CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2013 Special Needs Plans Model of Care Audits: Best Practices & Lessons Learned

Medicare Advantage Special Needs Plans Educational Session

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Objectives

- Discuss the SNP-MOC protocol
- Briefly review the 2013 audit protocol elements & why they were selected
- Share common findings
- Discuss best practices observed
- Discuss lessons learned, relate to 2014 audit protocol, and future guidance/training

Common Acronyms

HRAT	Health Risk Assessment Tool
ICP	Individualized Care Plan
ICT	Interdisciplinary Care Team
C-SNP	Chronic Condition Special Needs Plan
D-SNP	Dual Eligible Special Needs Plan
FIDE SNP	Fully Integrated Dual Eligible Special Needs Plan
I-SNP	Institutionalized Special Needs Plan
LOC	Level of Care
MOC	Model of Care
MOE	Method of Evaluation

SNP-MOC Audit Overview

Review of the Audit Elements

Overview of 2013 SNP-MOC Audit Elements

- I. Population to be served: Enrollment Verification Processes
- II. Health Risk Assessment (HRA), Interdisciplinary Care Team (ICT), & Implementation of Individualized Care Plan (ICP), & Use of Evidence Based Guidelines
- III. Plan Monitoring Performance and Evaluation of the MOC

2013 MOC Audit Background

- Results obtained from two independent reviews conducted in Contract Year 2012:
  - One project identified lessons learned through observation of MOC implementation.
  - Second project observed areas for improvement for writing a MOC.
- HPMS Memo (2/12/2013) summarized the findings and expectations identified in these two independent reviews.

2013 MOC Audit Background (cont.)

- CMS did not audit all 11 MOC Elements because this was the first year the MOC Audit was taking place.
- CMS wanted to use this first MOC Audit year to gain insight on the best approach for conducting the MOC Audit in proceeding years.
- Therefore, only the 3 main areas for MOC improvement summarized in the HPMS memo were used this first year.

Common Findings in 2013

SNP-MOC Audits in 2013

Enrollment Verification

- Overall, D-SNPs had few findings in this area
- C-SNPs – providers not completing annual recertification of chronic condition
- I-SNPs – did not ensure that third-party uses State-approved level of care
- I-SNPs – not verifying institutional level of care timely

Health Risk Assessments

- HRA not completed within 90 days of enrollment
- Reassessments not completed timely (need to update at least annually)
- HRA did not address all member needs as indicated in the plan documentation and ICP
- Gaps in documentation when plan systems were updated or transitioned to new platform

Interdisciplinary Care Team

- Non-clinical personnel not ensuring HRA needs are properly prioritized for care planning
- Need documentation to show ICT collaboration in coordinating care/services

Provider Training

- No methods to verify that providers' MOC training was completed as described in the MOC
- Plan sponsor documentation did not indicate provider training was completed

Individualized Care Plans (ICPs)

- Common findings included
  - No evidence of care plan initiated
  - Care plan was not updated after reassessment and noted change in member condition
  - Care plan did not address issues found in HRA
  - Plan sponsor could not show implementation of care plan through claims and/or case management notes

Monitoring & Evaluation of the MOC

- Overall, few findings in 2013
- A few examples of findings included:
  - Lack of evidence showing MOC was evaluated by plan leadership/staff (according to MOC)
  - MOC evaluation/data not presented to the Board
  - Corrective actions identified were not implemented

Best Practices

SNP-MOC Audits in 2013

Health Risk Assessments & Individualized Care Plans

- A few SNPs set their own standard of performing the HRA within 30 days of enrollment and every 6 months thereafter
  - Note this goes above & beyond CMS guidance (MMCM, Ch. 16b)
- Utilizing APRNs as care coordinators in institutions, i.e. nursing homes

Health Risk Assessments & Individualized Care Plans

- Electronic system accessible by all plan staff, case managers, including providers in network
  - All HRAs easily accessed/viewed, documented & updated
  - Care plan readily accessed by staff, updated by team as needed
  - Phone calls to members and care coordination notes also documented
  - Claims data and utilization of services clearly displayed for member(s)

Interdisciplinary Care Teams

- RNs “embedded” in hospitals and clinics to assist member assessment, care coordination
- RNs visiting members in the hospital to complete reassessments, help with care transitions
- Documentation of outreach/phone calls, encounters with member, providers, and/or specialists through electronic record

Training

- Plan sponsors conducted outreach to provider groups and completed onsite training
- Providing MOC training online for provider groups to complete
- Provider group attestations of training completion, with periodic monitoring by plan sponsor

Model of Care Monitoring & Evaluation

- SNP leaders initiated project with internal/external stakeholders to focus on care transitions
- Incorporation of electronic records with data gathering for quality measures
- Incorporation of MOC reporting into leadership/board meeting calendar

Moving Forward into 2014

Lessons Learned,
Training Opportunities

Frequently Asked Questions in 2013

- Common questions before the audit
  - Clarifying universes
  - Confirming documentation needed

- During the audit
  - Difficulty contacting members to complete HRA and/or ICP
  - Documentation needed to ascertain plan sponsor adherence to its MOC
  - Focusing evaluation of elements upon the SNP's MOC (most current, approved by CMS)

Feedback to Date

- Feedback from listening sessions
- Comments gathered from audit protocol changes/draft released
  - Will build upon training for plan sponsors and CMS staff

In Conclusion

- Many lessons learned in 2013
- Excellent best practices observed
- Looking forward to 2014 protocol
- Training opportunities forthcoming

QUESTIONS?

Thank you!