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 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

MEMBER
SecureCare SNP (HMO SNP)
TEST1, TOM
ID: H99999999 01
EFF: 5/1/2017

PHARMACY
RxBin: 610014
PCN: MEDDPRIME
RxGrp: THPMEDI
Issuer 9151014609 (80840)

MEDICARE

PROVIDERS
Providers: 1.877.847.7901
Claims: The Health Plan
1110 Main Street
Wheeling, WV 26003
EDI: 95677

MEMBERS
Member Services/Emergencies:
1.877.847.7907 (TTY: 711)
Mental Health/Substance Abuse Assistance:
1.877.221.9295

PHARMACY
Members: 1.800.624.6961, ext. 7914
TTY: 711
www.expressscripts.com
Pharmacists Only: 1.800.922.1557, 24/7
Submit non-electronic claims to Express Scripts,
ATTN: Medicare Part D
P.O. Box 2858, Clinton, IA 52733

Fraud Hotline: 1.877.296.7283
Coordination of Medicare and Medicaid

Members have benefits under both programs

- The Health Plan 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 The Health Plan (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

- The Health Plan 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.

The Health Plan will assist with access to providers that accept Medicare and Medicaid. The Health Plan will assist with access to staff who are knowledgeable in both programs. The Health Plan 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

**Coordination with Social Needs**
- Comprehensive database of community programs

**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 2020 medical benefits, members have additional coverage available:

- Hearing Aids: $2,000/year plan coverage for hearing aids, both ears combined
- Dental: $3,000/year for preventative and comprehensive dental services provided through the plan’s administrator
- Vision: $0 one 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: $165 every 3 months (quarterly) through Convey. Unused amount rolls from quarter to quarter until the end of the calendar year
- Diabetic monitoring supplies and nebulizer medications are covered
The SNP Model of Care (MOC) is the plan for delivering comprehensive case management services for Medicare Advantage members with special needs. 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.
Model of Care (MOC) Elements
Model of Care Elements

1. Description of the SNP population
2. Care coordination
3. Provider network with expertise and use of clinical practice guidelines
4. Quality measurement and performance improvement
SNP Benefits

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

- 51% over 65 years old with 70% being female
- Average age in 2020 was 63 years
- Overall enrollment shows 62% female
- Proportionally more females when compared to THP’s overall Medicare Advantage enrollment
- Approximately 50% under 65 did indicate they are eligible based on disability status

- High percentage with chronic conditions
  - Vascular disease
  - Congestive heart failure
  - Chronic obstructive pulmonary disease
  - Renal failure
  - Diabetes
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—ensure providers available
• Community resource needs 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

The Health Plan 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 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
  - 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
- Social worker/member advocate
- Care manager (THP staff)
- Mental health expert, when indicated

**Optional Team Members**
- Pharmacist
- Disease management nurse
- Nutrition specialist
- 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 will work with a company to assist)
• Provider website reference
• Clinical practice guidelines for reference
• Access to information on member for coordination of care delivery between providers and plan
Model of Care Training

Annual Training
- Network providers
- THP 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 specifically geared to D-SNP members and assesses physical, medical, psychological, functional and cognitive status, and social determinants of health.
- The HRA is completed through a mailed version or telephonically 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 interdisciplinary care team, to communicate the member’s care needs and goals.

**Review information to identify problems and needs**
- Health risk assessment results
- Claims data or history
- 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
- Plans to meet identified needs
- Plan shared with members of the care team

**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 member, provider and The Health Plan.

THP’s system tracks all facets of the member care management process, supports various communication avenues and is key to SNP program, including:

- Generating letters or mailings
- Performing assessments
- Generating email correspondence and reminders both internally and externally
- Documenting clinical reviews, discussions, education and interventions
- Keeping track of psychosocial needs and member preferences
- Providing information on effectiveness of interventions
Care Management of the Most Vulnerable Subpopulation

All major Vulnerable subpopulations are defined as members:

- With multiple chronic conditions
- That are frail and elderly over the age of 85
- Blind or disabled
- Near the end-of-life

Members are identified through various reports:

- Multiple comorbidities and/or complex diagnosis
- Readmissions
- High-cost report
- Health risk assessment
- 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 process
- Physician relationship (percent of populations with PCP or medical home relationship)
- Care meetings
- Care/case management performance

**Care Measures**
- Utilization patterns
- Prescribing patterns
- Drug interactions
- Readmissions

**Quality Measures**
- HEDIS®
- Quality of care concerns
- Satisfaction surveys
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
  • Complete HRA
  • Participate in care planning
  • Communicate with provider and/or plan regarding issues
  • Encourage prevention and healthy lifestyle

• 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
  • Contacts with the member

• 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)
Attestation Required

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

- Access THP’s D-SNP Attestation Form located under Resource Library, Training and Education on the provider website: myplan.healthplan.org
- Providers may also contact the provider engagement representative assigned to your county.
  - A map of the provider engagement reps’ territories is located on THP’s public website: healthplan.org “For Providers,” “Overview,” “Meet the Provider Engagement Team”
Medical Department – D-SNP Unit

1.877.847.7907