MedStar Medicare Choice

Knowledge and Compassion
Focused on You

Special Needs Plan (C-SNP/D-SNP)

Provider Course – Self-Learning Packet

1.75 CME credits available upon completion and submission of the completed Attestation of Course Completion

Objectives

Upon completion of this course, the learner will be able to:

- Define SNP and the eligible member's demographics
- List your responsibilities related to Balance Billing
- Describe the Model of Care (MOC) for our SNP programs and how it improves the member's health and health care experience
- Understand the key elements of the Model of Care's holistic management approach; including the Individualized Care Plan and Interdisciplinary Care Team
- Identify the measurable performance outcomes

Overview

- MedStar Medicare Choice's mission is to serve vulnerable populations with a holistic, integrated model to ensure they receive timely access to quality care in a setting most appropriate for their needs
- The MedStar Medicare Choice D-SNP/C-SNP are Special Needs Plans serving patients eligible for Medicare and Medicaid and patients diagnosed with diabetes or congestive heart failure (CHF)

Terms

Acronym	Definition
SNP (special Needs Plans)	A Medicare Advantage Coordinated Care Plan focused on certain vulnerable groups of Medicare patients that are: • Institutionalized • Dual-eligible • Patients with sever or disabling chronic conditions SNPs are designed to improve care for Medicare patients with special needs through improved coordination and continuity of care
C-SNP (Chronic Special Needs Plan)	A Medicare Advantage Coordinated Care Plan focused on patients with CHF and/or Diabetes
D-SNP (Dual Eligible Special Needs Plans)	A Medicare Advantage Plan for individuals eligible for both Medicare and Medicaid

Terms

Acronym	Definition
HRA (Health Risk Assessment) HAS (Health Assessment Survey)	A self-assessment tool used to determine a patient's level of health and functioning
ICT (Interdisciplinary Care Team)	A team comprised of the patient, care giver, Primary Care Physician, Care Advisor and other health care professionals, such as, social work, community health worker, pharmacy, etc.
ICP (Individualized Care Plan)	Developed by the Interdisciplinary Care Team and based upon a comprehensive assessment of the patient's needs
MAO	Medicare Advantage Organization
H9915	The CMS unique ID for the MedStar Medicare Choice Plan is H9915. CMS may name this Medicare Plan: MedStar Family Choice.
HOS	The Health Outcome Survey is used to help provide demographic information about the region

MedStar C-SNP Patients

Table 11: *2015 Cohort 18 Baseline* Demographics for MAO H9915 and HOS Total

HOS Demographic	MAO H9915 N (%)	HOS Total N (%)
Age	(N=635)	(N=215,135)
65-69	192 (30.2%)	65,250 (30.3%)
70-74	181 (28.5%)	58,097 (27.0%)
75-79	128 (20.2%)	40,645 (18.9%)
80-84	74 (11.7%)	27,522 (12.8%)
85+	60 (9.4%)	23,621 (11.0%)
Gender	(N=635)	(N=215,135)
Male	236 (37.2%)	89,622 (41.7%)
Female	399 (62.8%)	125,513 (58.3%)
Race	(N=635)	(N=215,135)
White	277 (43.6%)	172,721 (80.3%)
Black	336 (52.9%)	23,720 (11.0%)
Other/Unknown	22 (3.5%)	18,694 (8.7%)
Marital Status	(N=595)	(N=203,773)
Married	225 (37.8%)	108,349 (53.2%)
Widowed	180 (30.3%)	50,544 (24.8%)
Divorced or Separated	150 (25.2%)	35,230 (17.3%)
Never Married	40 (6.7%)	9,650 (4.7%)
Education	(N=582)	(N=200,645)
Did Not Graduate HS	186 (32.0%)	41,544 (20.7%)
High School Graduate	202 (34.7%)	65,382 (32.6%)
Some College	105 (18.0%)	49,720 (24.8%)
4 Year Degree or Beyond	89 (15.3%)	43,999 (21.9%)
Annual Household Income	(N=561)	(N=186,636)
Less than $10,000	68 (12.1%)	22,940 (12.3%)
$10,000-$19,999	142 (25.3%)	33,096 (17.7%)
$20,000-$29,999	97 (17.3%)	28,533 (15.3%)
$30,000-$49,999	94 (16.8%)	36,758 (19.7%)
$50,000 or More	54 (9.6%)	40,328 (21.6%)
Don't Know	106 (18.9%)	24,981 (13.4%)
Medicaid Status	(N=635)	(N=215,097)
Medicaid	98 (15.4%)	42,671 (19.8%)
Non-Medicaid	537 (84.6%)	172,426 (80.2%)

MedStar C-SNP Patients

Beneficiary demographics		
(H9915)	2016	2015 Nat'l Avg.
Gender (sample*)		
Female	66.52%	NA
Male	33.48%	NA
Age (sample*)		
Less than 65	17.39%	NA
65-74	40.87%	NA
75 or older	41.74%	NA
Race/ethnicity (Q90/Q91)		
White	46.37%	84.37% ◆
Black or African-American	52.02%	11.81% ◆
All others	NR	6.41%
Hispanic or Latino	NR	11.25%
Education (Q89)		
High school or less	66.67%	53.54% ◆
Some college	20.78%	25.63%
College graduate or more	12.55%	20.83% ◆
Currently live alone (Q92)	39.29%	35.70%

* The gender and age questions were removed from the survey in 2014 and are taken from the sample provided by the plan.

MedStar C-SNP Patients

Table 15: *2015 Cohort 18 Baseline* Prevalence of Impairments in ADLs and IADLs for MAO H9915 and HOS Total

Impairment Type	MAO H9915 Impairments N (%)	HOS Total Impairments N (%)
Activities of Daily Living		
Walking	209 (34.3%)	64,114 (31.2%)
Getting in or out of chairs	130 (21.2%)	41,860 (20.3%)
Bathing	83 (13.4%)	29,989 (14.5%)
Dressing	67 (10.8%)	23,548 (11.4%)
Using the Toilet	47 (7.7%)	17,304 (8.4%)
Eating	24 (3.9%)	9,825 (4.7%)
Instrumental Activities of Daily Living*		
Preparing meals	44 (7.8%)	18,929 (10.2%)
Managing money	35 (6.1%)	10,242 (5.3%)
Taking medication as prescribed	23 (3.9%)	9,857 (5.0%)

*Respondents that indicated "I don't do this activity" to IADL questions were removed from the denominator.

MedStar C-SNP Patients

Table 14: *2015 Cohort 18 Baseline* Prevalence of Chronic Medical Conditions for MAO H9915 and HOS Total

Medical Condition	MAO H9915 N (%)	HOS Total N (%)
Hypertension	489 (79.8%)	135,702 (66.2%)
Arthritis - Hip or Knee	298 (48.9%)	88,481 (43.4%)
Arthritis - Hand or Wrist	231 (38.1%)	72,704 (35.6%)
Diabetes	210 (34.6%)	55,503 (27.1%)
Sciatica	138 (23.0%)	50,638 (24.9%)
Other Heart Conditions	134 (22.0%)	42,718 (21.0%)
Osteoporosis	84 (14.0%)	40,495 (19.9%)
Depression	117 (19.4%)	38,248 (18.8%)
Pulmonary Disease	113 (18.6%)	35,529 (17.3%)
Any Cancer (except skin cancer)	61 (10.3%)	28,905 (14.5%)
Coronary Artery Disease	85 (14.1%)	27,018 (13.3%)
Myocardial Infarction	57 (9.4%)	18,492 (9.1%)
Congestive Heart Failure	65 (10.7%)	17,403 (8.5%)
Stroke	62 (10.1%)	16,109 (7.9%)
Gastrointestinal Disease	23 (3.8%)	10,410 (5.1%)

MedStar C-SNP Patients

Diabetes

Below is additional detail for the population diagnosed with diabetes by age and race/ethnicity for the MedStar Medicare Choice footprint:

	Ages 65 – 74	Ages 75+
District of Columbia	11,000	10,000
Maryland	93,000	61,000

Condition	Race/ Ethnicity	District of Columbia	Maryland	US Average
Diabetes (Deaths per 100,000)	White	NSD	15.4	19.0
	Black	35.4	35.5	38.7
	Other	NA	17.4	18.7

Source: Kaiser Family Foundation State Health Facts

MedStar C-SNP Patients

Congestive Heart Failure

Heart Failure (Deaths per 100,000) for the 65+ population

Condition	Race/ Ethnicity	District of Columbia	Maryland	US Average
Heart Failure (Deaths per 100,000)	TOTAL	384.9	462.9	619.8
	White	342.8	485	644.9
	Black	419	430.7	601.7
	Hispanic	NSD	163.1	414.6

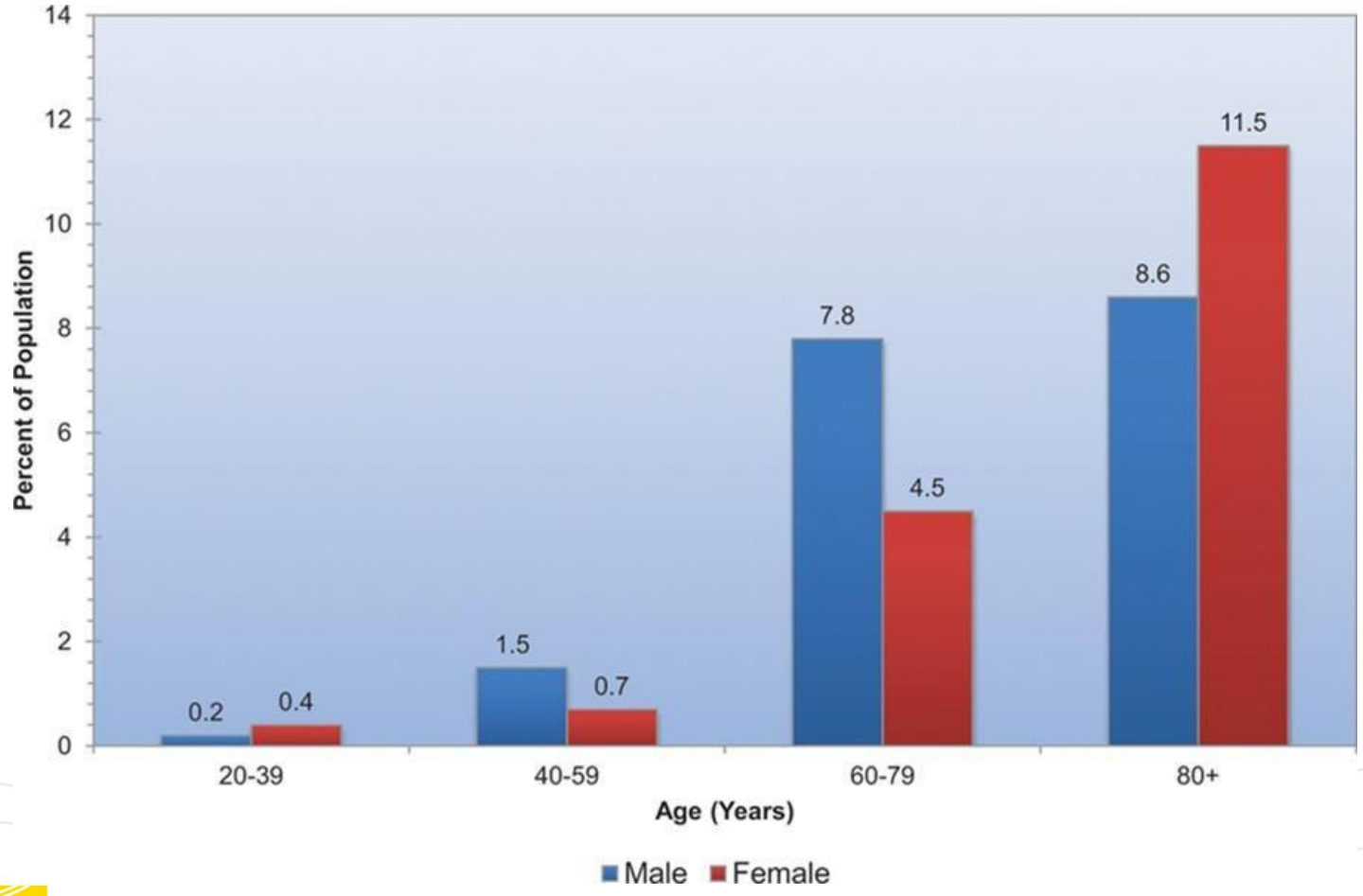
Heart Failure Hospitalization Rate per 1,000 Medicare Beneficiaries, 65+

Condition	Race/ Ethnicity	District of Columbia	Maryland	US Average
Heart Failure (Deaths per 100,000)	TOTAL	18.5	18.6	16.8
	White	7.8	16.7	15.9
	Black	21.5	27.9	27.4
	Hispanic	15.4	11.6	19.7

Source: CDC Interactive Atlas of Heart Disease and Stroke

Prevalence of Heart Failure by Age

National Health and Nutrition Examination Survey: 2007–2010



MedStar D-SNP Patients

Table 3: from the HOS results Table 11: 2015 Cohort 18 Baseline Demographics for MAO H9915 below.

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MedStar D-SNP Patients

Beneficiary demographics		
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Gender (sample*)		
Female	66.52%	NA
Male	33.48%	NA
Age (sample*)		
Less than 65	17.39%	NA
65-74	40.87%	NA
75 or older	41.74%	NA
Race/ethnicity (Q90/Q91)		
White	46.37%	84.37% ◆
Black or African-American	52.02%	11.81% ◆
All others	NR	6.41%
Hispanic or Latino	NR	11.25%
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High school or less	66.67%	53.54% ◆
Some college	20.78%	25.63%
College graduate or more	12.55%	20.83% ◆
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MedStar D-SNP Patients

Table 5: Of the Table 15: 2015 Cohort 18 Baseline Prevalence of Impairments in ADLs and IADLs for MAO H9915

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MedStar D-SNP Patients

Table 7: 2016 CAHPS® DATA: Beneficiary demographics

Beneficiary health		
(H9915)	2016	2015 Nat'l Avg.
Overall health (Q76)		
Excellent/Very good	27.09%	37.08% ◆
Good/Fair/Poor	72.91%	62.92% ◆
Overall mental health (Q77)		
Excellent/Very good	52.96%	57.00%
Good/Fair/Poor	47.04%	43.00%
Told you have the following condition (Q84):		
Heart attack	11.11%	11.09%
Angina or coronary heart disease	12.38%	15.79%
Hypertension or high blood pressure	72.84%	65.22% ◆
Cancer, other than skin cancer	8.88%	14.11% ◆
Emphysema, asthma or COPD	18.35%	19.32%
Any kind of diabetes or high blood sugar	38.10%	31.01% ◆
Average number of prescriptions in last 6 months (Q64)	4.01	4.14
Seen Dr. for same condition 3+ times in last 12 months (Q78)	42.86%	40.95%
Condition has lasted at least 3 months (Q79)	86.73%	91.04%
Now need or take medicine prescribed by doctor (Q80)	84.80%	86.52%
Rx taken to treat condition that has lasted 3+ months (Q81)	95.07%	95.81%
Delayed/not filled Rx because could not afford it (% No) (Q82)	82.45%	87.19%
Received mail order medicine did not request (Q83)	NR	1.25%
Got reminders from doctor's office (Q47):		
To make appointments for tests or treatment	56.02%	59.64%
To get a flu shot or other immunizations	46.89%	47.53%
About screening tests (breast cancer or colorectal cancer)	36.32%	39.45%
Spent one or more nights in a hospital (Q48)	10.50%	12.74%
Doctor's office followed up about hospital stay (Q49)	53.85%	69.03%
Doctor's office/pharmacy/drug plan contacted you (Q68):		
To make sure you filled or refilled a prescription	42.91%	38.69%
To make sure you were taking medications as directed	20.77%	21.42%

MedStar D-SNP Patients

Condition	Race/Ethnicity	District of Columbia	Maryland	US Average
Asthma (% Adults Reporting Asthma)	White	7.5%	7.8%	8.6%
	Black	11.4%	10.4%	10.5%
	Non-Hispanic Multiracial	26.3%	9.9%	14.8%
	Non-Hispanic Other	12.7%	5.4%	6.8%

Condition	Race/Ethnicity	District of Columbia	Maryland	US Average
SMI (% Adults Reporting Poor Mental Health)	White	36.2%	33.9%	35.0%
	Black	39.5%	33.7%	36.5%
	Hispanic	NSD	30.0%	36.8%

Condition	Race/ Ethnicity	District of Columbia	Maryland	US Average
Heart Disease (Deaths per 100,000)	White	135.2	174.8	176.9
	Black	279.0	217.8	224.9
	Hispanic	NSD	86.9	105.5

Source: Kaiser Family Foundation State Health Facts

Balance Billing Overview

- Clarify the billing rules that apply to Medicare-Medicaid Enrollees (i.e. dual eligible's) for Medicare Cost-Sharing
  - Your contract offers that you are to accept the contract payment in full or bill the state for any additional cost-sharing components.
    - Do not collect any Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from the member.
    - Applicable for ALL contracted providers and those that accept Medicaid
  - The balance billing restrictions apply regardless of whether the State Medicaid Agency is liable to pay the full Medicare cost sharing amounts.
  - "PLAN" monitors provider compliance with balance billing rules from plan grievance and CMS Complaint Tracking Module data.
    - As any abuse is identified, targeted provider outreach will occur.

Holistic Health Management

- Complex Care Management
  - Assessment and evaluation of individual needs
  - Assist in improving overall health and/or improving functional capabilities
  - Individual plan of care
- Chronic Condition Care Management using evidence-based guidelines
- Medication Therapy Management Program (MTM):
  - Therapeutic duplication
  - Medications filled that are on the CMS defined list of drugs for inappropriate use in the elderly
  - Potential drug/drug interactions
  - Drugs used to treat specific diseases that may not be appropriate
  - Compliance issues
  - Educational opportunities

Holistic Health Management

- Care Advisors
  - Identify gaps in care, ER visits, hospital admissions, chronic conditions
  - Collaboration with social worker, dietician, pharmacist, community health worker, etc.
  - Care planning based on patient goals
- Community Partners
  - Community Health Worker, as part of the ICT assists patients and their caregiver(s) identification and assistance in arrangement of community resources to maintain the patient's independence and safety in their home
  - Many services are available through the Department of Health in the District of Columbia's Office on Aging, and the Department of Health and Mental Hygiene in Maryland if the patient is over the age of 60 or meets other waiver criteria (e.g., home delivered meals, etc.)

SNP Model of Care (MOC)

Model of Care is best practice as it offers the following benefits:

- High level of attention to the patient's specific health and individual needs
- Health Assessments to identify risks and concerns
- Individualized attention and coordination of care from assigned Case Advisors
- Individualized Care Plan developed by the Interdisciplinary Care Team
- Transition of care across healthcare settings and providers
- Network Providers experienced with SNP Members

MOC Overview and Goals

- The Model of Care is designed to address the unique needs of those eligible for Medicare and Medicaid; including medical, pharmacy, and behavioral health. There is a focus on chronic conditions and socio-economic factors that may impact a patient's ability to access quality care by:
  - Improving a patient's access to medical and mental health services
  - Improving coordination of care through the Care Advisor
  - Improving and reducing transitions of care across health care settings and providers
  - Improving access to preventative health services
  - Assuring appropriate utilization of services
  - Improving patient health outcomes

MOC Key Performance Indicators

- Effective January 1, 2015 SNPs are required to have an evidence based Model of Care (MOC) that includes:
  - Measurable Goals
  - Use of Clinical Practice Guidelines across a specialized provider network
  - Health Risk Assessment (HRA) and annual reassessments
  - Individualized Care Plan (ICP)
  - An Interdisciplinary Care Team (ICT) for each patient
  - Annual Model of Care training for personnel and providers
  - Communication among staff, providers, and patients

Health Risk Assessment (HRA)

- MedStar Medicare Choice C-SNP/D-SNP uses an internally developed tool, known as the Health Risk Assessment (HRA), that was designed to include information on the use of services, access barriers, caregiver supports, assistance with daily activities, medical and behavioral health conditions, and lifestyle risk factors
- The HRA will be used to:
  - Identify a patient's needs
  - Develop the individual care plan
  - Identify changes in patient's health year to year

Interdisciplinary Care Team Members

Patient/
Caregiver

Primary Care/
Specialty
Physicians

Care Advisors/BH
Care Managers

Dietitian/
Pharmacist/ Social
Worker/Community
Health Worker

Communication, Patient-Centered Goals, Positive Outcomes

MedStar Medicare
Choice

Knowledge and Compassion **Focused on You**

Interdisciplinary Care Team (ICT)

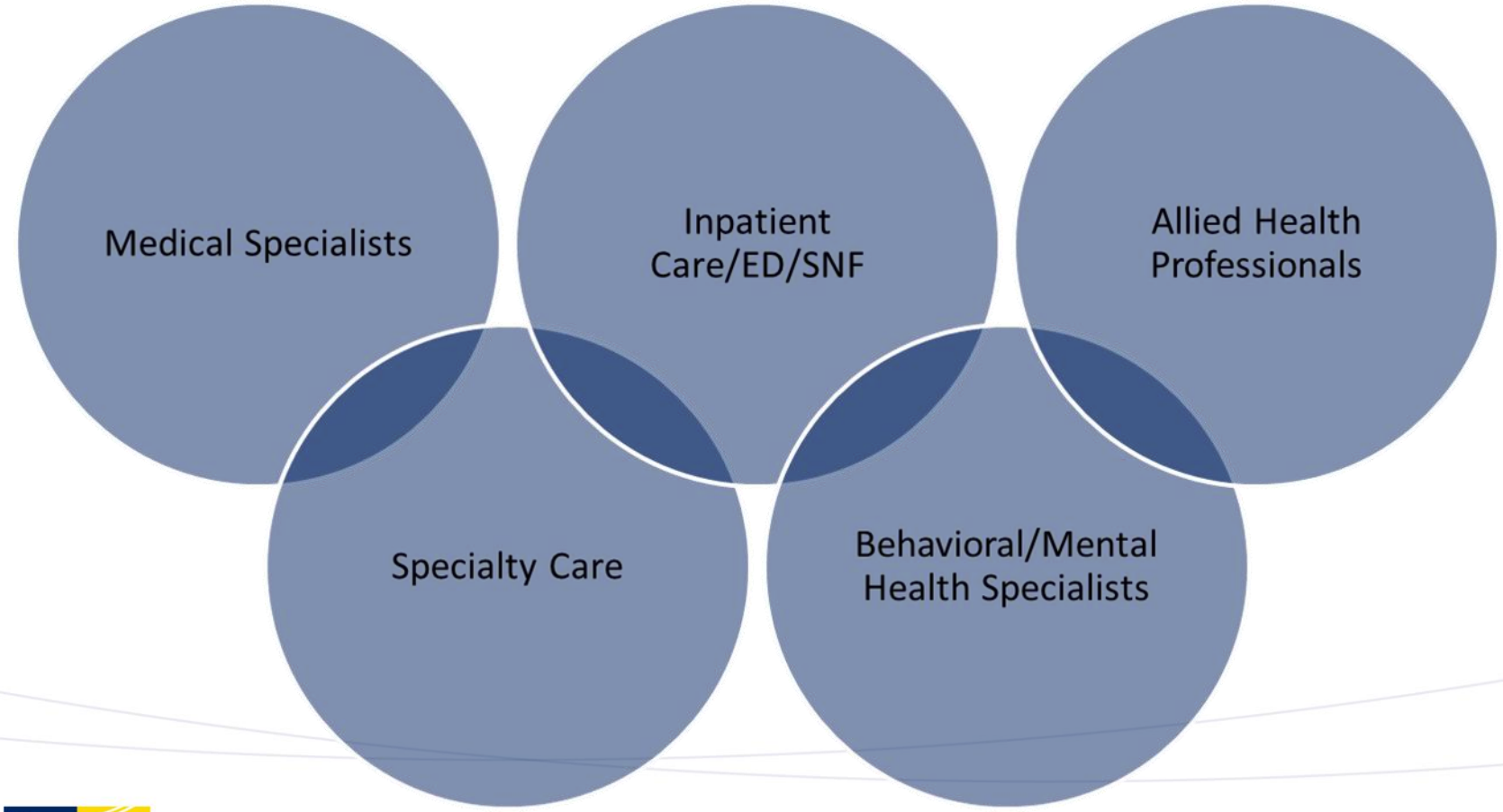
- Definition:
  - “A team of professionals from multiple disciplines who work together to coordinate and facilitate patient focused care.” The goal of the ICT is to seek input from a multidisciplinary team on the top priority problems, goals, interventions and barriers for the high risk, complex care population. Actions steps and responsibilities are determined”.
- Components of Team Meeting
  - All vulnerable patients will have an ICT meeting quarterly
  - The Care Advisor will engage the patient and start the initial assessment
  - A care plan will be started with input from the patient/caregiver and physician and will be reviewed/discussed with a focus on progress, barriers, and updates
  - Documentation will include participants, key topics, and the action plan with responsible team members

Individualized Care Plan (ICP)

- The Care Advisor, with active involvement from the patient/caregiver and the patient's PCP, specialists, and ancillary care providers works to identify and prioritize a problem list and comprehensive ICP
  - The ICP is a patient centered approach that emphasizes patient engagement and in-depth understanding of the patient's strengths and vulnerabilities
  - The ICP is developed after the Care Advisor reviews the HRA and completes a comprehensive assessment
  - The Care Advisor discusses the ICP with the patient/caregiver
  - If a SNP member cannot be contacted or refuses to participate, the Care Advisor will develop a care plan with clinical information that is available and will share this with the PCP

SNP Provider Network

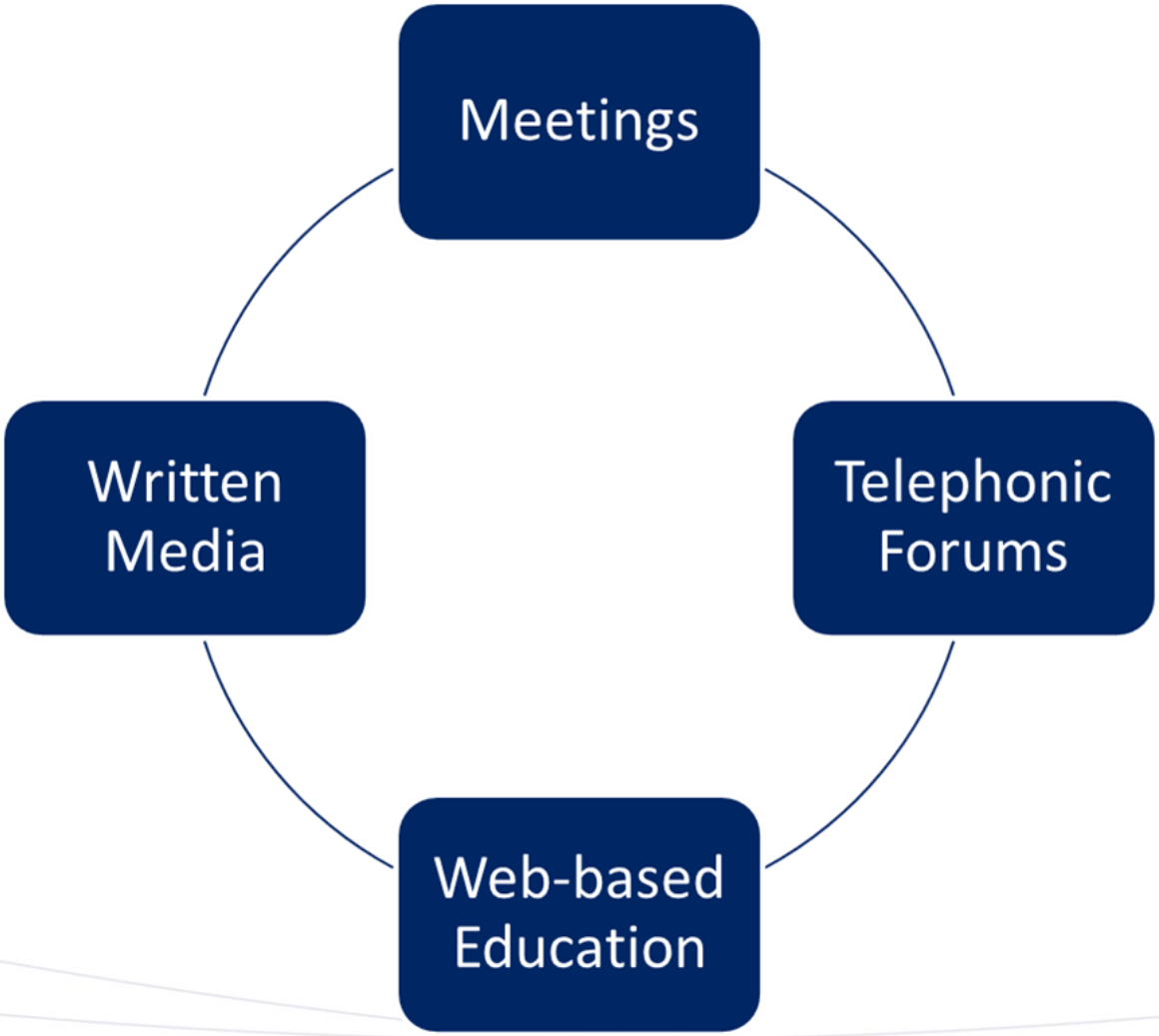
- MedStar Medicare Choice SNP maintains contracts with credentialed providers to ensure that Members in the targeted special needs population have access to high quality care.



SNP Provider Network

- MedStar Medicare Choice providers and facilities have physicians and staff trained in the use of clinical practice guidelines, protocols and evidence-based medicine. All MedStar Medicare Choice providers have access to clinical guidelines, UM guidelines, patient health guidelines and medical policies and procedures through the following website http://medstarprovidernetwork.com/
- MedStar Medicare Choice maintains an accurate and timely credentialing and re-credentialing process and monitors delegated credentialing activities to assess adherence to the processes outlined in the MedStar Medicare Choice policies
- Information related to a physician's quality of service is integrated into the re-credentialing process through a file review

Communication Network



- Network manager office visits
- Network pharmacy office visits
- Annual regional provider meetings
- Provider advisory committee meetings
- Physician portal
- Provider newsletters
- Provider manual

Measurable Performance Outcomes

Measurable Performance Outcomes

Improved Care Coordination

Decrease in Avoidable ED Visits

Increase Preventative Screenings

Improve F/U Post Medical Admission

Measurable Performance Outcomes

Improved Screening Services

Increase Breast Cancer Screening

Increase Glaucoma Screening

Increase Colonoscopy Screening

Measurable Performance Outcomes

Improved Health Outcomes

Decrease Gaps in Care

ICP Developed with Patient and PCP

Improve Patient Perception of Health Status

Ongoing Performance Improvement Evaluations

- MedStar Medicare Choice C-SNP/D-SNP Quality Improvement Program and an Annual Work Plan outline the quality management approach; including data to be collected and analyzed, measurement of health outcomes, effectiveness of the health management programs, HEDIS measures, and patient and provider satisfaction
- The Director for Performance Improvement and the senior clinical team work with MedStar Medicare Choice's Quality Improvement functional leadership team in the development of the SNP Annual QI Program description, Annual Evaluation, and Work Plan

Ongoing Performance Improvement Evaluations

- MedStar Medicare Choice C-SNP/D-SNP has multiple ongoing methods to assist in monitoring health outcomes, quality metrics, and surveying the cost and utilization of services and include but are not limited to:
  - Monthly Healthcare Effectiveness Data and Information Set (HEDIS) to identify opportunities for improvement
  - Monthly identification of patients for care management programs
  - Monthly analysis of cost and utilization of services for the entire population and sub-populations
  - Quarterly updates to the SNP QI Work Plan
  - Annual evaluation of the MOC

To Receive 1.75 CME Credits

Two Steps

- Complete a post-test:
  i. Select ‘Complete’ on the drop down next to ‘Launch’ for this presentation. The assessment (post-test) will activate.
  ii. Click ‘Activate’ then ‘Launch Test’ to complete the post-test.

- Complete an evaluation:
  i. Click ‘Training’, then ‘My Transcript’ from the main menu, then click ‘Evaluate’ for this activity to complete the evaluation.

- Upon completion of the evaluation, an email containing instructions on accessing the CME certificate will be sent to you.