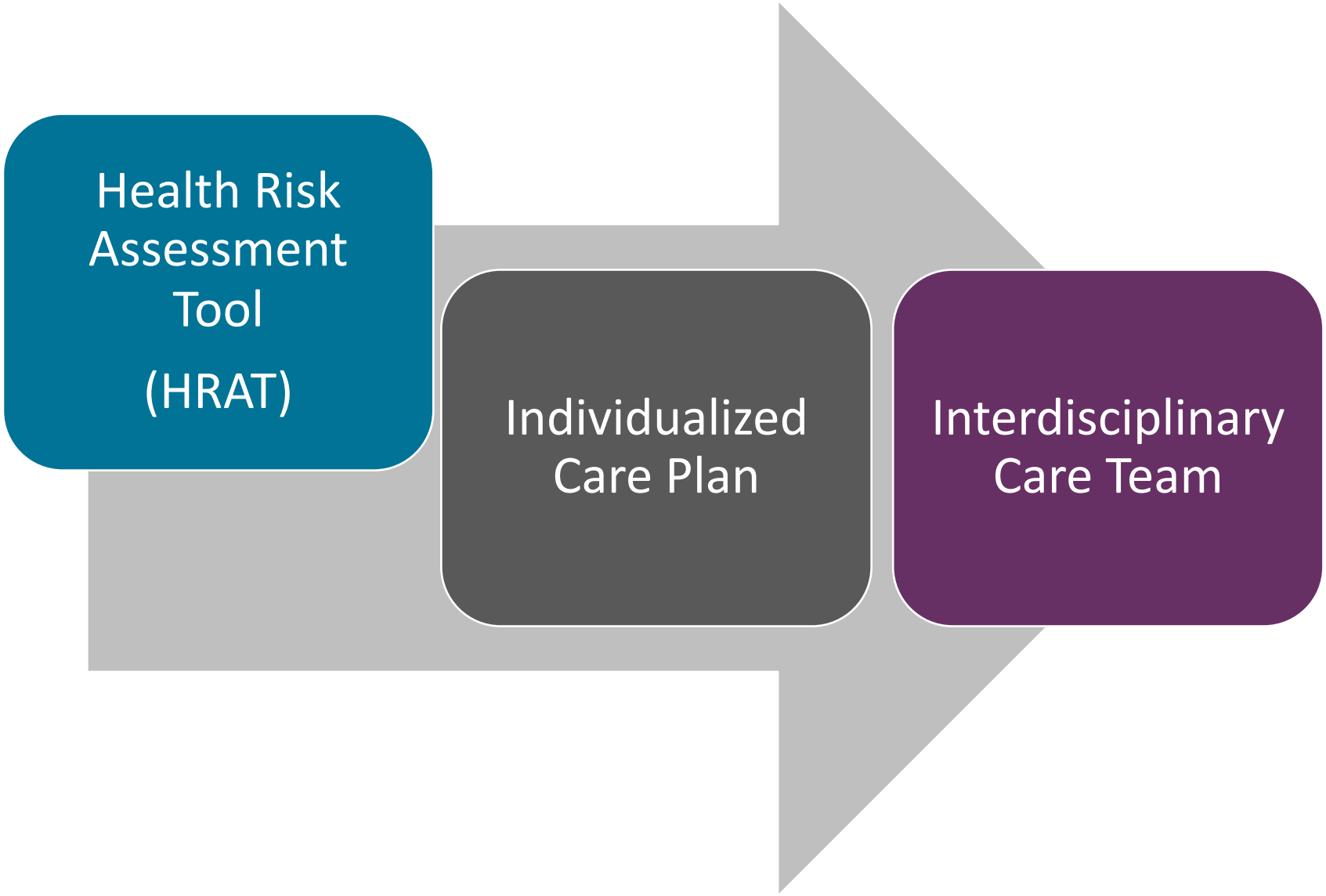
Understanding of the intended population with methods to identify the most vulnerable members of this population.



MOC Element #2

Detailed plan for care coordination utilizing the PCP and the member as the center of the care team.




Health Risk Assessment Tool
(HRAT)
Individualized Care Plan
Interdisciplinary Care Team

Health Risk Assessment Tool

Sample Questions

Does one of your medical conditions significantly overwhelm your ability to take care of yourself?

____ Yes ____ No Which condition? _____

Do you have trouble obtaining food on a frequent basis?

____ Yes ____ No

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			

If you smoke, are you thinking about quitting smoking and interested in receiving some information?

____ Yes ____ No

____ I do not smoke

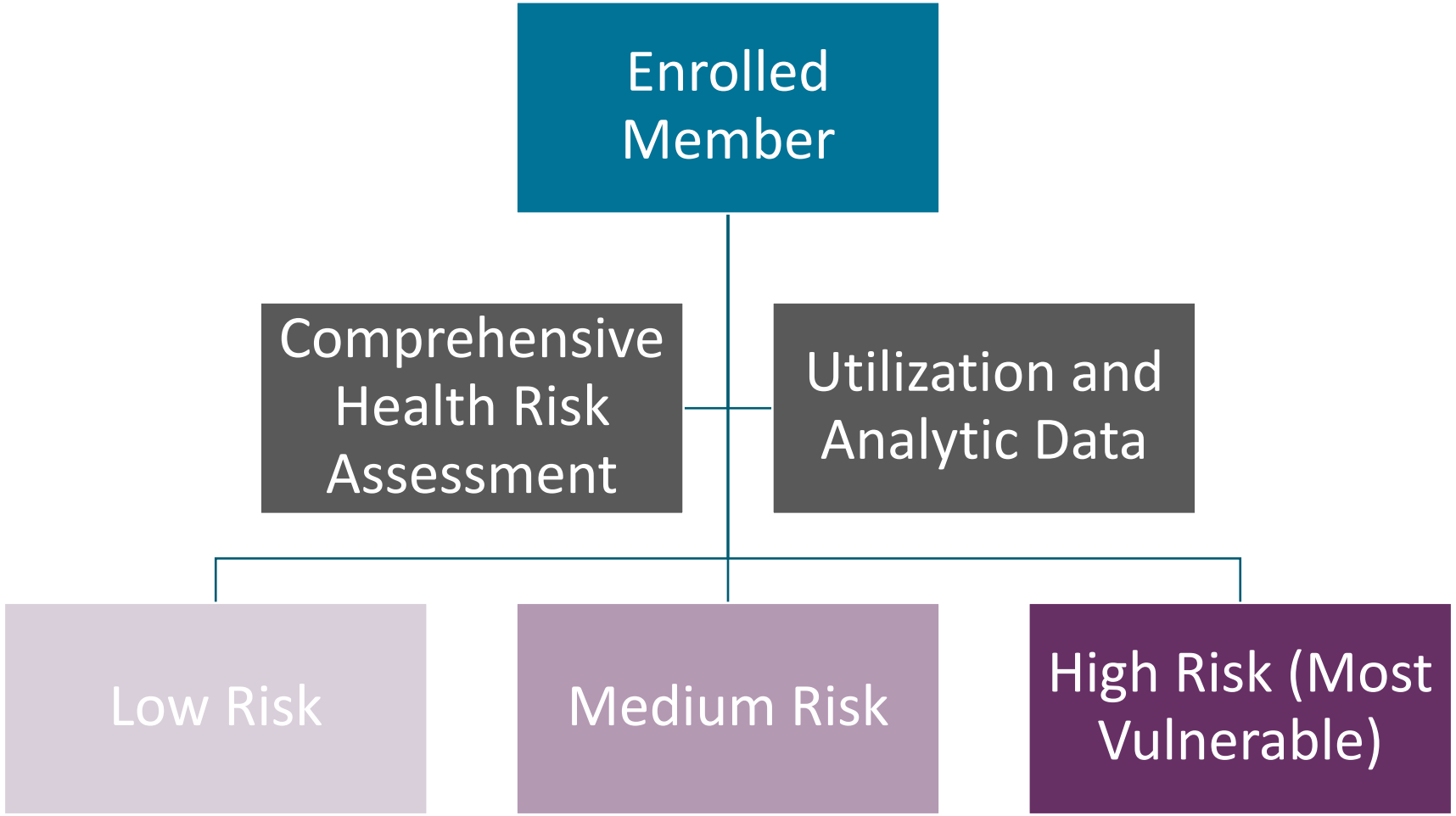
Do you take more than 10 medications?

____ Yes ____ No

Do you sometimes go without your medications due to cost?

____ Yes ____ No

Health Risk Assessments (HRAs) and Individual Care Plans (ICPs)

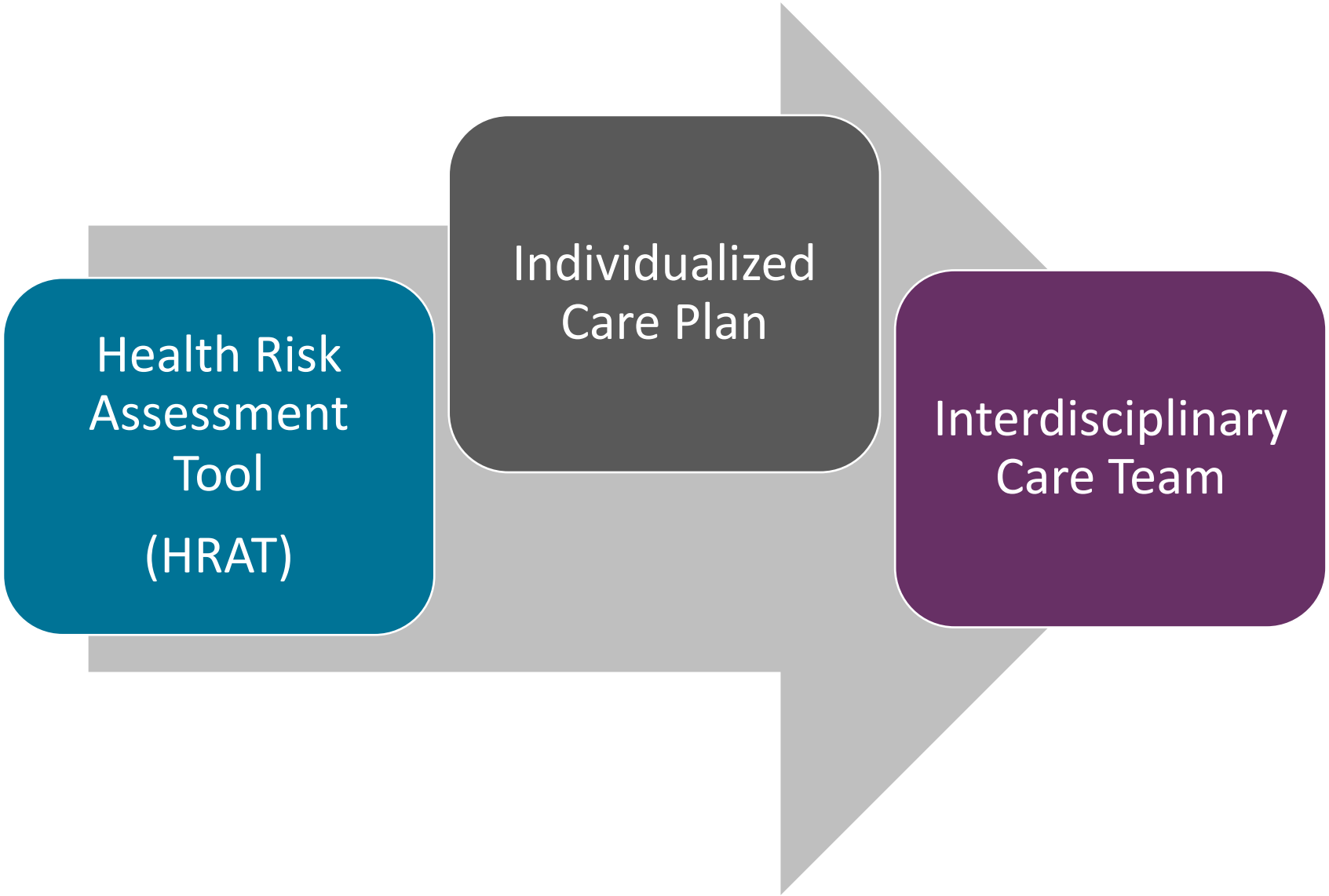


Key Triggers from HRAT and Historic UM Data to Identify High Risk Members

Vulnerability Trigger	Identification Method	"Most Vulnerable" Intervention
Landmark eligibility criteria Around multiple chronic conditions	Historic claims data and ongoing monthly claims data to identify members with 6+ chronic condition points (see point table)	Attempted enrollment in Landmark's coordinated in-home care model
Polypharmacy (10 + prescription medications)	HRAT question/ Part D data	Pharmacist outreach to reconcile medications and conduct education on medication adherence, if necessary
ER utilization > 6 times in 6 months	PatientPing^{tm} or claims data	Care management outreach To determine root cause of high utilization with tailored plan based on assessment. May include establishing member with new PCP or specialty care.
Hospital Admissions > 3 times in 6 months	PatientPing^{tm} or claims data	Care management outreach To determine root cause of high utilization with tailored plan based on assessment. May include establishing member with new PCP or specialty care.

Chronic Condition Point System

Chronic Condition	Points
Atrial Fibrillation	1
Cancer	1
Cerebral Vascular Disease	1
Chronic Kidney Disease	1
Coronary Heart Disease / Myocardial Infarction	1
Diabetes	1
Fluid and Electrolyte Disorders	1
Vascular Disease	1
Pulmonary Disease	1
Rheumatoid Arthritis/Osteoarthritis	1
Severe Chronic Liver Disease	1
Heart Failure	1
Behavioral Health	1
Substance Abuse Disorder	1
Disabling Condition	2
Frailty: Protein-Calorie Malnutrition	3
End Stage Renal Disease (ESRD)	1
Pressure Ulcers with Necrosis (Stage 4)	5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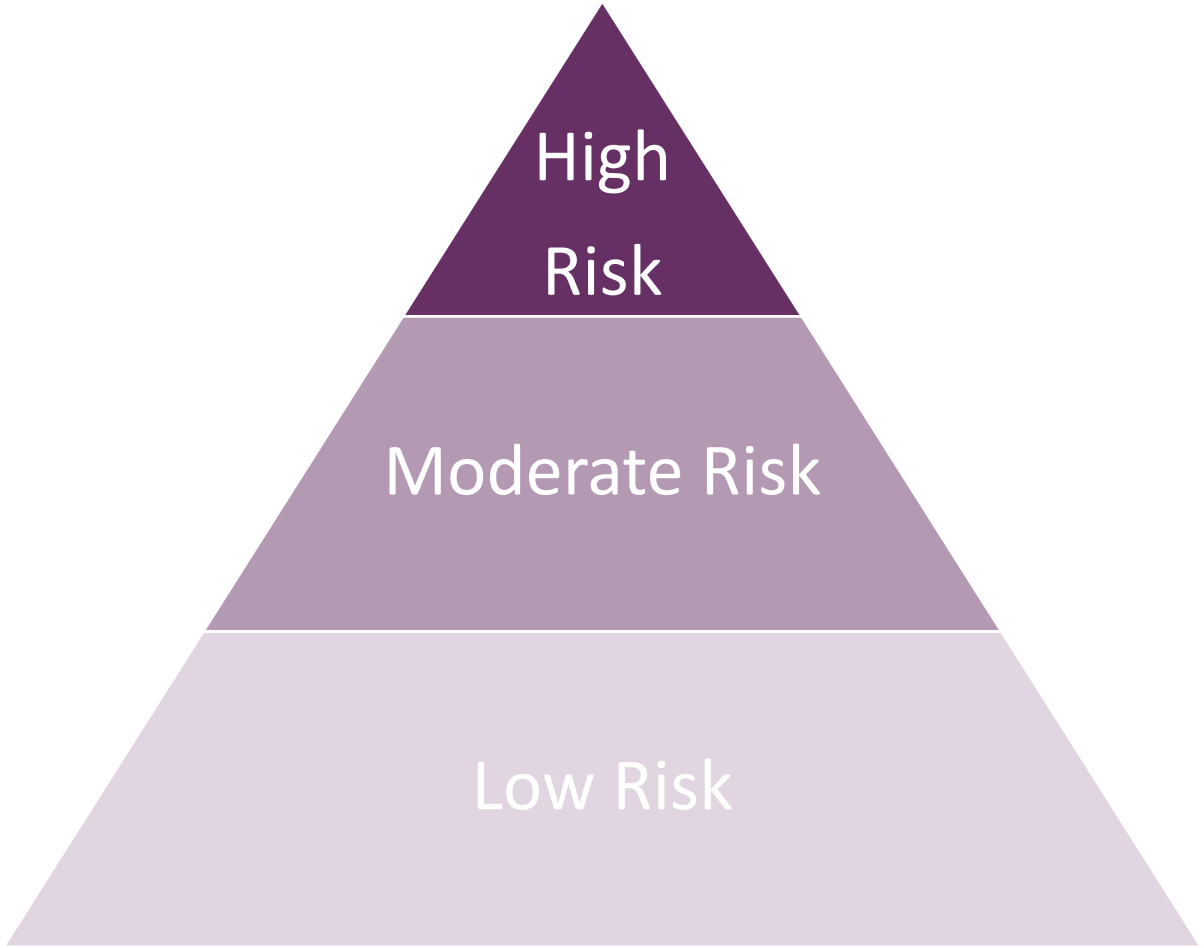
Individualized Care Plans (ICPs)



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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. 2021 American Diabetes Association Guidelines: https://care.diabetesjournals.org/content/44/Supplement_1/S1 b. Monitor gap closure of annual HEDIS diabetic measurement set c. Appropriate lab testing for monitoring including: HbA1c, LDL-C and renal function panels d. Monitoring of utilization metrics including annual wellness visits, emergency room utilization, and hospital admissions e. Monitoring abnormal results for further interventions
3. Additional monitoring a. Medication reconciliation b. Functional status assessment
GOALS
1. HbA1c <7% 2. Monitor HbA1c 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

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

This checklist can help you keep track of your care and treatment. Review it with your doctor at each office visit.

Quarterly visits and tests	**Year 1**				**Year 2**				**Year 3**			
(These tests are typically done 2 – 4 times a year)	qtr1	qtr2	qtr3	qtr4	qtr1	qtr2	qtr3	qtr4	qtr1	qtr2	qtr3	qtr4
Hemoglobin A1c (Goal is less than 7%[1]) **date**												
result												
Blood pressure (Goal is less than 140/90[1])												
Review medications												
BMI[2] (every visit)												

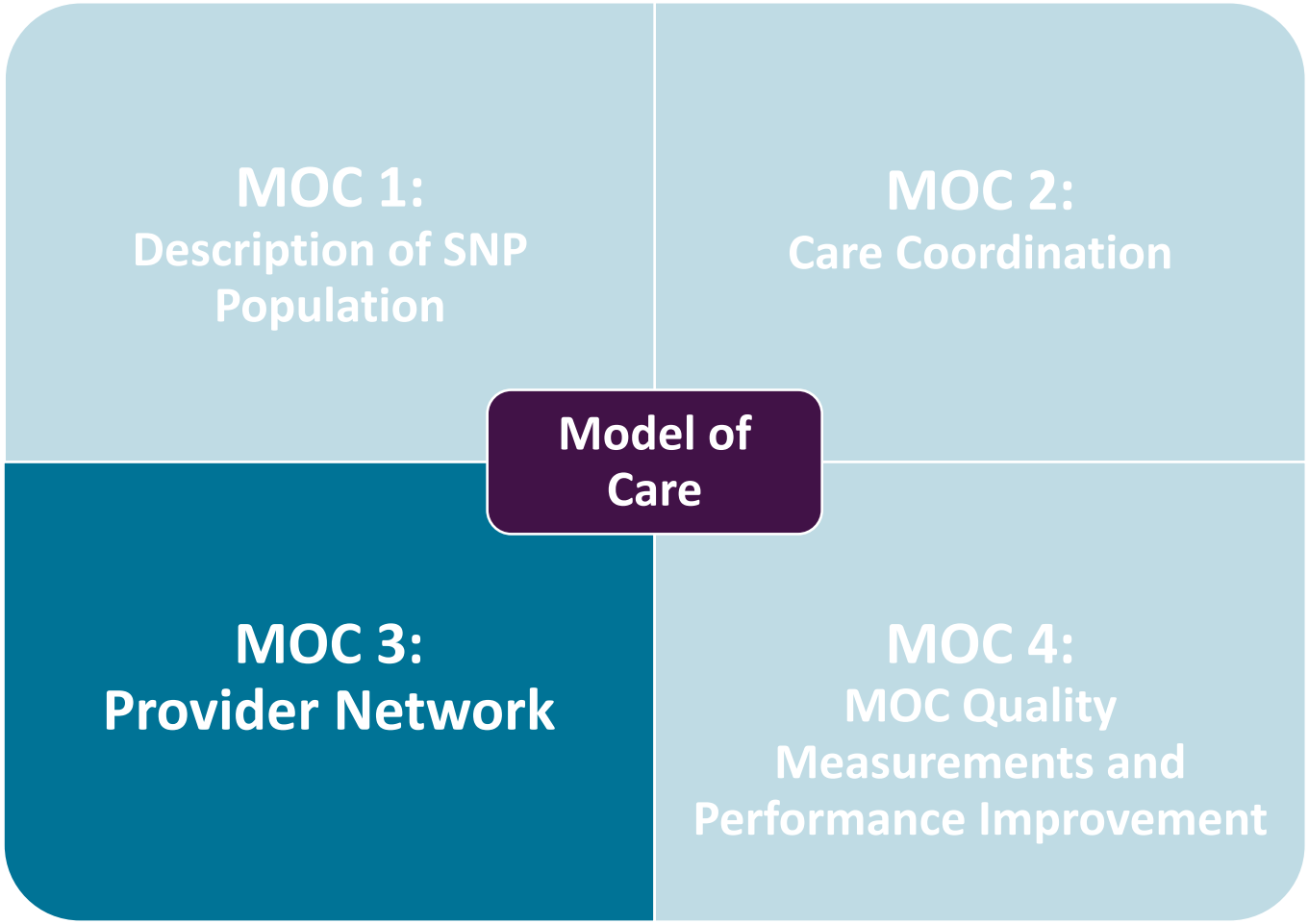
Annual visits and tests	**Year 1**		**Year 2**		**Year 3**	
(These tests are typically done once a year)	**date**	**result**	**date**	**result**	**date**	**result**
Dilated eye exam						
Kidney tests:						
• Urine Proteins (Microalbumin)						
• Serum Creatinine (in adults)						
Cholesterol and lipid tests (for patients with or at risk for heart disease):						
• Total (Goal is less than 200 mg/dl)						
• LDL (Goal is less than 100mg/dl)						
• Triglycerides (Goal is below 150 mg/dl)						

	Year 1		**Year 2**		**Year 3**	
Other annual visits and tests	**date**	**result**	**date**	**result**	**date**	**result**
Wellness Exam						
Foot exam Annually						
Immunizations:						
• Flu vaccine Annually						
• Pneumovax and Prevnar vaccine once over age 65						

Interdisciplinary Care Team

MOC Element #3

Detailed plan for care coordination utilizing the PCP and the member as the center of the care team.



HTA Clinical Practice Guidelines

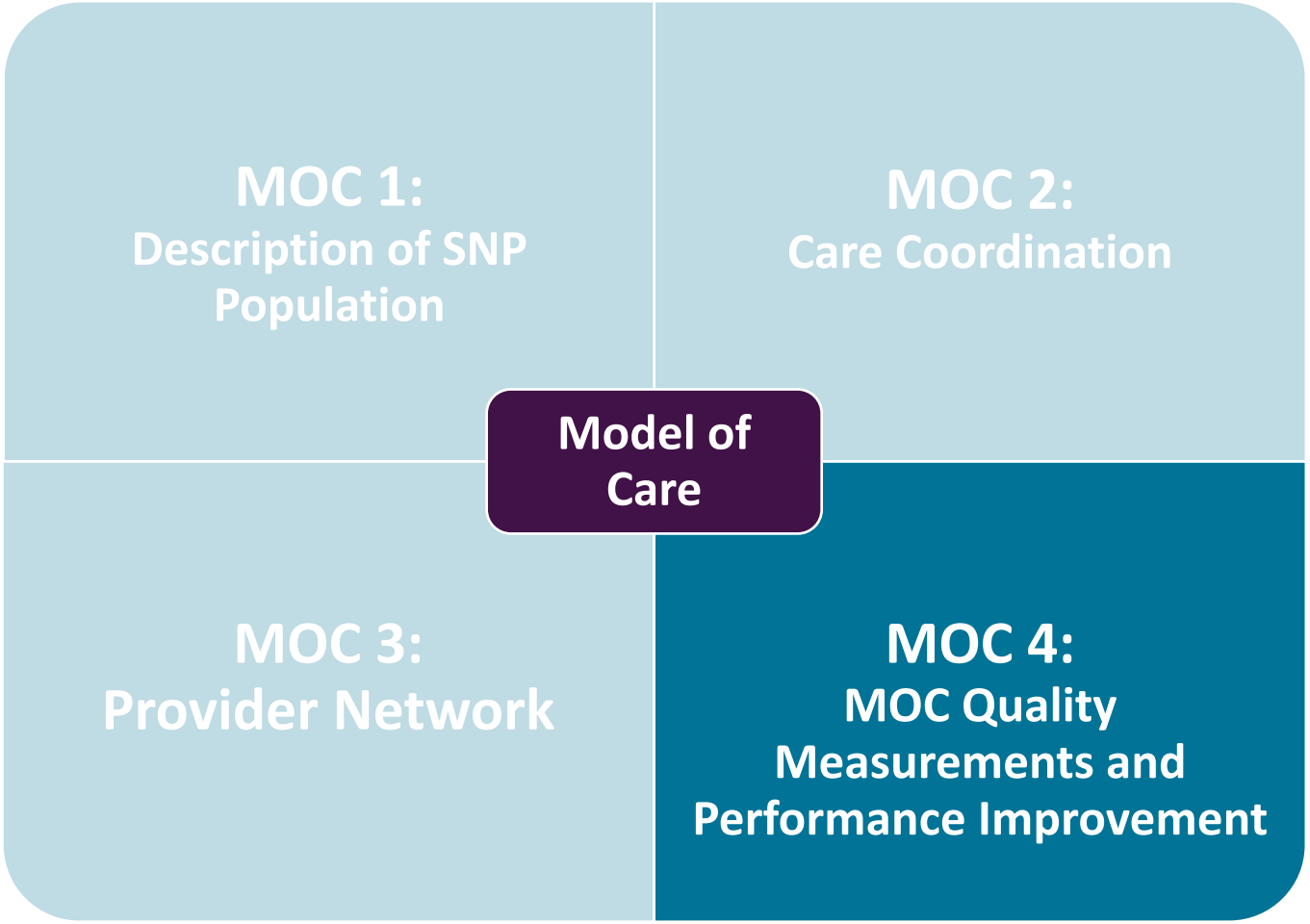
HealthTeam Advantage has adopted the following nationally accepted and locally vetted evidence-based guidelines:

- **Diabetes:**
  - American Diabetes Association: Standards of Medical Care in Diabetes 2024
  - Standards of Medical Care in Diabetes 2024 – Abridged for Primary Care Providers

- **Congestive Heart Failure:**
  - ACC/AHA/HFSA Focused Update Guideline for the Management of Heart Failure

MOC Element #4

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



Measurable Goal Examples

Process Measures

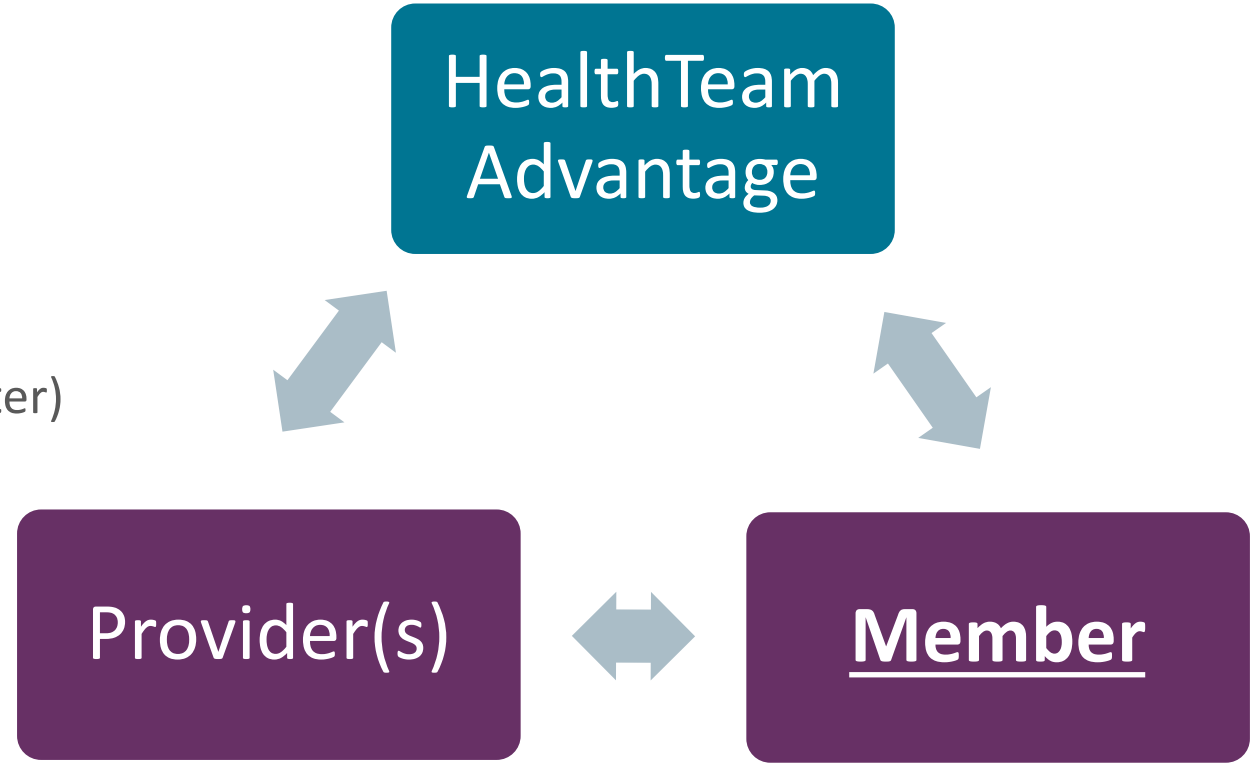
- HRA completion rate
- IDT meeting rates
- Percentage of members with ICPs
- Complaints about the plan
- Percentage of staff that completes annual MOC training
- CAHPs survey results around getting needed care and care quickly

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

Communication Plan

- Provider Portal
- Provider Manual
- Provider Phone Line
- Faxes and Emails
- HTA and THN Websites
- HTA Provider Connection (Provider e-newsletter)
- HTA Provider Concierges
- Member Newsletters
- Provider Division Meetings and Town Halls (virtual and in-person)
- Committee Meetings



For Questions or Concerns:

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Medical Director

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/