Model of Care Provider Training

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Model of Care Overview

The Model of Care (MOC) is Allwell from Superior HealthPlan's approach for delivering an integrated care management program for members with special needs. It is the architecture for promoting quality, care management policies and procedures and operational systems.

This MOC training manual 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 manual was created to meet the CMS regulatory requirements for a SNP's Model of Care. It also ensures that Allwell staff and providers who work with SNP members have the specialized training this unique population requires.

After reading this manual, providers will be able to:

- Describe the basic components of the Allwell MOC.
- Explain how Allwell's medical management staff coordinates care for members with special needs.
- Describe the role of the provider 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 Allwell from Superior HealthPlan (HMO SNP). Allwell is 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 Plan (D-SNP)
  - Members must have both Medicare and Medicaid benefits.
- Chronic Condition Special Needs Plan (C-SNP)
  - Members with chronic illness such as: Diabetes, COPD, Congestive Heart Failure.
- Institutional Special Needs Plan (I-SNP)
  - Members live in institutions such as: Nursing homes or long term acility.

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 Allwell from Superior HealthPlan (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 Allwell Medicare (HMO SNP) 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:

- Allwell (HMO SNP) is always the primary payor.
- Texas Medicaid (TMHP/Accenture) is secondary.
- Superior Medicaid pays long term services and supports (LTSS).

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 & 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 Allwell Care Management program for follow-up.

Care Coordination

Care Coordination is how Allwell coordinates the health-care needs and preferences of the member, and shares this information with the Interdisciplinary Care Team (ICT).

Allwell 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.

Individualized Care Plan (ICP)

An Individualized Care Plan (ICP) is developed by the Integrated Care Team (ICT) in collaboration with the member. The ICP includes:

- Member-centric problems.
- Interventions and goals.
- Services the member will receive.

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

Interdisciplinary Care Team (ICT)

Allwell Care 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 Allwell staff.
- The member and their family/caregiver.
- External practitioners.
- Vendors involved in the member's care.

Care 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

Allwell Care 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 Care 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, Allwell staff manages Transitions of Care to ensure members have appropriate follow-up care after a hospitalization or change in level of care.

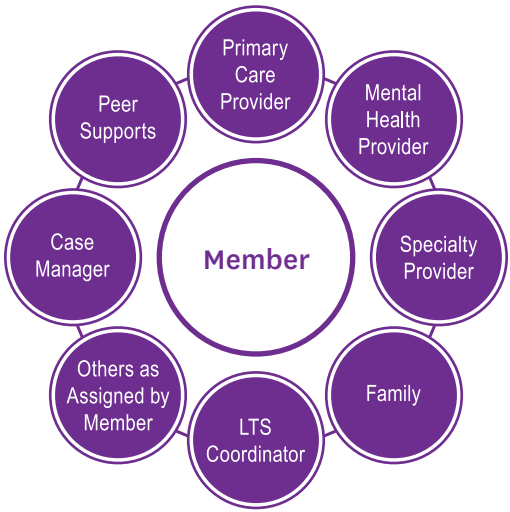
When members are ill they may receive care in multiple settings, which often results in fragmented and poorly executed transitions.

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 Care 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.

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



Allwell ICT Responsibilities

Allwell 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 Allwell Care 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

Allwell is responsible for maintaining a specialized provider network that corresponds to member needs. Allwell 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 Allwell 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.
- Have a contingency plan to avoid disruption in care and services for their members during natural disasters. Disruption can be avoided if:
    - Allwell's corporate or regional office personnel will fulfill 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.
    - During an emergency, calls are diverted to other regional offices within the Allwell network.

Quality Measurement and Performance Improvement

Allwell is required to have performance improvement and quality measurement plans in place. To evaluate success, Allwell disseminates evidence-based clinical guidelines and conducts studies to:

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

Allwell 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)

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

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

- Enhanced communication between members, caregivers, providers and Allwell.
- 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 Allwell Account Manager or to SHP.MOC@SuperiorHealthPlan.com **no later than December 31.**

If you have questions, please call your Allwell 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: