VIVA MEDICARE EXTRA VALUE (HMO SNP) Training 2020
Medicare Special Needs Plans (SNPs)

• Type of Medicare Advantage Plan (like an HMO or PPO)
• Created by Congress in the Medicare Modernization Act (MMA) of 2003, as a new type of Medicare managed care plan that focuses on certain vulnerable groups of Medicare beneficiaries
• Medicare SNPs limit membership to people with specific diseases or characteristics, and tailor benefits, provider choices, and drug formularies to best meet the specific needs of the groups served
• VIVA HEALTH has Dual-Eligible SNP(D-SNP) members who qualify for Medicare and Medicaid
Objectives

• MOC 1: Description of SNP Population
• MOC 2: Care Coordination
• MOC 3: Provider Network
• MOC 4: Quality Measurement and Performance Improvement
MOC 1: Description of SNP Population

- **Element A**: Description of Overall SNP Population
- **Element B**: Subpopulation—Most Vulnerable Beneficiaries
VIVA HEALTH’s Dual Eligible Special Needs Plan (D-SNP) is designed for:

• Individuals eligible for Medicare and full or partial Medicaid coverage

• Reside in one of the counties in VIVA MEDICARE Extra Value’s service areas within Alabama
Medicaid Eligibility Categories

- Full Medicaid (only)
- Qualified Medicare Beneficiary without other Medicaid (QMB Only)
- QMB Plus
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB Only)
- SLMB Plus
- Qualifying Individual (QI)
- Qualified Disabled and Working Individual (QDWI)
Top 10 Medical Factors

1. Hypertension
2. Diabetes
3. Back Pain
4. Hyperlipidemia
5. Osteoarthritis
6. COPD
7. Coronary Artery Disease
8. Neck Pain
9. Chronic Renal Failure
10. Cerebrovascular Disease
Identifying Most Vulnerable

• Claims and Encounter Data including pharmacy
• Health Risk Assessment (HRA) Data
• Inpatient Acute Care, Skilled Nursing, and Rehab Admission information
• ED Utilization Data
• Member Self Report
• Physician Referral
Element B: Subpopulation - Most Vulnerable

- Multiple uncontrolled comorbidities
- Multiple admissions and readmissions
- Multiple emergency room (ER) visits
- Extreme economic and social issues
- Transitioned to a higher level of care
- Chronic uncontrolled pain
- Acute Behavioral Health admissions
Social Work Assistance

- Patient Liaison
- Patient Advocate
- Referral Coordinator
- Assessing/Gathering Social History
- Assessing for additional care gaps
MOC 2: Care Coordination

• Element A: SNP Staff Structure
• Element B: Health Risk Assessment
• Element C: Individuated Care Plan (ICP)
• Element D: Interdisciplinary Care Team (ICT)
• Element E: Care Transition Protocols
Element A: SNP Staff Structure

- Medicare Sales Representatives
- Medicare Enrollment
- Medicare Member Services
- Medicare Claims
- Pharmacy
- Medical Management
- Care Management
- Connect for Quality (C4Q)
- SNP Administrator
- Quality Improvement
- Contracted Providers
- Pharmacists
- Health Services
Medical Management includes
- Utilization Review Staff
- C4Q Staff serves in clinical roles in conjunction with PCPs at the point of care

Care Management includes
- RNs
- LPNs
- Licensed Social Workers
- Case Managers in clinical roles coordinating member’s care
Improving Quality of Care

Connect for Quality

• Team works in conjunction with Primary Care Physicians at the point of care to improve quality, utilization, and member health status.

• Prevention and health screening are key components to this program.

Quality Improvement

• Team works in clinical roles when directly interacting with SNP members at Health Fairs and during telephonic outreach.
Element B: Health Risk Assessment (HRA)

• HRA is an internally developed tool that allows the member to self report their health status, functional status, and psychosocial issues.

• The HRA data is imported into the EMR or VIVA’S Care Management documentation system and the results are accessible to all team members.

• The HRA is required within 90 days of enrollment and annually thereafter.
Health Risk Assessment Tool (HRAT)

• Data from the HRA is reviewed by the SNP team, and assists with identifying members at risk for more complex health problems and care management needs.

• HRA data is reported to the IDCT and the UM/QI committees.

• After 3 attempts are made to reach member for completion of HRA, follow-up letter is sent to member.
Element C: Individuated Care Plan (ICP)

- ICP’s are developed using HRA responses, claims and encounter data, and PCP evaluation with recommendations.

- The individualized plan of care is provided to the primary care physician who is responsible for directing the plan of care.

- SNP members receive an annual ICP.

- High risk members are further assessed by a nurse or Social Worker, and an attempt is made to engage them in intensive Care Management.

- Care plans are updated through assessments, IDCT meetings, and interdisciplinary collaboration.
Element D: Interdisciplinary Care Team (ICT)

- Formal meetings are scheduled every 2 months for a minimum of 6 meetings per year.

- Bi-monthly Chief Medical Officer also meets with Care Managers to review care plans and discuss any barriers to care.

- SNP members in V-Care, and their caregivers are encouraged to participate.

- Members presented at the formal IDCT are informed of the team meeting.

- Members are given the opportunity to participate in their own case presentation in person or by telephone.
• **VIVA HEALTH** expanded its IDCT approach to include execution, updating, and modification of plan of care. Clinical team utilizes opportunities to provide the most comprehensive care possible to members.

• Chief Medical Officer, Director of Care Management, and SNP Administrator drive the initiatives of the IDCT.
Element E: Care Transition Protocols

• Transition – Movement of a member from one care setting to another as the member’s health status changes

• VIVA HEALTH maintains a comprehensive approach focusing on coordination of care throughout transitions

• Connecting members to the appropriate providers, and providing needed education and self-management support

• Health Services strives to empower members to be accountable for their care and to better understand how to manage their health across the care continuum
Transitional Care Coordination

4 Pillars of Care Transition:

- **Medication Self-Management** – Goal: Patient is knowledgeable about medication and has a medication management system.

- **Patient-Centered Record** – Goal: Patient understands and utilizes a personal health record to facilitate communications and ensure continuity of care planning across settings; the patient manages the personal health record.

- **Physician Follow-Up** – Goal: Patient schedules and completes follow-up visit with PCP/Specialist and is empowered to be an active participant in these interactions.

- **Red Flags** – Goal: Patient is knowledgeable about indicators that their condition is worsening and how to respond.
MOC 3: Provider Network

- **Element A**: Specialized Expertise
- **Element B**: Use of Clinical Practice Guidelines and Care Transition Protocols
- **Element C**: MOC Training for the Provider Network
VIVA HEALTH’s contracted provider network includes the full spectrum of primary and specialty care:

- Community and private health care providers
- Geriatricians
- Endocrinologists
- Cardiologists
- Oncologists
Element B: Use of Clinical Practice Guidelines

- **VIVA HEALTH** assures providers use evidence-based clinical practice guidelines:
  - Nationally recognized protocols through the authorization process of outpatient services
  - Inpatient admissions
  - Concurrent stay reviews
Element B: Care Transition Protocols

- **Transition**: Movement of a member from one care setting to another as the member’s health status changes.

- **Transition process**: The period from identification of a member who is at risk for a care transition through completion of a transition.
- PCP is responsible for assisting the member through any transition
- In collaboration with the PCP, the SNP Care Management team works with each member experiencing a transition
- Ensuring services are rendered appropriately and in a timely manner
Case Manager

- Makes every attempt to perform face-to-face or telephonic interviews with members in an inpatient setting during the hospitalization.

- Special attention is paid to our SNP members who are often more vulnerable due to chronic medical issues.

- Assessed for understanding of current health status and for any post-acute intensive care management services needed through VCare.

- Referral may be made to the VCare team. The “Safe Transitions” information is also provided to the member detailing contact information for the VCare services.
VCare Care Management

• The goal of the Care Management team is to empower members to take responsibility for their care which will lead to success in managing transitions.
VCare Care Management Services

- Visits made in the home, hospital, or health care facility
- Telephonic outreach to members and/or caregivers
- Education regarding the disease process and proper use of medications
- Assistance in accessing community, financial, and social resources
- Providing members with a personal contact within the plan
- Encouragement of members to follow-up with their PCP or specialist after a transition
- Referrals for additional services or specialty care as needed
- Teach disease-specific “red flags”
Element C: MOC Training for the Provider Network

- Initial MOC training is distributed to VIVA HEALTH’s contracted Medicare providers via a VIVA HEALTH Provider Brochure

- Annual MOC training provided to VIVA HEALTH’s contracted Medicare providers may be determined by the SNP Administrator and Provider Services Department

  - Training has included mailing of the VIVA HEALTH Provider Brochure and the VIVA HEALTH Provider Newsletter, “VIVA Voice.”
MOC 4: Quality Measurement and Performance Improvement

- **Element A**: MOC Quality Performance Improvement Plan
- **Element B**: Measurable Goals and Health Outcomes for the MOC
- **Element C**: Measuring Patient Experience of Care (SNP Member Satisfaction)
- **Element D**: Ongoing Performance Improvement Evaluations of the MOC
- **Element E**: Dissemination of SNP Quality Performance Related to the MOC
Quality Improvement Program

• Collaborates with VIVA HEALTH’S providers physicians, community agencies and members to identify the unique health care needs and characteristics of our SNP population

• Design outreaches and benefit structures to provide the most comprehensive quality care possible
Provides unique preventive services including:

- Yearly eye exams with up to $100 annual allowance toward eyewear
- Preventive and comprehensive dental services with up to $1000 allowance toward services
- Transportation benefit that includes 24 one-way or 12 round trip rides each year for health care related visits
- $110 allowance per calendar quarter for designated over-the-counter (OTC) medicines and other related items
SNP Goal #1

• Ensure Provider Network Adequacy
  – Primary Care Providers and Specialists across our service area
  – Meeting CMS compliance expectations
SNP Goal #2

• The *Extra Value* Plan has enjoyed a very low level of complaints/grievances regarding this plan’s benefits

• Our goal is to not to exceed 1.4 grievances per thousand SNP members annually (25 members)

• 2018 demonstrated 1.2 grievances per 1,000 SNP members regarding plan benefits (22 members)
SNP Goal #3

- Identified goal is zero Part C cost-sharing for the lowest income members, and $0 copay for PCP visits and non-emergency transportation

- Prescription drugs are offered at the low-income subsidy levels or lower to ensure cost is not a significant barrier
SNP Goal #4

- Increasing the number of SNP members engaged in VCare to 23 members per 1,000 SNP members monthly (417 members)
- Current analysis demonstrates an average of 22 per 1,000 (399 members)
SNP Goal #5

- Goal is to enhance safe transitions for SNP members
- 95% or greater of SNP members experiencing an acute transition will have safe transitions outreach through VIVA HEALTH’s Case and Care Management team
SNP Goal #6

- VIVA HEALTH would like over three years to reduce the number of 30-day readmissions to 10%
- Reported as a yearly average, keeping in mind this number is scalable based on member population
- 50 less readmits each calendar year
SNP Goal #7

• VIVA HEALTH will continue the goal related to 90% of SNP members to see their PCP at least annually

• Recent annual measurement of this metric was 82.84% (CY2017)
Element C: Measuring Patient Experience of Care

- **VIVA HEALTH** Collects and analyzes SNP specific grievance data
- Disenrollment information is also collected monthly and reported
- Health Services utilizes a SNP specific questionnaire mailed to a random selection of SNP members engaged in intensive care management with VCare
Element D: Ongoing Performance Improvement Evaluations

- Through monthly monitoring and evaluation of; utilization metrics, membership metrics, provider access metrics, appeals and grievances, and VCare engagement

- Quarterly results of the SNP Member Survey are compiled and reviewed for improvement opportunities

- Bi-monthly Interdisciplinary Care Team meetings are held to review challenging members, outcomes, and opportunities

- Annual Program Evaluation is presented to UM/QI, and Board of Directors
Element E: Dissemination of SNP Quality Performance

- Quality Improvement department presents monthly quality and STARS metrics to Medicare Operations.

- Bi-monthly SNP specific clinical data, updates are presented in Interdisciplinary Care Team meetings by the SNP Administrator and the Director of Care Management.

- VIVA HEALTH distributes four member newsletters each year to our Medicare and SNP members communicating health tips, outcomes, quality issues, upcoming special events, and preventive care reminders.