VIVA MEDICARE
MEMBER OF THE UAB HEALTH SYSTEM
417 20TH STREET NORTH, SUITE 1100 BIRMINGHAM, ALABAMA 35203

2015 Special Needs Plan Model of Care Training

In 2008, Special Needs Plans (SNPs) were mandated by the Medicare Improvements for Patients and Providers Act (MIPPA) to have a Model of Care (MOC). Dual Eligible Special Needs Plans were designed for patients who are entitled to both Medicare and Medicaid assistance, and offer the opportunity of enhanced benefits by combining those available through both Medicare and Medicaid, and managed by a single managed care organization. The Affordable Care Act (ACA) amended Section 1859(f) of the Social Security Act to require that, starting in 2012, all SNPs be approved by NCQA based on standards developed by the Secretary.

2017 Model of Care submission guidelines:

- 4 clinical and non-clinical elements
- Most elements are composed of multiple factors
- Evaluated and scored on a scale of 0 to 4
- Plans must provide detailed and in-depth responses to each element and factor
- Requires a minimum passing score of 70%
- VIVA's most recent submission in 2013 (for 2014) scored 98.75%. This allows a 3 year approval period.
- 2015 NCQA restructured the Model of Care, and the annual Structures and Processes component was eliminated
- Submission due to CMS by February 18, 2016 for MOC 2017 approval

VIVA HEALTH's Dual Special Needs Plan is called VIVA MEDICARE *Extra Value.* Individuals with Medicare and the following categories of Medicaid are eligible to enroll in the D-SNP plan:

- Qualified Medicare Beneficiary without other Medicaid (QMB only)
- Qualified Medicare Beneficiary with Comprehensive Medicaid Benefits (QMB+)
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only)
- Specified Low-Income Medicare Beneficiary with Comprehensive Medicaid Benefits (SLMB+)
- Qualifying Individual (QI)
- Qualified Disabled and Working Individual (QDWI)
- Other Full Benefit Dual Eligible (FBDE)

Goal 1- Improving Access to Essential Services

The plan goals for accessibility are to have providers in appropriate numbers and geographic locations to ensure plan standards for travel times, and ratio of members to providers are met. Types of data reviewed include the number of Primary Care Physicians, Specialty Care Physicians, and Hospitals per member. Access will be assessed against CMS standards on a semi-annual basis by the VIVA HEALTH Provider Relations Department using *Quest Analytics* beginning in late 2014.

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Below is an example of the VIVA Key Management report with data related to Network Adequacy for the SNP population:

VIVA HEALTH Medicare Monthly Management Report 2015						
CATEGORIES	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**
Pricing/Premium/Co-Insurance/Other Pricing Issue	0	0	1	0	0	0
Special Needs Plan Only						
# Dual SNP (Extra Value plan) Members	18,998	19,050	19,106	19,229	19,281	19,325
# Primary Care Physicians	1,825	1,830	976*	981	998	1,009
# Dual SNP Members Per PCP	10.41	10.41	19.58*	19.60	19.32	19.15
# Specialty Care Physicians	3,982	3,984	2729*	2,737	2,743	2,749
# Dual SNP Members Per Specialist	4.77	4.78	7.00*	7.03	7.03	7.03
# Hospitals	48	48	48	48	48	50

Goal 2 – Improving Access to Affordable Care

In addition to $0 plan premium and $0 PCP visits for most members, the plan offers other services and benefits that increase access to wellness and preventive care:

- Comprehensive Dental Benefit – up to $150 per calendar year.
- Transportation – up to 20 free rides to a medical or dental provider per year.
- Preventive Care – Annual eye and hearing exams as well as routine physicals and other preventive services listed in the Evidence of Coverage.
- Sports Fitness - $20 per month toward dues at participating sports fitness facilities.
- Eye Wear – up to $100 per calendar year

Goal 3 – Improving Coordination of Care

The SNP's goal is for each member to have an assigned PCP (Primary Care Physician) who serves as the identified point of contact to coordinate the member's care and treatment plans. The Connect for Quality Team works to ensure members see their PCP regularly. Coordination of Care is supported and facilitated by the VCare Program of intensive care management.

Goal 4 – Improving Seamless Transitions Across Healthcare Settings

A transition is defined as a change in care setting – for example, when a member goes from the home to the hospital, or from the hospital to a skilled nursing facility. The plan strives to ensure appropriate communication among the sending setting, receiving setting, and the member and/or caregiver. Management of transitions includes requiring providers to communicate between themselves and the member/caregiver at the time of transition. The plan reaches out to members experiencing a transition via an initial telephone call to assess current status, needs and necessary follow-up plans and support. This call is initiated by Eliza, a contracted vendor for outreach. Members are transferred to the Care Management department for further follow-up based on responses to scripted questions.

Goal 5 – Access to Preventive Health Services
The plan's goals are to ensure members have adequate coverage and access to preventive health services.

- Medicare covered preventive services are provided at no cost-sharing for SNP members.
- Routine eye exams are covered at no cost
- Additional preventive services such as hearing exams and dental coverage beyond the $150 allowance may require minimal cost-sharing.
- Examples of preventive service goals – increase annual flu vaccine rate to 72%, and increase colorectal screening rate to 68%

Goal 6 – Assuring Appropriate Utilization of Services
Members identified to be high risk receive additional care coordination services through a combination of nurse and social worker telephonic and in person care coordination visits. The goal is to maintain the member in the least restrictive setting of care. Goals are assessed by analysis of various member utilization reports such as Admissions per 1000 (ADK), Emergency Department utilization report, and readmission reports.

Goal 7 – Improving Beneficiary Outcomes
The goals are:

- Assist members in care planning
- Improve health and well-being
- Reduce transitions through Care Management

Health outcomes measured include quality measures such as annual HEDIS® elements including Care for Older Adults Medication Reconciliation Post-Discharge, and Controlling High Blood Pressure. Additional education on SNP and/or Medicaid benefits assists members with understanding how to use their benefits to improve outcomes. Improving beneficiary health outcomes is measured through reports on the numbers and types of transitions, measurable health outcomes, performance on standards of care by diagnosis, and member reported Health Outcomes Survey (HOS) data.

Goals are measured continually by reviewing a variety of data sources such as HEDIS® data, member satisfaction surveys (CAHPS data), Health Outcomes Survey data, and review of transition of care logs. Results are reviewed to identify opportunities for improvement. VIVA has a STARs Task Force that focuses on all quality measures as defined by CMS or NCQA. The Task Force has sub-groups that establish goals and action plans for specific measures.
The Interdisciplinary Care Team and the Utilization Management/Quality Improvement (UM/QI) Committee provides input on the evaluation of the SNP program. The program's goals, measures, and interventions are evaluated to determine if modifications or additional interventions are needed. Corrective action plans and process changes are implemented for identified gaps. A formal Care Management Program description is submitted to UM/QI annually. Annually, the UM/QI Team performs an evaluation of the Quality Program.

VIVA HEALTH has a variety of staff and departments that perform various functions related to its SNP administration: Medicare Sales Representatives, Medicare Enrollment, Medicare Member Services, Medicare Claims, Pharmacy, Medical Management, Care Management, Connect for Quality (C4Q), Credentialing, and Quality Improvement.

VIVA HEALTH employs and/or contracts with individuals to perform various clinical functions related to its SNP administration:

- Contracted Providers – includes a broad range of primary care physicians, specialists (including mental health providers), facilities and pharmacies to fully meet the special needs of the target population
- Pharmacists – provide clinical support for other clinicians, monitor prescription drug utilization and costs to identify and address quality, cost-effectiveness, and adherence.
- Health Services – includes Medical Management and Care Management staff. Medical Management includes Utilization Review staff and Case Managers that serve in clinical roles and in coordination of the member's care. Care management staff includes RNs, LPNs, and Licensed Social Workers to support members with care coordination needs, and assist members in maximizing their health status in the least restrictive environment.
- Connect for Quality – this team works in conjunction with Primary Care Physicians at the point of care to improve quality, utilization, and member health status. Prevention and screening are key components to this program.
- Quality Improvement – this team works in clinical roles when directly interacting with SNP members at Health Fairs and during telephonic outreach.

Oversight of the Special Needs Plan

Primary Oversight of the Special Needs Plan is provided by the Director of Health Services and the SNP Administrator. Secondary oversight is through the UM/QI committee, which consists of board certified physicians from appropriate disciplines and service areas, and are supported by Compliance, Health Services, Quality Improvement, and Network Development.

Interdisciplinary Care Team

VIVA HEALTH maintains an Interdisciplinary Care Management Team (IDCT) consisting of VIVA HEALTH's Medical Director, physicians, clinical pharmacists, licensed nurses, social workers, and a mental health professional. Other disciplines may be included on an as-needed basis. The team reviews and discusses the needs of the SNP members and develops or revises plans of care. Specific complex cases are presented for team discussion. SNP members in V-Care, and/or their caregivers, are encouraged to participate in the IDCT meetings. Members are informed of the IDCT, and are given the opportunity to participate in their own case presentation in person or by telephone.

Interdisciplinary Care Team Operation and Communication
The Medical Director, Director of Health Services, Manager of Clinical Services, and SNP Administrator drive the initiatives of the IDCT. Meetings are scheduled every 2 months for a minimum of 6 meetings per year. Interdisciplinary conferences also take place via phone conferences with Home HEALTH, Durable Medical Equipment representatives, Behavioral HEALTH agencies, and through collaboration with the PCP.

Provider Network and Use of Clinical Practice Guidelines
The SNP provider network covers the full spectrum of Primary and Specialty Care. Physicians and facilities are screened through a strict credentialing and re-credentialing process. Providers can access evidence-based guidelines on line at: http://vivaprovider.com/Providers/QI.aspx. The plan develops or adopts evidenced-based practice guidelines using criteria from various medically recognized organizations, such as the American Heart Association. Selection of topics for the development of practice guidelines and clinical pathways is coordinated by the UM/QI Committee.

Model of Care Training
Training is required for all VIVA staff and providers serving the Special Needs Program population. A mandatory annual staff training module is completed through the Learning Management System. For providers, the Model of Care (MOC) training is included in the Provider Manual, and on the provider website. The SNP Administrator, in conjunction with the Corporate Trainer, is responsible for developing and coordinating all MOC training and for its oversight. The Corporate Trainer tracks training completion for new employees and the annual training for staff.

Health Risk Assessment (HRA)
The Health Risk Assessment (HRA) is an internally developed tool that allows the member to self-report their health status, functional status, and life issues. The HRA data is imported into the Care Management documentation system and the results are stratified. The results are mailed to the Primary Care Physician. The HRA is required within the first 90 days after enrollment and annually thereafter.

Data from the HRA is reviewed by the SNP team, and assists with identifying members at risk for more complex health problems and care management needs. HRA data is reported to the IDCT and the UM/QI committees. In June of 2014, VIVA transitioned to telephonic outreach via Eliza for HRA completion. A total of 3 attempts are made for the initial HRA (first 90 days), and for each annual reassessment.

Identification of Vulnerable Members for Care Management
A variety of data sources are used to identify the most vulnerable subpopulation:

- HRA Data
- Transition Reports
- Admissions Data
- Re-admissions
- ER Reports

Benefits and interventions are designed to address gaps. In addition to plan-designed benefits, care managers have "tool boxes" that provide additional assistance, such as scales, and pill boxes.

Individualized Care Plan
The member's answers to the HRA questions, encounter data, claims data, and clinician assessments are used to develop individualized plans of care.. The PCP is ultimately responsible for directing the plan of care. High risk members are further assessed by a nurse or Social Worker. All SNP members receive an annual plan of care. Care plans are updated through assessments and IDCT meetings.

Communication Network
Communication with members takes place in a variety of ways: The www.VivaHealth.com website, the Evidence of Coverage, Summary of Benefits, Formularies, Directories, contacts such as case and care management, Newsletters, and VIVA MEDICARE Cafés. Internal communication takes place via the provider website, Town Hall meetings, the Learning Management System, and the Member Advisory Board.

Performance and Outcome Measures
Outcomes are measured in a variety of ways, such as HEDIS® measures. Interventions are designed to improve outcomes on health and wellness screenings and disease management. Utilization measures are also used to pinpoint areas where care and case management efforts can focus on maintaining the member in the least restrictive setting. Disenrollment measures are reviewed to determine why members leave the plan. Additionally, member satisfaction with care management is evaluated annually.