2023 SNP
MODEL OF CARE (MOC)
PROVIDER/VENDOR TRAINING

IMPERIAL HEALTH PLAN/ IMPERIAL INSURANCE COMPANIES

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SNP Overview

The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage Coordinated Choice Plans specifically designed to provide targeted care to individuals with special needs.

"Special needs individuals" are

1) dual eligible; Members who qualify for both Medicaid and Medicare
2) institutionalized individuals; and/or
3) individuals with severe or disabling chronic conditions, as specified by CMS

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SNP POPULATION

- **Imperial Health Plan/Imperial Insurance Companies services SNP members in the following Counties**

California			Texas	Arizona	Nevada
Alameda	Mendocino	San Mateo	Bexar	Coconino	Clark
Amador	Merced	Santa Barbara	Collin	Maricopa	
Butte	Modoc	Santa Clara	Comal	Pima	
Contra Costa	Monterey	Shasta	Dallas	Pinal	
Del Norte	Napa	Sisikyou	Denton	Yavapai	
El Dorado	Nevada	Solano	El Paso		
Fresno	Orange	Sonoma	Fort Bend		
Glenn	Placer	Stanislaus	Harris, Hays		
Humboldt	Plumas	Tehama	Montgomery		
Imperial	Riverside	Tulare	Nueces		
Inyo	Sacramento	Tuolumne	Tarrant		
Kern	San Benito	Ventura	Travis		
Kings	San Bernardino	Yolo yuba	Williamson		
Los Angeles	San Diego		Wise		
Madera	San Francisco				
Marin	San Joaquin				
Mariposa	San Luis Obispo				

SNP Overview

- We perform a population assessment to build a Model of Care that will best serve the needs of the members.
- Some of the factors identified include but not limited to the following:

Age
Gender
Ethnicity
Incidence of major diseases and chronic conditions
Language barriers and health literacy
Identification based on multiple hospital admissions, high pharmacy utilization, high cost
Combination of medical, psychosocial, cognitive and functional challenges

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SNPs

D-SNPs → Members that are dually eligible for Medicare and Medicaid

C-SNPs → Members with chronic and disabling disorders. One or more of the following chronic diseases depending on the specific plan →

- Diabetes
- Chronic Heart Failure
- Cardiovascular Disorders
  - Cardiac Arrhythmias
  - Coronary Artery Disease
  - Peripheral Vascular Disease
  - Chronic Venous Thromboembolic Disorder

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MOC Goals

Improve Transitions of Care	Improve Access to Services	Improve Outcomes
Communication between providers	Preventive Health both general & patient specific	Improve perceived Health Status
Assistance in Transition to care settings (home, hospital, etc.)	Community Resource needs both Clinical and Non-Clinical Health Department, Rural Clinics, Home Care Senior Centers, Food, Transportation, Housing	Medication adherence and safety

Performance of goals measured through reporting, monitoring and surveys of membership.

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Staff Structure

All staff work as an integrated team for care management of the enrollee.

Staff Roles include but are not limited to:

Administrative Staff

- Member/Enrollee Services
- Customer Service Staff
- Appeals and Grievances Staff
- Member/Enrollee Accounting Team
- Claims Team

Clinical Staff

- Behavioral Health Clinicians
- Licensed Clinical Social Workers
- Psychologists
- Mental Health Counselors

Medical Clinicians

Community Connectors

Staff Structure and Description

Administrative & Clinical Oversight Staff

The Quality Improvement Team monitors and evaluates MOC activities to help improve the programs.

The Human Resources team is responsible for ensuring ongoing monitoring is conducted in accordance with state and federal requirements.

The Credentialing Department is responsible for ensuring physicians are fully credentialed.

Provider Services is responsible for network availability/access, provider training, and evaluation to ensure valuable member experiences.

The Medial Director Team has oversight of the development, training and integrity of Healthcare Services and Quality Improvement programs.

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The team serves as a resource for Integrated Case Management Teams and providers regarding member/enrollee's health care needs and care plans
Selects and monitors usage of nationally recognized medical necessity criteria, preventive health guidelines and clinical practice guidelines.

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Specialized Provider Network

Imperial has an adequate and specialized provider network that maintains the appropriate licensure and competency to address the needs of the target population

Imperial provides the full SNP Model of Care with team based internal case management when it is not provided by the member's primary care provider and medical group.

Provider Network has Specialized Expertise, utilizes clinical practice guidelines and protocols

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Model of Care Training

Initial/Annual Training

-Network Providers

-Health Plan Staff

Training Methods

-Webinars

-On Site at Provider Office

-Provider Manual with written training materials for reference/attestations

Components of Training

-Model of Care Elements

-Plan Processes and Procedures

-Health Plan Tools and Resources

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Health Risk Assessment (HRA)

An HRA is conducted to identify medical, psychosocial, cognitive, functional, and mental health needs and risks.

Imperial attempts to complete initial HRA within 90 days of enrollment and annually via telephone.

Multiple attempts are made to contact the patient including mailed surveys.

The patient's HRA responses are used to identify needs, incorporated into the member's care plan and communicated to care team via electronic medical management system, the provider portal or by mail.

If patient is unreachable, medical history from member's provider will be used to complete HRA

Patient is reassessed if there is a change in health condition and these and annual updates are used to update the care plan.

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Individual Care Plan

1) Individual Care Plan (ICP) is created for each patient by the Case Manager with input from the care team.

2) The member and caregivers are involved in development of and agrees with the care plan and goals.

3) ICP is based on the patient's assessment and identified problems.

4) Goals are prioritized considering patient's personal preferences and desired level of involvement in the process.

5) ICP is revised when change such as new diagnosis/hospitalization or at least annually and communicated to Interdisciplinary care team (ICT) and member.

6) Patient's self-management plans and goals are described.

7) Barriers and progress towards goals are listed.

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Care Management

Case Managers coordinate the member’s care with the Interdisciplinary Care Team (ICT) which includes designated IHP’s staff, the member and their family/caregiver, doctors, specialists and vendors, anyone involved in the member’s care based on the member’s preference of who they wish to attend.

Case Managers strive to do the right thing for members by encouraging self-management of their condition as well as communicating the member’s progress toward these goals to the other members of the ICT

Imperial is responsible to maintain a single, integrated care plan that requires reaching out to external ICT members to coordinate many separate plans of care into one that is made available to all providers based on member’s preference.

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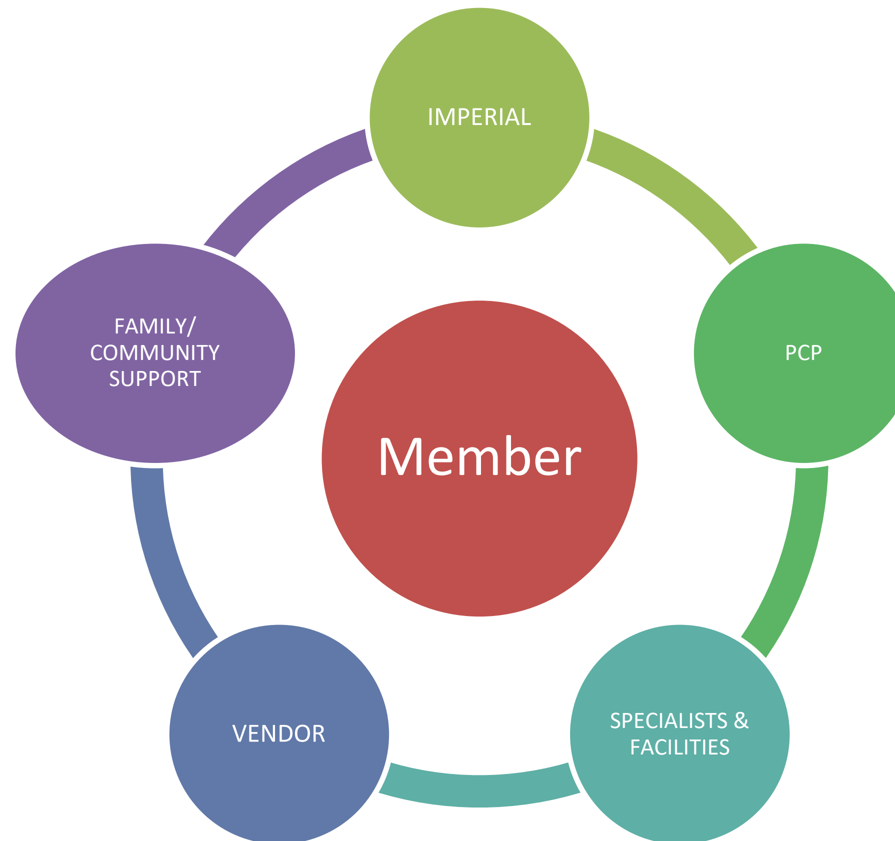
Interdisciplinary Care Team (ICT)/Integrated Communication Network

Imperial's staff works with all members of the ICT in coordinating the plan of care for the enrollee



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Face to Face Encounters

What are Face to Face encounters?

In-person doctor's visit
Teladoc

Appropriate Personnel for Face to Face

Physicians
Specialists
Contracted Providers/Physicians
Pharmacist
Behavioral Health

Clinical Functions of Face to Face

- **Completing HRA**
- **Care Plan Review**
- **Health Education Referrals**
- **Coordinating Appointments**
- **Home Health Enrollment**
- **Annual Wellness Visits & Preventative Exams**
- **Medication Management**
- **Behavioral Health Assessment**

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Performance and Health Outcomes Measurement

Process Measures

Timeliness of Assessment processes

Physician Relationship (% populations with PCP or Medical Home Relationship)

Care Meetings

Case/Care Management performance

Care Measures

Utilization Patterns

Prescribing Patterns

Drug interactions

Readmissions

Quality Measures

HEDIS

Quality of Care Concerns

Satisfaction Surveys

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QUESTIONS/COMMENTS

Providers:

- Please contact our Provider Relations Department at (626) 838-5100 Prompt 5

Staff:

- Please contact our Health Education Department at (626) 838-510 ext 266

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