2023 Dual Special Needs Plan Model of Care Evaluation Summary of Findings

What is a Dual Special Needs Plan (D-SNP) Model of Care (MOC)?

A D-SNP Model of Care describes how we give healthcare services to our members who have special needs. Our purpose is to provide them with access to care that is reliable, convenient, and accessible. Annually, we check the quality of the care and service we make available to these members. We set goals and follow steps and actions to correct our process if we do not meet those goals. This process is called a Corrective Action Plan (CAP).

Here are some checkpoints we used to evaluate the quality of the services we made available to our senior members who qualify as D-SNP plan members:

- Member Satisfaction Survey
- Availability and Location of Primary Care Doctors and Specialists Near Members' Homes
- Care Coordination
- Transitions of Care
- Health Effectiveness Data and Information Set (HEDIS) Measures
- Provider and Staff Training

What if we do not meet our goals outlined in a Corrective Action Plan (CAP)?

We continue to evaluate and look for the best possible means of meeting our goals.

How did we do in 2023?

1. **Member Satisfaction Survey –** Our goal is to ensure members are satisfied with the care they receive from their doctors and their health plan, improving year over year.

   Satisfaction goals for Care Coordination, Health Plan Customer Service, Rating of Health Plan, Rating of Health Care, Getting Care Quickly, and Getting Needed Care, were not met.

   We know these services are important to our members. We will focus on ways to improve services and make members' experience a positive one.

   We want to be a trusted health plan and listen to what members tell us in member satisfaction surveys. This is an important way of making positive changes for our members. Our CAP has initiatives in three areas: People, Process, and Technology. Please refer to the full 2023 SNP MOC Evaluation for details on our strategy for improvement.

2. **Availability and Location of Primary Care Doctors and Specialists Near Members' Homes** - Our goal is to ensure members have access to primary care and specialty care doctors near their homes.

   We met our goals of ensuring that primary care doctors (75%) and specialty care doctors (90%) are located within time and distance standards of our membership's homes. We also met our goals for ratios of doctor to members for both primary care doctors and specialty care doctors.

If a doctor is not available in a member's area, we offer free transportation services from the member's home to the doctor. We met both goals in 2023 of ensuring that 98% of transportation requests are fulfilled by the transportation vendor and that fewer than 1% of complaints are related to transportation services.

3. **Care Coordination –** Our goal is to improve members' health through care coordination. All members are contacted for completion of a Health Risk Assessment (HRA), which is a questionnaire to identify health care needs, and an Individualized Care Plan (ICP), which is a plan of action on how to meet health care needs. Members are also invited to participate in a meeting with their care team to discuss goals and interventions for their health.
   We did not meet HRA, ICP, and care team goals. However, operational changes led to improved compliance rates in 2023. The internal Care Management team insourced the HRA outreach team, implemented a new electronic Care Management system, and implemented use of a daily real-time Prospective Audit Tool (PAT) to improve timeliness of HRA and ICP completion.
   We will continue to implement operational changes to improve performance. For 2024, we will implement the following:
   - An HRA completion member incentive.
   - A process to complete HRAs with the broker at the time of member enrollment.
   - Streamline of the ICP process into the electronic Care Management system to improve ICP engagement and timeliness.

   Overall, our goal is to contact 100% of members for an HRA, ICP, and care team meeting. We will create an ICP and hold a care team meeting for every member (whether the member chooses to be involved or not).

4. **Transitions of Care -** Our goal is to improve transition of members' care between healthcare settings.
   We work with hospitals and skilled nursing facilities (SNFs) to make sure our health plan provides timely and efficient care for all members. We track the following measures:
   - Care manager updates ICP within 30 days of transition of care episodes.
   - ICP is shared with member and primary care doctor within 7 business days of the update.
   - Care manager contacts member within 2-4 business days of notification of discharge to home to help with transitional care needs.

   We did not meet the goals for these measures due to a manual process for identifying, monitoring, and reporting transition of care events, and data delays in discharge notifications. To address barriers, the Care Management team will be utilizing new data feed systems to help the organization better meet timelines for the measures above.

5. **Health Effectiveness Data and Information Set (HEDIS®) Measures -** Our goal is to improve member health outcomes with access to preventive health services.
   Health plans use data to evaluate how well they are doing with their care for members. The goals for the following topics were met:

- Making sure members who need an anti-depressant start and stay on the medication.
- Making sure members with high blood pressure maintain healthy blood pressure.

The goals for the following topics were not met:

- Making sure members have their medication records reviewed annually.
- Making sure members get their blood sugar checked due to diabetes.
- Making sure members have their medication records reviewed and updated after a hospital stay.
- Making sure members have a pain screening annually.
- Making sure members who are discharged from a hospital stay are not readmitted within 30 days.
- Making sure members access preventative care services.

Our CAP to meet goals on these measures is intended to educate and conduct outreach to our doctors to get members the help and services they need to prevent chronic health problems. We also offer Provider and Member Incentive Programs to reward providers and members for closing care gaps. Our goal is to ensure that members stay as healthy as possible all year long.

6. **Provider and Staff Training –** Our goal is to ensure all providers and staff members are trained initially and annually on the Model of Care.

   All new providers are notified of the training process and their obligation to complete the training upon acceptance to the network and then annually thereafter. New staff members are required to complete the training within 90 days of onboarding. Modes used to contact or remind providers and/or staff members of the training consist of blast fax and e-mail with instructions on how to access the web-based training module.

   For provider training, we did not meet our performance goal of 80% for initial training (43%). However, we did meet our performance goal of 80% for annual training (82%). We will make operational changes to address the low compliance rates for initial training.

   For staff training, we met our performance goal of 100% for initial training and annual training. The team will continue to use its system of reminders to ensure compliance.

The above summary is an excerpt from the full evaluation. A full version of the evaluation is available upon request. Please contact Case Management at (888) 548-5765, 8 a.m. to 6p.m., Monday through Friday.