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Model of Care Training

Zing Health CSNP 2027



SNP Training Objectives

Define

- Special needs plans
- Special needs populations

Describe

- Model of Care Overview
- Care Coordination

Understand

- Provider Roles
- Model of Care Effectiveness Assessment

Explain

- Enhanced benefits

Our Mission

Our Special Needs Plan (SNP) programs are designed to optimize the health and well-being of our underserved, vulnerable, aging, and chronically ill members through the provision of clinical and social services that best match their situations.



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Define

Special Needs Plans and Populations

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CMS Requirements

The Centers for Medicare and Medicaid Services (CMS) requires all contracted medical providers and staff to receive basic training about the Special Needs Plan (SNP) Model of Care (MOC). This training is required for all providers and internal staff upon hire or contract and annually thereafter.

Zing Health's Training

- Recognizes the *leadership role of providers* in determining the best options to achieving health outcomes for members
- Will describe how Zing Health and its contracted providers can work together to successfully deliver the SNP's Model of Care



Special Needs Plan (SNP) Background

2003

Authorization of Special Needs Plan as part of the Medicare Prescription Drug, Improvement and Modernization Act (MMA)

2008

Reauthorization and modifying SNPs as part of Medicare Improvement for Patients and Providers Act (MIPPA)

2012

Reauthorization and modifying SNPs as part of the Patient Protection and Affordable Care Act (PPACA)

2018

Permanent authorization of SNPs as part of the Bipartisan Budget Act



3 Types of Special Needs Plans

Zing Health offers CSNPs in specific counties in Illinois, Indiana, Michigan, Mississippi, Ohio and Tennessee

CSNP

Chronic Special Needs Plan for members with certain chronic conditions. CSNPs address members with cardiovascular disease, diabetes, or congestive heart failure; obesity, and Chronic kidney disease (CKD) including End-Stage Renal Disease (ESRD).

DSNP

Dual Special Needs Plan for members with Medicare *and* Medicaid benefits. Zing Health will no longer be offering these plans.

ISNP

Institutional Special Needs Plan for members in institutional settings, such as nursing homes or long-term care facilities. Zing Health does not offer ISNP plans.

Zing Health CSNP

Zing Health offers CSNPs in specific counties across 5 states

- **Cardiovascular Disorders (CD), Chronic Heart Failure, and/or Diabetes**
- **Chronic Kidney Disease (CKD) including End Stage Renal Disease (ESRD)**

State	Counties
Illinois	Boone, Cook, DeKalb, DuPage, Kane, Kankakee, Kendall, Lake, McHenry, Ogle, Will, Winnebago
Indiana	Boone, Delaware, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Monroe, Morgan, Porter, Shelby
Michigan	Genesee, Kent, Lapeer, Livingston, Macomb, Monroe, Oakland, Washtenaw, Wayne
Ohio	Cuyahoga, Fulton, Geauga, Lake, Lorain, Lucas, Mahoning, Medina, Ottawa, Portage, Stark, Summit, Trumbull, Wayne, Wood
Tennessee	Davidson, Fayette, Robertson, Shelby, Sumner, Williamson, Wilson

- **Overweight, Obesity, and Metabolic Syndrome**

State	Counties
Michigan	Macomb, Oakland, Wayne

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SNP Components

MOC 1: SNP population

MOC 2: Care coordination

MOC 3: Provider network

MOC 4: Quality measurement and performance improvement

3 Core Special Needs Plan Features

Enrollment — **Limited** to members with certain chronic conditions

Plan Design — **Custom** benefits designed for members with targeted conditions

Election Period — **Special** election period allows enrollment throughout the year

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CSNP Population

Zing members are eligible for enrollment if they have one of the following conditions diagnosed by a qualified provider:

- **Diabetes**
  - Insulin dependent diabetes
  - Non-insulin dependent diabetes
- **Obesity-including metabolic syndrome**
- **Cardiovascular disease (CVD)**
  - Peripheral vascular disease
  - Cardiac arrythmias
  - Coronary artery disease
  - Chronic venous thromboembolic disorder
- **Congestive Heart Failure (CHF)**
- **End-Stage Renal Disease (ESRD)**
  - Requiring any type of dialysis



Zing Health SNP Member Characteristics

SNP members may have several of these characteristics.

Plans are tailored to address the targeted population.

- Low income
- Lack of support in the community
- Multiple comorbidities
- Obesity or Metabolic syndrome- BMI greater than 26
- Lack of access to affordable, nutritious food
- Prevalence of hypertension, cardiovascular disease, diabetes or ESRD
- Lack of health literacy
- Undiagnosed and untreated depression and other mental health disorders
- Difficulty accessing affordable housing
- Socially isolated
- Lack of transportation to medical appointments

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Describe

Model of Care Overview and Care Coordination

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Model of Care Goals

Each Special Needs Plan program must develop a Model of Care specific to the targeted population within Zing Health's service area.

The Model of Care is a plan for delivering care management and coordination to:

- Improve quality and member outcomes
- Increase access
- Create affordability
- Integrate and coordinate care across the healthcare spectrum
- Provide seamless transitions of care
- Improve use of preventive health services
- Encourage appropriate use and cost effectiveness

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Enhanced Coordination of Benefits

Our care team is trained to assist our members in coordination of benefits between Medicare and Medicaid and to identify other community resources to support our members.

- Assists members in understanding and accessing benefits between both programs
- Identifies members who may benefit from additional Medicaid benefits such as long-term services and supports (LTSS)
- Identifies community resources and assists members in connecting to those resources

Health Risk Assessment (HRA)

Health Risk Assessments (HRAs) are required for all SNP members unless the member elects to opt out of participating in the HRA process.

The Health Risk Assessment (HRA):

- Is conducted to identify the medical, psychological, cognitive, functional and mental health needs and risks of our members
- Assists with identifying members with urgent and/or unmet needs
- Is an integral component of the member's care coordination
- Provides guidance to the care manager of the members risk level
- Utilized in the development of member's person-centered plan of care

CMS requires that HRAs are completed:

- Within **90 days of enrollment**
- **Annually** within 365 days of last HRA
- Any **change in health status**
- And that at least **one face-to-face encounter occurs each year**

Care Planning

Every SNP member must have an individualized care plan (ICP) developed based on the results of the HRA.

- The individualized care plan (ICP) is an ongoing plan to address the member's care needs. The care plan includes the member and his/her interdisciplinary care team.
- The care manager is the central contact for all integration and coordination of care for the member and works with the member on the ICP.
- The ICP encompasses member-specific problems, goals, interventions and the services the member will receive. Many of the problems listed on the ICP are identified in the HRA, through member interactions or identified through PCP information or other available health plan data.
- The ICP is a living document that changes as the member's needs and desires changes.

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Care Management Process

Zing Health has a well-defined care management process.

Care Plan Development

- Review of HRA
- Obtaining member input

Assessment

- Identify potential barriers or problems
- Identify opportunities
- Establish appropriate transitions

Implementation

- Commence care plan activities
- Coordinate with Interdisciplinary Care Team

Re-evaluate

- Conduct follow-up with member
- Refine care plan based on results

Interdisciplinary Care Team

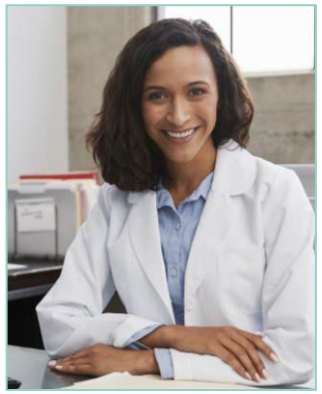
Meetings occur at least annually, and more frequently as needed.

The purpose of Interdisciplinary Care Team (ICT) meetings is to:

- Ensure coordination of member's care
- Assess member's problem and develop strategies to work towards resolution
- Review, update, and approve the ICP as needed
- Refer member to community resources as needed
- Assist with transitions and attempt to mitigate unplanned transitions
- Promote member's self-management of condition(s)



Interdisciplinary Care Team Members



Required Participants

- The member/member's representative, although they have the right to opt out of the meeting
- Zing's Care Team (integrated care manager, social worker, medical director)
- PCP



Potential Internal Participants

- Behavioral health clinician
- Pharmacist
- Social Service Coordinator



Potential External Participants

- Relevant specialists
- Facility staff if member is a resident of a skilled nursing facility
- Member-requested caregiver, family member, friend, neighbor, etc.



Provider Collaboration on ICT

Zing Health works collaboratively with providers to enhance health outcomes through 8 expectations of providers and Zing Health.

1. Maintaining open communication
2. Assisting the provider and member in accessing community-based resources
3. Focusing on the member's special needs
4. Supporting the member's plan of care
5. Promoting evidence-based practices
6. Referring the member appropriately for medical and non-medical needs.
7. Participating in the ICT meetings
8. Encouraging the member to work with their care team

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ICT Responsibilities

The success of the ICP and ICT are reliant upon open communications between the member and the ICT.



Educate members about their health conditions and medications and empower them to make good health-care decisions.



Prepare members/caregivers for their provider visits (utilize personal health record).



Refer members to community resources as needed.



Notify the member’s provider of planned and unplanned transitions via the ICP and ICT meetings.

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Understand

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Provider Network

Zing must maintain a specialized provider network that corresponds to the special needs of our SNP population.

Zing coordinates care and ensures that providers:

- Collaborate with the ICT and contribute to a beneficiary's ICP.
- Provide clinical consultation.
- Assist with developing and updating care plans.
- Provide consultation on prescription drugs and their interactions with other maintenance drugs prescribed for the member.
- Use nationally recognized clinical practice guidelines (where available).
- Maintain appropriate documentation in the member's medical record.

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Quality Measurement & Performance Improvement

Zing is required to have a performance improvement and quality measurement plan in place for its SNP.

To evaluate success, Zing disseminates evidence-based clinical guidelines and conducts analysis to:

- Measure member outcomes
- Monitor quality of care
- Evaluate the effectiveness of the Model of Care

Model of Care Goals

CMS requires that Zing Health assess the effectiveness of its Model of Care program at least annually to measure improvements in health outcomes for its at-risk members.

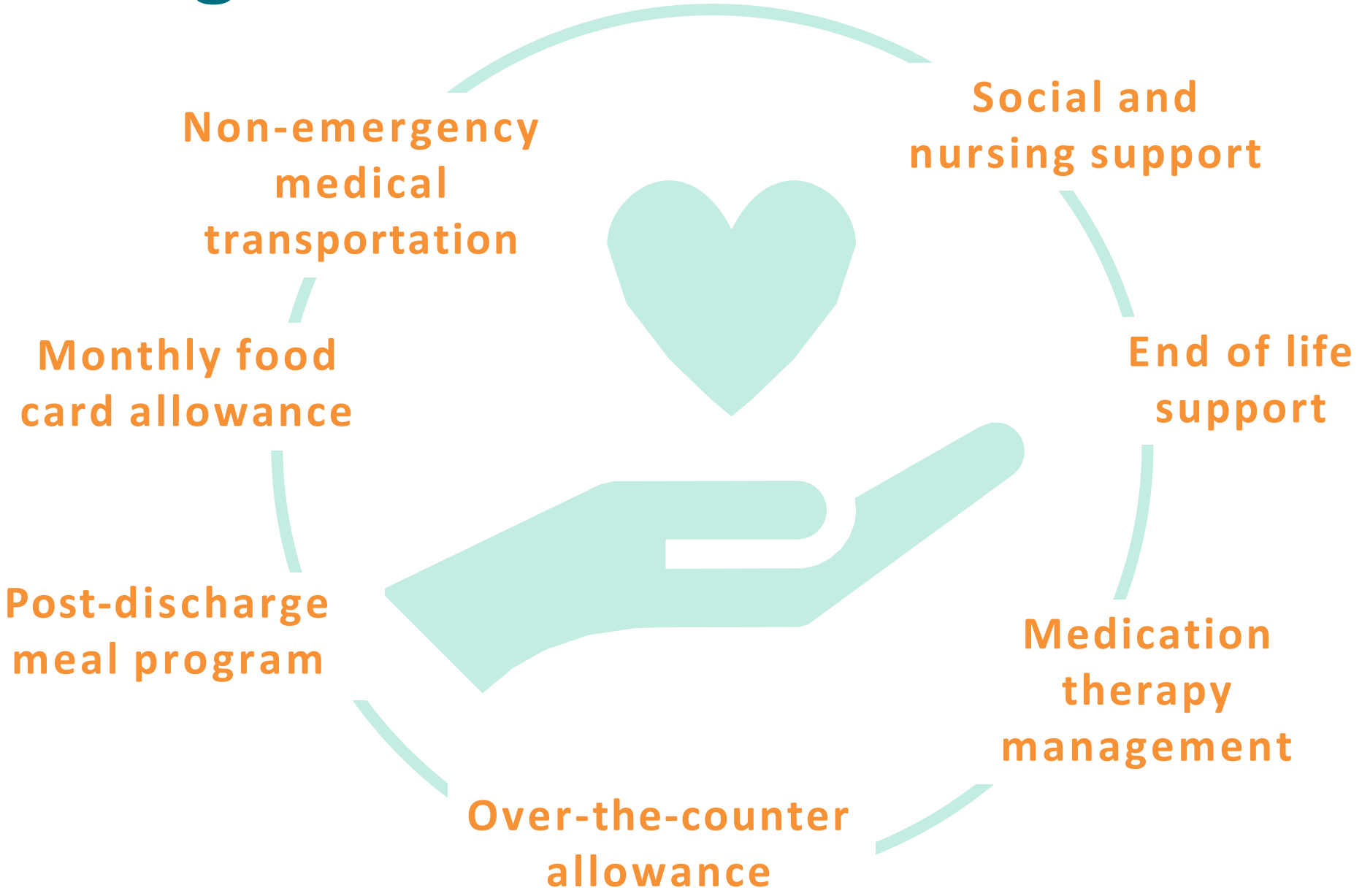
Zing Health's overarching MOC goals are aligned with various regulatory performance measures, including:

- Star Ratings
- Consumer Assessment of Healthcare Providers & Systems survey (CAHPS)
- Healthcare Effectiveness Data and Information Set data (HEDIS)
- Health Outcomes Survey (HOS)

Zing Health is also able to track and assess the effectiveness of its MOC program through the monitoring of individual on member's goals through:

- Data analysis
- Self-reporting by the member to their care manager,
- PCP updates and input from other stakeholders.
- Progress on these goals is reported through the ICT
- MOC evaluation is conducted annually

AmaZing Extra Benefits for SNP Members



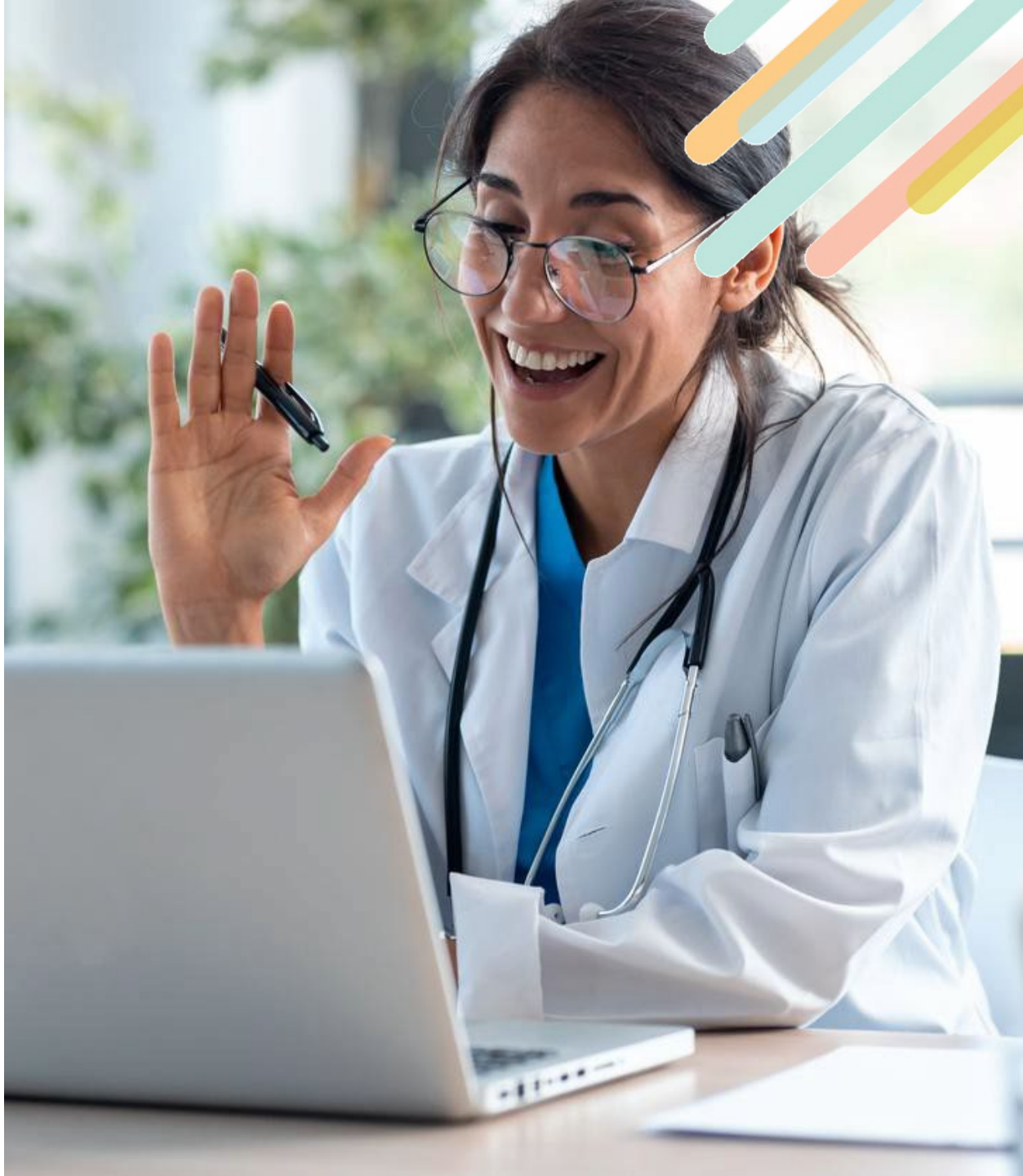
Knowledge Check 1 of 3

True or false?

The care manager is the central contact for all integration and coordination of care for the member.

Answer

True. The care manager serves as the central contact for all integration and coordination of care for the member. The integrated care manager coordinates care with the member, the member's PCP, and other participants of the ICT.



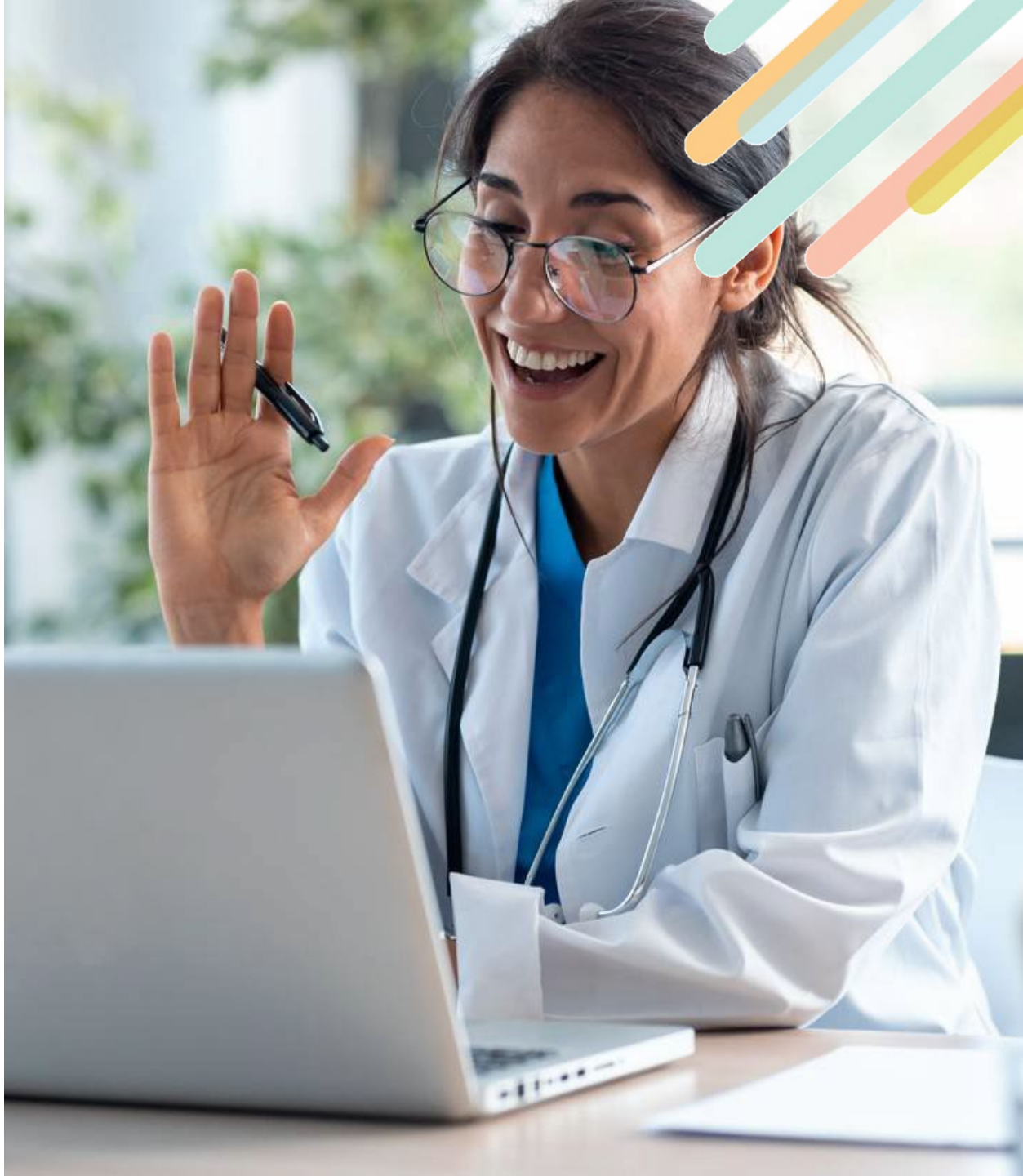
Knowledge Check 2 of 3

True or false?

All SNP members must have a care plan.

Answer

True. All SNP members must have a care plan developed within 90 days of enrollment and updated as needed. The plan of care is a living document that outlines the members prioritized goals. The care plan is shared with the member and Primary Care Provider.



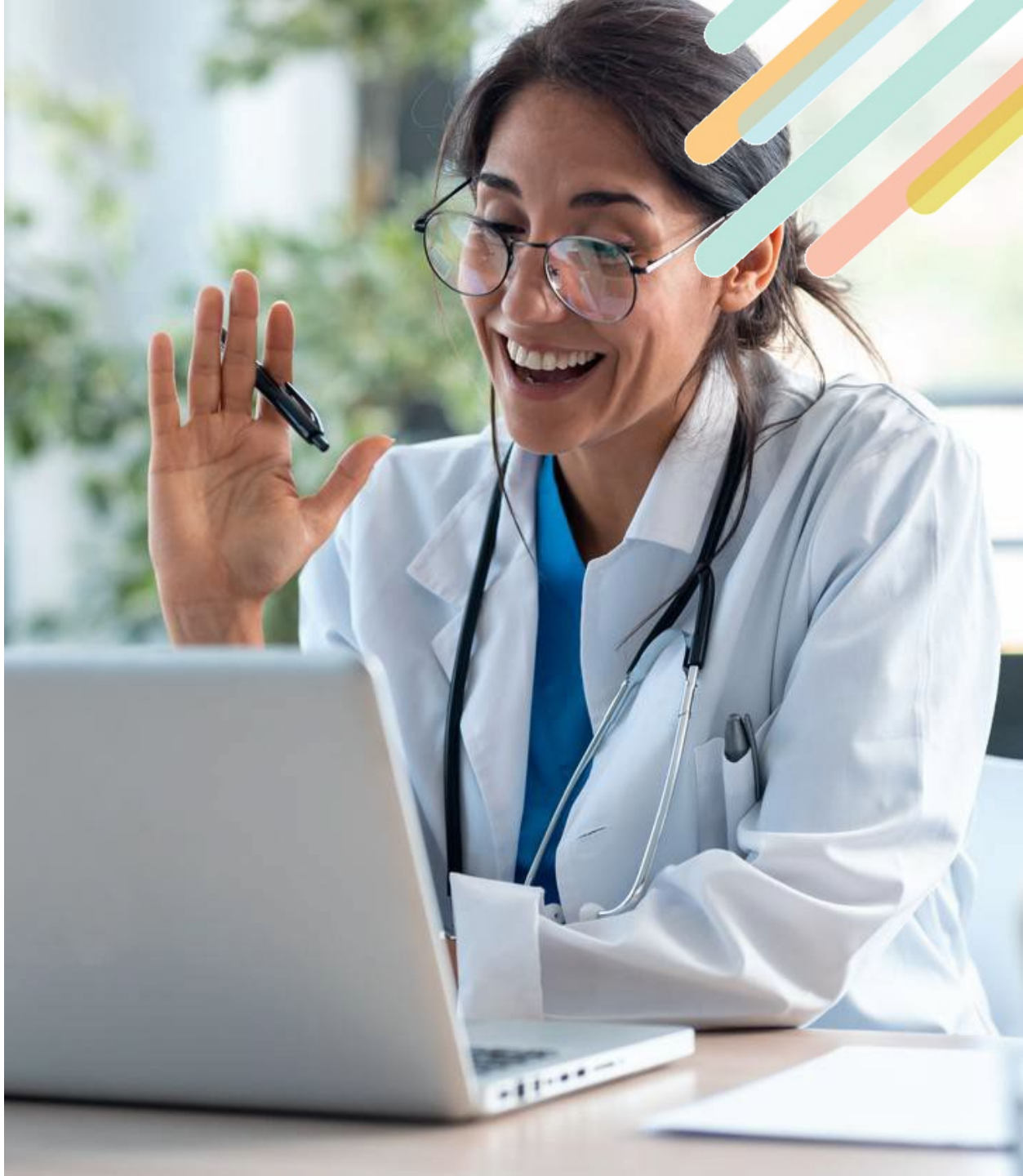
Knowledge Check 3 of 3

True or false?

CMS requires an annual assessment of the Model of Care to determine its effectiveness.

Answer

True. The Model of Care serves as the roadmap for improving health care outcomes for special needs population. Each year, SNP plans must conduct an assessment under its quality measurement and performance improvement plan to determine the effectiveness of the program.



Questions?





Thank You

Visit us online at www.myzinghealth.com
Email the Care Management team at caremgmt@myzinghealth.com
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Hours of Operations are:
Between 8 a.m. and 8 p.m. Monday through Friday
(from April 1 through September 30).
And 8 a.m. to 8 p.m. 7 days a week
(from October 1 through March 31).

Regulatory References

You can find more information on this topic at the links provided on this slide.

- CMS' Medicare Managed Care Manual for Special Needs Plans (SNPs): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf
- CMS' Requirements for Quality Assessment: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf
- CMS' SNP Model of Care (MOC) information: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC
- NCQA MOC Approval Process: https://snpmoc.ncqa.org/