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

**Model of Care Score: 70.00%**
**1-Year Approval[1]** **January 1, 2015 – December 31, 2015**

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## Target Population

Triple-S Salud, INC. works towards increasing access to preventive services and improving population health status for Special Needs Plan (D-SNP) members who are dually eligible for Medicare and receive Medicaid assistance from Puerto Rico. The plan places a focus on populations with special health needs such as chronic conditions or severe and acute episodes of illness.

Over a quarter of the population currently lives at or below the poverty level and is aging rapidly. A recent demographic analysis shows that the population 60 years and over increased threefold over the last 20 years.

Puerto Rico has a large population of those 65 years and older with a low income. Many are not employed and rely solely on Social Security benefits and the Puerto Rico's assistance program as their primary source of income. Of this population, 11 percent have less than a 9th grade level of education.

## Provider Network

To assess the adequacy of the provider network for members, TRIPLE-S gathers information regarding access standards for Puerto Rico. The provider network has expertise relevant to a population with a higher prevalence of diabetes, hypertension, coronary artery disease, chronic heart failure and cancer. The provider network consists of specialists, primary care physicians, ancillary services, facilities, allied professions, and behavioral health. Geographically, the provider network operates in a wide area throughout Puerto Rico including all major cities on the island.

TRIPLE-S maintains a web-based interface for conferences with the provider network. This provider web-based application provides access to payment schedules, claims, coordination of benefits, eligibility, provider manuals, policies, billing, incentive programs, guidelines, and all other forms of care communication. The web based provider portal acts as the primary way by which the network is monitored and maintained by TRIPLE-S.

## Care Coordination

TRIPLE-S performs periodic reviews of the characteristics and needs of its populations through its care coordination and management program. TRIPLE-S designs the program for members

[1] Per CMS guidance, plans that use the cure process receive a one-year approval, regardless of their final score.

with complex conditions. All new members are contacted by phone or in writing to obtain a basic health history and evaluation of chronic care needs. Members identified as potential chronic care enrollees are then contacted to complete a health risk assessment (HRA). The plan uses the HRA to facilitate an evaluation of a member's health status, preventive health needs, health education needs and assess the potential need for chronic care/case management intervention. Eligible members are automatically enrolled in the program and receive interventions without having a specific request.

To develop an individualized care plan (ICP), TRIPLE-S uses the results of the health risk data, along with existing claims information, to stratify members by risk. The plan develops the ICP with input from the primary care providers (PCP), the member, the member's family and caregivers. PCPs also work in conjunction with case managers in order to provide planned office encounters for follow up of chronic health issues, preventive testing and health activities, follow up of testing results, and access to urgent care needs.

Once the plan develops the ICP, TRIPLE-S creates an interdisciplinary care team (ICT) to facilitate the access and coordination of services to all members. The ICT maintains all of the support personnel that assist the primary and specialty providers in the delivery of care. All ICT staff interact with SNP members to provide coordinated care through a multidisciplinary care team, created to respond to the individual member's needs. While the composition of the members care team may vary, the primary composition consist of the member, PCP, plan medical directors and case managers.

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: sssadvantage.com