



Medicare: Model of Care Training

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 promoting quality, care management policy and procedures, and operational systems.

Model of Care Elements



- The MOC is comprised of four clinical and non-clinical elements:
 - Description of the SNP population
 - Care coordination
 - SNP provider network
 - Quality measurements and performance improvement

Model of Care Training



- The MOC training is a quality improvement tool that ensures the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed.
- The Affordable Care Act requires the National Committee for Quality Assurance (NCQA) to review and approve all SNP's MOC using standards and scoring criteria established by Centers for Medicare and Medicaid (CMS).
- This training is offered to meet the CMS regulatory requirements for a SNP Model of Care.
- It also ensures that Superior staff and providers who work with SNP members have the specialized training this unique population requires.

Training Objectives



- After the training, attendees will be able to do the following:
 - Outline the basic components of the Superior MOC.
 - Explain how Superior medical management staff coordinates care for Special Needs 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).



Description of the Population

Description of Member Population



- The characteristics of the member population that Superior and providers serve include social factors, cognitive factors, environmental factors, living conditions, and co-morbidities.
- Other characteristics may also include:
 - Determining and tracking eligibility
 - Specially tailored services for members
 - How Superior works with community partners

Special Needs Plan (SNP)

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- 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:
 1. Dual Eligible Special Needs Plan (D-SNP)
 - Members must have both Medicare and Medicaid benefits.
 2. Chronic Condition Special Needs Plan (C-SNP)
 - Members with chronic illness such as: Diabetes, COPD, Congestive Heart Failure.
 3. Institutional Special Needs Plan (I-SNP)
 - Members live in institutions such as: Nursing homes or long-term facilities.
- Health plans may contract with CMS for one or more programs. Currently, Superior has **D-SNP**.

Special Needs Plan (SNP)



- For D-SNP, 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 have Medicare with Superior but Medicaid coverage may not always be with Superior, so it is important to verify coverage prior to servicing the member.
 - You may see members with Superior Medicare but their Medicaid is under another health plan or traditional FFS Medicaid or vice versa.



Care Coordination

Care Coordination



- Care Coordination is how Superior coordinates the health care needs and preferences of the member, and shares this information with the Interdisciplinary Care Team (ICT).
- Superior conducts care coordination using the Health Risk Assessment (HRA), an Integrated Care Plan (ICP), and providing an ICT for the member.
- Care Coordination also includes:
 - Explanation of all the persons involved in care.
 - Contingency plans to avoid disruption in care.
 - Training that is required of all involved in member care and how it is administered.

Health Risk Assessment



- 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)

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- An Individualized Care Plan (ICP) is developed by the Integrated Care Team (ICT) in collaboration with the member.
- Case Managers and PCPs work closely together with the member and their family to prepare, implement, and evaluate the ICP.
- The ICP includes:
 - Member-centric problems
 - Interventions and goals
 - Services the member will receive

Individualized Care Plan (ICP)

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- Members receive monitoring, service referrals, and condition-specific education based on their individual needs.
- 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 counseling
 - Medical Transportation
 - Other services, as needed

Interdisciplinary Care Team (ICT)

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- Superior's Care Coordination 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) **based on the member's preference** of who they wish to attend. The ICT includes:
 - Appropriately involved Superior staff.
 - The member and their family/caregiver.
 - External practitioners.
 - Vendors involved in the member's care
- 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

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- 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

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- 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 72 hours 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 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 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.

CMS Expectations



- Natural disasters or emergencies can occur at any time. CMS requires Superior to have a contingency plan to avoid disruption in care and services for their members.
 - Disruption can be avoided when:
 - Superior's corporate or regional office personnel fulfills the duties of administrative staff.
 - Clinical employees are crossed-trained to ensure continuity and have the ability to work remotely using a web-based program on a secure network.
 - Calls are diverted to other regional offices within the Superior network during an emergency.



Provider Network

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 and contribute to a beneficiary's ICP.
 - 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.



Quality Measurement and Performance Improvement

Quality Measurement and Performance Improvement



- Superior is required to have performance improvement and quality measurement plans in place.
- To evaluate success, Superior disseminates evidence-based clinical guidelines and conducts studies to:
 - Measure member outcomes.
 - Monitor quality of care.
 - Evaluate the effectiveness of the MOC.

Model of Care Goals and Data Sources



- Superior determines goals related to improvement of the quality of care that members receive.
- This year's 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 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.
 - Improve member satisfaction.

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.