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Benefit Options

Special Needs Plan Model of Care Training

What is a Special Needs Plan (SNP)?

A SNP is a Medicare Advantage coordinated care plan (CCP) that is specifically designed to provide targeted care and limit enrollment to individuals with special needs.

What are the Types of Special Needs Plans (SNPs)?

- √ **Dual Special Needs Plan (D-SNP)** – Members who are eligible for both Medicare and Medicaid
- √ **Chronic Special Needs Plan (C-SNP)** – Members with specific, severe, or disabling chronic conditions
- √ **Institutional Special Needs Plan (I-SNP)** – Members who live in institutions such as nursing homes

The health plan currently offers D-SNPs and C-SNPs in multiple states across the nation.

What is a Model of Care?

As provided under section 1859(f)(7) of the Social Security Act, every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.

The MOC addresses four clinical and non-clinical elements:

- Description of the SNP population
- Care coordination
- The SNP provider network
- MOC quality measurement & performance

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Care Coordination and the Care Management Program

The health plan provides essential components of care coordination to all SNP beneficiaries. Additionally, members who are classified as moderate or high priority are automatically referred into our care management program. Members who enroll in our care management program receive more frequent and scheduled care management interventions and will have an assigned care manager to serve as a primary point of contact.

Essential Care Coordination Components:

Health Risk Assessment (HRA) – An HRA is conducted to identify the health needs and risks of members. SNP members will be contacted to complete an HRA within 90 days of becoming a member, and annually thereafter. Members are assigned a priority level based on the HRA results of either Low, Moderate, or High.

Based on changes to the members health status, the priority level could change. The priority level is used to determine the intensity of care management services the member receives. The HRA results are used to develop a member-centric care plan (ICP) and identify Interdisciplinary Care Team (ICT) participants based on member preferences.

Individualized Care Plan (ICP) – Each SNP member will have an ICP that includes all required components, such as self-management goals and health objectives, interventions to meet goals and address barriers, and services tailored to the member's needs. The ICP is shared with members, caregivers, and primary care physicians. Upon receipt of the care plan, providers should do the following:

- Review and discuss the plan with the member (and caregiver if appropriate).
- Update the care plan if you think changes are needed.
- Submit updated care plan by faxing it back to the number on the care plan. If no changes are required, there is no need to fax back.

Members who do not complete an HRA will receive a care plan based on general self-management goals and/or claims data if available.

Interdisciplinary Care Team (ICT) – Each SNP member will have an interdisciplinary care team to coordinate their care that consists of, at minimum, the member and/or their caregiver(s), and primary care provider(s). For members who are enrolled in care management, a Care Manager will be assigned to the care team and will serve as a primary point of contact. The team may also include specialists, pharmacists, nurses, social workers, coordinators, and other personnel, as well as persons requested by the member. The health plan asks providers to participate in care planning and ICT activities to deliver optimal care to the SNP member.

ICT collaboration can be done through formal meetings that are scheduled, ad hoc communications verbally, written or digitally, or through sharing the ICP.

Transitions of Care (TOC) – Care transitions from one level of care to another can present possible disruptions in member care. As a member's care setting and care providers change, there is a need to ensure that care needs are coordinated and communicated. The health plan will do the following:

- Collaborate with the member, caregiver, PCP, and treating providers
- Conduct additional assessments to identify needs and barriers
- Notify PCPs on record of a member's inpatient stay.
- Pre-discharge activities including discharge planning, authorization requests, and identifying needed community supports to support the transition to home
- Post-discharge follow-up includes a transition assessment, care coordination such as appointment setting or implementing services/supports, medication reconciliation and member education

To assist with coordination of care, the plan asks that providers communicate to the next level-of-care provider any updates to treatment plans, diagnoses, test results, treatments/procedures performed, discharge instructions, and a current medication list.

Essential Care Coordination Components:

The health plan provides SNP members with services tailored to their needs which include, but are not limited to the following:

- ✓ Care coordination and complex care management
- ✓ Care transitions management
- ✓ In-home wound care
- ✓ Disease management services
- ✓ Clinical management in long term care facilities as needed
- ✓ Medication Therapy Management
- ✓ Medicare and Medicaid benefit and eligibility coordination and advocacy
- ✓ Behavioral health and substance use services
- ✓ Occupational, physical, and speech therapy

SNP Provider Network and Quality Measurement

The SNP provider network is made up of healthcare providers with specialized expertise to meet the needs of the SNP population. Collaboration of the ICT is primarily facilitated through communication of the ICP.

The health plan is required to have a Quality Improvement Program to monitor and evaluate the Model of Care performance. The health plan establishes tailored measures and health objectives tied to coordination of care and appropriate delivery of services. Information about the Quality Improvement Program and Model of Care Plan performance is posted on our member and provider websites.