

Attachment A: Model of Care for Dual-eligible SNPs

MA Contract Name: Geisinger Health Plan

MA Contract Number: H3954-097

Type of Dual-eligible SNP: Full

The model of care describes the MAO's approach to providing specialized care to the SNP's dual-eligible population. It should highlight the extra benefits and services for dual-eligible beneficiaries that distinguish the SNP from the MAO's other MA products. CMS also expects plans to meet the needs of vulnerable subpopulations - beneficiaries who are frail/disabled, have multiple chronic illnesses, or are near the end of life - for each targeted population since these subsets are likely to be more prevalent among the special needs populations. CMS operationally defines frail as either "... a state of reduced physiologic reserve associated with increased susceptibility to disability ...;" or "...those who depend on others for the activities of daily living or who are at high risk of becoming dependent" (How to Select a Frail Elderly Population? A Comparison of Three Working Definitions; Paw, Dekker, Fesken, Schouten and Kromhout, Journal of Clinical Epidemiology, Volume 52, Issue 11, November 1999, pages 1015-1021).

Dual-eligible SNPs should complete and submit Attachment A and, if serving beneficiaries with end-stage renal disease (ESRD), Attachment D.

1. Goals and Objectives

a. List the goals and objectives of the model of care that drive service delivery under your dual-eligible SNP.

Goal:

Screen members to ascertain the correct level of care for the individual Special Needs Plan (SNP) member in order to provide the highest quality of care possible.

Objectives:

- 1) *Conduct timely screening of SNP members by a licensed physician, licensed mid-level provider, and/or Geisinger Health Plan case manager to ensure proper risk stratification is completed;*
- 2) *For members with a Case Management need and who are willing to participate, the Case Manager will develop plans of care specific to the beneficiaries' needs based upon a detailed member assessment;*
 - a. *Determine available benefits and resources for the members;*
 - b. *Provide SNP members with case management program information;*
 - c. *Document member's clinical history, including medications;*
 - d. *Assess activities of daily living and safety issues;*

- e. *Assess mental health status, including cognitive functions;*
 - f. *Assess life-planning activities;*
 - g. *Evaluate cultural and linguistic needs, preferences and limitations;*
 - h. *Evaluate caregiver resources and social supports;*
 - i. *Coordinate healthcare services as needed;*
 - j. *Develop and communicate self-management plans to members in conjunction with providers, if appropriate;*
 - k. *Evaluate barriers to meeting the care plan goals.*
- 3) *For those SNP members choosing not to enroll predictive modeling risk scores and utilization patterns will be reviewed at least annually to assure appropriate services are offered to meet medical, behavioral or other needs;*
 - 4) *Monitor SNP members for hospital admissions and re-admissions;*
 - 5) *Monitor SNP members for emergency department visits;*
 - 6) *Educate members and/or members' family on advance directives and life planning;*
 - 7) *Educate members and/or members' family on hospice services, coordinate services when indicated.*
- b. Address the goals and objectives specific to each of the following subpopulations: frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

Frail/Elderly Beneficiaries

Goal:

Identify SNP beneficiaries that fall into the frail and elderly category by screening members to ascertain their current level of functioning.

Objectives:

- 1) *Conduct timely screening of SNP members by a licensed physician, licensed mid-level provider, and/or Geisinger Health Plan case manager to ensure proper risk stratification is completed;*
- 2) *For members with a Case Management need and who are willing to participate, the Case Manager will develop plans of care specific to the beneficiaries' needs based upon a detailed member assessment;*
 - a. *Determine available benefits and resources for the members;*
 - b. *Provide SNP members with case management program information;*
 - c. *Document member's clinical history, including medications;*
 - d. *Assess activities of daily living and safety issues;*
 - e. *Assess mental health status, including cognitive functions;*
 - f. *Assess life-planning activities;*
 - g. *Evaluate cultural and linguistic needs, preferences and limitations;*
 - h. *Evaluate caregiver resources and social supports;*
 - i. *Coordinate healthcare services as needed;*
 - j. *Develop and communicate self-management plans to members in conjunction with providers, if appropriate;*
 - k. *Evaluate barriers to meeting the care plan goals.*

- 3) *For those SNP members choosing not to enroll, predictive modeling risk scores and utilization patterns will be reviewed at least annually to assure appropriate services are offered to meet medical, behavioral or other needs*
- 4) *Monitor SNP members for hospital admissions and re-admissions;*
- 5) *Monitor SNP members for emergency department visits;*
- 6) *Educate members and/or members' family on advance directives and life planning;*
- 7) *Educate members and/or members' family on hospice services, where applicable.*

Beneficiaries with Multiple Chronic Illnesses

Goal:

Identify SNP beneficiaries that fall into the category of multiple chronic illnesses by screening members to ascertain their current level of functioning.

Objectives:

- 1) *Conduct timely screening of SNP members by a licensed physician, licensed mid-level provider, and/or Geisinger Health Plan case manager to ensure proper risk stratification is completed;*
- 2) *For members with a Case Management need and who are willing to participate, the Case Manager will develop plans of care specific to the beneficiaries' needs based upon a detailed member assessment;*
 - a. *Determine available benefits and resources for the members;*
 - b. *Provide SNP members with case management program information;*
 - c. *Document member's clinical history, including medications;*
 - d. *Assess activities of daily living and safety issues;*
 - e. *Assess mental health status, including cognitive functions;*
 - f. *Assess life-planning activities;*
 - g. *Evaluate cultural and linguistic needs, preferences and limitations;*
 - h. *Evaluate caregiver resources and social supports;*
 - i. *Coordinate healthcare services as needed;*
 - j. *Provide condition-specific self-management plans and education to member and in conjunction with providers if appropriate;*
 - k. *Evaluate barriers to meeting the care plan goals.*
- 3) *For those SNP members choosing not to enroll, predictive modeling risk scores and utilization patterns will be reviewed at least annually to assure appropriate services are offered to meet medical, behavioral or other needs*
- 4) *Monitor SNP members for hospital admissions and re-admissions;*
- 5) *Monitor SNP members for emergency department visits;*
- 6) *Educate members and/or members' family on advance directives and life planning;*
- 7) *Educate members and/or members' family on hospice services, where applicable.*

Beneficiaries near the End of Life

Goal:

Identify SNP beneficiaries that fall into the end of life category by screening members to ascertain their current level of functioning.

Objectives:

- 1) *Conduct timely screening of SNP members by a licensed physician, licensed mid-level provider, and/or Geisinger Health Plan case manager to ensure proper risk stratification is completed;*
- 2) *For members with a Case Management need and who are willing to participate, the Case Manager will develop plans of care specific to the beneficiaries' needs based upon a detailed member assessment;*
 - a. *Determine available benefits and resources for the members;*
 - b. *Provide SNP members with case management program information;*
 - c. *Document member's clinical history, including medications;*
 - d. *Assess activities of daily living and safety issues;*
 - e. *Assess mental health status, including cognitive functions;*
 - f. *Assess life-planning activities;*
 - g. *Evaluate cultural and linguistic needs, preferences and limitations;*
 - h. *Evaluate caregiver resources and social supports;*
 - i. *Coordinate healthcare services as needed;*
 - j. *Develop and communicate member self-management plans;*
 - k. *Evaluate barriers to meeting the care plan goals.*
- 3) *For those SNP members choosing not to enroll, predictive modeling risk scores and utilization patterns will be reviewed at least annually to assure appropriate services are offered to meet medical, behavioral or other needs;*
- 4) *Monitor SNP members for hospital admissions and re-admissions;*
- 5) *Monitor SNP members for emergency department visits;*
- 6) *Educate members and/or members' family on advance directives and life planning;*
- 7) *Educate members and/or members' family on hospice services,; coordinate services when indicated.*

2. Organization of Staff

- a. Describe the specific organization of staff (e.g. employees, community service workers, nurse practitioners, and case managers) that interacts with dual-eligible individuals to provide the specialized services available under the model of care.
- b. Specify the role for each position described above.

Geisinger Health Plan implements case management screening for all new dual eligible members. The role of case management is the coordination of care and services provided to members to facilitate appropriate delivery of care and services. For those members who have Case Management needs and who are willing to participate, the Case Manager provides a comprehensive assessment of the member's past medical history and current condition; available benefits and resources; and development and implementation of a member-centered self-management plan with member directed goals, condition monitoring and schedule of follow-up. In addition, providers and case managers analyze members' ongoing health status using available resources, such as a predictive modeling tool and an electronic health record (EHR), where available.

Beyond new SNP membership, providers and case managers use clinical data sources to analyze dual eligible members' health status and determine any outstanding preventive services needed to assure quality care for chronic health conditions. Enrollment in case management or disease management occurs for members with chronic conditions such as, but not limited to, diabetes, cardiopulmonary disease, and hypertension. In addition, hospital admission triggers a referral to case management. The case manager serves as coordinator for post discharge review and follow-up. Other avenues for enrollment in case management include referrals from primary care, customer service, and utilization management or disease management providers.

Case management systems utilize policies based on evidence-based clinical guidelines or algorithms to conduct assessment and management. Documentation of the staff member's calls or other interactions with the member is found in the EHR. Automated prompts for follow-up are integrated into workflows, as required by the case management plan. The case management plan includes a schedule for follow-up that includes, but is not limited to, counseling, disease management, education and member self-management support.

Case managers provide members with case management program information via a written Self Management Action Plan. This includes how to use the services, how members become eligible to participate and how to opt in or opt out. It also includes information on self-monitoring and self-reporting, for early recognition and intervention of problems. The collaborative plan of care is developed with active discussion with the member /member's family (if approved by member) and includes: Short- and long-term goals; time frame for reevaluation; resources to be utilized, including the appropriate level of care based on specific triggers or symptoms. Case managers work with discharge planners, home health/hospice providers, behavioral health providers and community resources to assure efficient, effective planning for continuity of care, including transition of care and transfers. SNP members remain in Case Management as long as there are needs. Enrollment in Case Management is closed when needs are met or when a member no longer desires follow up.

Primary care physicians work in conjunction with the case managers, customer service and physician office staff to provide planned encounters and shared follow-up of chronic health issues, testing results, preventive health activities and access for urgent health needs. When appropriate, a self-management plan is developed including, but not limited to, members' monitoring of their symptoms, activities, weight, blood pressure and glucose levels. Diuretic Titration Protocols are available for Heart Failure and Rescue Kits are available for COPD, if the case manager and physician feel the resources are appropriate and that the member is able to understand the purpose and process for implementing the tool.

3. Describe the lines of communication and accountability between the SNP and the care delivery staff.

Care delivery staff provide updates to the SNP case management or utilization management staff via telephonic or written update. Services and updates are reflected in the EHR or paper medical record to assure continuity of care. In addition, Geisinger Health Plan case managers contact inpatient and SNF care managers/discharge planners to assure

coordinated transitions in care if an inpatient/SNF admission occurs. Contacts from providers to Geisinger Health Plan's customer service team (member services) are documented in a phone log, accessible to case managers. Geisinger Health Plan Medical Management provides utilization management reviews and acts proactively to contact case managers via on-line referral or place outbound calls to community or physician providers if other needs are identified during their reviews. Clinical pharmacists are available to support medication related issues. A delegated vendor supports behavioral health issues. Support is accessed via an on-line referral process.

4. Describe the specific steps the SNP takes (e.g. written protocols and training) to ensure that the staff understands how the model of care works and how to function in accordance with the model of care.

The organization provides practitioners with written information about the SNP program that includes the following: instructions on how to use services; how the organization works with a practitioner's patients in the program and appropriate contact numbers for services for dual eligible members. This information can be found at www.thehealthplan.com and is also distributed to providers by Provider Network management and Case managers. Clinical guidelines and disease management program information are also available at this web site.

New Geisinger Health Plan case management staff has orientation on all aspects of case management, clinical guidelines and disease management to assure quality services to members. Written protocols and clinical guidelines are reviewed annually, and are supported by two medical benefit policy coordinators who provide research to support all Geisinger Health Plan staff, including actively practicing Medical Directors. An on-line database of expert resources is made available for infrequent or complex medical issues. Ongoing continuing education is offered via live conferences, webinars or external conferences for both case managers and utilization management staff.

5. Specific Needs of dual-eligible beneficiaries

a. State how this model of care identifies and meets the specialized needs of dual-eligible beneficiaries.

All members of Geisinger Health Plan's dual-eligible SNP will go through a detailed screening process completed by a licensed physician, licensed mid-level provider, and/or case manager nurse. The goal of this screening is to properly identify in which category of care SNP members should reside. Upon enrollment into Case Management a detailed assessment will be completed. The assessment contains specific questions about caregiver resources, clinical history, activities of daily living, mental health status, etc., so that the member, Case Manager and/or provider can determine the proper self-management goals and objectives. An individualized plan of care will be developed to specifically meet the needs of the frail elderly, those beneficiaries with multiple chronic conditions, or those beneficiaries at the end of life.

For those members that choose not to enroll into Case Management, predictive modeling risk scores and utilization patterns will be reviewed at least annually to assure appropriate services are offered to meet medical, behavioral, or other needs.

b. State whether the model of care specifically addresses the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

The model of care is predicated on the training and skills of the clinical staff assigned the responsibility of screening all beneficiaries within the SNP. The screening process will stratify each beneficiary into one of the three care categories, as well as identify member needs and gaps in care, whereby a specific plan of care can be developed to meet the specific psychosocial, clinical, and life planning needs.

6. Extra Benefits and Services

a. List and explain extra benefits and services that are provided to meet the needs of dual-eligible beneficiaries.

Geisinger Health Plan provides the same extra benefits and services that are detailed in subparagraph 6b. for all SNP members enrolled in its dual-eligible SNP.

b. List and explain extra benefits and services that are provided to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

While case management is available to all Geisinger Health Plan Medicare Advantage members on a referral basis, each SNP beneficiary is proactively screened within twenty (20) days of enrollment into Geisinger Health Plan Gold to ascertain the correct level of care.

Direct out-of-pocket costs for FFS Medicare are higher than Geisinger Health Plan's dual-eligible SNP. There are no premiums for the medical benefits, which includes preventive health services and yearly physicals. There are no premiums for Part D prescription drug coverage. SNP members also have limited coverage for over-the-counter medication and supplies each quarter. As a member of Geisinger Health Plan's dual-eligible SNP, members have dental benefits and access to an extensive dental network for that coverage.

7. Outcome Measures

a. State what specific process and outcome measures are used to evaluate performance of the model of care for dual-eligible beneficiaries.

Geisinger Health Plan utilizes the same processes that are detailed in subparagraph 7b. for all SNP members enrolled in its dual-eligible SNP.

b. Address the specific process and outcome measures the plan used to evaluate performance of the model of care for frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

The following outcome and process measures will be collected and reported:

- 1) *Number of SNP members screened and stratified for dual-eligible categorization within twenty (20) days.*
- 2) *HEDIS results reporting.*
- 3) *Yearly monitoring of influenza vaccines*
- 4) *Yearly monitoring of pneumococcal vaccines*
- 5) *Clinical follow-up encounters within 1 week for members discharged from an acute care or skilled care nursing facility.*
- 6) *Annual review of the hospital admission rate/1000*
- 7) *Annual review of the hospital re-admission rate/1000*
- 8) *Annual review of the emergency room visit rate/1000*
- 9) *Yearly monitoring of complaints and appeals*
- 10) *Yearly monitoring of hospice elections*

8. State whether the SNP provider and pharmacy networks are different than the networks for the MAOs other Medicare coordinated care plans (CCP) plans in the same service area under this contract.

The provider and pharmacy networks for our SNP and other CCP plans in the service area are the same under this contract.

9. Clinical Expertise

- a. Describe the pertinent clinical expertise used in the provider network to meet the special needs of the dual-eligible population.

SNP members will be assessed by clinicians with certification specialties such as geriatrics, NP, RN case manager as well as physicians, pharmacists, physiatrists, Ph.D.s, RNs and MSWs, on an individual basis as indicated by the condition and service requirements needed by the member and family. Hospice will be provided by Medicare certified Hospice providers, ranging from social workers, Hospice volunteers, chaplains, and licensed nurses.

Disease management programs include: Diabetes Care, Asthma Care*, Tobacco Cessation, Congestive Heart Failure*, Hypertension*, Coronary Artery Disease*, Chronic Obstructive Pulmonary Disease (COPD)* and Osteoporosis* programs.*

*(*Accredited by the National Committee for Quality Assurance (NCQA), a private, non-profit organization dedicated to improving health care quality.)*

Clinical guidelines offer providers consistent and appropriate guidance for diagnosis and treatment of specific conditions or diseases. Geisinger Health Plan's clinical guidelines are evidence based, reflect the current literature and research about treatment protocols, and

reflect enterprise experience and best practices. Geisinger Health Plan's clinical guidelines present an opportunity to significantly reduce variation in the clinical setting and provide part of a framework necessary for measuring and improving the quality of care. Guidelines currently in place include: Adult Depression, Adult Sinusitis, Acute Low Back Pain, Congestive Heart Failure, Hyperlipidemia in CAD Patients, Hypertension, Diabetes Care, Asthma Care, Osteoporosis, Pediatric Otitis Media and Uncomplicated Urinary Tract Infection.

Our behavioral health program allows on-line referral by any member of Geisinger Health Plan or the provider network to assure prompt evaluation, assessment and delivery of services appropriate to the needs of the dual eligible member.

- b. Address the pertinent clinical expertise used to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

Our provider panel includes specialists who support primary care and case management resources for complex social and medical issues. Our provider network includes resources across the continuum of care with coordination of services via active communication during transitions of care. Our Home health and Hospice provider network supports programs that serve the needs of terminally ill and grieving individuals of all ages. Its mission is to improve access to quality care through public education, professional training, and advocacy on behalf of members. Geisinger Health Plan provider representatives work actively to support provision of education to members regarding options for end of life care, including palliative medicine.

10. If the existing network does not include sufficient specialists to fully meet the special needs of the target population, describe the policies and procedures used to arrange access to non-contracted specialists.

Geisinger Health Plan's current network meets required access and availability standards as set forth by CMS. Geisinger Health Plan has a sufficient number of Specialists to meet this SNP population; however, medical management and case management staff work together to provide continuity of care and to coordinate out of network services to assure appropriate and timely access to care on a case-by-case basis.