PROSPECT MEDICAL
Quality Service ~ Quality Care

Model of Care (MOC)

Special Needs Plan (SNP)

Learning Objectives of SNP Model of Care Training

Program participants will be able to:

- List two goals of the SNP Model of Care
- Describe member participation in the development of the individualized Care Plan and Interdisciplinary Care Team
- Define the Interdisciplinary Care Team (IDCT) and the three required disciplines
- Name two add-on benefits for members of SNP plans
- Identify two processes that improve coordination of Care Transitions
- Give three examples of data collected to evaluate SNP plans as part of the SNP Quality Improvement 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 for one of 3 distinct types of members:

- 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
- The different SNP types are commonly referred to as: C-SNP

SNP Background cont.

- CMS contracts with NCQA to evaluate SNP plans. NCQA gradually phased in 6 SNP structure and process measures and 16 HEDIS® measures for SNP plans. NCQA has evaluated SNP plans annually for their performance in the following key areas:
- SNP 1 Case Management
- SNP 2 Improving Member Satisfaction
- SNP 3 Clinical Quality Improvements
- SNP 4 Managing Transitions
- SNP 5 Institutional SNP
- SNP 6 Coordinating Medicare and Medicaid Coverage

Goals of Special Needs Plans

- Improving access to medical and 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

- Specialized Provider Network
- Integrated Communication Systems
- Additional Benefits
- Case Management for All Members
- 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 Case Management
- Member participates in development of the Care Plan
- Member agrees to the goals and interventions of the Care Plan
- Member informed of Interdisciplinary Care Team (IDCT) members and meetings
- Member either participates in the IDCT meeting or provides input through the Case Manager and is informed of the outcomes

Specialized Provider Network

- Prospect Medical maintains a comprehensive network of primary care providers and specialists to meet the health needs of chronically ill, frail and disabled SNP members
- Prospect Medical provides the full SNP Model of Care with team based internal case management when it is not provided by the member's primary care provider and medical group
- Delegated medical groups that demonstrate capability to meet the team based care requirements provide the SNP Model of Care for their members
- The Delegation Oversight team monitors that delegated medical groups meet the SNP Model of Care requirements

Integrated Communications

- Prospect Medical has integrated and extensive communication systems necessary to implement the SNP care coordination requirements:
- The **Electronic Medical Management System** integrates documentation of case management, care planning, input from the interdisciplinary team, transitions, assessments and authorizations for non-delegated members
- 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 Health Risk Assessment results and new member information to SNP delegated medical groups
- The **Member Portal** provides member access to online education, programs and the ability to create a personal health record
- **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

Added Benefits

- **Decision Power-** whole person approach to wellness with comprehensive educational and interactive health materials
- **Medication Therapy Management-** a pharmacist reviews medications quarterly and communicates with member and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Intensive Case Management-** case management services available for members experiencing catastrophic and end-of life diagnosis
- **Transportation** - number of medically related trips vary according to the specific SNP plan and region
- In addition, SNP plans may have benefits for **Dental, Vision**, **Podiatry, Gym Membership or lower costs for items such as Diabetic Monitoring supplies and Oxygen** - these benefits vary by region and type of SNP plan

Decision Power Disease Management

Prospect Medical's comprehensive disease management program focuses on the following chronic conditions:

- Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD),
- Coronary Artery Disease (CAD),
- Diabetes
- Asthma
- Musculoskeletal Pain Program

Additional components of the program can include:

- Biometric monitoring devices and reporting
- Care Alerts for members and providers when gaps in care or treatment are identified
- Preventive health reminders on the member portal
- 24/7 telephonic access to a nurse

Case Management

- All SNP members are eligible for case management and have an individualized care plan and IDCT developed. Members may opt out of active case management but remain assigned to a Case Manager who continues to contacts member especially if there is a change in status

- Members are stratified according to their risk profile to focus resources on the most vulnerable.

- Members with only a behavioral health diagnosis (drug/alcohol, schizophrenia, major depressive, bipolar/paranoid) receive case management from Prospect Medical Group.

Case Management Process

The Case Manager:

- 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

- Reviews and educates 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 Transitions

Health Risk Assessment (HRA)

- A health risk assessment should be conducted on each member to identify medical, psychosocial, cognitive and functional risks

- Prospect Medical attempts to complete the initial HRA telephonically within 90 days of enrollment and annually within 1 year of the last HRA

- Multiple attempts are made to contact the member and the survey is mailed if unable to reach them telephonically

- The member's responses to the HRA are incorporated into the member's care plan and communicated to the provider via provider portal or by mail

Individualized Care Plan

Created for each member by the Case Manager with input from the Interdisciplinary Care Team. The member and/or caregiver is involved in and agrees with the care plan and goals:

- Based on the member's assessment and identified problems
- Goals are prioritized considering member preferences and desired level of involvement in the case management 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 and the primary physician

Management of Care Transitions

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 or at-risk of an inpatient transition are identified (pre-authorization, facility notification, surveillance)
- Inpatient stays (acute, SNF, rehab) are monitored including the establishment of the Care Plan by the physician in 1 business day of admission
- When the member is discharged home, the Case Manager conducts post-discharge calls in 2 business days of notification to review changes to Care Plan, assist with discharge needs, review medications and encourage follow-up care with provider

D-SNP-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 Prospect Medical 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

C-SNPs - Diabetes

In addition to a Provider Network with practitioners and specialists skilled in managing diabetics, the program has available:

- Comprehensive diabetic education and disease management.
- Interactive programs for healthy activity and weight control.
- Additional benefits: zero cost for Diabetic monitoring supplies, low cost Podiatrist visits, gym membership (vary by plan).
- Clinical Practice Guidelines for diabetes and other chronic diseases located on the Provider Portal.

C-SNPs – Chronic Heart Failure and Cardiovascular Disease

In addition to a Provider Network with practitioners and specialists skilled in managing members with Cardiovascular Disease, the program has available:

Disease Management to assist members to manage their Cardiovascular disease including Chronic Heart Failure.

Additional benefits: zero cost cardiac rehab services, gym membership (vary by plan).

Clinical Practice Guidelines for Chronic Heart Failure located on the Provider Portal.

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 (Preventing Readmissions)
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness
- Collecting data to evaluate annually 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
- Board Certification

Data Collection

Each domain of care is evaluated to identify areas for improvement and if program goals have been met:

- Health Outcomes
- Implementation Of Care Plan
- Access To Care
- Provider Network
- Improved Health Status
- Continuum Of Care
- Implementation Of MOC
- Delivery Of Extra Services
- Health Risk Assessment
- Integrated Communications

References

- NCQA SNP Standards @ www.ncqa.org under Programs >Other>Special Needs Plans
- Chapter 16b Special Needs Plans of the Medicare Managed Care Manual
- www.cms.gov/SpecialNeedsPlans
- Title 42, Part 422, Subpart D,422.152