Model of Care

PruittHealth Premier

2023 Provider Training

© AllyAlign Health 2022

Background

The Centers for Medicare & Medicaid Services (CMS) requires all Special Needs Plans to provide Model of Care (MoC) training for all in-network and out-of-network providers who see the Plan's SNP members routinely.

This training will help you to:

- Describe the different types of Special Needs Plans (SNP)
- Understand the MoC key components
- Define your role in supporting the MoC

© AllyAlign Health 2022

Medicare/Medicare Advantage 101

Medicare

- A 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 health care.
- **Part B (Medical Insurance)**
  - Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.
- **Part D (Prescription Drugs)**

Medicare Advantage

- **Part C (Medicare Advantage)**
  - "All in one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D.
- **Health Plan Options**
  - Approved by Medicare
  - Run by Private Companies
  - Available across the United States
- **Enrolled Members Receive Services Through the Plan**
  - 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 pays the plan every month for the Member's care
  - Members have Medicare rights and protections

© AllyAlign Health 2022

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)

C-SNP

(Chronic Condition Special Needs Plan)

D-SNP

(Dual-eligible Special Needs Plan)

© AllyAlign Health 2022

Institutional Special Needs Plan (I-SNP)

PruittHealth Premier (HMO I-SNP)

Who can join an I-SNP?

- Enrolled in Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Lives in Plan service area (facility)
- Must reside (OR is expected to reside) in a participating I-SNP nursing facility for greater than 90 days at time of enrollment

© AllyAlign Health 2022

Dual-eligible Special Needs Plan (D-SNP)

PruittHealth Premier D-SNP (HMO D-SNP)

Who can join a D-SNP?

- Enrolled in Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Live in plan service area (at home)
- Beneficiaries who are entitled to both Medicare Medicaid

© AllyAlign Health 2022

What is the Model of Care?

The Model of Care (MoC) is considered a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed.

Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to develop and implement a Model of Care. The MoC is evaluated and approved by NCQA according to the CMS guidelines.

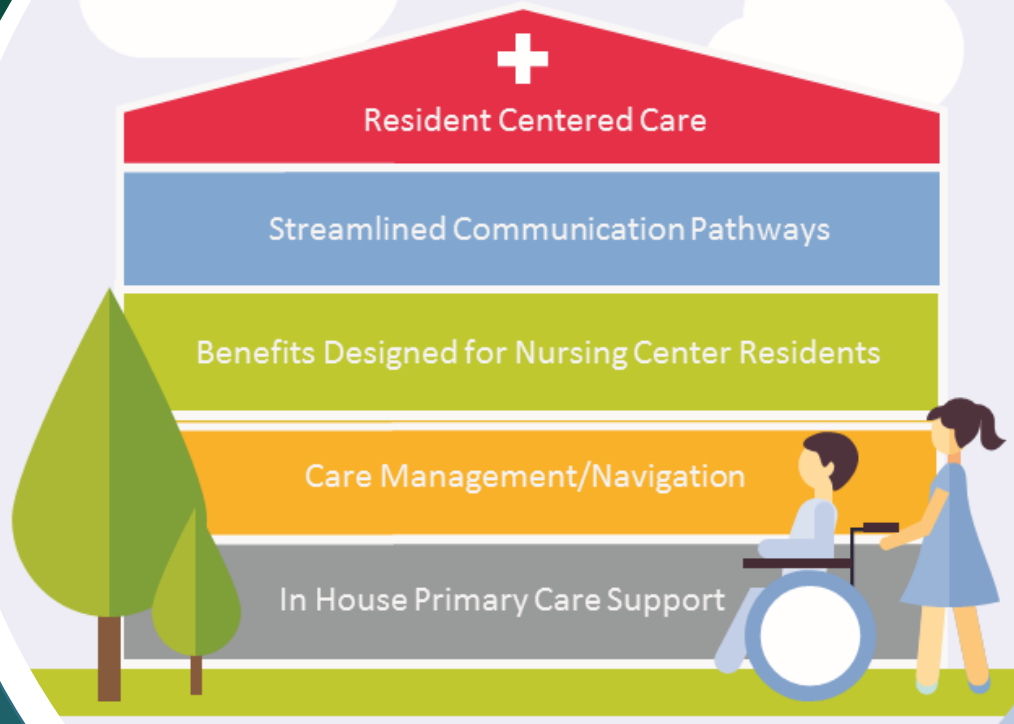
The MoC includes four elements:

- **MoC 1**: Description of the SNP Population
- **MoC 2**: Care Coordination
  - Health Risk Assessment Tool (HRAT)
  - Face-to-Face Encounter
  - The Individualized Care Plan (ICP)
  - The Interdisciplinary Care Team (ICT)
  - Care Transition Protocol
- **MoC 3:** Provider Network
- **MoC 4:** Quality Measurement and Performance Improvement

© AllyAlign Health 2022

A New Way of Delivering Care

- Uses Medicare Advantage Institutional Special Needs Plan platform to **modernize** Medicare benefits and their delivery.
- Employs Physician/Nurse Practitioner/Physician Assistant model that has been proven to deliver **improved clinical outcomes**.
- Transformational in nature and allows our team to **control its destiny**.
- Prepares organization to **successfully manage** under other alternative payment models such as Accountable Care Organizations (ACOs)and Bundled Payments.
- Allows for significant **reinvestment** into facilities and staff.
- **Protects facilities** against outside managed care plan penetration as States move toward Managed Long-Term Services and Supports (MLTSS).



© AllyAlign Health 2022

MOC 1: Description of the SNP Population

Medicare beneficiary	Frail /vulnerable	More likely to be female	Typically 65 years and older	Typically widowed or single
Often unable to make care decisions and 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 and 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

*List may vary. Please defer to your Plan's MOC for specific guidance.

© AllyAlign Health 2022

MOC 2: Care Coordination

- Health Risk Assessments (HRA)
- Face-to-Face Encounter
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT) Meetings
- Care Transition Protocols

© AllyAlign Health 2022

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

© AllyAlign Health 2022

Health Risk Assessment (HRA)

Requirements

- All new Plan members receive an HRA **within 90 days of enrollment**.
- Existing members should have an HRA annually (**within 364 days of their prior assessment**).
- The HRA **identifies immediate or overlooked health needs** and informs the care plan for the member.

© AllyAlign Health 2022

Face-to-Face Encounters

- The Plan's Care Team will conduct an initial Member face-to-face encounter within 90 days of the Member's enrollment to the Plan and annually thereafter.

- The Care Team may conduct more frequent face-to-face encounters based on the Member's health status and care needs.
  - Face-to-face encounters may be completed in person or via telehealth (video + audio).
  - If a face-to-face encounter is performed via telehealth, the Plan will obtain Member and/or caregiver verbal consent and document the consent in the Plan's care management platform.

- The intended outcome of these face-to-face encounters is to establish and/or further enhance the relationship between the Member and their care team and to elicit additional concerns that may not be achieved by telephonic contact alone to promote successful coordination of care and improve health outcomes.

© AllyAlign Health 2022

Individualized Care Plan (ICP)

An Individualized Care Plan (ICP) is developed by the Interdisciplinary Care Team (ICP) in collaboration with the member and or their caregiver.

The Plan's care team works closely with the member and the senior housing community to create, implement and evaluate the ICP.

The ICP must include, but is not limited to:

- The beneficiary's self-management goals and objectives
- The beneficiary's personal health care preferences
- A description of services specifically tailored to the beneficiary's needs
- Identification of measurable goals and action taken if goals are not met

The ICP is shared with members of the ICT using various methods such as, but not limited to:

- Verbal communication during face-to-face or telephonic activities
- Written communication delivered in person, mail, email, facsimile
- Electronic communication through access to clinical documentation

© AllyAlign Health 2022

Interdisciplinary Care Team (ICT)

- Every member has access to an Interdisciplinary Care Team (ICT).
- The **exact composition of the ICT working with members varies** and is dependent on each members' unique circumstances, risk-level, and individual needs and preferences.
- The ICT is developed to ensure **effective coordination** of care, especially through the member's care transitions, and to improve health outcomes.
- ICT **members are selected based on their functional roles**, knowledge, and/or established relationship with the member.
- The Plan Provider and the ICT reviews **progress towards goals** during clinical and monitoring visits with the member and during the ICT team meetings.

© AllyAlign Health 2022

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 MC /other ICT members for questions/concerns

Plan Provider

(Physician, Nurse Practitioner, Physician Assistant, or PCP)

- 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

Facility

- 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

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

© AllyAlign Health 2022

Interdisciplinary Care Team Meetings

Requirements

- All SNP members have at least one Interdisciplinary Care Team (ICT) meeting annually or more often if:
  1. Updates are needed to the Individualized Care Plan
  2. The facility ICT schedule requires more regular updates:
     - Nursing Home: quarterly
     - Other Levels of Care: 2x annually

© AllyAlign Health 2022

Care Transition Protocols

The Plan understands how **coordinated health care 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 Provider to serve as a centralized point of care coordination for members and families/caregivers for all care, including transitions.
- The Plan Provider will be responsible for preventive and primary care services delivered in the facility.
- Minimizing the need for transitions outside of the facility through delivery of wellness, preventive, and monitoring services delivered in coordination with the ICT members.

© AllyAlign Health 2022

Care Transition Protocols (cont.)

- Minimizing transitions outside of the senior housing community through a "**skill in place**" program.
- **Waiving the 3-day hospitalization requirement** for Skilled Nursing Facility services, enabling skill in place 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 Provider 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.

© AllyAlign Health 2022

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.
- Primary care services through the Plan Provider (MD, DO, NP, or PA) and supportive ancillary services like therapy, rehab, selected diagnostic radiology and lab, and home health are provided within the member's senior housing residence and coordinated by the Plan Provider.
- The Plan Provider also coordinates visits and services provided outside of the facility including specialist visits, radiology, lab, and other diagnostic testing not available on campus.
- Out of Network referrals may require prior authorization.

© AllyAlign Health 2022
9/15/2022

MOC 4:
Quality Measurement and 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 and promotes the mission, vision, and 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.

© AllyAlign Health 2022

Member Risk Prevention - PQI

Potential Quality Issues (PQI)

- A deviation or suspected deviation from expected provider performance, clinical care or outcome of care that cannot be determined to be justified without additional review. Examples of potential quality issues include:
  - Falls with injury/additional treatment required
  - Medication errors with injury/additional treatment required
  - Incident resulting in Death
  - Incident resulting in severe Brain or spinal damage to a patient
- All PQIs should be reported within three calendar days of the incident using the PQI form located on the Plan's website.
- Email completed form via secure email to pqireferral@allyalign.com.
- The PQI will be reviewed to determine if there should be a change in procedure to prevent further incidences.

© AllyAlign Health 2022

Member Risk Prevention – G&A

Grievance

A grievance is **any complaint or dispute** (other than an organization determination) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. Grievances can be filed within 60 days of occurrence.

- In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.
- Members/member representative reporting a grievance, should send a secure email with complete grievance details to: grievances@allyalign.com OR fax 1-833-610-2380.

Appeal

An appeal is **the right to ask the Plan to change their decision**. An appeal only occurs if the Plan makes a decision to deny in whole or in part a service or claim. Member/Member Representatives and providers can file an appeal within the allowed CMS timeframe which is 60 days from date of denial.

- Members/member representative/providers reporting an appeal, should send a secure email with complete appeal details to: appeals@allyalign.com OR fax 1-833-610-2380.

© AllyAlign Health 2022

We are here to support you!

PruittHealth Premier Training Department through AllyAlign Health:

clinicaltraining@allyalign.com

AllyAlign Health

PruittHealth PREMIER

© AllyAlign Health 2022