

Special Needs Plans

Model of Care and Quality Improvement Program Training May 27, 2009

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CMS

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Care Management through Special Needs Plans

Special Needs Individuals

As of January 1, 2010, all SNP enrollees must qualify as:

- **Dually eligible** for Medicare and Medicaid benefits and services

or

- **Institutionalized or institutional equivalent** residing in the community

or

- Having certain CMS-approved **severe or disabling chronic conditions**

SNP Model of Care

The SNP Model of Care is the **architecture** for care management policy, procedures, and operational systems.

SNP Model of Care

Gradual **evolution** of SNP Model of Care in legislation and CMS guidance:

MMA of 2003

Established SNPs

2007 Call Letter

Established network of specialized providers, use of clinical practice guidelines, goals, staff structure and roles, & communication network

SNP Model of Care

2008 Call Letter

Established training
for providers

MIPPA of 2008

Mandated health risk
assessment, care plan,
interdisciplinary care
team for beneficiaries, &
evaluation of care
effectiveness

Model of Care Elements

- 1) Measurable Goals
- 2) Staff Structure & Care Management Roles
- 3) Interdisciplinary Care Team
- 4) Provider Network Having Special Expertise and Use of Clinical Practice Guidelines
- 5) Model of Care Training
- 6) Health Risk Assessment
- 7) Individualized Care Plan
- 8) Communication Network
- 9) Performance & Health Outcome Measurement

CMS Oversight

- MAO has a **written care management plan** that describes the model of care
- MAO documents implementation of care management plan for **CMS review** during surveillance activities and audits
- MAO complies with SNP-specific **reporting requirements**

SNP Model of Care

Goals

SNP MOC Goals

- 1) Improve **access** to medical, mental health, and social services
- 2) Improve access to **affordable** care
- 3) Improve coordination of care through an identified **point of contact**
- 4) Improve **transitions of care** across healthcare settings and providers
- 5) Improve access to **preventive** health services

SNP MOC Goals

- 6) Assure appropriate **utilization of services**
- 7) Assure **cost-effective** service delivery
- 8) Improve **beneficiary health outcomes**
 - a) Reduce hospitalizations and SNF placements
 - b) Improve self-management and independence
 - c) Improve mobility and functional status
 - d) Improve pain management
 - e) Improve quality of life as self-reported
 - f) Improve satisfaction with health status and health services

SNP MOC Goals

The written care management plan should address:

- MOC goals are written as measurable outcomes
- How the MAO will know that MOC goals are met
- What actions the MAO will take if MOC goals are not met

Staff Structure and Care Management Roles

Care Management Staff

- Plan **administrative staff** (employed or contracted)
- **Provider network** (employed or contracted)
- **Interdisciplinary care team** (employed or contracted)
- **Management staff** (employed or contracted)

Care Management Roles

CMS believes MAOs have 3 essential care management roles:

- **Administer and coordinate benefits**, plan information, and data collection and analysis
- **Manage the delivery of services and benefits**
- **Oversee** administrative and clinical performance

Administrative Roles

MAO has administrative staff (employed or contracted) to:

- 1) Process **enrollment**
- 2) Verify **eligibility** for special needs plan
- 3) Process **claims**
- 4) Process and facilitate resolution of **grievances** and provider complaints
- 5) Communicate **plan information**

Administrative Roles

- 6) Collect, analyze, report, and act on performance and health outcome data
 - Conduct quality improvement activities
 - Review and analyze utilization data
 - Survey beneficiaries and providers, and analyze results
 - Report to CMS and States

Service Delivery Roles

MAO has service delivery staff (employed or contracted) to perform care management functions:

- 1) Advocate, inform, and educate beneficiaries
- 2) Identify and facilitate access to community resources
- 3) Triage care needs
- 4) Facilitates health risk assessment
- 5) Authorize or facilitate access to services
- 6) Obtains consultation and diagnostic reports

Service Delivery Roles

MAO has service delivery staff (employed or contracted) to perform assessment, diagnosis, and treatment functions:

- 1) **Medical and mental health care** (parity)
- 2) **Social services** (community-based)
- 3) **Education** on health risks and care

Service Delivery Roles

MAO has service delivery staff (employed or contracted) to perform healthcare information management functions:

- 1) Assure **maintenance** and sharing of records and reports
- 2) Assure **HIPAA** compliance
- 3) Maintains **paper-based and/or electronic** information systems

MAO Oversight Roles

MAO has management staff (employed or contracted) to monitor care management functions:

- 1) Administrative functions
 - a) Monitor MOC implementation
 - b) Assure licensure and competency
 - c) Assure statutory/regulatory compliance
 - d) Monitor contractual services
 - e) Evaluate MOC effectiveness

MAO Oversight Roles

2) Clinical Functions

- a) Monitors interdisciplinary care team
- b) Assures timely and appropriate delivery of services
- c) Assures providers use clinical practice guidelines
- d) Assures seamless transitions and timely follow-up
- e) Conducts chart and/or pharmacy reviews

Interdisciplinary Care Team

MIPPA Mandate

- The MAO must assign **EACH beneficiary** to an interdisciplinary care team
- The MAO may design a team comprised of employed or contracted practitioners

Role of the Team

- **Analyze and incorporate** the results of the initial and annual health risk assessment into the care plan
- **Collaborate** to develop and annually update an individualized care plan for EACH beneficiary
- **Manage** the medical, cognitive, psychosocial, and functional needs of beneficiaries
- **Communicate** to coordinate care plan

Composition of the Team

The interdisciplinary care team should minimally include:

- **Medical** expert
- **Mental health** and/or **behavioral health** expert
- **Social services** expert

Composition of the Team

Other care team members **may** include:

- **Pharmacist**
- **Nursing professional**
- **Restorative therapist**
- **Nutrition specialist**
- **Medical specialist**
- **Pastoral specialist**
- **Health educator**
- **Disease management specialist**

Composition of the Team

MIPPA of 2008 mandates participation of beneficiary and/or caregiver **whenever feasible.**

- Document process for having beneficiary/caregiver on team in the care management written plan
- Document beneficiary/caregiver participation when it occurs

Provider Network Having Specialized Expertise

and

Use of Clinical Practice Guidelines

Provider Network

Network Facilities:

- Acute care facility
- Laboratory
- Radiography/imaging facility
- Long-term care facility
- Rehab facility
- Specialty outpatient clinics

Provider Network

Providers with specialized expertise:

- **Medical specialists** (cardiology, psychiatry, neurologists, surgeons, etc.)
- **Behavioral specialists** (drug counselor, clinical psychologist, etc.)
- **Nursing professionals**
- **Allied health professionals**

Provider Network

MAOs must coordinate care and assure that providers:

- Collaborate with the interdisciplinary care team
- Provide clinical consultation
- Assist with developing and updating care plans
- Provide pharmacotherapy consultation

Provider Network

CMS expects MAOs to:

- Prioritize contracting with **board-certified** providers
- Monitor network providers to assure they use nationally recognized **clinical practice guidelines** when available
- Assure that network providers are **licensed and competent** through a formal credentialing review

Provider Network

CMS expects MAOs to:

- Document the process for **linking beneficiaries to services**
- Coordinate the maintenance and **sharing of beneficiary health care information** among providers, the interdisciplinary care team, and the MAO.

Model of Care Training for Plan Personnel and Provider Network

Model of Care Training

MAOs must **conduct** and **document** training on SNP Model of Care for all employed and contracted personnel:

- **Initial** and **annual** training
- Methodology may be:
 - **Face-to-face**
 - **Interactive** (web-based, audio/video conference)
 - **Self-study** (printed materials, electronic media)

Health Risk Assessment

Health Risk Assessment

MIPPA of 2008 mandated that MAOs conduct **initial** and **annual** health risk assessments for **EACH** beneficiary.

- Assess the **medical, psychosocial, cognitive, and functional** needs of special needs individuals
- Use the results to **develop the individualized care plan**

Initial Health Risk Assessment

- Conducted within 90 days of enrollment
- Comprehensive assessment of medical, psychosocial, cognitive, and functional needs
- Includes medical and mental health history
- May be face-to-face, telephonic, electronic, or paper-based

Annual Health Risk Reassessment

- Conducted within **one year** of last health risk assessment
- **Comprehensive** reassessment of medical, psychosocial, cognitive, and functional needs
- Includes **changes in health status** since last assessment
- May be **face-to-face, telephonic, electronic, or paper-based**

Health Risk Assessment Tool

MAOs may use a health risk assessment tool that is:

- Commercial or plan-developed
- Paper-based or electronic

Health Risk Assessment Tool

MAOs should:

- Use a **standardized** tool for all beneficiaries
- Determine the **effectiveness of the tool** to identify beneficiary needs
- **Stratify the identified risks** to develop the care plan

Analysis of Risks

- Clinically knowledgeable personnel should analyze health risk assessments and reassessments, and stratify health needs for care planning.
- Results should be communicated to beneficiaries, interdisciplinary care team, and pertinent providers.

Individualized Care Plan for Each Beneficiary

Individualized Care Plan

- Developed for **each beneficiary** by the respective interdisciplinary care team
- **Involve beneficiaries and/or caregivers** whenever feasible
- Reviewed and revised **annually** or when **health status changes**

Individualized Care Plan

The individualized care plan should include:

- Goal and objectives
- Specific services and benefits to be provided
- Measurable outcomes

Individualized Care Plan

- Communicated to beneficiary, caregiver, and providers
- Maintain care plan records to assure access by all stakeholders
- Maintain records per HIPAA and professional standards

Communication Network

Communication Network

- Develop and document a **structure** for communication among plan personnel, providers, interdisciplinary care team, and beneficiaries
- May include **low or high level technology**

Communication Network

- **Develop and document a process to maintain records of communication among stakeholders that complies with HIPAA and privacy laws**
- **Monitor and evaluate the effectiveness of the communication network**

Most Vulnerable Beneficiaries

Most Vulnerable

CMS recognizes SNP beneficiaries will include **vulnerable** individuals:

- **Frail** individuals
- **Disabled** individuals
- Beneficiaries developing **end-stage renal disease** after enrollment
- Beneficiaries **near the end-of-life**
- Beneficiaries having **multiple or complex chronic conditions**

Most Vulnerable

MAOs must document in written care management plan how to:

- **Identify** their most vulnerable beneficiaries' special needs
- **Address** the needs of the most vulnerable through **add-on benefits and services**

Performance and Health Outcome Measurement

MIPPA Mandate

MIPPA mandated special requirements for SNP quality reporting:

- 1) Collect, analyze and report data to measure health outcomes and indices of quality
- 2) Evaluate the effectiveness of the care management plan to assure an evidence-based model of care

Data Collection & Analysis

MAOs document their methods to collect and analyze data:

- **Internal** quality specialists implement and evaluate a quality improvement program
- **External consultants** implement and evaluate a quality improvement program
- Data are collected and analyzed using:
 - **Electronic software**
 - **Manual techniques**

Data Collection & Analysis

MAOs must collect data on **beneficiary health outcomes** such as:

- Reduced hospitalizations and SNF placements
- Improved self-management and independence
- Improved mobility and functional status
- Improved pain management
- Improved quality of life as self-reported
- Improved satisfaction with health status and health services

Data Collection & Analysis

MAOs must collect data on **quality indices** such as:

- Improved access to medical, mental health, and social services
- Improved access to affordable care
- Improved coordination of care through a single point of care management
- Improved transition of care across settings and providers
- Improved access to preventive health services

Model of Care Evaluation

MAOs may collect data on **model of care** structure or processes such as:

- Improved service delivery through a competent provider network having specialized expertise
- Improved coordination of care through use of an individualized care plan
- Improved coordination of care through management by an interdisciplinary care team
- Improved utilization of services through identification and stratification of health risks
- Improved coordination of care through effective communication among providers, beneficiaries, and interdisciplinary care team

Performance Measurement

In the care management plan, MAOs must document:

- How they will **involve** beneficiaries, providers, and the interdisciplinary care team in performance improvement
- How they will **communicate** performance measurement results to stakeholders
- How they will **maintain records** of improvement activities

Performance Measurement

In the care management plan, MAOs must document how they will **take actions** based on results of performance measurement such as:

- Change policies or procedures
- Change staffing patterns or personnel
- Change network providers or facilities
- Change systems of operation
- Communicate results internally and externally