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MODEL OF CARE 2024

Objectives

- Medicare/Medicare Advantage 101
- Outline the basic concepts of Special Needs Plans
- Identify the requirements for success
- Describe the key components of the Model of Care
- Identify the Key Elements of Care Coordination
- Explain the specialized provider network
- Overview of Quality Management & Performance

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Medicare/Medicare Advantage 101

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MEDICARE

Federal system of health insurance for people over 65 years of age and for qualifying individuals younger than 65 years of age with disabilities

- ❑ Part A (Hospital Insurance)
  - Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home healthcare.
- ❑ Part B (Medical Insurance)
  - Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.
- ❑ Part D (Prescription Drugs)
  - Part D Covers certain outpatient prescription drugs

MEDICARE ADVANTAGE

- ❑ Health Plan Options
  - Medicare Advantage (MA)
  - Medicare Advantage-Prescription Drug (MA-PD)
  - Special Needs Plan (SNP)
- ❑ Part C (Medicare Advantage)
  - All Part A and Part B Covered Services (A+B=C)
  - Some plans may provide additional benefits
- ❑ Part D (Prescription Drugs) Outpatient Prescription Drug Coverage
- ❑ Medicare Advantage-Prescription Drug (MA-PD) Program (Part C + Part D)

Special Needs Plan

A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals.

I-SNP

Institutional Special Needs Plan

IE-SNP

Institutional Equivalent Special Needs Plan

D-SNP

Dual-eligible Special Needs Plan

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What Creates Success?
The Model is Patient-Centric

Focus on Prevention

- ❑ Routine visits
- ❑ Individualized goals of care
- ❑ Early detection of changes in condition
- ❑ Medication management

Outcomes

- ❑ Reduced avoidable hospitalizations
- ❑ Reduced unnecessary ER Visits
- ❑ SNF (post-acute part A services)
- ❑ Reduced complications
- ❑ Positive patient outcomes

Quality

- ❑ Provides clear quality indicators and reporting progress to CMS
- ❑ Monitors & works to continuously improve quality, appropriateness, and outcome of care
- ❑ Supports and promotes the mission, vision, and values of the Plan
- ❑ Our model uses a “Care Team” approach*

**Depending on the needs of the Member and the LTC setting in which he or she lives, their primary care manager may be a Medical Doctor (MD), an Advanced Practice Provider (APP) or a Registered Nurse (RN) Personal Care Coordinator (PCC).*

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What is the Model of Care?

The Model of Care (MOC) is Simpra Advantage's detailed, written commitment to CMS on how we will provide care to our enrolled members.

Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care (MOC).

Consists of 4 Key Sections

MOC 1

Description of the SNP Population

MOC 2

- SNP Staff Structure
- Health Risk Assessment (HRA)
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT)
- Care Transition Protocols

MOC 3

Provider Network

MOC 4

Quality Measurement and Performance Improvement

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MOC 1: Description of the SNP Population

This is a hypothetical depiction. The actual description is contained in the Model of Care applicable to the SNP population.

Medicare beneficiary	Frail/Vulnerable	More likely to be female	Typically, 65 years & older	Typically, widowed or single
Often unable to make care decisions & participate in their own care	May be confined to a bed or wheelchair	Has multiple co-morbid chronic conditions (e.g. high blood pressure, heart disease, depression, diabetes, COPD)	Likely prescribed one or more high-risk medications per month	May need help with 5 or more activities of daily living (ADLs) including bed, mobility, dressing, eating & toileting (depending on senior housing location)
High likelihood of reporting daily pain	Has moderate to severe cognitive impairment	Overall low health literacy	Has socioeconomic issues creating barriers to care	Lacks consistent, engaged caregiver/family support

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MOC 2: SNP Staff Structure

Care Team Approach: RNCCs, APPs, PCPs, nursing facility staff

Extensive Executive and Administrative staff to support services, including

- ❑ Sales
- ❑ Enrollment
- ❑ Credentialing
- ❑ Utilization Management
- ❑ Pharmacy
- ❑ Quality
- ❑ Claims Processing
- ❑ Appeals and Grievances

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MOC 2
Care Coordination

- Health Risk Assessments (HRA)
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT) Meetings
- Care Transition Protocol

Health Risk Assessment (HRA)

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Health Risk Assessment Tool (HRAT)

The Plan's Health Risk Assessment Tool starts the **new Member assessment** and care planning process for the Plan and provides an **annual checkpoint** & reassessment of key geriatric health metrics.

The Plan's Health Risk Assessment Tool is a screening tool used by the Plan to

1. Collect Member self-reported or POA-reported health status
2. Identify potential gaps (medical, functional, cognitive, psychosocial, and mental health) in existing care & treatment plans and immediate care need
3. Monitor changes in self-reported health status on an annual basis

Health Risk Assessment (HRA)

MOC Requirements

- All new Plan Members receive an HRA within 90 days of enrollment effective date.
- An annual HRA is completed within 364 days of their initial or last assessment.
- The HRA identifies immediate, chronic, and/or other identified health needs and drives the care plan for the Member.

Health Risk Assessment (HRA) (cont.)

Results from the Health Risk Assessment directly contribute to a Member's Individualized Care Plan (ICP) in the following ways

The Plan will provide the HRAT information to the Interdisciplinary Care Team (ICT) members & Member/caregiver.

Identification of potentially life-threatening conditions and/or conditions requiring an immediate or near-immediate intervention (i.e. thoughts of harming myself/others).

Information from the HRA gives each member a "frailty score" which identifies the Plan's most vulnerable members for appropriate Advanced Care Planning and for extra attention and care.

At the Member's next routine visit, a Plan Provider will complete a physical exam. The Member's HRA, along with other medical records from specialists, diagnostic information, and hospitalization records (if applicable) will be reviewed.

Outcomes of the post-HRA visit (i.e. medication changes, therapy referrals, diagnostic tests, scheduling of next visit, etc.), will be included in the medical record and incorporated into the ICP.

Individualized Care Plan (ICP)

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Individualized Care Plan (ICP)

MOC Requirements

- ❑ All needs identified in the HRA should be documented in the Individualized Care Plan (ICP).
- ❑ ICPs should be reviewed and updated, at minimum
  - Nursing Home: Annually
  - DSNP: Annually
  - Other Levels of Care: Annually
- ❑ Annual ICP review should be completed directly following the HRA and in conjunction with the annual ICT Meeting
- ❑ All SNP Members have an ICP that is updated with significant changes in health status, including care transitions, and that is accessible to the Member and Care Team for updates.

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Care Plan Required Components

Medicare Managed Care Manual (Chapter 5 Section 20.2.1)

Beneficiary self-management goals, personal healthcare preferences, and roles/responsibilities of the Member's caregiver(s).

Description of services specifically tailored to the beneficiary's medical, psychosocial, functional, and cognitive needs.

Measurable timelines and measurable outcomes by using S-M-A-R-T Goals

S-M-A-R-T Goals contain

S = Specific	M = Measurable	A = Attainable /Achievable	R = Relevant	T = Time-Based
Direct, detailed, & meaningful	Quantifiable to track progressor success	Realistic	Aligns with the Member and/or ICT's goals	Deadline

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Care Plan Required Components

Medicare Managed Care Manual (Chapter 5 Section 20.2.1)

Evaluate if goals are met/not met.
If goals are not met, identified barriers should be documented.

Describe how the ICP is **documented and updated** as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, beneficiary and/or caregiver(s).

Explain how updates to the ICP are communicated to the beneficiary/caregiver(s), the ICT, applicable network providers, other SNP personnel and other ICT members, as necessary.

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Care Coach Care Plan Example

IMPAIRED MOBILITY AND FUNCTIONAL DECLINE

Priority 5 | ACTIVE | Show less

CATEGORY

Functional

RELATED DEFICITS

Falls Since Admission
Transfer
Falls With Minor Injury

RELATED DIAGNOSES

Fracture of femur following insertion of orthopedic implant, joint prosthesis, or bone plate, unspecified leg *(ICD-10: M96669)*

HCC Complications of ... (+0.469)

Problem Created
Jennifer Gomez, RN on Dec. 18, 2023

Problem Last Modified
Jennifer Gomez, RN on Dec. 18, 2023

Status Update Last Made
Jennifer Gomez, RN on Dec. 18, 2023

⊕ Add Goals

GOAL

_____ will utilize assistive devices appropriately as evidence by staff report.

Clinical Goal
Long Term

Due: Dec. 31, 2024

INTERVENTIONS

Encourage _____ to utilize walker when ambulating to bathroom.

Due: Dec. 31, 2024

⊕ Add Interventions

BARRIERS

No barriers yet.

⊕ Add Barriers

STATUS UPDATES *LASTEST: DEC. 18, 2023*

Jennifer Gomez, RN on Dec. 18, 2023 — Education provided to member to use walker while ambulating. JG

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Interdisciplinary Care Team (ICT) Meeting

Interdisciplinary Care Team (ICT) Meeting

- The Health Risk Assessment Tool is a starting point for the Plan to identify the different providers & support systems that the Member has in place & the role they play in the Member's overall care.
- The ICT is developed to ensure effective coordination of care, especially through the Member's care transitions, & to improve health outcomes.
- The continuity & regular schedule of ICT meetings allows the Plan Care Team to refine & re-evaluate the Member's ICP based on direct feedback from the ICT members.
- Ad hoc meetings are scheduled as needed with ICT members, the Plan Care Team and other pertinent clinical staff to review & address urgent issues.
- The exact composition of the ICT working with Members varies and is dependent on each Member's unique circumstances, risk-level, and individual needs & preferences.
- ICT members are selected based on their functional roles, knowledge, and/or established relationship with the Member.
- The Plan Care Team & the ICT reviews progress towards goals during clinical and monitoring visits with the Member and during the ICT team meetings.

Interdisciplinary Care Team Meetings

The ICT schedule requires regular updates

Nursing Home: **Annually**

D-SNP - Annually

Other Levels of Care - Annually

An ICT meeting is REQUIRED after a care transition and more frequently if needed.

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Interdisciplinary Care Team (ICT) Responsibilities

Member/Caregiver/ Responsible Party

- ICT process revolves around the Member
- Member can identify specific individuals they would like to participate in the ICT
- Participation in all HRAs
- Participation in the development of the ICP
- Vocalize needs, barriers, and prioritize goals
- Contact other ICT members for questions/concerns

Facility (if applicable)

- May be various staff members (nurse, MDS coordinator, social worker, nutritionist, pharmacist, activity director, etc.)
- Communicate with all ICT members regarding changes in treatment or recommendations
- Provide input to the ICT for the ICP development and ongoing updates
- Ensure transition of care protocols are followed, including notification of transfers

Plan Care Team

- Responsible for ensuring that needs/gaps identified in the HRA or subsequent visits are addressed in the ICP
- Participates in the development of the ICP and ensures progress is being made to meet ICP goals
- Providing preventative services/primary care
- Conducts oversight for all transitions of care events
- Member education

Other Medical Professionals/Specialist

- Each member of the ICT shares the responsibility for ensuring the Member's needs in relation to their specialty are met
- Communicate updates regarding changes in treatment/recommendations
- Provide input to the ICT regarding the development and ongoing updating of the Member's IPC
- Attend or provide input for ICT meetings, as appropriate

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Care Transition Protocol

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Care Transition Protocols

The Plan understands how **coordinated healthcare improves the care of its vulnerable membership**. The Plan incorporates care transition protocols to provide an integrated, proactive approach to safely transition Members between levels of care and across care settings using evidence-based clinical practices and targeted strategies including (but not limited to)

- Ensuring that every Member has a Plan Care Team to serve as a **centralized point of care coordination** for Members and families/caregivers for all care, including transitions.
- The Plan Care Team will be responsible for preventive and primary care services.
- Minimizing the need for transitions through delivery of wellness, preventive, and monitoring services delivered in coordination with the ICT members.

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Care Transition Protocols (cont.)

- **Waiving the 3-day hospitalization requirement** for Skilled Nursing Facility services, enabling skilled services without a prior hospital stay, and encouraging appropriate ER and Observation combined with follow up skilled services in the SNF instead of an inpatient hospitalization.

- **Following Members across care settings** during transitions (i.e. admission to a hospital) through the use of a Utilization Management Registered Nurse who coordinates discharge planning and post-discharge services with the hospital and Plan Care Team to ensure smooth transitions.

- **Identifying at-risk Members** through the HRA and reporting and notifying the Plan Care Team of status or status changes.

- Requiring Plan Care Team to provide **transitional care management visits** and communications.

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Transition Follow-up Timeline

The Plan Care Team is required to provide transitional care management visits & communications with the ICT.

Within 2 business days

Initial contact, either **telephonically or face-to-face**, is conducted within 2 business days.

Within 7-14 calendar days

The Member will have a visit with the **Plan Provider** within **7-14 days (depending on medical complexity)** of the Member's **return** home or to the facility.

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Transition Follow-up Timeline (cont.)

Within 45 calendar days

- ICP update is completed within 45 calendar days
- ICT meeting is completed within 45 calendar days, discussing hospitalization details in the ICT meeting note

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Care Transition Follow-up Timeline

Discharge from the hospital to SNF or home

2 Business Days

Interactive Contact:
This contact can be telephonic or face to face

7-14 Calendar Days

Face to Face Visit

45 Calendar Days

Care Plan update & ICT meeting

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Transition Coordination & Communication

The Plan Care Team

During the Interdisciplinary Care Team (ICT) meeting, the Plan Care Team updates the ICT on the Member's status and transition plan.

Post-discharge, the Plan Care Team educates the Member and/or caregiver on the reason(s) for hospitalization/ transition.

Provides instruction on who to contact for concerns at any point in time.

Provides instruction in recognition of warning signs for the disease processes and medications.

Provides instruction on self-care to the degree possible.

Discusses the next steps in the care management process (i.e., review updated ICP).

Coordination of orders for post-hospital specialist visits, diagnostic testing, home health services and/or therapy.

Coordinates post-transition follow up for the Member.

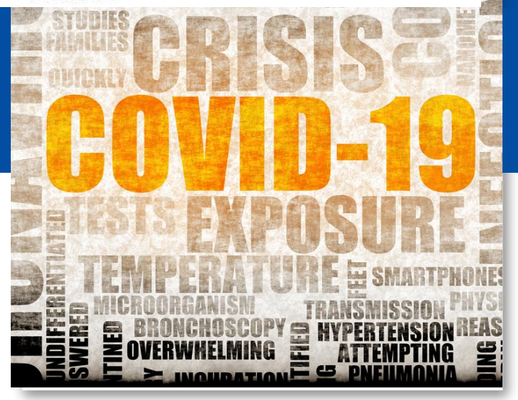
Care Transition Contingency Plan

Natural disasters or public health emergencies can occur at any time.

CMS requires SNPs and its healthcare partners to have a contingency plan to **avoid disruption in care and services** for members.

Disruption can be avoided when

- ❑ Administrative and Clinical employees are cross-trained to ensure continuity and can work remotely using web-based program on a secure network.
- ❑ Calls are diverted to back-up offices within the Simpra network during an emergency.



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MOC 3: Provider Network

- The Plan provides a comprehensive contracted network of providers, facilities, ancillary service providers, specialist physicians, and acute care facilities with the specialized clinical expertise pertinent to the care and treatment of individuals enrolled in special needs plans.
- Specialized expertise pertinent to the care and treatment of its Members (i.e., cardiologist, pulmonologist, neurologist, endocrinologists, etc.).
- Primary care services through the Plan Provider (MD, DO, NP, or PA) and supportive ancillary services like therapy, rehab, selected diagnostic radiology & lab, and home health are provided within the Member's home/community and coordinated by the Plan Care Team.
- The Plan Care Team coordinates visits and services provided outside of the Member's residence including specialist visits, radiology, lab, & other diagnostic testing.

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MOC 4: Quality Measurement & Performance Improvement

- The purpose of the Plan's Quality Improvement Program (QI Program) is to continually take a proactive approach to assure and improve the way the Plan provides care and engages with its Members, partners, and other stakeholders so that it may fully realize its vision, mission and commitment to Member care.
- The QI Program supports values of the Plan through continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services to Members.
- The Plan's QI Program is assessed annually and reviewed by the Quality Improvement Committee (QIC) to determine the overall effectiveness of the program, including the MOC, and appropriateness of care and services furnished to Members. Enhancements are made to the QI Program based on the annual evaluation.

MOC 4: Quality Measurement & Performance Improvement (cont.)

- The Quality Improvement (QI) Program provides the structure, framework, and governance used to guide the formal and informal processes for evaluating and improving the quality of care to Members.
- The QI Work Plan and Annual Evaluation are important materials used to guide Quality Improvement efforts.
- The Board of Directors (BOD) is responsible for the establishment, implementation, and oversight of the QI Program.
- The Plan Chief Medical Officer provides oversight of the QI Program on an ongoing basis. The Plan Chief Medical Officer reviews and provides guidance on all QI activities.
- The Plan Chief Medical Officer chairs the Quality Improvement Committee.
- The Plan educates its network on key performance measures and changes to the MOC.

Model of Care Performance Metrics/Goals

Performance Description	Targeted Goal
Members newly enrolled will have HRAT completed within 90 days of enrollment effective date.	100%
Members who remain enrolled in the plan will have an annual reassessment completed within 364 days of the initial or last HRA.	100%
Members enrolled in the plan longer than 90 days will have an initial interdisciplinary care plan (ICP) on file.	100%
Members who have been continuously enrolled in the plan longer than 365 days will have an updated annual ICP on file for the renewing year.	100%
Member transitions will be evaluated by the Care Team within 14 calendar days according to the Plan's Transition of Care Procedure.	90%
HEDIS Care for Older Adults Measures (Functional Status Assessment, Medication Review, and Pain Assessment) will be at the 5-star cut point.	100%
Hospital Admissions rate per 1,000 person-years.	≤ 400
Members meeting MTM qualifying criteria will receive a Comprehensive Medication Review (CMR).	90%
Grievances and appeals are reviewed and appropriate action initiated within the timeframe required as appropriate based on type of appeal, per CMS guidelines.	100%

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THANK YOU

FOR YOUR ATTENTION