# Special Needs Plans and Model-of-Care Training for Physicians and Other Healthcare Providers

Health Services Department | 2023

100805FL1122-A

CarePlus HEALTH PLANS

Welcome to **CarePlus**' 2023 training for physicians and other healthcare professionals who work with members enrolled in **CarePlus**' special needs plans. This annual training is required by the Centers for Medicare and Medicaid Services.

## Agenda

- CarePlus Overview
- Special Needs Plan (SNP) Overview
  - Dual-eligible Special Needs Plans (D-SNPs)
  - Chronic Condition Special Needs Plans (C-SNPs)
  - CarePlus SNP Features
- SNP Model Of Care (MOC)
- Social Services Resources
- Glossary, References, and Resources

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2

This is our training agenda.
We will first go over some basic CarePlus information then review the dual-eligible and chronic-condition special needs plans. After that, is an overview of the components of CarePlus' model of care, or MOC, which is our plan for ensuring that the unique needs of SNP members are identified and met.

## Objectives

After reviewing this training material, you will be able to:

- Describe D-SNP's and C-SNP's
- Outline the general characteristics of CarePlus' D-SNP and C-SNP populations
- Explain a model of care and describe CarePlus' MOC
- Discuss healthcare provider responsibilities under the MOC
- Access resources that can assist SNP members

3

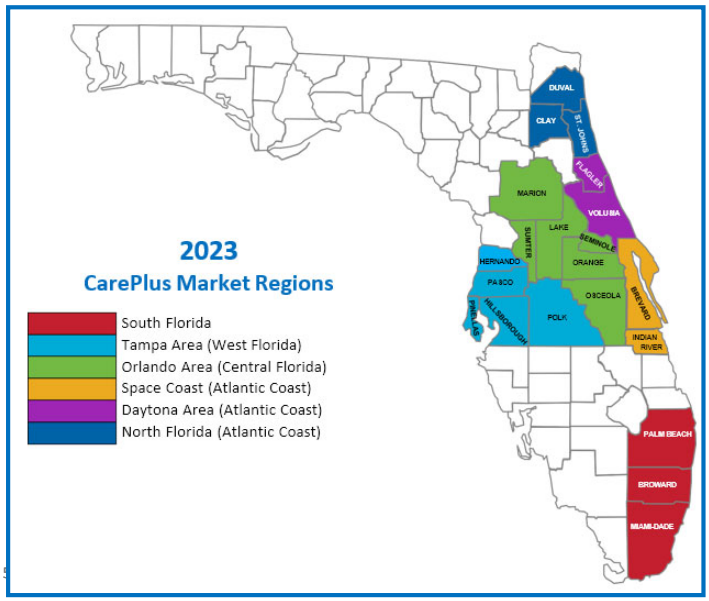
By the end of this module, you will be able to:

- Describe D-SNP's and C-SNP's
- Outline the general characteristics of CarePlus' D-SNP and C-SNP populations
- Explain a model of care and describe CarePlus' MOC
- Discuss healthcare provider responsibilities under the MOC
- Access resources that can assist SNP members

# CarePlus Overview

We will begin with a brief overview of **CarePlus**.

## CarePlus Overview




**CarePlus**

**CarePlus** offers a variety of health plans for Medicare beneficiaries in 21 Florida counties.

- Accredited by Medicare Advantage (MA) organization since 1998 and by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
- **Awarded 5-Star rating by CMS 5 years overall**
- Extensive provider network
- All members have Medicare Part A and Part B and live in our service areas

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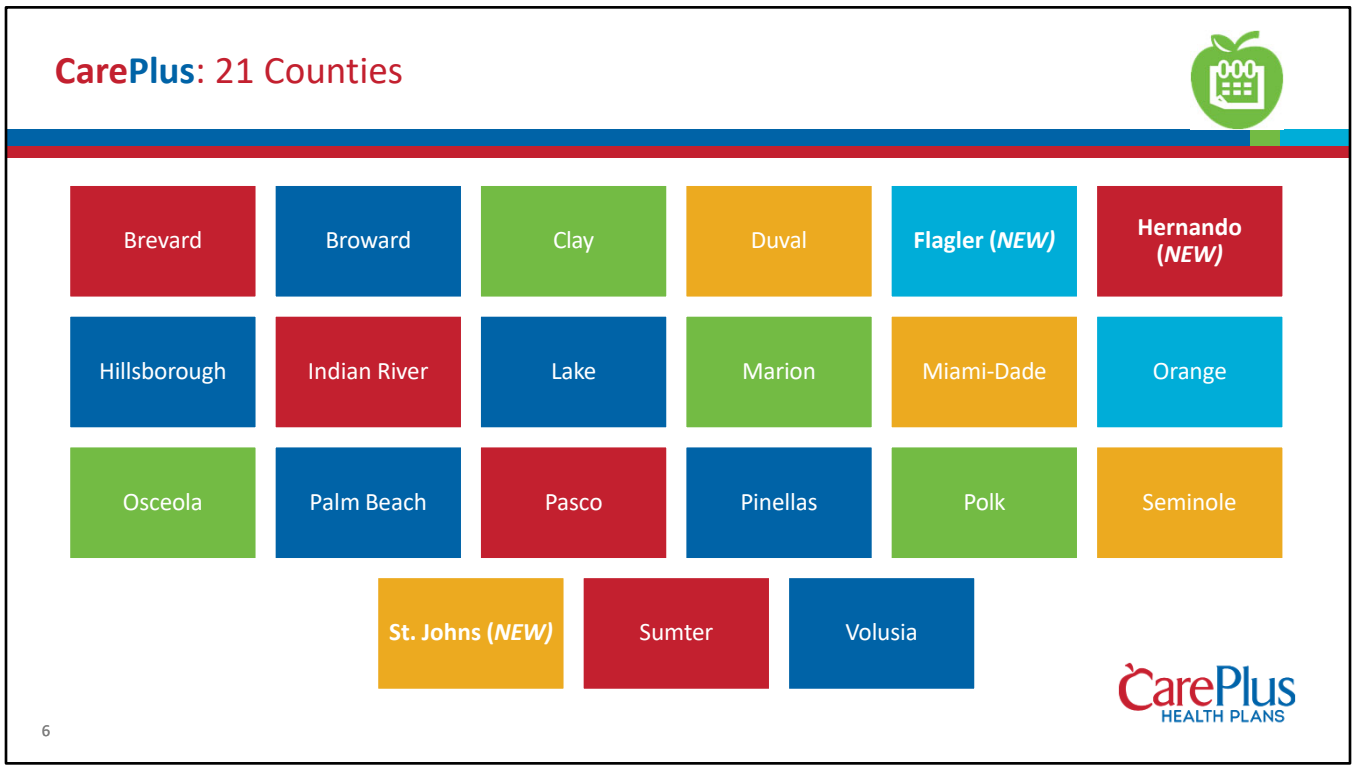
**CarePlus** offers a variety of health plans for Medicare beneficiaries in 21 Florida counties.

**CarePlus** was awarded the Medicare contract since 1998.

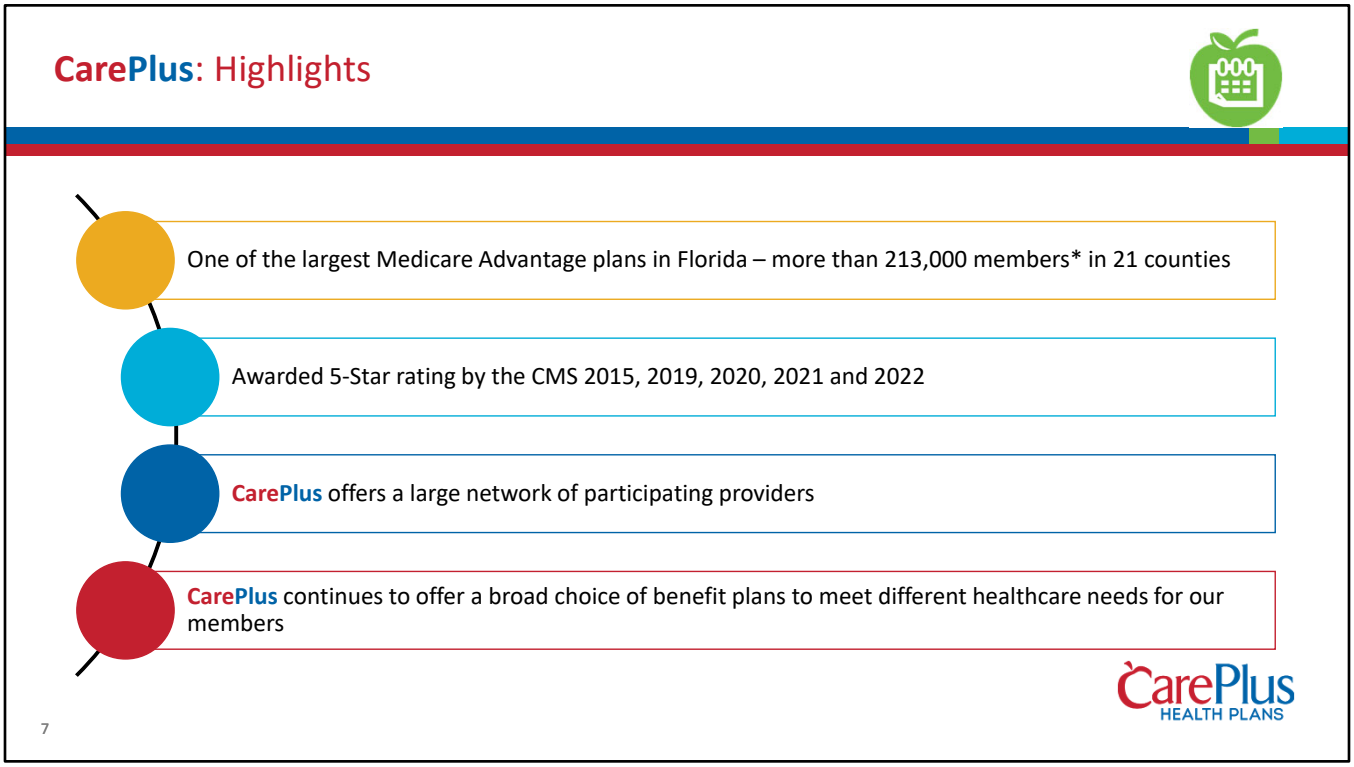
For 2022, **CarePlus** Health Plans was again awarded the 5-Star rating from the Centers for Medicare and Medicaid Services (CMS) for outstanding plan performance and care coordination, making it 5 years overall.

Our extensive network of fully credentialed physicians and other healthcare providers offer quality, compassionate, coordinated care to our members, all of whom have Medicare Parts A and B and reside in our service areas.




We have expanded from 18 counties in 2022 to 21 counties in 2023.

| | | | |
|---|---|---|---|
| Brevard | Broward | Clay | Duval |
| **Flagler** *(NEW)* | **Hernando** *(NEW)* | Hillsborough | Indian River |
| Lake | Marion | Miami-Dade | Orange |
| Osceola | Palm Beach | Pasco | Pinellas |
| Polk | Seminole | **St. Johns** *(NEW)* | Sumter |
| Volusia | | | |




As of September 14th, 2022 it is 1 of the largest Medicare Advantage plans in Florida, serving more than **213,000** members.

Of these members, more than 75,000 are in one of our **CarePlus** SNP Plans. (Source: Report of **CarePlus** SNP members enrolled as of Sept. 23rd, 2022)

CMS has awarded **CarePlus** a 5-Star rating for: 2015, 2019, 2020, 2021 and 2022

**CarePlus** offers a large network of participating providers.

**CarePlus** continues to offer a broad choice of benefit plans to meet different healthcare needs for our members.

# Special Needs Plans (SNP) Overview

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In this section, we will discuss everything you need to know about Special Need Plans (SNPs):

- SNPs common characteristics,
- The types of SNPs **CarePlus** offers,
- How **CarePlus** manages its SNPs,
- Eligibility and enrollment, including how to identify a patient enrolled in a SNP, and
- The healthcare professional's role in a SNP.

## Terms

**Special Needs Plan (SNP)**
A Medicare Advantage (MA) plan designed to provide targeted services to Medicare beneficiaries who are dual-eligible beneficiaries (D-SNP), have a severe/ disabling chronic condition (C-SNP), or reside in institutions (I-SNP). **CarePlus** only offers DSNP and C-SNP plans.

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## Special Needs Plans (SNP) Overview

**SNPs are MA plans focusing on vulnerable populations**

- Members with multiple chronic conditions and/or other barriers to self-care management such as low incomes and resources
- Care managers collaborate with healthcare providers to develop care plans that specifically address the SNP member's needs

**SNPs include Part C (medical) and Part D (drug) coverage, enhanced benefits and care coordination. They focus on:**

- Health-status monitoring
- Improved coordination and continuity of care
- Chronic-disease management

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10

A Special Needs Plan (SNP) is Medicare Advantage plan limited to specific populations. It is designed to provide enhanced benefits and targeted care that meet a patient's special needs. All SNP members are case-managed and monitored. Supported by their case manager, members work towards achieving the goals outlined in their individualized care plan – a plan designed to address their unique needs.

SNPs include medical (Part C) and drug (Part D) coverage and provide close care coordination, continuity of care, access to benefits and information, and chronic disease management.

## CarePlus SNP Plans

| Dual-eligible (D-SNP) | Chronic condition (C-SNP) | Institutional (I-SNP) |
|---|---|---|
| • **Covers members eligible for both Medicare and Medicaid**<br>• CareNeeds Plus (HMO D-SNP) | • **Covers members with specific chronic conditions**<br>• CareComplete (HMO C-SNP)<br>• CareComplete Platinum (HMO C-SNP)<br>• CareComplete Platinum (HMO-POS C-SNP)<br>• CareBreeze (HMO C-SNP)<br>• CareBreeze Platinum (HMO C-SNP)<br>• CareBreeze Platinum (HMO-POS C-SNP) | • **Covers members who reside in an institution**<br>• CarePlus does not offer I-SNPs |

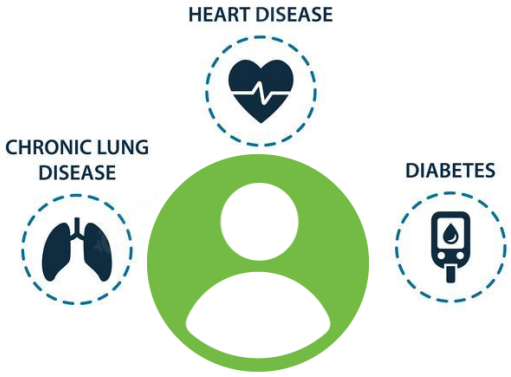
11

A special-needs individual may:
- Be dual-eligible for Medicare and Medicaid,
- Have severe or disabling chronic conditions, as specified by CMS, or
- Reside in an institution.

CarePlus does not offer institutional SNPs, called I-SNPs, for members who reside in institutions.

CarePlus now offers 5 different special needs plans, in all service areas:

- CareNeeds Plus (HMO D-SNP)
- CareComplete (HMO C-SNP)
- CareComplete Platinum (HMO C-SNP)
- CareComplete Platinum (HMO-POS C-SNP)
- CareBreeze (HMO C-SNP)
- CareBreeze Platinum (HMO C-SNP)
- CareBreeze Platinum (HMO-POS C-SNP)


## Dual-Eligible Special Needs Plan (D- SNP)

**and**

## Chronic Condition Special Needs Plan (C- SNP)

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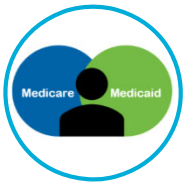
In this section, we will discuss everything you need to know about Dual-Eligible Special Needs Plan (D-SNPs) and Chronic Condition Special Needs Plan (C-SNP):

- Definition of D-SNPs and C-SNPs,
- The different categories of D-SNPs and C-SNPs,
- SNP Eligibility and enrollment
- SNP coverage

## Terms




**Dual Eligible Special Needs Plan (D-SNP)***
Special needs plans that enroll individuals who are receiving both Medicare and medical assistance from a state plan under Medicaid. States cover some Medicare costs, depending on the state and the individual's eligibility.

**Chronic Condition Special Needs Plan (C-SNP)**
Special needs plans that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions.

*The dual eligible special needs plans are sponsored by CarePlus Health Plans, Inc. and the Florida Agency for Health Care Administration (AHCA).

13

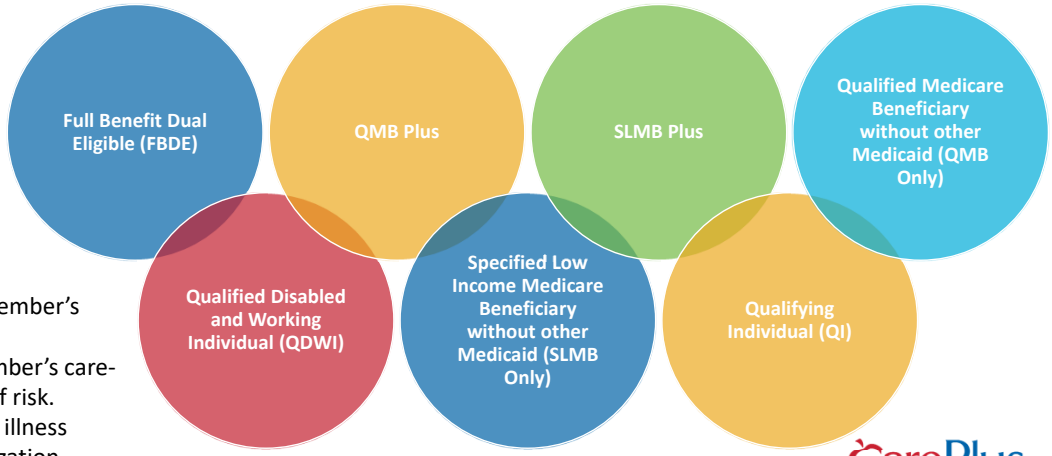
**Dual Eligible Special Needs Plan (D-SNP) -** Special needs plans that enrolls individuals who are entitled to both Medicare and medical assistance from a state plan under Medicaid. States cover some Medicare costs, depending on the state and the individual's eligibility.

**Chronic Condition Special Needs Plan (C-SNP) -** Special needs plans that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions.

The dual eligible special needs plans are sponsored by CarePlus Health Plans, Inc. and the Florida Agency for Health Care Administration (AHCA).

## Dual Eligible Special Needs Plans Categories

Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are receiving both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX).




Focuses on:

- Monitoring the member's health status
- Lowering the member's care-continuum level of risk.
- Managing chronic illness
- Avoiding hospitalization

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14

Briefly mention categories; for visual purposes only.

CareNeeds Plus focuses on:

- Monitoring the member's health status,
- Avoiding inappropriate hospitalization,
- Managing chronic disease, and
- Helping members move from high risk to lower risk on the care continuum.

## CareNeeds Plus (D-SNP) Coverage

CareNeeds Plus dual-eligible SNP covers both partial and full duals.

### Partial duals:

### QMB, SLMB, QDWI, QI

- Medicaid benefits are ***NOT*** covered. (Only Medicare-filed benefits are covered.)
- QMB members have no copay for medical services.
- SLMB, QDWI, QI members pay the filed plan copays.

### Full duals:

### QMB+, SLMB+, FBDE

- Most Medicaid benefits ***ARE*** covered.
- Receive Medicare and Medicaid Wrap benefits.*
- Members who are QMB+, SLMB+ and FBDE have no copy for medical services

15

*Wrap benefits: Assistive care, Behavioral-health targeted case management and community behavioral health, Dental x-rays, Home Health (non-skilled), Nursing Facility Transitional Days.

Patients with CareNeeds Plus who are partial duals can be categorized as:

- Qualified Medicare Beneficiaries, or QMB,
- Specified Low-income Medicare Beneficiaries, or SLMB,
- Qualified Disabled Working Individuals, or QDWI, or
- Qualified Individuals, or QI.

Partial duals receive Medicare-filed benefits only; they receive **no** wrap benefits.

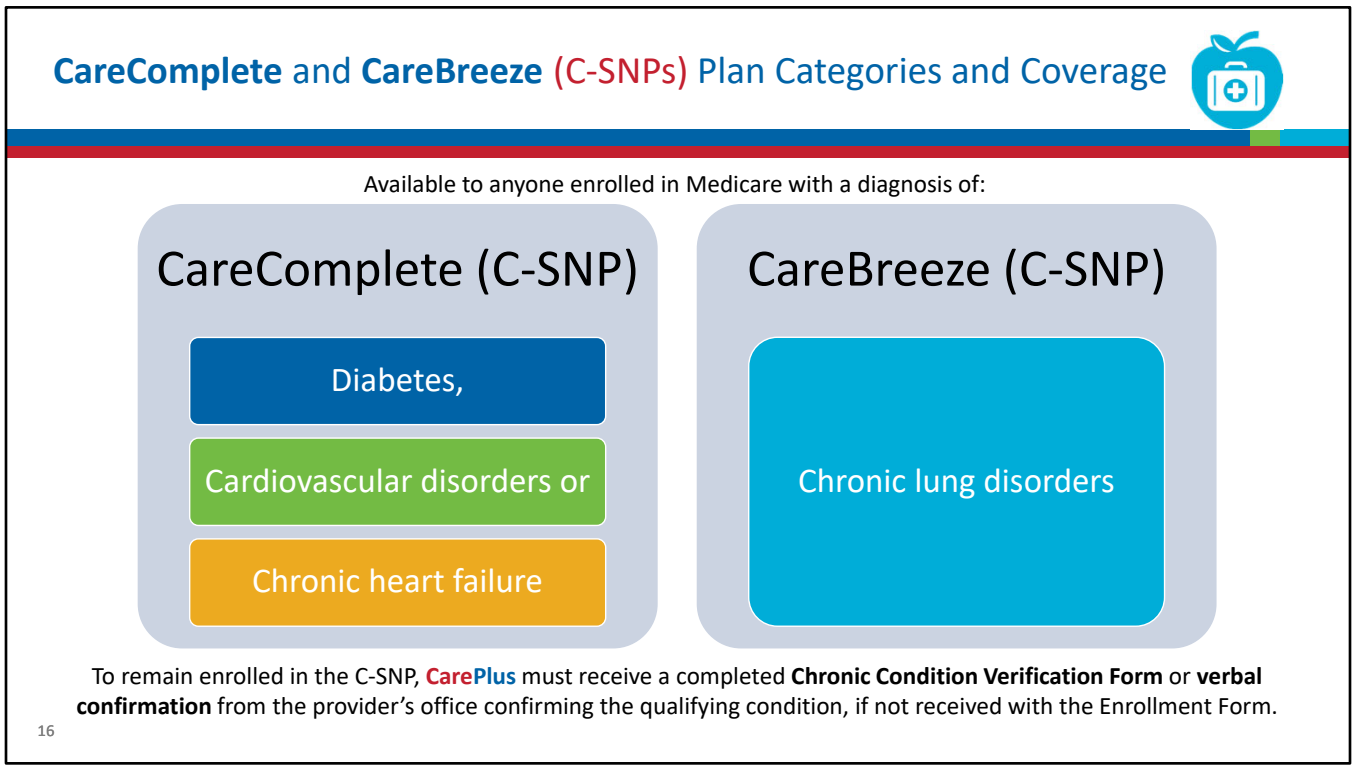
Full duals are designated as:

- QMB with comprehensive Medicaid benefits, or QMB+,
- SLMB with comprehensive Medicaid benefits, or SLMB+, or
- Full Benefit Dual Eligible, or FBDE.

QMB beneficiaries have no copay for ***medical*** services. SLMB, QDWI and QI individuals pay filed plan copays.

Full duals receive both Medicare and Medicaid benefits, **including** wrap benefits such as assistive care services, behavioral-health targeted case management and community behavioral health, dental X-rays, home health (non-skilled) nursing facility transitional days. These wrap benefits ensure that plan benefits are at least equal to coverage under Medicaid. Full duals have *no copay* for *all* services.

Please note: Healthcare providers may NOT balance-bill a cost-share protected member. In other words, they cannot balance-bill members who are QMB+, SLMB+, FBDE, or QMB.




Available to anyone enrolled in Medicare with a diagnosis of:

CareComplete (C-SNP)
- Diabetes,
- Cardiovascular disorders or
- Chronic heart failure

CareBreeze (C-SNP)
- Chronic lung disorders

Healthcare providers are required to submit a **Chronic Condition Verification Form** within the first month of enrollment.

# CarePlus
# Special Needs Plan (SNP)
# Features

## CarePlus SNP Enhanced Features

SNP benefits offer coverage ***beyond*** standard MA plan benefits:

| Mandatory supplemental benefits (MSB)**: | D-SNP and C-SNP highlights: | Enhanced care coordination: |
|---|---|---|
| • Vision, dental, hearing, transportation*<br>• Nutritional meals<br>• Over-the-counter (OTC) health and wellness products available via mail-order (CenterWell™)<br>• SilverSneakers® fitness program<br>• CareCard (members who do not have it, must request one). | • **$0 copays**, except for emergency and ambulance services, for CareNeeds Plus D-SNP members (cost-share-protected duals have no copays)<br>• Year-round enrollment<br>• Part D included<br>• Disease-focused care management<br>• CareEssentials Card (D-SNP)<br>• CareContigo tablet (C-SNP)* | • Individualized care plan (ICP)<br>• Disease management<br>• Access to care-management services<br>• Preventive care<br>• Health Risk Assessment (HRA)<br>• Interdisciplinary care team (ICT)<br>• Flexible Care Assistance |

*Benefits vary by plan, county, and eligibility.

18

Member benefits are determined by the level of "Extra Help/Low-Income Subsidy.

CarePlus SNPs provide members with meaningful opportunities to improve their health.

In addition to medical and prescription drug coverage, SNP members receive:

- Mandatory supplemental benefits for vision, dental, hearing, transportation and other services,
- Enhanced care coordination by an interdisciplinary care team of physicians, pharmacists, nurses, case managers, social workers, home health and behavioral health professionals and the member's caregivers, and
- An individualized care plan based on a comprehensive health risk assessment.

**CareCard:** CareNeeds plus (D-SNP) members in Orlando and Tampa areas may receive card loaded with a $250 allowance **to help pay for dental, vision, or hearing** needs beyond their used plan benefit limits. For example, dental plan covers one crown, but the member needs two. The members can use the allowance to pay for the 2nd crown.

CareNeeds Plus plans have no copays for medical services, except for emergency room and ambulance services. Cost-Share protected duals are not responsible for cost-shared filed on medical services.

**CareEssentials Card:** All CareNeeds Plus members receive **$150, $175, or $275 loaded** on a prepaid card every month to use toward the purchase of food, home and personal care supplies, over-the-counter (OTC) products from a national network of retailers, and other services.

Patients with a CareComplete or CareBreeze C-SNP are assured of targeted case management to help them manage their cardiovascular conditions, chronic heart failure or diabetes and enable them to live active, independent lives.

**CareContigo Tablet:** Available to most C-SNP members. $0 Copay, Communication device with unlimited calls and text services and limited data services, within the U.S. Designed to help members access healthcare services and benefit information. Members must request a tablet

**Flexible Care Assistance:** $500 available to C-SNP members and $1,000 for D-SNP members, if coordinated and authorized by a care manager, for primarily health related additional needs.

UNIQUE NEEDS (including but not limited to):

- Medical expense assistance
- Meal delivery services
- Caregiver services
- Adult day care
- Utilities
- Non-medical transportation
- Medical supplies and
- Prosthetics
- Pest control
- Alternative therapies
- Home and bathroom safety
- Devices

## SNP– Eligibility and Enrollment

### The individuals a eligible for SNP must be:

- Entitled to Medicare Part A,
- Enrolled in Medicare Part B, and
- Residing within a plan's service area.

### D-SNP

- Special needs plans that enroll individuals who are receiving both Medicare and medical assistance from a state plan under Medicaid. States cover some Medicare costs, depending on the state and the individual's eligibility.
- Special enrollment period (SEP) allowing members to change plans once per calendar quarter during the first 9 months of the year
- They also have a SEP to enroll, disenroll or change plans within three months of gaining, losing or experiencing a change in their Extra Help/Low-Income Subsidy (LIS) eligibility status or receiving notice of such a change.

### C-SNP

- Special needs plans that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions.

19

For D-SNPs and C-SNPs is open year-round.

Dual-eligible and chronic condition members may enroll at any point during the year.

D-SNP members have a special enrollment period, or SEP, once per calendar quarter during the first nine months of the year, in which they can change plans.

Duals and other Medicare beneficiaries receiving the LIS, or low-income subsidy, also have an SEP in which to enroll, disenroll or change plans within three months of gaining, losing or changing their LIS eligibility status or receiving notice of such a change.

**CarePlus** validates that SNP members are:

- Entitled to Medicare Part A,
- Enrolled in Medicare Part B, and
- Living within a plan's service area.

**CarePlus** also must validate that:

- D-SNP members receive Florida Medicaid, and
- C-SNP members are receiving treatment for one of the specified chronic conditions.

## Medicare Improvements for Patients and Providers Act (MIPPA)

| SNP'S require: | |
|---|---|
| | Initial and Annual Health Risk Assessments (HRA) |
| | An HRA after critical events, such as a hospitalization |
| | Care-management and individualized care plans |
| | A dedicated Interdisciplinary Care Team (ICT) |
| | A process for reporting health outcomes and quality measurements |

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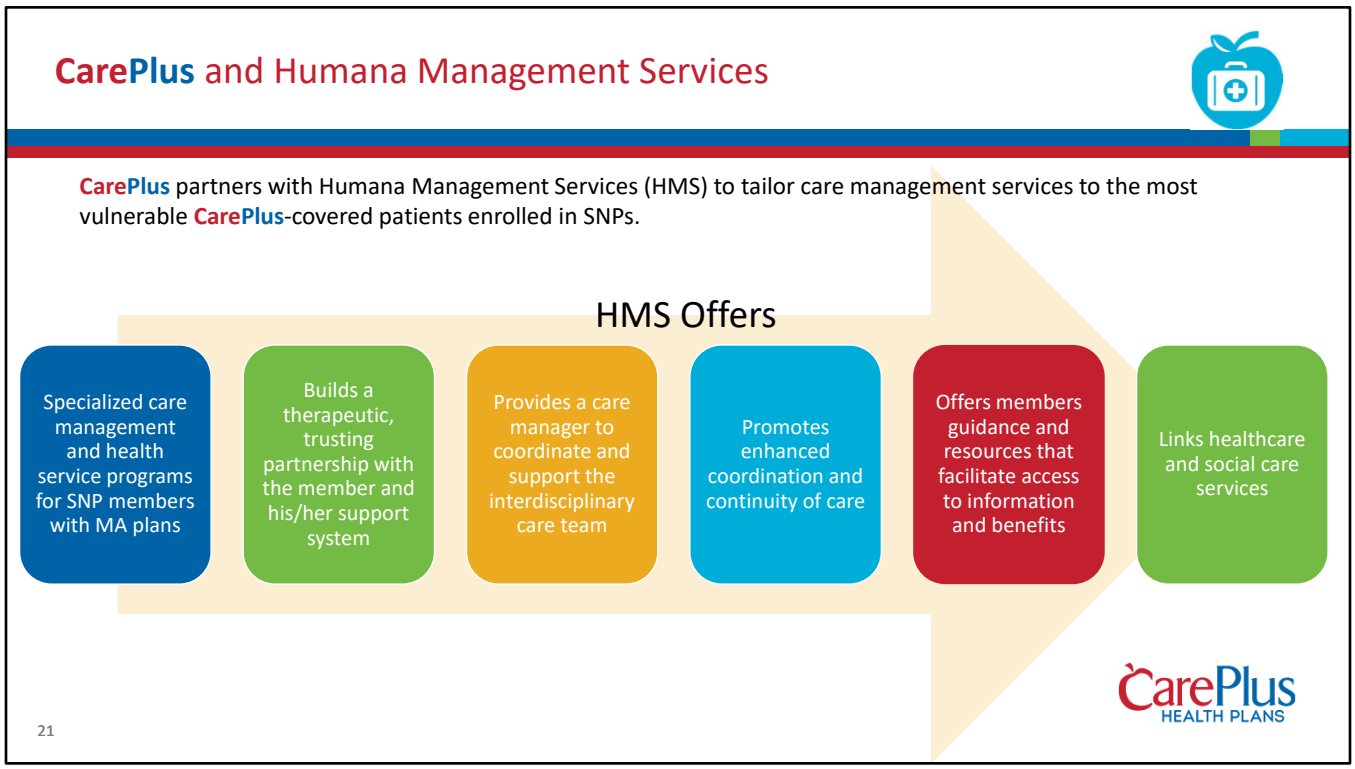
20

CMS requires that plans conduct initial and annual health risk assessments, or HRAs, for all SNP members. For **CarePlus**-covered SNP members identified as clinically at risk, primary care physicians receive HRA reports for review and input. Critical events, such as a hospitalization or other significant changes in health status, trigger a new HRA.

SNPs also are required to have:

- Care-management and individualized care plans,
- A dedicated interdisciplinary care team, or ICT, and
- A process for reporting health outcomes and quality measurements.

Our model of care, which we'll discuss later in this presentation, outlines our plan for meeting the needs of our special needs population and complying with these requirements.




Humana Management Services is the **CarePlus** partner that provides care management services to the most vulnerable SNP members. Areas of risk are identified through an approved health risk assessment.

HMS builds therapeutic, trusting partnerships with members, their significant others and caregivers while promoting enhanced coordination and continuity of care.

Acute and chronic care management services are delivered to members by telephone. HMS care managers assume the roles of liaison, coach and advocate. They work one-on-one with members and support the ICT's effort to deliver comprehensive, timely solutions that mitigate complications.

HMS' programs link healthcare and community-based social care services, with the goal of improving health outcomes and enabling members to remain as healthy, safe and independent as possible.

## Physician's Role in Care Management

Physician involvement is an integral part of SNP interdisciplinary care teams (ICTs).

PCPs:

- Receive pertinent HRA reports for review and input, and collaborate in the development of the individualized care plan (ICP)
- Participate in ICT care conferences and communicate actively to foster care coordination
- Ensure Healthcare Effectiveness Data and Information Set (HEDIS®) and National Committee for Quality Assurance (NCQA) quality measures are addressed

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22

Physician involvement is an integral part of SNP interdisciplinary care teams. PCPs:

- Receive pertinent HRA reports for review and input and collaborate in the development of the individualized care plan,
- Participate in ICT care conferences and communicate actively to foster care coordination, and
- Ensure HEDIS and NCQA quality measures are addressed.

## Reimbursement for D-SNP services

- For *Medicare*-covered benefits, submit claims to **CarePlus**.
- For *Medicaid*-covered benefits or cost-shares, submit claims to **CarePlus** or bill the appropriate state agency for additional reimbursement.


There is **no copay** for medical services for members designated:

- Qualified Medicare Beneficiary and Qualified Medicare Beneficiary with comprehensive Medicaid benefits (QMB, QMB+)
- Specified Low Income Medicare Beneficiary Plus (SLMB+)
- Full Benefit Dual Eligible (FBDE)

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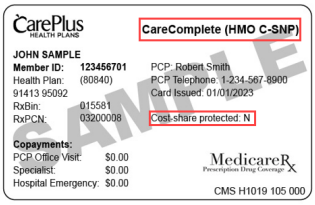
23

Services rendered to patients with **CarePlus** D-SNPs are reimbursed as follows:

- Practitioners submit claims to **CarePlus** for Medicare-covered benefits
- For Medicaid benefits or cost-share amounts, **CarePlus** coordinates reimbursement with the state.

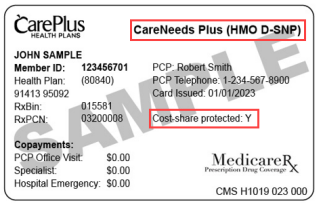
Please bear in mind that patients with **CarePlus** D-SNPs who receive full Medicaid benefits – designated QMB PLUS, SLMB PLUS and FBDE – are not responsible for copays or coinsurance or any other type of reimbursement, including Part B drugs. QMB members who do not receive Medicaid benefits also are cost-share protected and not responsible for copays/coinsurance.

# Identifying SNP Members





C-SNP ID





D-SNP ID

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24

Sample ID cards for SNP members: identify the member's plan, cost-share protected status and PCP.

# Accessing the member's Summary of Benefits

1. To access an SNP member's Summary of Benefits, go to: **https://www.careplushealthplans.com/careplus-providers/**

2. Click on **CarePlus Medicare Advantage Plans**

3. Select **2023 Medicare Advantage Plans.**

4. Click on the **region** in which your patient lives, then select **Summary of Benefits,** or for a more detailed explanation of benefits, select **Evidence of Coverage**.


25

Providers may access the details of a member's SNP benefits from the **CarePlus** website. Click on **CarePlus** Medicare Advantage Plans, and from there select the 2023 Medicare Advantage Plans. The different plans are listed under the region where the member lives – South Florida, Orlando area, etc. Select either Summary of Benefits for a quick overview, or Evidence of Coverage for more details and other important member plan guidance.

# Knowledge Check

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## Knowledge Check

**1. A SNP is a health plan that :**

A. Provides healthcare coverage for vulnerable populations with special needs.
B. Provides health care coverage for members with Medicare parts A and B.
C. Focuses on health-status monitoring, care coordination and chronic-disease management.
D. All of the above.

**2. D-SNP Plans _____**

A. Only enroll Medicare beneficiaries with certain chronic diseases
B. Only enroll Medicare beneficiaries who reside in institutions such as nursing homes or skilled nursing facilities.
C. Only enroll individuals who have both Medicare and Medicaid

**3. C-SNP Plans _____**

- A. Only enroll Medicare beneficiaries with specific chronic health conditions including heart failure, diabetes, and emphysema.
- B. Only enroll Medicare beneficiaries who reside in institutions such as nursing homes or skilled nursing facilities.
- C. Only enroll individuals who have both Medicare and Medicaid.

27

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Correct Answers are:

1) D. All of the above
2) C. Provide healthcare coverage for members who are both Medicare and Medicaid eligible
3) A. Provide health coverage for members with specific chronic health conditions including heart failure, diabetes, and emphysema.

# Special Needs Plan (SNP) Model Of Care (MOC)

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In this section we'll look at the components of **CarePlus**' SNP model of care, or MOC. We will also review the services provided by **CarePlus**' Social Services Department. Lastly, we'll conclude the training with information about resources to supplement this training and assist your patients who have SNPs.

## Model of Care (MOC)

| | |
|---|---|
| Model of Care | Is required by CMS and reinforced by the Affordable Care Act |
| | Describes how the plan will identify and address the unique needs of the SNP population and provide quality care to meet those needs |
| | Guides quality improvement |
| CarePlus Model of Care | Is patient-centric |
| | Addresses preventive care and acute and chronic disease management |
| | Uses an interdisciplinary team approach |
| | Emphasizes health status monitoring |
| | Incorporates evidence-based protocols and strategies |

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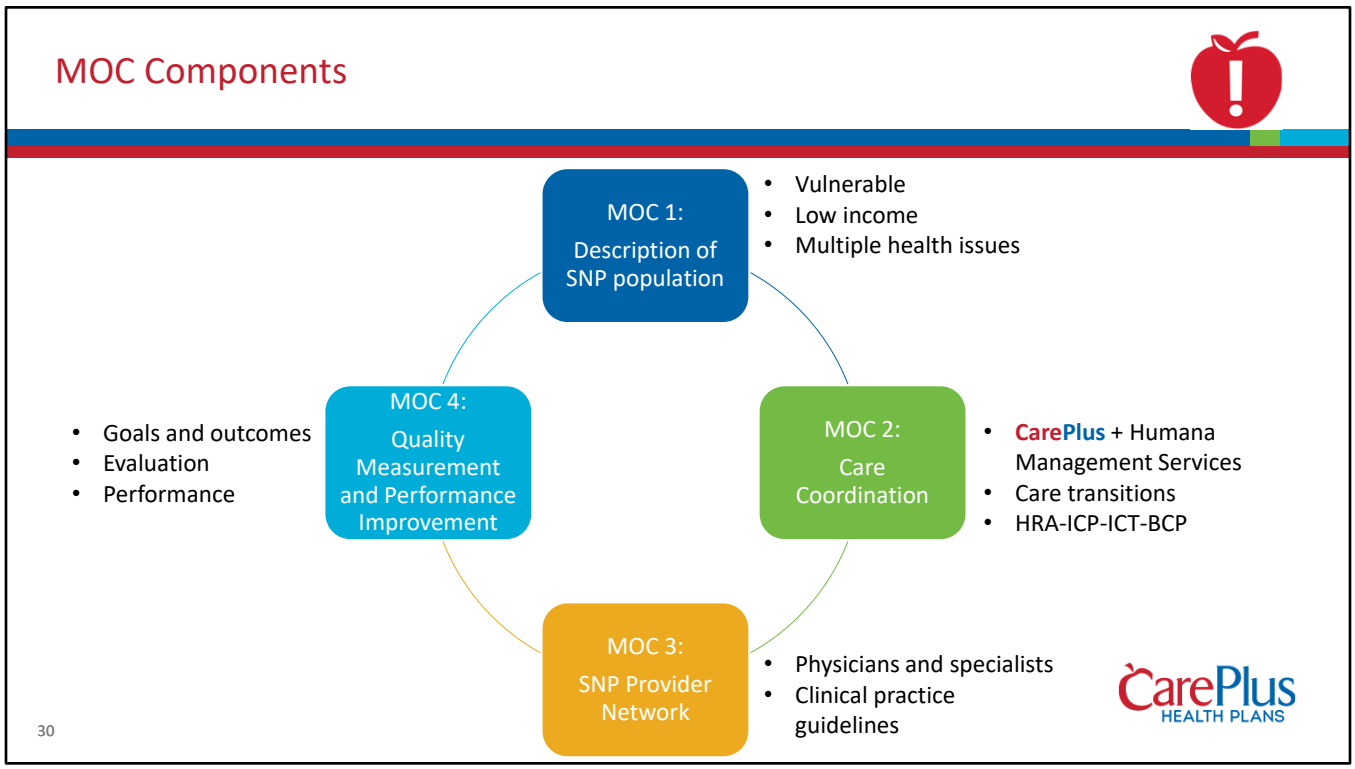
29

Medicare Advantage organizations are required by CMS to create and maintain a Model Of Care (MOC) for their special needs plans.

The MOC is a tool that ensures that SNPs address member's unique needs. It also guides quality improvement efforts.

The Affordable Care Act has reinforced the MOC's importance as a fundamental component of SNP quality improvement. This act requires the National Committee for Quality Assurance to review and approve every MOC, using CMS standards and scoring criteria.

CarePlus' MOC focuses on how care is delivered to our members by using an interdisciplinary approach that emphasizes health status monitoring and preventive care.




Let's talk about the Special Needs Plan Model of Care components.

The Centers for Medicare and Medicaid Services (or CMS) Model of Care requirements include 4 Model of Care Components.

The Model of Care Components include :

- A description of the SNP Population (identifies the target population that we are serving)
  - The most vulnerable are poor and less healthy, with a stratification level of intervention (LOI), in the high-to-severe range.
- Care Coordination (addresses "How" we are caring for the beneficiaries and how the services will be rendered)
  - **CarePlus** and Humana Management Services have a functional structure to ensure all required services are coordinated through qualified staff.
  - Care coordination entails use of:
    - The Health Risk Assessment Tool (HRA)
    - Formulation of the Individualized Care Plan (ICP)
    - Basic Care Plans (BCP)
    - The Interdisciplinary Care Team (ICT)
    - Care Transition Protocols
- The Provider Network (addresses who the clinicians are that will assist in providing the healthcare)
  - Describes the plan's physician network, including specialized expertise, clinical practice guidelines and care transition protocols, as well as, provider network training.
- Model of Care Quality Measurement and Performance Improvement (addresses what the measures are and how we will monitor and ensure that we have met those measures)
  - Outlines measurable goals and health outcomes,
  - Measures the experience of care with ongoing performance improvement evaluation, and
  - Ensures dissemination of **CarePlus**' SNP quality performance results.

## MOC Measurable Goals

### Expectation

- Improve access to healthcare services for SNP population
- Improve coordination of care and services
- Promote enhanced care transitions
- Facilitate the appropriate use of health and chronic care services

### Implementation

- Collaborating with physicians
- Reinforcing their treatment plans
- Information sharing
- Care plan compliance

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31

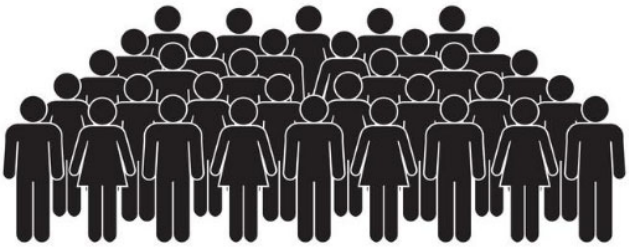
**CarePlus**' MOC has four measurable goals that address what we expect our SNPs to accomplish.

- Improving access to and affordability of healthcare services,
- Improving coordination of care and appropriate delivery of services through direct alignment of the health risk assessment, integrated care plan and interdisciplinary care team,
- Promoting enhanced care transitions across all healthcare settings and among all medical professionals, and
- Facilitating the appropriate use of preventive health and chronic-care services.

We achieve our MOC goals and promote the optimum health of **CarePlus**-covered patients by:

- Collaborating with physicians,
- Reinforcing their treatment plans,
- Keeping physicians informed of care transitions and changes we observe in their patients' health status, and
- Reinforcing the need for members to comply with their care plans, including medication regimen, diet, exercise and therapy recommendations.

# SNP Population

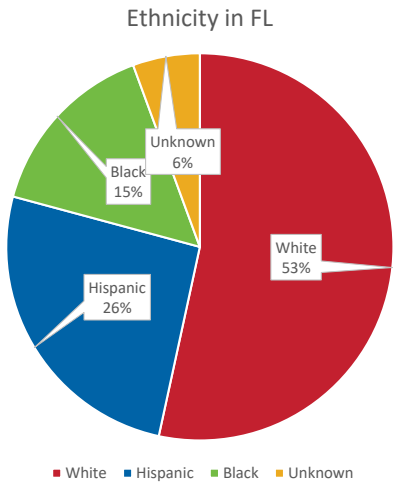


**Model Of Care 1:**
**SNP Population**

CarePlus HEALTH PLANS

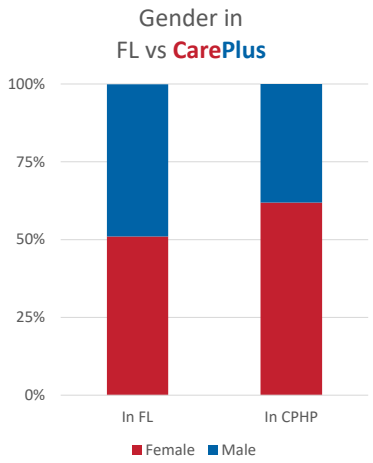
Let’s take a look at the first of our MOC components: the SNP population.

## CarePlus' Special Needs Plan Population




**CarePlus' SNP members are diverse**

In Florida, 32.5% of the population aged 65+ has a disability




CarePlus HEALTH PLANS

33

CarePlus' SNP population is diverse and tends to have multiple chronic health conditions. The social determinants of health help identify issues and opportunities for developing the right plans for health improvement. For example, ethnicity information helps us understand the language and cultural needs of our SNP population.

Based on the Florida Dept. of Health, the majority of our Florida population is:
White 53.4%
Hispanic 25.8%,
Black 15.2%,
Other 5.6%,

Female 51.1% (In Florida)
Male 48.9%

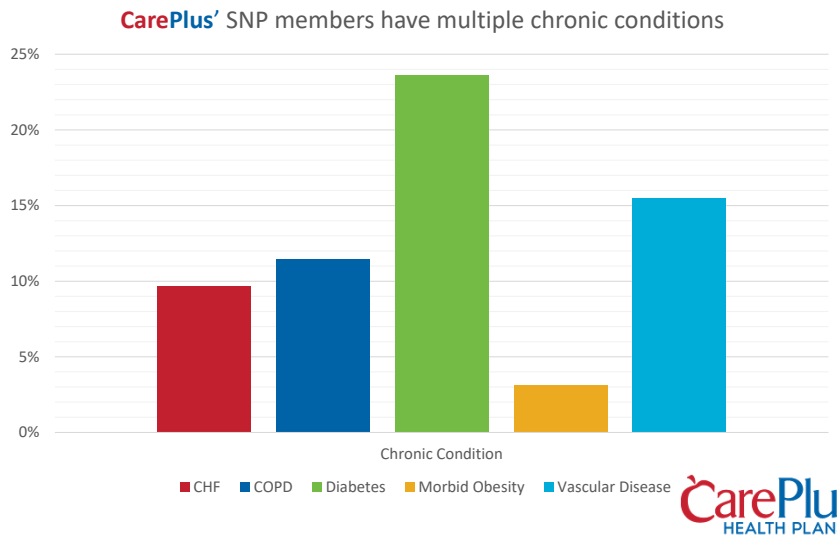
Female 61.9% (In CarePlus)
Male 38.1%

Age 65 and older 32.5% with disability

## CarePlus' Special Needs Population

**CarePlus' SNP members are diverse**

**CarePlus** members speak:
50% Spanish
46.9% English
3.1% Other




CarePlus HEALTH PLANS

34

The majority of our population is diagnosed with diabetes with chronic complications, cardiovascular disease, and congestive heart failure. While these diagnoses are often correlated, our members with these conditions also tend to have comorbidities including morbid obesity and chronic obstructive pulmonary disease.

Vascular diseases include cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and/or chronic venous thromboembolic disorder

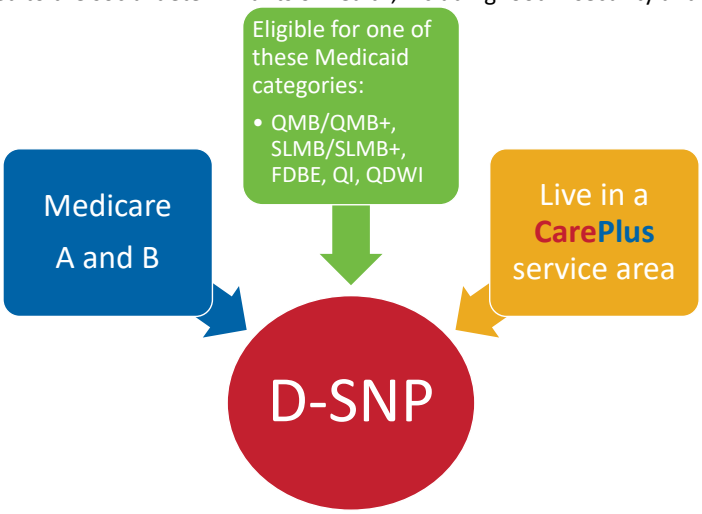
Other unique characteristics of this population include: having been prescribed multiple prescription medications and tending to be at a higher risk financially and cognitively.

**CarePlus** members speak:
50% Spanish
46.9% English
3.1% Other

**CarePlus** Members with:
CHF 9.7%
COPD 11.5%
Diabetes 23.6%
Morbid Obesity 3.1%
Vascular Disease 15.5 %

## CarePlus' Dual-Eligible Special Needs Population (D-SNP)

Members are often frail and/or disabled, exhibit low health literacy and have chronic comorbidities, psychosocial issues and needs related to the social determinants of health, including food insecurity and social isolation.




CarePlus HEALTH PLANS

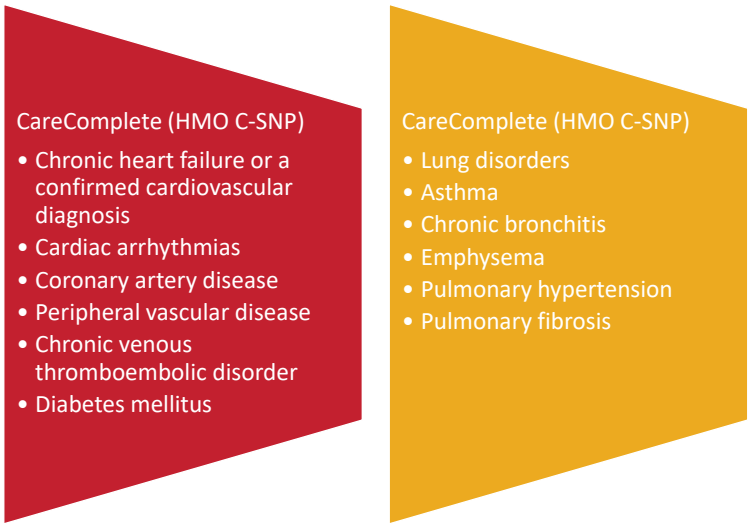
35

**CarePlus** D-SNP members must be entitled to Medicare Part A, enrolled in Medicare Part B, and be eligible for one of these Medicaid categories: Qualified Medicare Beneficiary (QMB/QMB+), Specified Low-Income Medicare Beneficiary (SLMB/SLMB+), Qualified Individual (QI), Qualified Disabled and Working Individual (QDWI), or Full Benefit Dual Eligible (FBDE).

They must also live in one of our service areas.

The most vulnerable are low-income, frail and disabled members with low health literacy. They often have chronic comorbidities, psychosocial issues and needs related to social determinants of health, such as food insecurity, social isolation, financial strain related to affordable housing, inability to afford medications and caregiver services, lack of access to transportation for medical appointments and so on.

## CarePlus' Special Needs Population (C-SNP)




The most vulnerable C-SNP members have more complex comorbidities, more frequent ER visits and/or hospital admissions, have experienced a major change in health, functional or mental status, lack caregiver support, and are near the end of life.

Health disparities mirror differences in socioeconomic status, racial and ethnic background and education level. Income level contributes to poor/unsafe living conditions.

CarePlus HEALTH PLANS

36

CarePlus C-SNP members may have multiple chronic conditions exacerbated by psychosocial factors that impact care compliance and health outcome. Most have three or more comorbidities, take multiple prescription medications and tend to be at a higher risk financially and cognitively.

There is a high incidence of heart disease, diabetes mellitus and diabetic psychoses, chronic pulmonary disease and chronic kidney disease.

The majority of our CarePlus SNP population is diagnosed with diabetes, vascular disease, including cardiac arrhythmias, coronary artery disease, peripheral vascular disease and/or chronic venous thromboembolic disorder, congestive heart failure, and COPD.

The most common health conditions experienced by our C-SNP Population are cardio-vascular disease, diabetes, CHF, asthma and chronic bronchitis.
Again the impact of the social determinants of health is very apparent, and those with lower income and educational levels demonstrate a greater degree of health disparities.

The most vulnerable C-SNP members report more frequent emergency room visits and/or hospital admissions; more complex comorbid conditions; a major change in health, functional or mental status; a lack of caregiver support; and may be near the end of life.

Barriers faced regularly by our C-SNP members are the high rate of prevalence with multiple chronic conditions and the lack of coordination between multiple providers.

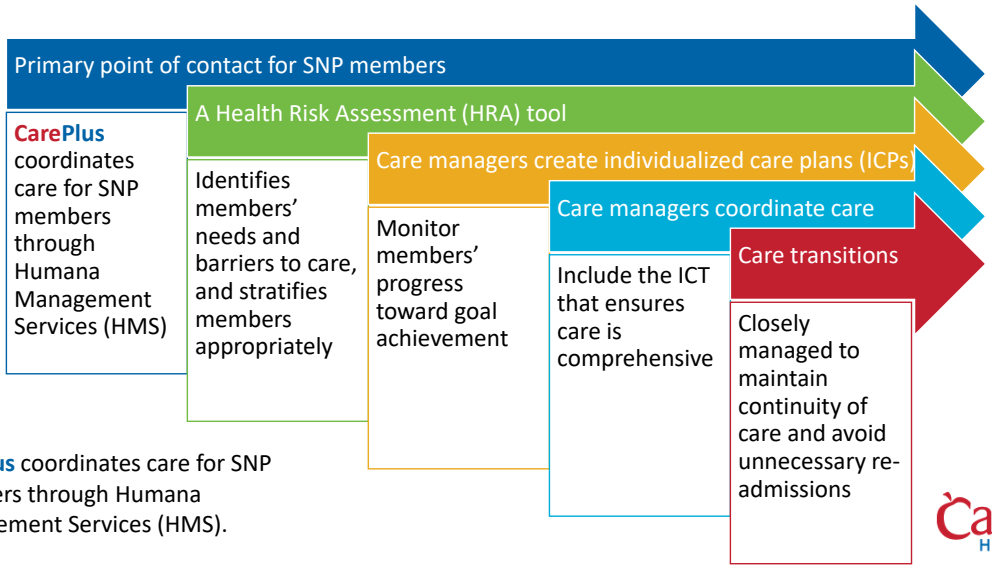
Health disparities mirror differences in socioeconomic status, racial and ethnic background, and education level. Income also contributes to poor and unsafe living conditions within this CVD/CHF/DM C-SNP population. Hazards in a member's home may contribute to falls, may result in nutritional deficiencies, and may even result in death. Language barriers may affect educational attainment, income, and access to care. Ethnicity, language, and cultural beliefs may increase the gaps in care faced by our SNP population. These factors are taken into consideration when developing programs. Methods for addressing health literacy and elements of cultural diversity are integrated into the Model of Care. For example, written materials sent to the member are at a 4th to 6th grade reading level based on state requirements. The majority of materials are available in English and Spanish. CarePlus/Humana Management Services also has bilingual staff and access to a language translation line as needed.

## Model Of Care 2:
## Care Coordination and Staff Structure

CarePlus HEALTH PLANS

Let’s take a look at the Second of our MOC components: the Care Coordination and Staff Structure

## Care Coordination and Staff Structure




**CarePlus** coordinates care for SNP members through Humana Management Services (HMS).

38

Through Humana Management Services, **CarePlus** employs a staffing structure that ensures all necessary services are coordinated by qualified staff. Staff functions address clinical issues, administration and oversight for **CarePlus** and HMS.

CMS requires that all SNP members receive a health risk assessment focused on their acute and chronic health needs. The HRA enables **CarePlus**' case managers to identify concerns and stratify members.

The HRA also is used to create individualized care plans that address identified care opportunities. ICPs incorporate interventions designed to help members meet prioritized goals. Plans are shared with members and their PCPs.

An interdisciplinary care team approach enhances the ability to provide comprehensive care that promotes wellness, improves member health status, reduces unplanned transitions and increases member safety. The member's PCP is in charge, with HMS' care manager coordinating the team's work, including contributions from pharmacy personnel, behavioral health providers, social workers and other care providers.

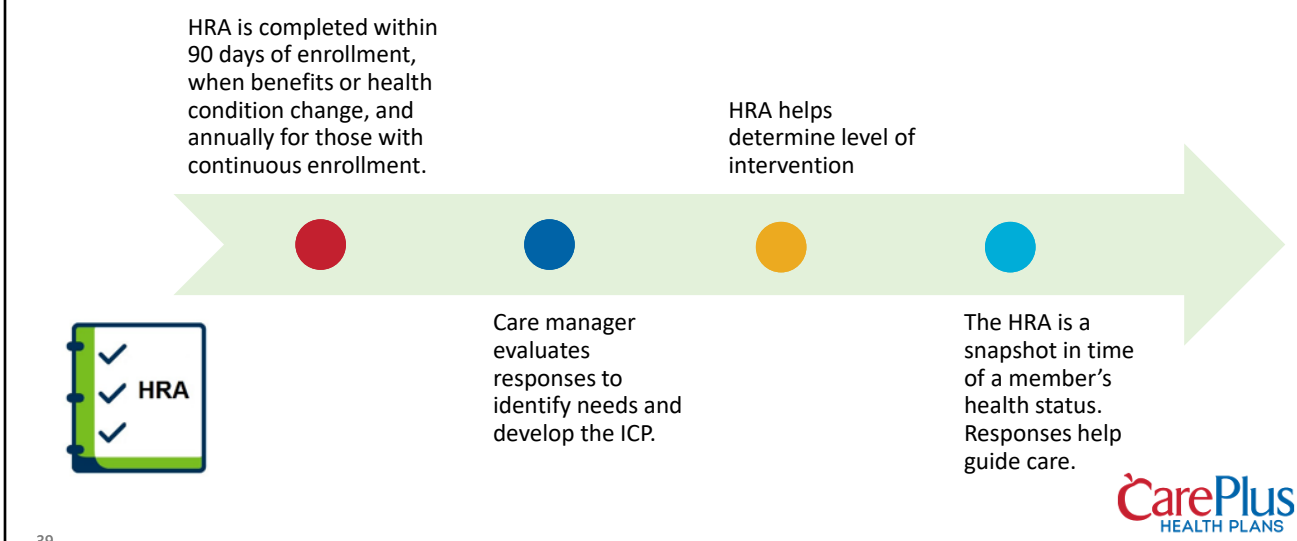
When a SNP member moves from one care setting to another due to health status changes, he or she is vulnerable to receiving fragmented care, The HMS team strives to maintain continuity of care during transitions by communicating with the field case manager and the member's PCP and by attempting to contact the member within 24 hours of discharge to address needs and prevent an avoidable re-admission.

The care management team ensures that the member:

- Understands the discharge plan and medication regimen
- Is receiving needed care, including prescriptions, nutritional support, home health therapy, durable medical equipment and supplies
- Has scheduled a follow-up visit with the PCP
- And knows the warning signs that may indicate a need for immediate medical attention.

The case manager facilitates referrals for any services needed and educates the member and his or her caregiver about available resources that might expedite a return to optimal health.

## Care Coordination: Health Risk Assessment (HRA)




Using a CMS-approved Health Risk Assessment, an HMS care manager seeks to identify any unknown medical, functional, cognitive, environmental, social, financial and/or psychosocial issues and needs that the SNP member may have.

Plan members must receive an assessment:

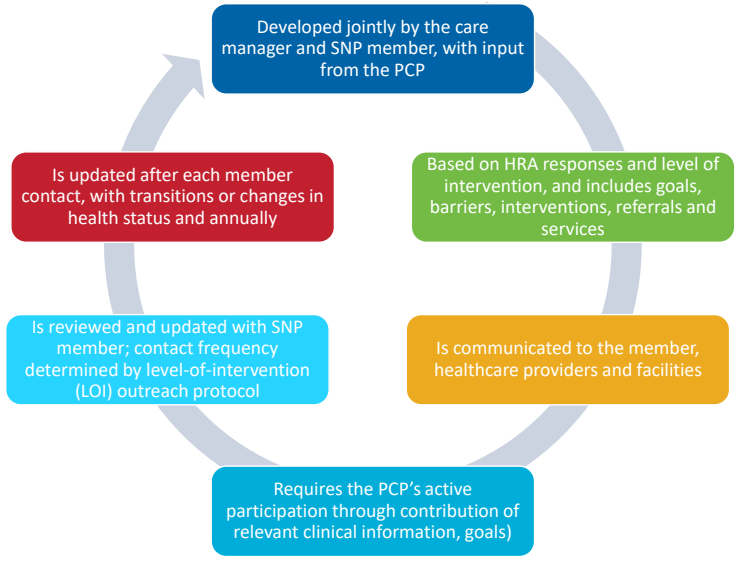
- Within 90 days of enrollment,
- Whenever they experience a significant change in health status,
- When their benefits change, and
- Annually.

The member's HRA responses help the care manager develop the individualized care plan; determine the member's appropriate level of intervention, - either low, medium, high or severe; and make appropriate referrals.

Ultimately, the HRA serves as a tool to help guide treatment, with care managers making every effort to provide members with the right care management services at the right time to best meet the members' needs.

HRA is also a CMS STAR measure. It must be reviewed and manually analyzed by the Care Manager to stratify the member's health risk.

## The Individualized Care Plan (ICP)





- Individualized
- Measurable
- Prioritized

40

The ICP outlines goals for member needs, is developed by the Care Manager in collaboration with the member and is communicated to the member's PCP to contribute relevant clinical information. It is based on medium, high and severe risk needs identified during the health risk assessment.

The plan is communicated to the member, the member's healthcare providers and facilities, as appropriate.

ICPs address:

- Member preferences,
- Barriers to self-management and access to care,
- Short- and long-term goals,
- Interventions,
- Referrals,
- Educational opportunities,
- Medication and safety reviews,
- Preventive care, and
- Other services, as required.

Care plan records are available to all stakeholders, with confidentiality maintained in accordance with HIPAA and state requirements.

The ICP must be initiated or updated following the administration of any HRA or significant changes in member's needs.
The frequency of meetings is established in a document called the Level of Intervention Outreach Protocol. Meetings may be required weekly, monthly, quarterly, or occur as needed.

The member's HRA drives the care plan, and the PCP's active participation is imperative.

Goals must be individualized, measureable and prioritized based on the member's identified needs and preferences. When setting the goals, identification of barriers to meeting goals and target date for completion should be documented.

## The Basic Care Plan (BCP or Healthy Action Plan)

The Basic Care Plan -- an alternative to an ICP, is meant to help members meet health and well-being goals.

**Care Manager**

- Engages with the member to meet health goals.
- If member is not reached telephonically, the health educational material is mailed.


**Member**

- Members are asked to commit to their health goals, one of which is to take the Basic Care Plan to their next physician visit.

**PCP or Specialist**

- Reviews, discusses recommendations with the member, and faxes the completed document to **CarePlus** at **1-866-232-0979**.

**Member**

- Follows instructions outlined in the plan regarding medication adherence, healthy behaviors, regular health checks, communicating with PCP about significant symptoms and advance care planning as well as learns about health screenings and preventive services from the PCP.

4

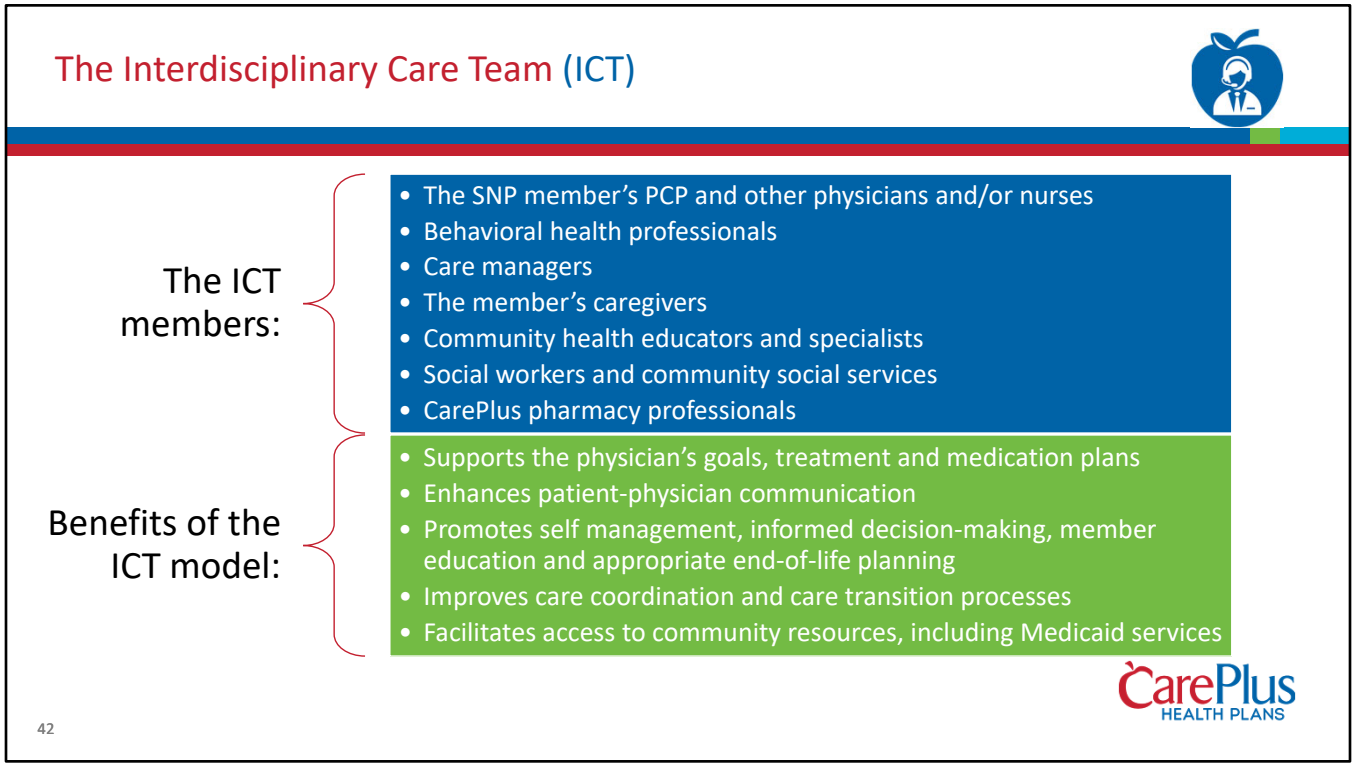
Basic Care Plan development is required to be completed in collaboration with PCPs for SNP members who are unable to be reached, refuse active care management or request not to be called/visited. The care manager develops a basic care plan and mails it to the member.

The member is asked to provide input and commit to the plan. The member also is asked to take the document to his or her next PCP visit and review it with the PCP, who adds recommendations.

Basic Care Plans are tailored to the member's SNP type and/or additional information available.

Basic care plan goals are measurable and achievable; they are formulated to engage the member with his or her PCP and care manager and move the member toward optimum health. The member is asked to commit to healthy behaviors, including medication adherence, regular health checks, preventive services, advance care planning, and communicating with the PCP about any symptoms they are experiencing,.

If at any point in time the SNP member engages in active care management, an ICP is created between the Care Manager and the member and/or his/her proxy and is accessible by the member's Provider for collaboration and input of relevant clinical information.




The MOC requires that care managers incorporate the input and interventions of an interdisciplinary care team, or ICT, comprising a variety of healthcare professionals.

It is a team of associates from different disciplines who work together to manage the member's Individualized Care Plan.

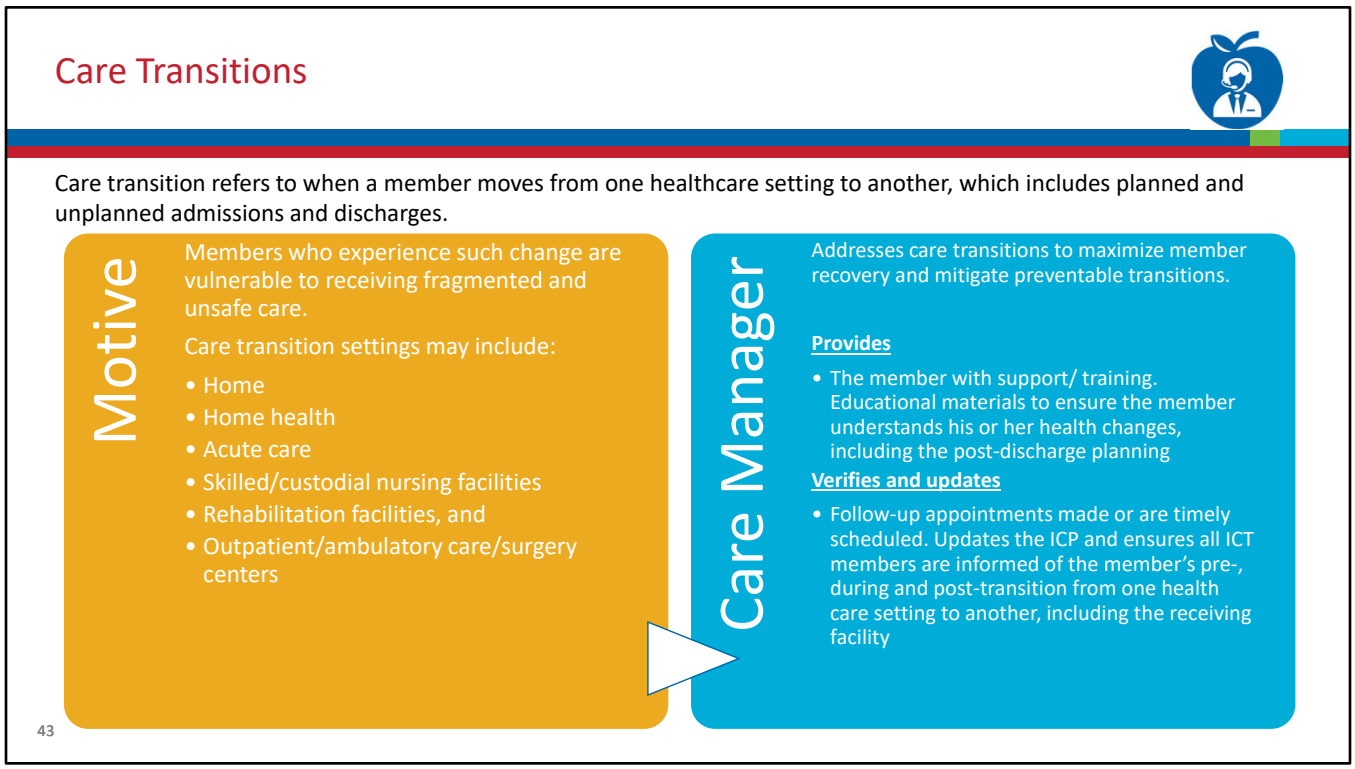
The ICT meets on an ad hoc basis, but it must meet at least annually to review progress and identify additional interventions.

The ICT harnesses the power of collaboration among dedicated medical professionals. It

- Supports the physician's goals for the member, with contributions from the CarePlus team of nurses, social workers, pharmacy specialists and behavioral-health specialists,
- Reinforces the physician's treatment and medication plans,
- Enhances direct patient-physician communication,
- Promotes member self-management and informed decision-making about healthcare,
- Provides comprehensive member education and appropriate end-of-life planning,
- Ensures more effective care coordination and care transitions, and
- Gives the member access to additional community resources and services

The ICT must include at minimum the member and/or caregiver, the member's care manager, and the member's Primary Care Physician.

Note: Any recommendations made by the ICT must be incorporated and properly documented in the ICP.

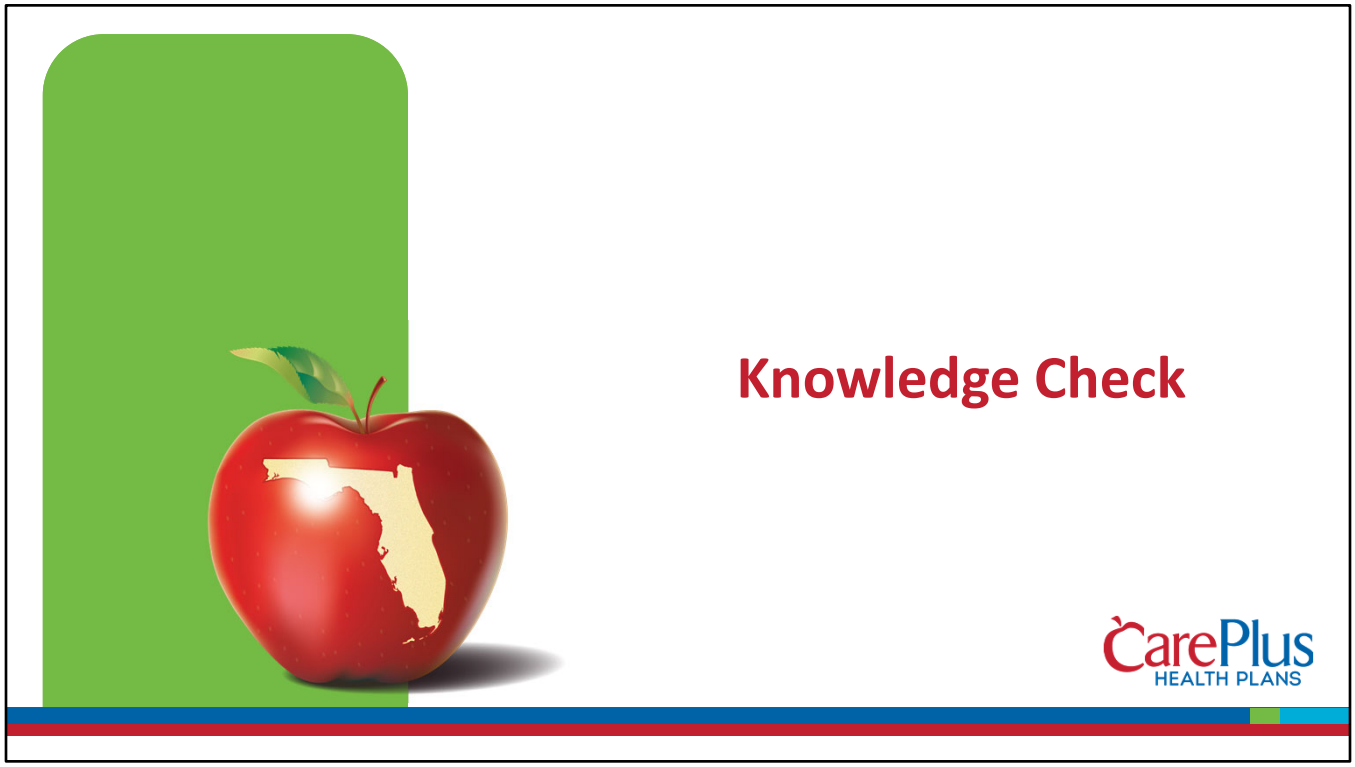



CMS defines a care transition, as a member moves from one health care setting to another. This includes planned and unplanned admissions and discharges.

Members who experience such change are vulnerable to receiving fragmented and unsafe care.

Care transition settings may include:
- Home
- Home health
- Acute care
- Skilled/custodial nursing facilities
- Rehabilitation facilities, and
- Outpatient/ambulatory care/surgery centers.

The Care Manager is responsible to share elements of the member's ICP with the new health care setting or provider. During the transition, the Care Manager:
- Provide the member with educational materials and ensure the member understands his or her health changes
- Verify that physician follow-up appointments are made, or assist the member in scheduling a timely follow-up appointment
- Ensure the member understands the post-discharge plan
- Provide member and caregiver support/training
- Update the Individualized Care Plan
- Ensure all applicable ICT members are informed of the member's needs pre, during, and post transition from one care setting to another, including the receiving facility.




It’s time again to see how much you remember

## Knowledge Check

1. Which of the following best describes CarePlus' MOC?

- A. Collaboration between the member, care manager and providers to address how care is delivered and emphasizes health status monitoring and care.
- B. Developed based on the results of the member's Health Risk Assessment only.
- C. Harnesses the power of collaboration among the member's caregivers only.

2. Which of the following elements are part of CarePlus MOC? Select all that apply:

- A. Description of population served.
- B. Care management.
- C. Physician network.
- D. Administration of benefits.
- E. Quality measurement/metrics.

CarePlus HEALTH PLANS

45

Correct Answers:

1) A. Collaboration between the member, care manager and providers to address how care is delivered and emphasizes health status monitoring and care.
2) A, B, C and E. D- administration of benefits, is not a component of CarePlus' model of care.

## Knowledge Check

**3. What are the goals of the CarePlus model of care? Select all that apply:**

- A. Improve patient heath outcomes and access to healthcare services
- B. Improve coordination of care and appropriate delivery of services
- C. Promote enhanced care transitions across all healthcare settings and among all medical professionals
- D. Facilitate the appropriate use of preventive health and chronic care services
- E. All of the above
- F. To increase plan enrollment

**4. Which of the following characteristics does not apply to CarePlus' D-SNP Population?**

- A. Eligible for both Medicare and Medicaid
- B. Have barriers to care access, including language, lack of transportation and lack of familiarity with how the healthcare system works
- C. Have limited financial resources
- D. Only for members who reside in an institution
- E. Are negatively affected by social determinants of health, including food and housing insecurity

CarePlus HEALTH PLANS

46

Correct Answers:

3) A, B, C, D and E are correct answers. F is NOT correct – CarePlus' model of care does not seek to increase plan enrollment.
4) D. I-SNPs are for members who reside in an institution.

## Knowledge Check

5. What is a characteristic of a beneficiary who would enroll in one of CarePlus' C-SNP plan?

- A. Eligible for both Medicare and Medicaid
- B. Diagnosed with diabetes, cardiovascular disorders or heart failure
- C. Diagnosed with pulmonary disorders including asthma, chronic bronchitis, emphysema, pulmonary fibrosis or pulmonary hypertension
- D. Reside in an institutional setting
- E. A only
- F. B and C
- G. I only

CarePlus HEALTH PLANS

47

Correct Answers:

5) F. Diagnosed with diabetes, cardiovascular disorders or heart failure and Diagnosed with pulmonary disorders including asthma, chronic bronchitis, emphysema, pulmonary fibrosis or pulmonary hypertension

## Model Of Care 3:
## Provider Network

Component three of **CarePlus**' MOC addresses the SNP provider network.

## The Provider Network

- **CarePlus**' SNP provider network has specialized expertise to augment/ support PCPs.
- Current clinical-practice guidelines are observed.
- Network providers must complete annual SNP MOC training.

CarePlus HEALTH PLANS

49

In accordance with MOC 3, **CarePlus** offers a comprehensive network of PCPs, in addition to medical and surgical specialists and facilities available to support PCPs and meet the needs of the targeted populations.

Per CMS guidelines, providers must use current clinical-practice guidelines. Compliance is monitored by medical record documentation reviews and quality-of-care reviews.

**CarePlus**" network providers and their staff are required by CMS to complete annual MOC training, Training also is available for out-of-network providers who care for **CarePlus**-covered patients on a routine basis.

## Physician Involvement in Care Management

CMS requires the SNP member's PCP to:

- Review, collaborate with Care Managers, and promote care coordination to ensure care plans are comprehensive for each member.
  - Health Risk Assessments (HRA)
  - Individualized Care Plans (ICP)
  - Basic Care Plans (BCP) for those members who cannot be reached or refused active care management
- Act as an ICT participant to manage the member's ICT via phone or through an exchange of written communications.
- Promote HEDIS® quality measures and capture data related to medication reconciliation post-discharge, and care for older adults.


CarePlus HEALTH PLANS

50

CMS considers PCPs to be the "gatekeepers" of healthcare services, overseeing and coordinating all medical care for their patients. All physicians are part of the care coordination effort and promote HEDIS quality measures in order to improve health outcomes.

CMS requires the SNP member's PCP to:

Review, collaborate with Care Managers, and promote care coordination to ensure care plans are comprehensive for each member.

- Health Risk Assessments (HRA)
- Individualized Care Plans (ICP)
- Basic Care Plans (BCP) for those members that cannot be reached or refused active care management

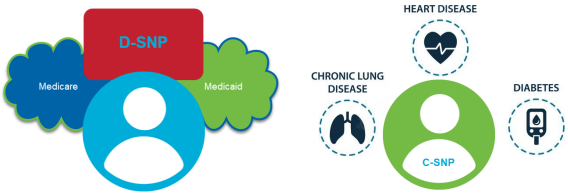
Act as an ICT participant to manage the member's ICT via phone or through an exchange of written communications.

Promote Healthcare Effectiveness Data and Information Set also known as HEDIS® quality measures and capture data related to medication reconciliation post-discharge, and care for older adults.

## Physician Involvement in Care Management

In addition, PCPs must:

- Coordinate D-SNP members' Medicare and Medicaid benefits
- Verify/Document C-SNP members' chronic conditions (Chronic Condition Verification Form) within 1 month of the member's enrollment
- Meet the cultural and linguistic needs of SNP members and be able to tell their patients how to access services
- Alert **CarePlus** to any changes in their Medicaid participation status
- Complete SNP-MOC training annually




CarePlus HEALTH PLANS

51

Physician coordination of Medicare and Medicaid benefits is essential for patients with CareNeeds Plus. CMS requires physicians to know that certain Medicaid benefits, such as those for long-term care and waiver services, are not covered by CareNeeds Plus.

For C-SNP members, those with CareBreeze and CareComplete Plans, physicians are required to attest that the member is being treated for one of the specified health conditions.

Physicians must be able to tell patients how to access services. All benefits covered by **CarePlus** are listed in a member's summary of benefits and/or evidence of coverage documents, accessible from the **CarePlus** website.

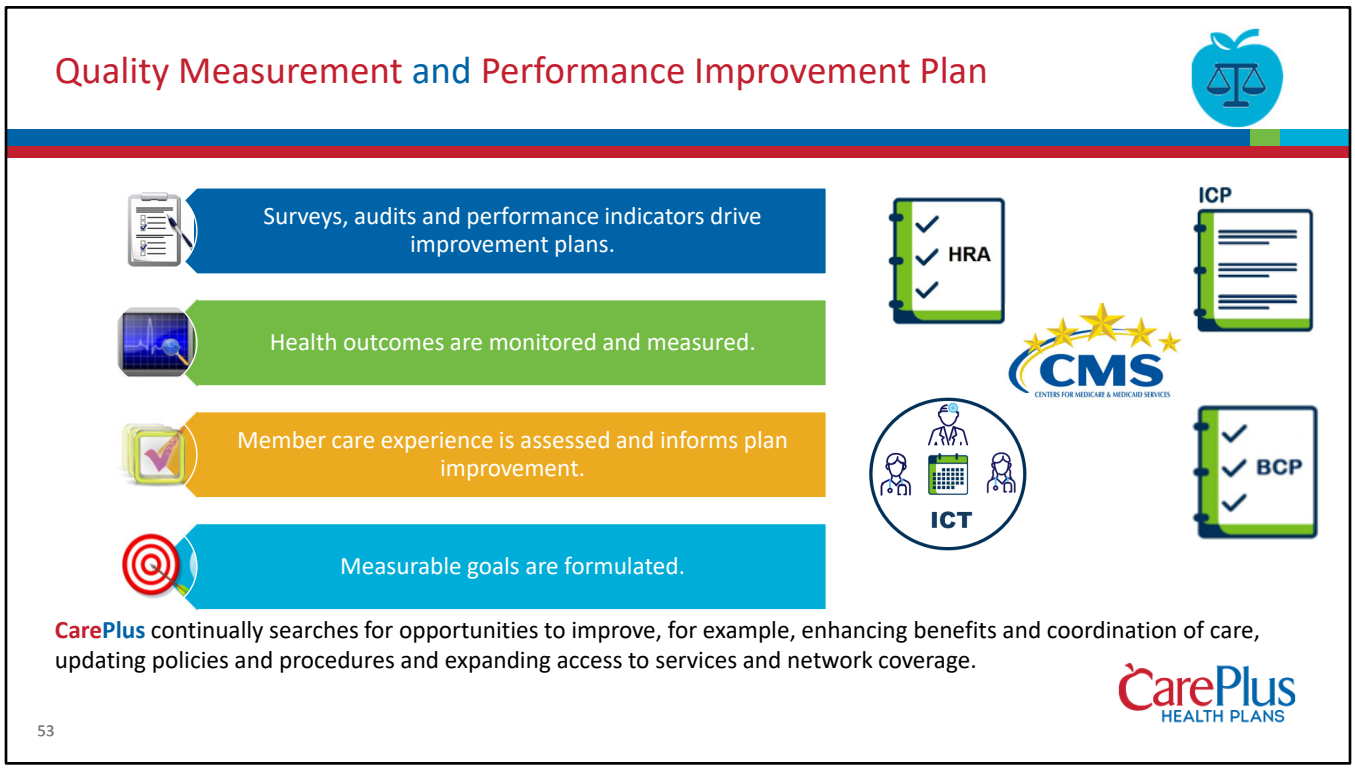
Physicians must take the necessary steps to meet the cultural and linguistic needs of SNP members, and they are required to alert **CarePlus** to any changes in their Medicaid participation status.

Finally, CMS requires physicians to complete SNP MOC training annually.

## Model Of Care 4:
## Quality Measurement and Performance Improvement Plan

CarePlus HEALTH PLANS

The last MOC component is all about quality and improving our SNPs.




The MOC contains provisions for continuous improvement. We assess how we're doing, then we take steps to improve.

Opportunities for improvement are identified from surveys, audits and monitoring of performance indicators including member satisfaction, health outcomes and access to and availability of services.

Areas targeted for improvement include the following:

- Optimizing benefits and policies
- Increasing services
- Facilitating access to medical, behavioral, social and preventive services
- Adjusting physician and provider network coverage
- Streamlining processes
- Enhancing coordination of care
- Maximizing health outcomes
- And implementing system updates

The goal of the program is to improve member health outcomes.

## Knowledge Check

CarePlus HEALTH PLANS

## Knowledge Check

**Which of the following is required of physicians? Select all that apply:**

- A. Receive Health Risk Assessment (HRA) reports for review and input, and collaborate in development of the individualized care plan
- B. Participate in interdisciplinary care team conferences and communicate actively to foster care coordination
- C. Ensure that HEDIS® quality measures and SNP-specific measures are addressed, i.e., medication reconciliation post-discharge, HRA completion, and care for older adults
- D. Help D-SNP members access services
- E. Inform **CarePlus** of any changes in your Medicaid participation status
- F. Complete annual SNP MOC training
- G. Risk-stratify members as low, medium, high or severe

CarePlus HEALTH PLANS

55

Correct Answer:

Answers A through F are physician responsibilities. Item G. – Risk-stratify members as low, medium, high or severe – is a case manager responsibility.

# Social Services

CarePlus HEALTH PLANS

**CarePlus**' Social Services Department supports your patients who have **CarePlus** special needs plans.

## Social Services Assist Members

The Dual Eligibility Outreach Program assists prospective and current members; and the community with applying for public assistance through a variety of state and federal programs. This assistance and guidance is offered at no cost.

Social Services Coordinators are here to:

- Educate and conduct initial screening to determine potential eligibility for state/federal assistance programs such as:

| | |
|---|---|
| ✓ LifeLine program (Wireless /landline phone discount) | ✓ Community partner with Department of Children and Families |
| ✓ SSI referrals | ✓ **CarePlus** DCF/ACCESS Application processing center |
| ✓ Extra Help with Medicare Prescription Drug Plan Costs | ✓ Comprehensive Assessment and Review for Long-Term Care Services (CARES) referrals |

- Assist members throughout the renewal eligibility process
- Help members with reported changes
- For assistance, members can call: **1-855-392-3900**

CarePlus HEALTH PLANS

57



**CarePlus**' Social Services Department is dedicated to helping all interested and potentially eligible **CarePlus**-covered patients, including dual-eligible individuals, understand and apply for state and federal assistance programs.

An initial screening determines a person's potential eligibility for benefits. Available federal benefits may include:

- The Lifeline program, which offers a free cell phone or a discount on a landline to those with SNP eligibility,
- Supplemental Security Income, or SSI, and
- Help with Medicare Prescription Drug Plan costs.

Please note that Lifeline is a value-added item and service promoted to the member after enrollment.

The department also has an in-house application processing center staffed by associates who assist all interested and potentially eligible individuals.

## ACCESS Florida Partnership

A DCF/CarePlus assisted-service site partnership

**ACCESS Florida** is the state's economic self-sufficiency program:

*Automated Community Connection to Economic Self Sufficiency*

**ACCESS** enables users to apply, report any changes or complete an updated review for public assistance benefits, such as:

- Medicaid*
- Food stamps (SNAP)*
- Temporary Cash Assistance*
- Long Term Care Community Diversion Program
- Referral*

**ACCESS:**

Go to: www.myflorida.com/accessflorida
Call **1-866-76-ACCESS (1-866-762-2237)**

*The Department of Children and Families (DCF) is the state agency designated to determine eligibility for these services/benefits.

58

**CarePlus** proudly serves the community as a partner with the Florida Department of Children and Families' ACCESS Florida.
ACCESS Florida is a website that enables users to connect to programs and benefits that foster economic self-sufficiency.

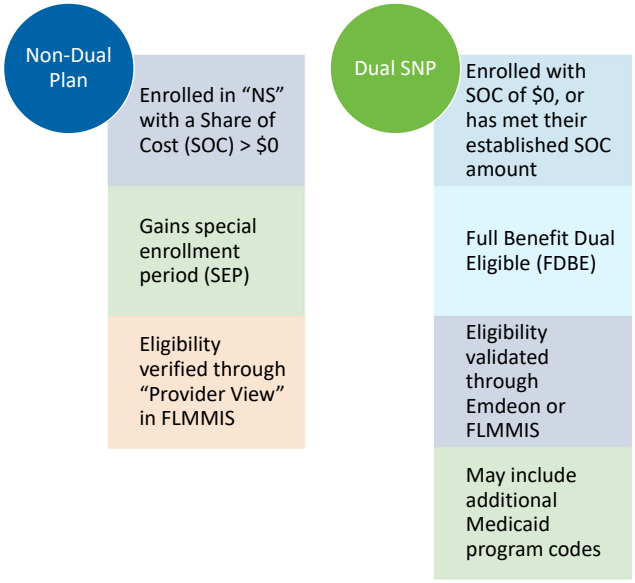
Site users can apply, report any changes or complete an updated review for public assistance benefits, such as:

- Medicaid,
- Food stamps (SNAP),
- Temporary Cash Assistance, and
- Long Term Care Community Diversion Program Referral

ACCESS is run by DCF's Economic Self-sufficiency Division, as part of the department's mission to protect the vulnerable, promote strong and economically self-sufficient families and advance personal and family recovery and resiliency.

DCF is the state agency designated to determine eligibility for benefits and services.

## Medicaid Medically Needy Program




This program helps to pay medical expenses for individuals whose household income is too high for them to qualify for Medicaid.

Both are:

- Eligible for LIS
- Member receives a notice of case (NOCA) from DCF

59

The Social Services Department also will help members apply for the Medicaid Medically Needy Program. This program is designed to assist low-income members whose household incomes are too high to qualify for Medicaid benefits.

The Medically Needy Program helps pay for medical services covered by Medicaid, but it does not pay health coverage in its entirety. Recipients must pay a portion of their medical expenses each month before receiving benefits. Once they reach the limit of the amount they must pay, Medicaid steps in and pays the rest of their medical expenses for that month.

The Medically Needy Program's eligibility income limits differ from those for regular Medicaid. The dollar amount of an applicant's medical expenses each month determines how much Medicaid will cover. The costs and benefits covered by the Medically Needy Program apply only to allowable expenses. These typically are the same expenses that Medicaid would cover. They include unpaid medical bills, medical bills paid within the last three months, medical bill copays, health insurance premiums, doctor-prescribed medical services and transportation to get medical treatment.

# CarePlus Link

CarePlus HEALTH PLANS

**CarePlus** Link is  a member-centered educational initiative that provides assistance and education to all of your **CarePlus**-covered patients.

## The CarePlus Link


**Accessible from the comfort of home, CarePlus Link (Conexión CarePlus in Spanish) is a series of phone and web-based virtual presentations, offered at various dates and times, to CarePlus members.**

CarePlus Link consists of participants, staff, facilitators, and presenters who will be providing topics on the value of continued growth and balance around the physical, mental, social, lifestyle choices, and other useful plan information.

For a copy of the most current CP Link Calendar of Events scan QR code, visit CarePlus' website, or can contact Member Services to have a copy sent by mail.

CarePlus HEALTH PLANS

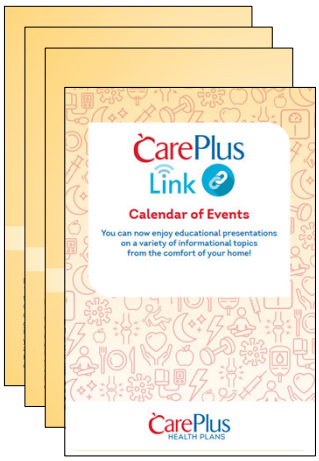
61

CarePlus Link brings health-related information right to the SNP member's home. Topics related to physical, mental, social and lifestyle choices are available in Spanish and English.

Members can use their electronic devices to log into sessions, or they can simply call in to listen.

The CarePlus Link Calendar of Events booklet provides information about topics that will be covered and the dates and times to connect.

# The CarePlus Link




The **CarePlus Link** Booklet provides program information available to members, such as topics being offered, schedules and how to access the presentations.

Program information, including the most up-to-date booklet information, can be obtained by visiting the **CarePlus** website or by calling Member Services to have a copy sent by mail

Members can connect from their electronic devices (iPad, iPhone, Android, PC, etc.) to see and hear their chosen presentation

Members can connect by phone to listen to an audio presentation

# Abbreviations
# References
# Resources

CarePlus HEALTH PLANS

The following slides contain a glossary of terms used in this presentation, a list of the references consulted, and a compilation of resources that you may consult for more information about our special needs plans.

## Abbreviations

| Abbreviation | Word |
|---|---|
| ACCESS | Automated Community Connection to Economic Self Sufficiency |
| BCP | Basic Care Plan |
| CARES | Comprehensive Assessment and Review for Long-Term Care Services |
| CMS | The Centers for Medicare and Medicaid Services |
| C-SNP | Chronic Condition Special Needs Plan |
| D-SNP | Dual-eligible Special Needs Plan |
| Dual-eligible (Full Duals): | FBDE Full Benefit Dual Eligible; QMB+ Qualified Medicare Beneficiary with comprehensive Medicaid Benefits SLMB+ Specified Low-income Medicare Beneficiary with comprehensive Medicaid Benefits; |
| Dual-eligible (Partial Duals): | QDWI Qualified Disabled Working Individual; QI Qualified Individual; QMB Qualified Medicare Beneficiary; SLMB Specified Low-income Medicare |
| HCP | Healthcare provider |
| HEDIS® | Healthcare Effectiveness Data and Information Set |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| HMO | Health Maintenance Organization |

CarePlus HEALTH PLANS

64

These are the acronyms used during this presentation

## Abbreviations

| Abbreviation | Word |
|---|---|
| HMS | Humana Management Services (care partners who case manage the SNP members) |
| HRA | Health Risk Assessment |
| ICP | Individualized Care Plan |
| ICT | Interdisciplinary Care Team |
| LIS | Low Income Subsidy (AKA Extra Help) |
| LOI | Level of intervention |
| MA | Medicare Advantage |
| MIPAA | Medicare Improvement for Patients and Providers Act |
| MOC | Model of Care |
| MSB | Mandatory Supplemental Benefits |
| NCQA | National Committee for Quality Assurance |
| PCP | Primary care physician |
| SNP | Special Needs Plan |

CarePlus HEALTH PLANS

65

These are the acronyms used during this presentation

## References and Resources

| Refrences and Resources | Website |
|---|---|
| CarePlus Health Plans Special Needs Plan Model of Care 2022 | N/A |
| 2023 Benefits Training Manual for CarePlus Associates | N/A |
| Florida Agency for Healthcare Administration (AHCA) | www.ahca.myflorida.com |
| Florida Medicaid Web Portal | http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_%20ProviderSupport_%20ProviderHandbooks/tabId/42/Default.aspx |
| Florida Department of Children and Family Services | www.myflorida.com/accessflorida |
| The Centers for Medicare & Medicaid Services | https://www.cms.gov/ |
| CMS Medicare Managed Care Manual | (Ch. 5, Ch. 16B SNPs) Medicare Managed Care Manual (cms.gov) |
| | www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN |

66

Shown here are references cited on preceding slides.

## References and Resources

| Refrences and Resources | Website |
|---|---|
| Medicaid | www.medicaid.gov |
| Office of the assistant secretary for planning and evaluation | https://aspe.hhs.gov/ |
| Florida Health Charts | www.flhealthcharts.gov |
| Kaiser Family Foundation | www.kff.org |
| CarePlus provider information – Email: CPHP_SNPINFO@CAREPLUS-HP.COM | www.careplushealthplans.com/careplus-providers/snp |
| | http://www.careplushealthplans.com/providers |

| Additional Resources |
|---|
| Florida Medicaid program information: 1-888-419-3456 |
| CarePlus Member Services for members: 1-800-794-5907 or TTY 711 |
| CarePlus Care Management Team: 1-800-734-9592 or TTY 711 |
| CarePlus provider operations helpline: 1-866-220-5448, Monday – Friday 8 a.m. – 5 p.m. (EST) |

CarePlus HEALTH PLANS

67

This slide and the next offer resources you can access for further information about CarePlus' SNPs and model of care.

## End of Presentation

Thank you!

CarePlus HEALTH PLANS

68

**CarePlus** special needs plans are designed to improve care for members with complex needs by improving continuity of care and coordination among healthcare professionals and caregivers.
Thank you for completing this training module and for being an important part of our special needs plans. We appreciate the high-quality care you give to our special-needs members.

**After you complete this training module, a certificate of completion will be sent to the email you entered during the guest sign-in process. Please retain this certificate in your records as proof of completion.**