Spotlight on Innovation: Medicare Advantage Special Needs Plans

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Overview

Special Needs Plans (SNPs) are a type of Medicare Advantage plan that specializes in care for the health care system's fastest growing and most costly and complex care beneficiaries – frail, disabled, and chronically-ill Medicare beneficiaries.[1][2] SNPs are authorized to tailor services and models of care to the unique population they serve through the Medicare Advantage framework. SNPs are paid in the same way as Medicare Advantage plans, and required to offer all Medicare Part A and B benefits. SNPs are also required to comply with the same Medicare Advantage program and reporting requirements. Targeted populations include beneficiaries who are dually-eligible for Medicare and Medicaid, have certain chronic conditions, or are living in an institution or in the community and require an institutional level of care.

The Medicare Modernization Act of 2003 established the SNP program and enabled Medicare Advantage plans to target care to beneficiaries by creating three types of SNPs: Dual-Eligible SNPs (D-SNPs), Chronic Condition SNP (C-SNPs), and Institutional SNP (I-SNPs).[3] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the SNP program through December 31, 2018. Congressional action is necessary to extend the program to ensure continuity in care to the population of beneficiaries served by SNPs.[4][5]

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Key Characteristics of Three Innovative SNPs

This Spotlight on Innovation provides an overview of the SNP program and three successful models of care under Medicare Advantage: Aetna's D-SNP, SCAN Health Plan's (SCAN) C-SNP, and UnitedHealthcare's Nursing Home Plan I-SNP. Core elements of these three successful SNPs include robust care management, health risk assessments, individualized care plans, and a framework that enables beneficiaries to be treated in the most appropriate setting.

AETNA D-SNP

The Aetna Florida D-SNP provides robust care management services for over 20,000 high risk beneficiaries to address their clinical needs and social determinants of health by integrating Medicare and Medicaid services and supplementing benefits with community resources. A case manager, in conjunction with an interdisciplinary team and care managers help high risk beneficiaries get the care they need. Care needs range from medical, to mental health, financial, and social supports. The plan has reduced inpatient admissions through care coordination and effective transitions of care.

SCAN C-SNP

SCAN SNPs provide care to about 30,000 beneficiaries. Roughly 15,000 are in SCAN C-SNPs. One of the C-SNPs, SCAN Balance attends to the needs of beneficiaries with chronic diabetes, and aims to improve health outcomes through increased access to more affordable and coordinated care. A care manager is assigned to each beneficiary to help coordinate care with an interdisciplinary care team, additional care managers, and disease specific programs. The C-SNP addresses risk factors for diabetes by putting high value pharmaceutical benefits in lower cost tiers and waiving co-pays for high value providers. The plan has improved access to medical, mental health, and social services.

UNITEDHEALTHCARE NURSING HOME PLAN I-SNP

The UnitedHealthcare Nursing Home Plan I-SNP delivers coordinated care to roughly 50,000 institutionalized beneficiaries through advanced practice clinicians. Each beneficiary is assigned a Nurse Practitioner (NP) who

treats beneficiaries in place, while managing pain and maintaining the highest level of daily function possible. The embedded NP builds a connection with the beneficiary by providing a high level of care and acting as a liaison between the interdisciplinary care team and care givers to prevent avoidable hospitalizations and improve frail and complex beneficiaries' quality of life. The plan has improved quality, while reducing costs by 50% due to fewer inpatient admissions, readmissions, emergency department visits, and Skilled Nursing Facility (SNF) admissions.

Background on Medicare Advantage SNPs

SNPS ARE A TYPE OF MEDICARE ADVANTAGE PLAN TAILORED TO HIGH RISK BENEFICIARIES

Traditional Fee-For-Service (FFS) Medicare was designed for short episodes of acute illness and expensive hospitalizations. The capitated, or fixed dollar amount per member, per month system in Medicare Advantage incentivizes the appropriate level of care and better care management for chronic conditions. Data show that by emphasizing early intervention and better care coordination, Medicare Advantage directs beneficiaries to the most appropriate site of care and prevents adverse, high cost events such as avoidable hospitalizations. Research shows the positive impact Medicare Advantage is having on care delivery is spilling over to FFS Medicare resulting in reduced health care costs.[6][7][8]

The Medicare Advantage framework aligns payment and care delivery to incentivize innovative ways to prevent, diagnose, and treat complex chronic conditions to achieve better outcomes for beneficiaries. 18.5 million Medicare eligible beneficiaries---one third of all beneficiaries have chosen Medicare Advantage. Over 2.3 million beneficiaries are enrolled in nearly 600 SNPs nationwide. [9]

SNPs are a type of Medicare Advantage plan that attend to the needs of high risk beneficiaries who typically incur higher costs. According to the Medicare Payment Advisory Commission (MedPAC), the costliest 10 percent of Medicare beneficiaries accounted for almost 60 percent of annual FFS Medicare spending in 2010.[10] It is estimated that roughly 90 percent of all SNP beneficiaries are dual-eligible beneficiaries who are often poor and chronically ill.[11] SNPs are at the forefront of innovations that combines programs to harmonize, manage, and integrate targeted models of care for beneficiaries.

Evidence shows SNPs are providing quality care. According to the Centers for Medicare & Medicaid Services (CMS) I-SNPs perform well on quality measures, and have proven success in lowering hospital readmission rates.[12] D-SNPs had the most performance measures with a statistically significant improvement from 2012-2013.[13] A 2012 study found beneficiaries in C-SNPs had lower rates of hospitalizations and readmissions than their peers in FFS Medicare.[14] A Commonwealth Fund Case Study found in 2015, CareMore plan beneficiaries had 20 percent fewer hospitalizations, while delivering Medicare benefits more efficiently. The CareMore plan has an I-SNP, D-SNP, and C-SNP.[15] SNPs have grown by 65% over the last five years.[16] [17]

SNPS UTILIZE EVIDENCE-BASED MODELS OF CARE TO ENSURE EFFECTIVE CARE DELIVERY

SNPs were established to enable plans to tailor models of care to a unique population of high need beneficiaries. SNPs must design and use an evidence-based model of care, with an appropriate network of providers and specialists and care coordination through inter-disciplinary teams. In addition, each beneficiary must receive an annual health assessment and an individualized care plan to address personalized goals and objectives. Each SNP model of care must be approved by the National Committee for Quality Assurance (NCQA) and report additional SNP-specific quality measures to CMS.[18] [19]

The SNP models of care provide a foundation to ensure beneficiary needs are identified and addressed. The Model of Care must contain a description of the SNP population being served, the care coordination that will be provided, details

about the SNP provider network, and quality and performance measurements. The elements of the model of care are scored, and the score determines the number of years the model of care is approved. SNP models of care are evidence-based and include annualized assessments and reassessments, individualized care plans, and the use of interdisciplinary care teams for every beneficiary. SNP benefit packages provide beneficiaries with services that attend to vulnerable beneficiaries specialized needs.[20]

SNPS SERVE A TARGETED POPULATION OF BENEFICIARIES

SNPs provide specialized care to serve beneficiaries who are dually-eligible for Medicare and Medicaid, have certain chronic conditions, or receive long-term care in an institutional setting such as a SNF. Three types of SNPs are spotlighted below:

- D-SNPs serve beneficiaries eligible for coverage under both Medicare and Medicaid, known as dual-eligible beneficiaries. In June 2017, there were 377 D-SNP plans serving over 1.9 million beneficiaries.

- C-SNPs serve beneficiaries with a disabling chronic condition, such as End Stage Renal Disease (ESRD), severe diabetes, dementia, or cancer. In June 2017, there were 123 C-SNPs serving over 339,000 beneficiaries.

- I-SNPs serve institutionalized beneficiaries residing in a long-term care facility, such as a SNF, or living at home but requiring an institutional level of care. In June 2017, there were 83 I-SNPs serving over 65,000 beneficiaries.[21] [22]

Spotlight on a Successful D-SNP: Aetna Florida D-SNP

BENEFICIARY CARE IN AETNA FLORIDA D-SNP

When a 61-year-old man enrolled in the Florida Aetna D-SNP, he was assigned a nurse case manager (case manager) who conducted a health risk assessment. The assessment revealed that he was a former smoker with history of heart failure (HF), hypertension, Chronic Obstructive Pulmonary Disease (COPD) and diabetes. The information from his health risk assessment, medical records, and health goals facilitated the development an individualized care plan.

The beneficiary has had multiple hospitalizations for COPD and heart failure. The most recent hospitalization in April 2017 was due to his chronic COPD. During the hospitalization, his individualized care plan was shared with his care team, and the hospital. Due to his hospitalization, an additional care manager was assigned to identify his discharge needs. The care manager worked with a pharmacy to ensure he received his new medication, facilitated a home skilled registered nurse and physical therapy evaluation, and confirmed follow-up appointments with the primary care physician and specialists. The beneficiary needed transportation to and from these follow-up visits, and meal delivery service during recovery at home, all of which was facilitated by the care manager.

As the beneficiary recovered he continued to lose weight. After involuntarily losing 25 pounds, his case manager arranged a social worker home visit and nutrition evaluation with his primary care physician. The additional assessments revealed that the beneficiary was having financial challenges paying his electrical bill and gaining access to the proper nutrition. His case manager connected him with community assistance for his electrical bill, and helped him obtain nutritional supplements ordered by his primary care physician.

The managed care and support services provided by the D-SNP enabled the beneficiary to learn how to more actively manage his chronic conditions. He is also working with Vital Decisions, which provides telephonic advanced care planning, to develop his advance care directive. The patient's care team continues to monitor his progress and provide reminders about medication adherence and upcoming appointments. The resources available to him through the D-SNP have enabled him to fulfill one of his personal goals to remain in his own home and community.

D-SNPS MANAGE VULNERABLE BENEFICIARIES

The Aetna Florida D-SNP offers high quality care to beneficiaries enrolled in both Medicare and Medicaid.[23] In 2016, the plan provided care to 20,320 beneficiaries in counties across Florida out of 1.9 million total D-SNP beneficiaries nationwide. The goal of the D-SNP is to optimize care for low-income, aging, and chronically ill beneficiaries through effective population management. Population management strategies focus on the early identification of chronic conditions, comprehensive assessments of health care needs, and individualized care plans.

Figure 1 shows how the D-SNP plan tiers beneficiaries to prioritize care for the most vulnerable. The beneficiary's tier determines the intensity of interventions, how often the member is reassessed, and the level of involvement the care management team has with the beneficiary and care giver. The beneficiary's tier can change over time as a reflection of changing needs and conditions.

FIGURE 1:

High tier 3 contains the **most vulnerable members**, including those at risk for unplanned transitions of care

Medium tier 2 members are generally **enrolled in several disease-specific programs**.

Low tier 1 contains the **most stable SNP members**.

Aetna. "Dual Eligible Special Needs Plans (D-SNPs): Model of Care training." Nov. 2016. Web.

AETNA FLORIDA D-SNP BENEFICIARIES

The D-SNP population often has multiple medical, socioeconomic, and behavioral health challenges that may impact beneficiaries' health status. Lack of financial and social supports, sometimes coupled with language and cultural barriers, means certain beneficiaries in the D-SNP population have additional challenges to face in obtaining medical care and meeting clinical goals to improve their health.

The top three conditions Aetna Florida D-SNP beneficiaries suffer from are diabetes, neurological, and cardiology conditions. In the D-SNP, 66% of beneficiaries are over 65, 64% of beneficiaries are female, and 62% of beneficiaries have behavioral health issues. Over 50% of beneficiaries in the D-SNP have three or more chronic conditions.[24]

Research has shown socio-economic status is a fundamental cause of health disparities, and impact health care, environmental exposure, and health behaviors. Addressing these needs, particularly for low income beneficiaries is essential if there is to be improvement in health status. Economic challenges have been linked to health problems including cardiovascular disease, hypertension, arthritis, diabetes, and cancer.[25]

AETNA FLORIDA D-SNP BENEFITS

The D-SNP program offers some additional flexibility in plan design due to the combination of Medicare and Medicaid benefits. In the Aetna D-SNP, all beneficiaries have the lowest possible cost-sharing requirements. The D-SNP has a specialized network of providers that includes specialists and services tailored to care for complex beneficiaries with multiple chronic conditions, long-term care, and cognitive needs. Core benefits include zero-dollar co-pays for primary care physicians, provision of in-home assessments, and routine chiropractic, podiatry, hearing, dental and vision coverage. The D-SNP population needs are re-evaluated annually to ensure network adequacy.

The Aetna Florida D-SNP provides additional services based on the beneficiary's needs. These additional benefits include more frequent contact with SNP case managers, house calls by a social worker or physician, and telemonitoring to ensure beneficiaries with difficulty leaving their homes have access to care. The plan also provides transportation, assistance scheduling appointments and obtaining medication, and additional meal services as needed. Providers work to ensure beneficiaries receive education about their conditions and the services available to them in the community and through the plan. Regular assessments of the beneficiaries' home, financial, and psychosocial environment enable providers to determine which tailored benefits are most appropriate to meet these needs.

AETNA FLORIDA D-SNP CARE MODEL

The D-SNP model of care improves beneficiary health through assessments of quality, access, affordability, care coordination, seamless care transitions, and the use of preventive health services to encourage the appropriate utilization of services. The model of care outlines the roles of the interdisciplinary care team, which includes the beneficiary, the beneficiary's support system, a primary care provider, a case manager, care managers, a pharmacist, social workers, and other clinical team members as needed. The care team makes sure beneficiaries have access to affordable care, medication, healthy food, and safe transportation. Care management is at the core of the D-SNP model.

Each beneficiary has a personalized case manager to manage care through the interdisciplinary care team. The case manager is assigned based in part on language and cultural preferences to facilitate comfortable interactions for the

beneficiary. The case manager assesses the benefits provided by the Medicare and Medicaid programs, barriers the beneficiary may be facing in accessing care, and educates the beneficiary about their condition and medications. This personalized case manager walks the beneficiary though their individualized care plan, coordinates provider visits, and manages care transitions. Figure 2 illustrates key D-SNP team roles and Figure 3 illustrates how the interdisciplinary care team interacts with the beneficiary.

FIGURE 2:

Key D-SNP Team Roles

TEAM MEMBER	ACTIVITIES
NURSE CASE MANAGER (CASE MANAGER)	Assigned to beneficiary to help navigate the health system
CARE MANAGER	Manages care transitions and works alongside the Nurse Case Manager
INTERDISCIPLINARY CARE TEAM	Primary care physician, care giver, specialists, home and community-based partners

Aetna Health, Inc., Dual Eligible Special Needs Plans (D-SNP), Model of Care

FIGURE 3:

Interdisciplinary Care Team
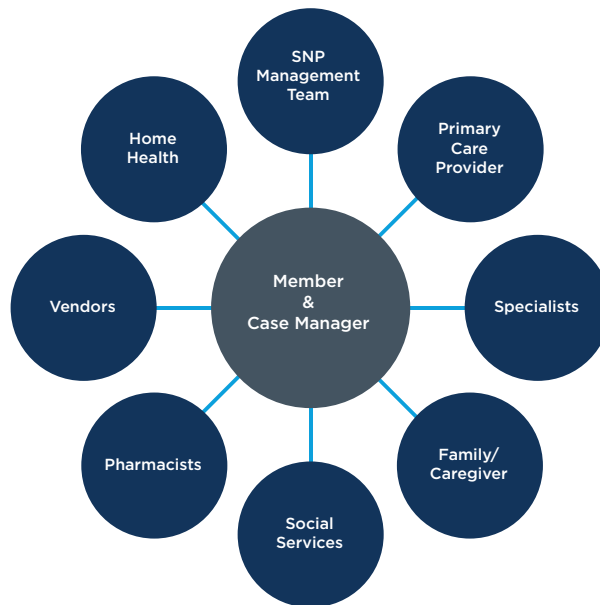
Aetna. "Dual Eligible Special Needs Plans (D-SNPs): Model of Care training." Nov. 2016. Web.

The core elements of the Aetna D-SNP model of care are:

- Improve quality of care through early intervention and education;

- Improve access to affordable care;

- Integrate and coordinate care;

- Provide seamless transitions across care settings;

- Improve access to preventive services; and

- Deliver effective and efficient health care services.

IMPROVED QUALITY OF CARE

Using the individual care, plan the case manager tracks the quality of care through early intervention and education. Case managers conduct health risk assessments and work with the beneficiary to ensure care goals are being met. Health risk assessments are designed to identify beneficiaries' urgent needs, to coordinate care, and to enable a beneficiary to share goals and concerns. Specific assessments include beneficiary's language preferences, conditions, medications, care givers, social resources, environment, and preventive health screenings.

The role of the case manager is critical in coordinating each beneficiary's care with the interdisciplinary care team, which meets a minimum of every two weeks to determine if any changes are needed to the care plan. Individualized care plans are also used to identify the correct tier for each beneficiary to determine the appropriate level of care. The tiers inform beneficiary outreach, education, and enrollment in specialized programs. The case manager helps ensure care reflects the health risk assessment, medical records, and the team's interactions with the beneficiary and care givers.

IMPROVED ACCESS TO AFFORDABLE CARE

The D-SNP is designed to leverage benefits in the Medicare and Medicaid programs to increase access to affordable care. Medicaid provides additional flexibility with benefits, allowing the D-SNP to offer transportation, meals programs, and assistance for purchasing over-the-counter medications. The D-SNP conducts an annual review to verify that beneficiaries have access to necessary benefits for which they are eligible.

Improving access to care is achieved through a team approach to collaborative care management. In addition to the education and support provided by the beneficiary's case manager, care coordinators assist the beneficiary with scheduling doctor's appointments, arranging transportation, and obtaining medications. Resources are identified at the federal, state, and local level to assist beneficiaries. Social workers and interdisciplinary teams help beneficiaries address socioeconomic needs such as unstable housing, food insecurity, and social isolation. Additional support is provided to beneficiaries with declining health or behavioral health needs and to those who require further education to manage their chronic condition.

The D-SNP interdisciplinary care team works with the behavioral health team and specialists from the advanced illness team, based on each beneficiary's needs. The advanced illness program is designed to help beneficiaries identify their health care preferences, make decisions about advanced care directives, and communicate wishes to their family and providers. If appropriate, beneficiaries are placed on telemonitoring devices in their home that help identify deterioration in their diabetes, heart failure or hypertension so the case manager can arrange for a primary care appointment before the beneficiary becomes ill. If a beneficiary is homebound, home visits are performed by primary care physicians and NPs.

INTEGRATED AND COORDINATED CARE

Integrating and coordinating care across specialties is achieved by ensuring every D-SNP beneficiary is served by an interdisciplinary care team that includes a primary care provider and a personal nurse case manager. The primary care provider is responsible for identifying the needs of the beneficiary. The nurse case manager, along with a care manager and social worker, help the beneficiary address physical, behavioral health and socioeconomic barriers. This team coordinates the beneficiary's Medicare and Medicaid benefits decreasing confusion regarding the scope of available services.

The nurse case manager contacts the beneficiary shortly after enrollment to introduce him or herself and the interdisciplinary care team. This initial contact is followed by regular calls to help foster a relationship of trust. Because the relationship between member and nurse case manager is so essential to the beneficiaries' quality of life, the D-SNP reminds the beneficiary to engage with their case manager via mail, during calls to customer service, and during meal deliveries. For example, if the beneficiary states they are unaware of who their case manager is, the meal delivery person provides the phone number for case management and that case manager also makes another call attempt to establish a relationship with the beneficiary.

SEAMLESS TRANSITIONS ACROSS CARE SETTINGS

Seamless transitions of care are achieved by sharing the beneficiary's care plan with all providers and providing ongoing education throughout care transitions to beneficiaries and their care givers, which help beneficiaries know when it is necessary to go to the hospital. In the first quarter of 2017, the D-SNP shared beneficiaries care plans with their primary care physician, and notified the physician during unplanned transitions 100% of the time. When a D-SNP beneficiary is admitted to the hospital, the primary care physician is notified and the care plan is

shared. If the transition is planned, a care manager educates the beneficiary on what to expect during the transition of care. The care manager addresses any questions or concerns and sends appropriate information and educational materials regarding the care transition.

While the beneficiary is in the hospital, the care manager calls to help address any needs that might complicate transfer to the next most appropriate setting of care. Upon discharge, the beneficiary's nurse case manager works with the beneficiary, care givers, and providers to ensure the beneficiary understands discharge instructions. During these post-hospital calls, the care manager facilitates follow-up appointments, assists with obtaining home services and supplies, and helps the beneficiary understand and fill prescriptions.

In 2016, the D-SNP handled approximately 9,500 care transitions. In each of these cases, the case managers notified the primary care provider, shared the individual care plan with the interdisciplinary care team, and contacted the beneficiary, or the beneficiary's care giver about the care transition. In addition, as part of the post-hospitalization program, case management provided follow-up calls to ensure beneficiary's pharmacy, nutrition, and physician follow-up needs were met to prevent repeat hospitalization.[26]

IMPROVED ACCESS TO PREVENTIVE SERVICES

Given their low income, D-SNP beneficiaries face socioeconomic barriers. Solutions to encourage and facilitate access to preventive health services include zero-dollar copays to for preventive screenings and education regarding the importance of these screenings. Also, for certain preventive

services beneficiaries are rewarded with points that can be used to obtain additional over-the-counter items. In addition, language barriers, food insecurity, and housing needs are addressed by Social Workers. Data from health risk assessments and disease-specific assessments facilitate additional education and care. There are disease specific assessments for Coronary Artery Disease (CAD), COPD, HF, diabetes, Domestic Violence, Fall Risk, Emergency Evacuation, Renal, Seizures, Behavioral Health, and nutrition to ensure chronic conditions and barriers to treatment are identified and addressed.

DELIVER EFFECTIVE AND EFFICIENT HEALTH CARE

To ensure certain high risk beneficiaries receive the right care at the right time, the Aetna Florida D-SNP developed a Complex Case Management Program (CCM). The main goal of the CCM is to help the most vulnerable beneficiaries navigate the health care system, while facilitating the appropriate delivery of care and services at the right time and in the right setting. Beneficiaries with HF, diabetes, COPD, and CAD are eligible for the program. While in CCM, the beneficiary and case manager interact more frequently. A root cause analysis is performed to identify factors that are contributing to frequent hospital or Emergency Department utilization. The case manager coaches the beneficiary on signs, symptoms and appropriate steps to remain as healthy as possible. The program is designed to keep the beneficiary in the home setting, and has shown promising results. Inpatient admissions among beneficiaries engaged in the CCM were reduced by 93% in the fourth quarter of 2016.[27]

Spotlight on a Successful C-SNP: SCAN Balance for Diabetes

BENEFICIARY CARE IN SCAN BALANCE C-SNP

When a 75-year-old man enrolled in the SCAN Balance C-SNP in 2015, he had been diagnosed with chronic diabetes and was living in Los Angeles. As a plan beneficiary, he completed a comprehensive annual health risk assessment with a care navigator to identify any issues that may impact his ability to manage his diabetes, and other chronic conditions. During the assessment, the care navigator learned he was having difficulties with hearing, which negatively impacted his ability to manage his medications and communicate with providers. He also said he had been feeling lethargic and was having trouble swallowing, leading to weight loss. The care navigator also learned he had not yet had a preventive colon cancer screening.

As a result of this assessment, SCAN coordinated a medication review with a pharmacist to develop a plan for improved medication management. The care manager also encouraged him to request a colonoscopy and assisted him with scheduling and receiving the procedure. The care navigator also encouraged the beneficiary discuss his hearing issues with his primary care physician.

Several months later the man's sister contacted SCAN and thanked the C-SNP for encouraging her brother to get a colonoscopy because the screening led to a diagnosis of colon cancer. Since the cancer was diagnosed early he underwent surgery and was recuperating. He is currently cancer free and working with his interdisciplinary care team to manage his diabetes, hypertension, and recent weight gain. His care navigator continues to encourage him to utilize his Silver Sneakers gym membership to increase his physical activity.

C-SNPS MANAGE BENEFICIARIES WITH COMPLEX CONDITIONS

SCAN C-SNPs are committed to providing beneficiaries with complex conditions with the necessary care management support, dietary and lifestyle interventions, and access to community resources. This is achieved through assessments, individual care planning and interventions, education, and coordination of services. The interdisciplinary care team's approach of collaboration with the beneficiary ensures needs are appropriately identified, assessed, and addressed. Roughly 30,000 beneficiaries are in SCAN SNPs, and about half of those beneficiaries are in C-SNPs.[28] [29] SCAN offers three types of Medicare Advantage C-SNPs:

1. Heart First, for beneficiaries with Congestive Heart Failure, Cardiac Arrhythmia, Coronary Artery Disease, Peripheral Vascular Disease, or Chronic Venous Thromboembolic Disorder.

2. VillageHealth, for beneficiaries with End Stage Renal Disease (ESRD)

3. SCAN Balance, for beneficiaries with diabetes.[30]

The SCAN Balance C-SNP attends to the needs of beneficiaries with diabetes, one of the most expensive chronic conditions in Medicare, both because of the high number of beneficiaries with the condition, and the high cost of care as the disease progresses. The Centers for Medicare & Medicaid Services (CMS) estimates Medicare spends billions of dollars every year on diabetes.[31] Roughly 11 million Americans age 65 or older have diabetes, and cost an estimated $7,900 per person in 2012.[32] [33] According to the Centers for Disease Control and Prevention (CDC) over 29 million Americans

are living with diabetes and another 86 million have pre-diabetes. People with diabetes do not make enough insulin, or fail to use insulin properly. People with diabetes have a buildup of blood sugar that can lead to heart disease, kidney failure, blindness, and amputation of the toes, feet, or legs.[34]

C-SNPs can help bend the cost curve for diabetes. A 2012 study found that people with diabetes in C-SNPs had lower rates of hospitalizations and readmissions than their peers in FFS Medicare.[35] Studies have also shown Medicare Advantage disease management programs are effective in lowering hospital admissions and significantly reducing health care spending.[36] [37]

SCAN C-SNP BENEFICIARIES

The SCAN C-SNP population differs from the Medicare population. Beneficiaries are more diverse, more likely to face economic challenges, require care giver support, and have 3 or more activities of daily living impairments. Ninety percent of SCAN C-SNP beneficiaries reported having two or more chronic conditions, compared to 76% of the Medicare population. Additionally, 43% of beneficiaries had four or more chronic conditions. Social determinants of health also impact the complex health needs of C-SNP beneficiaries. Roughly 15% of SCAN SNP beneficiaries qualify for a low-income subsidy, 40% of beneficiaries need support with instrumental daily activities such as transportation, and 25% of beneficiaries live alone.[38]

SCAN TAILORS C-SNP BENEFITS

The SCAN Balance C-SNP provides benefits and a model of care designed to meet the

unique needs of diabetic beneficiaries. The plan seeks to address risk factors for diabetes and better manage the complex chronic conditions that often accompany diabetes by enabling beneficiaries to access tailored benefits and a network of providers who specialize in treating patients with multiple chronic conditions.

The C-SNP benefits package has the core Medicare Part A, B, and D benefits, but offers them within a model of care designed to improve access, affordability, and health outcomes. The C-SNP also offers zero-dollar co-pays for certain specialist office visits such as diabetic self-management training, diabetic supplies such as test strips, and lab services, tests, and procedures. To encourage medication adherence and to control costs to the beneficiary, the C-SNP is able to place high value pharmaceutical benefits in lower cost tiers. For example, insulin prescription drugs are placed in a lower cost tier for insulin dependent diabetic beneficiaries.

C-SNP TAILORS PROVIDER NETWORKS

The C-SNP tailors the network of providers to ensure specialty access for diabetic beneficiaries. For example, endocrinology and ophthalmology are key focus areas for the diabetic C-SNP provider networks, in addition to dietary, hearing, and podiatry services. Diabetes can damage blood vessels and nerves, reducing blood flow to feet, and increasing the risk of infection and amputation. SCAN Balance provides routine coverage for podiatrists to reduce beneficiaries' risk of infection and amputation. The plan does not charge a co-pay for podiatry services because visits are so important to the overall health of the beneficiary.

C-SNP TAILORS SERVICES

The C-SNP utilizes the ability to add services covered by Medicaid tailor benefits to include zero-dollar co-pays for certain transportation and meals.[39] Services are also modified every year to include interventions such as acupuncture, not traditionally covered in Medicare. Current law gives Medicare little flexibility to offer innovative benefit designs or supplemental benefits to a specific population of beneficiaries. The flexibility available through C-SNPs due to the capitated payment system and use of both Medicare and Medicaid benefits in some cases, helps the plan manage beneficiaries' health by controlling blood glucose, blood pressure, and emphasizing dietary and lifestyle interventions to prevent and slow diabetes.[40]

SCAN BALANCE C-SNP CARE MODEL

The C-SNP supports diabetic beneficiaries in a comprehensive way through the care continuum. The core elements of the model of care are to improve health outcomes through better access to care, increase the affordability of care, and effectively coordinate care and care transitions. Working with an interdisciplinary team, beneficiaries receive assistance navigating the health care system and identifying their health goals. Figure 4 lays out the key C-SNP team members. In addition to the primary care physician, and care manager, beneficiaries have access to specialized care managers and providers.

Key C-SNP Team Roles

TEAM MEMBER	ACTIVITIES
CARE NAVIGATOR	Completes a welcome call with new beneficiaries and helps coordinate benefits and care.
CARE MANAGER	Assigned to each C-SNP beneficiary to ensure access to providers, and help coordinate care
COMPLEX CARE MANAGER	Provide case management and disease management services to beneficiaries over the phone, and provides care transition coaching to beneficiaries who have been recently hospitalized
INTERDISCIPLINARY CARE TEAM	Primary care physician, pharmacist, geriatrician, behavioral health specialist, care givers, and member services

SCAN Health Plan. "Special Needs Plan (SNP) Model of Care - Basics."
www.scanhealthplan.com. N.p., 2016. Web.

The C-SNP is designed to address the stated and unstated barriers to quality care outcomes, by developing a rapport with the beneficiary through high quality care and person-centered programs. The C-SNP avoids relying solely on surveys and standardized assessments that may mask beneficiaries needs. [41] Looking at the whole person means addressing dietary and lifestyle interventions to preventing and slow the complications of diabetes and other chronic conditions.

The core elements of the SCAN Balance C-SNP model of care are:

- Improve health outcomes through access;

- Increase the affordability of care; and

- Effectively coordinate care and care transitions.

The C-SNP improves health outcomes through preventive care, disease monitoring and ongoing intervention, and chronic care management for diabetic beneficiaries. The C-SNP manages each beneficiary's health by monitoring blood glucose, blood pressure, and emphasizing dietary and lifestyle interventions to slow the progression and adverse health consequences of diabetes. Health risk assessments, risk stratification, and care coordination facilitate high value care in the right setting to prevent hospital admissions and readmissions. Figure 5 shows the different ways beneficiaries engage with the C-SNP.

FIGURE 5:

Beneficiary Engagement

SCAN Health Plan. "Special Needs Plan (SNP) Model of Care - Basics." www.scanhealthplan.com. N.p., 2016. Web.

All C-SNP beneficiaries must have an initial health risk assessment within 90 days of enrollment. The assessment is designed to assess the physical, mental, and functional status of the beneficiary. Based on the

initial assessment, an individual care plan is developed and updated by a care manager, who is usually a nurse or social worker. Additional assessments are done throughout the year to analyze the beneficiary's medical records, encounters with providers, and pharmacy utilization. Risk stratification is conducted based on data from the assessments. The utilization of hospital and emergency services is also assessed. Data is collected to tailor care to the beneficiary's health needs, wishes, and goals.[42]

The beneficiary is assigned an interdisciplinary team based on care needs. The team includes a care manager, and primary care physician at a minimum. The team may also include a medical director, nurses, social workers, behavioral health specialists, and other health care professionals as needed to ensure beneficiaries needs are being met. The primary care physician meets the beneficiary and updates the care plan. The care manager is critical to enabling the beneficiary to obtain health services and establishing a strong relationship between the beneficiary and primary care physician.

SCAN measures beneficiaries access to health care services and health outcomes. The C-SNP has improved access to medical, mental health and social services based on NCQA measures of access to preventive and ambulatory health services. The C-SNP has also improved diabetes care eye exams, diabetes blood sugar controls, and statin and hypertension medication adherence.[43] The goal of the C-SNP is to improve beneficiaries' self-management of diabetes to facilitate better health outcomes.

INCREASE THE AFFORDABILITY OF CARE

The C-SNP is designed to make health care tailored to diabetic beneficiaries affordable and accessible. The C-SNP has demonstrated improvement in the beneficiary satisfaction category of "getting needed care" as measured by the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.[44] The C-SNP works to enhance the affordability and accessibility of care by measuring the percentage of beneficiaries accessing their primary care physicians who connect beneficiaries to the appropriate medical, mental health, and social services.

Care managers facilitate beneficiaries access care by using medical, psychosocial, cognitive, and mental health data from the health risk assessment to develop an individualized care plan. Care managers connect beneficiaries with resources to improve health based on the care plans. Weekly care management review of the latest hospitalization and medical data trigger reports that are also used to identify high risk beneficiaries and additional care management assistance.

In addition to tracking the individual care plan, care managers help determine if a beneficiary would benefit from specialized programs tailored to diabetic beneficiaries. SCAN Balance works to ensure the programs are accessible and affordable, through community partnerships to address home health, mental health, and end of life care needs. Beneficiaries have access to an array of specialized services like a memory program for dementia patients, assistance

for care givers, exercise and diet classes, and meal delivery programs. Beneficiaries can enter different programs at different points in their health care journey. For example, if a beneficiary has a fall or a hospitalization, new support programs are identified, such as complex care management. All care is coordinated with the interdisciplinary team and centered on primary care.[45]

EFFECTIVELY COORDINATE CARE AND CARE TRANSITIONS

The C-SNP utilizes a multi-tiered care management framework illustrated in figure 6. The end of life care management program assists beneficiaries in developing advance care planning documents. The complex care and medical management program facilitates the development of an individualized care plan based on chronic condition management to prevent hospitalizations. The care coordination program conducts health risk assessments and assists beneficiaries and care givers in navigating health care systems to meet care needs. Population health management strategies are utilized in all the programs to stratify beneficiaries based on risk, develop predictive models, and suggest interventions to promote health and wellness among beneficiaries. The figure below illustrates the different levels of care management.

FIGURE 6:

Multi-Tiered Care Management Framework
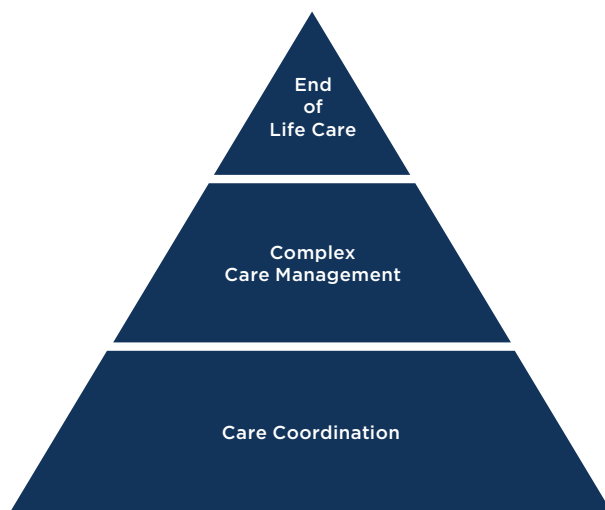
SCAN Health Plan. "2018 Model of Care: Chronic Special Needs Plan for Diabetes Mellitus (C-SNP)." N.p., n.d. Print.

The interdisciplinary team is at the center of the complex care management strategies the C-SNP utilizes to coordinate beneficiaries care across settings. Managing symptoms related to diabetes and other chronic conditions requires facilitation of successful care transitions.[46] SCAN Balance manages care transitions to improve care, reduce readmissions, and improve medication reconciliation. Before a care transition occurs, a care transition team works with the beneficiary's care manager to develop a plan. Then the team works with the beneficiary to answer questions, reconcile medications, discuss warning signs, ensure follow-up visits are scheduled, and health records are shared between care settings. All SNP beneficiaries who have been hospitalized or plan to go to the hospital receive care transition interventions.

After the transition takes place, the primary care physician is notified and the care transition team makes a warm hand off to the beneficiaries' care manager. The care manager works with the beneficiary to identify any barriers to keeping appointments, clarifies test results, and develops questions for the primary care physician or specialist follow-up appointments. Care managers can also help with personal health goals, referrals to additional care management programs, and health benefit questions.

Spotlight on a Successful I-SNP: UnitedHealthcare Nursing Home Plan

I-SNPS MANAGE BENEFICIARIES IN LONG-TERM CARE

I-SNPs are designed for Medicare Advantage beneficiaries who require permanent nursing home placement. I-SNPs may also care for beneficiaries living at home who require an institutional level of care.[47] I-SNP beneficiaries are often permanently institutionalized and typically have higher rates of chronic conditions than the general Medicare Advantage population.

Beneficiaries living in long-term care facilities account for a disproportionate share of Medicare spending. In 2006, average Medicare spending was roughly two-times greater for beneficiaries living in long-term care facilities.[48] The most common chronic conditions for beneficiaries in I-SNPs are dementia, congestive heart failure (CHF), diabetes with chronic complications, and chronic obstructive pulmonary disease (COPD).[49] In 2014, about 15,000 SNFs facilitated 2.4 million Medicare-covered stays for 1.7 million FFS Medicare beneficiaries.[50] Over 90% of SNFs are certified to provide both short-term and long-term services.

Over 25 years ago, two Minnesota NPs leveraged their professional experience to improve the lives of nursing facility residents. The NP's noticed many people living in nursing facilities had difficulty seeing their doctors regularly and transitioning between care settings. As a result, these residents were often in and out of hospitals and emergency rooms. The NPs recognized the importance of ensuring every nursing facility resident had a dedicated NP, who could effectively manage and coordinate their care. This compassionate care model founded by the NPs was called Evercare in 1987, and today it is known as the UnitedHealthcare Nursing Home Plan.[51]

The UnitedHealthcare's Nursing Home Plan delivers coordinated, individualized, and carefully provided care by Optum's providers to roughly 50,000 Medicare Advantage beneficiaries. The I-SNP embeds advanced practice clinicians, primarily NPs, in SNFs and Assisted Living Communities. The NPs work with physicians, long-term care institutions, and care givers to coordinate care across settings.[52] Providers are committed to reviewing care goals, managing pain, coordinating care, and maintaining or increasing daily function and quality of life for beneficiaries.

UNITEDHEALTHCARE NURSING HOME PLAN I-SNP BENEFICIARIES

A typical UnitedHealthcare Nursing Home beneficiary could have several chronic conditions, such as heart failure, COPD, dementia, kidney disease, diabetes with complications, or visual and hearing impairment, and require assistance with routine daily activities. Additionally, beneficiaries are typically taking 9 to 11 medications, and many have been in and out of different care settings prior to enrolling in an I-SNP.

UNITEDHEALTHCARE NURSING HOME I-SNP BENEFITS

The UnitedHealthcare Nursing Home I-SNP provides services tailored to the unique needs of institutionalized beneficiaries. In addition to the core Medicare Parts A, B provided to all Medicare Advantage beneficiaries, UnitedHealthcare Nursing Home benefits include specialized, personalized services. These services include an NP to coordinate care with a clinical team, and coverage for transportation, physician visits, and skilled nursing care.[53] Beneficiaries can access a network of clinicians with expertise in treating institutionalized residents. The plan is specifically designed for patients with complex needs. Care is also supported by a tailored network of skilled pharmacists, physical/occupational therapists, speech pathologists, radiology and laboratory specialists, and dialysis centers.[54]

UNITEDHEALTHCARE NURSING HOME I-SNP CARE MODEL

The UnitedHealthcare Nursing Home puts advanced practice clinicians, usually an NP, at the center of the model to coordinate care. When a beneficiary enrolls in the I-SNP, an NP is assigned to assess needs, provide care, and develop a plan to maintain the beneficiary's health. Acting as the advanced practice clinician as well as the care manager, the NP works with the beneficiary's family, providers and the facility staff to address acute problems, deliver preventive care, and follow-up to avoid unnecessary hospitalizations and monitor ongoing treatments.

CarePlus NPs work closely with the beneficiary's interdisciplinary care team to coordinate care and to ensure there are smooth transitions of care, as shown in figure 7. Since CarePlus NPs work directly in the facility setting, they can provide valuable information to the beneficiary's physicians that the beneficiary or beneficiary's family may not have otherwise been able to convey. This leads to less fragmented care and helps avoid unnecessary hospital admissions.

FIGURE 7:

Key I-SNP Team Roles

TEAM MEMBER	ACTIVITIES
UNITEDHEALTHCARE NURSING HOME NURSE PRACTITIONER	Assigned to each I-SNP beneficiary to assess needs, provide care, and develop a plan to maintain the beneficiary's health
INTERDISCIPLINARY CARE TEAM	Primary care physician, registered nurse, hospice, behavioral health, specialists, and family

Optum. "Program Description CarePlus Institutional."

The core elements of the UnitedHealthcare Nursing Home Nurse Practitioner I-SNP model of care are:

- Care coordination with collaborating providers;

- Specialized care planning;

- Communication;

- Anticipating care needs; and

- Emphasis on efficacy and data.[55]

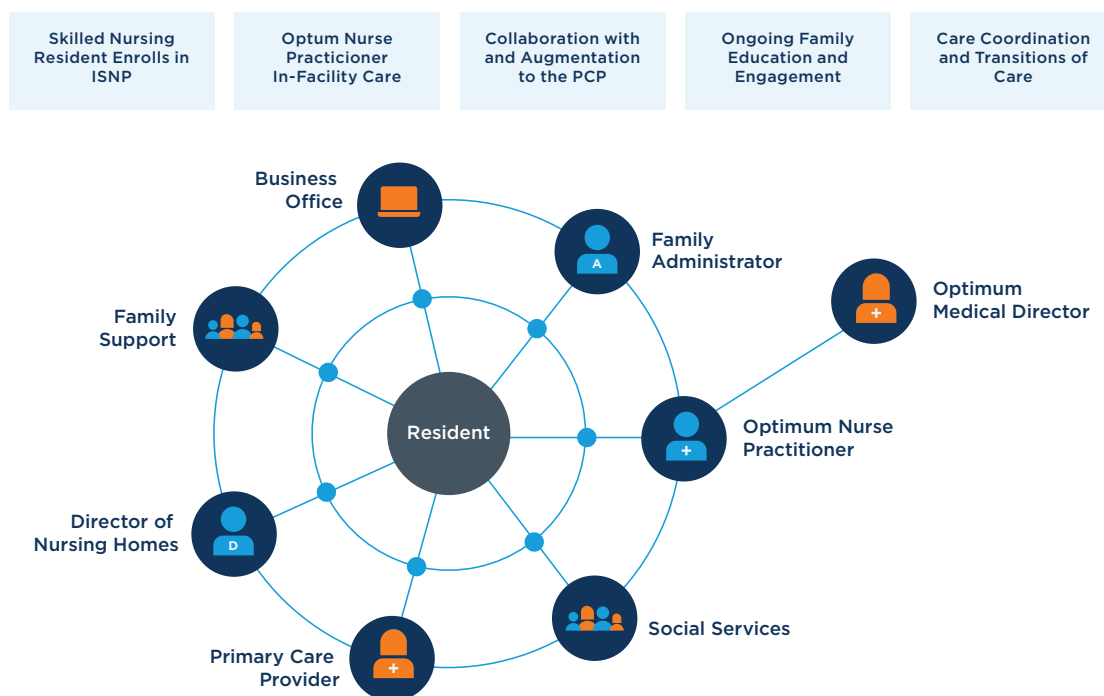## CARE COORDINATION WITH COLLABORATING PROVIDERS

An interdisciplinary care team ensures the beneficiary is receiving the appropriate level of care.[56] [57] The NP partners with the beneficiary's primary care physician and facility staff to monitor care, as figure 8 illustrates.[58] The NP works with the care team, beneficiary, and care givers to manage advance care-planning, provide personal attention, and act as an advocate for beneficiaries where they live.

Within 30 days of enrollment in the UnitedHealthcare Nursing Home Plan, the beneficiary receives a face-to-face comprehensive initial health risk assessment with their NP to determine the beneficiary's health status. The health risk assessment is a screening tool used to identify the medical, functional, and mental health of the beneficiary every year. The tool is updated regularly for care transitions like hospitalizations, falls, and changes in medication. The NP uses the data from the assessment and works with the beneficiary's providers to develop an individualized care plan.

The individualized care plan is developed in collaboration with the beneficiary and care givers. The care plan is reviewed and updated at least monthly. An interdisciplinary care team consisting of the NP, a case manager, specialty physicians, pharmacists, nutritionists, therapists, mental and/or behavioral health experts, home care providers, and other social service providers as needed, also review the care plan monthly, updating and reassessing the care plan as necessary. [59]

UnitedHealthcare Nursing Home I-SNP Model

Skilled Nursing Resident Enrolls in ISNP	Optum Nurse Practicioner In-Facility Care	Collaboration with and Augmentation to the PCP	Ongoing Family Education and Engagement	Care Coordination and Transitions of Care

Business Office

Family Administrator

Optimum Medical Director

Family Support

Resident

Optimum Nurse Practitioner

Director of Nursing Homes

Social Services

Primary Care Provider

Optum Care. "CarePlus program overview."

COMMUNICATION

The NP brings the fragmented pieces of the health care system together for the beneficiary and their family.[60] The robust care management practices are designed to effectively communicate with the beneficiary and care givers to keep everyone informed of changes in condition. NPs facilitate routine face-to-face visits with providers, urgent visits within 24-48 hours based on a change of condition, and advance care planning discussions. The goal of the model is to foster effective communication and facilitate seamless transitions of care to ensure beneficiaries are treated at the most appropriate site of care.[61]

ANTICIPATING CARE NEEDS

The goal of the I-SNP is to stay one step ahead of beneficiary care needs. The model facilitates contingency planning between the beneficiary, their family, and the care team to facilitate decision making. This is one of the reasons patient satisfaction is high, and providers are looking for ways to continue expanding the success of the model.

EMPHASIS ON EFFICACY AND DATA

The UnitedHealthcare Nursing Home Plan closely tracks outcomes to continually improve its care model. The I-SNP has been shown to improve quality of care by embedding advanced care clinicians in nursing facilities to treat beneficiaries in place. A 2017 MedPAC report highlighted the model as reducing unnecessary hospitalizations, and cited a 2002 evaluation of the Evercare demonstration, now known the UnitedHealthcare Nursing Home Plan, which resulted in fewer hospitalizations.[62] The I-SNP has improved quality, and reduced costs by 50% due to fewer inpatient admissions, readmissions, emergency department visits, and SNF admissions.[63] As figure 9 illustrates, the model has reduced hospitalizations by 40% and ER visits by almost 50% by filling gaps in care.[64] [65] Additionally, every hospitalization is reviewed by the I-SNP to see if greater collaboration or different care could prevent hospitalizations and improve future outcomes.

FIGURE 9:

Effect of Treat-in-Place Care Model on Hospital Use

Admits per 1000 Enrollees
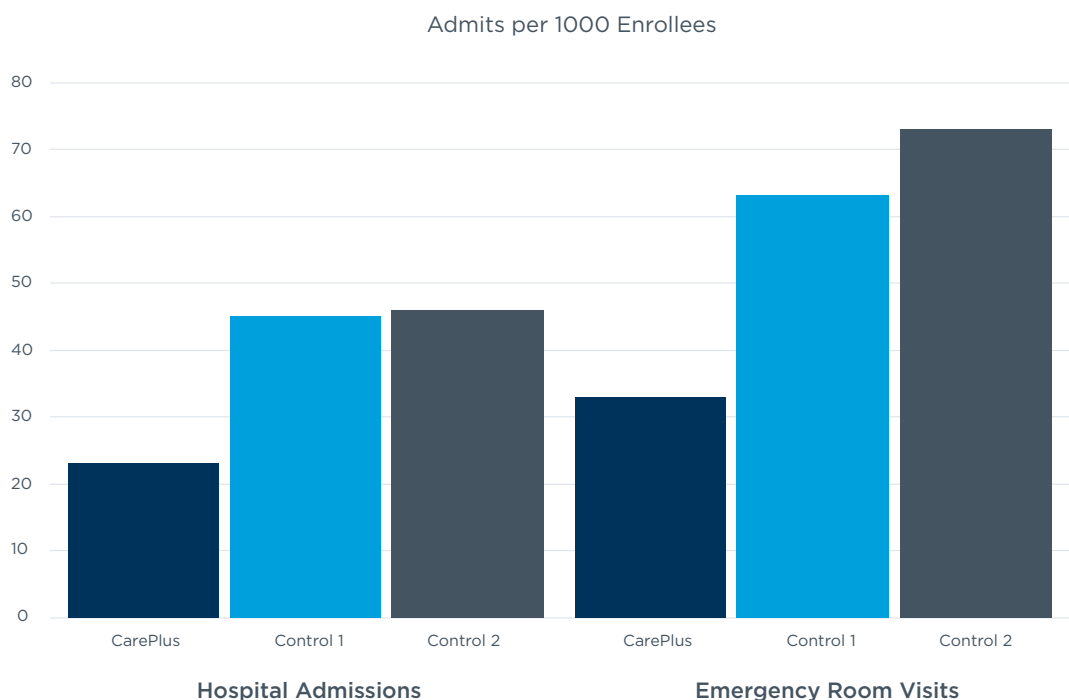
Optum Care. "CarePlus program overview."

One of the primary metrics of success for the I-SNP is preventing avoidable hospitalizations. FFS Medicare provides limited coverage for skilled nursing facility care if it is preceded by a hospital inpatient stay of at least three days.[66] "The I-SNP is able to waive the Medicare three-day rule to improve care transitions by enabling the beneficiary to avoid the hospital and still receive skilled nursing care in the SNF. The goal of the I-SNP in Medicare Advantage is to treat the beneficiary "in place" when possible to improve the beneficiary's quality of life, avoid difficult and unnecessary transitions of care, and deliver value to the health care

POLICY RECOMMENDATIONS

SNPs are providing the highest risk and the highest need Medicare beneficiaries with comprehensive, coordinated, and personalized care to manage chronic conditions and avoid costly preventable hospitalizations. SNPs enable tailored services to be delivered to beneficiaries who are dually-eligible for Medicare and Medicaid, have certain chronic conditions, or receive long-term care in an institutional setting such as a SNF. Aetna's D-SNPs, SCAN Health Plan's C-SNPs, and UnitedHealthcare's Nursing Home Plan I-SNPs are providing care management, health risk assessments, individualized care plans, and tailored care that brings the fragmented pieces of the health care system together for vulnerable beneficiaries and their care givers.

Without Congressional action, SNP authority will expire in 2018. Congress has continued to reauthorize the program since 2003 because SNPs have been recognized as a valuable care delivery model for high cost, high need beneficiaries. There is broad consensus in Congress, MedPAC, and among stakeholders that SNPs should be permanently authorized. The Senate Finance Committee Chronic Care Working Group recommended permanently authorizing SNPs.[67] In 2016, MedPAC recommended Congress permanently authorizing all I-SNPs, certain D-SNPs and certain C-SNPs.[68] Greater certainty will unlock the potential of these innovative, successful models that are meeting the needs of high cost, high need beneficiaries under Medicare Advantage across the country. [69]

SNPs provide preventive care, cost effective care management, and tailored care delivery and benefits driven by the needs and goals of the individual beneficiary. Increasing flexibility for SNPs to further tailor services to specific populations would improve health outcomes for vulnerable beneficiaries. SNPs must adhere to Medicare Advantage benefit design regulations that limit plans ability to tailor networks and cost sharing.

In addition, Medicare Advantage supplemental benefits are currently narrowly defined as health related, which limits spending on non-medical interventions that may address social determinants of health. Increased flexibility in plan design and supplemental benefits in Medicare Advantage would provide greater flexibility for plans and providers to further tailor benefits to address the needs of beneficiaries.[70]

Action both to permanently reauthorize SNPs, and to broaden the definition of allowable supplemental benefits to better address social determinants of health would provide certainty. These policy changes would also enhance the availability of cost effective models of care that meet the needs of Medicare's high need, high cost beneficiaries, improve outcomes, and achieve high patient satisfaction.
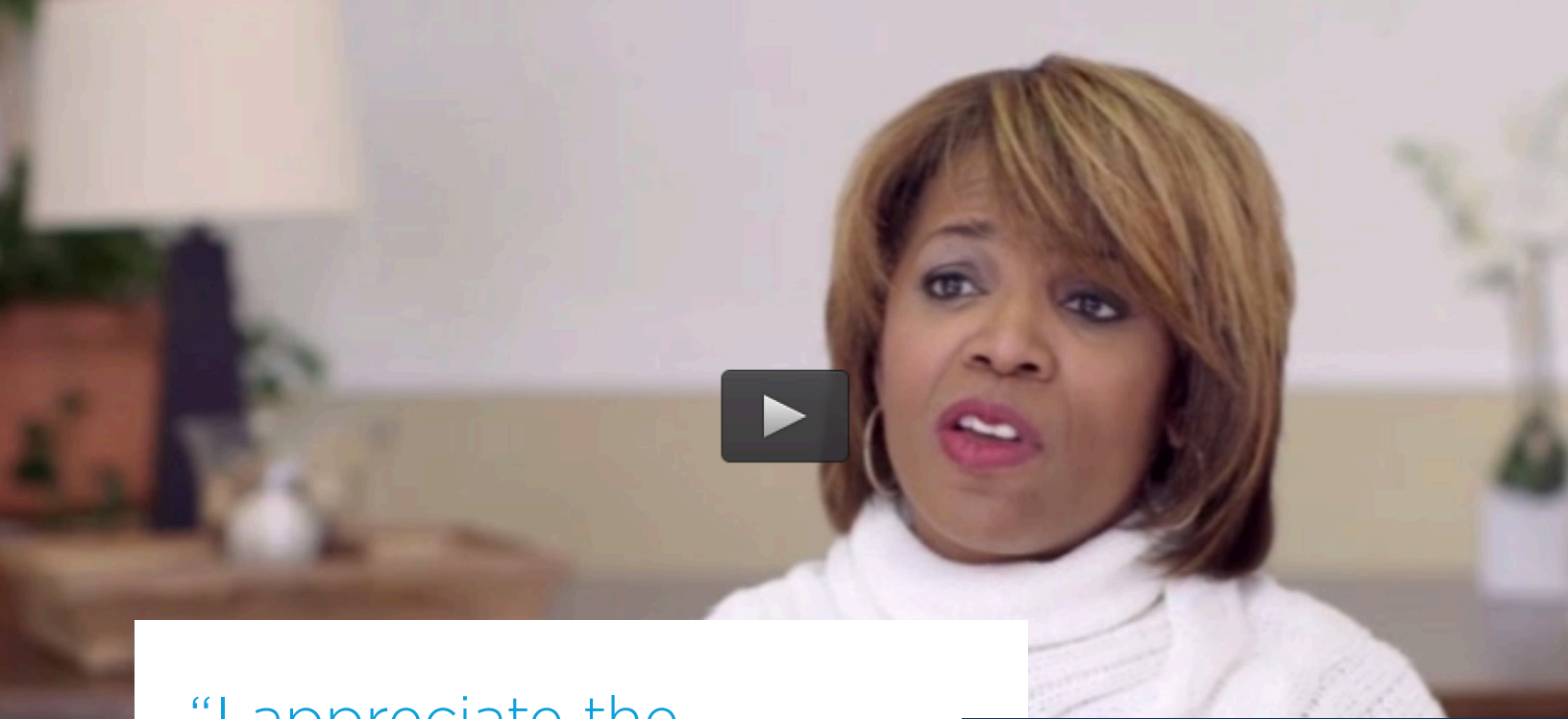
"I appreciate the communication between the nurse practitioner and myself."

"With the Optum program, communication is at the heart of it. The communication between the staff and nurse practitioner, the communication between the nurse practitioner and the physicians, and then of course the communication between the resident and their family."

"The biggest benefit for having Optum in a nursing facility is they bridge the gap between the nursing staff and your medical director and his staff. They are there for extra help and extra support."

"The nurse practitioner is so involved. That's one the things we love about the Optum program is that they initiate phone calls to the family and they initiate phone calls to other physicians and consulting physicians, and then follow up with the family to let them know which gives them peace of mind."

Video: Peace of mind comes standard

Bonita's mother needed extra care and support. And Optum CarePlus was there to provide it. Hear her story, as well as interviews from the nurse practitioners, social workers and physicians that help people like Bonita's mother every day.

Watch:

https://www.optumcare.com/landing/care-plus-video.html

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