Superior HealthPlan Model of Care Provider Training

2017
Model of Care Overview

The Model of Care (MOC) is Superior’s plan for delivering an integrated care management program for members with special needs. It is the architecture for care management policies, procedures and operational systems.

This MOC training manual meets the requirements set forth by the Centers for Medicare and Medicaid Services (CMS) for Superior HealthPlan Medicare Advantage (HMO SNP) and Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan (MMP). It serves as Superior’s documentation of the CMS directed plan for delivering coordinated care and case management to members with both Medicare and Medicaid, ensuring that the unique needs of each dual-eligible member are identified and addressed.

CMS requires all Superior staff and contracted medical providers to receive basic training about the MOC for Superior’s duals programs. This manual describes how Superior and its providers work together to successfully deliver the MOC program for dual-eligible members.

After reading this manual, providers will be able to:

- Describe the basic components of the Superior MOC.
- Explain how Superior’s medical management staff coordinates care for dual eligible members.
- Describe the role of providers in the implementation of the MOC program.
- Explain the role of the provider as part of the MOC required Interdisciplinary Care Team (ICT).
Dual Programs

The MOC training educates providers and employees who serve dual-eligible members in Superior HealthPlan Medicare Advantage (HMO SNP) and/or STAR+PLUS Medicare-Medicaid Plan (MMP). MMP is a fully integrated managed care model in which Superior coordinates both Medicare and Medicaid benefits for the member. Superior HealthPlan Medicare Advantage is also a dual-eligible plan in which Superior coordinates the Medicare benefits.

D-SNP

Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health-care needs. CMS has defined three types of SNPs that serve the following types of members:

- Dual-eligible special needs members (D-SNP)
- Individuals with chronic conditions (C-SNP)
- Individuals who are institutionalized or eligible for nursing home care (I-SNP)

Health plans may contract with CMS for one or more programs. Of the three types of SNPs, Superior currently contracts for D-SNP only. Superior’s D-SNP product is called Superior HealthPlan Medicare Advantage (HMO SNP).

It is important to verify coverage prior to serving the member. This is because D-SNP members may have both Medicare and Medicaid provided by Superior, but not always. Providers may see members with Superior Medicare who have their Medicaid under another health plan or traditional Fee-For-Service (FFS) Medicaid.

Acute care services for D-SNP members are paid as follows:

- Superior HealthPlan Medicare Advantage is always the primary payor.
- Texas Medicaid (TMHP/Accenture) is secondary.
- Superior Medicaid pays long term services and supports (LTSS).
Dual Programs

Medicare-Medicaid Plan (MMP)

MMP is a three-way program between CMS, Medicaid and Superior as defined in Section 2602 of the Affordable Care Act. By having one Medicare-Medicaid health plan, Medicare and Medicaid benefits work together to better meet the member’s health-care needs.

MMP is an innovative payment and service delivery model designed to improve coordination of services for dual-eligible members, enhance quality of care and reduce costs for both the state and the federal government.

Model of Care Goals

The goals of the MOC are to:

- Improve access to medical, mental health and social services.
- Improve access to affordable care.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health-care settings and providers.
- Improve access to preventive health services.
- Assure appropriate utilization of services.
- Assure cost-effective service delivery.
- Improve beneficiary health outcomes.
Model of Care Elements

In 2014, CMS re-organized the original 11 MOC elements in order to:

- Integrate the related elements.
- Promote clarity and enhance the focus on care needs and activities.
- Highlight the importance of care coordination.
- Address care transitions as well as other aspects of care coordination, which were not explicitly captured in the 11 elements.

The revised MOC elements are:

- Description of the SNP population.
- Care coordination.
- SNP provider network.
- Quality measurements & performance improvement.

Model of Care Process

Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment. Members are evaluated annually or more frequently with any significant change in condition or transition of care. The HRA collects information about the member’s medical, psychosocial, cognitive and functional needs, as well as medical and behavioral health history. Members are then triaged to the appropriate Superior Case Management program for follow-up.
Individualized Care Plan (ICP)

An Individualized Care Plan (ICP) is developed with input from all parties involved in the member’s care. This plan includes:

- Goals and objectives.
- Specific services and benefits to be provided.
- Measureable outcomes.

Members receive monitoring, service referrals and condition-specific education. Case Managers and PCPs work closely together with the member and the member’s family to prepare, implement and evaluate the ICP.

Superior disseminates evidence-based clinical guidelines and conducts studies to:

- Measure member outcomes.
- Monitor quality of care.
- Evaluate the effectiveness of the MOC.

Interdisciplinary Care Team (ICT)

Superior Case Managers coordinate the member’s care with the Interdisciplinary Care Team (ICT), which includes Superior staff, the member, the member’s family/caregiver, external practitioners and vendors involved in the member’s care. The ICT is formed based on the member’s preference.

Superior Case Managers work with the member to encourage self-management of the member’s condition. They also communicate the member’s progress toward these goals to the other members of the ICT.
ICT and Inpatient Care

Superior Case Managers play an important role in:

- Coordinating with facilities to assist members in the hospital or in a skilled nursing facility to access care at the appropriate level.
- Working with the facility and the member or the member’s representative to develop a discharge plan.
- Proactively identifying members with potential for readmission and enroll them in Case Management.
- Notifying the Primary Care Provider (PCP) of the transition of care and anticipated discharge date and discharge plan of care.

In order to prevent re-admissions, Superior staff manages Transitions of Care to ensure members have appropriate follow-up care after a hospitalization or change in level of care.

When members are ill they may receive care in multiple settings, which often results in fragmented and poorly executed transitions.
ICT and Transition of Care

Managing Transition of Care interventions for all discharged members may include:

- Face-to-face or telephonic contact with the member or the member’s representative in the hospital prior to discharge to discuss the discharge plan.
- In-home visits or phone calls within 72 hours post discharge, preferably within one to two (1-2) business days to ensure:
  - Member understands his/her discharge plan and medication plan.
  - Follow-up appointments have been made.
  - Home situation supports the discharge plan.
- Enrollment into the Case Management program.
- Ongoing member education, including preventive health strategies, that will help the member maintain care in the least restrictive setting possible for the member’s health-care needs.

Superior’s program is member-centric with the PCP being the primary ICT point of contact. Superior staff works with all members of the ICT in coordinating the plan of care for the member.
Superior ICT Responsibilities

Superior works with each member to:

- Coordinate care and services between the member’s Medicare and Medicaid benefits.
- Develop personal goals and interventions for improving health outcomes.
- Provide education about their health conditions and medications, while empowering the member to make good health care decisions.
- Identify and anticipate problems, and act as the liaison between the member and the member’s PCP.
- Prepare members/caregivers for their provider visits using the member’s personal health record.
- Notify the member’s physician of planned and unplanned transitions.
- Monitor implementation and barriers to complying with the physician’s plan of care.
- Identify LTSS needs and coordinate services.
- Make referrals to community resources as identified.

Provider ICT Responsibilities

Provider responsibilities include:

- Accepting invitations to attend member’s ICT meetings whenever possible.
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member’s medical record when received.
- Collaborating and actively communicating with Superior Case Managers, the ICT, members and caregivers.
CMS General Expectations for the ICT

CMS expects the following related to the ICT:

- All care is based on member preference.
- Family members and caregivers are included in health-care decisions as the member desires.
- Continuous communication between all members of the ICT regarding the member’s plan of care.
- All team meetings/communications are documented and stored.
- All team members are involved and informed in the coordination of care for the member.
- All team members are advised on the ICT program metrics and outcomes.
- All internal and external ICT members are trained annually on the current MOC.
CMS Expectations for the ICT: Provider Network

Superior is responsible for maintaining a specialized provider network that corresponds to member needs. Superior coordinates care and ensures that providers:

- Collaborate with the ICT.
- Provide clinical consultation.
- Assist with developing and updating care plans.
- Provide pharmacotherapy consultation.
- Provide care that is preferred by the member.
- Involve family members and caregivers in health-care decisions, as the member chooses.
- Document and store all ICT meeting notes and communications.

CMS expects Superior to:

- Prioritize contracting with board-certified providers.
- Monitor network providers to assure they use nationally recognized clinical practice guidelines when available.
- Assure that network providers are licensed and competent through a formal credentialing process.
- Document the process for linking members to services.
- Coordinate the maintenance and sharing of member’s health care information among providers and the ICT.
Summary

Superior values provider partnerships. The MOC requires collaboration to benefit members in the following ways:

- Enhanced communication between members, caregivers, providers and Superior.
- Interdisciplinary approach to the member’s special needs.
- Comprehensive coordination with all care partners.
- Support for the member’s preferences in the plan of care.
- Reinforcement of the member’s connection with their medical home.
Attestation of Completion: Model of Care Training

Annual MOC training is a CMS Regulatory requirement. By signing below, you are attesting to the fact that this training has been reviewed by you or by you on behalf of the providers listed below.

Please detach this page, complete the information and return/email it to your Superior Account Manager or to SHP.MOC@SuperiorHealthPlan.com no later than December 31, 2017.

If you have questions, please call your Superior Account Manager or Provider Services at 1-877-391-5921.

Training Completion Date:

Provider Name(s):

Provider Address:

Provider Phone:

Provider Tax ID(s):

Signature:

Printed Name: Title: