Medicare:
Model of Care Training

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).

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:
    1. Dual Eligible Special Needs Plan (DSNP)
        – Members must have both Medicare and Medicaid benefits.
    2. Chronic Condition Special Needs Plan (CSNP)
        – Members with chronic illness such as: Diabetes, COPD, Congestive Heart Failure.
    3. Institutional Special Needs Plan (ISNP)
        – 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 MAPD, DSNP and MMP.

Medicaid-Medicare Plans (MMP)

- A Medicare-Medicaid Plan (MMP), sometimes referred to as a "Duals" plan, is a demonstration that combines Medicare and Medicaid. It's a three-way contract between CMS, Medicaid and Superior as defined in Section 2602 of the Affordable Care Act.

- The purpose of the MMP plan is to improve quality, reduce costs and improve the member experience. This is accomplished by the following:
    - Ensuring dually eligible members have full access to the services they are entitled.
    - Improving coordination between the federal government and state requirements.
    - Developing innovative care coordination and integration models.
    - Eliminating financial misalignments that lead to poor quality and cost shifting.

Medicaid-Medicare Plans (MMP) cont.

- Eligibility rules vary from state to state, however, general eligibility guidelines must be met. Members must be eligible for Medicare and Medicaid, and have no private insurance.

- MMP members have full Medicare and Medicaid rights and benefits.

- The Medicare and Medicaid benefits are integrated as one benefit with Centene coordinating services and payment.

- MMPs do not require a Model of Care.

Specific Services

- Superior provides members with services tailored to the needs of the SNP and MPP populations. These services can include, but are not limited to:
    - Care coordination and complex care management
    - Care transistions management
    - Physician home visiting services
    - 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

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 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.

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

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

Care Coordination

Care Coordination

- Care Coordination is how Superior coordinates the health care needs and preferences of the member, and share 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)

- 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)

- 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 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.

Mental Health Provider

Specialty Provider

Peer Supports

Member

Primary Care Provider

Care Coordinator

Others as Assigned by Member

Family

LTS Coordinator

Interdisciplinary Care Team (ICT)

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- 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, but is not limited to:
  - 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 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.

ICT Responsibilities Providers

- 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.

Transition of Care

- During an episode of illness, members may receive care in multiple settings, often resulting in fragmented and poorly executed transitions.

- Superior staff will 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.

Transitions of 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.

- Ongoing education of members to include preventive health strategies in order to maintain care in the least restrictive setting possible for their health care needs.

- In-home visits or phone calls are conducted for the following:

  - Evaluate member's understanding of their discharge plan.

  - Assess member's understanding of medication plan.

  - Ensure follow up appointments have been made.

  - Make certain home situation supports the discharge plan.

Provider Network

Provider Network

- Superior is responsible for maintaining a specialized provider network that corresponds to the needs of our members.
- This includes:
  - How the network corresponds to the target population.
  - How Superior oversees network facilities.
  - How providers collaborate with the ICT and contribute to a member's ICP.
  - Superior is responsible for maintaining a specialized provider network that corresponds to the needs of our members.
  - Superior coordinates care with and ensures that providers:
    - Collaborate with the Interdisciplinary Care Team.
    - 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.

Provider Network

- 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.

- DSNP members have both Medicare and Medicaid but not always with Superior.

  – You may see members with Superior Medicare but their Medicaid is under another health plan or traditional FFS Medicaid or vice versa.

- It is important to verify coverage prior to servicing the member.

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

- Superior determines goals for the MOC related to improvement of the quality of care that members receive.

- This year's goals are based on the following:
    - Stars Measures
    - 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 may include:
  - Access to care
  - Access to preventative health services
  - Member satisfaction
  - Chronic care management

Summary

- Superior values our partnership with our physicians and providers.

- The MOC requires all of us to work together to benefit our members through:
  - Enhancing communication between members, physicians, providers, and Superior.
  - Providing 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.

Contact Information

- For questions or additional information, please contact your Account Management team.
  - You can find your Account Manager by visiting: https://www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html