Special Needs Plan (SNP)
Model of Care Annual Training

Effective January 2022

TheHealthPlan
healthplan.org

1110 Main Street, Wheeling, WV 26003

What is a SNP?

A Special Needs Plan (SNP) is a type of Medicare Advantage (SecureCare) plan targeting "special populations" with special needs within the overall Medicare population.

Types of SNPs

There are three types of Medicare SNPs:

- Individuals with dual eligibility for Medicare and Medicaid benefits and services
- Individuals with chronic conditions
- Individuals who are institutionalized or eligible for nursing home care

Since January 1, 2014, The Health Plan (THP) has offered a Special Needs Plan for the dual-eligible population in our regions.

Member Characteristics

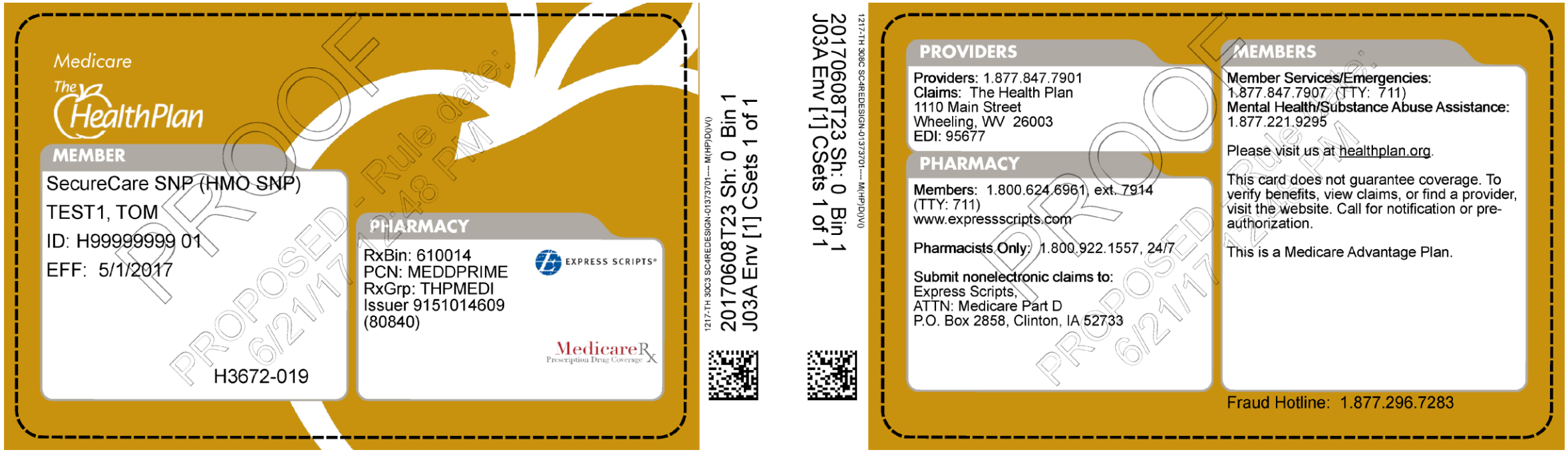
Often a very vulnerable population

- Complex or multiple medical issues
- Serious mental illness
- Frail and elderly
- Disabled
- Near end-of-life

Often have socioeconomic needs

- May not have transportation
- May not have access to healthy food
- May not be able to afford adequate housing or utilities

Sample D-SNP ID Card



Coordination of Medicare and Medicaid

Members have benefits under both programs

- THP's Medicare Advantage Program (SecureCare) is primary coverage and is billed first for services covered under the program.
- State Medicaid is billed for amounts not paid by THP (i.e., co-insurances, deductibles, etc.) and for services covered by Medicaid that are not covered under the Medicare Advantage Plan when the member has FULL benefits under Medicaid.
- In most cases, the member has $0 responsibility.

Members have right to pursue appeals and grievances through both programs

- THP will assist with this process.

Coordination of Medicare and Medicaid

Services should be coordinated so that the member obtains the maximum benefits of their dual coverage.

THP will assist with access to providers that accept Medicare and Medicaid.

THP will assist with access to staff who are knowledgeable in both programs.

THP will ensure members are informed of requirements to maintain Medicaid eligibility.

Non-Discrimination Reminder

It is discrimination for a health care provider to refuse to serve enrollees due to receiving assistance with Medicare cost-sharing from a State Medicaid program.

SNP Benefits

Medicare Advantage

All covered Medicare services paid by the plan applying Medicare deductible and co-insurance amounts.

Additional Benefits

- Preventive dental care
- Supplemental hearing exam and hearing aids
- Vision services
- Wellness education services
- Routine transportation
- Life Alert Systems
- Home delivered meals after surgery or hospitalization
- Coordination with Social Needs

State Medicaid

Medicare deductible and co-insurance amounts for all covered Medicare services covered by WV or OH Medicaid. Medicaid Benefits (as set forth in state benefit documents and dependent upon Medicaid qualification):

- Private duty nursing
- Nursing care facility, long-term home and community care
- Hospice
- Dental*
- Vision services*
- Personal care services

**Limited Benefits*

Additional Benefit Details

In addition to 2022 medical benefits, members have additional coverage available:

- Hearing Aids: $2,000/two year plan coverage and free routine hearing exams through the plan's administrator.
- Dental: $3,000/year for preventative and comprehensive dental services provided through the plan's administrator.
- Vision: Free eye exam/year and $200 toward routine eyewear provided through the plan's administrator.
- Transportation: assistance for health-related locations up to 35 round trips OR $1,000/year
- Wellness programs: smoking cessation and fitness (Silver Sneakers is covered)
- Over the counter items: $185 every 3 months (quarterly) through Convey. Unused OTC amounts do not roll over from quarter to quarter or to the next calendar year.
- Diabetic monitoring supplies and nebulizer medications are covered
- Delivered meals following surgery or inpatient hospital stays through the plan's administrator.
- Personal emergency response system through the plan's administrator.

What is the SNP Model of Care?

The SNP Model of Care (MOC) is the plan for delivering comprehensive case management services for Medicare Advantage members with special needs.

It incorporates a comprehensive approach of managing and coordinating the care and services to enhance access, improve quality of care and ensure continuity of all services.

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Model of Care (MOC) Elements

Model of Care Elements

1. Description of the SNP population
2. Care coordination for medical, behavioral and social determinants of health
3. Access to THP's provider network with specialized expertise in medical and behavioral health.
4. Quality measurement and performance improvement

SNP Benefits

Dual-eligible throughout WV and eastern OH demographics (based on previous THP Medicare Advantage statistics)

- Average age for Medicare population (no DSNP) in 2021 was 77
- Average age in 2021 for DSNP population was 62
- Proportionally lower average age when compared to THP's overall Medicare enrollment due to the percentage of enrollee disability status
- DSNP enrollees are 59.89% female and 40.11% male.
- DSNP enrollees average medical Risk Score is 4.64 compared to 3.00 in the other Medicare population. Behavioral Health Risk Score average is 5.01compared to 1.22 in the other Medicare population
- 60.5% percent of the DSNP population's health category is chronic - at risk with chronic conditions
- The top 5 chronic conditions are:
  - Diabetes
  - Chronic obstructive pulmonary disease (COPD)
  - Low back pain
  - Joint degeneration/inflammation
  - Psychotic/schizophrenic disorders

Goals

Improve Transitions of Care

- Communication between providers
- Assistance in transition to care settings (home, hospital, etc.)
- Avoidance of readmission and/or ER

Improve Access to Services

- Preventive health both general & patient specific
- Provider accessibility– primary and specialists
- Community resources both clinical and non-clinical
- Health departments, rural clinics, home care, senior centers, food, transportation, housing

Improve Outcomes

- Reduce admissions and re-admissions
- Improve perceived health status
- Medication adherence and safety

All goals are measured for performance through reporting, monitoring, and surveys of membership.

Staff Structure and Care Management Role

THP recognizes the needs of the SNP population and provides the appropriate staff to perform various functions.

Clinical Services staff includes:

- **Physicians:** full-time medical directors, consultant reviewers
- **Nurses:** RN and LPN care managers with broad clinical backgrounds, providing care coordination, disease management, utilization review, quality improvement
- **Social Workers:** on-site and in the community
- **Behavioral Health Specialists:** nurses, counselor/clinical psychologist, consultant reviewers
- **Administrative Staff:** member advocates, appeals coordinators, customer service representatives

Interdisciplinary Care Team (ICT)

Each member, based on his/her specific needs, is assigned to a team responsible for determining the appropriate plan of care to assure that the medical, functional, cognitive and psychosocial needs of the member are considered.

Role of ICT:

- Establish care plan for the member
- Meet periodically to evaluate care plan progress
  - Keep minutes and provide feedback making sure key care providers are aware, and supportive, of plan of care
- Modify and distribute care plan to the member and providers
  - Changes in status
  - Transitions in care

Interdisciplinary Care Team (ICT)

Required Team Members

- Member, if able and willing to participate, and/or designated caregivers or advocates
- Primary care physician and/or specialist provider involved in day-to-day care needs
- Care manager (THP staff)

Optional Team Members

- Pharmacist
- Social Worker
- Behavioral health nurse/LPCC/clinical psychologist
- Disease management/perinatal nurse
- Home care provider
- Others, as appropriate to the member's needs

Provider Network

- All major specialties and services represented on THP's network of participating practitioners/providers
- Secondary care providers identified to meet specific needs of members requiring direct and ongoing specialty care
  - Nephrology
  - Cardiology
  - Psychiatry
- Others, as appropriate to member
- Community care provider identification
- Service entities to meet other needs (personal care, meals, daycare, etc.)
- Home care providers
- Transportation (THP's transportation team will work with a vendor platform to assist)
- Provider website reference
- Access to clinical information on member for coordination of care delivery between providers and plan

Model of Care Training

Annual Training

- In Network/Out of Network providers
- THP staff and contracted staff

Training Methods

- Seminars
- Web-based
- On-site at provider offices
- Provider manual with training materials for reference

Components of Training

- Model of Care elements
- Plan processes and procedures
- THP tools and resources

Health Risk Assessment (HRA)

- The HRA tool is comprehensive and assesses the enrollee's physical, medical, functional and cognitive status, and social determinants of health
- The HRA is completed through a mailed version, telephonically, or with the assistance of a vendor within 90 days of enrollment and then annually within one year of the last HRA
- The member's responses to the HRA are incorporated into the care plan and communicated to the PCP and/or specialist
- The HRA tool is useful in measuring changes in status over time and provides recommendations for the care plan

Individualized Care Plan (ICP)

An ICP is a document created for each member by the care manager, with input from the ICT, to communicate the member's care needs, goals and interventions.

Review information to identify problems and needs

- Health risk assessment results
- Claims data or history
- Clinical Information from provider or member
- Complex clinical assessment (where appropriate) completed by a care manager

Develop care plan to address problems and needs

- Goals prioritized and coordinated with member and providers
- Interventions to meet identified needs
- ICP shared with care team and member

Evaluate and update plan to meet changes in status

- Updated based on:
  - Care transitions
  - Clinical changes
  - Annual evaluation

Communication Network

Integrated communications ensure constant and efficient communications between the member, providers and THP.

THP's integrated case management system houses all facets of the member care, supports scheduling of communication and outreach and is key to the SNP program, including:

- Generating letters and documenting mailings and fax correspondence
- Performing assessments, generating and completing care plans and ICT meetings
- Serving as a holistic electronic medical record
- Documenting clinical reviews, discussions, education and utilization
- Documenting referral notes of social workers, behavioral health specialists, and/or pharmacy staff
- Providing information on transitions of care

Care Management of the Most Vulnerable Subpopulation

All major vulnerable subpopulations are defined as members:

- With multiple chronic conditions
- With social determinant of health (SDoH) disparities
- That are frail and elderly
- Over the age of 85
- Blind or disabled
- Near the end-of-life

Members are identified though reporting and clinical analytics by:

- Diagnoses (multiple comorbidities and/or complex diagnosis)
- Rising clinical risk scores
- Readmissions or risk for readmission
- High-cost/segmentation reports
- Health risk assessment responses
- Behavioral health diagnosis/dual diagnosis
- Referrals from members, caregivers, physicians, social agencies and other areas of medical management

Performance and Health Outcomes

Process Measures

- Timeliness of assessment and reassessment process
- Physician relationship (percent of populations with PCP or medical home relationship)
- Care meetings
- Care/case management performance

Care Measures

- Utilization patterns
- Medication adherence
- Drug interactions
- Readmissions

Quality Measures

- HEDIS®
- Quality of care concerns
- Member satisfaction

How Case Management Can Help Providers

- Manage the transition of care process
- Identify problems and anticipate potential crises
- Help coordinate Medicare/Medicaid benefits for members
- Reinforce the providers' care:
  - Ensure medications are obtained and taken appropriately
  - Encourage members to follow their physician's plan of care
  - Encourage appropriate follow-up with providers
  - Ensure understanding of provider's instructions
  - Obtain community resources for non-medical needs
- When possible, prevent unplanned transitions and/or adverse outcomes

Role of the Provider

- **Provide or arrange medically-necessary care**
- **Encourage members to participate in the care process through:**
  - HRA completion
  - Participating in care planning
  - Communicating with provider and/or plan regarding issues
  - Practicing healthy lifestyles
- **Communicate with case managers, ICT and caregivers and collaborate on the individualized care plan (ICP):**
  - Review the plan and respond to concerns
  - Attend care plan meetings when possible (CPT: 99366, 99367, 99368)
- **Review and respond to patient concerns and questions**
- **Ensure that necessary information is in the medical record**
  - Medical history
  - Treatment, consultation and diagnostic reports
  - ICP
  - Contact with the member

Attestation Required

CMS requires annual attestation of training from providers of care for D-SNP members

- Access THP's D-SNP Attestation Form located on the provider website: myplan.healthplan.org under "Resource Library," "Training and Education"
- Providers may also contact the practice management consultant (PMC) assigned to their county.
  - A map of the PMC territories and contact information is located on THP's public website: healthplan.org "For Providers," "Overview," "Meet the Provider Servicing Team"

Contact Information

Medical Department – D-SNP Unit

1.877.847.7907