Medicare: 2017 Model of Care Training

4/13/2017

Training Objectives

This course will describe how MHS Health Wisconsin Medicare Advantage and its contracted providers work together to successfully deliver the Model of Care (MOC) program.

- After the training, attendees will be able to:
  - Outline the basic components of the MHS Health Model of Care (MOC)
  - Explain how MHS Health medical management staff coordinates care for Special Needs members
  - Describe the essential role of providers in the implementation of the MOC program
  - Define the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT)

Model of Care Training

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- The Model of Care (MOC) is a quality improvement tool that ensures that the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed
- The Affordable Care Act requires the National Committee for Quality Assurance (NCQA) to review and approve all SNPs MOC using standards and scoring criteria established by Centers for Medicare and Medicaid (CMS)
- This course is offered to meet the CMS regulatory requirements for MOC Training for our SNPs
- It also ensures all employees and providers who work with our SNP members have the specialized training this unique population requires

Current Medicare Plans

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Centene provides different types of Medicare Advantage plans all over the country. The plans all have MOCs that must be adhered to.

- **Dual Special Needs Plans (D-SNP)**
  - Bridgeway Health Solutions Medicare Advantage- Arizona
  - Buckeye Health Plan Medicare Advantage- Ohio
  - MHS Health Wisconsin Medicare Advantage- Wisconsin
  - Peach State Health Plan Medicare Advantage- Georgia
  - Sunshine Health Medicare Advantage- Florida
  - Superior Health Plan Medicare Advantage- Texas
  - Trillium Advantage Dual- Oregon
- **Dual Special Needs Plans (I-SNP)**
  - Trillium Advantage TLC ISNP- Oregon
  - Trillium Advantage TLC Community ISNP- Oregon
- **Medicare-Medicaid Plans (MMP)**
  - Absolute Total Care - South Carolina
  - Buckeye Health Plan - MyCare Ohio
  - IlliniCare Health - Illinois
  - Superior HealthPlan STAR+PLUS – Texas
  - Fidelis SecureLife - Michigan

What is Model of Care?

- The Model of Care (MOC) is MHS Health Wisconsin Medicare Advantage's comprehensive plan for delivering our integrated care management program for members with special needs

- It is the architecture for promoting quality, care management policy and procedures, and operational systems

Model of Care

The Model of Care is comprised of four clinical and non-clinical elements:

1. Description of the SNP Population
2. Care Coordination
3. SNP Provider Network
4. Quality Measurements & Performance Improvement

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Element I: Description of the SNP Population

Description of Population

- Element 1 includes characteristics related to the membership that MHS Health and providers serve including social factors, cognitive factors, environmental factors, living conditions, and co-morbidities

- The element also includes:
  - Determining and tracking eligibility
  - Specially tailored services for members
  - How MHS Health works with community partners

Special Needs Plan (SNP)

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- Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs. CMS has defined types of SNPs that serve the following types of members:
  - Dual Eligible Special Needs Plan (D-SNP)
  - Chronic Condition Special Needs Plan (C-SNP)
  - Institutional Special Needs Plan (I-SNP)
  - Medicare-Medicaid Plan (MMP)
- Health plans may contract with CMS for one or more programs

Special Needs Plan (SNP)

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- Medicare is always the primary payor and Medicaid is secondary payor, unless the service is not covered by Medicare or the Medicare service benefit cap is exhausted for D-SNP members

- SNP members have both Medicare and Medicaid but not always with MHS Health Wisconsin. Medicaid benefits may be via another Health Plan or the State.

- It’s important to verify coverage prior to servicing the member

Specific Services

MHS Health provides members with services tailored to the needs of the SNP population. These services can include, but are not limited to:

- Care coordination and complex care management for high risk and most vulnerable members
- Care transitions management
- Physician home visiting services
- In-home wound care
- Disease management services
- Clinical management in long term care facilities as needed
- Medication Therapy Management and medication reconciliation
- Medicare and Medicaid benefit and eligibility coordination and advocacy

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Element II: Care Coordination

Care Coordination

- The Care Coordination element includes a description of how the SNP will coordinate the health care needs and preferences of the member, and share information with the Interdisciplinary Care Team (ICT)
- MHS Health conducts care coordination using the Health Risk Assessment (HRA), an Individualized Care Plan (ICP), and providing an ICT for the member
- The Care Coordination element also includes:
  - Explanation of all the persons involved in care
  - Contingency plans to avoid disruption in care
  - Training that is required of all involved in member care and how it is administered

Care Coordination: HRA

An HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks of members.

- MHS Health attempts to complete the initial HRA within 90 days of enrollment and annually; or if there is a change in the members condition or transition of care
- HRA responses are used to identify needs, are incorporated into the member's care plan, and communicated to the care team
- Members are reassessed if there is a change in health condition
- Change(s) in health condition and annual updates are used to update the care plan

Note: Physicians should encourage members to complete the HRA in order to better coordinate care and create an individual care plan.

Individualized Care Plan (ICP)

- An ICP is developed by the Interdisciplinary Care Team (ICT) in collaboration with the member
- Case Managers and PCPs work closely together with the member and their family to prepare, implement, and evaluate the ICP

Individualized Care Plan (ICP)

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Members receive monitoring, service referrals, and condition specific education based on their individual needs.

ICPs include member-centric problems, interventions, and goals, as well as services the member will receive.

- Medical conditions management
- Long-term services and supports (Members with LTSS benefits)
- Skilled nursing
- Occupational therapy (OT), Physical therapy (PT), Speech therarpy (ST)
- Behavioral health and substance use
- Transportation
- Other services, as needed

Interdisciplinary Care Team (ICT)

- MHS Health Case Managers coordinate the member's care with the ICT **based on the member's preference** of who they wish to attend. The ICT includes:
  - Appropriately involved MHS Health staff
  - The member and their family/caregiver
  - External practitioners
  - Vendors involved in the member's care
- MHS Health Case Managers work with the member to encourage self-management of their condition, as well as communicate the member's progress toward these goals to the other members of the ICT

Interdisciplinary Care Team (ICT)

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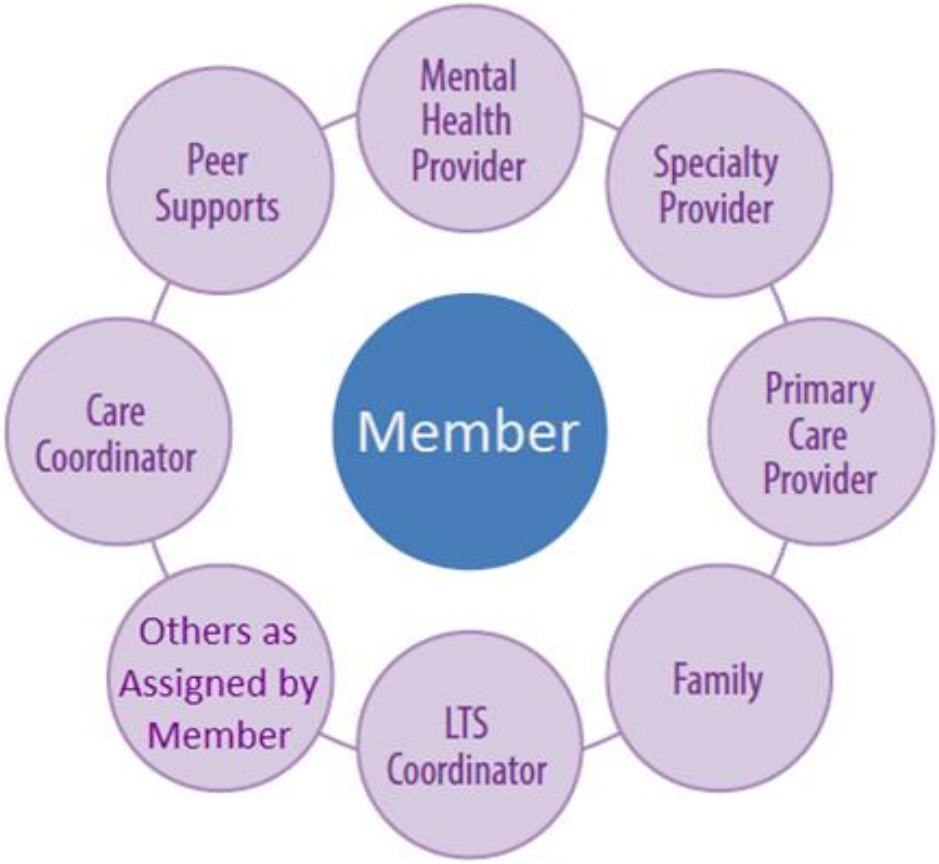
- MHS Health's program is member centric with the PCP being the primary ICT point of contact
- MHS Health staff works with all members of the ICT in coordinating the plan of care for the member



ICT and Inpatient Care

- During an episode of illness, members may receive care in multiple settings, often resulting in fragmented and poorly executed transitions

- MHS Health staff manage transitions of care to ensure that members have appropriate follow-up care after a hospitalization or change in level of care to prevent re-admissions

ICT and Inpatient Care

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MHS Health's Care Managers:

Coordinate with facilities to assist members in the hospital or in a skilled nursing facility to access care at the appropriate level	Collaborate with the facility and the member or the member's representative to develop a discharge plan	Proactively identify members with potential for readmission and engage them in case management	Notify the PCP of the transition of care and anticipated discharge date and discharge plan of care

ICT and Inpatient Care

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Managing Transitions of Care interventions for all discharged members may include, but is not limited to:

- Face-to-face or telephonic contact with the member, or their representative, in the hospital prior to discharge to discuss the discharge plan
- In-home visits or phone call within 72 hours post discharge
- Enrollment into the Case Management program
- Ongoing education of members to include preventive health strategies in order to maintain care in the least restrictive setting possible

ICT and Inpatient Care

- During in-home visits or phone calls, Care Managers will:
  - Evaluate member's understanding of their discharge plan
  - Assess member's understanding of medication plan
  - Ensure follow up appointments have been made
  - Make certain home situation supports the discharge plan

ICT Responsibilities

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- MHS Health works with each member to:
  - Develop their personal goals and interventions for improving their health outcomes
  - Monitor implementation and barriers to compliance with the physician's plan of care
  - Identify/anticipate problems and act as the liaison between the member and their PCP
  - Identify Long Term Services and Supports (LTSS) needs and coordinate services as applicable

ICT Responsibilities

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- Coordinate care and services between the member's Medicare and Medicaid benefit
- Educate members about their health conditions and medications and empower them to make good healthcare decisions
- Prepare members/caregivers for their provider visits – Encourage use of personal health record
- Refer members to community resources as identified
- Notify the member's physician of planned and unplanned transitions

Provider ICT Responsibilities

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Provider responsibilities include:

- Accepting invitations to attend member's ICT meetings whenever possible
- Maintaining copies of the ICP, ICT worksheets, and transition of care notifications in the member's medical record when received
- Collaborating and actively communicating with:
  - MHS Health's Case Managers
  - Members of the ICT
  - Members and caregivers

CMS ICT Expectations

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CMS expects the following related to ICT:

- All care is per member preference
- Family members and caregivers are included in health care decisions as the member desires
- There is continual communication between all members of the ICT regarding the member's plan of care
- All team meetings/communications are documented and stored

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Element III: Provider Network

Provider Network

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Element 3 explains the specialized expertise that is made available to members in MHS Health's provider network.

This element also describes:

- How the network corresponds to the target population
- How MHS Health oversees network facilities
- How providers collaborate with the ICT and contribute to a beneficiary's ICP

Provider Network

- MHS Health is responsible for maintaining a specialized provider network that corresponds to the needs of our members

- MHS Health coordinates care with and ensures that providers:
  - Collaborate with the ICT
  - Provide clinical consultation
  - Assist with developing and updating care plans
  - Provide pharmacotherapy consultation

CMS Expectations

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CMS expects MHS Health to:

- Prioritize contracting with board-certified providers
- Monitor network providers to assure they use nationally recognized clinical practice guidelines when available
- Assure that network providers are licensed and competent through a formal credentialing process
- Document the process for linking members to services
- Coordinate the maintenance and sharing of member's health care information among providers and the ICT

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Element IV: Quality Measurement & Performance Improvement

Quality Measurement & Performance Improvement

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- Element 4 requires plans to have performance improvement and quality measurement plans in place

- To evaluate success, MHS Health disseminates evidence-based clinical guidelines and conducts studies to:
  - Measure member outcomes
  - Monitor quality of care
  - Evaluate the effectiveness of the Model of Care (MOC)

Model of Care Goals and Data Sources

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- MHS Health determines goals for the MOC related to improvement of the quality of care that members receive

- The 2017 goals are in alignment with the Medicare and Medicaid regulatory agencies performance measurement systems:
  - Stars
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - Health Outcomes Survey (HOS)

2017 Model of Care Goals and Data Sources

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1. Assure Access to Medical, Behavioral/Mental Health, & Social Services	• Star C20 CAHPS Getting Needed Care • Star C21 CAHPS Getting Appointments and Care Quickly
2.Provide Access to Affordable Care	• HEDIS Adults' Access to Preventive/Ambulatory Health Services
3. Improve Coordination of Care through an Identified Point of Contact	• Star C25 CAHPS Care Coordination • Star C08 Health Risk Assessment (HRA) Completion
4. Assure Seamless Transitions of Care across Healthcare Settings, Providers & Health Services	• Star C19 HEDIS Plan All-Cause Readmissions • Star (pend.) HEDIS Medication Reconciliation Post-Discharge

2017 Model of Care Goals and Data Sources

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5. Improve Access and Utilization of Preventive Health Services	• Star C03 CAHPS Annual Flu Vaccine • Star C01 HEDIS Breast Cancer Screening • Star C02 HEDIS Colorectal Cancer Screening
6. Improve Appropriate Utilization of Services for Chronic Conditions	• Star (pend.) HEDIS Hospitalization for Potentially Preventable Complications - Chronic
7. Improve Experiences of Care	• Star C05 HOS Improving/Maintaining Mental Health • Star C04 HOS Improving/Maintaining Physical Health

Summary

- MHS Health values our partnership with our physicians and providers and our members

- The Model of Care requires all of us to work together to benefit our members by:
  - Enhanced communication between members, physicians, providers, and MHS Health
  - Using an interdisciplinary approach to the member's special needs
  - Employing comprehensive coordination with all care partners
  - Supporting the member's preferences in the plan of care
  - Reinforcing the member's connection with their medical home

Attestation Form

All MHS Health Wisconsin Medicare Advantage network providers are required to complete the Model of Care training. To verify training was completed:

1) Click on the link below to access the form
2) Complete the form
3) Click submit after completion

https://www.mhswi.com/providers/resources/provider-training.html