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DENTAL AND VISION SERVICES

Special Needs Plan Model of Care Training

What is a Special Needs Plan (SNP)?

A SNP is a Medicare Advantage coordinated care plan (CCP) that is limited to individuals with special needs and is specifical y designed to provide targeted care to plan members.

What are the Different Types of SNPs

- √**Dual Special Needs Plan (D-SNP)** – Members who are eligible for both Medicare and Medicaid.
- √**Chronic Special Needs Plan (C-SNP)** – Members with specific, s vere, or disabling chronic conditions.
- √**Institutional Special Needs Plan (I-SNP)** – Members who live in institutions such as nursing homes.

The health plan currently offe s D-SNPs and C-SNPs in multiple states across the nation.

What is a Model of Care?

As provided under section 1859(f)(7) of the Social Security Act, every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC provides the basic framework under which the SNP will meet the needs of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified y the SNP and addressed through the plan's care management practices.

The MOC addresses four clinical and non-clinical elements:

- Description of the SNP population.
- Care coordination.
- The SNP provider network.
- MOC quality measurement and performance.

Transitions of Care (TOC) – Care transitions from one level of care to another can present possible disruptions in member care. When a member's care setting and care providers change, it is essential that care needs are coordinated and communicated, and that elements of the member's ICP are transferred between settings. The health plan will do the following:

- Collaborate with the member, caregiver, PCP, and treating providers.
- Conduct additional assessments to identify needs and barriers.
- Notify PCPs on record of a member's inpatient stay.
- Conduct pre-discharge activities, such as discharge planning, authorization requests, and identifying needed community services to support the transition to home.
- Conduct post-discharge follow up, which includes an assessment, care coordination, appointment setting, medication reconciliation, member education, and implementing services and supports outlined in the discharge plan.

To assist with coordination of care, the health plan asks that current providers communicate with the provider(s) who will be conducting the next level of care for the member. This communication should include any updates to treatment plans, diagnoses, test results, treatments or procedures performed, discharge instructions, and current medication lists.

Services Provided to Members

The health plan provides SNP members with services tailored to their needs. This includes, but is not limited to, the following:

- √ Care coordination and complex care management.
- √ Care transitions management. In-home wound care.
- √ Disease management services.
- √ Clinical management in long-term care facilities, as needed.
- √ Medication therapy management.
- √ Medicare and Medicaid benefit and eligibilit coordination and advocacy.
- √ Behavioral health and substance use services.
- √ Occupational, physical, and speech therapy.
- √ Services addressing SDOH needs.

SNP Provider Network and Quality Measurement and Performance

The SNP provider network is made up of healthcare providers with specialized expertise to meet the needs of the SNP population. Collaboration of the ICT is primarily facilitated through communication of the ICP.

The health plan is required to have a Quality Improvement Program to monitor and evaluate its Model of Care performance. The health plan establishes tailored measures and health objectives tied to coordination of care and the appropriate delivery of services. Information about the Quality Improvement Program and Model of Care plan performance is posted on our member and provider websites.