The Fidelis Care Special Needs Plans Model of Care

Background

Special Needs Plans (SNPs) were created by Congress 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: the institutionalized, dual-eligibles and beneficiaries with severe or disabling chronic conditions. These beneficiaries are typically older, with multiple co-morbid conditions, and thus are more challenging and costly to treat.

Model of Care

CMS requires that all SNP plans have a model of care (MOC), namely, a structure and process by which they deliver healthcare services and benefits to the special needs individuals they elect to target. CMS emphasizes that as Medicare Advantage Plans, all SNPs offer coordinated care delivered by a network of providers who have the clinical expertise to meet the target population's specialized needs, and who do not discriminate against its most vulnerable beneficiaries. The SNP MOC is designed to support service delivery for special needs individuals through eleven components. These components include:

1) Target population
2) Measurable Program Goals
3) Staff Structure and Care Management Roles
4) Interdisciplinary Care Team
5) Provider Network Having Specialized Expertise and Use of Clinical Practice Guidelines
6) Model of Care Training for Personnel and Provider Network
7) Health Risk Assessment
8) Individualized Care Plans
9) Communication Network
10) Care Management for the Most Vulnerable Subpopulation
11) Performance and Health Outcomes

The Medicare Improvements for Patients and Providers Act (MIPPA), signed into law on July 15, 2008, added new specific requirements pertaining to a SNP MOC. Beginning January 1, 2010, all SNPs must not only have an evidence-based care model with specialized providers, but must also have care management services that add the following components:

1) A comprehensive initial health risk assessment and annual reassessment of the physical, psychosocial, and functional needs of the special needs individual;
2) A care plan for each beneficiary that addresses goals and objectives, services and benefits provided, and measurable outcomes; and
3) An interdisciplinary team used in the care management of each beneficiary.

The Fidelis Care SNP

Fidelis Care has two Special Needs Programs (SNP) - both are for dual Medicare/Medicaid-eligible members. Add-on services for the most vulnerable, frail, and members at end-of-life include but are not limited to:

1) Non-emergency Transportation
2) Private Duty Nursing
3) Home Health Aide
4) Inpatient Mental Health Services
Fidelis Care SNP plan benefit packages are structured to ensure members have access to affordable, quality care. Moreover, the Fidelis Care network has been developed to provide cost-effective health services delivery in the least restrictive setting.

The Fidelis Care SNP Model of Care description, and the related policies and procedures, address the following goals:

1) Improving access to essential services such as medical, mental health, and social services
2) Improving access to affordable care;
3) Improving coordination of care through a identified point of contact;
4) Improving seamless transitions across healthcare settings, care providers, and health services.
5) Improving access to preventive health services;
6) Ensuring appropriate utilization of services; and
7) Improving beneficiary health status through improved:
   a. Independence and self-management
   b. Mobility and functional status
   c. Pain management
   d. Quality of life perception

The model of care that drives service delivery for the SNP members is comprehensive and promotes primary care. Fidelis Care, the member, and the PCP coordinate and collaborate with the interdisciplinary healthcare team to develop a plan of care that will support and sustain the member’s optimal level of wellness in the community.

The Fidelis Care SNP Model of Care includes the delivery of specialized services and benefits to special needs members who are: medically complex or have multiple chronic conditions, frail and disabled, or who are near the end of life.

**Model of Care Elements**

The regulations for this program are found in .Section 20.2.1 of the Medicare Managed Care Manual and was updated by CMS under revision 117, issued 8/8/2014, effective 8/8/2014. The Model of Care Elements include:

**The SNP Population**

**Medically Complex or Multiple Chronic Conditions**

These are members who suffer from Diabetes, COPD, CAD, CHF, CKD Stage 3 or greater and on permanent hemodialysis, HIV, Dementia, Depression, Substance Abuse, or are in active treatment for Cancer. Specific goals include:

1) Reduction in the risk of unnecessary hospitalizations and SNF admissions by providing case management to identify symptoms of conditions that require early intervention.
2) Early identification of members at risk through member or provider referrals
3) Ensuring quality, cost effective care by appropriate and proactive utilization of benefits, i.e. PCP visits and onsite assessments in the member’s home.
4) Education and care coordination related to end of life or long term planning such as advance directives, palliative care, and hospice care.
Sub-Population: Most Vulnerable Beneficiaries - The Frail and Disabled

These members, including those with limited physical and or cognitive function, require more frequent assessment to ensure support and understanding of the treatment plan. Specific goals include:

1) Assessment of the home setting for safety and ability to self manage.
2) Assessment of fatigue, cognitive, and functional status.
3) Early identification through member, family, or provider referrals.
4) Close collaboration with members, their physicians, and the interdisciplinary healthcare team to support and reinforce the member’s treatment plan, emphasizing symptom management, education, and coordination of services.
5) Ensure quality, cost effective care by appropriate and proactive utilization of benefits, i.e. PCP visits and onsite assessments in the member’s home.

End-of-Life Care

Advanced Care Planning is assessed on all members, regardless of diagnosis, cognitive, or functional status. Specific goals include:

1) Education of members and family regarding full range of options for advanced care planning including advance directives, palliative care, and hospice care.
2) Facilitation of member and family direction through conferences, counseling, and education.
3) Implementation of the member’s advance care plan and/or following the instructions of the member’s health care proxy or the designated family healthcare decision maker.
4) Implementation of palliative care services to optimize pain control and functional status.
5) Working closely with members, their physicians, and the interdisciplinary healthcare team to support and reinforce the member’s treatment plan, emphasizing symptom management, education, and coordination of services.

Care Coordination

Care coordination helps ensure that SNP beneficiaries’ healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the SNP’s provider network as well as the care coordination roles and responsibilities overseen by the beneficiaries’ caregiver(s).

Complex Case Management

The Fidelis Care Management program includes the delivery of specialized services and benefits for members who are medically complex, have multiple chronic conditions, are frail and disabled, or facing end-of-life issues. With early identification and close collaboration with the member, family and you, the Fidelis Care SNP Case Management program can support and reinforce the treatment plan, emphasize symptom management, provide education, and coordinate services. The Fidelis Care SNP Case Management Program manages the patient’s condition and co-morbidities, assesses lifestyle issues that directly and indirectly affect the patient’s ability to access care, and monitor the patient’s adherence to the medication and treatment regimen you prescribe.

Maintaining the patient in the least restrictive care setting is best and achieved through the assessment and management of the patient’s:
APPENDIX XVI

SPECIAL NEEDS PLAN

- ADL and IADL abilities,
- Cognitive function,
- Cultural needs and preferences,
- Barriers to care,
- Caregiver assistance abilities,
- Safety of the home environment,
- Self-management activities including medication administration, medical procedures, and treatment and management of equipment.

Case Management assures: Access to medical services, preventive health services, mental health services and social services; seamless transitions across healthcare settings, care providers and health services; appropriate utilization of services and benefits, continuous care across the life cycle, and reduces hospitalization and nursing home placement.

When you identify one or more of your patients who are members of the Fidelis Dual Advantage Special Needs Plan, and who are in need of the monitoring or management identified here, please contact:

Fidelis Dual Advantage SNP
Case Management Program
1-800-247-1441

1) SNP Staff Structure - Staff roles include but are not limited to administrative, clinical, and oversight roles. This includes, for example, activities such as enrollment, claims processing, care coordination, and pharmacy consultation.

2) Health Risk Assessment Tool (HRAT) - The HRA is completed within 90 days of enrollment and annually thereafter. There may be other assessments and interim assessments such as transition assessment or pain assessment as determined by the needs of the member.

3) Individualized Care Plan (ICP) - Each member received a care plan individualized to their health concerns. It includes self-management goals and objectives and personal healthcare preferences.

4) Interdisciplinary Care Team (ICT) - Expertise and capabilities of the ICT members align with the identified clinical and social needs of the SNP members. ICT members include the care manager, PCP, member and others as identified such as specialists or member caregiver. The ICT members contribute to improving the health status of SNP beneficiaries. The ICT uses healthcare outcomes to evaluate established processes to manage changes and/or adjustments to the beneficiary’s health care needs on a continuous basis.

5) Care Transitions Protocols - Protocols for members that transition between care settings provides for continuity of care. Older and disabled adults moving between different healthcare settings are particularly vulnerable to receiving fragmented and unsafe care when transitions are poorly coordinated. The member’s care plan is shared with providers and the member during these transitions which may contain updates and require care coordination activities.

SNP Provider Network

Fidelis Care ensures that members are able to select providers from a wide range of specialties and facility types by maintaining a Network of Quality Providers in compliance with CMS. All network providers are required to meet credentialing requirements and routine assessments are conducted to ensure all standards are met. Fidelis Care also conducts geo-mapping assessments of provider locations to ensure Access along with Quality of Service and Quality of Care for our members.
1) **Specialized Expertise** - Fidelis has a specialized network that maintains the appropriate licensure and competency to address the needs of the SNP population. This network includes but is not limited to, internal medicine, endocrinologist, cardiologists, oncologists and mental health specialists.

2) **Use of Clinical Practice Guidelines & Care Transitions Protocols** - Evidence-based clinical guidelines and protocols, such as Care Transitions Protocols promote the use of nationally recognized and accepted practices for providing the right care at the right time.

3) **Annual MOC Training for the Provider Network** - The Medicare Special Need Program (SNP) Model of Care Training (MOC) is provided by Fidelis Care annually and during new contract process to all network providers and also providers who regularly see our Special Needs Program (SNP) members, as required by CMS. The training describes in detail the role of providers in relation to corresponding elements of the SNP Model of Care, which is essential in order to assure the quality in delivery of the health services to the most vulnerable of populations in New York State.

**SNP Quality Reporting**

All SNPs are required to have an overall quality improvement program. MIPPA expanded the quality improvement requirements for SNPs to collect, analyze, and report data that measures health outcomes and quality indices of care management, as well as the effectiveness of their models of care. The evaluation of the SNPs includes two types of assessment, HEDIS measures, and measures that evaluate structure and process requirements through submission of documentation. (Structure and Process Measures) These measures may be variable from year to year.

**HEDIS Measurements**

Below are listed examples of some of the types of HEDIS measurements utilized in reporting for 2010.

1) Colorectal Cancer Screening  
2) Glaucoma Screening in Older Adults  
3) Pharmacotherapy of COPD Exacerbation  
4) Controlling High Blood Pressure  
5) Antidepressant Medication Management  
6) Follow-up after Hospitalization for Mental Illness  
7) The use of Spirometry Testing in the Assessment and Diagnosis of COPD  
8) Use of High Risk Medication in the Elderly

**Structure and Process Measures**

Review will focus on evidence on various Structure and Process Measures such as:

1. Complex Case Management  
2. Care Transitions  
3. Coordination of Medicare and Medicaid Benefits  
4. Improved satisfaction with health status and health services  
5. Improved coordination of care through use of an individualized care plan  
6. Improved utilization of services through identification and stratification of health risks
Fidelis Care’s Quality Healthcare Management Program

Fidelis Care’s Quality Healthcare Management Program articulates the Plan’s dedication to quality care and service to its members and providers. The program describes how Fidelis Care, working with its participating providers, monitors and evaluates the provision of appropriate and timely care for its members and takes action to improve care and service. The program measures care and service through administrative data, medical record review, surveys, and operational reports. Through its monitoring efforts and its actions, the Plan will enhance quality and service through a structure that encourages continuous internal and external quality improvement.

Fidelis Care uses data collected via HEDIS methodology for SNP-specific measures. Claims, pharmacy, provider, laboratory, encounter, surveys and medical record data are integrated to produce accurate rates. Fidelis Care also tracks member complaints and grievances, medical utilization, and care management activities of the SNP population.

Data on inpatient admissions and ER utilization is collected and tracked for members with certain chronic conditions in order to ascertain if case management efforts are able to lower the rates of each.

Summary

The Fidelis Care SNP Model of Care offers the opportunity for the Plan to work together with the provider network for the benefit of the member. Through enhanced communication, focus on special needs, and effective care management programs, we can develop a plan of care to improve the health status and quality of life of our members.