Bright HealthCare

Medicare Advantage Special Needs Plan (SNP) Model of Care Training

CY 2021

SNP Model of Care Training Requirement

- The Centers for Medicare & Medicaid Services (CMS) requires Bright Health employees, vendors and providers who serve Medicare Advantage Special Needs Plan (SNP) members to complete annual training on the SNP Model of Care (MOC)
- The MOC provides the framework for how the SNP will identify and address the unique needs of its members
- Annual MOC training ensures that providers and relevant staff are educated, aware and will leverage the SNP MOC to deliver care and services to SNP members

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Objectives

- Provide an overview of Medicare Advantage Special Needs Plans (SNPs)
- Review SNP benefits for CY 2021
- Review components of the SNP Model of Care (MOC)
- Review the provider's role in the SNP MOC
- Review components of the SNP MOC Quality Program
- Provide links to additional resources
- Complete Training Attestation

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SNP Overview

What is a Special Needs Plan (SNP)?

- Created by Congress in 2003 as a new type of Medicare Advantage (MA) Plan that focuses on certain vulnerable groups of Medicare beneficiaries
- SNPs must have robust clinical and care management programs to meet the special needs of members
- Bright Health offers two types of SNPs:

Dual Eligible SNP (D-SNP)	• Enrolls beneficiaries eligible for both Medicare and Medicaid
Chronic Condition SNP (C-SNP)	• Enrolls beneficiaries with certain chronic or disabling conditions

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What is a D-SNP?

- An MA plan available to individuals who are eligible for both Medicare and Medicaid
- Enrollees must:

Be entitled to Medicare Parts A (hospital) and B (medical) and eligible for Part D (drugs)

&

Be eligible for Medicaid (receive full Medicaid benefits and/or assistance with Medicare premiums or cost-sharing via a Medicare Savings Program)

&

Reside in the D-SNP service area

- Medicare coverage is primary; Medicaid coverage supplements Medicare coverage
- Some D-SNPs are "integrated," meaning they administer Medicare *and* Medicaid benefits
    - **Note:** All D-SNPs must assist members with accessing both Medicare and Medicaid benefits, even if the D-SNP does not administer the Medicaid benefit

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What is a C-SNP?

- An MA plan available to individuals with certain chronic or disabling conditions
- CMS has identified 15 chronic conditions that can be the focus of a C-SNP:

- Chronic Alcohol & Other Drug Dependence
- Certain Autoimmune Disorders
- Cancer
- Certain Cardiovascular Disorders (CVD)*
- Congestive Heart Failure (CHF)*

- Dementia
- Diabetes Mellitus*
- End-Stage Liver Disease
- End-Stage Renal Disease (ESRD) requiring dialysis
- Certain Severe Hematologic Disorders

- HIV/AIDS
- Certain Chronic Lung Disorders
- Certain Chronic & Disabling Mental Health Conditions
- Certain Neurologic Disorders
- Stroke

- C-SNPs may focus on one chronic condition or a group of commonly co-morbid and clinically-linked conditions

*Focus of Bright Health 2021 C-SNP

Bright Health SNPs – New York City

- D-SNP
  - First offered in 2019
  - Must have both Medicare & Medicaid
- C-SNP
  - First offered in 2021
  - Must have diagnosis of:
    - Diabetes Mellitus;
    - Congestive or other Heart Failure; and/or
    - Certain Cardiovascular Disorders (cardiac arrhythmias, coronary artery disease, peripheral vascular disease, or chronic venous thromboembolic disorder)
- For both, must reside in one of three New York counties:
  - New York County (Manhattan)
  - Kings County (Brooklyn)
  - Queens County (Queens)
- Both provided in partnership with Mount Sinai Health System
  - Unique care partnership model integrates care between Bright Health and Mount Sinai to better coordinate care and optimize member experience

In Collaboration with

Bright HealthCare™ | Mount Sinai

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SNP CY 2021 Benefits

D-SNP Benefits

Rich benefits that support care management

Key Takeaways

- All members eligible for the D-SNP plan qualify for Medicaid
- The NY Medicaid program covers the member's premium and medical copays that Bright does not cover
  - Bright pays 80% for most services
  - The member's cost share after Medicaid is $0 on all services covered by Medicare and Medicaid
- Part D cost shares depend on the member's level of Extra Help

Medicare Plan Comparison Chart		
	Plan Benefit Type	**Bright Advantage Special Care (H2288-003)**
Overview	Premium	LIPSA
	Max Out of Pocket	$7,550*
Part D	Part D Deductible	$0, $92 or $445 depending on level of Extra Help
	Part D Cost Sharing	$0, $1.30, $3.70 or 15% for generics $0, $4, $9.20 or 15% for brands
Essentials	PCP/Specialist Visit	$0
	IP Hospital	$0
	ER/UC	$0
Supplemental	Worldwide ER	$90 copay with a $50,000/year limit
	Comprehensive Dental	Included
	Hearing Aids	$750 allowance every year
	Vision Materials	$130 allowance every 2 years
	OTC Allowance	$158 / month
Additional Benefits	Transportation	Unlimited rides
	Meals	Up to 3 meals/day based on Care Management/member's ICP

C-SNP Benefits

Rich benefits that support care management

Key Takeaways

- Bright is the only payer for members on these plans
- Both C-SNP plans are nearly identical for 2021, including Part D

Medicare Plan Comparison Chart			
	Plan Benefit Type	**Bright Advantage Senior Savings (H2288-009)**	**Bright Advantage Senior Savings Assist (H2288-010)**
Overview	Premium	$0	LIPSA
	Max Out of Pocket	$6,700	$6,700
Part D	Part D Deductible	$0	$0
	Part D Network	Standard	Standard
Essentials	PCP/Specialist Visit	$0 / $0	$0 / $0
	IP Hospital	$275 / day, days 1-5	$275 / day, days 1-5
	ER/UC	$90 / $35	$90 / $35
Supplemental	Worldwide ER	$90 copay with a $50,000/year limit	$90 copay with a $50,000/year limit
	Comprehensive Dental	Included	Included
	Hearing Aids	$750 allowance every year	$750 allowance every year
	Vision Materials	$130 allowance every 2 years	$130 allowance every 2 years
	OTC Allowance	$100 / 3 months	$100 / 3 months
Additional Benefits	Transportation	Unlimited rides	Unlimited rides
	Meals	Up to 3 meals/day based on Care Management/member's ICP	Up to 3 meals/day based on Care Management/member's ICP
	Senior Savings	$0 Insulin & diabetic supplies	$0 Insulin & diabetic supplies

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SNP Model of Care

What is a Model of Care (MOC)?

- Unique CMS requirement for Special Needs Plans
- All SNPs must develop and operate under a MOC that has been approved by NCQA
- MOC provides the framework for how the SNP will identify and address the unique needs of its members
- Overall goals of the MOC include:
  - Ensure access to affordable health care services
  - Ensure coordination of care and supported care transitions across payers and care settings
  - Improve health outcomes
  - Facilitate appropriate utilization of services for preventive health and chronic conditions

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Model of Care Elements

- MOC must address multiple elements, including:
  - Characteristics of the SNP population
  - Care coordination/care management model
    - All SNP members are assigned a **Care Manager** who is the member's primary point of contact
    - All SNP members have an **Individualized Care Plan** that is based on a comprehensive **Health Risk Assessment**
    - All SNP members are managed by an **Interdisciplinary Care Team**
      - The member's providers (e.g., PCP, specialists) play a key role in the ICT
    - **Care Transition Protocols** are implemented to ensure coordination of care across settings and providers
  - Clinical programs and services available to SNP members (e.g., chronic condition management)
  - Specialized provider network for the SNP population
  - MOC training plan for employees, providers and vendors
  - Comprehensive quality program to evaluate effectiveness of the MOC

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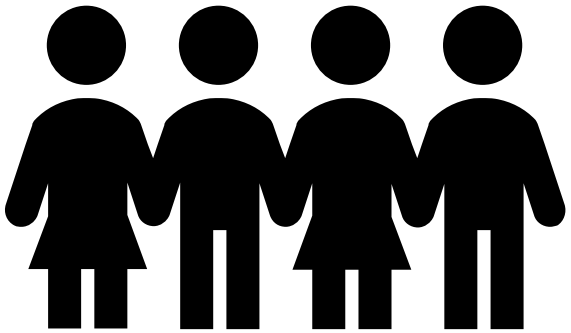
Bright Health D-SNP – Population Characteristics

- Small population – 40 enrollees as of 1/1/21
- Average Age = 69 years
- Race and Ethnicity (among members who reported):
  - 50% white
  - 25% Black
  - 12.5% Hispanic/Latino
- All D-SNP members are low income and eligible for full Medicaid benefits
- Many D-SNP members are experiencing multiple chronic conditions – heart failure and diabetes are two of the most common.
- **Note:** C-SNP launched 1/1/21 – population too small for meaningful data



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Bright Health D-SNP & C-SNP Models of Care

- Designed in partnership with Mount Sinai
- All SNP members assigned a local **Mount Sinai Care Manager** upon enrollment
- Care Manager is member's primary point of contact
  - Completes **Health Risk Assessment (HRA)** with member upon enrollment, annually and if significant change in health/needs
  - Assists member in identifying **Interdisciplinary Care Team (ICT)**
  - Works with member and ICT to develop an I**ndividualized Care Plan (ICP)** addressing the member's unique medical and psychosocial needs
  - Coordinates services across providers and care settings
  - Provides ongoing support through regular telephonic and/or in-person contact

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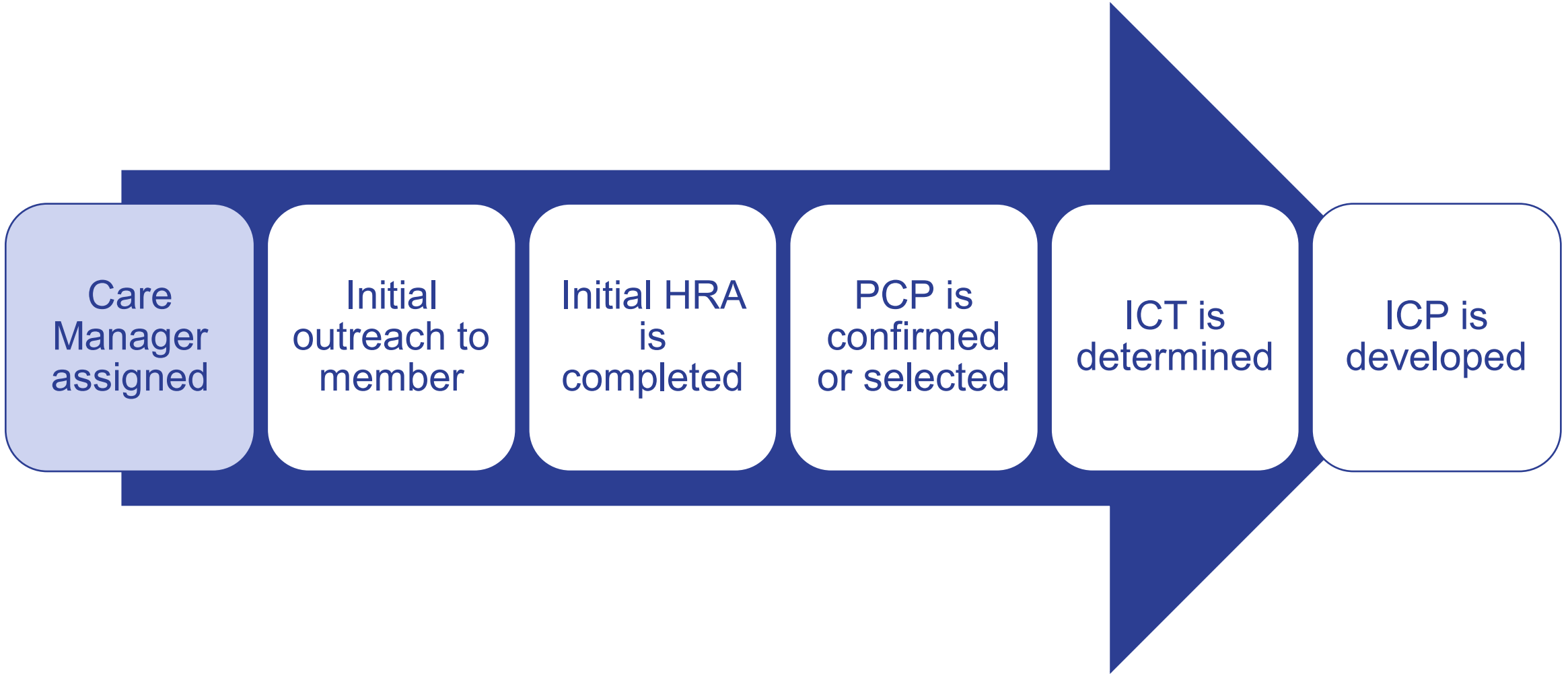
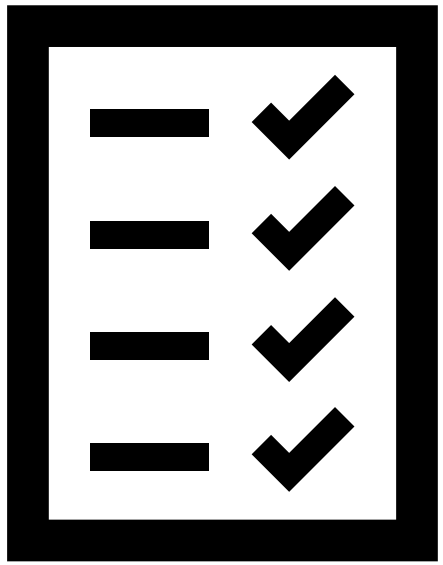
SNP Member Experience

The First 90 Days of Enrollment



Health Risk Assessment (HRA)



- The **HRA** is a comprehensive assessment completed by the Care Manager within 90 days of enrollment and annually thereafter or sooner if there is a change in condition
- HRA assesses the member's needs/risk in the following areas:
  - Medical
  - Psychosocial
  - Behavioral/Mental Health
  - Cognitive
  - Functional
- HRA results are shared with the member's Primary Care Provider (PCP). Providers can access HRA information via the member's electronic health record.
- HRA results drive development of the member's Individualized Care Plan (ICP)

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Health Risk Assessment (HRA)

What is the Health Risk Assessment Tool (HRAT)?

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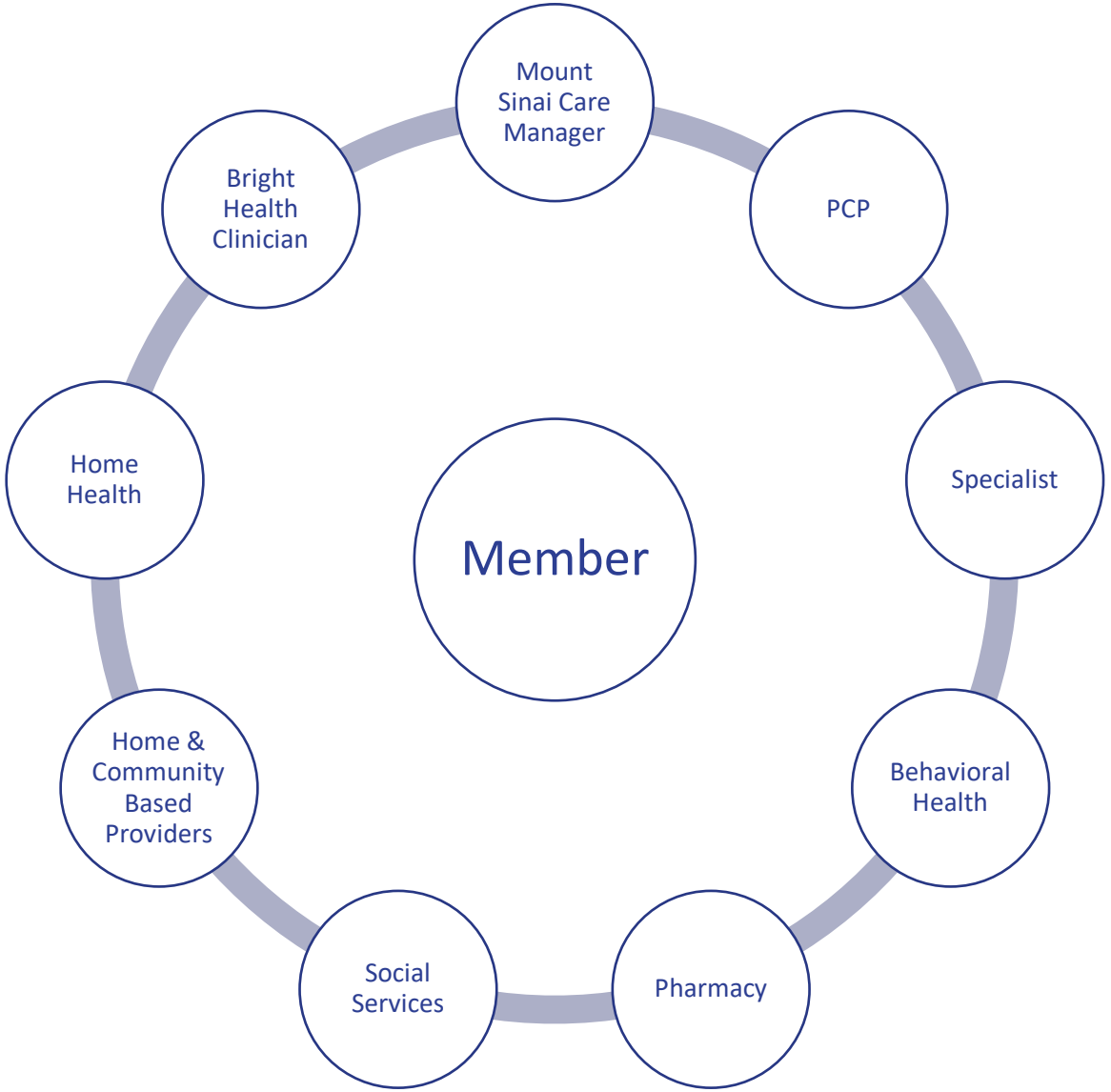
Interdisciplinary Care Team (ICT)

- Each member is managed by an **Interdisciplinary Care Team (ICT)**
- Composition of ICT depends on the member's needs. PCPs are integral participants.
- During HRA process, Care Manager works with member to identify ICT participants
- Care Manager facilitates communication with ICT to address member's needs, coordinate care and develop and implement member's Individualized Care Plan (ICP)
- Each member has at least an annual ICT meeting



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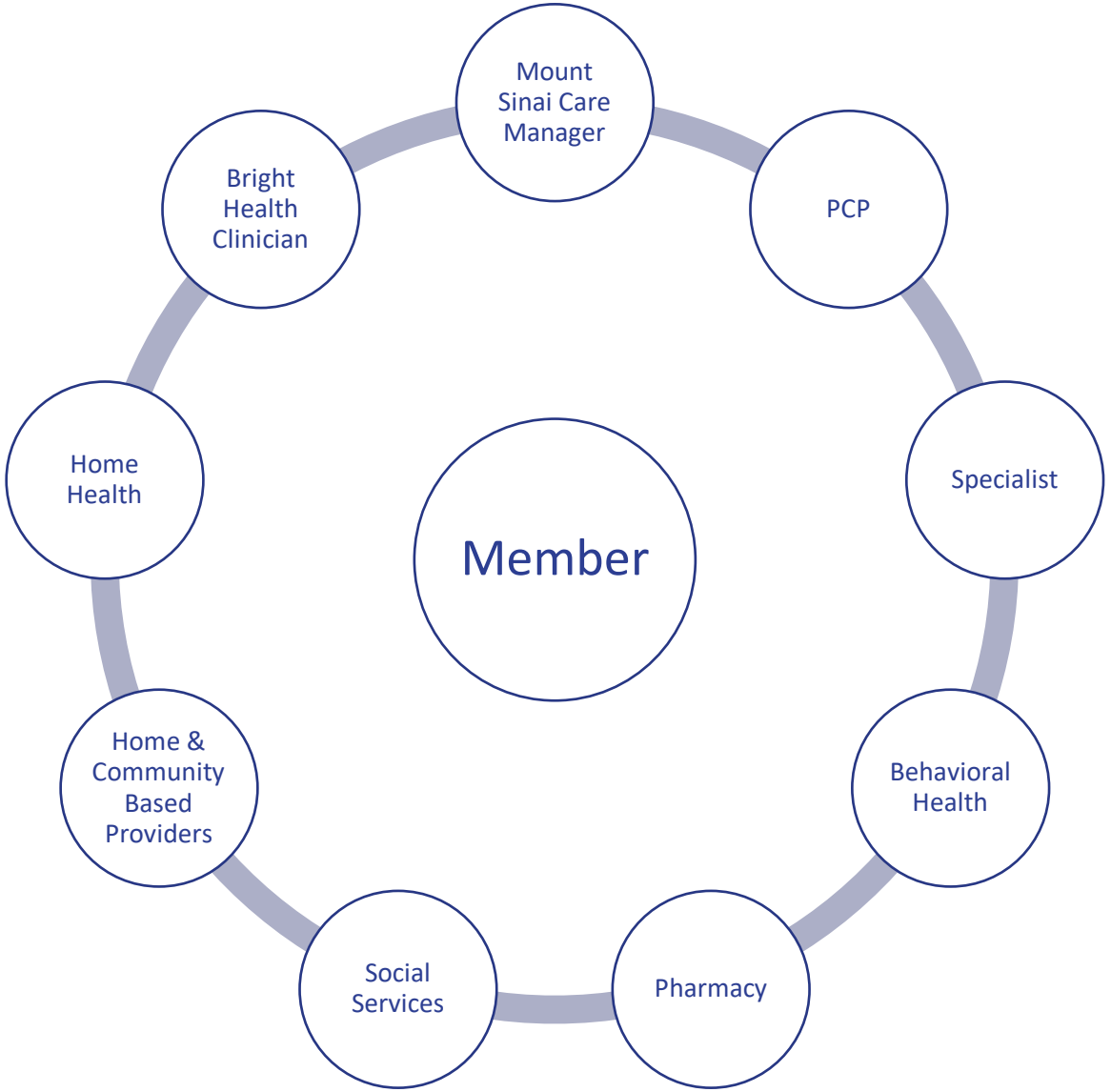
Providers' Role in the Interdisciplinary Care Team (ICT)

- Review and contribute to the member's Individualized Care Plan (ICP)
- Offer expertise regarding the member's medical needs
- Communicate recommendations for preventive care and treatment
- Work directly with the member to help make health care decisions
- Work with the Care Manager, member and/or member's authorized representative and other ICT members to manage and coordinate the member's care
- Participate in member's ICT meeting at least annually



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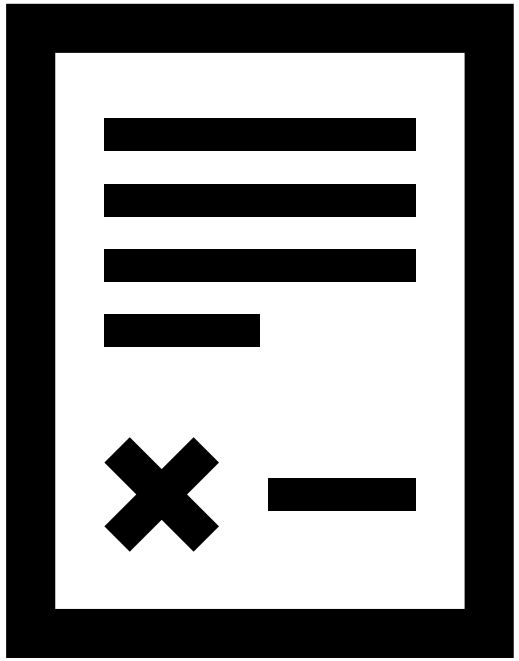
Individualized Care Plan (ICP)

- All SNP members have an **Individualized Care Plan (ICP)**
- ICP is driven by the HRA results and developed by the Care Manager in conjunction with the member, PCP and other members of the ICT
- ICP contains member-specific needs, measurable goals and interventions
- Addresses the following areas:
  - Medical
  - Psychosocial
  - Behavioral/Mental Health
  - Cognitive
  - Functional
  - Pharmaceutical
- ICP is dynamic document that is updated as the member's needs change
- All members must have an ICP, even if the Care Manager is unable to reach them or they refuse to participate in the HRA process
- Providers can access the member's ICP via the electronic health record,, direct request to the member, or request to the member's Mount Sinai Care Manager



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Individualized Care Plan (ICP)

What's Included in an ICP?

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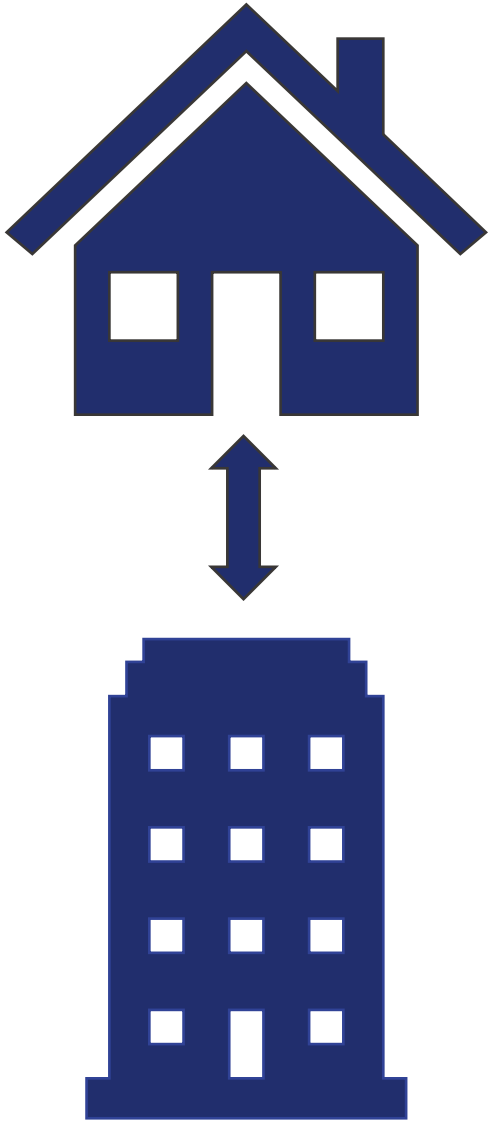
Member Support During Transitions of Care



- Care Manager acts as central point of contact for member across all settings and providers
- When a SNP member experiences a transition in care (e.g., admitted to the hospital), the Care Manager helps coordinate care across settings and providers
  - Notifies member's PCP and other ICT members of the transition
  - Reaches out to receiving setting to assist with coordination of care
  - Reaches out to member to ensure member's needs are addressed
- Updates ICP as necessary and shares with member and ICT

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Working with the Care Manager

- PCP and other ICT participants are provided with the Care Manager's contact information and encouraged to contact the Care Manager to assist with any interaction with the member
- Care Manager is responsible for communicating with PCP and ICT:
  - At least annually
  - When any updates are made to the member's HRA or ICP and/or after a member experiences a transition in care
- PCP and other ICT participants review and provide input on member's ICP
- PCP and other ICT participants participate in ICT meetings for their patients
- For additional information about care management services available to your patients, you may contact the **Mount Sinai Health Partner's Care Management office at (212) 241-7228**

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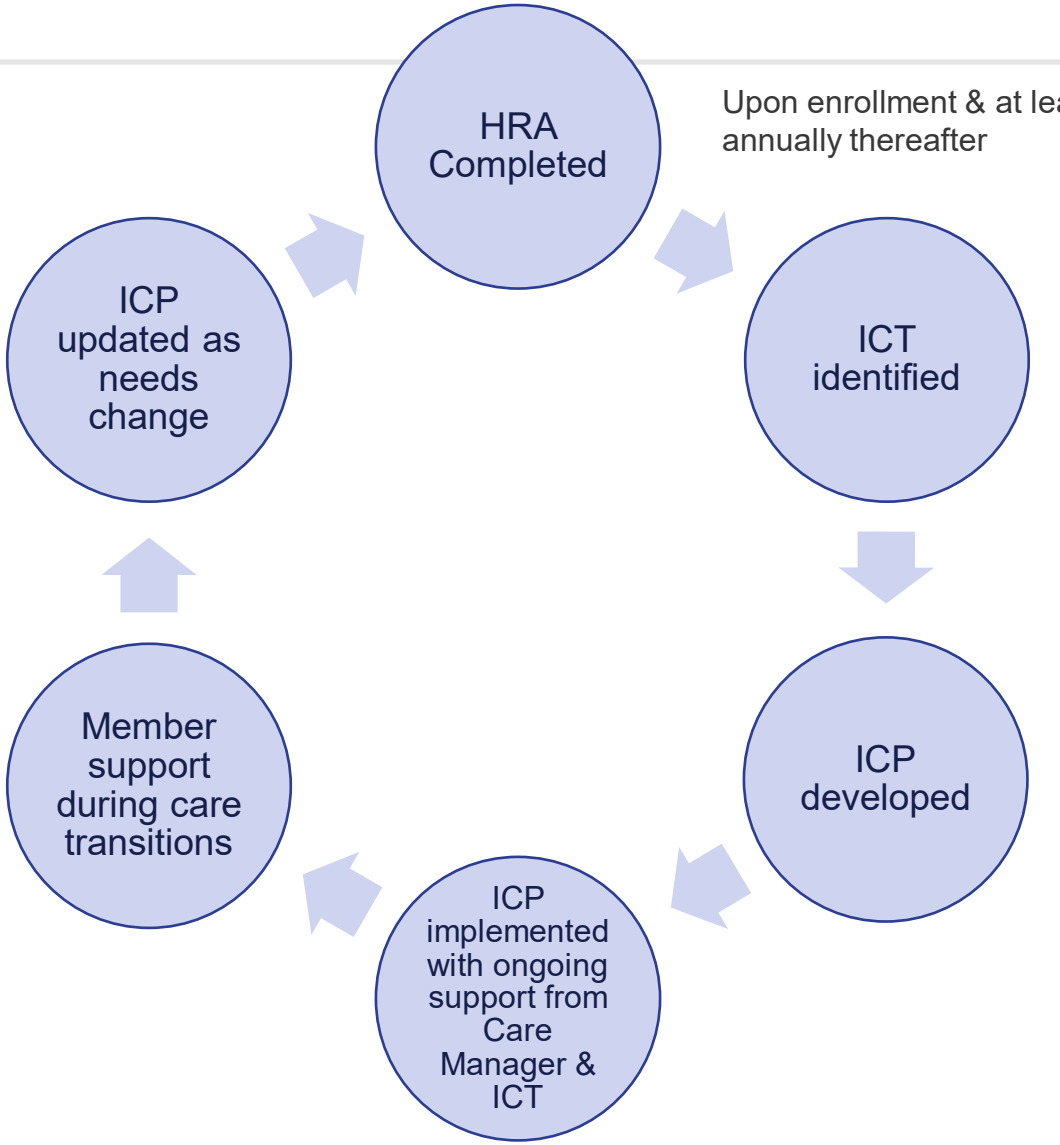
SNP Member Experience

- All members assigned a Mount Sinai Care Manager upon enrollment
- Care Manager is member's primary point of contact throughout Bright Health enrollment



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SNP Model of Care Quality Program

- CMS requires SNPs to have a comprehensive quality program that evaluates the effectiveness of the MOC
- Bright Health MOC goals and outcome measures include:

Goal		Outcome Measure
1.	Members will have a medical home	Percent of members assigned a PCP within 120 days of enrollment
2.	Members will receive coordinated medical and social services to manage acute, chronic and preventive care needs	1. Percent of members assigned a Care Manager within 10 days of enrollment 2. HEDIS & Star Measure Performance: i. Diabetic Eye Exam ii. Kidney Disease Monitoring iii. Controlling Blood Pressure iv. Med Adherence for Diabetes Medication v. Med Adherence for Hypertension
3.	Members will have access to the right service at the right time from the right provider to meet their unique medical and psychosocial needs	1. Percent of members who have completed an initial HRA within 90 days of enrollment or an annual HRA within 365 days of the previous HRA 2. Percent of members who have an ICP developed within 30 days of a completed HRA
4.	Members will receive supported transitions of care across all health care settings and providers	1. Percent of members contacted by a Care Manager within two business days of notice of a transition 2. HEDIS/Star Measure Performance – Plan All Cause Readmissions

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MOC Training Attestation

Thank you for reviewing the Bright Health SNP Model of Care Training

To acknowledge completion and receive credit, please click the link below to complete the **MOC Training Attestation** (hold control + click to follow link)

Bright Health SNP Model of Care Training Attestation Form (office.com)

Remember to hit **"Submit"** at the bottom of the attestation form to complete the Attestation

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To learn more

- Additional Resources
  - Bright Health Provider Manual
  - NCQA Website: https://snpmoc.ncqa.org/about-the-program/
  - CMS Website: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans
- Questions? Email:
  - Danielle Perez Valadez: dvaladez@brighthealthcare.com
  - Lisa Benrud: lbenrud@brighthealthcare.com

Thank you for completing the Bright Health SNP Model of Care Training!

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