Triple-S Salud, INC., H4012
Dual Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Triple-S Salud (Triple S) Medicare Dual SNP population targets those who are dually eligible for Medicare and Medicaid as qualified by the State Health Insurance Agency. Puerto Rico's and Triple-S' dual SNP population is characterized by the following: 95% of the population is classified as indigent. General statistics for the 65 and over population in Puerto Rico demonstrate that 86% of females and 78% of males are not in the labor force. These elderly rely on Social Security benefits and the State's Assistance Programs as the only source of income. 11% of this population have less than a 9th grade level of education. The most prevalent diseases for the dual-SNP members are hypertension, hyperlipidemia, urinary tract infections, anemia, and chest pain.

Provider Network

Triple-S Preferred Specialists Network has over 130 physicians and was developed by considering physicians with the best practice parameters available in the following specialties: rheumatology, ophthalmology, cardiology, pulmonology and gastroenterology. Triple-S' provider network is currently composed of 56 acute care facilities including 11 hospitals and the Puerto Rico Medical Center where in-patient acute services are provided. Also available: 14 independent ambulatory care facilities, 26 dialysis facilities, 7 skilled nursing facilities and 2 inpatient rehabilitation hospitals, 662 clinical laboratories, 1045 pharmacies, 3 specialized infusion pharmacies, 2 long term care pharmacies, and 243 radiologists. Currently none of the 16 federally qualified long-term care facilities are in Puerto Rico.

Care Management and Coordination

Triple-S requires that all primary care physicians perform a comprehensive annual health evaluation to all Dual-SNP members during the first 90 days of the year. The member health risk assessment (HRA) provides data to collect personal information and information for caregiver emergency contacts. Participation of members or assigned caregivers in the interviews and assessments of care planning is usually by phone but may require face to face assessments from the visiting nurse, social worker or behavioral health specialist.

Triple-S integrates internal and external resources to create an interdisciplinary care team (ICT) that may include all of the following: behavioral and/or mental health specialist (psychiatrist, psychologists and drug and alcohol therapist) restorative health specialist (physicians, audiologists, physical therapists, occupational therapists, speech pathologists) nutritionists and dieticians. The ICT starts with the primary care provider (PCP) selected by the member as the

physician in charge as a gatekeeper to monitor and guide all care needs. Face to face participation of members in the development of the care plan occurs at the primary PCP level.

The individualized care plan (ICP) is updated as member health status changes. The case manager (CM) has the responsibility of periodically updating the ICP according to needs. Written summaries of the ICP will be sent by mail and shared with members, caregivers and PCPs. The case manager/disease manager (CM/DM) nurses developing the ICP will notify respective providers and members when they initially develop and further update care plans as a result of health status changes. CMs work with discharge planners, home health/hospice providers, and community resources, among others, to assure effective and efficient planning for continuity of care, including transitions of care and transfers.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://sssplanesmedicare.net/eng/