CHOICE℠ Health Plans

Medicare

Special Needs Plan (SNP)

Model of Care

Medicare SNP Model of Care

The Model of Care is a structural framework guiding:

- Care Management Policies
- Operational framework for Medicare members

Medicare SNP Model of Care

Model of Care goals to improve:

- Improve coordination of care via Individualized Care Plan (ICP)
- Integrate benefits and improve care coordination
- Access to affordable care
- Access to services (preventive, medical, mental health and social)
- Coordination of care via integrated care planning
- Seamless transitions of care
- Assure appropriate utilization of services
- Health outcomes of member

Medicare SNP Model of Care

- Member's are **Auto-enrolled in Care Management** upon enrollment into a VNSNY CHOICE Health Plan
- A Health Risk Assessment (HRA) is completed upon enrollment
- The data from the Health Risk Assessment Tool (HRA) is used to develop an Individualized Care Plan (ICP) for the member.

Roles within Medicare SNP

- Care Manager
- Medical Director
- Interdisciplinary Care Team
- Utilization Management Nurse
- Pharmacy Services Specialist
- Behavioral Health Specialist

Medicare SNP Model of Care

- A Care Manager is responsible for identifying and coordinating Medicare services to meet the immediate and ongoing need of the member.
- Coordination of care will assist members along the health care continuum.
- Utilization managers review and authorize inpatient admissions and service requests. Care managers coordinate with utilization managers to oversee the appropriate allocation of resources and ensure a safe transition throughout all healthcare delivery settings.

Medicare SNP Model of Care

Consists of:

- Health Risk Assessment (HRA)
- Case Management of high risk members and development of an Individual Care Plan (ICP)
- Assistance with transitions in care to help members navigate through appropriate care settings.
- Coordinated Care through an Interdisciplinary Care Team (ICT)
- A network that includes specialists and the use of nationally recognized clinical practice guidelines.
- Quality Improvement Plan (QIP)

Individualized Care Plan (ICP)

- An Individualized Care Plan is developed and updated by the Care Manager.
- The ICP includes Opportunities/Goals and Interventions (OGI)
- It is used to manage and monitor member's care, their needs and progress towards goals.

Interdisciplinary Care Team (ICT)

Participants can include:

Care Managers

Utilization Managers

Beneficiaries and caregivers

Medical Director

Behavioral/Mental Health experts

Social Workers

Pharmacists

Primary Care and/or treating Provider

Community Partners/Resources

Interdisciplinary Care Team (ICT)

- Individualized comprehensive care planning process
- Participate in ICT Meetings and Rounds
- Ensures the integration of the member's medical, psychosocial, cognitive and functional needs and specific preferences into an Individualized Care Plan
- Review encounter information on referrals, hospital stays, and other data to identify possible areas of under/over utilization
- Dedicated to quality and accountability in ensuring appropriate case/services consistent with evidence-based practice, CMS guidelines and the VNSNY CHOICE mission

Medicare SNP Benefits

- Prescription drug
- Doctor and Hospital coverage
- Interdisciplinary Care Team
- Care Manager
- Vision
- Dental
- Over the Counter (OTC) items
- Worldwide coverage
- Transportation
- Health Club Membership
- Nutrition Counseling
- Acupuncture
- Personal Emergency Alert Device
- Nurse Hotline Support

Summary

- This presentation outlined the different components of our Medicare SNP Model of Care.
- Our Model of Care is intended to provide a broad overview of how VNSNY CHOICE Medicare SNP addresses the member's needs and achieves positive outcomes.

CHOICE℠
Health Plans

Thank You