Medicare:
Model of Care Training

SHP_20184560

Training Objectives

- This course will describe how Superior and its contracted providers work together to successfully deliver the duals Model of Care (MOC) program.
- 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.
- Many of the Superior Medicare Health Plans are DSNP.

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, State 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 Superior coordinating services and payment.
- MMPs do not require a Model of Care. However, you, as a provider, must be informed of the 3 way contract.

Specific Services

- 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
  - 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 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 MOCs using standards and scoring criteria established by Centers for Medicare and Medicaid (CMS).
- This course 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.

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

Element 1: Description of the Population

Description of Member Population

- Element 1 includes characteristics related to the membership that Superior and providers serve including social factors, cognitive factors, environmental factors, living conditions, and co-morbidities.
- The element also includes:
  - Determining and tracking eligibility
  - Specially tailored services for members
  - How Superior works with community partners

Element 2: Care Coordination

Care Coordination

- The Care Coordination element includes a description of how the SNP will coordinate the care of health care needs and preferences of the member, and share information with the Interdisciplinary Care Team (ICT)
- Superior conducts care coordination using the Health Risk Assessment (HRA), an Individualized 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 and education assessment for all caregivers

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)

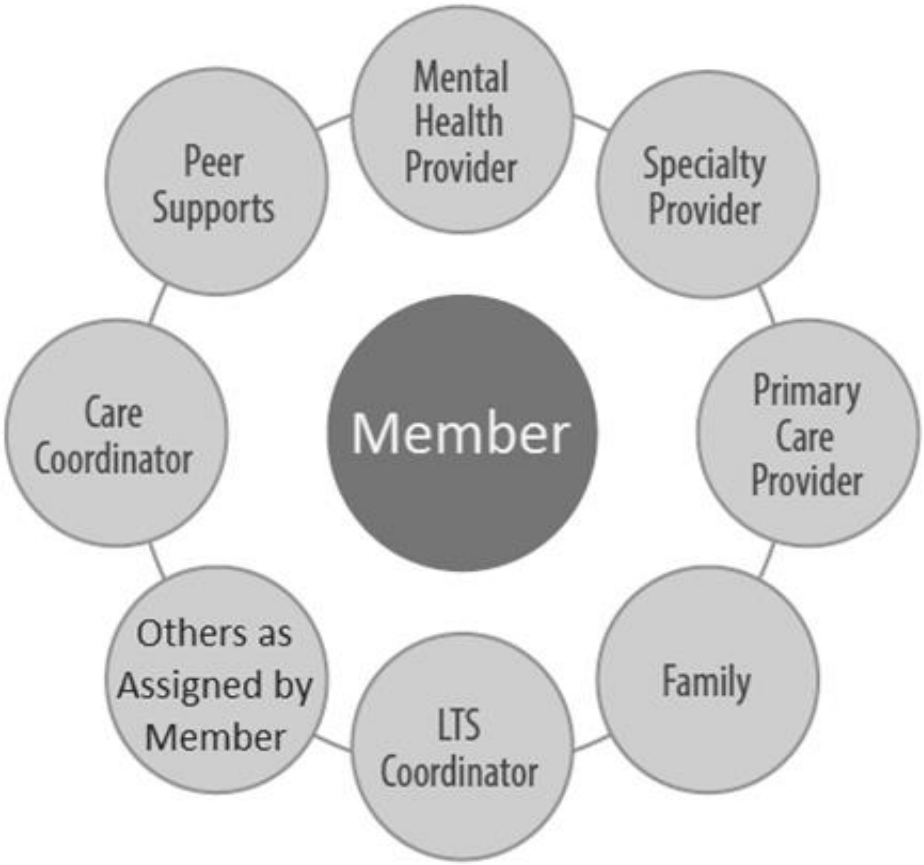
- An Individualized Care Plan (ICP) is developed by the Integrated Care Team (ICT) in collaboration with the member.
- Case Managers and PCPs work closely together with the member and their family to prepare, implement, and evaluate the ICP.

Individualized Care Plan (ICP)

- Members receive monitoring, service referrals, and condition-specific education based on their individual needs.
- ICPs include problems, interventions, and measurable goals, as well as services the member will receive:
  - Medical condition management
  - Long-term services and supports (LTSS benefits)
  - Skilled nursing, DME, home health
  - Occupational Therapy (OT), Physical Therapy (PT), Speech Therapy (ST)
  - Behavioral health and substance use disorder
  - Transportation
  - Other services, as needed

Interdisciplinary Care Team (ICT)

- Superior's program is member centric with the PCP directing the care for the member.
- The Case Manager (CM) serves as the single/one point of contact for the member and is responsible for care coordination.



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, but is not limited to:
  - Appropriately involved Superior staff
  - The member and their family/caregiver
  - External practitioners
  - Vendors involved in the member's care
  - PCP
  - Specialty Providers
  - Pastoral 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.
  - Encourage use of personal health record.
- Refer members to community resources as identified.
- 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 (TOC) 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

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
  - Ensure home situation supports the discharge plan

Element 3: Provider Network

Provider Network

- Element 3 explains the specialized expertise that is made available to members in Superior's provider network.
- 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 DSNP members.
- DSNP members have both Medicare and Medicaid but not always with Superior. Medicaid benefits may be via another health plan or the State.
- It is important to verify coverage prior to servicing the member.

Element 4: Quality Measurement and Performance Improvement

Quality Measurement and Performance Improvement

- Element 4 requires Superior 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

- Model of Care Goals 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 by:
  - 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: www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html