CDPHP Care Advantage (HMO C-SNP)

Model of Care Training

CMS Training Requirement

The Centers for Medicare & Medicaid Services (CMS) requires that all contracted medical providers and staff receive training on the CDPHP Care Advantage (HMO C-SNP) Model of Care (MOC). This training and completion of an attestation is required annually for all participating providers and staff.

The Model of Care is the plan for delivering coordinated care and care management to dual special needs members.

The following training will review the components of the CDPHP Care Advantage (HMO C-SNP) Model of Care.

Honest Medical Group

CDPHP delegates Care Management activities to Honest Medical Group for activities mentioned in the CDPHP Model of Care Section 2: Care Coordination.

Activities include:

- SNP staff structure
- Health Risk Assessment tool
- Face-to-face encounters
- Individual Care Plans
- Interdisciplinary Care Teams
- Care transition protocols

Honest and CDPHP collaborate to ensure implementation of these activities are conducted in compliance with CMS regulations and best practices.

Objectives

- Overview of Special Needs Plans
- Review the CDPHP Care Advantage Model of Care
  - Description of the SNP Population
  - Care Coordination
  - Provider Network
  - Quality Measurement & Performance Improvement
- Highlight benefits offered by CDPHP Care Advantage
- Review attestation requirements

Overview of Special Needs Plans (SNPs)

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) that is specifically designed to provide targeted care and benefits to special needs individuals.

SNP Type	Characteristics of Eligible Individuals:
Chronic Condition SNP (C-SNP)	An individual with a severe or disabling chronic condition, as specified by CMS, such as chronic heart failure, diabetes, end-stage renal disease (ESRD)
Dual Eligible SNP (D-SNP)	Individuals who are eligible for both Medicare and Medicaid
Institutional SNP (I-SNP)	Individuals who live in certain institutions, like a nursing home

This training focuses on the **CDPHP Care Advantage (HMO C-SNP).**

Chronic Condition Special Needs Plans

Chronic Condition Special Needs Plans restrict enrollment to individuals with specific chronic conditions as identified by CMS.

CDPHP Care Advantage enrollment is limited to individuals with conditions identified as Group IV:

- Diabetes mellitus
- Chronic Heart Failure (CHF)
- Cardiovascular disorders, which are limited to:
  - Cardiac arrhythmias
  - Coronary artery disease
  - Peripheral vascular disease
  - Chronic venous thromboembolic disorder

Requirements for the Model of Care

CMS and NCQA require each Special Needs Plan to submit a Model of Care detailing four areas:

1. Description of the SNP population
- Outlines how CDPHP will track and verify eligibility
- Identifies characteristics and demographics of the target population
- Reviews most vulnerable beneficiaries and health conditions

2. Care Coordination
- Outlines SNP staff structure, roles, and training/qualification requirements
- Reviews the Health Risk Assessment (HRA)
- Individual Care Plan (ICP) development
- Interdisciplinary Care Team (ICT) composition and requirements
- Face-to-face encounter requirements
- Care transition

3. SNP Provider Network
- Outlines the specialized expertise available to SNP beneficiaries
- Identifies the use of clinical practice guidelines and care transition protocols by providers
- MOC training for provider network

4. Quality Measurement & Performance Improvement
- Highlights how CDPHP will measure the quality performance of the SNP
- Measurable goals and health outcomes
- Measures patient experience
- Ongoing performance evaluation
- How CDPHP will disseminate SNP quality performance to stakeholders, regulatory agencies, and the general public

Description of the SNP Population

CDPHP Care Advantage eligibility is limited to individuals who:

- Have Medicare Part A and Part B
- Are age 21 and over
- Reside in one of the following counties in New York State:
  - Albany
  - Rensselaer
  - Saratoga
  - Schenectady
- Have one or more of the conditions in Group IV:
  - Diabetes mellitus
  - Chronic Heart Failure (CHF)
  - Cardiovascular Disorders (CVD)

CDPHP verifies eligibility on an ongoing basis.

Chronic Condition Verification Process

CMS requires provider verification of a member's condition(s).

- The Pre-Enrollment Qualification Assessment tool provides an attestation for the provider to complete
- If the attestation is not signed by the provider at time of enrollment, a follow-up notice will be sent to the member's provider to capture this information
- If the verification is not received by the second month, the member will be disenrolled

Your support in providing confirmation of a member's condition(s) is essential.

Care Coordination – Individual Care Team (ICT)

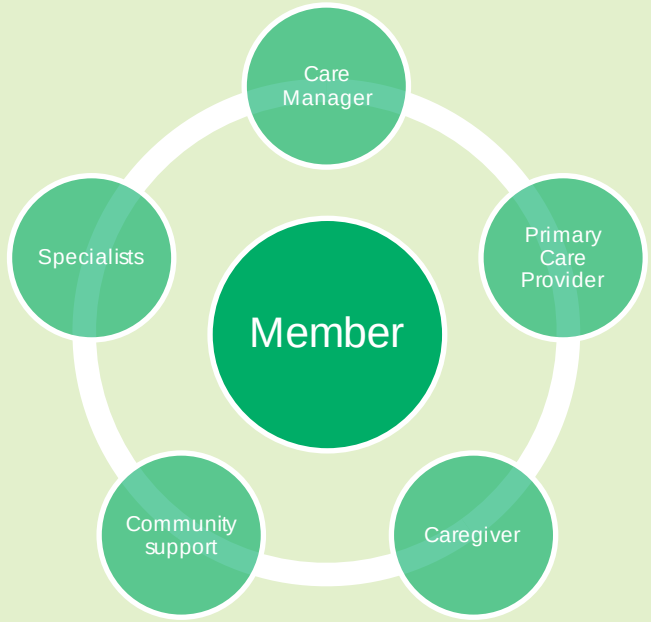
Every CDPHP Care Advantage member is offered a dedicated Care Manager and Interdisciplinary Care Team (ICT).

The goal of the ICT is to help members achieve their best health and provide support to enable the member to reach health goals.

The dedicated Care Manager is responsible for maintaining communication with the member, documenting notes, sharing updates with the ICT, and coordinating ICT discussions, and is the primary owner of the member's Individual Care Plan (ICP).

The Interdisciplinary Care Team includes:

- A dedicated Care Manager
- The member
- The member's caregiver (if applicable)
- The member's primary care provider (PCP)
- Community support providers
- Specialists, as needed
- Other support members as needed



Care Coordination – Individual Care Plan (ICP)

Individual Care Plans are designed to effectively manage the health of a member as well as promote health management and wellness activities.

Individual Care Plans (ICPs) are developed for every SNP member and contain:

- Health Risk Assessment (HRA) results
- Self-management goals and objectives
- Personal health care preferences
- Description of services specifically tailored to the member's needs
- Role of the caregiver (if applicable)
- Identification of goals

The ICP is a dynamic, data-collecting process within the Honest care management system that is extracted and shared with the member and members of the ICT.

ICP Life Cycle

The ICP is the initial and ongoing mechanism of evaluating the member's current health status and formulating an action plan to address care needs and care gaps in collaboration with the member, the member's caregiver, and the ICT.

ICPs are fluid and are expected to be updated frequently throughout the year as member's needs change.

Changes to the ICP are communicated to everyone on the ICT.

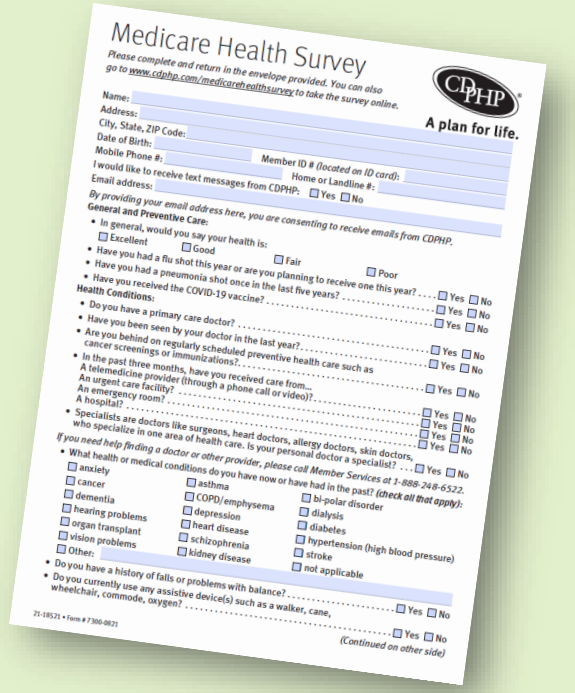
Care Coordination – Health Risk Assessment (HRA)

The Health Risk Assessment (HRA) is a health survey that helps identify the member's most urgent needs and serves as the foundation of the ICP.

The HRA assesses medical, functional, cognitive, psychosocial, and mental health needs of the member.

It is completed:

- At time of enrollment or
- Within 60 days of enrollment
- Annually, within 364 days of last assessment
- Upon health status changes


Medicare Health Survey

Please complete and return in the envelope provided. You can also go to www.cdphp.com/medicarehealthsurvey to take the survey online.

A plan for life.

Name:

Address:

City, State, ZIP Code:

Date of Birth:

Mobile Phone #:

Member ID # (located on ID card):

Home or Landline #:

I would like to receive text messages from CDPHP: Yes No

Email address:

By providing your email address here, you are consenting to receive emails from CDPHP.

General and Preventive Care:

- In general, would you say your health is: Excellent Good Fair Poor
- Have you had a flu shot this year or are you planning to receive one this year? Yes No
- Have you had a pneumonia shot once in the last five years? Yes No
- Have you received the COVID-19 vaccine? Yes No

Health Conditions:

- Do you have a primary care doctor? Yes No
- Have you been seen by your doctor in the last year? Yes No
- Are you behind on regularly scheduled preventive health care such as cancer screenings or immunizations? Yes No
- In the past three months, have you received care from... A telemedicine provider (through a phone call or video)? Yes No An urgent care facility? Yes No An emergency room? Yes No A hospital? Yes No
- Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, who specialize in one area of health care. Is your personal doctor a specialist? Yes No

If you need help finding a doctor or other provider, please call Member Services at 1-888-248-6522.

- What health or medical conditions do you have now or have had in the past? (check all that apply):
  - anxiety
  - asthma
  - bi-polar disorder
  - cancer
  - COPD/emphysema
  - dialysis
  - dementia
  - depression
  - diabetes
  - hearing problems
  - heart disease
  - hypertension (high blood pressure)
  - organ transplant
  - schizophrenia
  - stroke
  - vision problems
  - kidney disease
  - not applicable
  - Other:
- Do you have a history of falls or problems with balance? Yes No
- Do you currently use any assistive device(s) such as a walker, cane, wheelchair, commode, oxygen? Yes No

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The HRA data is shared with the ICT and maintained in the member's electronic case file.

Care Coordination – Face-to-Face Encounters

All SNP members must have a face-to-face encounter within the first 12 months of enrollment and once a year thereafter.

Face-to-face encounters may be conducted by:

- Care Manager
- Primary care physician (PCP)
- Specialists
- Pharmacists
- Nurse educators
- Community contacts
- Behavioral health providers
- Social workers

Face-to-face encounters expected outcomes include:

- ICP review
- Goal assessment
- Social Determinants of Health review
- Discussion of obstacles to care
- Annual Wellness Visit
- HRA completion (if not yet completed)
- Medication administration
- Engagement with member to manage, treat, and oversee health care

Care Coordination – Care Transition

Care transition planning is used to support members through transitions between health care settings.

Key components of care transition include:

- Communication
- Care Coordination
- Preventing Readmissions

The Care Manager is responsible for ensuring members of the ICT are informed of any transitions, as well as ensuring coordination of services, continuity of care, and ensuring updates are made to the ICP.

Provider Network

The role of the provider involves:

- **Communicating** with care managers, Interdisciplinary Care Team (ICT), the member, and caregiver
- **Collaborating** with care managers on the Individual Care Plan (ICP)
- **Reviewing** and responding to patient-specific communications
- **Maintaining** the ICP in the member's medical record
- **Participating** in the ICT
- **Encouraging** the member to work with their care management team
- **Reminding** the member to complete the Health Risk Assessment (HRA)
- **Completing** Model of Care (MOC) training annually

Quality Measurement & Performance Improvement

CDPHP has established health outcome goals that reflect the needs and characteristics of the SNP population.

- Performance results and pertinent information will be shared with providers through Provider Relations and Physician Engagement team activities
- Providers will also have access to information through provider newsletters, provider manuals, and related committee meetings
- Adhoc communications will occur through the CDPHP website, provider portal, emails, over the phone, or in person

Enhanced Benefits

Benefit	CDPHP Care Advantage (HMO C-SNP)
Premium	**$0**
Maximum out-of-pocket (MOOP)	$7500
Primary care physician (PCP)	$0
Doctor On Demand (live video doctor visits)	$0
Endocrinologists / Cardiologists	$10
All other specialists	$35
Urgent Care	$60
Emergency Room	$90
Ambulance	$265
Outpatient surgery	$315 - $365
Physical therapy	$35
Inpatient hospitalization	$330 days 1-5
Labs	$0 – 20%
Radiology services (X-ray)	$35
Advanced imaging studies (CT, MRI, etc.)	$195
Over-the-counter (OTC) benefit	$50 / quarter
Routine eye exam	$20
Eyewear allowance – flex card*	$175 per year
Dental allowance – flex card*	$750 per year

Benefit	CDPHP Care Advantage (HMO C-SNP)
Hearing benefit	$599/$899 for hearing aids
Routine hearing exam	$35
In-home support	60 hours per year
Meals post discharge (14 meals)	Covered
CDPHP Life Points Rewards	Up to $175 per year
CDPHP Senior Fit / SilverSneakers	Covered
T1, T2, T6 mail-order prescriptions	$0
Part B & D Senior Savings	$35 for select Part B and Part D insulins

***Members receive a **Benefits Mastercard Prepaid Card** with funds to use on eyewear and dental products and services at eligible locations.

6-Tier Formulary

CDPHP Care Advantage members have access to a **sixth formulary tier** at **$0** (mail order and retail) with drugs that:

- Have been recommended by national guidelines (AHA, ADA, etc.) for the Group 4 chronic disease states
- Are available as lower-cost generic drugs

Contributing to the goals of providing **tailored benefits**, **reducing financial barriers** to care, and **improving medication adherence.**

Complete the Attestation to Receive Credit

Thank you for participating in the CDPHP Care Advantage (HMO C-SNP) Model of Care Training.

To receive credit and meet the regulatory requirement, please complete the attestation online at https://www.cdphp.com/provider-CSNP

Questions? Please contact your CDPHP representative.