Model of Care Training

SPECIAL NEEDS PLAN (SNP)
MEDICARE MEDICAID PLAN (MMP)

Coverage for every stage of life™

Learning Objectives

- List the three overall goals of the Model of Care
- Describe population characteristics and special health needs of SNP/MMP patients
- Understand components of the care plan and team based care to improve care coordination for SNP/MMP patients
- Define the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT)
- Identify three outcomes being measured to evaluate the Model of Care

Overall Goals of the Model of Care

Improve Access

- Improving access to medical and mental health and social services
- Improving access to affordable care, long-term supports and services (LTSS) and preventive health services

Improve Coordination

- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, provider and health services
- Assuring appropriate utilization of services

Improve Health Status

- Improving patient health outcomes

Model of Care (MOC) and SNP/MMP Population

What is a Model of Care?

- ✓ The Model of Care (MOC) is a quality improvement tool that ensures the unique needs of each member enrolled in a Special Needs Plan (SNP)/Medicare-Medicaid Plan (MMP) are identified and addressed
- ✓ It is Health Net's comprehensive plan for delivering our integrated care management program for members with special needs
- ✓ It promotes quality measures, care management policy and procedures and operational systems

Description of Member Population

The Model of Care outlines characteristics related to the membership that Health Net and providers serve including demographics, social factors, cognitive factors, environmental factors, living conditions and co-morbidities.

This includes:

- Description of most vulnerable population
- Determining and tracking eligibility
- Specially tailored services for members
- How Health Net works with community partners

MOC – Health Net SNPs

Health Net has two types of SNPs:

- D-SNPs for patients that are dually eligible for Medicare and Medicaid known as the Amber SNPs
- C-SNP for patients with chronic and disabling disorders known as the Jade SNP - one or more of the following chronic diseases is required depending on the specific plan:
  - Diabetes
  - Chronic Heart Failure
  - Cardiovascular Disorders:
    - Cardiac Arrhythmias
    - Coronary Artery Disease
    - Peripheral Vascular Disease
    - Chronic Venous Thromboembolic Disorder

MOC – Health Net MMP

Health Net has a Medicare-Medicaid Plan (MMP) referred to as Cal MediConnect (CMC).

- The MMP is a “demonstration plan” that combines Medicare and Medicaid. It’s a three-way contract between CMS, Medicaid and Health Net as defined in Section 2602 of the Affordable Care Act.
- The goal of an MMP plan is to improve quality, reduce costs and improve the patient experience. This is accomplished by:
  - Ensuring dually eligible patients have full access to the services they are entitled
  - Improving coordination between the federal government and state requirements
  - Developing innovative care coordination and integration models
  - Eliminating financial misalignments that lead to poor quality and cost shifting
- MMPs follow a team based MOC, however, individual States may establish additional regulations and requirements for MMPs

MOC – Vulnerable Sub-Populations

Health Net

Populations at greatest risk are identified in order to direct resources towards those with increased need for care management services:

- **Complex and multiple chronic conditions** – patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems
- **Disabled** – patients unable to perform key functional activities (walking, eating, toileting) independently such as those with amputation and/or blindness due to diabetes
- **Frail** – may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF
- **Dementia** – patients at risk due to moderate/severe memory loss or forgetfulness
- **End-of-life** – patients with terminal diagnosis such as end-stage cancers, heart or lung disease

MOC – Benefits to Meet Specialized Needs

- **Population Health Management** – whole person approach to wellness with comprehensive online and written health educational and materials
- **Medication Therapy Management** – a pharmacist reviews medication profile quarterly and communicates with patient and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** – the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP/MMP and region
- Additional benefits vary by region and type of SNP/MMP but may include **Dental, Vision, Podiatry, Gym Membership, Hearing Aides** or lower costs for items such as **Diabetic Monitoring supplies, Cardiac Rehabilitation**

MOC – Language/Communication Needs

SNP/MMP patients may have greater incidence of limited English proficiency, health literacy issues and disabilities that affect communication with negative impact on health outcomes. Services to meet these needs include;

- Office interpretation services – in-person and sign-language with minimum of 3-5 days notice
- Health Literacy – training materials and in-person training available
- Cultural Engagement – training materials and in-person training available
- Translation of vital documents
- 711 relay number for hearing impaired

Care Management (CM) and Care Coordination

Care Management & Care Manager

- **Care Management** is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the patient and their caregiver's comprehensive health needs through communication and available resources to promote patient safety, quality of care and cost-effective outcomes.
- **Care Managers** are healthcare professionals like nurses and social workers trained to meet healthcare needs by assisting the patient to navigate the healthcare system and collaborating with providers, their social support system, their community and other professionals associated with their care.

http://www.cmsa.org/who-we-are/what-is-a-case-manager/

Coordinating Care

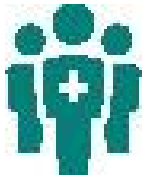
Health Net conducts care coordination using the Health Risk Assessment (HRA), an Individualized Care Plan (ICP) and providing an Interdisciplinary Care Team (ICT). Basic components of care coordination are:

HRA

CMS required assessment for every SNP member to determine member's health status including cognitive functions and SDOHs

ICP

CMS required plan for every member based on HRA results that includes health goals, barriers and interventions



ICT

CMS required team of individuals involved in the member's care either professionally or personally

TOC

Coordinating Transitions of Care (TOC) and its impacts to the member's health status determined by their HRA, their ICP and ICT

Health Risk Assessment (HRA)

An HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks of members.

- Health Net attempts to complete the initial HRA within 90 days of enrollment and annually, or if there is a change in the members condition or transition of care
- HRA responses are used to identify needs that are incorporated into the member's care plan and communicated to care team
- Members are reassessed if there is a change in health condition
- Change(s) in health condition and annual updates are used to update the care plan

Note: Physicians should encourage members to complete the HRA in order to better coordinate care and create an individual care plan.

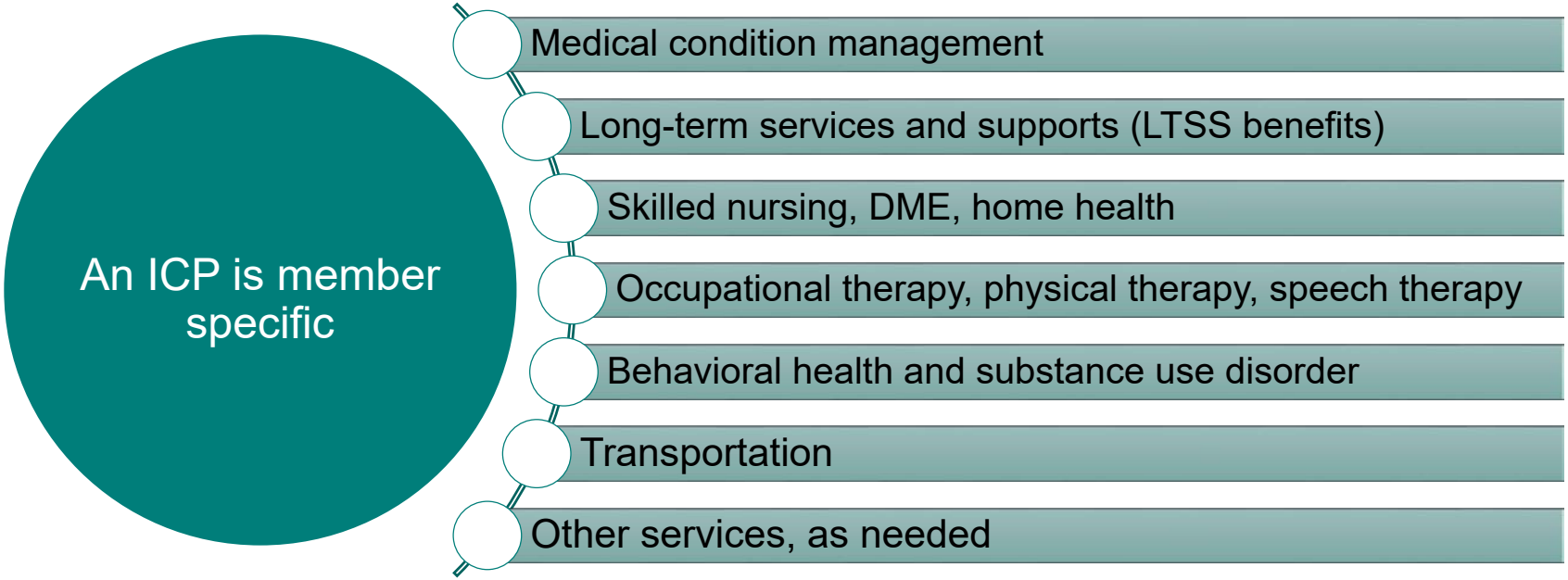
Individualized Care Plan (ICP)

An Individualized Care Plan (ICP) is developed with input from the Interdisciplinary Care Team (ICT) in collaboration with the member

Care Managers and PCPs work closely together with the member and their family to prepare, implement and evaluate the Individualized Care Plan (ICP)

Individualized Care Plan (ICP)

Members receive monitoring, service referrals and condition-specific education based on their individual needs.



ICP – Building Individualized Care Plans

Person Centered Care Plan

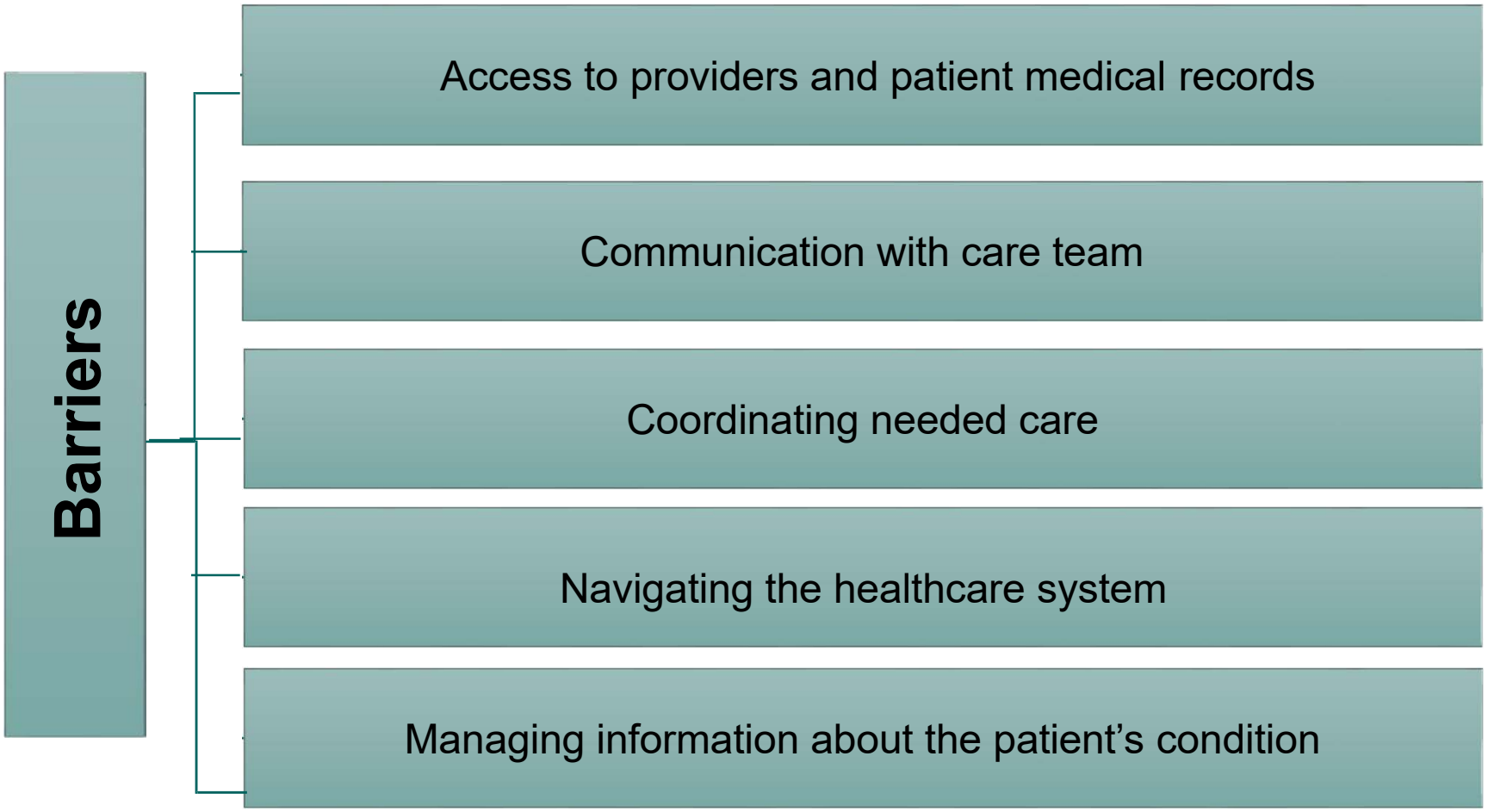
Problems	Goals	Barriers	Interventions
Communicated by the patient regarding their life, health, worries and behaviors	What the patient hopes to achieve regarding their health	Lack of transportation, finances, housing, treatment side effects	Actions to support problem resolution and support goal decrease stress

Note: ICP needs to be completed and updated by an appropriately licensed individual.

ICP – Member Centered Goals

- **Measurable** goals provide a clear description for the patient and care manager on how and when the goals have been achieved, patient behavior and improvement in health outcomes.
- Goals and outcomes reflect **patient behaviors** and responses expected as a result of nursing interventions, not the care manager's goals or interventions.
- Each goal (short term or long term) should address only **one behavior or response**. The outcome should be **measurabl**e and **evidence-based**.

ICP – Individualized Care Plan Barriers

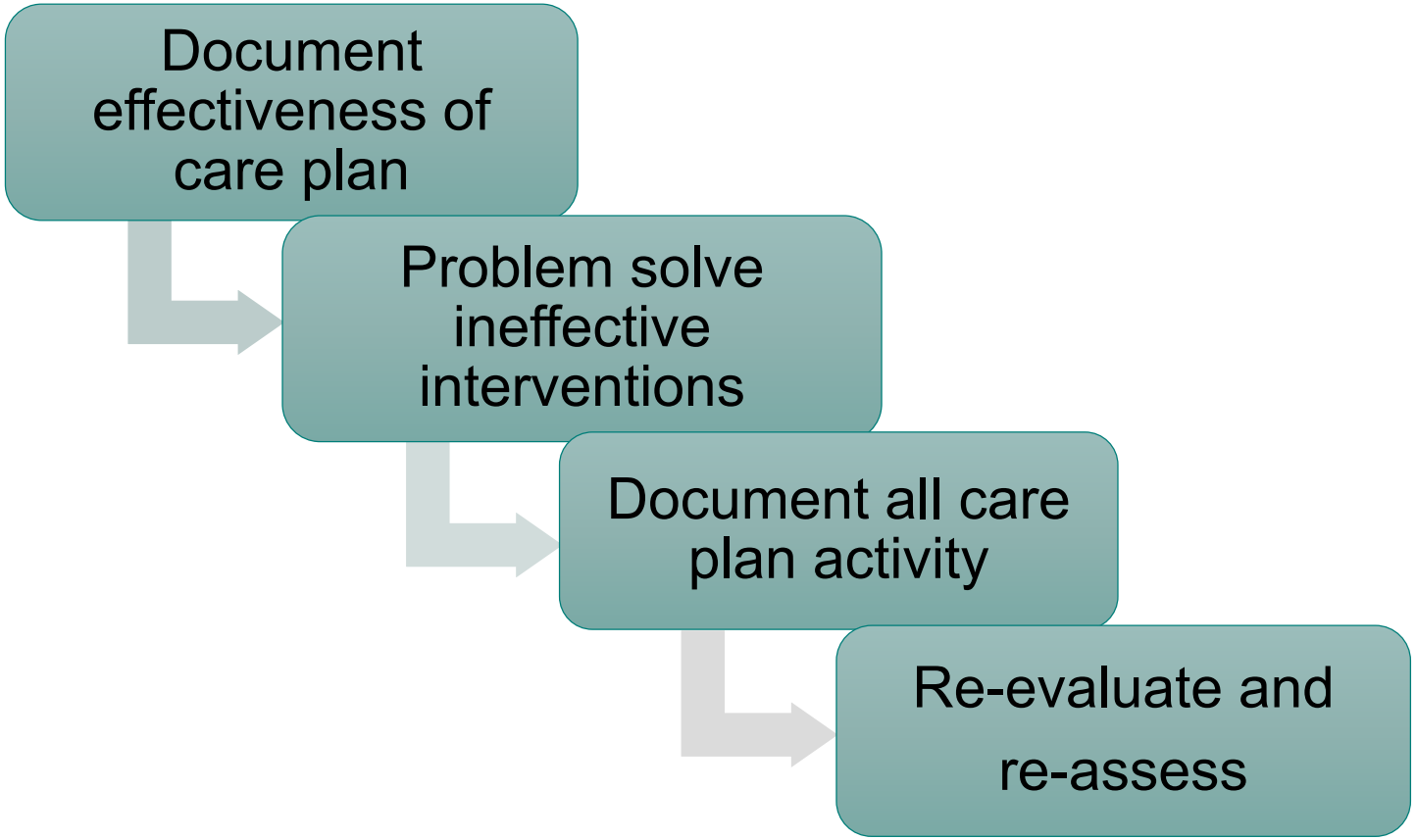


ICP – Individualized Care Plan Interventions

An intervention is an action to help the patient achieve their goals (including overcoming barriers)

ICP – Monitoring the Care Plan

The care plan is an active, dynamic document.

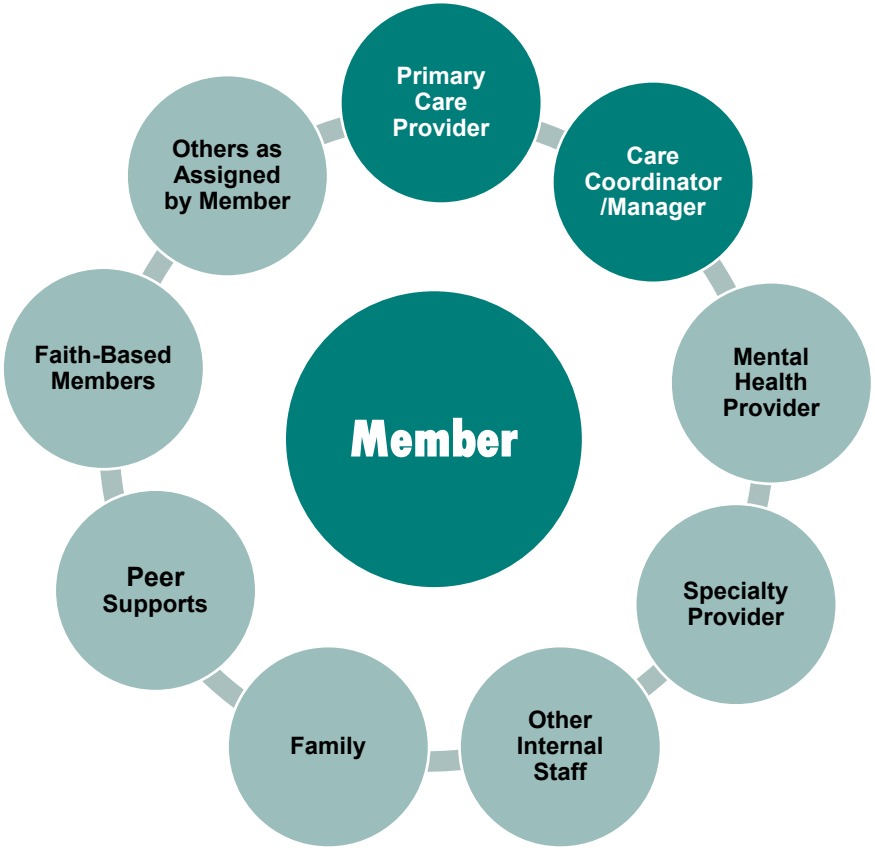


Interdisciplinary Care Team (ICT)

Care Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) and operate as the single point-of-contact for all ICT members

The ICT is designed to provide the expertise needed to manage the member's care. The PCP, member/caregiver and the Care Manager make up the core members of the ICT

Staff works with members of the ICT in coordinating the plan of care with the member and to encourage self-management of their condition



ICT Responsibilities

Care Managers work with each member to manage the following:

- Develop their personal goals and interventions for improving their health outcomes
- Monitor implementation and barriers to compliance with the physician's plan of care
- Coordinate care and services between the member's Medicare and Medicaid benefits
- Educate members about their health conditions and medications and empower them to make good healthcare decisions

ICT Responsibilities Providers

- Communicate with, and respond to communication from the plan regarding the member's care, including accepting meeting invitations when applicable
- Maintaining copies of the ICP and transition of care notifications in the member's medical record when received
- Collaborating and actively communicating with the following:
  - Care Managers
  - Members of the Interdisciplinary Care Team (ICT)
  - Members and caregivers

ICT Communications

Members of the ICT engage in discussions related to the member's health status and care coordination activities through a variety of methods:


Telephone


General mail


Secure e-mail


Fax


In person


Member apps


Member/Provider Portals


Virtual/ Teleconference Meetings


Other methods preferred by member/provider

Transition of Care (TOC)

Patients are at risk of adverse outcomes when transitioning between settings (hospital, nursing home, rehabilitation center, outpatient surgery centers or home health).

Managing TOC interventions for all discharged members may include, but is not limited to, the following:

Face-to-face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan

In-home visits or phone call within 72 hours post discharge to evaluate member's understanding of their discharge plan, medication plan if applicable, ensure follow-up appointments have been made, and make certain the home supports the discharge plan

Ongoing education of members to include preventive health strategies in order to maintain care in the least restrictive setting possible for their health care needs

Quality Improvement (QI)

QI – Quality Improvement Program

Health Plans offering a SNP/MMP must conduct a Quality Improvement program to monitor health outcomes and implementation of the Model of Care by:

- Identifying and defining measurable Model of Care goals and collecting data to evaluate annually if measurable goals are met from multiple domains of care
- Collecting SNP/MMP specific HEDIS® measures
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness
- Communicating Model of Care outcomes to stakeholders

QI – HEDIS® Measures

Data is collected, analyzed and evaluated at the SNP and MMP level to monitor performance. Measure examples:

- Colorectal Cancer Screening
- Spirometry Testing for COPD Pharmacotherapy
- Management of COPD Exacerbations
- Controlling High Blood Pressure
- Persistence of Beta-Blockers after Heart Attack
- Osteoporosis Management Older Women with Fracture
- Transitions of Care

- Breast Cancer Screening
- Implement Care Plan
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental illness
- Potentially Harmful Drug Disease Interactions
- Use of High Risk Medications in the Elderly
- Care for Older Adults

Training Requirements and Frequently Asked Questions

Staff Training

- Requirements are based on the SNP/MMP Model of Care guidelines
- All care managers and current or potential members of the ICT MUST be trained on the Model of Care upon hire and annually thereafter (MOC Element C, 42 CFR 422.101)
- All training MUST be documented

Frequently Asked Questions

1. Can an RN sign off on an ICP created by a LVN?

No. An RN cannot simply sign off on an ICP create by a LVN. If an ICP is drafted by an LVN, the RN must review and analyze the content of the ICP to validate that it aligns with the patient's needs and is clinically accurate. To demonstrate this level of oversight by an RN there must be documented evidence within the care plan of the RN's review, edits, and updates. Adding an RN's name to the ICP file is not sufficient evidence of oversight.

2. What do we do with a new HRA?

When a new HRA is received for an existing member, the member's ICP should be reviewed to ensure alignment with the details in the HRA. For new members, the HRA should be used as an input in the creation of the ICP. These two documents need to align.

3. Is it a requirement to review data as part of the Care Management process?

Yes. Claims and other available information (medical, pharmacy, etc.) should be reviewed as an input to your care management activities. These reviews must be documented in the file.

4. What should we do if we are unable to reach a member?

In addition to completing all of the care management requirements on behalf of a member that is unable to reach, you must also make attempts to find additional contact information (and document these attempts). Every attempt to reach the member, or find new information on the member, should be documented.

Frequently Asked Questions

Health Net

5 Do members under hospice care need an ICP?

Yes. According to CMS guidelines, as long as the member remains enrolled with the plan, they are to receive all of the benefits not covered by hospice care. The care management process and all requirements are still applicable until the member disenrolls from the plan.

6 Who should receive a copy of the completed ICP?

The member and ICT members should receive a copy of the ICP. Documented evidence of mailing must be stored in the case file.

7 What are the reading level requirements for documents provided to the member?

The SNP program requires all documents to be no higher than 8th grade reading level. The CMC program requires all documents to be no higher than 6th grade reading level.

8 What should be included in the ICT meeting documentation?

ICT meetings, like any meeting, should include detailed documentation on all aspects of the ICT meeting including, but not limited to:

- Date and time of dissemination of meeting invitation and response by invitees (accepted, declined, no response).
- Names and status of all invitees (present/absent).
- Detailed evidence of the discussion, not just the information shared with the ICT.
- Recommendations and decisions, including updates to care plan, should be clearly documented.

Frequently Asked Questions

9 <u>As a provider group, when we receive a new SNP or CMC member, what are the timeliness requirements for ICP completion?</u>

The expectation is that an ICP is completed within 90 days of enrollment with Health Net regardless of whether the HRA has been received or not.

For a member that transfers from one PPG to another, the ICP requirement is based on the date of the last ICP. The clock **does not** restart if a member moves to a new PPG.

The ICP needs to be reviewed and updated as needed within 12 months of the previous ICP no matter who completed it.

MMP Specific FAQs

ICP related FAQs

#	Questions	Answers
1	What if outreach or ICP completion occurred after the 90th day/3rd month of enrollment?	All care management activity should be reported in the CM Log
2	How can I get weekly enrollment activity (new members, disenrolled members, PPG or PCP Changes, etc.)?	Please contact your HN Provider Network Director and request weekly activity reports for your PPG
3	What if the member joined my PPG beginning on their 3rd month (Ex member original start date was 4/1/20 but joined current PPG as of 6/1/20)???	The PPG assigned as of the members 90th day/last day of 3rd month is responsible for all ICP outreach and completion. The assigned PPG should ensure all 3 attempts are made by the 90th day/last day of 3rd month from the enrollment date into CMC. The current PPG will get credit for the work completed previously. The member will need to sign a release to be shared with the legacy PPG to receive the previous ICP Activity If their PCP is with both the old and new PPG, the PCP should have received the copy of the ICP and can share with you as well.
4	If an HRA is available, do I need to use it in the ICP?	Yes, if an HRA is available on the HN Provider Portal you must incorporate (documenting the review and any impacts to the ICP)
5	What if an HRA is NOT available?	You are still required to have an ICP. Utilize all other available information to build the care goals [E.g., member risk level (high or low) as reported on the CM Log from HN, historical claims available on the provider portal]
6	Do I need an HRA to be completed to start my ICP outreach?	No, HRAs do not need to be completed prior to an ICP outreach or completion date
7	What if the Care Manager spoke with the member within the 1st 90 days/3 months but the member wants to complete the care plan/discussion AFTER the 90th day/last day of 3rd month?	The member should be reported as a “Able to Connect with Member- Refused CM” dated the day the member refused to do it at that time. Please complete the Care Plan and have the discussion when the member is able/willing to complete it. SEE ALSO CMS FAQ #8 scenario 2
8	Do all Members need an ICP regardless of if member was reached or not?	Yes, all members should have an ICP document regardless of the outcomes of the ICP outreach within 1st 3 months of enrollment with the plan
9	What happens if outreach or care management activity occurs outside of the initial ICP period?	All care management activity should be reported in the CM Log
10	What is the timeframe for ICP revisions/annual updates	Timeframes for updating of Care Plan to be done at least every 12 months and/or if a significant change in condition occurs (this should include the 3 outreach attempts)
11	What if the member re-enrolls after they have disenrolled previously? (with a lapse in coverage with HN)	These members should be treated as new enrollees to the plan. All outreach and ICP requirements apply. SEE ALSO CMS FAQ #4 Any data you have for the patient/member from a prior plan or enrollment period can be used as a draft/baseline.

ICP related FAQs (Continued)

#	Questions	Answers
12	What if member is in custodial care, long term care facility or skilled nursing facility?	PPGs delegated for Care Management remain responsible for the required outreach to the member or their authorized representative. Calling the facility does not count as an outreach. SEE ALSO CMS FAQ # 26 A Care Plan (by the PPG) is still required based on data available data/information. Should the member, while in the facility, agree to participate in Care Management with the PPG, the PPG CM team should proceed as usual with ongoing CM.
13	If a member (or their authorized representative) is refusing care management because of their physical location (LTC/SNF/Hospice) what do I do?	This should be documented and reported as a “refusal”/unwilling to participate with documentation reflecting as such
14	What constitutes and ICP Revision?	Only additions, changes or removal of actual care goals are considered revisions to the ICP.
15	What happens if the member was reached on 1st or 2nd attempt, and request to complete care plan discussion after the members 90th day/last day of 3rd month of enrollment?	PPGs are expected to make all 3 attempts within the timeframe, therefore even if you have a scheduled time to discuss with the member after, you still must have made 3 attempts & have them documented during the timeframe
16	If a PPG has completed a member’s outreach for the ICP and ICT meeting requirement and then receives an HRA, does the PPG have to initiate the outreach process again?	1) The care manager needs to review the HRA and incorporate the information into the member’s ICP. 2) If the ICP is revised as a result of the HRA, a care goal discussion with the member is required in order to count the revision as complete. 3) If the ICP does not require updating, there is no need to contact the member.
17	How does the HRA requirement affect the member’s annual outreach? Ex- We receive an HRA in Dec & completed an ICP revision. The member’s annual outreach is due in Feb, would we have to re-assess/re-engage the member in Feb even though we created a new ICP in December?	1) No, If an ICP is updated prior to the member's annual outreach date, the clock starts over, and outreach is not required again until a year from the most recent update or if there is a significant change in the member’s condition. 2) There is no issue if the PPG policy is to keep the annual cycle intact.

ICP related FAQs (Continued)

#	Questions	Answers
18	Does CMS (the regulator) have guidance on ICPs?	Yes- https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements
19	Do we need to send a copy of care plans to members who we are unable to contact or who decline to participate?	Guidance states a Cal MediConnect member must be provided copies of their care plan and any of its amendments. We are interpreting this to include members who decline or who we are unable to contact.
20	Do we need to send a copy to the member's PCP?	Yes, our 3-way contract and Health Net requires the care plan to be shared with the member's PCP (CMS checks for this in an audit). The date shared must be documented.
21	What is the frequency requirement for member contact per month for Complex, Moderate, and Basic Levels of Care Management?	1) For Cal MediConnect members, the frequency of outreach does not vary between the different risk levels. Frequency of outreach is dependent on the individual needs of the member and should be documented in your policies and procedures. 2) At a minimum, outreach is required within 90 days of a member's Cal MediConnect effective date to complete an ICP and then annually thereafter unless there is a significant change in the member's condition.

For questions or training on this process, please contact CalMediConnectPerformance@Centene.com

ICP related FAQs (Continued)

#	Questions	Answers
22	What does “HRA Prioritization Level” really mean on the CM Log? (Column L)	**Enrollees new to CMC who are identified as “High Risk” have HRA outreach requirements to be completed by the members 45th day of enrollment. If no HRA is available by the 46th day, proceed with ICP development without the HRA.** **Note- please refer to # 16 for updating an ICP after an HRA is completed** <u>Members are classified using the criteria below:</u> Per Duals Plan Letter 17-001: MMP must identify an enrollee as higher risk if he or she, at a minimum, meets any one of the following criteria: • Has been on oxygen within the past 90 days; • Has been hospitalized within the last 90 days, or has had three or more voluntary and/or involuntary hospitalizations within the past year; • Has had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases); • Has IHSS greater than or equal to 195 hours/month. Higher risk IHSS beneficiaries can be identified in the IHSS assessment files; • Is enrolled in MSSP; • Is receiving Community Based Adult Services; • Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant; • Has cancer and is currently being treated; • Has been prescribed anti-psychotic medication within the past 90 days; • Has been prescribed 15 or more medications in the past 90 days; or • Has other conditions as determined by the MMP, based on local resources. Beginning December 1, 2014, all new enrollees who have no historical data must be stratified as higher risk.

ICP related FAQs (Continued)

#	Questions	Answers
23	Where can I find the latest HRA completion date?	Column M on your monthly CM Log
24	How do I determine the due date of the ICP (New members only) when the outreach must be completed by?	Use the date in Column K→ "CMC Enrollment Date with Health Net" and add 3 months. Example: • 20210101 + 3 months would be due end of March 2021 • 20210301 + 3 months would be due end of May 2021 SEE ALSO CMS FAQ #3
25	How do I document CM activity on the CM Log?	Please refer to the "Data Dictionary" tab on the CM Log for instructions
26	If a member requires or is currently accessing specialized behavioral health support (including any BH or SUD Facility they may be currently admitted to), what do I do?	PPGs delegated for Care Management remain responsible for the required outreach to the member or their authorized representative. Calling the facility does not count as an outreach. SEE ALSO CMS FAQ # 26 A Care Plan (by the PPG) is still required based on data available data/information. Should the member, while in the facility, agree to participate in Care Management with the PPG, the PPG CM team should proceed as usual with ongoing CM. PPG CM is expected to coordinate/partner with Health Net's behavioral health administrator, MHN, or the county agencies, as needed.
27	If a member changes PPGs, how does the new PPG get their HRA/ICP	HRAs will be available on the Provider portal regardless of which PPG the member was/is assigned.
28	Do I need to share the member's current risk/acuity each month?	Yes
29	What if it is impossible or inappropriate to complete a care plan within the required timeframes?? For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a care plan	PPGs delegated for Care Management remain responsible for the required outreach to the member or their authorized representative. CMS FAQ #27

ICP related FAQs (Continued)

#	Questions	Answers
30	What types of outreach can be counted in the three documented outreach attempts?	Attempt to reach members via multiple modes (e.g., phone, mail, email, or in-person visits) and over various times and days of the week during the course of the member's first 90 days of enrollment. MMPs are also encouraged to work with community organizations, network providers, and other available resources to help determine accurate contact information for its members and promote member engagement through the member's trusted support networks. Plans must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, email, or in-person)- CMS FAQ #14, 24 Outreach attempts made using the same mode of outreach must be conducted on different days of the week in order to count each outreach attempt -CMA FAQ #17 NOTE: Calling anyone other than the member or their authorized representative does not count as an attempt- CMS FAQ # 26 and 28
31	If we have a member that is LA Care and we do the ICP and the member is engaged in December 2021 and then the member changes to Health Net February 2022. The member will think we are nuts making another outreach and ICP. Is there documentation we can do if the data is the same? Do we need to issue new goals and close the goals from December?	It is a pain point, but we have to report the member as a new member for our plan and complete the required outreach again. You can use the prior care plan as a base. CMS FAQ#4
32	If a provider's office refuse to accept care plans will the PPG be penalized? They change their fax numbers and refuse to share their number	PPGs as a whole are responsible and the ICP must be shared with the PCP. Send ICP via USPS mail (documenting the date sent) Additional suggestions: • Escalate to your PPG leadership • Make note in system the outcome of the outreach to the Provider Group

ICP related FAQs (Continued)

#	Questions	Answers
33	In the case that a member is selected for an audit who has changed PPGs during their enrollment period and the prior PPG is who completed the ICP/related outreach, what happens?	When members are sampled, the CMC Reporting Team will identify where the data came from and include applicable PPGs in the audits to tell the whole story about the member.
34	What if a patient stayed with the same PPG/PCP but just changes health plans (e.g., LA Care to Health Net)? Ex- If we have a member that is LA Care and we do the ICP and the member is engaged in December 2021 and then the member changes to Health Net February 2022.	Member will need to be treated as a new HN CMC Member (3 attempts in 90 days/1st 3 months). Any data you have for the patient/member from a prior plan or enrollment period can be used as a draft/baseline. Same applies if member changes plans within Health Net (ex- DSNP/other MA plan to CMC) See also #11
35	if a patient has been in the hospital and transferred to a SNF, we have to call them? Currently we wait until they are discharged and then outreach and update the ICP and do a ICT	This is more of a change in the member's condition, this would constitute a revision in their Care Plan If this process is for a brand new member, then we have to make the 3 attempts during the 90 days See also # 12 Side note- we expect coordination to occur PRIOR to a member bring discharged to their home in order to ensure they have the right supports in place as to not readmit
36	What if the member is unresponsive, no AOR and (per #12) cannot use the facility?	Attempts to the member still need to be made and documented SEE ALSO CMS FAQ # 26 and 27