Seaside Health Plan Policies and Procedures	**Effective Date:** **Note: For origination date see History at the end of Policy**
SUBJECT: SPECIAL NEEDS PROGRAM	**Approval Signature:** Barry Smith, MD Chief Medical Officer
Manual: Utilization Management **Policy/Procedure #** UM-900 **Section:** SPECIAL NEEDS PROGRAM	**Sponsor Signature:** Kimberly Ward, RN Director, Utilization Management
☐ **COMMERCIAL** ☐ **MEDI-CAL**	☒**MEDICARE**

AUTHORITY
Medicare Modernization Act.
NCQA
Title 42, Part 422, Subpart D, 422.152

POLICY
Seaside Health Plan's Special Need Program provides a specialized benefit packages for members with distinct health care needs to improve care and decrease the costs for the frail and elderly through improved coordination.

Seaside SNP Model of Care (MOC) manages the delivery of specialized services and benefits for members with special needs that are:

- Dually-eligible
- Medically complex or has multiple chronic conditions
- Near the end-of-life

GOALS
Seaside SNP goals include:

- Improving access to medical and mental health and social services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, providers and health services
- Improving access to preventive health services

- Assuring appropriate utilization of services
- Improving beneficiary health outcomes

MEMBER IDENTIFICATION
Seaside identifies eligible members for the SNP through process enrollment, Primary Plan eligibility reports and/or HRA results obtained by the Primary Plan.

Eligible members may also be referred for SNP services through discharge planner referral, UM or concurrent review referral, member self-referral, and practitioner referral.

STAFF STRUCTURES AND ROLES
Seaside ensures to have appropriate staff to perform case management and coordination of services and benefit functions which includes the following:

- Care Manager or coordinator
- Durable medical equipment (DME) coordinator
- Utilization review coordinator
- Discharge planning specialist
- Nurse manager or coordinator
- Health information specialist
- Training
- Data Analysis

Administrative and clinical oversight duties are performed by Seaside staff that includes:

- Medical Director
- Administrator
- Director
- Executive staff

Seaside ensures designation of staff to perform the following responsibilities:

- Collecting and submitting data to the Primary Plan for analysis.
- Coordination of care for members across care settings including behavioral health services with Primary Plan approved behavioral health vendor.

Seaside ensures effective performance of administrative and clinical oversight activities in of the SNP. These duties include:

- Developing a process to assess and/or observe interdisciplinary team meetings and effectiveness such as weekly team meetings where UM/CM manager or medical director are present.
- Reviewing medical charts
- Assessing claims
- Processing of provider complaints & resolution
- Processing communication with network providers.
- Perform administrative oversight processes to assess, observe and improve effectiveness of the IDCT.

SNP MODEL OF CARE (MOC)

- Specialized Provider Network that is board-certified with expertise specific to targeted SNP population.
- Integrated Communication Systems
- Additional Benefits
- Case Management for All Members
- Annual Health Risk Assessments
- Individualized Care Plan for Each Member
- Interdisciplinary Care Team (IDCT) to Coordinate Care
- Management of Care Transitions
- Coordination of Medicare and Medicaid Benefits for D-SNPs
- Specialized Benefits for C-SNPs
- Quality Improvement Program

Seaside provides a member centered MOC by ensuring members are included in the coordination and planning of care. Seaside ensures SNP members are:

- Informed of and consents to Case Management
- Participates in development of their Care Plan
- Agrees to the goals and interventions of their Care Plan
- Informed of IDCT members and meetings
- Either participates in the IDCT meeting or provides input through the Case Manager and is informed of the outcomes.

CASE MANAGEMENT
All SNP members are eligible for case management and have an individualized care plan and IDCT developed. Members may opt out of active case management but remain assigned to a Case Manager who continues to attempt to engage member especially if there is a change in status.

The Case Manager:

- Performs an assessment of medical, psychosocial, cognitive, and functional status;
- Develops a comprehensive individualized care plan;
- Identifies barriers to goals and strategies to address;
- Provides personalized education for optimal wellness;
- Encourages preventive care, such as flu vaccines and mammograms;
- Reviews and educates on medication regimen;
- Promotes appropriate utilization of benefits;
- Assists member to access community resources;
- Assists caregiver when member is unable to participate;
- Provides a single point of contact during Care Transitions.

Eligible members for SNP are provided with the following case management program information in writing and in-person or by telephone:

- How to use the services
- How to opt in or opt out

The SNP case management procedures address the following with members:

- Member's right to decline participation or disenroll from case management programs and services offered by the organization.
- Initial assessment of member's health status, including condition-specific issues.
- Documentation of clinical history, including medications (dosage & frequency).
- Initial assessment of activities of daily living.
- Initial assessment of mental health status, including cognitive functioning.
- Initial assessment of life planning activities.
- Evaluation of cultural and linguistic needs, preferences or limitations.
- Evaluation of visual and hearing needs, preferences or limitations.
- Evaluation of member's caregiver resources and involvement.
- Evaluation of member's available benefits.
- Development of an individualized case management plan, including prioritized goals, that considers the member's and caregivers' goals, preferences and desired level of involvement in the case management plan.
- Identification of barriers to member's meeting goals or complying with the plan.
- Development of a schedule for follow-up and communication.
- Development and communication of member self-management plans.
- Process to assess progress against the case management plans for members.
- Conducts member medical record reviews for information relative to the care plan.
- Identifies and facilitates access to community resources and social services.
- Monitors provision of services and benefits to ensure follow up.
- Results from the initial health risk assessment are used to develop the individualized care plan when available.
- Each beneficiary is assigned an interdisciplinary care team that develops the individualized care plan with beneficiary involvement when feasible.

At least annually, Seaside evaluates satisfaction with its SNP CM program by obtaining feedback from members. Feedback must be specific to the SNP CM program being evaluated.

HEALTH RISK ASSESSMENT (HRA)
A health risk assessment are conducted on each member to identify medical, psychosocial, cognitive and functional risks

Seaside PCP completes the initial HRA within 90 days of enrollment and annually within 1 year of the last HRA

Multiple attempts will be made to contact the member who have not scheduled or are no-show to their HRA appointments

HRA data are incorporated into the member's care plan and communicated to the provider via provider portal or by mail.

INDIVIDUALIZED CARE PLAN (ICP)
ICPs are created for every SNP member by the Case Manager with input from the IDCT. The member and/or caregiver are involved in and agree with the care plan and goals. SNP member ICP:

- Includes ember's assessment and identified problems;
- Prioritized goals considering member preferences and desired level of involvement in the case management process;
- Updated when there is a change in the member's medical status or at least annually;
- Shared with all the members of the care team;
- Communicated when there is a transition to a new care setting, such as the hospital or skilled nursing facility;
- Communicated to the member and the primary physician.

Interdisciplinary Care Team (IDCT)
The IDCT meets regularly to manage the medical, cognitive, psychosocial, and functional needs of the member. The member is included on the IDCT whenever possible:

Required Team Members:

- Medical Expert
- Social worker, community resource specialist
- Behavioral and/or mental health specialist (if member has an identified Behavioral Health need)

Additional members of the interdisciplinary care team (IDCT) appropriate for that beneficiary may include the following:

- Registered Nurse
- Restorative health specialist (physical, occupational, speech, recreation therapist)
- Board certified physician
- Dietician, nutritionist
- Pharmacist, clinical pharmacist
- Nurse educator
- Caregiver/family member
- Preventive health/health promotion specialist
- Pastoral Specialist

Seaside submits reporting requirements, including ICP, as delineated in the Primary Plan's UM reporting requirements for SNP in adherence to HIPAA.

SPECIALIZED PROVIDER NETWORK
The IDCT identifies the most vulnerable SNP members: frail/disabled members and members near the end of life through the use of the health risk assessment findings, medical history, and current clinical diagnostics. Individualized Care Plans (ICP) are develop to identify standard and any required add-on benefits and services.

Seaside ensures the coordination and delivery of required add-on benefits and services that meet the specialized needs of the most vulnerable SNP members by ensuring availability within its network of:

- Network facilities that provide special diagnostic and treatment services such as acute care facility, laboratory, radiography/imaging facility, long-term care facility, rehab facility, specialty outpatient clinics.

- Providers with specialized expertise that include medical specialists (cardiology, psychiatry, neurologists, surgeons, etc.), behavioral specialists (drug counselor, clinical psychologist, etc.), nursing professionals and allied health professionals.

Seaside Health Plan specialized clinical experts deliver services beyond the scope of the interdisciplinary team. Specialized clinical expert's duties include:

- Assess, diagnose, and treat in collaboration with the interdisciplinary team
- Conduct communication with the interdisciplinary team on a regular basis
- Assist with developing and updating individualized care plans
- Provide specialized services such as a wound management service/referral to wound Management specialist
- Provide pharmacotherapy consultation and/or management clinics
- Conduct home visits for clinical assessment for treatment
- Conduct home safety assessments
- Conduct risk prevention programs such as fall prevention or wellness promotion
- Provide in-patient acute care services
- Provide hospital-based or urgent care facility-based emergency services
- Provide home-based palliative or end-of-life care
- Provide home health services

In addition, any of the following may be offered to the member if appropriate: telemonitoring, telemedicine and in-patient acute care services.

INTEGRATED COMMUNICATIONS
Seaside SNP ensures a coordinated communication among the IDCT, to include the beneficiary/caregiver when feasible. The process includes the following:

- Face-to-face in care planning
- Telephonic in care planning
- Care planning through:
    - exchange of written correspondence with their interdisciplinary team
    - web-based electronic interface or virtual correspondence
    - as needed without a set schedule
- Care Coordination meetings
- Committees (standing and ad-hoc)
- Conference

COORDINATING DELIVERY OF SERVICES
Seaside ensures coordination the delivery of services, benefits and other services such as dental, vision and transportation, by:

- IDCT approving all referrals, including those for the frail/disabled beneficiaries and beneficiaries near the end of life, to the provider network prior to the delivery of services.
- IDCT determination of whether members require services outside the existing provider network and approves services prior to delivery.
- Available specialized clinical experts to assess diagnose and treat in collaboration with the interdisciplinary care team.
- Specialized clinical experts assistance in developing and updating individual care plans.

- Processes to track and analyze services and benefits utilization.
- Dissemination of results of the utilization analysis to the interdisciplinary team.
- Contacting beneficiaries to remind them about upcoming appointments.
- Contacting beneficiaries to follow up on missed appointments.

COORDINATION OF BENEFITS
Seaside coordinates benefits for members that are dual-eligible to ensure:

- Members informed of benefits offered by both programs
- Members informed how to maintain MediCal eligibility
- Member access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and MediCal claims when Seaside is contractually responsible
- Members informed of rights to pursue appeals and grievances through both programs
- Members assisted to access providers that accept Medicare and MediCal

MANAGEMENT OF CARE TRANSITIONS
Members are at increased risk of adverse outcomes when there is a transition from one care setting to another, such as admission to or discharge from a hospital, skilled nursing, rehabilitation center, or home health:

SNP members experiencing or at-risk of an inpatient transition are identified through prior authorization, facility notification, and/ or surveillance.

Inpatient stays (acute, SNF, rehab) are monitored including the establishment of the Care Plan by the physician in 1 business day of admission

When the member is discharged home, the Case Manager conducts post-discharge calls in 2 business days of notification to review changes to ICP, assist with discharge needs, review medications, and encourage follow-up care with provider

MOC STAFF/PROVIDER TRAINING
Seaside conducts initial and annual MOC training that includes:

- How the plan assures and documents completion of training by employed and contracted personnel (e.g., attendee lists, results of testing, web-based attendance confirmation, and electronic training record)
- Personnel responsible for oversight of the MOC training
- Actions the plan will take when the required MOC training has not been completed (e.g., contract evaluation mechanism, follow-up communication to personnel/providers, and incentives for training completion).

MOC training strategy may include varieties of methods including:

- Face-to-face training
- Web-based interactive training
- Self-study program (electronic media, print materials)

Seaside assures and documents completion of training by employed and contracted personnel through attendee lists, results of testing, web-based attendance confirmation, and electronic training record.

The Director of Utilization Management is responsible for oversight of the MOC training.

Seaside will take appropriate actions when the required MOC training has not been completed including contract evaluation mechanism, follow-up communication to personnel/providers, and incentives for training completion.

QUALITY IMPROVEMENT PROGRAM
Seaside conducts Quality Improvement monitoring to assess health outcomes and implementation of the MOC by:

- Collecting SNP specific HEDIS measures
- Meeting NCQA SNP structure and process standards
- Conducting a Quality Improvement Project (QIP) annually that focuses on improving a clinical or service aspect that is relevant to the SNP population i.e. preventing readmissions
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness (Cardiovascular Disease)
- Collecting data to evaluate annually if SNP program goals are met

The following domains of care are evaluated to identify areas for improvement and if program goals have been met:

- Health Outcomes
- Access to Care
- Improved Health Status
- Implementation of Model of Care
- Health Risk Assessment
- Implementation of Care Plan
- Provider Network
- Continuum of Care
- Delivery of Extra Services
- Integrated Communications

If not delegated, all complaints grievance and appeals will be forwarded to the Primary Plan within 24 hours.

MOC IMPROVEMENT
Seaside takes actions to improve the SNP model of care including the following:

- Changes in policies or procedures, as applicable
- Changes in staffing patterns or personnel, as applicable
- Changes in systems of operation, as applicable

Collected data are submitted annually to the Primary Plan to evaluate the effectiveness of Seaside's MOC guidelines

MEASURES TO MEASURE EFFECTIVENESS OF SNP CASE MANAGEMENT PROGRAM
Seaside annually measures the effectiveness of its SNP CM program using three measures or processes that have significant and demonstrable bearing on a defined portion or subset of the SNP CM population or process so that appropriate interventions would result in significant improvement for the population.

With all three selected measures, Seaside:

- Identifies a relevant process or outcome
- Assures appropriately credentialed providers and IDCT members qualified to address relative process and outcomes
- Uses valid methods that provide quantitative results
- Sets a performance goal
- Clearly identifies measure specifications
- Analyzes results
- Identifies opportunities for improvement, if applicable

Based on the results of its measurement and analysis of SNP Case Management effectiveness, Seaside implements at least one intervention for all three opportunities to improve performance and develops a plan for evaluation of the intervention and re-measurement.

REQUIRED REPORTING
Seaside submits required reporting data that monitors performance as requested by the Primary Plan. These data elements may include any of include the following:

- Hospital discharge outreach and follow-up rates
- Screening for elder/physical/sexual abuse
- Community service access/utilization rates
- Facilitation of beneficiary developing advance directives/health proxy
- Hospice referral and utilization rates
- Care plan initiation status, initiation date, closure date and closure reason

History: New

Origination Date: