Special Needs Plans (SNP) Model of Care

Annual Training Program

Presentation Overview

Presentation will cover:

- Goals of the Model of Care
- Provider Network
- Integrated Communications
- Additional Benefits
- Case Management
- Health Risk Assessments
- Individualized Care Plan
- Interdisciplinary Care Team
- Care Transitions
- Coordination of Medicare and Medicaid for D-SNPs
- Quality Improvement Program

Special Needs Plans Background

- 2003: Special Needs Plans (SNP) were created as part of the Medicare Modernization Act. Medicare Advantage plans must design special benefit packages for groups with distinct health care needs, providing extra benefits, improving care and decreasing costs for the frail and elderly through improved coordination.
- A SNP can be one of 3 types:
  - Dual Eligible SNP for members eligible for Medicare and Medicaid
  - Chronic SNP for Members with severe or disabling chronic conditions - initial and annual Attestation (that member has condition) is required from provider
  - Institutional SNP for members requiring an institutional level of care or equivalent living in the community

CCHP D-SNP

- CCHP is a Dual eligible SNP or “D-SNP”
- CCHP has one D-SNP product: Senior Select
- The SNP population is 100% Medi-Medi
- This population requires additional resources when compared to regular senior plans

D-SNPs -Coordination of Medicare and Medicaid

Goals of coordination of Medicare and Medicaid Benefits for members that are dual-eligible:

- Members informed of benefits offered by both programs
- Members informed how to maintain Medicaid eligibility
- Member access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and Medicaid claims when CCHP is contractually responsible
- Members informed of rights to pursue appeals and grievances through both programs
- Members assisted to access providers that accept Medicare
- and Medicaid

Goals of Special Needs Plans

- Improving access to medical, mental health, and social services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, providers and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving beneficiary health outcomes

SNP Model of Care Includes:

- Provider Network
- Integrated Communication Systems
- Additional Benefits
- Case Management (Care Coordination) for All Members
- Initial and Annual Health Risk Assessments
- Individualized Care Plan for Each Member
- Interdisciplinary Care Team to Coordinate Care
- Management of Care Transitions
- Coordination of Medicare And Medicaid Benefits
- Specialized Services for Chronic SNPs
- Quality Improvement Program

Member Centered Model of Care

- Member is informed of and consents to Care Coordination
- Member participates in development of the Care Plan
- Member agrees to the goals and interventions of the Care Plan
- Member either participates in the IDCT meeting through Care coordinator input

Provider Network

- CCHP maintains a comprehensive network of primary care providers and specialists to meet the health needs of chronically ill, frail and disabled SNP members
- We provide the full SNP Model of Care with team based internal Care Coordination when it is not provided by the member's primary care provider and medical group
- Currently we do not have any provider groups who assume the SNP MOC

Integrated Communications

- The Customer Call Center is staffed with associates trained to assist with enrollment, eligibility and coordination of benefit issues and questions for SNP members
- The Provider Portal securely communicates authorizations, benefit and other member related information to providers on demand
- The Member Education Programs provides member access to multiple personal and health education, and programs
- Member and Provider Communications such as member newsletters, educational outreach, Provider Updates and Provider Online news may be distributed by mail, phone, fax or online
- Nurse Advice Line 24/7

Added Benefits for SNP Members

- Medication Therapy Management – a pharmacist reviews medications quarterly and communicates with member and PCP regarding issues such as duplications, interactions, gaps in Rx, adherence issues
- Intensive Case Management – as part of Care Coordination we provide services for members experiencing catastrophic and end-of life diagnosis
- Transportation – CCHP provides 36 medically related, free trips annually
- In addition, SNP plans may have additional benefits for Dental, Vision and Zero Cost for items such as Diabetic Monitoring supplies

Care Coordination Program

- All SNP members are eligible for Care Coordination which includes the Post Discharge Program, disease and case management services
- Members may opt out of active Care Coordination but remain assigned to a Coordinator who contacts member if there is a change in status
- Members are stratified according to their risk profile to focus resources on the most vulnerable
- CCHP Care Coordinators participates in and coordinates the recommendations from the member's Interdisciplinary Care Team (IDCT)

Care Coordination Activities

- Performs an assessment of medical, psychosocial, cognitive and functional status
- Develops a comprehensive individualized care plan
- Identifies barriers to goals and strategies to address
- Provides personalized education for optimal wellness
- Encourages preventive care such as flu vaccines and mammograms
- Review of and education on medication regimen
- Promotes appropriate utilization of benefits
- Assists member to access community resources
- Assists caregiver when member is unable to participate
- Provides a single point of contact during Care Transition

Health Risk Assessment (HRA

- CCHP has recently revised our HRA (see sample) to include additional assessment questions
- A health risk assessment should be conducted on each member to identify medical, psychosocial, cognitive and functional risks
- CCHP mails the initial HRA upon enrollment and annually within 1 year of the last HRA (begins 3rd quarter 2012)
- With the revised HRA, the member's responses to HRA will be input into CareConnect for current and future care planning
- A copy of the HRA is sent to the members PCP

Individualized Care Plan

Created by the Care Coordinator with input from the Interdisciplinary Care Team. The member and/or caregiver is involved in the development of the care plan (problems, goals and interventions):

- Based on the member's assessment and identified problems
- Goals are prioritized considering member preferences and
- desired level of involvement in the Care Coordination process
- Updated when there is a change in the member's medical status or at least annually
- Shared with all the members of the care team
- Communicated when there is a transition to a new care setting such as the hospital or skilled nursing facility
- Communicated to the member or caregiver and the primary physician

Interdisciplinary Care Team (IDCT)

The IDCT may include the following:

Required:

- Medical Director, Care Coordination staff, Director of Clinical Services

Optional:

- Network providers, UM staff, Hospice or behavioral health professionals, social workers

Care Transition: Post-discharge Program

- Members are at increased risk of adverse outcomes when there is a transition from one care setting to another such as admission or discharge from a hospital, skilled nursing, rehabilitation center or home health:
- SNP members experiencing an inpatient transition are identified using the acute and SNF census
- Inpatient stays (acute, SNF, rehab) are monitored for discharge ; discharge instructions are obtained by CC staff from facility
- When the member is discharged home, the Care Coordinators
- Conduct post-discharge calls with in 24 hours of discharge to review changes to Care Plan, assist with discharge needs, review medications and encourage follow-up care with provider within 5 business day

Quality Improvement Program

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

- Collecting SNP specific HEDIS® measures
- Meeting NCQA SNP Structure and Process standards
- Conducting a Quality Improvement Project (QIP) annually that focuses on improving a clinical or service aspect that is relevant to the SNP population (for example Fall Prevention)
- Providing a Chronic Care Improvement Program (CCIP) for chronic disease that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness
- Collecting data to evaluate if SNP program goals are met

SNP HEDIS® Measures

- Colorectal Cancer Screening
- Glaucoma Screening
- Spirometry Testing for COPD
- Pharmacotherapy
- Management of COPD
- Exacerbation
- Controlling High Blood
- Pressure
- Persistence of Beta-Blockers after Heart Attack
- Osteoporosis Management Older Women with Fracture
- All Cause Readmission
- Antidepressant Medication Management
- Follow Up after Hospitalization for Mental Illness
- Annual Monitoring for Persistent Medications
- Potentially Harmful Drug Disease Interactions
- Use of High Risk Medications in Elderly
- Care for Older Adults
- Medication Reconciliation
- Post-Discharge

The End

Thank you