SCAN Health Plan, H5811
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 87.50%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

SCAN health plan D-SNP currently serves members who are dually eligible and dually enrolled in Medicare and Medicaid, located in Los Angeles, San Bernardino and Riverside Counties, California. SCAN's contract with the Medi-Cal program offers wrap-around Medi-Cal services to dually enrolled members. A sub-section of the D-SNP members meet nursing facility level of care (NFLOC) and are in separate plan benefit packages (PBPs); these PBPs meet criteria for a Fully Integrated Dual-Eligible SNP. For the other plan, SCAN serves members in San Joaquin County, who are dually eligible, but are singularly enrolled with the health plan. SCAN continues to coordinate care for these members through the same model of care.

Provider Network

The provider network is designed to provide adequate access to covered services to meet the needs of the targeted D-SNP population. These networks include, but are not limited to, primary care physicians (PCP), specialists, acute care facilities, long term care facilities, diagnostic and rehabilitation services, home health agencies, ambulatory clinics and ancillary providers. The PCP's office is the central point for determining, organizing and coordinating care, based on individual member needs and priorities. The PCP manages the medical, cognitive, psychosocial and functional needs of the member. The PCP helps each person access specialists and other health care providers and services such as care management, social services, behavioral health, health education and other special programs as they are needed.

Care Management and Coordination

SCAN developed its own health risk assessment (HRA) tool, drawing from validated questions tested for use with older and frail individuals. The questionnaire assesses risk in four broad domains: the medical, psychosocial, cognitive, and functional needs of vulnerable SNP members. HRAs must be completed within 30 days (and annually thereafter) of mailing out the questionnaire and if not, attempts are made over a two-week period via interactive voice response. For members in NFLOC, an initial HRA is conducted during the member's home visit. Any triggers from either HRA, members are referred to case management for follow-up. Responses to these key questions suggest the need for a higher level of care or a need for referral to specialized programs and services.

Every member has an individualized care plan (ICP) based on identified needs and member's input on the HRA. Finalized care plans are documented in SCAN's software platform and the member is encouraged to review their care plan with their physician. Copies are mailed to members and faxed to the primary care physician with a request to review, comment, sign and fax back. For dual-eligible members meeting NFLOC criteria, the field specialist develops a care plan in collaboration with the

SCAN Registered Nurse (RN) and the member/caregiver. In addition, the field specialist develops a home and community based service plan, identifying additional services such as personal care services and meals on wheels. The ICP is developed either face-to-face with the member or via phone.

The interdisciplinary care team (ICT) is composed of highly-skilled clinical staff at both the health plan and the provider organization caring for the member. Team members include members from the health plan such as medical directors, geriatricians, case managers; and from the provider organization: PCP, specialists, nurse practitioners and physician assistants. The team's role is to analyze findings from the HRA and comprehensive geriatric assessment and build or review an ICP for each SNP member, and include the member in the care planning process whenever feasible. The ICT communicates primarily through shared communication between PCP and SCAN case managers, the member/caregiver, and other relevant medical personnel.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://www.scanhealthplan.com/