SPECIAL NEEDS PLAN

Model of Care Provider Training

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Special Needs Plans - Model of Care

- **Chapter 42 of the Code of Federal Regulations, Part 422** (42 CFR 422.101 (f)(2)(ii)) mandates that Special Needs Plans (SNPs) conduct SNP Model of Care (MOC) training for all employed and contracted providers
- The Special Needs Plans **Model of Care** (MOC) is the evidence-based process (Clinical Core Model) by which we integrate benefits and coordinate care for Members enrolled in Cigna Care Plan's Special Needs Plans
- All providers must receive training on the MOC initially and annually thereafter

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Special Needs Plans

There are three types of SNPs. Each requires its own distinct Model of Care, tailored to the needs and conditions of the eligible beneficiaries (target populations).

Chronic Condition SNP (C-SNP)

- Chronic Condition Special Needs Plan
- For Medicare beneficiaries with a specific medical condition
- Condition = Diabetes

Dual Eligible SNP (D-SNP)

- Dual Eligible Special Needs Plan
- For Medicare beneficiaries who are also eligible for Medicaid

Institutional SNP (I-SNP)

- Institutional Special Needs Plan
- For Medicare beneficiaries who reside in a long-term care facility

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Special Needs Plan Model of Care (MOC): 4 Domains; 14 Elements

The SNP Model of Care document includes the following sections:

Domain	Elements
MOC 1: Description of the SNP Population	• A. Sub-Population: Most Vulnerable Beneficiaries
MOC 2: Care Coordination	• A. SNP Staff Structure • B. Health Risk Assessment Tool • C. Individualized Care Plan (ICP) • D. Interdisciplinary Care Team (ICT) • E. Care Transitions Protocols
MOC 3: SNP Provider Network:	• A. Specialized Expertise • B. Use of Clinical Practice Guidelines & Care Transitions Protocols • C. MOC Training for the Provider Network
MOC 4: MOC Quality Measurement & Performance Improvement	• A. MOC Quality Performance Improvement Plan • B. Measureable Goals & Health Outcomes for the MOC • C. Measuring Patient Experience of Care (SNP member Satisfaction) • D. Ongoing Performance Improvement Evaluation of the MOC • E. Dissemination of SNP Quality Performance related to the MOC

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Health Risk Assessment and Coordination of Care

- You play a critical role in HRA completion by conducting an annual 360 exam
- By completing a 360, your patient will receive an Individualized Care Plan
- Depending on the results of the Health Risk Assessment or changes in health status, members may be referred to case management

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Health Risk Assessment and Coordination of Care (continued)

- All MMP Members receive an HRA assessment and are stratified in the appropriate risk level based on the assessment. All MMP members are assigned a designated service coordinator to assist with case management

- **MMP Plans are required to report HEDIS measures which include completion rates of the Comprehensive Health Risk Assessment**

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SNP Model of Care Core Clinical Process

Improving Care Coordination and Health Outcomes

1. Health Risk Assessment (HRA)

For new members, the HRA must be completed within 90 days of enrollment (30 days for I-SNP members). For renewing members, the HRA must be completed within 364 days of the last HRA.

2. Risk Stratification

HRA results and other data is used to stratify members and determine their risk levels.

3. Individualized Care Plan (ICP)

Every SNP member will have an ICP to facilitate their coordination of care. ICPs are revised with changes in health status.

4. Interdisciplinary Care Team (ICT)

Every SNP member will have access to a care team to support the care plan development and maintenance process.

5. Care Transition Protocols (If applicable)

Reassess the SNP member and update the care plan if a care transition or change in health status occurs.

The SNP MOC is continuous based on change in health status and applies to all SNP Members.

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Special Needs Plans – Model of Care (MOC)

Cigna CarePlan's Special Needs Plan Model of Care has the following goals:

- Improve access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across health care settings and providers
- Improve access to preventive health services
- Ensure appropriate utilization of services
- Improve beneficiary health outcomes

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You are the key element to improving our members health outcomes

Interdisciplinary Care Team

- PCPs and other Providers are invited to actively participate in care team meetings and lead the development of the plan of care
- Your participation is key in the Interdisciplinary Care Team meetings. Meetings are based on member needs
- Together, we will develop a functional care plan
- Cigna CarePlan will develop and maintain a prevention-oriented care plan

Communication and Collaboration

- The care plan serves as a communication tool and increases collaboration with all members of the Interdisciplinary Care Team
- Transition of Care notices are sent to the PCP
- Encourage patients to follow-up with you within 7 days of discharge

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We’re here to help! SNP Resource Contact Information

For Dual and Chronic SNP Members

- To discuss and/or request a copy of a SNP patient’s care plan, refer a SNP patient for an Interdisciplinary Care Team meeting or participate in an Interdisciplinary Care Team meeting, please contact our Service Coordination department at 1-877-725-2688

- Member Services: 1-877-653-0327

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Clinical Guidelines

> Evidence-based guidelines serve as the foundation of the care management program

> Evidenced based guidelines are reviewed, amended as needed to meet local practice by the Physician Advisory Committee and approved by the Quality Committee

- Cigna CarePlan clinical practice guidelines can be found in your provider manual
  - Link to manuals on the Cigna CarePlan website https://careplantx.cigna.com/health-care-providers/

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