



MODEL OF CARE 2026

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

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

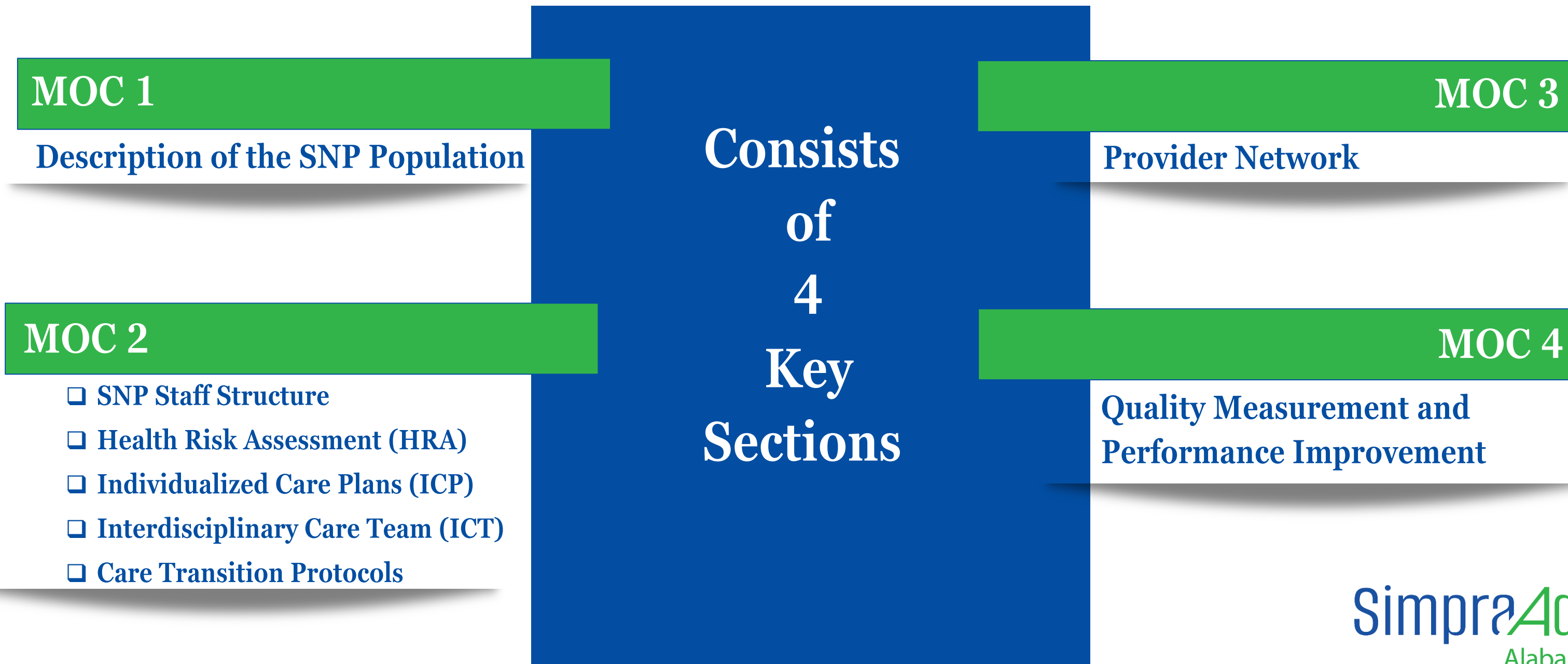
**Dual-eligible
Special Needs
Plan**

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What 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).



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

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

MOC 2 Care Coordination

Health Risk Assessments (HRA)

Individualized Care Plans (ICP)

Interdisciplinary Care Team (ICT) Meetings

Care Transition Protocol



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.**



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.



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 &
more frequently if needed.



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.

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.



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.

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



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.

Provides instruction on self-care to the degree possible.

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

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

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

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

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

Coordinates post-transition follow up for the Member.

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.

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.

METRICS



Model of Care Performance Metrics/Goals

Performance Description	Targeted Goal
Members newly enrolled will have HRAT completed <u>within 90 days</u> of enrollment effective date.	100%
Members who remain enrolled in the plan will have an annual reassessment completed <u>within 364 days</u> of the initial or last HRA.	100%
Members enrolled in the plan longer than 90 days will have an <u>initial interdisciplinary care plan (ICP)</u> 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%

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 setting in which he or she lives, their primary care manager may be a Medical Doctor (MD/DO), an Advanced Practice Provider (APP) or a Personal Care Coordinator (PCC).*



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THANK YOU
FOR YOUR ATTENTION