Model of Care Training

All Staff and Contracted Staff

LEON HEALTH

Model of Care Training Objectives

Introduction Medicare Advantage Prescription Drug (MAPD) Plan

Outline the basic concepts of Special Needs Plans

Identify the requirements for success

Describe the purpose and key components of the Model of Care

- MOC 1: Population of the SNP Plan
- MOC 2: Care Coordination
- MOC 3: Provider Network
- MOC 4: Quality Measurement and Performance Improvement

Medicare Health Insurance

Population

- People 65 or older
- Disabled
- End-Stage Renal Disease

Health Plan Parts

- Medicare Part A (Hospital coverage)
- Medicare Part B (Medical coverage)
- Medicare Part D (Pharmacy Coverage)

Enrolled Members Receive Services Through the Plan

- All Part A and Part B Covered Services (A+B=C)
- Some plans may provide additional benefits

MAPD Part C & D Plans

MA Plans- Private Contracted Companies

- **All Part A and Part B Covered Services (A+B=C)**
- Some plans may provide additional benefits

Includes Prescription Drug Coverage (Part D)

- This is known as an MA-PD plan

Members are still in the Medicare Program

- Medicare will pay Leon Health Plan every month for the Member's care
- Members have Medicare rights and protections

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. Three categories
  - **Chronic Conditions Special Needs Plans (C-SNP)**
  - **Dual Eligible Special Needs Plans (D-SNPs)**
  - **Institutional or Institutional Equivalent (I-SNP, IE-SNP)**

Dual Special Needs Plan Medicaid Eligibility Categories

The Medicaid eligibility categories encompass all categories of Medicaid eligibility including:

- Full Medicaid (only);
- Qualified Medicare Beneficiary without other Medicaid (QMB Only);
- QMB Plus;
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB Only);
- SLMB Plus;
- Qualifying Individual (QI); and
- Qualified Disabled and Working Individual (QDWI)

Leon D-SNP

Who can join?

- Be at least 18 and under age 65
- Enrolled in Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Have a certified disability through the Social Security Administration or meet Medicaid status
- Lives in Plan service area (Miami-Dade)

Successful Performance elements

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Medical Management

- Focus on Prevention and Improve Access to services:
  - Routine Visits
  - Care Protocols
  - Skill in Place (for applicable Plans)
- Goals:
  - Limit Avoidable Hospitalizations
  - Avoid Emergency Visits
  - Avoid Re-admissions
- As the Payer, Leon can pay for benefits that directly contributes to better outcomes clinically or member satisfaction.

Quality

- Improving access and affordability
- Improving coordination of care and delivery of services through the direct alignment of the HRAT, ICP and ICT
- Enhancing care transitions across health care settings and providers
- Ensuring appropriate utilization of preventive health and chronic conditions

What is Model of Care (MOC)?

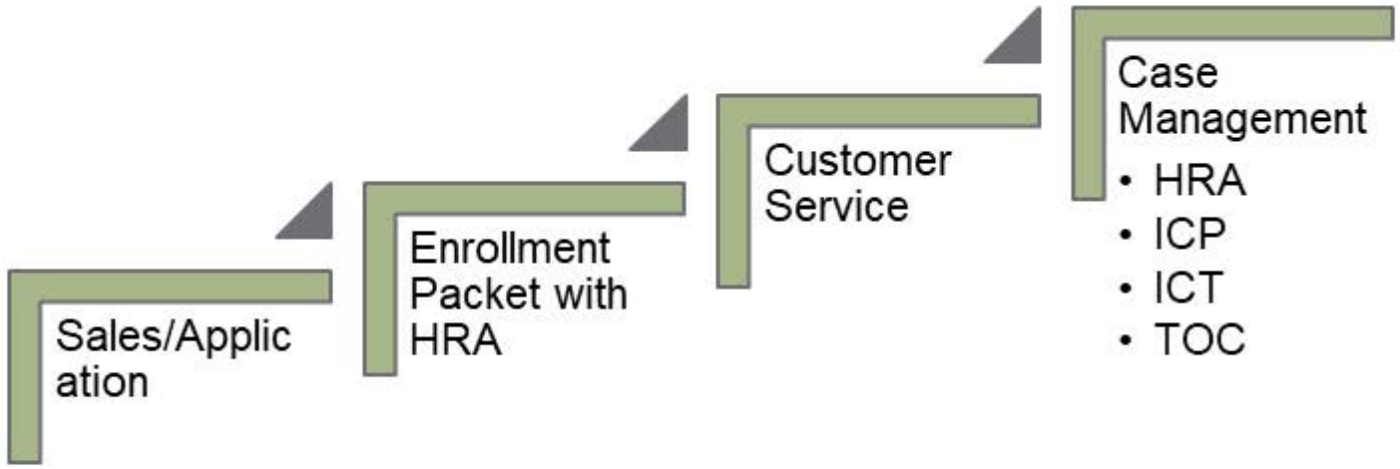
- A requirement for the application to start a Special Need Plan. Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care.
- *The Model of Care (MOC) is considered a vital tool and integral component for ensuring that the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed.*

Model of Care Sections and Elements

- MOC 1: Population of the SNP Plan
  - Description of overall SNP Population
  - Description of Most Vulnerable Population
- MOC 2: Care Coordination
  - Staff Structure and MOC Training
  - Health Risk Assessment Tool (HRAT)
  - The Individualized Plan of Care (ICP)
  - The Interdisciplinary Care Team (ICT)
  - Care Transition Protocol (TOC) for change in health status

Model of Care Sections and Elements

- MOC 3 Provider Network
  - Specialized Network
  - Use of Clinical Practice Guidelines
  - MOC Training
- MOC 4:Quality Measurement and Performance Improvement
  - Quality Performance Improvement Plan
  - Measurable goals and Health Outcomes for the MOC
  - Measuring Patient Experience of Care
  - Ongoing Performance Improvement Evaluation of the MOC
  - Dissemination of SNP Quality Performance related to the MOC



Potential Member Touch points

Sales & Enrollment

Talk to an authorized sales agent

- (866) 393-5366 | TTY: 711
  (305) 559-5366 Monday – Friday; 8 am - 8 pm
- Members or their authorized reps can complete an application through sales dept.
  - Paper
  - Telephonic enrollment
- Members will receive a new ID card upon enrollment.

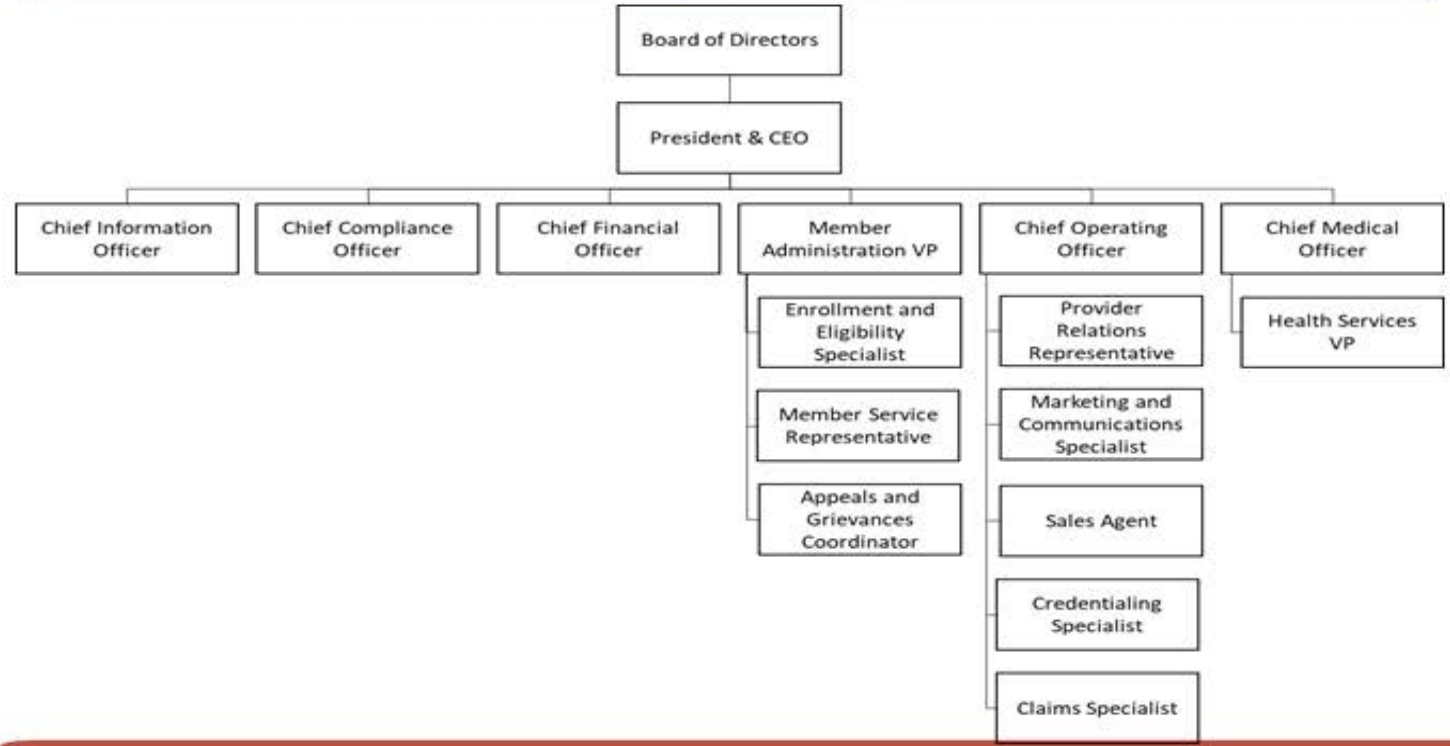
Description of the SNP Population and Most Vulnerable

- Individuals who are 85 and older
- Adults with disabilities
- Aged, Blind or Disabled (ABD) populations
- Members with Severe Mental Illness Diagnosis
- Members with Complex Health Care Needs

MOC 2: Care Coordination

- Staff Structure and MOC Training
- Health Risk Assessment Tool (HRAT)
- Individualized Plan of Care (IPOC)
- Interdisciplinary Care Team (ICT)
- Care Transition Protocol

Administrative & Clinical Staff Structure



Health Risk Assessment (HRA)

- Regulations at 42 CFR §422.101(f)(i); 42 CFR §422.152(g)(2)(iv) require that all SNPs conduct a Health Risk Assessment for each individual enrolled in the SNP.
- The Health Risk Assessment Tool is a screening tool used by the Plan to:
  - Initially obtain member health information and stratify by risk level **(High-Complex/Moderate/Low)**
    - Identify problems (medical, functional, cognitive, psychosocial, and mental health) in existing care and treatment plans and/or immediate care need
    - Helps to develop an Individual Care Plan (ICP) timely with priorities and preferences
  - Monitor for changes in health status
    - Re-assessments when there is a change in health status or at least annually from the last administered HRA

Results from the HRA directly contribute to a member's ICP in the following ways:

- The Plan will distribute the HRAT outcomes to the **Interdisciplinary Care Team (ICT)** members and member/caregiver through a developed ICP
- Identification of potentially life- threatening conditions and/or conditions requiring that require immediate or near- immediate intervention (i.e. recent hospitalization).
- Stratification of HRA responses (high, moderate or low) allows the CM to follow-up **timely when** executing the ICP

Individual Care Plan (ICP)

- Regulations at 42 CFR §422.101(f)(ii); 42 CFR §422.152(g)(2)(iv) stipulate that all SNPs must develop and implement an ICP for each individual enrolled in the SNP.
- The HRA outcome, and/or plan data is used to develop and ICP regardless of unable to reach a member or unwilling to participate.
- Updates to the ICP are timely based on risk level but at least annually after re-assessments for low-risk members.

ICP ESSENTIAL COMPONENTS AND PROCESSES

- **Should Contain SMART Goals:**
  - ✓**S= Specific** (direct, detailed, and meaningful)
  - ✓**M= Measurable** (quantifiable to track progress or success)
  - ✓**A= Attainable/Achievable** (realistic, Include member preferences)
  - ✓**R= Relevant** (aligns with the member and/or ICT's goals)
  - ✓**T= Time-Bound** (time-based, time limited, time/cost limited, timely, time-sensitive)
- **Measurable and realistic outcomes.**
- Identification if goals are met/not met.
- **Barriers should be documented.**

ICP ESSENTIAL COMPONENTS AND PROCESSES

- **Member self-management goals** & personal healthcare preferences.
- Description of services specifically tailored to the beneficiary's medical, psychosocial, functional, and cognitive needs.
- **Process for how the ICP** is **documented** and **updated** as well as, where the documentation is maintained to ensure accessibility **by** the ICT, provider network, member and/or caregiver(s).
- **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.

Interdisciplinary Care Team (ICT)

Regulations at 42 CFR §422.101(f)(iii); 42 CFR §422.152(g)(2)(iv) require all SNPs to use an ICT in the management of care for each individual enrolled in the SNP.

ICT meeting are organized by the members risk level

- All SNP members have at least one Interdisciplinary Care Team (ICT) meeting annually or more often if high risk (most vulnerable) or moderate risk (rising risk)

Updates to the Individualized Plan of Care

- Experiencing rising risk **or significant change in health status**
- Transitions of Care

Interdisciplinary Care Team (ICT)

- The HRA outcome data is a starting point for the Plan to identify the different ICT members and the role they play in the member's overall care.
  - The exact composition of the ICT is dependent on each members' unique circumstances, risk-level, individual needs and preferences.
  - ICT members are selected based on their functional roles, knowledge, and/or established relationship with the member.
- **The CM is responsible for identifying the members needed for the ICT and organizing the meeting frequency, date and times of each meeting in correlation with the member**
- The ICT is developed to ensure effective coordination of care, especially through the member's care transitions, and to improve health outcomes.

Interdisciplinary Care Team (ICT)

- The continuous communication and regular schedule of ICT meetings allows the case manager to refine and 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 Provider, and other pertinent clinical staff to review and address urgent issues.
- The CM and the ICT reviews progress towards goals during clinical monitoring and communication with the member and during the ICT team meetings.

Transitions of Care (TOC)

- Regulations at 42 CFR §422.101(f)(2)(iii-v); 42 CFR §422.152(g)(2)(vii-x) require all SNPs to coordinate the delivery of care.
- **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, Plan Provider and CM to ensure smooth transitions.
- **Identifying at-risk members** through the HRA and Most Vulnerable Member reports and notifying the Plan Provider of status or status changes.
- Requiring Plan Providers to provide **transitional care management visits** and communications.

MOC 3: Provider Network

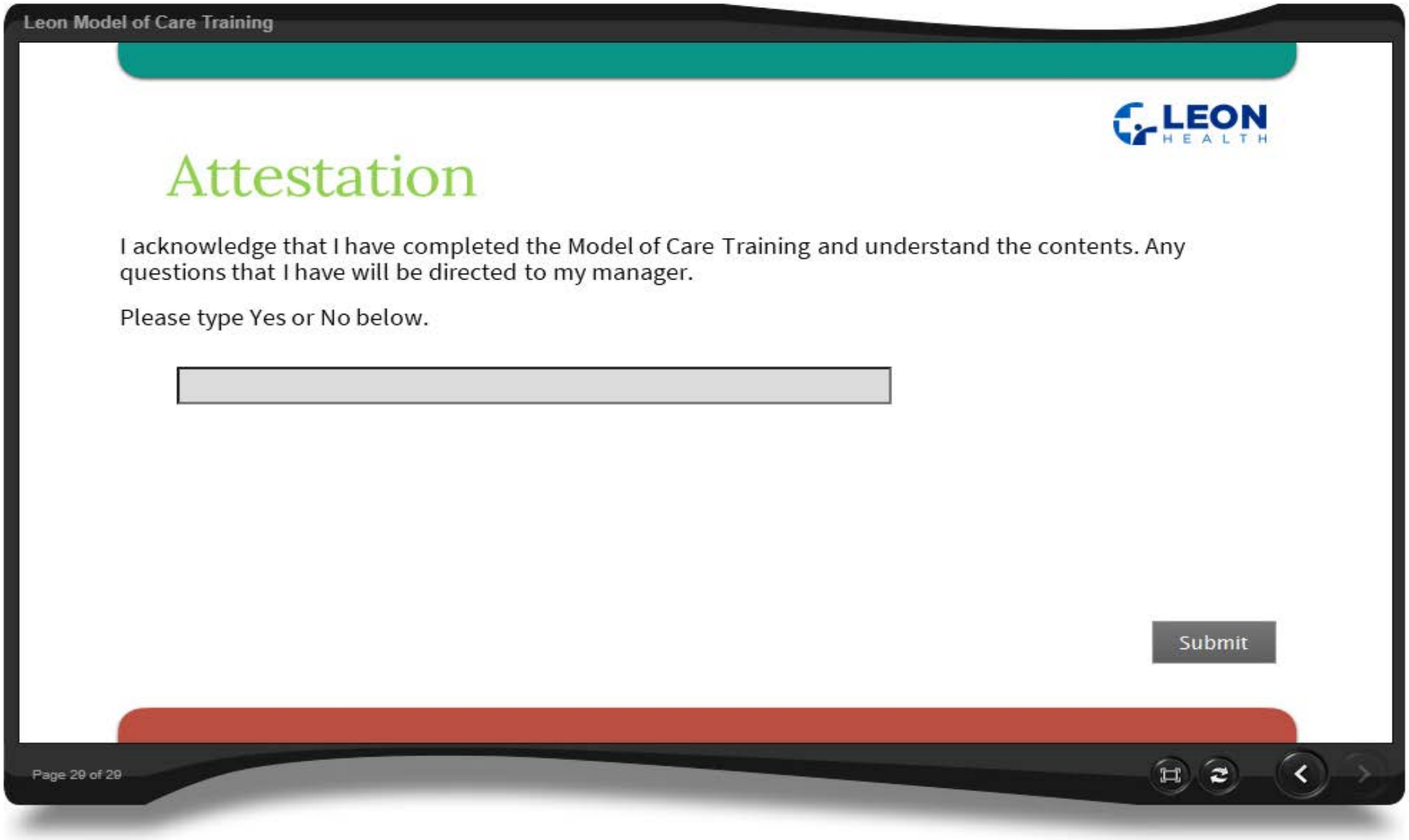
- The Plan provides a comprehensive contracted network of providers, facilities, ancillary service providers, specialist physicians, and acute care facilities with the specialized clinical expertise pertinent to the care and treatment of long-term senior housing residents.
- Providers are responsible to be an active member of the interdisciplinary care team supporting continuity of care
- Providers are responsible to follow clinical practice guidelines including transitions of care
- Providers are required to administer a Model of Care Training initially and annually there after

MOC 4: MOC Quality Measurement and Performance Improvement

- Quality Performance Improvement Plan
  - 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.
- Measurable goals and Health Outcomes for the MOC are reviewed continually and analyzed at least annually in line with the annual evaluation
- Measuring Patient Experience of Care throughout the year through plan data and surveys.

MOC 4: MOC Quality Measurement and Performance Improvement

- Ongoing Performance Improvement Evaluation of the MOC occurs through the plan committees
- Dissemination of SNP Quality Performance related to the MOC
  - 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. Performance is communicated to stakeholders.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Attestation
I acknowledge that I have completed the Model of Care Training and understand the contents. Any questions that I have will be directed to my manager.
Please type Yes or No below.
Submit
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