2024 Model of Care Training

PruittHealth Premier

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Objectives

- Medicare/Medicare Advantage 101
- Outline the basic concepts of Special Needs Plans
- Identify the requirements for success
- Describe the purpose and key components of the Model of Care
    - Health Risk Assessments (HRA)
    - Individualized Care Plans (ICP)
    - Interdisciplinary Care Team (ICT) Meetings
    - Care Transition Protocols
- Plan communications

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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

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Special Needs Plans

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)

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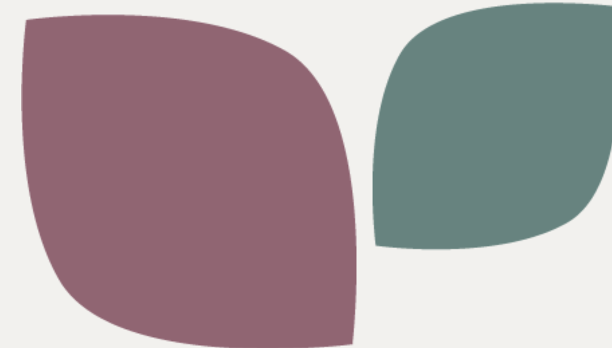
Institutional Special Needs Plan (I-SNP)

Who can join an I-SNP?



- Entitled to 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

Institutional-Equivalent Special Needs Plans (IE-SNPs):

For an I-SNP to enroll MA eligible individuals living in the community, but requiring an institutional level of care (LOC), the following two conditions must be met:

1. A determination of institutional LOC that is based on the use of a state assessment tool. The assessment tool used for persons living in the community must be the same as that used for individuals residing in an institution.
2. The I-SNP must arrange to have the LOC assessment administered by an independent, impartial party (i.e., an entity other than the respective I-SNP) with the requisite professional knowledge to identify accurately the institutional LOC needs. Importantly, the I-SNP cannot own or control the entity.

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Chronic Condition Special Needs Plan (C-SNP)

Who can join a C-SNP?

- Entitled to Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Live in plan service area (facility or home)
- Enrollees must have proof of one or more of the below severe or disabling chronic conditions to be eligible:
  - Chronic alcohol and other dependence
  - Autoimmune disorders
  - Cancer (excluding pre-cancer conditions)
  - Cardiovascular disorders
  - Chronic heart failure
  - Dementia
  - Diabetes mellitus
  - End-stage liver disease
  - End-Stage Renal Disease (ESRD) requiring dialysis (any mode of dialysis)
  - Severe hematologic disorders
  - HIV/AIDS
  - Chronic lung disorders
  - Chronic and disabling mental health conditions
  - Neurologic disorders
  - Stroke

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

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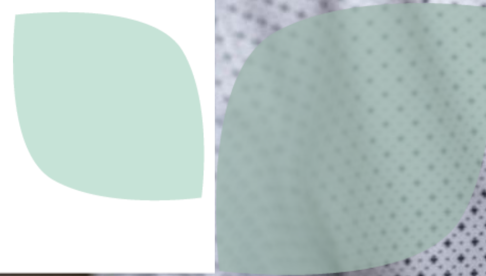
Dual-eligible Special Needs Plan (D-SNP)

PruittHealth Premier D-SNP (HMO D-SNP)

Who can join a D-SNP?

- Entitled to 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



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What Creates Success?

- **Membership**
- **Medical Management**
  - Focus on Prevention:
    - Routine Visits
    - Care Protocols
    - Skill in Place (for applicable Plans)
  - Goals to Avoid:
    - Avoidable Hospitalizations
    - ER Visits
    - SNF (post-acute part A services)
    - Unnecessary Specialist Visits

As the Payer (instead of Traditional FFS Medicare), the Plan can pay for the visits, activities, and work that directly contributes to better care.

- **Quality**

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Model of Care Overview

- ✓ Scored by National Committee for Quality Assurance (NCQA)
  - Score determines 1, 2, or 3-year approval timeline
- ✓ Must be monitored, process documented, and changes updated
- ✓ Must be approved by CMS

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What is the Model of Care?

The Model of Care is the contract that the Plan submits to CMS clearly outlining who our members are, how we take care of them, how we demonstrate that care, and how we manage the quality of that care. We use this contract to individualize the unique needs of our members.

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

Key Sections:

- MOC 1: Description of the SNP Population
- ***MOC 2: Care Coordination (clinical team's focus)**
    - Health Risk Assessment Tool (HRAT)
    - The Individualized Care Plan (ICP)
    - The Interdisciplinary Care Team (ICT) Meetings
    - Care Transition Protocol
- MOC 3: Provider Network
- MOC 4: Quality Measurement and Performance Improvement

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A New Way of Delivering Care

- Employs Physician/Nurse Practitioner and/or Physician Assistants to provide additional services than just traditional Medicare.
- The model focuses on routine visits and preventative care which has shown **improved clinical outcomes**.
- Allows for significant **reinvestment** into facilities and staff.

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MOC 1:
Description of the SNP Population

- Usually in a long-term care facility, assisted living, or independent living
- Requires additional care coordination than the general population
- Has multiple co-morbid chronic conditions requiring close monitoring
- Likely prescribed high-risk medications
- May need help with 5 or more activities of daily living (ADLs)
- May have moderate to severe cognitive impairment
- Likely reporting pain
- Lacks consistent, engaged caregiver / family support

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MOC 2:
Care Coordination

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

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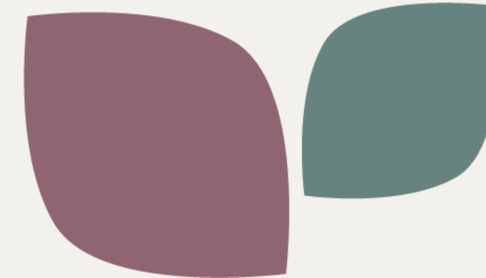
Health Risk Assessment (HRA)



The Plan’s Health Risk Assessment:

1. Starts the **new member assessment**
   - Collect member self-reported health status

2. Starts the **care planning** process
   - **Needs identified should be documented in the care plan** (medical, functional, cognitive, psychosocial, and mental health, etc.)

   **This is a CMS requirement (for initial HRAs and Annuals)!*

3. Provides an **annual checkpoint** and reassessment of key geriatric health metrics and monitor for changes in self-reported health status.

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Health Risk Assessment (HRA)

Requirements

- All new Plan members receive an HRA **within 90 days of enrollment** (start effective date).
- 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.

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Health Risk Assessment (cont.)

HRA Outcomes

1. **Results from the HRA directly contribute to a member's Individualized Care Plan (ICP):**
    - Identification of potentially life-threatening conditions and/or conditions requiring an immediate or near-immediate intervention (i.e., thoughts of harming myself/others, uncontrolled pain).
2. **Stratification of HRA responses set the timing of the post-HRA visit with the Advanced Plan Practitioner:**
    - NEW members: comprehensive visit
    - Existing members: rounding visit

HRA Stratification Level	Post-HRA Visit
High	Within 7 days
Medium	Within 14 days
Low	Within 30 days

**Model of Care & Plan rounding policies may vary. Refer to your Plan Leadership for specific guidance.*

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Post –HRA Visit & Ongoing Rounding

- The APP will complete a post-HRA visit per the stratification timeline. Visit will include:
  - HRA review *(Provider visit notes should include documentation of HRA results/outcomes)*
  - Review of available historical hospital, specialist, and diagnostic information
  - A Comprehensive exam (new members only)- like an H&P
- Outcomes of the post-HRA visit (i.e., medication changes, therapy referrals, diagnostic tests, scheduling of next visit, etc.), will be included in the facilities EMR and incorporated into the **Individualized Care Plan**.
- After the post-HRA visit, (initial or annual), the Advanced Plan Practitioner should round at minimum **MONTHLY**, or more often based on clinical judgement, utilization management, Plan Medical Director guidance, or transition protocols.

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Individualized Care Plan (ICP)

Requirements:

- Needs identified in the HRA should be documented in the Individualized Care Plan.
- All SNP members have an ICP that is updated with **significant changes in health status** and that is accessible to the member and with the Care Team for updates.
- Updated should be made, at minimum:
  - Nursing Home: quarterly
  - Other Levels of Care: annually

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Care Plan Required Components:

Medicare Managed Care Manual:

(Chapter 5 Section 20.2.1)

- Designed to address the needs identified in the HRA.
- Services specifically tailored to the member's need.
- Roles/responsibilities of the member's caregiver(s).
- Measurable timelines and measurable outcomes.
- Identification if goals are met/not met.
- Barriers should be documented if goals are not met.
- Member self-management goals & personal healthcare preferences.
- Description of services specifically tailored to the member's medical, psychosocial, functional, and cognitive needs.

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SMART Goals

S — **Specific**
(direct, detailed, and meaningful)

M — **Measurable**
(quantifiable to track progress or success)

A — **Attainable Achievable**
(realistic)

R — **Relevant**
(aligns with the member and/or ICT's goals)

T — **Time-Based**
(deadline)

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SMART Goal Example

Problem	Goal	Intervention
	Measurable timeline & measurable outcome!	Advanced Plan Practitioner will educate member, caregiver, and facility staff on increased risk of falls associated with medications (i.e., antihypertensive agents, diuretics, opiates, etc.).
Fall Risk	Member will remain free from falls for next 3 months. Date Initiated: xx/xx/xxxx Target Date: xx/xx/xxxx *(Documentation should include initiation date/target timeline)*	Facility staff will utilize assistive mobile devices (i.e., walker) while member ambulates.
		Facility staff, member, and caregivers will be educated on appropriate non-skid socks/shoes, appropriate fitting clothing (i.e., long pants, loose shoes, etc.) to prevent falls.
		Facility staff will toilet member prior to naps and bedtime.
		Facility staff will ensure bed alarm is activated when member is not under direct supervision.
		Facility staff will verify member has call bell within reach at each shift.
		Facility staff to relocate member to room close to nursing station for easier access to nursing staff.

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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

*Best practice is to attend in person, if possible. If unable to attend in person or during scheduled ICT, the APP can discuss needs individually with appropriate care team members (i.e., DON, therapy, dietary, etc.).

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Interdisciplinary Care Team Meeting (cont.)

- The Health Risk Assessment is a **starting point** for the Plan to identify the different providers and support systems that the member has in place and 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, and to improve health outcomes.
- The **continuity** and regular schedule of ICT meetings allows the APP 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 APP, and other pertinent clinical staff to review and address **urgent issues**.
- 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.
- ICT **members are selected based on their functional roles**, knowledge, and/or established relationship with the member.
- The APP and the ICT reviews **progress towards goals** during clinical and monitoring visits with the member and during the ICT team meetings.

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Interdisciplinary Care Team (ICT) Members

1. Member/Caregiver/Responsible Party
2. Advanced Plan Practitioner (APP)
    - Physician / PCP
    - Nurse Practitioner
    - Physician Assistant
3. Facility Staff- MDS, Nursing, Pharmacy, Dietary, Activities, etc.
4. Other Medical Professionals/Specialist

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Role:
Member/Caregiver/Responsible Party

- ICT process revolves around the member.
- Member can identify specific individuals they would like to participate in the ICT.
  - POA and Member are always invited to ICT. Should they not attend, the APP should discuss care plan meeting outcomes with them 1:1.
- Participation in all HRAs.
- Participation in the development of the Individualized Care Plan.
- Vocalize needs, barriers, and prioritize goals.
- Contact Plan Representative/other ICT members for questions/concerns.

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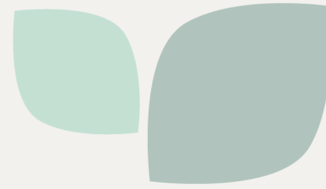

Role:
Advanced Plan Practitioner

- Initial introduction and communication with member/family upon enrollment/HRA completion.
- Ongoing communication and coordination with member/family (best practice is quarterly as a part of the ICT meetings).
- Responsible for ensuring that needs/gaps identified in the HRA or subsequent visits are addressed in the Care Plan.
- Participates in the development of the Care Plan and ensures progress is being made to meet goals.
- Attends Interdisciplinary Care Team (ICT) Meetings.
  - Best practice is to attend in person, if possible. If unable to attend in person or during scheduled ICT, the APP can discuss needs individually with appropriate care team members (i.e., DON, therapy, dietary, etc.).
- Providing preventative services/primary care.
- Conducts oversight for all transitions of care events.
- Member education.

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Role:
Facility Staff

1. May be various staff members (i.e., nurse, MDS coordinator, social worker, nutritionist, pharmacist, activity director, etc.).
2. Communicate with all ICT members regarding changes in treatment or recommendations.
3. Provide input to the ICT for the ICP development and ongoing updates.
4. Make sure transition of care protocols are followed, including notification o unplanned **transfers** and **changes in conditions**.
    - Expectation is staff to follow INTERACT policy and procedure includir & WATCH and SBAR.
    - Facility should then call APP team with information from the SBAR, chan condition and transitions in levels of care.
5. Document and implement the care plan.

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Role:
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 Care Plan.
- Attend or provide input for ICT meetings, as appropriate.
- May provide pre-meeting feedback to the ICT via the Care Ally or the APP.

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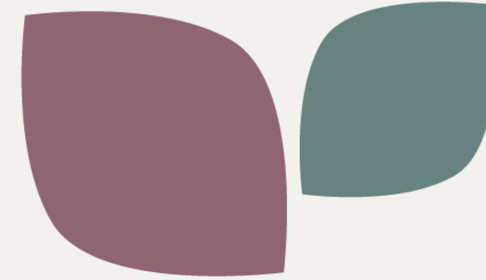
Interdisciplinary Care Team (cont.)



Effective ICT communication helps to improve the health status of our member by the following:

- Minimized errors and potential adverse events.
- Improved care coordination, including during transitions.
- Improved communication and understanding of health status and treatment across the team and with the member and/or caregiver.
- Improved management of the member's medical, cognitive, psychosocial, and functional needs through collaboration and revision of the Care Plan.
- Improved access to needed services and support as gaps in care and outstanding needs are identified.
- Member and/or caregiver satisfaction with care planning process.

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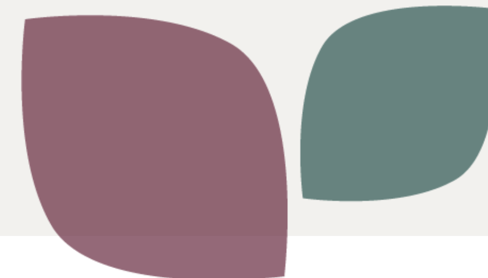
Care Transition Protocols (Triggering Events)

Transition definition: anytime the member has a change in level of care (regardless of the location).

The Plan understands how **coordinated health care improves the care of its vulnerable membership**. The Plan incorporates care transition protocols to provide a collaborative, 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 an assigned Care Ally and Advanced Plan Practitioner to serve as a centralized point of care coordination for members and families/caregivers for all care, including transitions.
- The Advanced Plan Practitioner will be responsible for preventive and primary care services (see next slide) 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.



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Transition Follow-up Timeline (Triggering Events)

Member LEAVES a facility

(IP, ER, OBS, LTAC)

Within 2 business days:

The APP coordinates an initial updated care plan with the facility within two business days of the member's return to the facility.

Within 7 days:

The APP completes a visit with the Member within 7 days of the member's return to the facility and coordinates an updated ICP with the ICT.

Change in level of care WITHIN the facility

(Skill in Place/SNF)

Within 2 business days:

The APP coordinates an initial updated Care Plan with the facility within two business days of the START of the skilled service.

Within 7 days:

The APP completes a visit with the Member within 7 days of the START of the skilled service and coordinates an updated ICP with the ICT.

**Follow additional protocols and best practices established by your Plan Leadership.*

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Care Transition Protocols (cont.)

- **Minimizing transitions outside of the facility through the Skill in Place (SIP) program.**
  - Waiving the 3-day hospitalization requirement for Skilled Nursing Facility services, enabling SIP and encouraging appropriate ER and Observation combined with follow-up skilled services in the SNF *instead of an inpatient hospitalization*.
  - Goal is to prevent avoidable hospitalizations, when appropriate.
  - SIP requires a **SKILLABLE** need in combination with meeting the SIP criteria. (Criteria will be reviewed in a separate course).
  - *Important Reminder: to meet SIP, the member cannot have been hospitalized in the last 30 days for the SAME or RELATED diagnosis related to the hospitalization.*

**Note: For new hires, the complete SIP course will be presented later in your training.*

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Care Transitions (cont.)

An important goal in **continuity** of care processes for the Plan is to **reduce the incidence of inappropriate care transitions**, particularly those resulting in **unnecessary re-hospitalizations**. As part of the Plan's approach to ensuring a safe care transition process, the Plan focuses on the following:

1. **Member-Centered Care**
   - Care Ally is the main point of contact for coordinating all transitions
   - The Advance Plan Practitioner oversees and approves all care transitions
   - Educate member/caregiver as to the reasons for the transition and prevention of transitions
   - Transitions align with the member's goals and advance care directives
2. **Communication**
   - Peer to peer communication is established across sites of care
     - It is an expectation that if a member transfers out of the facility (i.e., IP, Obs, ER, LTAC, etc.) that the APP has verbal communication with the intake team to give report and to facilitate return to the facility.
     - It is also an expectation that the APP will keep the PCP team informed of member changes in level of care.
   - Information about the member (i.e., medications and care plans) are collected prior, during, and post care transition
3. **Safety**
   - Appropriate assessment of the member PRIOR to transition
   - Prompt and consistent medication reconciliation at every transition point
   - Accurate and timely transition of key information (i.e., functional/cognitive status, current problem list, allergies, advance directives, recent labs, consultations, diagnostic testing results, etc.

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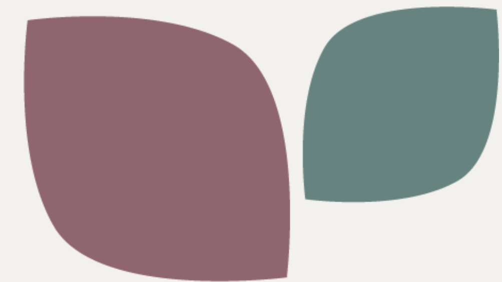
Typical Transitions Specific to the Plan's Population Include:

- Facility to Emergency Department
- Facility to Hospital
- Emergency Department to facility/SNF
- Hospital to facility/SNF
- Facility to Hospice Care
- Facility to Skilled Care (may be in same facility, but care level change)
- Facility to community with home health
- Facility to a non-contracted facility



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Transition Coordination & Communication

Advanced Plan Practitioner (APP)

- During the Interdisciplinary Care Team (ICT) meeting, the APP updates the ICT on the Member's status and transition plan.
- Post-discharge, the APP educates the Member and/or caregiver on the reason(s) for hospitalization/transition and future prevention, including Care Pathways for management of future events.
- 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 or to caregiver
- Discusses the next steps in the care management process (i.e., review updated ICP).
- Coordination of or orders for post-hospital specialist visits, diagnostic testing, home health services and/or therapy.
- Coordinates post-transition follow up for the Member.

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Care Transition Personnel

The personnel responsible for coordinating the care transition process include:

- The **Advanced Plan Practitioner** (APP) should be notified of all planned or unplanned care transitions with every effort made to consult with the APP ***before*** a facility sends a member to the hospital.
- The **facility** has the responsibility of notifying the APP ***before*** an unplanned care transition or, when a member requires immediate emergency services, ***right after*** contacting emergency services. The facility should also notify the Plan of transfers to hospital so that the Utilization Management team can ensure appropriate care level, engage in care coordination including exchange of patient information with the hospital, and begin discharge planning.
- The Plan's **Utilization Management** (UM) team takes over the care coordination role when members are admitting to a short term or long-term acute care hospital or when members are admitted to a non-contracted SNF.
- The **Care Coordinator** (part of the UM team), coordinates care for members who discharge from the contracted facility while the member is pending disenrollment from the Plan.

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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 long-term senior housing residents.
- The Plan provides network of providers, specialists, and facilities with specialized knowledge pertinent to the care and treatment of its members (i.e., cardiologist, pulmonologist, neurologist, endocrinologists, etc.).
- Primary care services through the Advanced Plan Practitioner (APP) 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 APP.
- The APP 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

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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.

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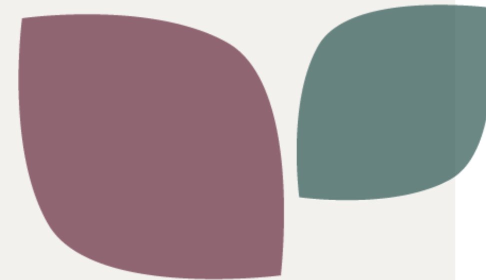
MOC 4:
Quality Measurement and Performance Improvement (cont.)



- 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 Medical Director is accountable for oversight of the QI Program on an ongoing basis. The Plan Medical Director reviews and provided guidance on all QI activities.
- The Quality Improvement Committee reviews and provides oversight of the QI Program.
- The Plan educates its network on key performance measures and changes to the MOC.

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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
- Surgical procedure being performed on the wrong patient
- Surgical procedure unrelated to the patient's diagnosis or medical needs

All PQIs should be reported as soon as identified using the PQI form.

- 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.

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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.

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We are here to support you!

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Thank You

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