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# SNP Alliance

# Gold Standards Framework

## for Special Needs Populations



Revised September 2018





# GOLD STANDARDS FRAMEWORK FOR SPECIAL NEEDS POPULATION

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**S**pecial Needs plans (SNPs) and Medicare-Medicaid plans (MMPs) are specialized managed care plans that target high-risk/high-cost and vulnerable populations. These individuals are more likely to have multiple chronic conditions, complex medical and behavioral health issues, functional limitations, social determinant of health risk factors, and ongoing support needs.

Since the initial publication of the Gold Standards Framework in 2009, Special Needs and Medicare-Medicaid Plans have grown exponentially in both consumer awareness and enrollment. This 2018 update is intended to reengage stakeholders in light of dynamic changes since initial publication: namely, SNP permanency, statutory and marketplace advances toward value-based payment, enhanced care model/management strategies including the use of remote access health technology, the growing understanding of the influence of social risk factors, and the importance of digital privacy, for vulnerable population groups, such as frail elders and the disabled.

To be successful, SNP and MMP payment methods, oversight structures, and care arrangements must all recognize the multidimensional, complex and ongoing nature of conditions exhibited by the majority of special needs populations. The infrastructure for financing, administration, and delivery of care by SNPs and MMPs must offer providers the flexibility to monitor and adjust the plans of care for those individuals served in response to an ever-changing set of circumstances.

Policy, plan, care network structures, and procedures must embrace an “extra mile” attitude in offering multidimensional specialized

care. The exception for traditional insurance plans must be the standard operating procedures for SNPs and MMPs. Furthermore, focus on persons with special needs must remain at the core. Care plans and services must be driven, to the extent possible, *by* the person and their identified care partners, not merely *for* them.

***The Gold Standards Framework for Special Need Populations*** outlined in this report was originally developed by consensus by the National Health Policy Group, a panel of outside experts, and the SNP Alliance Medical Directors, who sought to identify the most important issues in serving frail elders, adults with disabilities and other persons with severe or disabling chronic conditions. The framework was built upon the insights and training of national leaders with extensive experience in high-risk care, as well as currently available research and best practice. Now, nearly a decade later, the SNP Alliance has expanded these recommendations to encompass a broader understanding of special needs populations, and look beyond traditional clinical services to the full range of support, service, and integration that is required to best serve these individuals.

For SNPs to succeed over the long term, stakeholders should reassess the adequacy of existing practices in light of these standards, and work together to reengineer and tailor payment methods, oversight structures, plan administration, and care management processes to reach the triple aim goals around quality, cost, and care for these special needs populations.





# STANDARDS OF EXCELLENCE

*The standards are organized around five goals:*

## **1 MEMBER ACTIVATION**

To support persons with serious chronic conditions and their family caregivers in optimizing their health and well-being, with full recognition of the values and preferences of plan enrollees. The term *member activation* denotes not only a sense of individual control, but access to meaningful information and choices that, whenever possible, reflect true person-centered care and service.

## **2 CARE SYSTEM EXPERTISE ACROSS SERVICES AND SETTINGS**

To ensure that benefits and services are designed, organized, implemented, and maintained according to the unique needs of the high-risk group(s) being targeted, and in accordance with relevant evidence-based and culturally competent practices.

## **3 CARE NAVIGATION**

To accurately and proactively stratify beneficiary groups within the SNP / MMP enrollment, in order to target, assess, organize, reflect, and respond to their needs, together with their family or other designated caregivers. This requires proactive outreach, with a focus on an interdisciplinary, person-centered and comprehensive approach to evaluating and responding to needs, including medical, behavioral, and social—to provide support and services at the proper time, in the appropriate care setting, and reflecting the individual's care preferences.



## **4 COORDINATION AND ALIGNMENT**

Identify strategies to ensure that the service array and network provider arrangements are aligned to achieve and promote desired care outcomes. From a shared understanding of the spectrum of needs and person's preferences and living situation, care must be coordinated across providers, settings, and time to support the individual. Care should be aligned with individual goals whenever possible, and these goals are coordinated across care teams and services. This also requires an understanding that there will often be more than one individual providing various components of care management and coordination. Cooperative and complimentary coordination is key for optimum management of the populations served.

## **5 SYSTEM HARMONIZATION**

Systems of care must be structured to enable the spectrum of providers, caregivers, agencies, and programs to work together to optimize total quality and cost performance. It assumes alignment of incentives, information sharing and quality monitoring, to the degree possible, all with the goal of improving outcomes of care and supporting the individual's stated goals and preferences.



# GOAL #1: Member Activation

**E**mpowering the person/member with the information, knowledge, access, and support to promote maximum independence and informed choice is what all Gold Standard plans ought to strive for. This includes: ensuring information is provided in a format and manner that it can be understood, facilitating an environment in which individuals are treated fairly and access is afforded without bias, and ensuring that care decisions are made transparently with equitable opportunities for grievance and appeals. The goal of member activation should be considered in the context of significant developments over the last decade in understanding health literacy, cultural competency, data privacy, family and caregiver rights, and development of independence-enhancing technology and digital communication.

## 1 SIMPLIFY AND FACILITATE MEMBER ENROLLMENT AND COMMUNICATIONS.

- **Access information** about benefits and services that is accurate, easily understandable, and using materials that address language and cultural differences, as well as any limitations related to physical and visual deficits or health literacy.
- Be **fully informed**, *prior to enrollment*, of benefits and services available to them using common, simple, integrated methods of communication, including any limitations on plan benefits and services as well as differences in the cost of benefits and services, premiums, co-pays and deductibles.
- **Understand** the best way to access and use available benefits and services as well as information about quality and satisfaction data for providers within the service network.

## 2 ENHANCE SELF-CARE CAPABILITIES.

- **Access** medical, behavioral and social services through a simple and standardized process.
- **Receive** the most up-to-date information about their condition including information about symptoms and risk factors for disease onset and illness progression, genetic predisposition, and information of importance regarding a person's medical history, dietary considerations, and environmental circumstances, and in a format and manner tailored to the person's literacy, language, and other characteristics affecting understanding.
- **Access** the most current information available about best practices in caring for persons with multiple, complex care needs, and including tools for assessing quality and selecting providers, and in a manner that addresses challenges with health literacy and language needs.
- **Have the right to privacy**, granting informed permission about what information is retained and shared by the plan and the individual's network providers, to support the person's goals of care. This may include community assessments, home care services, technologies for homecare and home monitoring, and other information gathered that may pertain to medical, behavioral, functional, social, or financial status.





### 3 IMPROVE ACCESS TO NEEDED BENEFITS AND SERVICES.

- **Have access** to a full array of health care services, including primary care, specialized medical care, acute care, transitional care, home health care, rehabilitation services, residential care, community-based long-term care, adult day-care, pharmacy services, palliative care, assisted housing, and supportive services. Access must consider: (1) accommodation for disabilities, language or cultural diversity or health literacy; (2) amenability, or acceptability of the service or provider; (3) affordability; and (4) applicability—whether or not it actually meets the needs of the individual. Not every SNP or MMP may be able to address all of the member’s needs directly through available specialized managed care (Medicare or Medicaid) financing, but the plan should nonetheless provide coordination for available community or auxiliary resources, as much as possible, for all members enrolled.
- **Obtain information** about how to access these services from any provider in the SNP/MMP care network—including access to specialized chronic illness care services, care management services, chronic illness care technologies and adaptive devices. Information should be available in the primary language of the members, and accommodate for sensory disabilities (seeing and hearing) and address health literacy challenges.
- Whenever possible, **have access** to care and service in the place they call home. While this is not always possible for variety of reason, health care professionals should consider and discuss with the individual their ability to safely and comfortably return to their home environment, and recognize how health care planning decisions may either support or hinder such.



### 4 PROVIDE FAMILY AND IDENTIFIED CAREGIVER SUPPORT.

- **Have structures, resources, and outreach strategies in place** that inform, train and provide emotional support to family caregivers in their efforts to help their loved ones deal with the complications of frailty, disability and or the presence of complex medical or behavioral health conditions, including preparing for care transitions with the proper education, skills demonstration and home support; necessary and timely equipment, supplies and appropriate education for use.
- **Provide access** to or help family caregivers get respite care as well as linking caregivers to resources that would assist in making financial and legal decisions.
- **Direct health care professionals** to complement and support, rather than supplant, the self-directed activities of family caregivers, while being sensitive to the potential for caregiver burnout.
- **Require** medical, behavioral, and other health and social service staff to have proper training and guidance, including the use of protocols that ensure family and identified caregivers are an integral part of the ongoing care team, while giving primary consideration to the needs and interests of the individual.





## GOAL #2: Care System Expertise across Services and Settings

**A**n effective care system for individuals with complex illness is one that that advances interdisciplinary medical and non-medical services for physical behavioral, mental and social care needs and continuously assesses and adapts these services based on changing needs and individual responses. The care systems managed by Gold Standard SNPs and MMPs must be designed to modify current guidelines and identified best practices to account for a higher-than average presence of comorbidity and complexity

### 1 ADDRESS CO-MORBID AND COMPLEX CONDITIONS.

- **Ensure** medical direction is provided by persons with knowledge and skills in complex care. Such direction should establish procedures that enable primary care providers to utilize interdisciplinary care teams and account for the presence of comorbidities during the screening and assessment processes, including behavioral health issues and history or presence of substance abuse.
- Attempt to **identify and contract** with physicians and other providers who have specific skills in adapting evidence-based guidelines and best practices for individual diseases in relation to age, complex conditions, functional limitations, and member goals and preferences, and develop ways in incent providers to focus on these complex populations.

- **Establish** a health record/ documentation system that enables the development of individual care plans that fully account for co-morbid conditions and other factors.

### 2 ADDRESS BENEFICIARY USE OF MULTIPLE MEDICATIONS.

- **Conduct** an initial assessment of overuse, underuse and inappropriate use of medications. Regularly reassess medication management—at least, annually—and have care maps in place for conducting reassessments at other appropriate times. Emphasize the importance of medication therapy management, utilizing tools to prioritize high-risk medication review.
- **Have systems** in place for defined subsets of plan members for monitoring and managing high-risk medications; including tracking the use of potentially inappropriate medications for older patients; monitoring use of medications with potential for misuse such as opioids, benzodiazepines, and muscle relaxants; and improving the continuity of drug management for patients transitioning between care settings.
- **Ensure** that principal care teams, all treating providers, hospital, nursing home, home health and other settings of care medical records have a *current* record of all the individual's medications and usage, including over-the-counter products and supplements.
- **Include** the pharmacists function as part of care teams for patients are at high-risk of medication errors resulting from multiple drug usage and involvement of multiple prescribers.





- **Educate** patients and family caregivers in the management of multiple drug usage, with emphasis on issues of adherence, as well as recognizing potential adverse effects of drug regimens on activities of daily living, and the importance of early report of these effects to the prescribing provider.

### 3 INTEGRATE MENTAL, BEHAVIORAL, SOCIAL, AND PHYSICAL HEALTH.

- **Identify** persons with mental, behavioral, social, and physical health expertise to provide leadership in advancing the integration of these domains.
- **Encourage** all primary care providers and care teams responsible for managing care for high-risk beneficiaries to work with mental and behavioral health care professionals in addressing the interdependence between mental, behavioral and physical health.
- **Ensure** that every care plan for persons with multiple, complex and ongoing care needs contains basic information about a person's mental and behavioral health status, as well as the social determinants of health risk factors, which may include self-report.
- **Have structures** in place to facilitate communication among care network providers with mental, behavioral and physical health expertise in the ongoing care of frail elders, adults with disabilities and persons with severe and disabling chronic conditions, including use of shared data while preserving patient confidentiality, as allowed by state regulations

### 4 RESPOND TO THE VOLATILE, COMPLEX AND ONGOING NATURE OF FRAILTY, DEFINED AS A SYNDROME OF PHYSIOLOGICAL DECLINE IN LATE LIFE, CHARACTERIZED BY MARKED VULNERABILITY TO ADVERSE HEALTH OUTCOMES, AND PROGRESSIVE DISABILITY, REGARDLESS OF AGE.

- **Provide** for the routine assessment of an individual's frailty as uniquely different from chronic disability and medical complexities. And provide for monitoring of real-time changes in symptoms and circumstances related to frailty.
- **Enable** health care professionals to successfully modify treatment protocols to account for frailty and disability, including interventions involving therapies, medications and diagnostic evaluations.
- **Align** understanding among related primary, acute and long-term care professionals, as well as related medical and nonmedical providers, individual goals of care that includes goals of improved function vs. maintenance vs. supportive care focused on comfort.

### 5 MANAGE ILLNESSES WITHIN THE CONTEXT OF DISABILITY.

- **Address** disability within the context of a person's total care needs, functional abilities, and interests, and that all care network providers can effectively address the spectrum of disability concerns.
- **Support** individuals with physical and cognitive disabilities to manage their own affairs, as much as possible.
- **Ensure** every care setting is fully accessible to individuals with disabilities, with technological assistance provided, as appropriate.



## 6 ADDRESS THE UNIQUE NEEDS AT THE END OF LIFE.

- **Consider** end-of-life and palliative care approaches based on the individual's stated goals and preferences when the person: has a condition where their prognosis is likely less than six months; has a condition with organ system failure with a significant risk of sudden death; and has a condition where the person is likely to lose their ability to take care of themselves long before death, and thus require intensive personal care throughout their period of dependency; or is burdened with significant symptoms, physical, emotional, or spiritual, in the course of their illness or condition.
- Regularly **evaluate** members with serious illness at the end of life for pain, dyspnea, anxiety, and depression, and treat accordingly using evidence-based guidelines and provide support services to keep individuals and caregivers fully informed of symptoms and options to address their palliative care needs. Utilize an *advanced illness management* approach to care delivery.
- **Encourage** all beneficiaries diagnosed with serious chronic conditions to complete advance care planning, including making decisions about advance directives, with information updated, through to death. This information is retained in the individual's medical record and made available to all care providers at the time of admissions and transfers of care. Such information should include personal preferences that go beyond medical interventions, and include preferred services as settings of care, as much as possible.



## GOAL #3: Care Navigation

**A**t the heart of complex care management for members with special needs is a sufficiently empowered interdisciplinary care team. Gold Standard SNPs and MMPs should seek to advance standards of regular assessment and care planning support, as well as ongoing management of care for all persons with complex care needs. Gold Standard SNPs and MMPs will employ a care navigation framework that is inclusive of the spectrum of chronic conditions beneficiaries may experience, including but not limited to: persons with co-morbid and/or medically complex conditions; advanced or late-stage chronic conditions; chronic conditions associated with physical or mental impairment; disabling chronic conditions; frailty; and conditions that qualify for institutional level of

### 1 IDENTIFY HIGH-RISK MEMBERS.

- **Establish methods to** identify persons at risk of disease progression and functional decline.
- **Continuously monitor** risk, triage and perform risk-reduction interventions throughout its care network, with special attention toward adverse drug events, potentials for treatment failure, and acute events that may trigger hospitalization or rehospitalization.
- **Establish methods to triage** beneficiaries into primary, secondary and/or tertiary interventions designed to prevent, delay or minimize chronic disease and disability progression, as well as to reduce overall costs for the defined risk group.





## GOAL #4: Coordination and Alignment

- **Ensure** that members have the appropriate tools to monitor their own risk factors, information on who of their care team should be contacted, and are aware of appropriate and adoptable risk-reducing strategies.

## 2 PROVIDE COMPREHENSIVE ASSESSMENT AND REASSESSMENT.

- **Establish procedures** to routinely assess and reassess the medical, mental, psycho-social, functional, environmental and financial circumstances involved for every high-risk member served on, at a minimum, an annual basis.
- **Develop and/or update** a care plan in accordance with the person's assessment or reassessment and stated preferences that addresses the spectrum of medical and non-medical needs.
- **Share** assessment findings and care plan information with all relevant care providers, while addressing privacy protections and acknowledging restrictions on sharing which may be stated by the individual.

**I**ncreased care continuity saves lives; through commitment to increased multi-directional communication, Gold Standard SNPs and MMPs can dramatically improve members' experience and outcomes. This starts with a dedication to knowledge management that provides all relevant parties with timely and regularly updated information. It also requires that leadership from the medical home and care network providers, who serve many of the same persons, develop consensus expectations of what will be done, by whom, in what setting, and in relation to a defined set of circumstances. The care team must work together to achieve a mutually-agreed upon set of care and cost outcomes for members with high-risk conditions to ensure continuity of clinical and care management in all needed settings—including home, primary care, hospital, outpatient clinics, pharmacy, skilled nursing facility, home health care, day

## 1 ESTABLISH AND MAINTAIN INTEGRATED CARE NETWORKS.

- **Identify networks** of primary, acute, long-term care, and community-based providers who serve many of the same high-risk beneficiaries.
- **Work with** these care network providers to establish safe and effective care transitions, awareness of the benefits of the SNP and MMP models, and common care practices to optimize care continuity in serving people with common, interrelated care needs.
- **Provide incentives** for care network providers to work together around a common care plan and optimize total quality and cost.







## 2 ESTABLISH AND MAINTAIN ADVANCED MEDICAL HOMES.

- **Designate** advanced medical home(s) for SNP and MMP enrollees in defined service areas where providers are aligned to provide specialty care across the continuum.
- **Develop** arrangements that enable the medical home to assume a central role in the ongoing, real-time monitoring of member conditions and coordinating care among related network providers.
- **Encourage** the medical home to create an ongoing partnership with members and their families to serve as a coach and support in addressing the volatile, complex and ongoing care needs of high-risk individuals.
- **Enable** the primary care provider, and/or care team to be kept informed of all admissions, treatments and changes in condition, medication, care or living arrangements.
- **Work** with the medical home in monitoring key quality indicators for continuous quality improvement for special needs populations.

## 3 PARTNER WITH COMMUNITY PROGRAMS.

- **Identify and engage** community service organizations of importance to the high-risk members enrolled in their health plan, simplify referrals and enhance collaboration.

- **Develop** coordinated care arrangements wherever it holds the potential for improving total quality and cost performance and is of interest to those served.
- **Engage** the member on the quality and usefulness of relationships with community organizations, their overall impact on the life of the patient and prospects for improvement.

## 4 ENSURE SAFE AND EFFECTIVE TRANSITIONS.

- **Establish** compatible approaches to intake and assessment and improve communication among providers involved in care transitions.
- **Improve** care team follow-up with members following transitions to another care setting or home.
- **Engage** members to help minimize errors in transitioning between care settings by supporting appropriate education about their new care setting and what to expect and their roles in self-care
- **Reduce** rates of iatrogenic illness and medical errors caused by a failure to provide for safe and effective transitions between care settings.



## 5 ADVANCE INTER-PROVIDER COMMUNICATION.

- a. **Structure** the composition of organizational and community advisory boards and senior executive teams to assure adequate representation from the full spectrum of a care continuum.
- b. **Identify** network-wide goals and quality measures for complex care members, in addition to general business and program specific objectives.
- c. **Revisit** contracting options where there are incentives for providers within designated care networks to work together around common goals and objectives.
- d. **Train** health care professionals from different professions and care settings in team management, SNP and MMP model of care, and interdisciplinary and inter-program communication.
- e. **Develop** and share collective performance reports on high-risk beneficiaries served by network providers.

## 6 ALIGN HEALTH RECORDS AND INFORMATICS.

- **Expand** the concept of health records to include the full spectrum of psycho/social, functional, environmental and medical considerations, as well as the member's self-identified goals of care.
- **Extend** routine information sharing across the spectrum of primary, acute and long-term care providers.
- **Accelerate** the timeliness of communication upon referral and discharge.
- **Ensure** that all pharmacy information is included and updated in one central medical record that is accessible to all prescribers and reconciled with the individual or identified care givers.

## 7 PROVIDE ONGOING TRAINING AND SUPPORT.

- **Develop** training programs that enable independent but related programs and health care professionals working with complex or high-risk members to see themselves as members of a common, interdisciplinary care team. This should include an understanding of the SNP/MMP model of care, the roles of care coordination across setting and services, and the principles of advanced illness management.
- **Create training opportunities** for nurses, social workers, rehab specialists and other health care professionals, including direct care workers, who serve many of the same persons in different care settings, to become more acutely aware of their interdependence and adopt care practices that are more fully aligned.







## **GOAL #5:** System Harmonization

### **1** ALIGN MEDICARE AND MEDICAID.

- **Work with** county and state governments, other managed care companies and other persons responsible for helping members access needed benefits and services to enable any dually-eligible person to access and receive all their Medicare and Medicaid benefits and services from a single entity through:
  - Aligned enrollment for both Medicare and Medicaid under one plan sponsor
  - Unified enrollment processes and forms
  - One integrated set of marketing materials and unified, simplified member communications
  - Aligned models of care and care coordination systems
  - Aligned networks and network review processes
  - Coordinated or integrated grievance and appeals procedures

- **Work with** state, regional and CMS policy staff to align regulations and oversight functions to support the alignment of care delivery for members. This includes:
  - Aligned SNP application and Medicaid contracting provisions.
  - Coordinated contract management and communication mechanisms
  - Aligned plan and provider payment methods
  - Aligned oversight and operational requirements
  - Aligned auditing and performance evaluation measures and methods

### **2** ALIGN FINANCIAL INCENTIVES.

- **Recognize** the interdependence of Medicare and Medicaid expenditures in contracting for services and establishing payment methodologies.
- **Create** financial incentives for related administrators, plans and providers to collaborate around common goals and objectives.
- **Create** financial incentives to avoid inappropriate cost shifting between programs and providers without regard to the cumulative effects.



### 3 ALIGN QUALITY MEASUREMENT AND COST PERFORMANCE.

- Accurately **evaluate and monitor** total quality and cost performance, and align quality efforts, where possible, toward meaningful and relevant outcomes.
- **Seek** new or refine existing measures and methods to monitor:
  - Identification and support of person-centered goals
  - Continuity of care
  - Safe and effective care transitions
  - End-of-life and palliative care
  - Assessment of functional status and approaches to promote independence
  - Medication management
  - Management of multiple and/or co-morbid conditions
  - Use of specialized care in treating targeted high-risks conditions
  - Treatment of mental illness and behavioral health, including integration of medical care and social support
  - Self-care and family caregiver support
  - Member experience of care and member choice
- **Work** to align quality improvement efforts with providers and to monitor the effectiveness of care network strategies and meaningful outcomes. This would include measures listed above, as well as measures related to reducing potential avoidable hospitalizations, nursing home stays and emergency room usage.

## CONCLUSION

**W**ith the provisions for permanency now as law in the 2018 Balanced Budget Act, the SNP Alliance is committed to advancing the concepts of integration: integrating policy and practice. This Gold Standards Framework is intended to focus on those aspect of care delivery we believe are integral to defining how specialized managed care health plans can, and should, differentiate themselves from general Medicare Advantage plans. Integration must focus on the whole person served, as well as their family and other designated care partners. While many of these elements are yet stretch goals, the SNP Alliance believes that they represent core elements of true person-centered, integrated care for those at highest risk. We hope this Gold Standards Framework will serve as a guide and road map in that journey. We welcome discussion. For further information about the SNP Alliance, our mission and our work, please visit [www.snpalliance.org](http://www.snpalliance.org).







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