Special Needs Plan Model of Care

2024 Training

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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 that have both Medicare and Medicaid coverage

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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:

- Healthfirst Life Improvement Plan - D-SNP
- Healthfirst CompleteCare Plan - D-SNP with Long Term Care (LTC) benefits
- Healthfirst Connection Plan – D-SNP
  - This plan is only designed for people who are current members of a Healthfirst Medicaid plan

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, behavioral/mental, functional and medical 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, functional, cognitive, psychosocial, and behavioral/ mental health 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 HRA, 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 quarterly 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 and availability.
- Improvement in member health status through specific metrics such as HEDIS, PCP Visits, Admission, Emergency Room utilization and readmissions.
- Completion of comprehensive Health Risk Assessment.
- Implementation of an Individualized Care Plan (ICP) for SNP beneficiaries.
- Care coordination during transitions.
- Medication management.
- Follow-up after hospitalization for members with mental illness.
- Member/caregiver experience with the provision of care.

Role of Providers

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

- Communicating with Healthfirst Care 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
- Collaborating with Healthfirst to update 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

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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

Provider Update: Individualized Care Plan

Individualized Care Plan (ICP) report is available in the Healthfirst provider portal; a printed report will no longer be sent to provider by postal mail. This report provides actionable information about patient's perceived health. As either the patient's primary care provider (PCP) or a member of their Interdisciplinary Care Team (ICT), provider input is requested to ensure effective coordination of care.

Description of the ICP Process

- Your patient completed a Health Risk Assessment.
- Healthfirst analyzed the results and determined your patient's overall health risk.
- Healthfirst mailed a copy of the ICP report to your patient, with instructions to share the report with their PCP.

Next Steps

- To access the Healthfirst Provider Portal, go to HFproviderportal.org.
- Once logged in, find your patient's ICP report at Provider Letters > Care Plans.
- If you don't already have an account, you can create one by clicking "Create your account."
- Instructions are available in the Account Creation Guide.
- Because you're part of this member's ICT, we request your input on the plan of care. Please contact Healthfirst with any changes or recommendations at 1-888-801-1660 within 14 days from the date of this letter. If we do not hear from you, we will assume that you agree with the plan of care.
- Keep a copy of the ICP report in your patient's chart for your use and reference.
- Discuss the ICP report with the patient at their next appointment and address their identified healthcare needs.

If you have any questions about the report or feedback about this process, please contact Case Management at HFCMreferral@healthfirst.org.

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

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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.

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