Quality
Department

MCS Model of Care

For Special Needs Plans (SNP)

2019 Providers network and delegated entities annual training

Rev. 2.2019

VÍVELA >> MCS

AON MEJORESPATRONOS PUERTO RICO | 2018 15ta EDICIÓN

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CMS Requirements

- The Centers for Medicare & Medicaid Services (CMS) require that all MCS employees, delegated entities and providers receive the Special Needs Plan Model of Care training at the hiring moment and annually thereafter.
- CMS requires that MCS ensures a 100% compliance with initial and annually trainings for all employees, delegated entities and providers.

Objectives

- Memorize the 4 Model of Care elements.
- Describe the Model of Care that MCS offers to its dual eligible members with special needs (D-SNP).
- Name the Interdisciplinary Care Teams for the D-SNP.
- Explain the integrated role of employees and providers in the Model of Care of MCS.

Definitions

- **CAHPS** (Consumer Assessment of Healthcare Providers and Systems): Survey that collects, evaluates and reports about the experience (perception) of members in relation to services received from insurers and providers.
- **CHRA** (Comprehensive Health Risk Assessment): Assessment performed by clinicians to identify member's needs and risk factors.
- **CM** (Care Management): Care Management Program/Care Manager
- **HCC** (Hierarchy Condition Category): Classification system based on health status (diagnostic data) and demographic characteristics (such as age and sex) of a beneficiary to calculate risk scores.
- **HOS** (Health Outcomes Survey): Survey that gathers valid and clinically significant data on patients' mental and physical wellness.

Definitions

- **ICP** (Individualized Care Plan): Individualized Care Plan created for the member.
- **ICT** (Interdisciplinary Care Team): Interdisciplinary Care Team responsible for the care plan development, care coordination, among others.
- **PCP** (Primary Care Physician): Physician who is mainly responsible for the member's care under the Model of Care.
- **RAPS** (Risk Adjustment Processing System): Process that allows CMS to grant the corresponding premium payment to the health plan, according to the beneficiary health risk.

Special Needs Plans
Background

2003

- Under the Medicare Modernization Act, the U.S. Congress developed the Special Needs Plan (SNP) as part of the requirements for Medicare Advantage plans (MA).
- SNPs are classified in three categories:
  - Dual Eligible (D-SNP)
  - Chronic Diseases (C-SNP)
  - Institutionalized Individuals (I-SNP)

2012

- Affordable Care Act amended Section 1859(f)(7) of the Social Security Act:
  - Requires that all MA plans offering SNPs plans submit a Model of Care (MOC) to CMS for the evaluation and approval of NCQA (National Committee for Quality Assurance) that ensures compliance with CMS guidelines.

CMS regulation **42 CFR §422.101(f)** requires that all MA organizations must implement a Model of Care for its members with Special Needs to satisfy their health needs and improve their quality of life.

MCS Classicare Platino

Dual Eligible Special Needs Plans Background (D-SNP)

Definition:

- Health plan for people who are eligible to receive benefits from Medicare Parts A and B, and Medicaid.

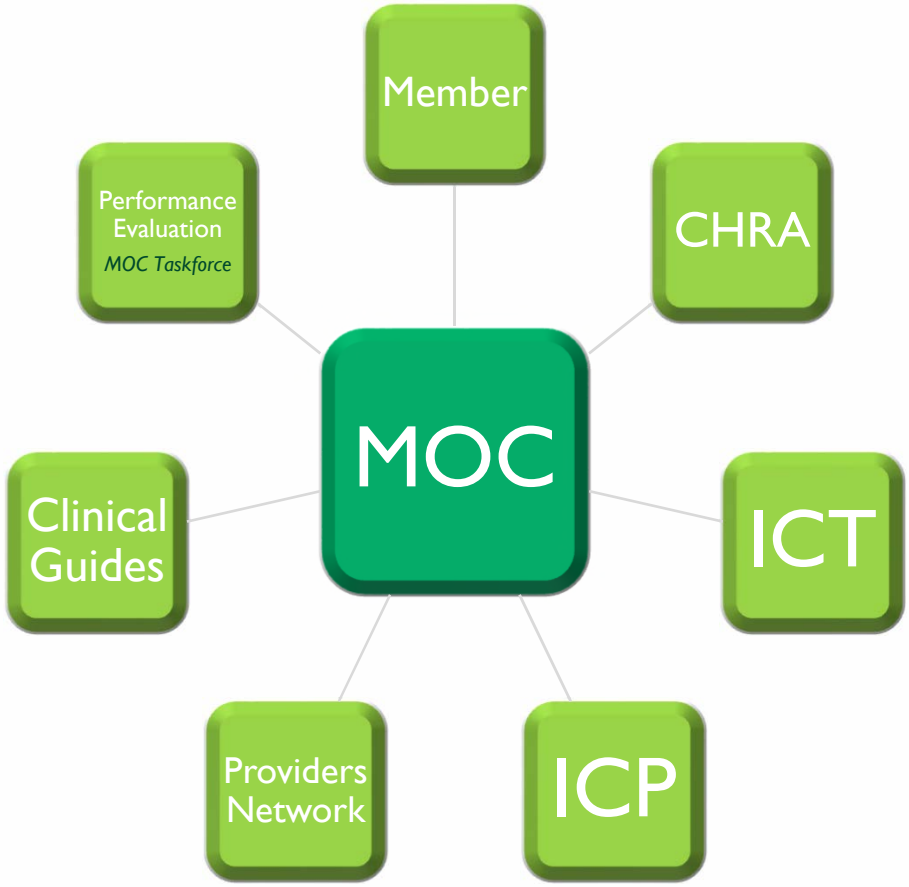
MCS Advantage, Inc. has a contract with Medicare and ASES in order to offer Platino plans to their dual eligible beneficiaries.

Model of Care (MOC)

CMS describes the **Model of Care** as a vital quality improvement tool that integrates components to ensure that the unique needs of each enrolled beneficiary are identified and addressed. MOCs provide the needed infrastructure to promote quality, care management and care coordination processes for SNPs members.

- MCS Quality Department is responsible for overseeing, monitoring, and evaluating actions related to MOC.

MOC Support Components



- MCS's MOC has the necessary structure to communicate and satisfy the needs of our SNP members.
- Communicates regularly with the member and his/her PCP about the member's medical, cognitive, mental, psychosocial, and functional management and includes the caregiver as necessary.
- Initiatives facilitate the preauthorization processes, care transition, chronic conditions follow-ups, and communication between providers.
- The MOC performance and its components are evaluated regularly to guarantee compliance with CMS guidelines.

Model of Care (MOC)

4 constituent elements

MOC 1	• Description of SNP Population
MOC 2	• Care Coordination *Care Transition Protocol*
MOC 3	• Provider Network
MOC 4	• Quality Measurement and Performance Improvement

2019 MCS Classicare Platino plans

In **2019**, MCS has 6 Platino plans for the SNP population.

Plan Name	MCS Contract Number	MCS Group Number
MCS Classicare		
Platino Ideal (HMO SNP)	H5577-002 **(Renewal)**	850614
Platino Progreso (HMO SNP)	H5577-017 **(Renewal)**	850717
Platino Cómodo (HMO SNP)	H5577-027 **(Renewal)**	850721
Platino Clásico (HMO SNP)	H5577-028 **(Renewal)**	850722
Platino Más Ca$h (HMO SNP)	H5577-029 **(Renewal)**	850723
Platino OTC (HMO SNP)	H5577-036 ***(New)***	850724

On **January 2018,** the total MCS D-SNP population was **95,471** members.

MOC 1

- Description of SNP Population

MOC 2

- Care Coordination
  Care Transition Protocol

MOC 3

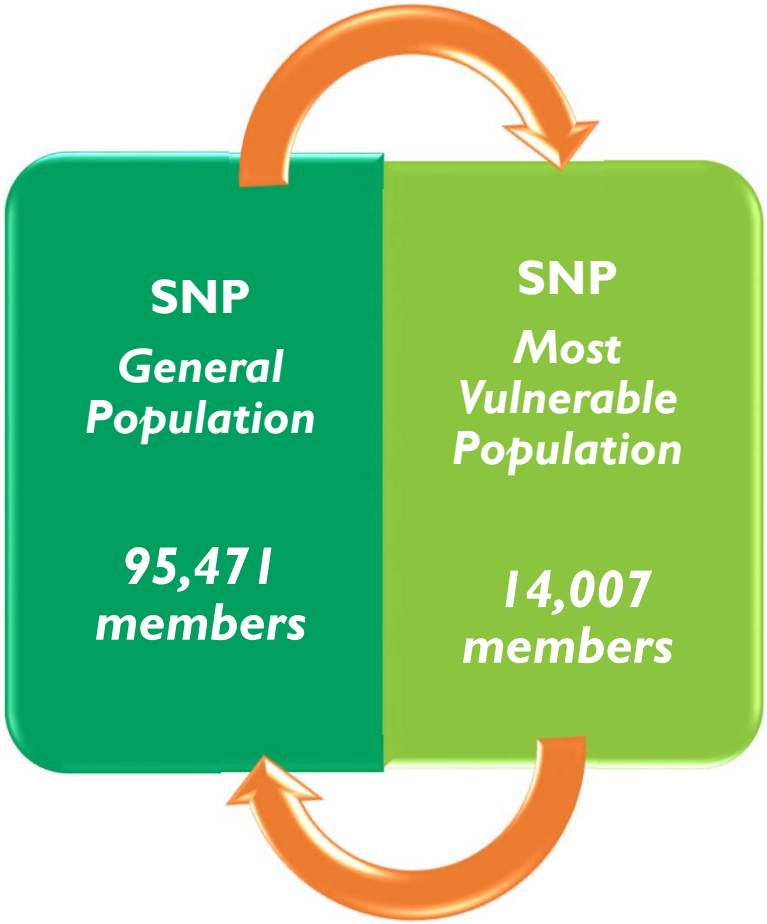
- Provider Network

MOC 4

- Quality Measurement and Performance Improvement

MOC 1: Description of SNP Population

Most Vulnerable Population



Total SNP Population
MCS Classicare Platino

The most vulnerable population is part of the **MCS Classicare Platino** total population identified with complex health risks that require intervention of a ***Care Manager*** to assist their needs.

2017 Data

MOC 1: Description of SNP Population

Important data to describe the population:

- Eligibility
- Social factors, cognitive and environmental
- Life conditions
- Comorbidities
- Physical and mental health conditions
- Specified characteristics identified in the population

- 30% have less than 65 years
- 57% are female
- 46% live in rural zones
- 53% report requiring a caregiver

- The three main diagnostics identified in SNP population are: 1. Diabetes Mellitus 2. Hypertension and 3. Recurrent Major Depression.
- 68% of the population is overweight/obese.
- 11.6% of members didn't visit their PCP during 2017.
- According to the CHRA, 37% of the members consider they have a good quality of life.

- 30% didn't complete High School
- 99% identified as Hispanic
- 99.72% prefer to use Spanish as the primary language.

2017 Data

MOC 1	• Description of SNP Population
MOC 2	• Care Coordination *Care Transition Protocol*
MOC 3	• Provider Network
MOC 4	• Quality Measurement and Performance Improvement

MOC 2: Care Coordination

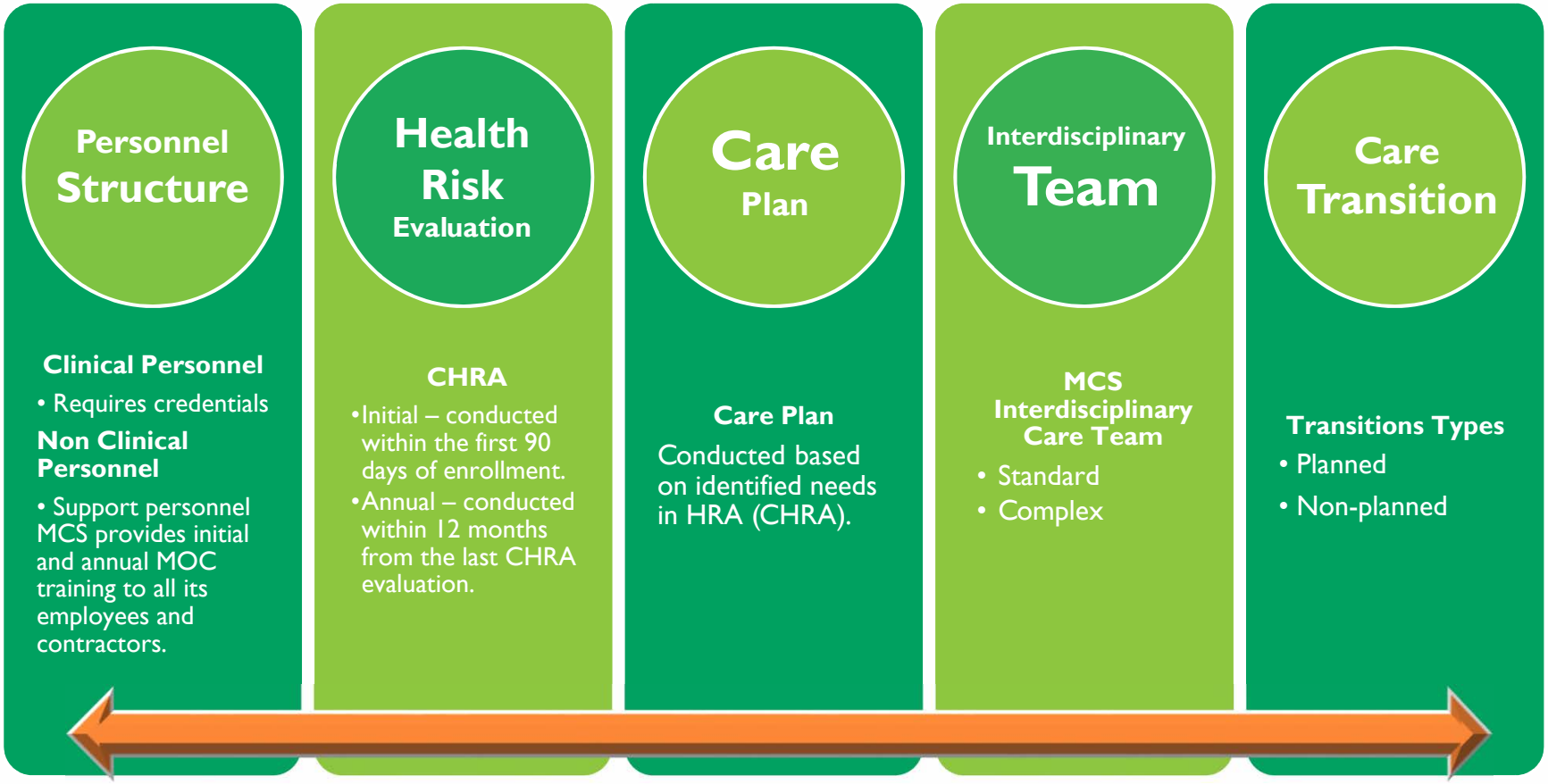
- Regulations 42 CFR §422.101(f)(ii)-(v) and 42 CFR §422.152(g)(2)(vii)-(x) require that all SNPs **coordinate and evaluate the effectiveness** of the services provided as required by the MOC.
- Care Coordination ensures that all SNPs member's **health needs and service preferences are covered.**
- Also ensures that the medical information between health professionals is shared **maximizing the effectiveness, the efficiency, the high quality of services and improving members' health outcomes.**
- MOC also describes the **roles, responsibilities and vigilance** of clinical and non-clinical personnel.
- MOC establishes a contingency plan that **ensures the continuity of critical functions** of MCS operation during an emergency.
- Also requires that **all personnel must be MOC trained** at the hiring moment and annually.

MOC 2: Care Coordination

Integral Role of the Employees

- Ensure compliance with CMS requirements for the MOC
- Participate in the initial and annual MOC training
- Assist members and providers satisfying their service needs
- Support initiatives to comply with MOC goals

MOC 2: Care Coordination



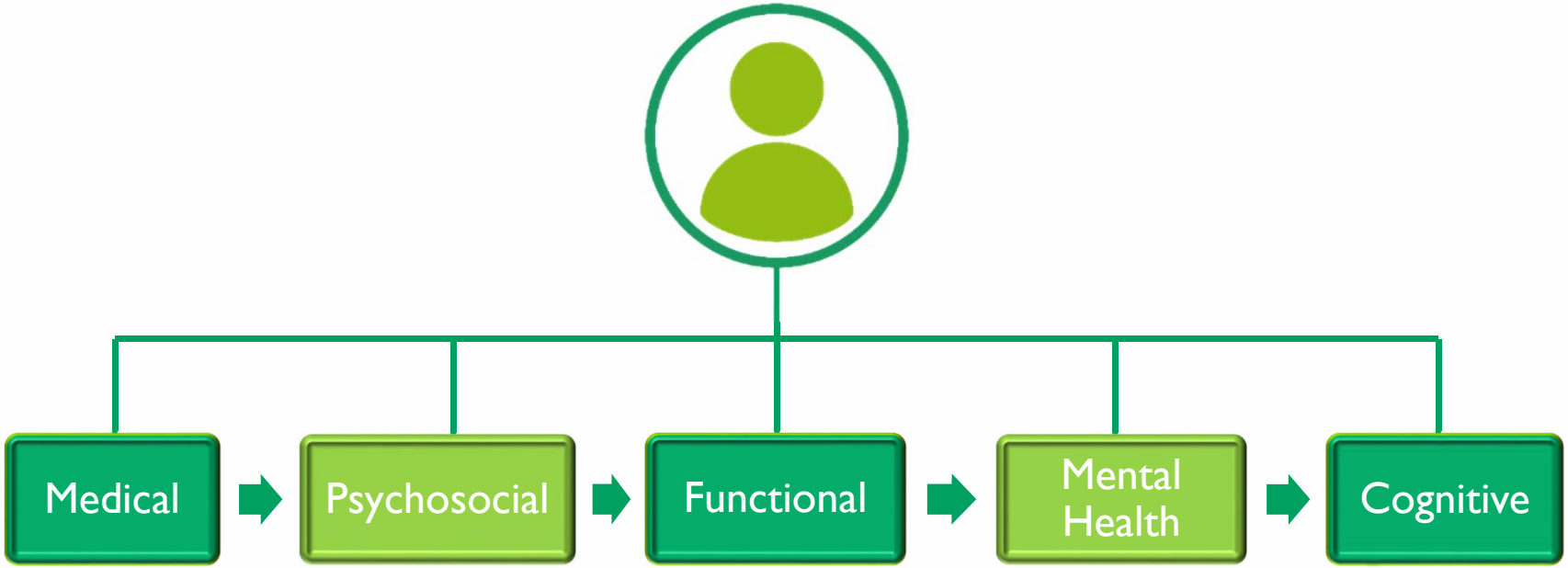
MOC 2: Care Coordination

CHRA Health Risk Evaluation

- Comprehensive Health Risk Assessment (CHRA) is a tool designed to gather all the elements that help to identify our members needs.
- Consists of a risk evaluation conducted by clinical personnel during the first 90 days of affiliation and annually before the 12 months of the last CHRA.
- CHRA sections are carefully selected by the Interdisciplinary Care Team (ICT) to evaluate member's possible risks and needs, both clinical and non-clinical.
- In case of any change in the member's health status, the CHRA or General Assessment (GA) should be updated.

MOC 2: Care Coordination

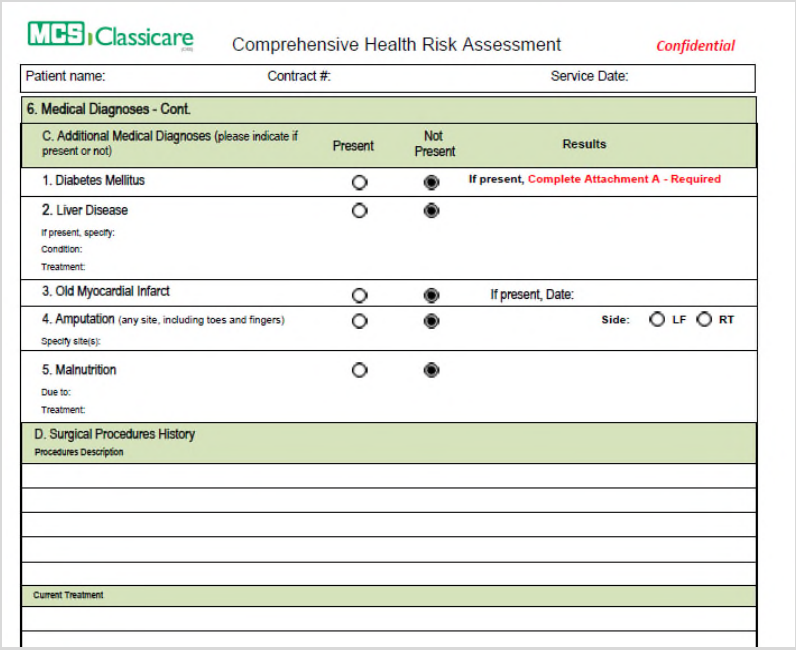
Health Risk Evaluation identified in the CHRA



MOC 2: Care Coordination

Health Risk Evaluation CHRA 2019

Clinical Information Section



MCS Classicare — Comprehensive Health Risk Assessment — *Confidential*

Patient name: Contract #: Service Date:

6. Medical Diagnoses - Cont.

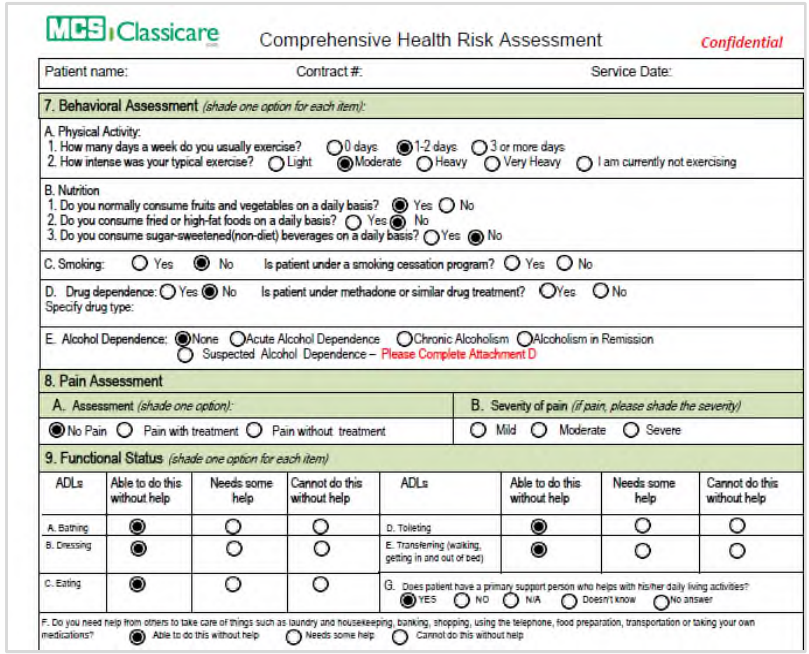
C. Additional Medical Diagnoses (please indicate if present or not)	Present	Not Present	Results
1. Diabetes Mellitus	○	◉	If present, Complete Attachment A - Required
2. Liver Disease	○	◉	
If present, specify: Condition: Treatment:			
3. Old Myocardial Infarct	○	◉	If present, Date:
4. Amputation (any site, including toes and fingers)	○	◉	Side: ○ LF ○ RT
Specify site(s):			
5. Malnutrition	○	◉	
Due to: Treatment:			

D. Surgical Procedures History

Procedures Description

Current Treatment

Non-Clinical Information Section



MCS Classicare — Comprehensive Health Risk Assessment — *Confidential*

Patient name: Contract #: Service Date:

7. Behavioral Assessment *(shade one option for each item):*

A. Physical Activity:
1. How many days a week do you usually exercise? ○ 0 days ◉ 1-2 days ○ 3 or more days
2. How intense was your typical exercise? ○ Light ◉ Moderate ○ Heavy ○ Very Heavy ○ I am currently not exercising

B. Nutrition
1. Do you normally consume fruits and vegetables on a daily basis? ◉ Yes ○ No
2. Do you consume fried or high-fat foods on a daily basis? ○ Yes ◉ No
3. Do you consume sugar-sweetened(non-diet) beverages on a daily basis? ○ Yes ◉ No

C. Smoking: ○ Yes ◉ No Is patient under a smoking cessation program? ○ Yes ○ No

D. Drug dependence: ○ Yes ◉ No Is patient under methadone or similar drug treatment? ○ Yes ○ No
Specify drug type:

E. Alcohol Dependence: ◉ None ○ Acute Alcohol Dependence ○ Chronic Alcoholism ○ Alcoholism in Remission ○ Suspected Alcohol Dependence – Please Complete Attachment D

8. Pain Assessment

A. Assessment *(shade one option):*	B. Severity of pain *(if pain, please shade the severity)*
◉ No Pain ○ Pain with treatment ○ Pain without treatment	○ Mild ○ Moderate ○ Severe

9. Functional Status *(shade one option for each item)*

ADLs	Able to do this without help	Needs some help	Cannot do this without help	ADLs	Able to do this without help	Needs some help	Cannot do this without help
A. Bathing	◉	○	○	D. Toileting	◉	○	○
B. Dressing	◉	○	○	E. Transferring (walking, getting in and out of bed)	◉	○	○
C. Eating	◉	○	○	G. Does patient have a primary support person who helps with his/her daily living activities? ◉ YES ○ NO ○ N/A ○ Doesn't know ○ No answer			

F. Do you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medications? ◉ Able to do this without help ○ Needs some help ○ Cannot do this without help

Needs identified in the CHRA determine the health risk level of SNP member in one of three categories:

low-moderate-severe

MOC 2: Care Coordination

CHRA Health Risk Evaluation

Health Levels Logistic based on the score obtained in CHRA

Standard
Individualized Care Plan is required. **(annual)**

Low

> 65 points

Standard
Individualized Care Plan is required. **(annual)**

Moderate

Between 20 to 65 points

Individualized Care Plan is required for **Complex** and Care Management Intervention. **(every 6 months)**

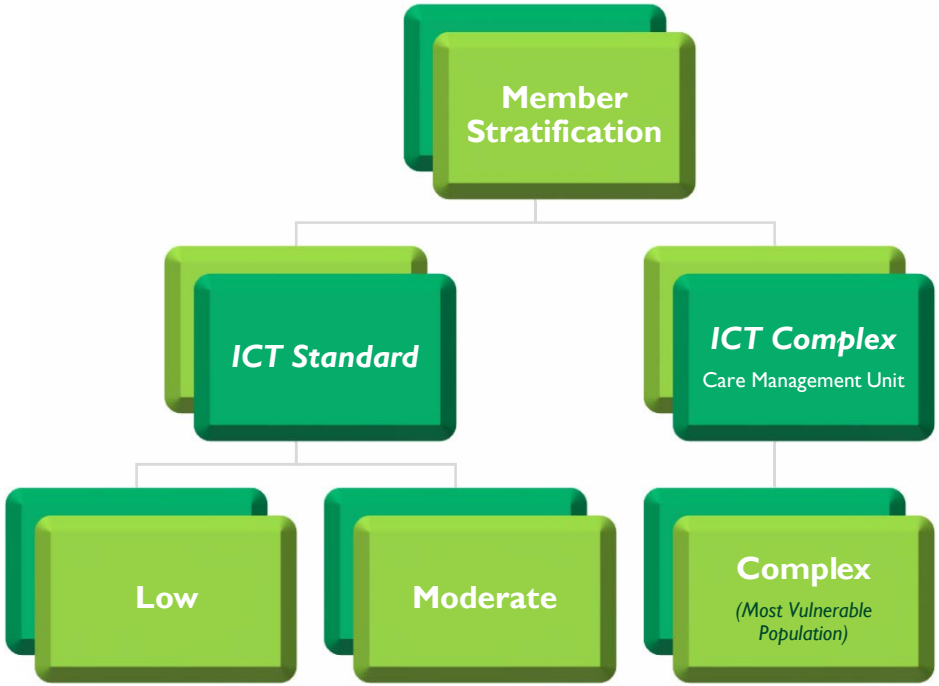
Severe

<20 points

MOC 2: Care Coordination

Individualized Care Plans

- A highly qualified Interdisciplinary Care Team (ICT) develops Individualized Care Plans (ICP) according to the member's health risk identified in the CHRA.



MOC 2: Care Coordination

Interventions and recommendations established in the Care Plans are based on the following criteria:

ICT Standard

Risk Level:
Low or Moderate

Preventive Care by Age and Gender

Women
- <65 years
- >65 years

Men
- <65 years
- >65 years

Current Chronic Diseases

- Cardiovascular
- Diabetes
- Respiratory Diseases
- Renal Diseases
- Arthritis
- Osteoporosis
- Hepatitis C
- HIV/AIDS
- Depression
- Mood Disorder
- Alzheimer
- Hypothyroidism

Assessment of Individual Needs

- Performed by a Care Manager to establish specific interventions to address member's health status.

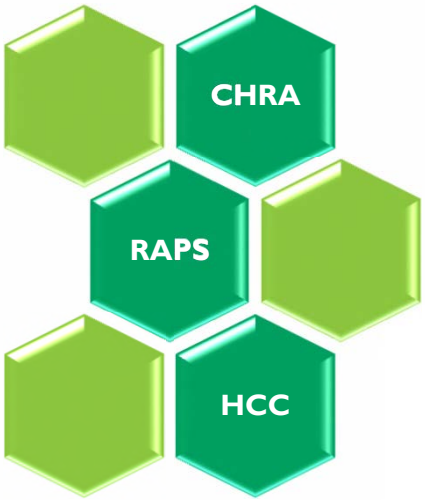
ICT Complex

Risk Level: Severe

MOC 2: Care Coordination

Sources and Process for Individual Care Plan Generation

Initial Referral Source



Health risk levels according to reported diagnostics and demographic data

Members with risk level: ***Low or Moderate***

Preliminary Care Plan based on age, gender and diagnostics found in referral sources

Members with risk level: ***Severe***

Referred to Care Management

Individual risk evaluation by a Care Manager

Individualized care plan is established considering the General Assessment responses as well as age, gender and identified diagnosis by CM

MOC 2: Care Coordination

Individual Care Plan format includes:

Header

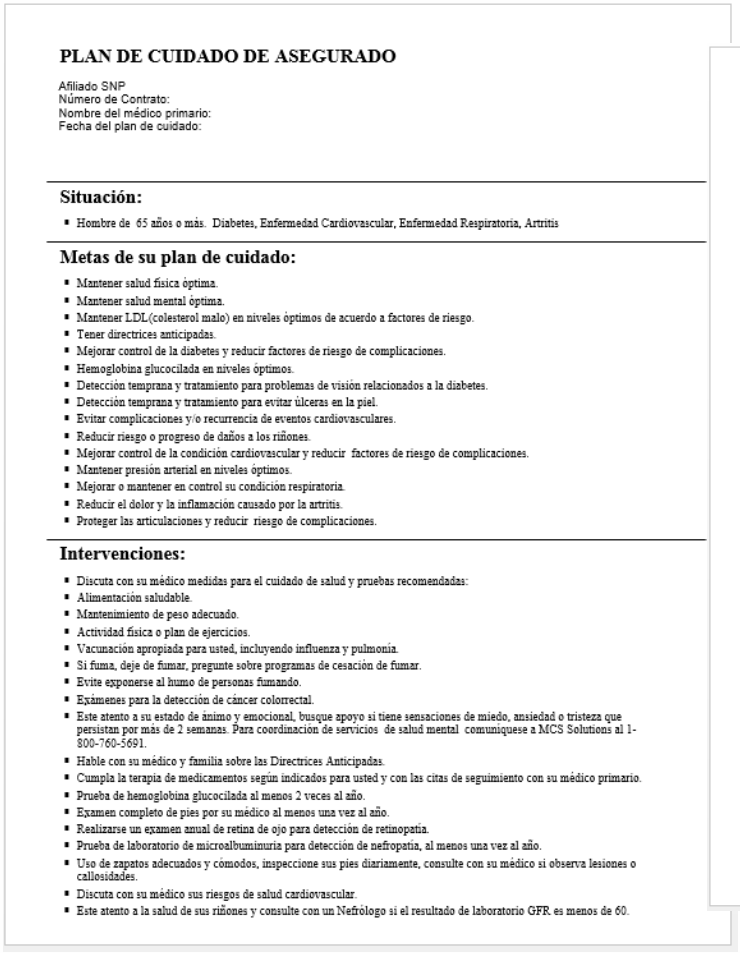
- Member's Name
- Contract Number
- Primary Care Physician's Name

Situation

- Age and gender
- Member's chronic conditions

Interventions

- Preventive self-care recommendations by age, gender and chronic conditions.
- Support interventions
  - MCS interventions to promote member's health care
- PCP interventions
  - For the evaluation and management of member's health



PLAN DE CUIDADO DE ASEGURADO

Afiliado SNP
Número de Contrato:
Nombre del médico primario:
Fecha del plan de cuidado:

Situación:

- Hombre de 65 años o más. Diabetes, Enfermedad Cardiovascular, Enfermedad Respiratoria, Artritis

Metas de su plan de cuidado:

- Mantener salud física óptima.
- Mantener salud mental óptima.
- Mantener LDL(colesterol malo) en niveles óptimos de acuerdo a factores de riesgo.
- Tener directrices anticipadas.
- Mejorar control de la diabetes y reducir factores de riesgo de complicaciones.
- Hemoglobina glucocilada en niveles óptimos.
- Detección temprana y tratamiento para problemas de visión relacionados a la diabetes.
- Detección temprana y tratamiento para evitar úlceras en la piel.
- Evitar complicaciones y/o recurrencia de eventos cardiovasculares.
- Reducir riesgo o progreso de daños a los riñones.
- Mejorar control de la condición cardiovascular y reducir factores de riesgo de complicaciones.
- Mantener presión arterial en niveles óptimos.
- Mejorar o mantener en control su condición respiratoria.
- Reducir el dolor y la inflamación causado por la artritis.
- Proteger las articulaciones y reducir riesgo de complicaciones.

Intervenciones:

- Discuta con su médico medidas para el cuidado de salud y pruebas recomendadas:
- Alimentación saludable.
- Mantenimiento de peso adecuado.
- Actividad física o plan de ejercicios.
- Vacunación apropiada para usted, incluyendo influenza y pulmonía.
- Si fuma, deje de fumar, pregunte sobre programas de cesación de fumar.
- Evite exponerse al humo de personas fumando.
- Exámenes para la detección de cáncer colorrectal.
- Este atento a su estado de ánimo y emocional, busque apoyo si tiene sensaciones de miedo, ansiedad o tristeza que persistan por más de 2 semanas. Para coordinación de servicios de salud mental comuníquese a MCS Solutions al 1-800-760-5691.
- Hable con su médico y familia sobre las Directrices Anticipadas.
- Cumpla la terapia de medicamentos según indicados para usted y con las citas de seguimiento con su médico primario.
- Prueba de hemoglobina glucocilada al menos 2 veces al año.
- Examen completo de pies por su médico al menos una vez al año.
- Realizarse un examen anual de retina de ojo para detección de retinopatía.
- Prueba de laboratorio de microalbuminuria para detección de nefropatía, al menos una vez al año.
- Uso de zapatos adecuados y cómodos, inspeccione sus pies diariamente, consulte con su médico si observa lesiones o callosidades.
- Discuta con su médico sus riesgos de salud cardiovascular.
- Este atento a la salud de sus riñones y consulte con un Nefrólogo si el resultado de laboratorio GFR es menos de 60.
- Prueba de LDL (colesterol malo) una vez al año.
- Plan de control para su condición respiratoria.
- Conozca la terapia de medicamentos adecuada para usted.
- Consulte si el uso de espirómetro (instrumento para medir la función pulmonar) es recomentado para usted.
- Evite los factores ambientales que pueden empeorar su condición respiratoria, tales como humo, irritantes, polvo, etc.
- Cumpla con la terapia de medicamentos recomendada para la artritis y citas de seguimiento con su médico primario. Estos le ayudaran a retrasar el daño a las articulaciones.
- Mantenga un buen equilibrio entre el descanso y el ejercicio.

Intervenciones de apoyo:

- Recibirá de MCS las siguientes intervenciones:
- Guía de Cuidado Preventivo
- Carta indicando pruebas recomendadas de acuerdo a edad y género que debe realizarse.
- Recordatorios preventivos por correo, según aplique.
- Revista Cuidate con temas de salud.
- Calendario de actividades Club Amigos Clásicos: Charlas de salud, sesiones de ejercicios, actividad de socialización y recreación.
- Llamadas telefónicas sobre cuidado preventivo y estilos de vida saludable.

Intervenciones del médico primario:

- Intervenciones clínicas de evaluación y seguimiento para cumplir metas de tratamiento de acuerdo a guías clínicas basadas en evidencia.
- Monitoreo del cumplimiento con pruebas de laboratorio y exámenes clínicos recomendadas por edad, género, factores de riesgo y diagnósticos.
- Monitoreo de resultados de laboratorio para determinar próximas intervenciones de acuerdo a la necesidad.
- Evaluación de factores de riesgo y orientación sobre modificación de estilos de vida.
- Educar al paciente sobre importancia del cumplimiento de terapia de medicamentos para el control de sus condiciones crónicas.
- Realizar prueba de detección de tuberculosis si paciente va a comenzar, o se encuentra tomando agentes biológicos para Artritis Reumatoide.
- Considerar las recomendaciones de vacunación en pacientes con Artritis Reumatoide.

Completar y documentar en expediente médico:

- Evaluación de riesgos de salud anual (CHRA).
- Discusión de Directrices Anticipadas.
- Revisión de medicamentos anual.
- Evaluación de estado físico, mental, funcional, cognitivo y sicosocial anual.
- Cernimiento de manejo de dolor anual.
- Índice de Masa Corporal al menos una vez al año.
- Resultados de prueba de LDL una vez al año si tiene factores de riesgo.
- Identificación de barreras que interfieran en el cumplimiento del plan de cuidado y plan de acción.
- Resultado de prueba de hemoglobina glucocilada al menos dos veces al año.
- Resultado de examen de retina del ojo al menos una vez al año.
- Resultado de examen de microalbúmina para deteccion de nefropatía al menos una vez al año.
- Examen de pies al menos una vez al año.
- Resultado de prueba de LDL-C una vez al año.
- Niveles de presión arterial en cada visita.
- Medida de función pulmonar al menos una vez al año.
- Discusión de plan de acción para control condición respiratoria.

MOC 2: Care Coordination

Updating and communication process of the Care Plan

Low & Moderate

- Care Plan at least once a year.
- Care Plan is modified if a new CHRA is reported and there are changes in risk levels and/or of diagnoses.
- A letter is generated with the information of the member's Care Plan. It is then shared with him or her, and with the PCP. It's also included in the CM electronic system.

Severe

- Care Plan is revised and discussed with the member as needed and is sent at least every 6 months, modified according to the member's health needs while participating in the Care Management Program.
- Goal achievement is assessed and the results of each intervention are documented in the CM application. A letter is generated, containing the Care Plan for the member and his or her PCP and is included in the CM electronic system.
- Care Plan is available for the ICT through the CM application.

*Care Plan and letters are sent via postage services to member and the PCP.

MOC 2: Care Coordination

Strategies to support Care Plan's data collection and communication

With members

- Individual Care Management interventions with members with severe risk
- Preventive care and chronic management conditions reminders
- Clinical Management warning letters
- Educational campaigns
- Educational material and self-care guide sent
- Chronic conditions management workshops
- Health talks
- Cuídate Magazine
- Workout routines through MCS Salud Paso a Paso

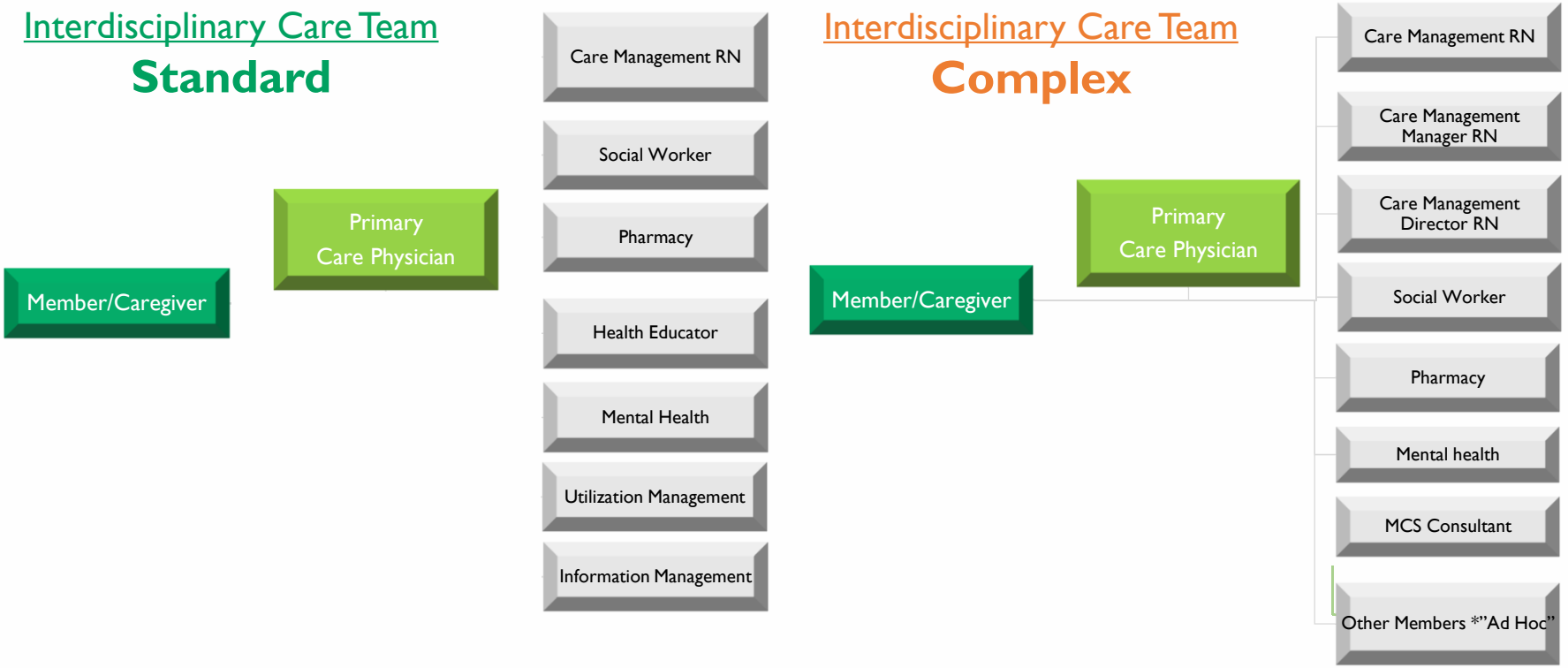
With PCP

- Delivery and discussion of quality measure report by PCP
- Clinical management warning letters
- Accredited clinical educational interventions with continued education
- Educational campaigns
- Clinical care coordination call to members with severe risk
- MCS MOC annual training

MOC 2: Care Coordination

Interdisciplinary Care Team

The Interdisciplinary Care Team (ICT) provides the structure and necessary processes to offer and coordinate services for the health care of our MCS Special Needs Plan members, according to the identified health and needs status.



MOC 2: Care Coordination

Care Transition

- When a member suffers a change in their health status and needs to move from one health setting to another to maintain their care, we refer to a Care Transition
- **Care Transition to a lower level:**
  - ❖ Example: From the hospital setting to a Rehab facility and then to the member's home
- **Care Transition to increase level:**
  - ❖ Example: From the member's home to a hospital setting

MOC 2: Care Coordination

Care Transition

Unplanned Transition

- Emergency Room visit that involves hospital admission

Planned Transition

- Elective surgery or planned procedures
- Admission into a Skilled Nursing Facility (SNF)
- Home Health Agency Admission (HHA)

MCS has different Care Transition protocols to make it easier for our members to change the health scenario according to their needs.

MOC 2: Care Coordination

Care Transition

During Care Transition we educate our members through:

- Care Transition Letter to the member and its PCP
- Medilínea 24/7
- Educational self-care material (Cuídate Magazine, preventive reminders for diabetes, cardiovascular conditions, among others)
- Phone call from a nursing professional

MOC 1

- Description of SNP Population

MOC 2

- Care Coordination
  Care Transition Protocol

MOC 3

- Provider Network

MOC 4

- Quality Measurement and Performance Improvement

MOC 3: Providers Network

Providers

Primary Care Physicians

Specialists:
-Internal Medicine
-Endocrinology
-Cardiology
-Among others

Experts on Mental Health Services
-Among others

Trainings

MCS offers *initial and annual* MOC training to all its providers
- Participants
- Non-Participants that assist MCS members routinely

Delegated Entities:
-FHC
-Eye Management
-TNPR
-TeleMedik
-Among others

Clinical Guidelines and Care Transition Protocols

MCS adopts, revises and shares clinical guidelines to support the PCP and member in decision - making of the appropriate medical care.

Care Transition
-Continuity of Care

Clinical Guidelines Examples:
-Diabetes
-Asthma
-Cancer

MCS' transition protocols ensure care continuity for our members.

MOC 3: Providers Network

Role of Primary Care Physician and Specialist Physician

- Participate in planning patient's care
- Provide the necessary medical care
- Provide education about the condition to member and/or caregiver
- Offer preventive care and guide members to maintain a healthy lifestyle
- Encourage patient participation in the care process (self-care)

MOC 3: Providers Network

Role of Primary Care Physician and Specialist Physician

- Participate in interdisciplinary team meetings
- Maintain communication with the care manager, the interdisciplinary care team and/or caregiver, and collaborate in the Individual Care Plan
- Provide access and integrate other physicians or providers within the patient care management, if necessary
- Use the Clinical Practical Guidelines (CPG) adopted by MCS (available in Provinet)
- Revise and update the Care Plan and address member concerns and/or preferences
- Ensure the continuity of care and/or services to the patient, and provide follow up to the treatment

MOC 3: Providers Network

Role of Primary Care Physician and Specialist Physician

- Provide necessary medical care
- Incorporate the Primary Care Physician on member's care
- Notify the medical plan of any barrier that affects access to services or care transition process
- Encourage patient participation in their care process
- Provide services on time, effectively and guaranteeing quality

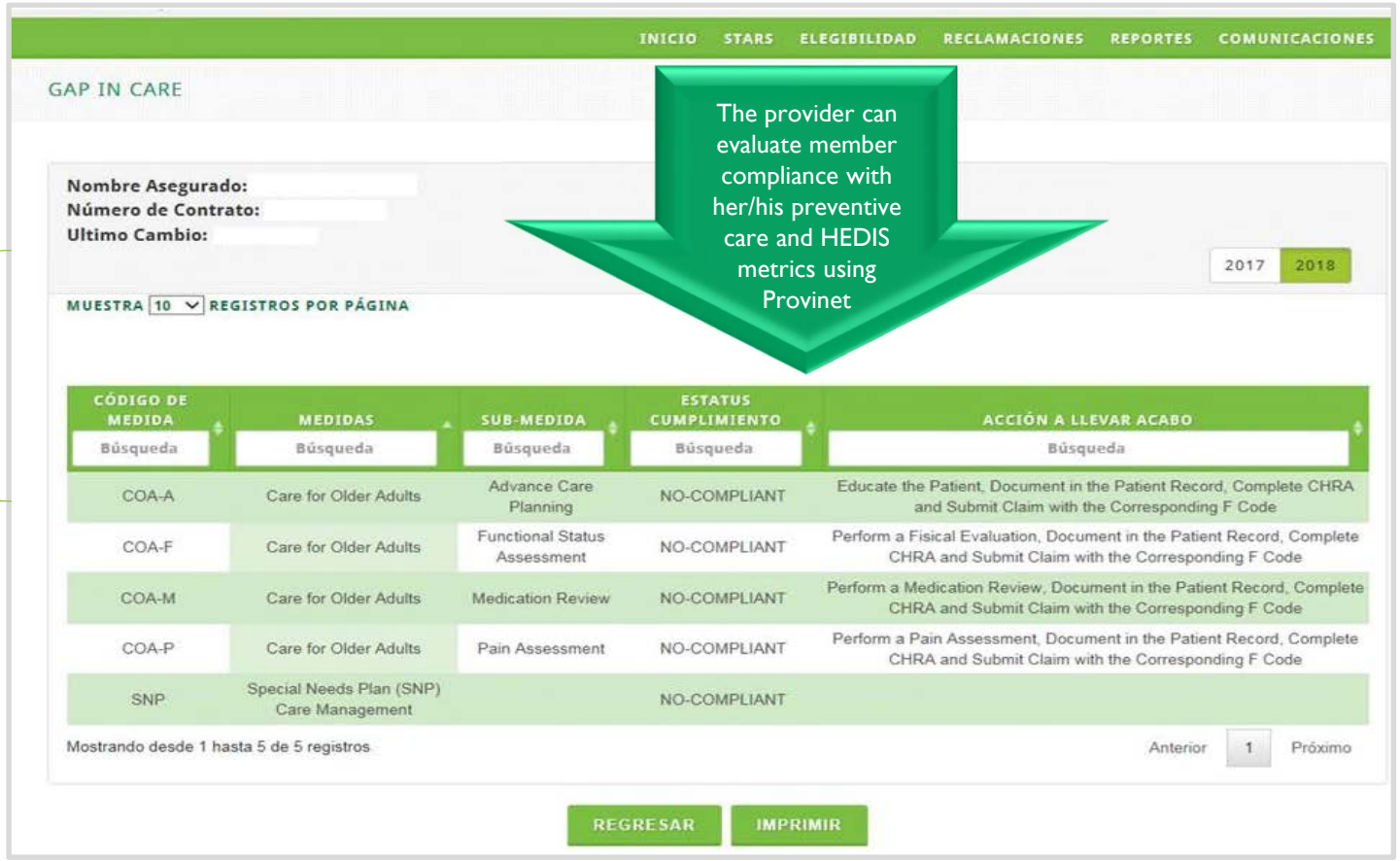
MOC 3: Providers Network

Provinet: A Tool for Providers

MOC 3: Providers Network

Supporting Tool for PCP to Coordinate Member's Care (Gap in Care)

HEDIS Metrics



MOC 3: Providers Network

Clinical Guidelines adopted by MCS Advantage, accessible for Providers

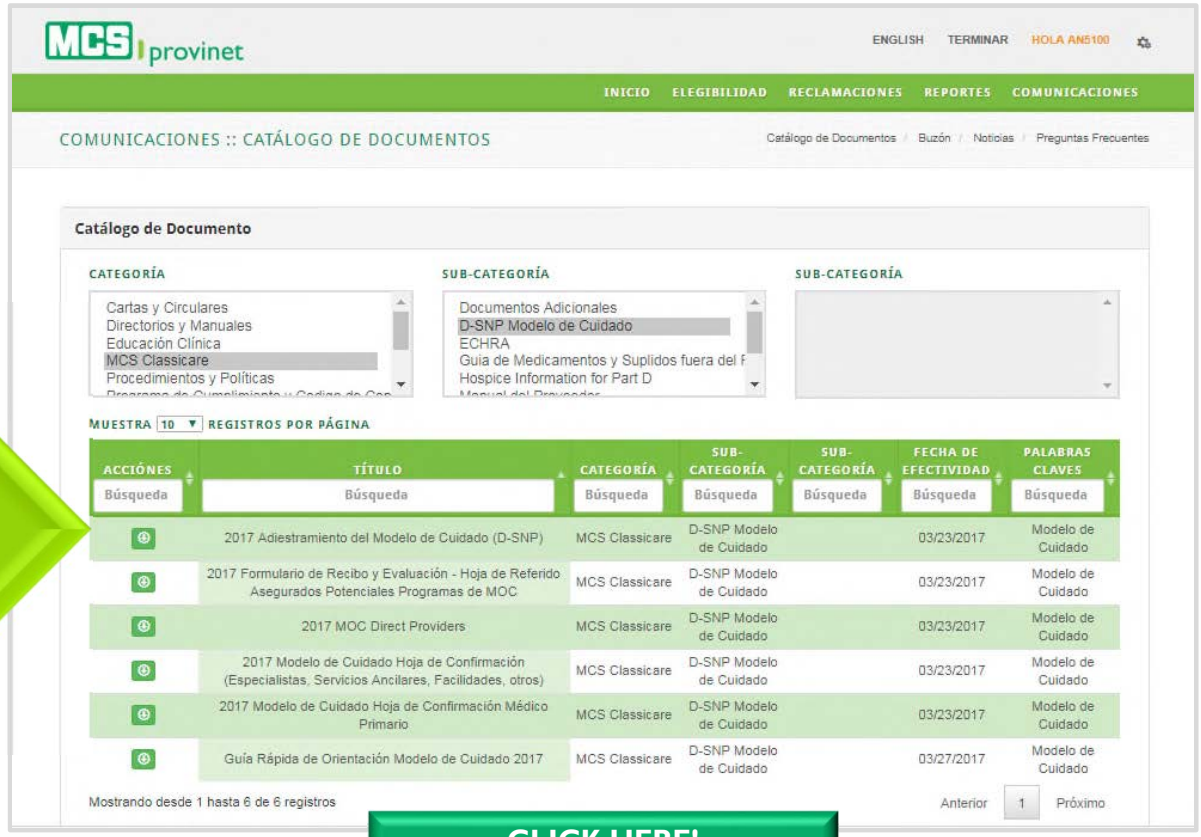
The ***Clinical Guidelines*** are available in Provinet

Examples:
- Asthma
- Cancer
- Among others

MOC 3: Providers Network

MOC training accessible for Providers through Provinet

Our providers can access the MOC Training in Provinet



CLICK HERE!

MOC 3: Providers Network

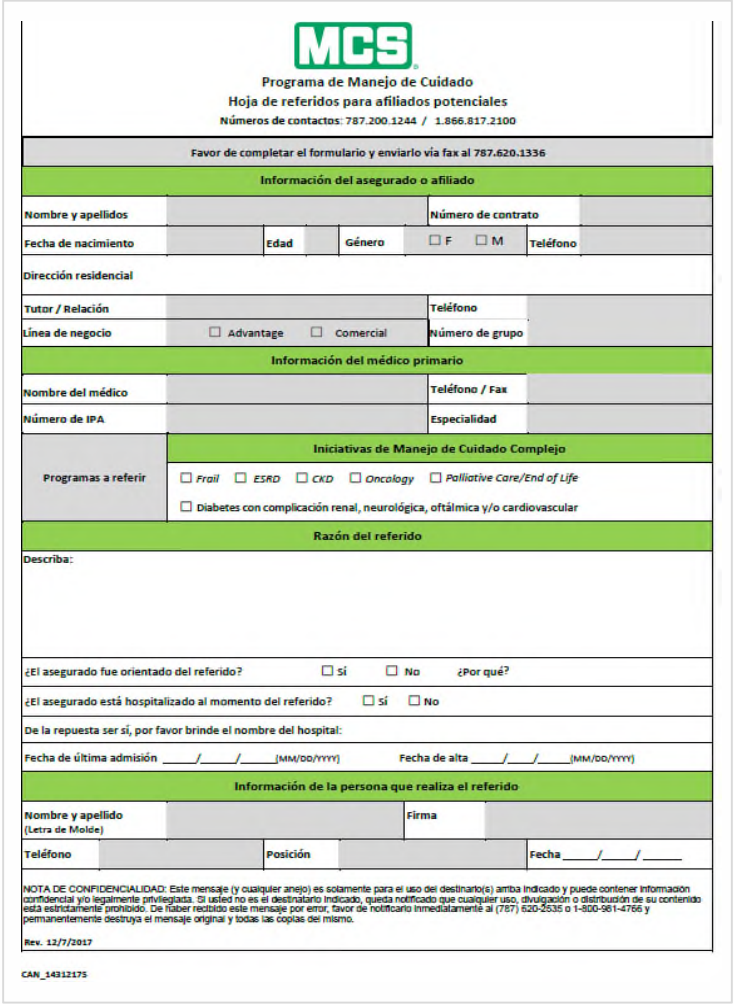
Care Management Programs Referral

Care Management Programs Referral for potential members

Send fax:

787.620.1336

Document available in **Provinet**



MCS

Programa de Manejo de Cuidado
Hoja de referidos para afiliados potenciales
Números de contactos: 787.200.1244 / 1.866.817.2100

Favor de completar el formulario y enviarlo vía fax al 787.620.1336

Información del asegurado o afiliado

Nombre y apellidos				Número de contrato	
Fecha de nacimiento		Edad		Género ☐ F ☐ M	Teléfono
Dirección residencial					
Tutor / Relación				Teléfono	
Línea de negocio	☐ Advantage ☐ Comercial			Número de grupo	

Información del médico primario

Nombre del médico		Teléfono / Fax	
Número de IPA		Especialidad	

Programas a referir	**Iniciativas de Manejo de Cuidado Complejo**
	☐ *Frail* ☐ *ESRD* ☐ *CKD* ☐ *Oncology* ☐ *Palliative Care/End of Life*
	☐ Diabetes con complicación renal, neurológica, oftálmica y/o cardiovascular

Razón del referido

Describa:

¿El asegurado fue orientado del referido? ☐ Sí ☐ No ¿Por qué?

¿El asegurado está hospitalizado al momento del referido? ☐ Sí ☐ No

De la repuesta ser sí, por favor brinde el nombre del hospital:

Fecha de última admisión ____/____/____(MM/DD/YYYY) Fecha de alta ____/____/____(MM/DD/YYYY)

Información de la persona que realiza el referido

Nombre y apellido (Letra de Molde)		Firma	
Teléfono		Posición	Fecha ____/____/____

NOTA DE CONFIDENCIALIDAD: Este mensaje (y cualquier anejo) es solamente para el uso del destinario(s) arriba indicado y puede contener información confidencial y/o legalmente privilegiada. Si usted no es el destinatario indicado, queda notificado que cualquier uso, divulgación o distribución de su contenido está estrictamente prohibido. De haber recibido este mensaje por error, favor de notificarlo inmediatamente al (787) 620-2535 o 1-800-981-4766 y permanentemente destruya el mensaje original y todas las copias del mismo.

Rev. 12/7/2017

CAN_14312175

MOC 1

- Description of SNP Population

MOC 2

- Care Coordination
  Care Transition Protocol

MOC 3

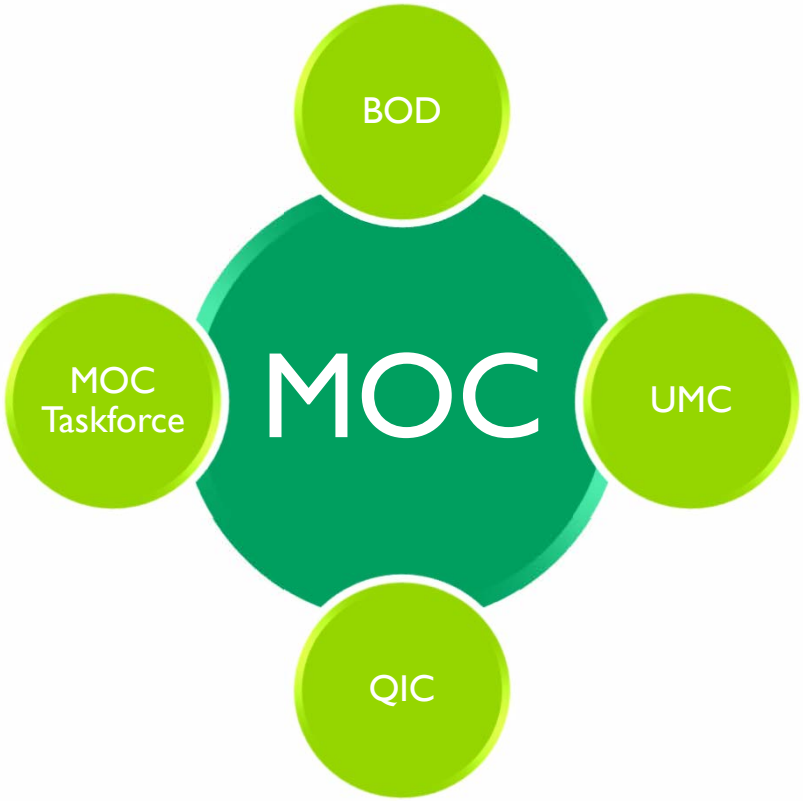
- Provider Network

MOC 4

- Quality Measurement and Performance Improvement

MOC 4: Quality Measurement

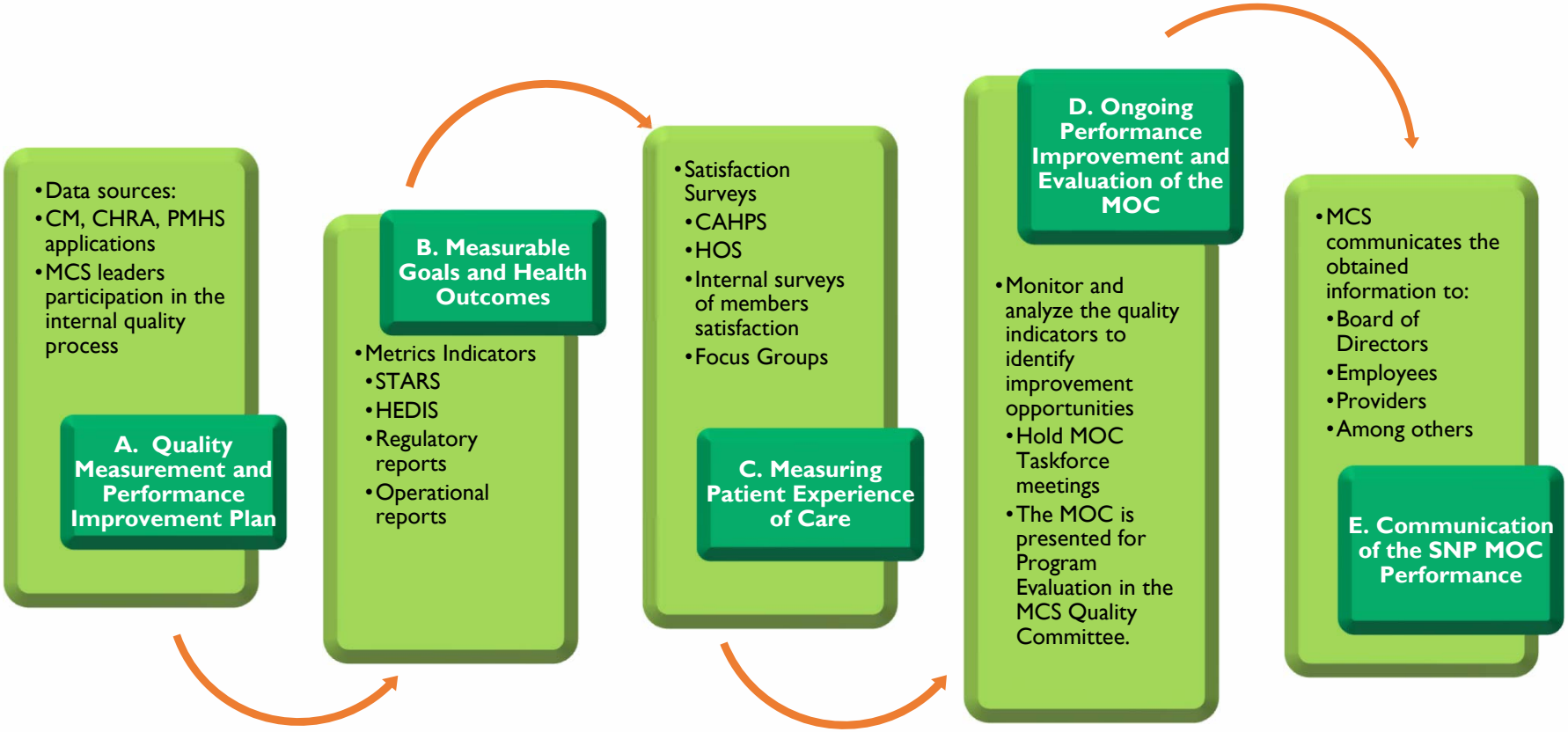
And Performance Improvement



- MCS's MOC is currently approved for a cycle of 3 years (2018-2020).
- Requires annual approval of MCS Board of Directors, Utilization Committee and Quality Committee.
- The MOC Taskforce, integrated by the management team of the areas impacted by the MOC including delegated entities, meet at least six times a year to discuss and monitor the operational compliance with MOC requirements including metrics aligned to STARS, HEDIS, CAHPS, HOS and those of its own departments.

MOC 4: Quality Measurement

And Performance Improvement



THANK YOU FOR YOUR COMMITMENT

to improving the quality of life of our members!

References

- MCS SNPs (2018) Model of Care Description
- Medicare Managed Care Manual-Chapter 16-B: *Special Needs Plans* (Rev.123, Issued: 08-19-16)
- Medicare Managed Care Manual-Chapter 5 - *Quality Assessment* (Rev. 117, 08-08-14)
- *MOC Scoring Guidelines* CY (2019)

WE ARE HERE TO SERVE YOU!

Any further information you can contact:

Please include your contact information