Special Needs Plan Model of Care Training

What is a Special Needs Plan (SNP)?

An SNP is a Medicare Advantage coordinated care plan (CCP) that is limited to individuals with special needs and is specifically designed to provide targeted care to plan members.

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

Wellcare By Health Net (Health Net*) currently offers D-SNPs and C-SNPs in California.

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 Plan's care management model provides essential components of care coordination to all SNP beneficiaries. Care management programs enhance care coordination services through intense engagement and interventions. These programs also assign care managers to serve as members' primary point of contact. Care management programs are available to all members through a referral, but members classified as moderate or high priority receive an automatic referral into the care management program.

Essential care coordination components:

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

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

Individualized Care Plan (ICP) – Each SNP member will have an ICP that includes 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 the member's primary care physician (PCP). 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 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 ICT to coordinate their care that consists of, at minimum, the member, their caregiver(s), if applicable, and the member's PCP. 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 Plan asks providers to participate in care planning and ICT activities so as to deliver optimal care to each SNP member.

ICT collaboration can be done through scheduled meetings, ad hoc communications (verbal, written, or digital), or by sharing the ICP.

Face-to-Face Encounters – The Plan ensures that each member has a qualified face-to-face encounter with their PCP or a provider on the member's ICT on an annual basis, beginning within the first 12 months of enrollment. This encounter must be conducted in person or through a live virtual conference (e.g., telehealth). The purpose of this encounter is to ensure the delivery of health care, care management, or care coordination services. Clinical functions or services that may be performed during a qualified face-to-face encounter include:

- Routine and preventive care.
- Treatment for a chronic condition.
- Conducting a health assessment.
- Reviewing the member's care plan.
- Health education.
- Care coordination.

If an in-person or live virtual conference encounter cannot be conducted with the member's PCP or treating providers, the Plan's care management team should be contacted to schedule a live virtual conference with a member of the care management staff.

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Transitions of Care (TOC) – Care transitions from one level of care to another can present possible disruptions in member care. When a member's care setting and care providers change, it is essential that care needs are coordinated and communicated, and that elements of the member's ICP are transferred between settings. The Plan will do the following:

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

To assist with coordination of care, the Plan asks that current providers communicate with the provider(s) who will be conducting the next level of care for the member. This communication should include any updates to treatment plans, diagnoses, test results, treatments or procedures performed, discharge instructions, and current medication lists.

Services provided to members

The 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
- ✓ Services addressing social determinants of health needs

SNP provider network and quality measurement and performance

The SNP provider network is made up of health care 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 Plan is required to have a Quality Improvement Program to monitor and evaluate its Model of Care performance. The 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.

Contact Wellcare By Health Net Case Management team toll free at 833-340-0083 or via the provider portal.