SPECIAL NEEDS PLAN (SNP) MODEL OF CARE TRAINING 2015
Introduction

This course is offered to meet the CMS regulatory requirements for Model of Care Training for our Special Needs Plan at Care Wisconsin.

It also ensures all employees and providers who work with our Special Needs Plan members have the specialized training this unique population requires.
What is a Medicare Advantage Special Needs Plan (SNP)?

- Special Needs Plans (SNPs) were created by Congress as part of the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare Advantage managed care plan focused on certain vulnerable groups of Medicare beneficiaries.

- Care Wisconsin offers a Dual-Eligible SNP (Partnership) which includes individuals who are enrolled in Medicare and eligible for Medicaid either categorically or through optional coverage groups such as medically needy or special income levels.
Partnership Program

Care Wisconsin Partnership is a Dual-Eligible Special Needs Plan (D-SNP) that fully integrates Medicare Parts A, B & D, Medicaid acute and primary, Medicaid long-term care, and Medicaid Home and Community Based Waiver services through contracts with Wisconsin Department of Health Services and the Centers for Medicare and Medicaid.

Care Wisconsin improves access to affordable care through its model of care that provides a comprehensive package of services spanning the entire continuum of care by receiving a capitated payment from Medicare and Medicaid to fund these services.

Care Wisconsin’s Partnership Program is a “zero cost share” plan with no premiums or copays.
Partnership Eligibility and Membership

- Members must live in the Care Wisconsin service area.
- Members must be eligible for Medical Assistance (Medicaid) from the state of Wisconsin.
- Members must be 18 years and older
- Members must meet a State target group of frail elder, intellectual/development disability, or physical disability
- Members must meet a nursing home level-of-care
Partnership Eligibility and Membership

• If eligible, members must have Medicare Part A and Part B
• Medicare-eligible members are enrolled in the D-SNP
• While most members in Partnership have Medicare, and are enrolled in the SNP, a small percentage are Medicaid-eligible only
Service Area

Partnership is available in the following counties in 2015.

- Sauk
- Columbia
- Dodge
- Dane
- Jefferson
Model of Care Requirements

As part of the approval process to offer the Partnership FIDE-SNP, Care Wisconsin is required to create a written Model of Care (MOC).

This MOC must be approved by CMS on a regular basis.
Model Of Care Elements

The Care Wisconsin Partnership Model of Care covers 4 key topics:

1. Description of the SNP-specific Target Population
2. Care Coordination
3. Provider Network
4. Quality Measurement & Performance Improvement
SNP-Specific Target Population

Demographics

- 84% dual-eligible and 16% non-dual eligible
- 53% adults with physical disabilities
- 35% frail elders
- 12% adults with intellectual/developmental disabilities
- 69% female and 31% male
- 58% of all members are between the ages of 55 and 85
SNP-specific Target Population

The 10 most prevalent diseases in the Partnership membership:

- Diabetes
- Renal Failure
- Drug/Alcohol Dependence
- Major Depression, Bipolar, Paranoia/Schizophrenic Disorders
- Polyneuropathy
- COPD
- Congestive Heart Failure
- Vascular Disease
- Morbid Obesity
- Angina Pectoris/Old Myocardial Infarction
Most Vulnerable Members

All members enrolled in Partnership meet a nursing home level of care, and all are low-income status. Within the entire population Care Wisconsin identifies its most vulnerable members as:

• Members with frequent hospitalizations
• Members that are end-of-life
• Members dependent on a ventilator
• Members with end-stage renal disease
• Members with severe & persistent mental illness
• Members with behavioral issues
Most Vulnerable Members

These most vulnerable members require more intense case management by the Care Wisconsin care team.

Additionally, these members typically need a high level of collaboration and coordination between Care Wisconsin, their medical providers and their informal supports.
Care Coordination: Staff Structure

The Staff Structure section of the Model of Care provides an overview of the roles and responsibilities of employed staff who perform clinical, administrative and oversight functions.

Care Wisconsin uses a staffed model that includes care management staff that provide outreach to members to perform health risk assessments, develop individualized member care plans, and facilitate care transition activities.

Additional roles pertinent to the Model of Care include enrollment and eligibility staff, provider services staff, quality improvement staff, and clinical and administrative oversight positions.
Care Coordination: Health Risk Assessment

Each member of the Partnership IDT has a set of standardized assessments they are expected to complete in order to gain the necessary information to appropriately identify medical and social needs while taking into account member goals and preferences.

The frequency and method for completion of the Health Risk Assessment (HRA) includes the following:

- Initial and annual comprehensive assessment
- 6-month re-assessment
- Quarterly to review active issues
- Other assessments may be completed as needed
Care Coordination: Health Risk Assessment

The Care Wisconsin Partnership HRA is a compilation of assessments completed by various clinical care management staff, and includes the following:

- Initial and Annual Health Assessments by a Registered Nurse (RN)
- Initial and Annual Psychosocial Assessments by a Social Worker (SW)
- Initial History & Physical (H&P) by a Nurse Practitioner or Physician’s Assistant (annual H&Ps may be coordinated with the member’s PCP)
- Each member has a 6-month re-assessment completed by the RN or SW
Model Of Care
Element 2 - Care Coordination: Health Risk Assessment

The initial HRA begins within 10 days of enrollment and is completed within the first 90 days.

6-month and annual assessments are completed according to the members enrollment month.

Specific templates are used to complete the HRA in order to ensure comprehensiveness and consistency, and are documented in a centralized care management system.

The HRA is completed in-person with the member, typically in their home environment.
Care Coordination:
Individualized Care Plan

Care Plan Development:

• Within 60 days of enrollment, Care Wisconsin Partnership develops a Member-Centered Plan (MCP) for each member.

• This plan includes needs identified during the HRA as well as member-identified goals.

• The Interdisciplinary Team (IDT) staff develops the MCP face to face with the member, any legal representative for the member, and anyone else the member designates.
Care Coordination:  
**Individualized Care Plan**

**Care Plan Review**
- The MCP is reviewed at least every 6 months from the date of the most recent MCP.
- The care plan review is completed in-person with the member and care management staff.

**Care Plan Communication**
- Pertinent components of the MCP are shared with medical and long-term care providers as appropriate.
  For example: Problem Lists and Medication Lists are shared with the PCP and other medical specialists, as needed to coordination of care.
Care Coordination:
Interdisciplinary Care Team (IDT)

Every enrolled member is assigned an IDT. The IDT for every member includes a:

- Nurse Practitioner (NP) or Physician Assistant (PA)
- Registered Nurse (RN)
- Social Worker (SW)
- Care Coordinator (CC)
- Administrative Assistant (AA)

Other members of the IDT may include the primary care physician and other health care professionals, as needed.
Care Coordination: Interdisciplinary Care Team (IDT)

In addition to the core IDT, members have access to other Care Wisconsin staff, directly, or indirectly, who assist the IDT with care planning and care coordination activities. These positions include:

– Medical Director
– Pharmacists
– Transition Support Nurses
– Licensed Clinical Social Workers
Care Coordination: Interdisciplinary Care Team (IDT)

The IDT provides ongoing assessment and care planning with all members to ensure clinical, functional, and long-term care needs are addressed.

IDT staff are sought who have experience working with elderly and disabled individuals, as well as competency to address the needs of the enrolled populations.

All IDT staff receive extensive initial and annual training to support their understanding of requirements and to strengthen their knowledge of the populations.
Care Coordination:
Care Transitions

Care Wisconsin recognizes care transitions as a vulnerable time for all members and has developed extensive protocols for use during hospital and non-hospital transitions.

The Care Wisconsin IDT is responsible for assisting members with care transitions and for mitigating risk factors.
Care Coordination: Care Transitions

The IDT activities for a non-hospital care transitions include, but are not limited to:

– Assisting the member in identifying the appropriate setting to meet the member’s level of care
– Assisting with transition activities that promote safety and reduce risks (home evaluations, medical equipment, medication management)
– Initiating and discontinuing services, as indicated
– Sharing the member’s plan of care across settings
Care Coordination: Care Transitions

Hospital care transitions are closely monitored and managed by the IDT and other CW clinical staff.

- The CW NP or PA is involved with hospital staff providing clinical care, throughout the stay
- CW RN and SW staff, to include the Transition Support Nurse, actively coordinate discharge needs with hospital staff
Care Coordination: Care Transitions

Care Wisconsin seeks to partner closely with hospital staff to improve outcomes and reduce readmissions.

– It is important for hospitals to alert Care Wisconsin of admissions as quickly as possible so the IDT can begin working on transition plans.

– Open communication throughout the course of the stay is imperative to ensure good outcomes and to reduce readmissions.
Care Coordination: Care Transitions

Care Transition Follow-up Care

The IDT staff follow robust protocols to promote successful care transitions. These include:

- Post-transition follow up contacts to assess the member in their environment
- Post-transition evaluations focusing on prevention of hospital admissions and readmissions
- Post-transition, and ongoing, assessment and care planning
Provider Network: Specialized Expertise

Care Wisconsin has established a host of long-term care and medical providers that specialize in the care of the dual-eligible population across all programs, such as providers with traumatic brain injury experience, psychiatrists specializing in geriatric or intellectual disability needs, residential providers with specific training in complex behaviors, and a full array of primary care and specialty medical providers.

Our services area is robust with medical centers that provide dialysis services and specialty outpatient clinics such as therapy services, and heart and vascular physicians.
Provider Network: Clinical Guidelines

Care Wisconsin IDT staff, under the direction of the Medical Director, utilize an array of evidence-based clinical guidelines.

These guidelines include, but are not limited to:

- US Preventive Task Force
- National Guideline Clearinghouse
- Medicare
- Medicaid
- McKesson InterQual Review Criteria
Provider Network: Training

Upon contracting with Care Wisconsin, Provider Services notifies providers of the availability of online Model of Care training. Informal training occurs whenever Care Wisconsin staff is communicating with providers.
Quality Measurement & Performance Improvement

Care Wisconsin has a Quality Management Program designed to monitor the quality of services and outcomes for members.

This program meets standards set forth by Wisconsin Department of Health Services (WI DHS) and the Centers for Medicare and Medicaid Services (CMS).
Quality Measurement & Performance Improvement

The Partnership Program measures the Model of Care through the following:

- Health Effectiveness Data and Information Set (HEDIS)
- Health Outcomes Survey (HOS)
- Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)
- Medicare Advantage Part C & Part D reporting
- Annual Quality Review (conducted by MetaStar)
- Measurable Goals & Health Outcomes
Quality Measurement & Performance Improvement

Measurable goals & health outcomes are developed in the following categories:

– Improved access & affordability of the healthcare needs of the population
– Improved coordination of care
– Enhanced care transitions across healthcare settings and providers
– Appropriate utilization of services for preventive health & chronic conditions
– Health outcome measures
Quality Measurement & Performance Improvement

Member satisfaction is measured in the following ways:

- Wisconsin Member Satisfaction Survey
- HOS
- CAHPS Survey
Quality Measurement & Performance Improvement

Care Wisconsin engages in ongoing quality improvement activities through WI DHS and CMS approved Performance Improvement Projects (PIPs), Chronic Care Improvement Program (CCIP), and Quality Improvement Projects (QIPs).

Metrics are established for the Measurable Goals and quality improvement activities. The specific measures and goals are evaluated and adjusted annually.

Additional information on our quality results can be found on our website at: https://www.carewisc.org/about/quality
Partnership is a fully-integrated, dual eligible Special Needs Plan. To be eligible, members must live in the Care Wisconsin service area and be enrolled in Medicare and eligible for Medicaid from the State of Wisconsin.

Partnership members have an interdisciplinary care team which consists of registered nurses, social workers, the member’s PCP, and the member or responsible party. The team works with the member to complete assessments and develop an individualized plan of care.

Partnership has a provider network that has the specialized knowledge needed to care for the enrolled population.

Care Wisconsin monitors and measures quality of service delivery to ensure:

- Access to essential available services
- Access to affordable care
- Seamless care coordination and transitions of care
- Appropriate utilization of health care services
- Overall improved member health outcomes
Contacts

Prior Authorization/Precertification

– Prior authorization/precertification is required for hospital admissions, certain services, and claims will not be paid without specific authorization. Contact the member’s Care Wisconsin care team to receive prior authorization/precertification for services. To connect with a member’s care team call 1-800-963-0035.

Claims & Billing

– If you have specific eligibility or billing questions about Partnership, contact the Care Wisconsin Provider Help Desk at 1-855-878-6699 or go to carewisc.org.

Pharmacy

– Please contract Pharmastar at 1-888-290-7770 for contracting, prior authorization, and pharmacy claims information.

Contracting Questions

– Contact Provider Services for questions regarding your Care Wisconsin contract at 1-844-503-5072