

Attachment B: Model of Care for Institutional SNPs

MA Contract Name: Geisinger Health Plan

MA Contract Number: H3954-106

Type of Institutional SNP: Institutionalized

The model of care describes the MAO's approach to providing specialized care to the SNP's institutionalized beneficiaries or beneficiaries living in the community but requiring an institutional level of care.

It should highlight the extra benefits and services that distinguish the SNP from the MAO's other MA products. CMS also expects plans to meet the needs of vulnerable subpopulations - beneficiaries who are frail/disabled, have multiple chronic illnesses, or are near the end of life - for each targeted population since these subsets are likely to be more prevalent among the special needs populations. CMS operationally defines frail as either "... a state of reduced physiologic reserve associated with increased susceptibility to disability ...;" or "...those who depend on others for the activities of daily living or who are at high risk of becoming dependent" (How to Select a Frail Elderly Population? A Comparison of Three Working Definitions; Paw, Dekker, Fesken, Schouten and Kromhout, Journal of Clinical Epidemiology, Volume 52, Issue 11, November 1999, pages 1015-1021).

Please note that if an institutional SNP beneficiary changes residence, the MAO must have appropriate documentation that the beneficiary's new residence will implement the SNP model of care. Appropriate documentation includes a contract with the LTC facility to provide the SNP model of care, and written documentation of the necessary arrangements in the community setting to ensure beneficiaries will be assessed and receive services as required under the SNP model of care.

SNPs approved to serve institutionalized beneficiaries should complete and submit B1, B3, and B4. SNPs approved to serve or beneficiaries living in the community but requiring an institutional level of care should complete and submit B2, B3, and B4. Institutional SNPs serving beneficiaries with end-stage renal disease (ESRD) should complete and submit Attachment D.

B1: Model of Care for Institutional SNPs - Beneficiaries Living in an Institutional

1. Goals and Objectives

- a. List the goals and objectives of the model of care that drive service delivery under this institutional eligible SNP.

Geisinger Health Plan's goal is to properly assess all institutionalized members to ascertain the correct model of care for the individual member, whether frail/disabled, chronically ill or at end of life. Our objective is to provide timely assessment by a Geisinger Health Plan ("GHP") clinical staff person (e.g., physician, mid-level provider or case manager) or their designee to ensure proper model of care is instituted.

- b. Address the goals and objectives specific to each of the following subpopulations: frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

Frail/disabled beneficiaries:

Objectives:

- to improve quality of care for each beneficiary;
- decrease avoidable hospital admissions and readmissions;
- decrease avoidable emergency room visits;
- decrease avoidable observations admits; and
- promote completion of advance directives.

Beneficiaries with multiple chronic illnesses:

Objectives:

- to improve quality of care for each beneficiary;
- decrease avoidable hospital admissions and readmissions;
- decrease avoidable emergency room visits;
- decrease avoidable observations admits; and
- promote completion of advance directives.

Beneficiaries at the end of life:

Objectives:

- increase the member's resources for end of life care (comfort, spiritual, bereavement support, palliative care);
- promote completion of advance directives;
- promote Hospice referrals; and
- monitor Hospice care length of stay.

An additional goal of our Model of Care for institutionalized beneficiaries is to verify that all appropriate diagnoses are recorded. Reporting all appropriate

diagnoses will ensure our clinical care data bases are accurate and all members that will benefit from our Model of Care will be identified.

2. Describe how the model of care is implemented in the plan's defined setting, specifically the approach to patient assessment, as well as the organization, coordination, and delivery of Medicare (and other) services.

Once member's institutionalized status has been confirmed, the member will be enrolled into our Model of Care by GHP clinical staff person. Upon admission a comprehensive assessment will be completed by a physician, mid-level provider, and/or a nurse case manager. Enrollment into our Model of Care includes the assessment of:

- **member health status (including condition specific issues and co-morbidities)**
- **clinical and psychosocial history (e.g., disease onset, exacerbations, inpatient or emergency department care, treatment history, comprehensive medication, etc)**
- **activities of daily living (ADLs)(e.g., adequate nutrition, mobility, and safety)**
- **mental health status and cognitive functioning (e.g., ability to communicate, understand instructions, and process information about illness)**
- **life planning activities (e.g., wills, living wills, or advance directives, health care powers of attorney and representative statements)**
- **cultural and linguistic needs, preferences or limitations.**
- **care giver resources (e.g., general family support, available benefits and financial support).**

GHP will coordinate and ensure delivery of required services to the member.

3. Describe the specific organization of staff (i.e., LTC staff, employees, nurse practitioners, case managers) that interacts with institutionalized individuals to provide the specialized services available under the model of care.

A Clinical staff person or their designee will directly interact with GHP's Medical Management Department and State Medicaid Office, on an as need basis, to coordinate coverage of services.

The facility's clinical staff personnel will develop the Plan of Care for each beneficiary. The SNP's clinical staff person will monitor adherence with the Plan of Care for those identified as needing CM services and interact with the LTC staff as necessary.

Case Management information is entered and updated in the electronic health record (EHR). The clinical data collected in this system enables enhanced care integration.

4. Roles and Interactions between SNP and LTC

- a. Describe the key roles and interactions between the SNP and LTC facility personnel for the model of care to perform as planned.

The Model of Care Team will interact with the LTC facility staff to assure GHP that the care needed by each beneficiary will be provided. The LTC will be responsible for developing the Plan of Care for each beneficiary based upon their unique needs.

- b. List the key services provided by the SNP, and key services provided by the LTC facility.

LTC staff is responsible for the direct patient care of the member 24/7/365. The staff will develop, oversee, and amend as needed each beneficiary's Plan of Care.

GHP is responsible for benefit coordination, provider education, clinical care coordination and oversight, and beneficiary advocacy as needed.

- c. Describe lines of communication and accountability between the SNP and LTC facility.

There are direct lines of communication and accountability between the SNP and LTC staff. Written, telephonic, electronic, and on-site communications are available as needed.

5. Describe the specific steps the SNP takes (e.g., written protocols and training) to ensure that the LTC facility personnel know how the model of care works and how to function in accordance with that model of care.

The SNP will provide protocols and training material to ensure proper implementation of GHP's Model of Care. Medical Management protocols are in place to meet the needs of the institutionalized member.

6. Special Needs of Institutionalized beneficiaries

- a. State how this model of care identifies and meets the needs of institutionalized beneficiaries.

All members of Geisinger Health Plan's institutionalized SNP will go through a detailed screening process completed by a licensed physician, licensed mid-level

provider, and/or case manager nurse. The goal of this screening is to properly stratify SNP members into frail elderly, multiple chronic conditions or end of life. For those SNP members being enrolled into Case Management a detailed assessment will be completed. The assessment contains specific questions about caregiver resources, clinical history, activities of daily living, mental health status, etc., so that the member, Case Manager and/or provider can determine the proper clinical goals and objectives. An individualized plan of care will be developed to specifically meet the needs of the frail elderly, those beneficiaries with multiple chronic conditions, or those beneficiaries at the end of life.

- b. Address how the model of care identifies and meets the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

Frail Elderly

The SNP will identify the frail enrollee(s) as those who depend on others for the activities of daily living or who are at high risk of becoming dependent by using a detailed assessment process. The detailed assessment, completed by a GHP clinical staff person, includes assessment of:

- the member's health status including condition specific issues and comorbidities;
- clinical and psychosocial history (e.g., disease onset, exacerbations, review of inpatient and emergency department care, treatment history, and a comprehensive medication review);
- activities of daily living (ADLs) including adequate nutrition, mobility, and safety.
- mental health status, including cognitive functioning (ability to communicate, understand instructions, and process information about illness);
- life planning activities such as wills, living wills, or advance directives, health care powers of attorney and representative statements;
- cultural and linguistic needs, preferences or limitations;
- care giver resources such as general family support;
- evaluation of available benefits and financial support

Upon completion of the assessment an individualized Plan of Care and protocol(s) will be developed by the LTC and implemented for each member. GHP clinical staff will directly interact with the LTC staff to assist with coordination of services related to the Plan of Care and protocols needed. The clinical staff will directly interact with GHP's Medical Management Department and State Medicaid office, on an as needed basis to coordinate coverage of services.

Multiple Chronic Conditions

The SNP will identify members with 3 or more chronic conditions by using a detailed assessment process and any historical claims information available. The detailed assessment, completed by a GHP clinical staff person, includes assessment of:

- the member's health status including condition specific issues and co-morbidities;
- clinical and psychosocial history (e.g., disease onset, exacerbations, review of inpatient and emergency department care, treatment history, and a comprehensive medication review);
- activities of daily living (ADLs) including adequate nutrition, mobility, and safety.
- mental health status, including cognitive functioning (ability to communicate, understand instructions, and process information about illness);
- life planning activities such as wills, living wills, or advance directives, health care powers of attorney and representative statements;
- cultural and linguistic needs, preferences or limitations;
- care giver resources such as general family support;
- evaluation of available benefits and financial support

Upon completion of the assessment an individualized Plan of Care and protocol(s) will be developed by the LTC and implemented for each member. GHP clinical staff will directly interact with the LTC staff to assist with coordination of services related to the Plan of Care and protocols needed. The clinical staff will directly interact with GHP's Medical Management Department and State Medicaid office, on an as needed basis to coordinate coverage of services.

An important component of our Model of Care is our high intensity Case Management program in which complex case management nurses provide disease/ care management programs for members with chronic illnesses. These programs are aimed at outreach, promoting standards of care and proper management of Heart Failure, Diabetes, COPD/Asthma, Cardio/Cerebral Vascular Disease, Hypertension, and Osteoporosis. The complex case management nurses monitor each member's condition based on feedback for the LTC. When the member's care falls outside acceptable guidelines or their condition deteriorates, the nurse will directly interact with the member's physician and/or LTC staff.

End-of-Life

The SNP will identify the member's at the end of life by using a detailed assessment process. The detailed assessment, completed by a GHP clinical staff person, includes assessment of:

- the member's health status including condition specific issues and co-morbidities;
- clinical and psychosocial history (e.g., disease onset, exacerbations, review of inpatient and emergency department care, treatment history, and a comprehensive medication review);
- activities of daily living (ADLs) including adequate nutrition, mobility, and safety.
- mental health status, including cognitive functioning (ability to communicate, understand instructions, and process information about illness);
- life planning activities such as wills, living wills, or advance directives, health care powers of attorney and representative statements;
- cultural and linguistic needs, preferences or limitations;
- care giver resources such as general family support;
- evaluation of available benefits and financial support

Upon completion of the assessment an individualized Plan of Care and protocol(s) will be developed by the LTC and implemented for each member. GHP clinical staff will directly interact with the LTC staff to assist with coordination of services related to the Plan of Care and clinical protocols needed. The clinical staff will directly interact with GHP's Medical Management Department and State Medicaid office, on an as needed basis to coordinate coverage of services.

7. Extra Benefits and Services

- a. List and explain extra benefits and services that are provided to meet the needs of institutionalized beneficiaries.

GHP plans to offer an enhanced benefit plan dedicated to the institutionalized SNP members. This enhanced plan will include:

- a detailed Model of Care with protocols individually designed specifically for each institutionalized member;
- a modified drug benefit designed to lower the out of pocket expenses paid by the members;
- Class 1 and Class 2 dental coverage which includes limited coverage for dentures;
- no copay for services received at a skilled nursing facility
- no prior hospitalization required for admission to skilled nursing facility (2 day-stay provision is waived)
- transportation services; and
- access to various social service advocacy programs.

As detailed above, an important component of our Model of Care is our high intensity, complex case management program which provides members and/or

their families' education on disease management and proper medication usage. The complex case management nurses monitor the member's condition and directly communicate with the member's physician and/or LTC staff when the member's care falls outside acceptable guidelines or when their condition deteriorates.

- b. List and explain extra benefits and services that are provided to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

The benefits listed above are available to all institutionalized SNP members in all categories.

8. Outcome Measures

- a. Discuss the specific process and outcome measures the plan uses to evaluate performance of the model of care for institutionalized beneficiaries.

The following outcome and process measures will be collected and reported:

- 1) **Number of SNP members screened and stratified for institutionalized categorization within twenty (20) days.**
- 2) **HEDIS results reporting.**
- 3) **Yearly monitoring of influenza vaccines**
- 4) **Yearly monitoring of pneumococcal vaccines**
- 5) **Clinical follow-up encounters within 1 week for members discharged from an acute care or skilled care nursing facility.**
- 6) **Annual review of the hospital admission rate/1000**
- 7) **Annual review of the hospital re-admission rate/1000**
- 8) **Annual review of the emergency room visit rate/1000**
- 9) **Yearly monitoring of complaints and appeals**
- 10) **Yearly monitoring of hospice elections**

- b. Discuss the specific process and outcome measures the plan uses to evaluate performance of the model of care for frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

GHP utilizes the same processes that are detailed in subparagraph 8a. for all SNP members enrolled in its institutionalized SNP.

B2: Description of Model of Care for Institutional SNP - Beneficiaries Living in the Community but Requiring an Institutional Level of Care

Not applicable.

1. Goals and Objectives

a. List the goals and objectives of the model of care that drive service delivery under this institutional SNP.

b. Address the goals and objectives specific to each of the following subpopulations: frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

2. Describe how the model of care is implemented in the community setting, specifically the approach to patient assessment, as well as the organization, coordination, and delivery of Medicare (and other) services.

3. Describe the specific organization of staff (e.g. employees, ALF staff, community service workers, nurse practitioners, case managers) that interacts with beneficiaries living in the community but requiring an institutional level of care to provide the specialized services available under the model of care.

4. Interfaces between the SNP, ALF staff and community service workers

a. Describe the key interfaces between the SNP, ALF staff and community service workers for the model of care to perform as planned.

b. List the key services provided by the SNP, and key services provided by the ALF staff and community service workers.

c. Describe lines of communication and accountability between the SNP and ALF staff and community service workers.

5. Describe the specific steps the SNP takes (e.g., written protocols and training) to ensure that the ALF staff and community service workers know how the model of care works and how to function in accordance with that model of care.

6. Specific Needs for beneficiaries living in the community but requiring an institutional level of care

a. State how this model of care identifies and meets the needs of beneficiaries living in the community but requiring an institutional level of care.

b. Address how the model of care identifies and meets the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

7. Extra Benefits and Services

a. List and explain extra benefits and services that are provided to meet the needs of beneficiaries living in the community but requiring an institutional level of care.

b. List and explain extra benefits and services that are provided to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

8. Outcome Measures

a. Discuss the specific process and outcome measures used to evaluate performance of the model of care for beneficiaries living in the community but requiring an institutional level of care.

b. Discuss the specific process and outcome measures the plan uses to evaluate performance of the model of care for frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

9. State whether the SNP provider and pharmacy networks (if any) are different from the networks for the plan's other Medicare coordinated care plans (CCP) in the same service area under this contract.

10. Clinical Expertise

a. Describe the pertinent clinical expertise the plan uses to meet the special needs of the institutional population.

b. Address the pertinent clinical expertise the plan uses to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries at the end of life.

11. If the network does not include sufficient specialists to meet the special needs of the target population, describe how the plan arranges access to non-contracted specialists. Specifically, describe the policies and procedures that will be followed to make sure enrollees have meaningful access to all necessary providers.

12. List in Attachment B4: Long-term care Facilities all of the plan's long-term care facilities contracted to serve the institutional population under this SNP model of care.

13. Assure that, for each contracted facility listed in Attachment B4, the following conditions have been addressed in 1) the facility contract agreement or 2) provider materials such as policies and procedures or provider manuals:

- a. Facilities in a chain organization that are contracted to deliver the SNP model of care - If the contract is with a chain organization, the chain organization and SNP agrees to a list of those facilities that are included to deliver the SNP model of care.
- b. Facilities providing access to SNP clinical Staff - The facility agrees to provide appropriate access by SNP clinical staff (i.e., physicians, nurses, nurse practitioners, and care coordinators) to the SNP beneficiaries residing in the applicant's contracted facilities in accordance with the SNP protocols for operation.
- c. Providing protocols for the SNP model of care - The SNP agrees to provide protocols to the facility for serving the beneficiaries enrolled in the SNP in accordance with the SNP model of care. These protocols are referenced in the contract.
- d. Delineation of services provided by the SNP staff and the LTC facilities under the SNP model of care - A delineation of the specific services provided by the SNP staff and the facility staff to the SNP enrollees in accordance with the protocols and payment for the services provided by the facility.
- e. Training plan for LTC facility staff to understand SNP model of care - The SNP implements a training plan to ensure that LTC facility staff know their responsibilities in accordance with the SNP model of care, protocols, and contract. If the training plan is a separate document, it is referenced in the contract.
- f. Procedures for facility to maintain a list of credentialed SNP clinical staff - Procedures ensure cooperation between the SNP and facility in maintaining a list of credentialed SNP clinical staff in accordance with the facilities' responsibilities under Medicare conditions of participation.
- g. Contract Year for SNP - Contract must include the full CMS contract cycle which begins on January 1st and ends on December 31st. The SNP may also contract with additional LTC facilities throughout the CMS contract cycle.
- h. Grounds for early termination and transition plan for beneficiaries enrolled in the SNP - Termination clause must clearly state any grounds for early termination of the contract. The contract must include a clear plan for transitioning the beneficiary should the applicant's contract with the long term care facility terminate.

B3: Attestation for SNP Serving Institutionalized Beneficiaries

See signed attestation, dated 3/9/07, on file with CMS per the original application filed for Contract Year 2008.

Geisinger Health Plan

H3954-106

I attest that the above referenced organization has a CMS approved institutional SNP and will only enroll beneficiaries in the SNP who 1) reside in a long-term care (LTC) facility under contract with or owned by the organization offering the SNP to provide services in accordance with the institutional SNP model of care approved by CMS or 2) agree to move to such a facility following enrollment.

I attest that the above referenced organization has a CMS approved institutional SNP to provide services to community dwelling beneficiaries who otherwise meet the institutional status as determined by the State, and the SNP will assure that the necessary arrangements with the community are in place to ensure beneficiaries will be assessed and receive services as specified by the SNP model of care.

I attest that if a SNP enrollee changes residence, the SNP will have appropriate documentation that it is prepared to implement the SNP model of care at the beneficiary's new residence, or disenroll the resident in accordance with CMS enrollment/disenrollment policies and procedures.

Appropriate documentation includes that the SNP has a contract with the LTC facility to provide the SNP model of care, and written documentation of the necessary arrangements in the community setting to ensure beneficiaries will be assessed and receive services as required under the SNP model of care.

CEO

DATE

CFO

DATE

B4: Long Term Care Facilities Table

Long Term Care Facilities Table on file with CMS per the original application filed March 9, 2007 for Contract Year 2008.

Long Term Care Facilities

Date Submitted to CMS: _____

Applicant's Contracting Name (as provided in HPMS): _____

Contract #/Plan #: ____

Long-term Care Facilities

Medicare Provider #

Facilities Address