

MTM In A World Of SNPs



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What is a Special Needs Population in Medicare?

- Section 231 of Medicare Modernization Act authorizes Medicare contracting with Special Needs Plans (SNPs) to care for three distinct populations:
 - Institutionalized beneficiaries
 - Dual eligibles
 - Severely chronically ill and disabled (undefined by CMS)
- SNPs paid on same basis as Medicare Advantage plans, with risk adjustment
- Collaboration with state I/S is critical for duals.

Market for SNPs in 2006

- 276 SNP plans for 2006 including:
 - 226 DE SNPs, 13 Chronic condition SNPs
 - 37 Institutional SNPs
 - 42 States and Puerto Rico
- Top States are:
 - NY – 43
 - FL – 35
 - PR – 16
 - CA – 15
 - TX – 14
 - AZ – 13
- WellCare leads the way with 65 SNPs
- United is next with 55 (includes Evercare)
- HealthSpring is third with 12
- For 2007, 471 SNPs (195 new)

Chronic Ill SNPs

- Simple Sick
 - COPD
 - CAD
 - CHF
 - Diabetes
- Complex Sick
 - Multiple HCC coded members
 - Diabetes and CHF for example
 - Frail Elderly (build definition for CMS for this category)

Chronic Ill SNPs pre-evaluation

- **Look at current and historical claims paid**
- **Look at potential numbers**
- **Can you capture all the risk adjusters?**
- **Can you develop partnerships with local support groups?**
- **Do you have the capabilities for the specific management needed to tightly manage this population?**
 - Medication Therapy Management Program
 - Utilization/Medical Management
 - Case Management
 - Disease Management
 - Strong downstream provider relationships

Medication Therapy Management Program

- Prospective Drug Use Review
- Targeted Patients
- Detailed Health Risk Assessment
- Therapeutic Assessment (Gap Analysis)
 - Appropriate Therapy
 - Medication Adherence
 - Proper Monitoring
- Interventions (patients and providers)
 - Mailings/email
 - Telephonic
 - Face to Face
 - Outcomes
 - Clinical
 - Financial
 - Humanistic

Keys to MTMP

“Move the Marker in 90 Days”

- Hedis measures
- Adequate reporting support from I/T
- Ability to construct a data warehouse
- Dedicated professionals (including pharmacist) to the program
- Standardized reporting
- Standard and custom queries into the data warehouse

A New Model To Deliver Care



- We need to build a better mouse trap
- Utilizing skills and specialists that already exist in acute and ambulatory care settings to deliver the benefit
- Satisfies goal of closing the gaps in the continuum of care

Case Management

- Coordinate activities of medical professionals, community agents, funding sources, client and family for the goal of achieving maximum functional outcomes.
- Facilitate inpatient, outpatient, and home services as well as medical evaluations and environmental modifications as needed.
- Assist in securing funding for medical equipment, supplies, medications and services in a cost effective manner.
- Provide information to the client to help facilitate timely and appropriate treatment.
- Guide member to self directed care, self-advocacy and decision making to the degree possible.

Case Management

- Maintain open communication with all members of the health plan team so that the care plan can be discussed objectively, problems identified and adjustments made as needed.
- Make adjustments in the care plan to promote better outcomes, if the plan is static or regressive.
- Coordinate the care plan and disease course with an established critical pathway to determine variances.
- Support the stability of the client and family environment

Disease Management

- Primary care interventions
- Reduction of hospital admissions
- Reduction in “length of stay” of members when hospitalized
- Facilitate open communications between providers, health plan, and community agencies to utilize services available through social service networks
- Reduction in medications with improved health outcomes
- Reduction in urgent care visits

In Conclusion

Hope is not a strategy.

