



superior
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Medicare: 2017 Model of Care Training

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What is the Model of Care?



- The Model of Care (MOC) is Superior's plan for delivering our integrated care management program for members with special needs.
- It is the architecture for care management policy, procedures and operational systems.
- This course is offered to meet the CMS regulatory requirements for MOC training for our special needs plans.
- It also ensures all employees and providers who work with our special needs plan members have the specialized training this unique population requires.

Model of Care Training



- The MOC is Superior's documentation of the CMS directed plan for delivering coordinated care and Case Management to members with both Medicare and Medicaid.
- The Centers for Medicare and Medicaid (CMS) require all Superior staff and contracted medical providers to receive basic training about the Superior MOC for dual programs.
- This course will describe how Superior and its contracted providers work together to successfully deliver the MOC for dual programs.

Training Objectives



- After the training, attendees will be able to do the following:
 - Describe the basic components of the Superior MOC.
 - Explain how Superior medical management staff coordinates care for dual eligible members.
 - Describe the essential role of providers in the implementation of the MOC program.
 - Explain the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT).

Special Needs Plan (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 members:
 - Dual eligible 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.

Special Needs Plan (SNP)



- For D-SNP members, Medicare is always the primary payor and Medicaid is the secondary payor, unless the service is not covered by Medicare or the Medicare service benefit cap is exhausted for D-SNP members.
- D-SNP members may have both Medicare and Medicaid, but not always with Superior, so it is important to verify coverage prior to servicing the member.
 - You may see members with Superior Medicare and their Medicaid is under another health plan or traditional FFS Medicaid or vice versa.

STAR+PLUS Medicare-Medicaid Plan (MMP)



- STAR+PLUS Medicare-Medicaid Plan (MMP) is a 3-way program between CMS, Medicaid and Superior as defined in Section 2602 of the Affordable Care Act.
 - Purpose: Improve quality, reduce costs and improve the member experience.
 - Ensure dual eligible members have full access to the services to which they are entitled.
 - Improve the coordination between the federal government and state requirements.
 - Develop innovative care coordination and integration models.
 - Eliminate financial misalignments that lead to poor quality and cost shifting.

STAR+PLUS Medicare-Medicaid Plan (MMP)



- Eligibility rules vary from state to state, but general eligibility guidelines must be met:
 - Eligibility for Medicare
 - Eligibility for Medicaid
 - No private insurance
- For STAR+PLUS MMP, the Medicare and Medicaid benefits are rolled up as one benefit with Superior coordinating services and payment.
- MMP members have full Medicare and Medicaid benefits.

STAR+PLUS Medicare-Medicaid Plan (MMP)



- Superior provides members with services tailored to the needs of the SNP and MMP populations. These services can include, but are not limited to:
 - Care coordination and complex care management for high risk and most vulnerable members.
 - Care transitions management.
 - Physician home visiting services.
 - In-home wound care.
 - Disease management services.
 - Clinical management in long-term care facilities as needed.
 - Medication Therapy Management and medication reconciliation.
 - Medicare and Medicaid benefit and eligibility coordination and advocacy.

Model of Care Goals



- The goals of the MOC are to:
 - Assure access to medical, behavioral/mental health and social services.
 - Provide 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 and utilization of preventive health services.
 - Improve appropriate utilization of services for chronic conditions.
 - Improve experiences of care.

Model of Care Elements



- CMS re-organized the 11 MOC elements in 2014 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 2017 goals are in alignment with the Medicare and Medicaid regulatory agencies performance measurement systems:
 - Stars
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
 - Healthcare Effectiveness Data and Information Set (HEDIS)
 - Health Outcomes Survey (HOS)

Model of Care Elements



- The revised MOC elements are:
 - Description of the SNP population.
 - Care coordination.
 - SNP provider network.
 - Quality measurements and performance improvement.

Model of Care Process



- A Health Risk Assessment (HRA) is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks of members.
 - Superior attempts to complete the initial HRA within 90 days of enrollment and annually, or if there is a change in the member's condition or transition of care.
 - HRA responses are used to identify needs that are incorporated into the member's care plan and communicated to the care team.
 - Members are reassessed if there is a change in health condition.
 - Change(s) in health condition and annual updates are used to update the care plan.

Please Note: Physicians should encourage members to complete the HRA in order to better coordinate care and create an Individualized Care Plan.

Individualized Care Plan (ICP)



- An Individualized Care Plan (ICP) is developed with input from all parties involved in the member's care.
- Case Managers and PCPs work closely together with the member and their family to prepare, implement and evaluate the ICP.
- The ICP includes:
 - Goals and objectives.
 - Specific services and benefits to be provided.
 - Measureable outcomes.

Individualized Care Plan (ICP)



- Members receive monitoring, service referrals and condition-specific education.
- Superior disseminates evidence-based clinical guidelines and conducts studies to:
 - Measure member outcomes.
 - Monitor quality of care.
 - Evaluate the effectiveness of the MOC.

Individualized Care Plan (ICP)



- ICPs include member-centric problems, interventions and goals, as well as services the member will receive:
 - Medical conditions management.
 - Long-term services and supports (members with LTSS benefits).
 - Skilled nursing.
 - Occupational Therapy (OT), Physical Therapy (PT), Speech Therapy (ST).
 - Behavioral health and substance use.
 - Transportation.
 - Other services, as needed.

Interdisciplinary Care Team (ICT)



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



Interdisciplinary Care Team (ICT)



- Superior Case Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) which includes:
 - Appropriately involved Superior staff.
 - The member and their family/caregiver.
 - External practitioners.
 - Vendors involved in the member's care **based on the member's preference** of who they wish to attend.
- Superior Case Managers work with the member to encourage self-management of their condition, as well as communicate the member's progress toward these goals to the other members of the ICT.

ICT and Inpatient Care



- Superior Case Managers:
 - Coordinate with facilities to assist members in the hospital or in a skilled nursing facility to access care at the appropriate level.
 - Work with the facility and the member or the member's representative to develop a discharge plan.
 - Proactively identify members with potential for readmission and enroll them in Case Management.
 - Notify the PCP of the transition of care and anticipated discharge date and discharge plan of care.

ICT and Inpatient Care



- During an episode of illness, members may receive care in multiple settings, often resulting in fragmented and poorly executed transitions.
- Superior staff manage transitions of care to ensure that members have appropriate follow-up care after a hospitalization or change in level of care to prevent re-admissions.

ICT and Inpatient Care



- Managing Transitions of Care interventions for all discharged members may include but is not limited to:
 - Face-to-face or telephonic contact with the member, or their representative, in the hospital prior to discharge to discuss the discharge plan.
 - In-home visits or phone call within 72 hours post discharge.
 - Enrollment into the Case Management program.
 - Ongoing education of members to include preventive health strategies in order to maintain care in the least restrictive setting possible.

ICT and Inpatient Care



- During in-home visits or phone call (within 1-2 days post-discharge) Case Managers will:
 - Evaluate the member's understanding of their discharge plan.
 - Assess the member's understanding of medication plan.
 - Ensure follow-up appointments have been made.
 - Make certain the member's home situation supports the discharge plan.

ICT Member Responsibilities



- Superior works with each member to:
 - Develop their personal goals and interventions for improving their health outcomes.
 - Monitor implementation and barriers to compliance with the physician's plan of care.
 - Identify/anticipate problems and act as the liaison between the member and their PCP.
 - Identify Long-Term Services and Supports (LTSS) needs and coordinate services as applicable.
 - Coordinate care and services between the member's Medicare and Medicaid benefits.

ICT Member Responsibilities



- Educate members about their health conditions and medications and empower them to make good health-care decisions.
- Prepare members/caregivers for their provider visits (utilize personal health record).
- Refer members to community resources as needed.
- Notify the member's physician of planned and unplanned transitions.

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.
 - Members of the ICT.
 - Members and caregivers.

CMS Expectations for the ICT



- CMS expects the following related to the ICT:
 - All care is per member preference.
 - Family members and caregivers are included in health-care decisions as the member desires.
 - There is continual communication between all members of the ICT regarding the member's plan of care.
 - All team meetings/communications are documented and stored.

Provider Network



- Superior is responsible for maintaining a specialized provider network that corresponds to the needs of our members.
- Superior coordinates care and ensures that providers:
 - Collaborate with the ICT.
 - Provide clinical consultation.
 - Assist with developing and updating care plans.
 - Provide pharmacotherapy consultation.

Provider Network



- 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 our partnership with our physicians and providers.
- The MOC requires all of us to work together to benefit our members by:
 - Enhancing communication between members, physicians, providers and Superior.
 - Using an interdisciplinary approach to the member's special needs.
 - Employing comprehensive coordination with all care partners.
 - Supporting the member's preferences in the plan of care.
 - Reinforcing the member's connection with their medical home.