Regulatory Provider Training

Updated February 2025

HealthPlan OF SAN MATEO
Healthy is for everyone

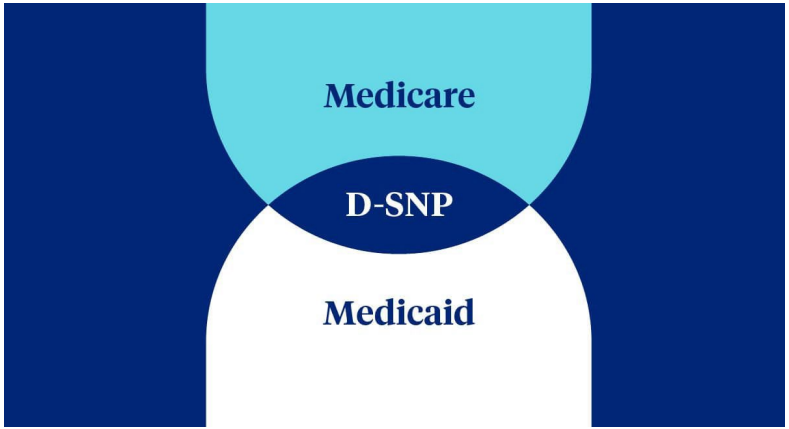
CareAdvantage Dual Special Needs Plan (D-SNP) Program

CareAdvantage D-SNP Program: Eligibility

HPSM offers a Dual-Eligible Special Needs Program (D-SNP) program for members.

Eligible beneficiaries:

- Have Medicare Part A and Part B.
- Have full-scope Medi-Cal through HPSM.
- Reside in San Mateo County.



CareAdvantage D-SNP Program: Description of Population

Dual eligible individuals often experience fragmented care and poor health outcomes due to lack of care coordination.

Social determinants of health such as housing instability, low income, lack of education and transportation, food insecurity, and poor family/social support are some of the barriers this population faces when attempting to access health care.

Dual eligibles have a higher incidence of disability, multiple chronic conditions, and behavioral health disorders.

CareAdvantage D-SNP Program: Description of Population

HealthPlan OF SAN MATEO
Healthy is for everyone

Most vulnerable D-SNP enrollees

HPSM identifies the following CICM populations as its most vulnerable D-SNP enrollees:

- Adults experiencing homelessness.
- Adults at risk for avoidable hospital or ED utilization.
- Adults with serious mental health or substance use disorder needs.
- Adults transitioning from incarceration.
- Adults living in the community at risk for LTC institutionalization.
- Adult nursing facility residents transitioning to the community.
- Adults pregnant or postpartum and subject to racial or ethnic disparities.
- Members with serious illness eligible for community-based palliative care.
- Adults with documented dementia needs.
- Members receiving or eligible for palliative care.

CareAdvantage D-SNP Program: Initial Screening and Comprehensive Assessment for Dementia

HealthPlan OF SAN MATEO
Healthy is for everyone

The following resources around comprehensive cognitive health assessment and other relevant dementia care topics may be useful to providers:

Patient Assessment Tools:

- General Practitioner assessment of Cognition (GPCOG)
- Mini-Cog

Informant tools (family members and close friends):

- Eight-item Informant Interview to Differentiate Aging and Dementia
- GPCOG
- Short Informant Questionnaire on Cognitive Decline in the Elderly

Additional resources include but are not limited to:

Dementia Care Aware Resources California Alzheimer's Disease Centers
Clinical Practice Guidelines - Alzheimer's Association

CareAdvantage D-SNP Program: Model of Care

The Centers for Medicare and Medicaid Services (CMS) requires all D-SNP plans have a model of care (MOC).

The MOC is a document that details how HPSM will provide coordinated care and case management to D-SNP members. The MOC's goals are to:

- Improve access to preventive, medical, mental health, and social services.
- Improve communication and coordination of care.
- Assure appropriate service utilization.
- Assure cost effective service delivery.
- Improve health outcomes.
- Improve quality, reduce costs, and improve the member and provider experience by coordinating service delivery that meets regulatory requirements.

CareAdvantage D-SNP Program: Core Components of Care Coordination

HealthPlan OF SAN MATEO
Healthy is for everyone

Every D-SNP member receives an initial Health Risk Assessment (HRA) and a reassessment within 365 days of the previous assessment.

The results of the HRA — along with claims, utilization management and pharmacy data — are used to develop an **Individualized Care Plan (ICP)** for every member.

The ICP is reviewed by an Interdisciplinary Care Team (ICT) which includes the member's primary care physician. The team may also include specialists and other community and ancillary providers, as relevant.

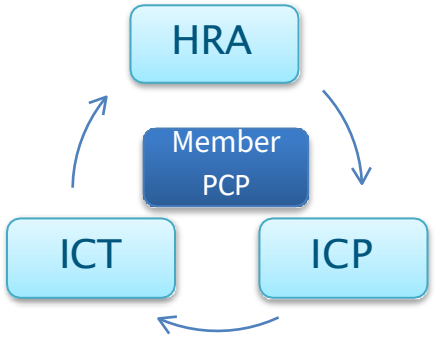
Every D-SNP member requires one face-to-face encounter per year with a contracted provider for the delivery of health care. This can be done in-person, or a visual, real-time, interactive telehealth encounter.

CareAdvantage D-SNP Program: Individualized Care Plans

HealthPlan OF SAN MATEO
Healthy is for everyone

To create an Individualized Care Plan (ICP), HPSM:

- Conducts the Health Risk Assessment (HRA).
- Creates the Individual Care Plan (ICP).
- Coordinates with the Interdisciplinary Care Team (ICT) on the development and implementation of the ICP.
- Applies member risk identification/stratification.



The outcome is an Individualized Care Plan.

CareAdvantage D-SNP Program: Individualized Care Plans (Continued)

HealthPlan OF SAN MATEO
Healthy is for everyone

More on Individualized Care Plans (ICPs):

- ICPs are developed with input from the member and the primary care provider.
- ICPs are at minimum updated annually and upon a significant change of condition.
- A copy of the ICP is mailed to every member.
- An ICP summary is communicated to the member's primary care provider.
- HPSM's Integrated Care Management team and the member's ICT contribute to the development of the ICP, monitoring of effectiveness, and modifying as needed.

CareAdvantage D-SNP Program: Provider Role in Model of Care

HealthPlan OF SAN MATEO
Healthy is for everyone

Here are tasks assigned to the provider for the D-SNP model of care:

- Actively engage in the development of member's ICP and notify HPSM's Integrated Care Management team of any changes.
- Participate in the member's Interdisciplinary Care Team (ICT) meetings.
- Review the ICP summary with the member during office visits to reinforce goals.
- Coordinate with HPSM's Integrated Care Management team on care coordination services for high risk D-SNP members as needed.

CareAdvantage D-SNP Program: Care Management Referrals and Forms

HealthPlan OF SAN MATEO
Healthy is for everyone

Any provider can refer HPSM members for Care Coordination support.

Care Coordination Provider Page:
https://www.hpsm.org/provider/care-coordination

Complex Case Management Referral Form:
https://www.hpsm.org/docs/default-source/provider-forms/complex_case_management_referral_form.pdf

Contact:
650-616-2060
carecoordinationrequests@hpsm.org

CareAdvantage D-SNP Program: Clinical Practice Guidelines and Care Transition

HealthPlan OF SAN MATEO
Healthy is for everyone

- HPSM inpatient review nurses and care coordination staff assist members with transitions between different settings of care, such as discharge from an acute care facility to a skilled nursing facility.
- The goal of the care transitions program is to ensure continuity of care, reduce hospital readmissions, and improve health outcomes for members.
- Members experiencing a care transition may be followed by the care transitions team for 30 days post-discharge to ensure a smooth transition in levels of care.
- PCPs are notified of member admission and discharges via fax within one business day of notice of event.
- HPSM reviews and approves evidenced-based clinical practice guidelines relevant to the D-SNP population. Guidelines can be accessed on the HPSM Provider Resources page: **https://www.hpsm.org/provider/resources/guidelines**

CareAdvantage D-SNP Program: Model of Care Quality Measurement

HealthPlan OF SAN MATEO
Healthy is for everyone

In compliance with Centers for Medicare & Medicaid Services (CMS) requirements, HPSM must conduct a Quality Improvement Program to monitor health outcomes and the implementation of the model of care by:

- Identifying measurable goals and collecting data to determine if goals have been met.
- Reporting on identified trends/issues requiring evaluation and/or remediation.
- Developing targeted strategies and opportunities to enhance care delivery.

CareAdvantage D-SNP Program: Model of Care Quality Measurement (Continued)

HealthPlan OF SAN MATEO
Healthy is for everyone

Performance measures include clinical and non-clinical indicators:

Clinical examples

- Health outcomes (e.g., HEDIS data).
- Chronic care (e.g., Chronic Care Improvement Program).
- Compliance with clinical practice guidelines (e.g., gaps in care reports).

Non-clinical examples

- Member access to care.
- Plan adherence to care transition protocols.
- Timely completion of Care Coordination activities (e.g., HRA, ICP, ICT).
- Generic dispensing rate for Part D medications.

CareAdvantage D-SNP Program: Performance Assessment

HPSM assesses its quality improvement plan on an annual basis, at minimum. Results are presented to the Quality Committee. If an identified goal has not been achieved the following processes are preformed to identify opportunities for improvement:

- Root cause analysis.
- Discussion with stakeholders.
- Implementation of corrective actions.
- Re-measurement.
- Development of a plan to measure and monitor.

CareAdvantage D-SNP Program: Summary

The model of care requires us to work together to enhance care and services for DSNP members through:

- Effective communication between members, physicians, providers, and HPSM staff.
- An interdisciplinary approach to managing the member's specific care needs.
- Development and implementation of a comprehensive member care plan.
- Improving transitions of care across health settings and providers.
- Identifying benefits that will best serve the D-SNP membership.
- Monitoring model of care performance and health outcomes to continually improve care and services.

Contact Information

Here is important contact information for HPSM providers:

- **General email: PSInquiries@hpsm.org**
- **General phone number: 650-616-2106**
- **Contracting: HPSMcontracting@hpsm.org**
- **Credentialing: HPSMcredentialing@hpsm.org**