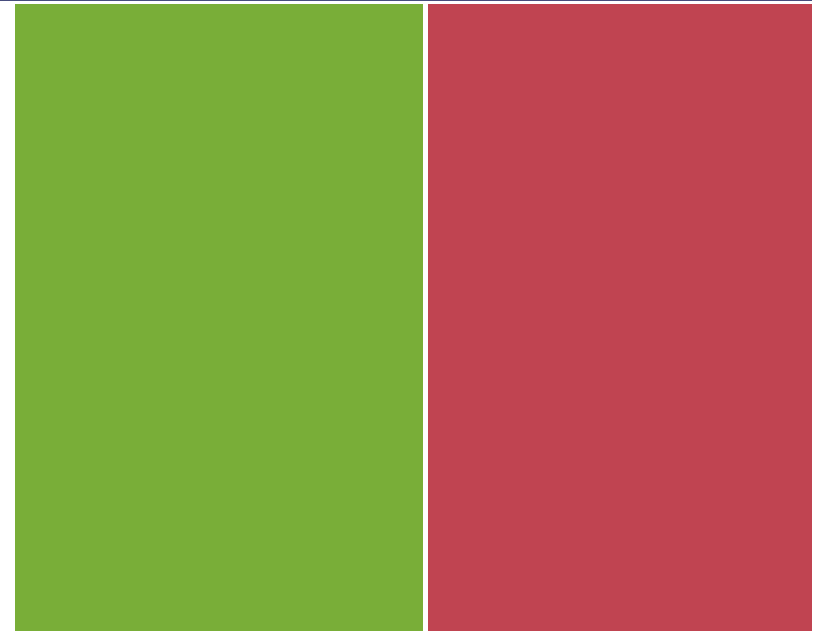


# SCAN Health Plan: A Plan for California's Dual Eligibles

August 30, 2011





## SCAN's Pedigree

- Founded in 1977 by senior citizen activists frustrated by lack of access to appropriate services
- Model of Care emphasizes prevention, early intervention, and providing right care at right time
- Original MSSP participant
- Two decades in CMS' Social HMO Demo
- Has successfully delayed or prevented 100,000 nursing home admissions in California



## Current Operations

- Nation's 4<sup>th</sup> largest not-for-profit MA plan
- Manager of California's largest MSSP site
- More than 8,000 CA dual eligibles in D-SNPs, I-SNP, and other MA-PD plans
- Also operates Dual and SPD plans in Arizona



# A Mission-Driven Enterprise

*SCAN's mission is to continue to find innovative ways to enhance seniors' ability to manage their health and to continue to control where and how they live.*

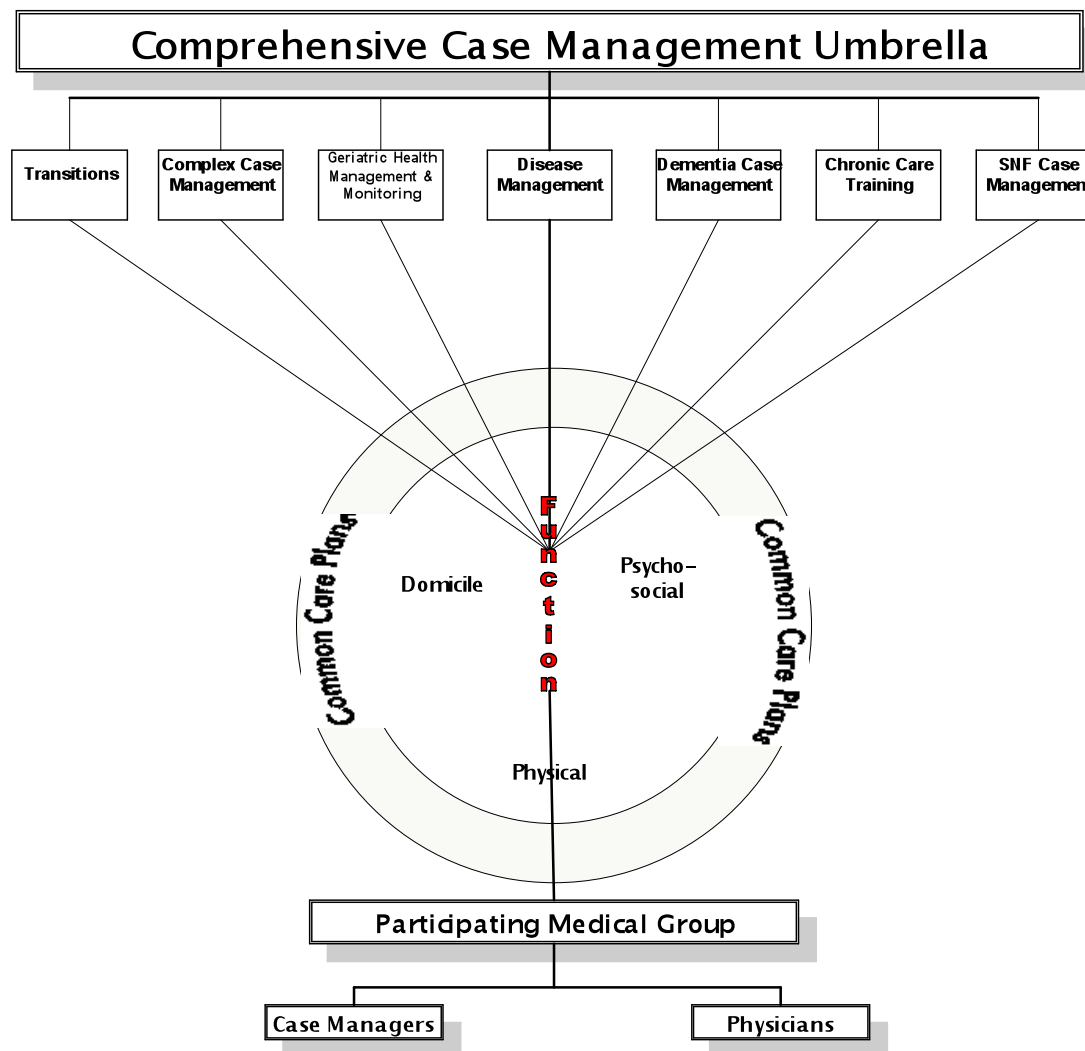
*We will achieve our mission by developing partnerships that allow us to deliver the right health care, in the right setting, and at the right cost, while maximizing seniors' ability to remain independent.*



# SCAN's Philosophy of Care

- A holistic approach to meeting members' physical, mental, social, and spiritual needs
- Empowering members to live safely and manage their care in the setting of their choice
- Coordinating PCP, case manager, caregiver, and member to better manage acute and long-term care, and chronic conditions
- Improving access to medical, mental health, and social services
- Improving clinical and quality-of-life outcomes
- Managing appropriate utilization of services

# SCAN's Comprehensive Case Management





# Model of Care: Geriatric Health Management

- Distinctly designed for vulnerable, institutional-level population that typically has functional and cognitive impairments and suffers from complex chronic conditions
- Case managers use Comprehensive Geriatric Assessment (CGA) tool to identify additional member needs, track changes in health status, and create individualized care plans
- The CGA evaluates:
  - physical, cognitive/behavioral, and social function
  - the need for preventing tests and screenings
  - self-management skills
  - member health preferences
  - caregiver perspectives/needs
- Interventions are tailored to issues identified during assessment and appropriate to a member's readiness to change
- Member health education focuses on the benefits of routine preventive health screenings
- When appropriate, conference calls between members, caregivers, and primary care physicians may be scheduled to clarify plan/medications



# Care Transitions

- At SCAN, a social worker ensures that a member being discharged from a hospital or SNF transitions home safely and avoids unnecessary readmission
- We follow the Coleman Model, based on Four “Pillars”:
  - Use of a Personal Health Record to communicate information to primary and specialty physicians
  - Reconciliation of pre- and post-hospital medications
  - Knowledge of warning signs and symptoms
  - Understanding of appropriate follow-up care post-discharge
- Recognizing the age and vulnerability of its membership, SCAN added a fifth “Pillar” regarding advance-care planning





## SCAN's Dual Eligible Metrics

- Duals with NFLOC average 3-4 chronic conditions and more than 4 prescriptions
- Less than 2% of NFLOC membership are enrolled in LTC institutions
- More than 96% of SCAN members with six or more chronic conditions currently live at home
- USC found a 26% greater likelihood of discharge from SNF to home through SCAN HCBS (avoiding conversion of short term to long term stay)
- NFLOC members average less than 12% acute hospital readmission rate
- HEDIS scores for most duals = 75<sup>th</sup> - >90<sup>th</sup> percentile



# High Satisfaction Reported

- Over 90% of enrollees in SCAN's Care Transitions, GHM&M, CHF, and COPD Programs say that:
  - SCAN has helped them recognize if their health is getting better or worse
  - SCAN has given them new information to better manage their health
  - they know who to call to get the care they need
  - their case manager listens and works on their concerns
  - they are satisfied, overall, with their SCAN program



# SCAN's Integrator Proposal

- Comprehensive model that integrates Medicare and Medi-Cal funding for covered services into a single, fully-capitated payment
- Regulatory streamlining to eliminate conflicting or duplicative administrative and reporting requirements across the Medicare and Medi-Cal programs
- Automatic enrollment of target population based on medical needs and current use of services, with an opportunity to “opt out”
- Patient-centered care delivery model that focuses on care improvement through an interdisciplinary team, member/caregiver/family education, CME, and use of information technology
- Transparent payment model to provide shared savings to State, CMS, the plan, and providers



# Benchmarking

- Establishment of plan and member goals with regular reporting of metrics against an established benchmark
- Use of SCAN's sophisticated infrastructure assessment tool to improve the ability of provider groups to meet the specific needs of the duals population
- Incentive payments to providers based on performance measures
- Real time monitoring of quality and utilization, with transparent reporting of data to members, providers and to the State