

Special Needs Plan Model of Care

2020 Training



Agenda

Training Objective:

Educate all providers, delegated vendors, and appropriate staff on the Healthfirst Special Needs Plan (SNP) Model of Care (MOC), the goal of which is to enhance member health outcomes through the use of an integrated care delivery system.

- SNP Background
- Healthfirst SNP MOC
- How Does MOC Work?
- Care Coordination
- Quality Measurement and Performance Improvement
- Role and Responsibilities of Providers

SNP Background

What is a Special Needs Plan?

Congress created Special Needs Plan (SNP) in the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries.

What is Model of Care?

Model of Care (MOC) is the basic framework under which the SNP will identify and meet the needs of each of its enrollees.

The MOC requirements comprise the following clinical and nonclinical standards:

- Description of the SNP Population
- Care Coordination
- SNP Provider Network
- MOC Quality Measurement and Performance Improvement

SNP CLASSIFICATIONS

Chronic SNP (C-SNP) -
for individuals with **severe**
or chronic conditions

Institutional SNP (I-SNP) -
for individuals who are
institutionalized or eligible for
nursing home care

Dual Eligible SNP (D-SNP) -
for dual-eligible individuals

Healthfirst SNP Model of Care

The Healthfirst Model of Care strives to meet the specialized needs of its members and to optimize their health outcomes by using *evidence-based practices* with an *appropriate network of providers and specialists*.

Healthfirst Special Needs Plans are:

- Life Improvement Plan - KHF D-SNP
- CompleteCare Plan - D-SNP with LTC benefits

How Does MOC Work?

Healthfirst's Model of Care promotes quality care management and optimal health outcomes for members through facilitation of **access to needed resources** and **care coordination**, including:

- Coordinating care through a central point of contact—the member's PCP, in collaboration with a Healthfirst Care Manager
- Monitoring transitions through the timely coordination of care plans to ensure vulnerable SNP populations do not receive fragmented care
- Providing preventive health, medical, mental health, social services, and added-value services

Care Coordination

Healthfirst conducts **Care Coordination** to meet the targeted needs of our members by utilizing the following strategies:

- Conducting a **Health Risk Assessment (HRA)** of the individual's physical, psychosocial, and functional needs, using a tool approved by CMS and other appropriate regulatory agencies
- Developing a member's **Individualized Care Plan (ICP)** using the results of the HRA and the member's input
- Each member has an **Interdisciplinary Care Team (ICT)** that manages the member's care and meets regularly to manage the medical, cognitive, psychosocial, and functional needs of the member

Special Needs Plan

Model of Care Goals

- Improving access and affordability to medical, mental health, and social services
- Improving coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT
- Provide seamless transitions of care across all healthcare settings and providers
- Improve use of preventive health services
- Encourage appropriate utilization of services
- Improve member health outcomes

Quality Measurement and Performance Improvement

SNPs strive to continuously improve their performance.

Healthfirst monitors the effectiveness of the Model of Care through ongoing evaluation of member health outcomes. The information is reported at the bimonthly meeting of the Model of Care Committee, which reports to the Quality Improvement Committee.

Evaluation of the Model of Care Committee includes collecting, analyzing, and reporting unique data related to each of Healthfirst's Special Needs Plans.

Model of Care metrics include:

- Access to care
- Improvement in member health status through specific metrics such as HEDIS, PCP Visits, Admission & Emergency Room utilization
- Completion of comprehensive Health Risk Assessment
- Implementation of an Individualized Care Plan (ICP) for SNP beneficiaries

Role of Providers

Providers are integral in the execution of and compliance with the Model of Care elements

- Communicating with Healthfirst Case Managers, members of the ICT, caregivers, and enrollees
- Participating in the ICT
- Collaborating with Healthfirst to develop the ICP
- Maintaining the ICP in the member's record
- Empowering the member to continue the treatment established in the ICP
- Updating the ICP as the member's health status changes
- Submitting documentation in a timely manner
- Communicating the member's plan of care before and after the member transitions from one care setting to another
- Utilizing the Healthfirst evidence-based Clinical Practice Guidelines and Protocols, which are the foundation of the Care Management Program

Provider Responsibilities

What does this mean for providers?

It is important for SNP providers to understand the Healthfirst Model of Care and its goal: to enhance the medical and social health outcomes of our members.

Providers support the integrated care delivery system through:

- Active involvement with the ICT
- Collaboration with the Healthfirst case management staff to:
 - maintain and update the member's ICP
 - ensure cost-effective, appropriate care

SNP MOC Resources

What resources are available to help you participate with the SNP MOC?

- [Clinical Practice Guidelines: Healthy Resources](#)
- [Provider Alert: Model of Care](#)
- Questions?
 - Contact Provider Services, **1-888-801-1660**, Monday to Friday, 8:30am–5:30pm

Coverage is provided by Healthfirst Health Plan, Inc.

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Thank you

We value your partnership in delivering quality healthcare to our members.

Your participation is appreciated, and we look forward to working with you.