MCS Model of Care for Special Needs Plans (SNP)

2020 Annual training

Quality Department

Rev. 02/2020

CMS Requirements

- The Centers for Medicare and 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 annual trainings for all employees, delegated entities and providers.

Objectives

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

Definitions

- **ASES:** Administración de Seguros de Salud de Puerto Rico
- **D-MOC** (Dual eligible Model of Care): Model of care for beneficiaries with dual eligibility
- **C-MOC** (Chronic Conditions Model of Care): Model of care for members with certain chronics conditions
- **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.
- **CHRAT** (Comprehensive Health Risk Assessment Tool): 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

Definitions

- **HOS** (Health Outcomes Survey): Survey that gathers valid and clinically significant data on patients' mental and physical wellness.
- **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 (SNP)

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

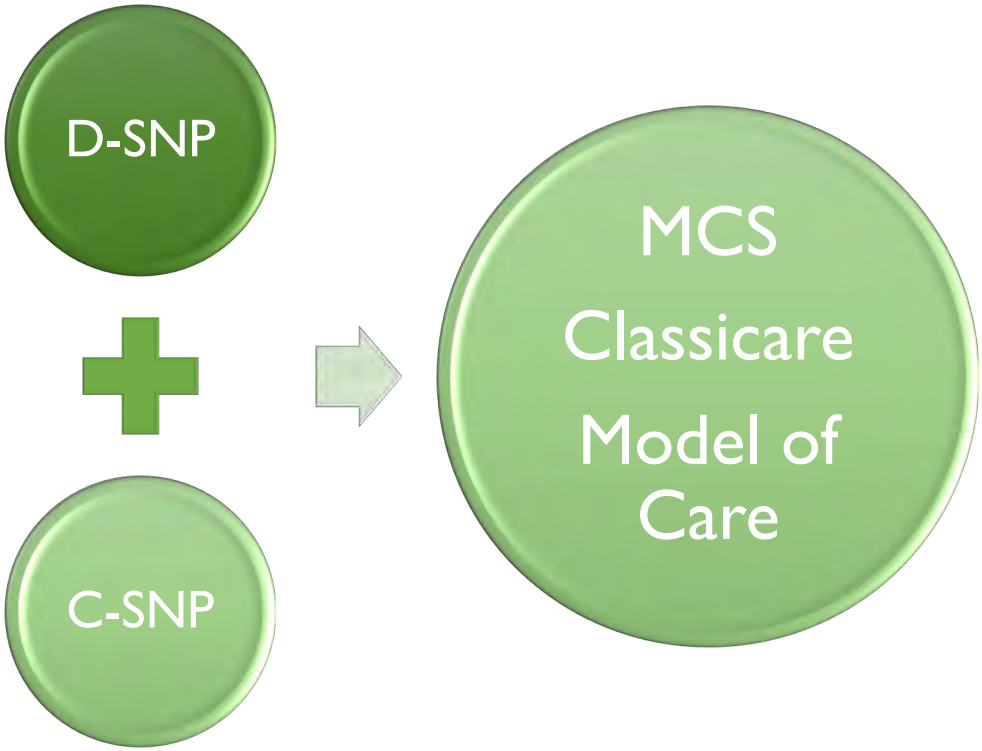
- Affordable Care Act amended Section 1856(f)(7) of the Social Security Act:
  - Requires that all MA plans offering SNPs plans submit a Model of Care (MOC) to CMS for the evaluation and approval of NCQA (National Committee for Quality Assurance) that ensures compliance with CMS guidelines.

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 Models of Care

D-SNP	C-SNP
Dual Eligible	Chronic Conditions
(Platino)	(Non Platino)

MCS Classicare Models of Care



Which are the criteria to participate in each MOC?

D-MOC

- Dual eligible beneficiaries (Medicare and Medicaid)
- Known as "Platino" population and in PR is administered by ASES
- MCS currently has 6 D-SNP products

C-MOC

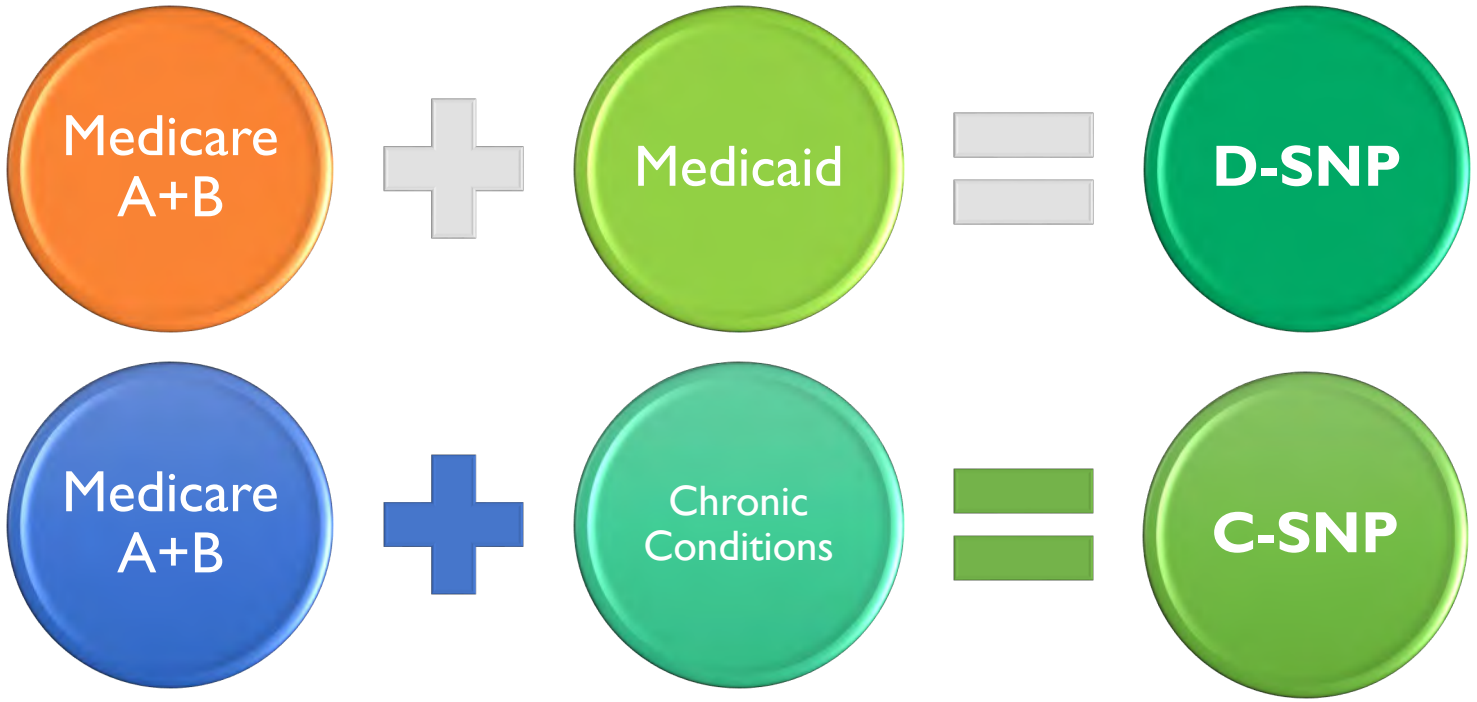
- Beneficiaries with the following chronic conditions:
  - *Diabetes Mellitus*
  - *Chronic Heart Failure and/or*
  - *Cardiovascular disorder (cardiac arrhythmias, coronary artery disease, peripheral vascular disease and/or chronic venous thromboembolic disorder)*
- Currently MCS has one C-SNP product

MCS Classicare

Special Needs Plans Background (SNP)

Definition:

- Health plan for people who are eligible to D-SNP or C-SNP:



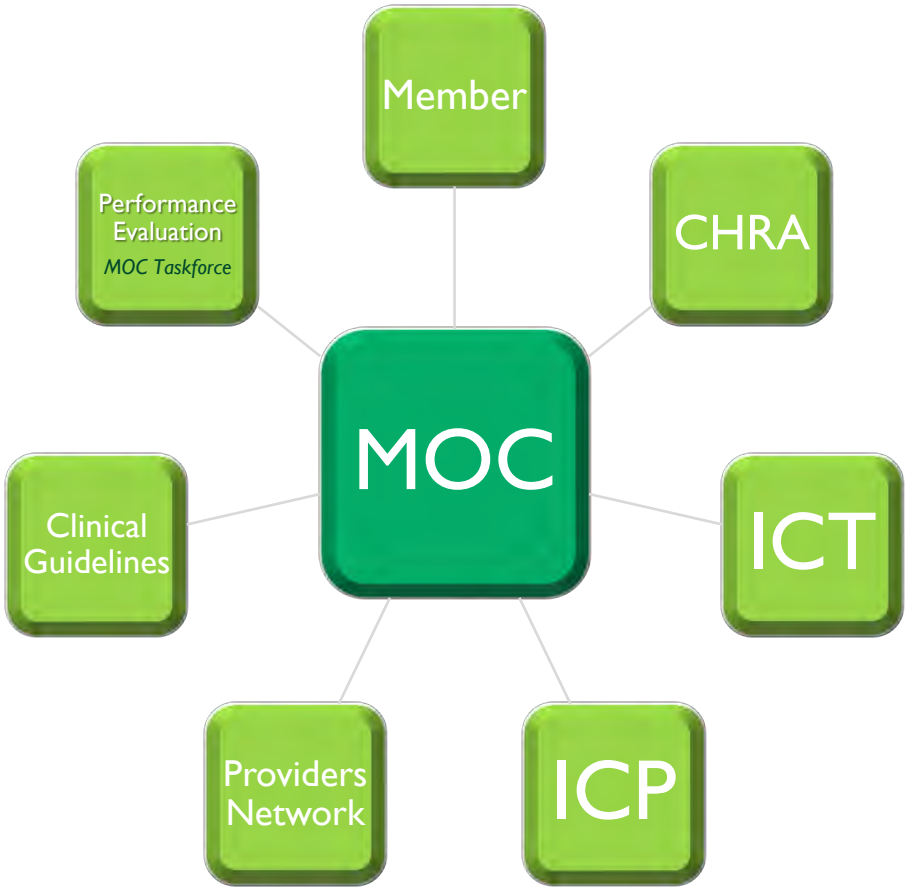
The CMS regulation **42 CFR §422.101(f)** require that all MA organizations implement a Model of Care for its members with special needs to satisfy their health needs and improve their quality of life.

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 the 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)

Four constituent elements

MOC 1	• Description of SNP population
MOC 2	• Care coordination *Care Transition Protocol*
MOC 3	• Provider network
MOC 4	• Quality measures and performance improvement

2020 MCS Classicare SNP

For **2020**, MCS has six Platino plans for the D-SNP population and one plan for the population with chronic conditions C-SNP.

MCS Classicare		
Product name	**MCS contract number**	**MCS group number**
Platino Ideal (HMO D-SNP)	H5577-002 (Renewal)	850614
Platino Progreso (HMO D-SNP)	H5577-017 (Renewal)	850717
Platino Clásico (HMO D-SNP)	H5577-028 (Renewal)	850722
Platino Más Ca$h (HMO D-SNP)	H5577-029 (Renewal)	850723
Platino Te Lleva (HMO D-SNP)	H5577-036 (Renewal)	850724
Platino Expreso (HMO D-SNP)	H5577-037 ***(New)***	850729
Primero (HMO C-SNP)	H5577-038 ***(New)***	850728

On **January 2020,** the total MCS D-SNP population is 82,509 beneficiaries for the D-SNP and 979 for the C-SNP

Model of Care (MOC)

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: D-SNP population description

Platino most vulnerable population

- MCS Classicare Platino general population (D-SNP)
- 95,471 members

From the total D-SNP population 14,007 were identified as most vulnerable.

The most vulnerable D-SNP-population is part of the **MCS Classicare Platino** total population with identified complex health risks that require intervention from a **care manager** to assist them in their needs.

MOC 1: Description of D-SNP population

Important data to describe the population:

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

- 25% are males and 17% of the females have less than 60 years of age
- 49% the beneficiaries are female

- The three main diagnostics identified in SNP population are:
1. Diabetes mellitus
2. Hypertension
3. Recurrent major depression
- 3.71% of members didn't visit their PCP

- 43% didn't complete high school
- 99% identified as Hispanic
- 99% prefer to use Spanish as their primary language

2018 Data

MOC 1: C-SNP Population Description

Most vulnerable population

- MCS Classicare chronic conditions general population (C-SNP)
- 47,150 members

From the total C-SNP population 4,421 were identified as most vulnerable.

The most vulnerable C-SNP-population is part of the **MCS Classicare** total population with identified complex health risks that require intervention from a **care manager** to assist them in their needs.

MOC 1: Description of C-SNP Population

Important data to describe the population:

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

- 30% are between 80 to 89 years
- 55% are females
- 64% live in urban zone

- The three main diagnostics identified in C-SNP population are:
1. Diabetes mellitus
2. Chronic heart failure
3. Cardiovascular disorders (cardiac arrhythmias, coronary artery disease, peripheral vascular disease and/or chronic venous thromboembolic disorder)
- 8% of members didn't visit their PCP

- 50% didn't complete high school
- 99% identified as Hispanic
- 94% prefer to use Spanish as their primary language.

2018 Data

MOC 1: Description of the C-SNP Population
Specialized services

Specialized services to be considered for the most vulnerable target population:

- Transportation services for medical appointments
- Specialized comprehensive in-home evaluation to complete CHRAT and:
  - Identification of potential safety issues in the home
  - Skin integrity evaluation at home visit
  - Monofilament test for beneficiaries with diabetes mellitus
  - Evaluation of social determinants of health and the need for community and/or non-clinical services
  - Evaluation of need for non-emergency transportation
  - Evaluation of health literacy
  - Medication reconciliation at home
- Enhanced diabetes mellitus supplies such as glucose monitor/strips (only for C-SNP)
- Additional support groups and health education specific to the chronic conditions
- Special supplemental benefits for the chronically ill:
  - Transportation to non-health related locations
  - Allowance (healthy food, electricity, water, telephone)
  - Home assistance (plumbing, electricity, locksmith, home windows repair)

Model of Care (MOC)

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

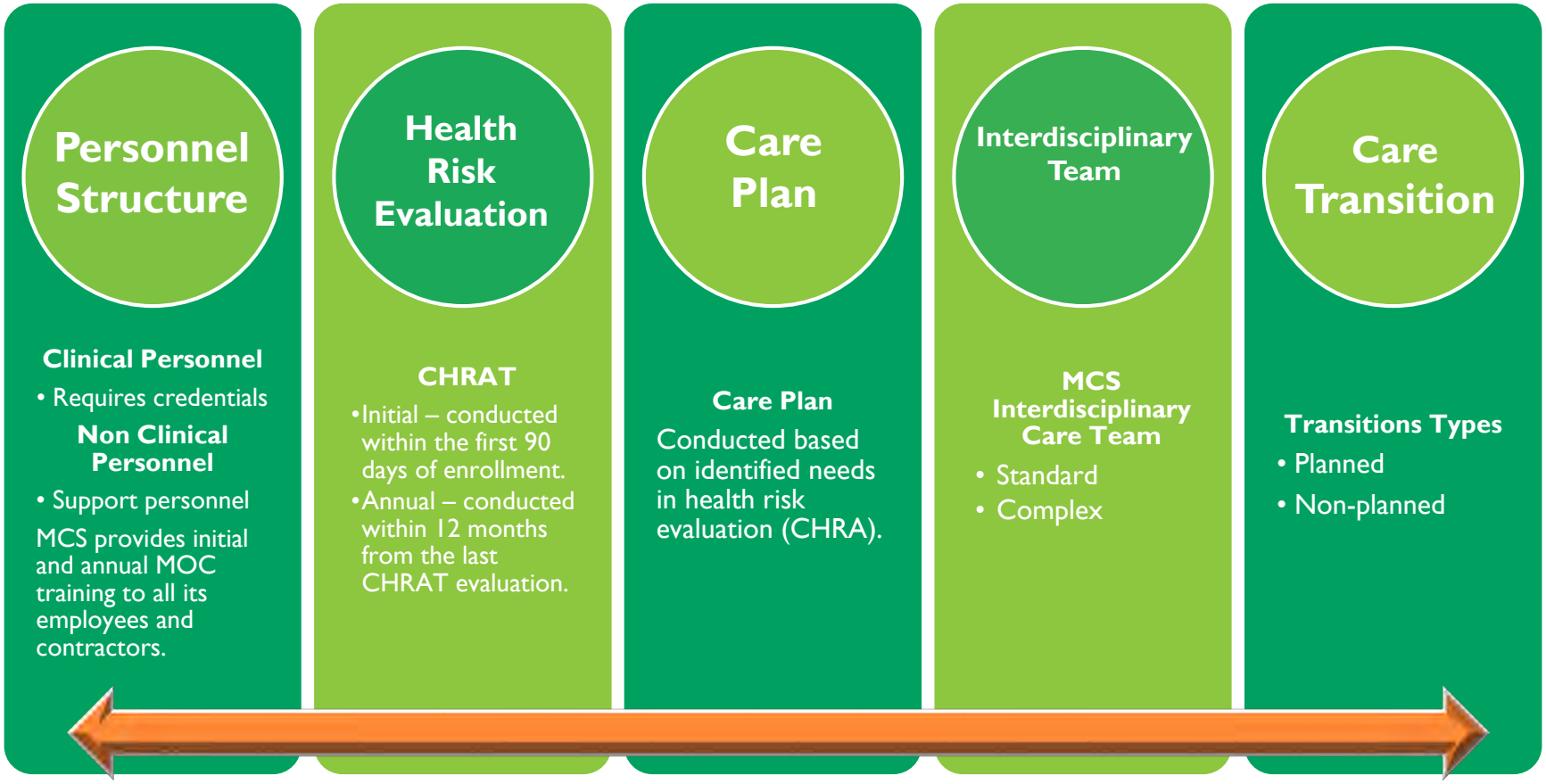
MOC 2: Care coordination

- 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 the **health needs and service preferences** of all SNPs members **are covered.**
- It also ensures that the medical information between health professionals is shared **maximizing the effectiveness, the efficiency, and the high quality of services and improving members' health outcomes.**
- The MOC also describes the **roles, responsibilities and vigilance** of clinical and non-clinical personnel.
- The 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 trained about D-SNP and C-MOC** at the hiring moment and annually.

MOC 2: Care coordination
Integral role of the employees

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

MOC 2: This is the structure for the care coordination of the SNP members

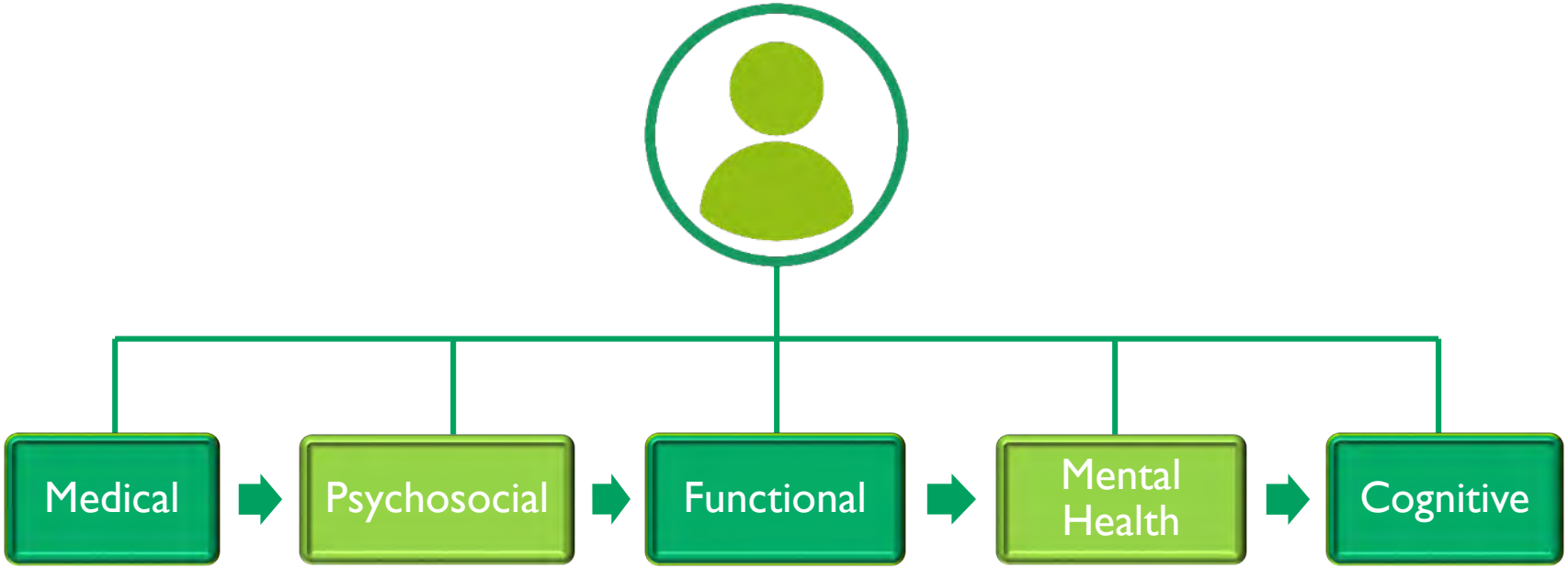


MOC 2: Care coordination

Comprehensive Health Risk Assessment Tool (CHRAT)

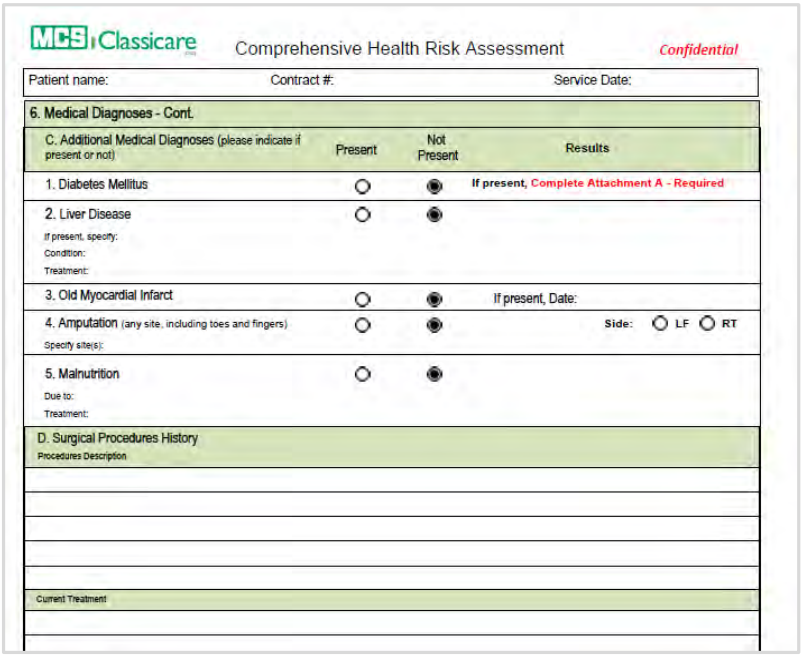
- *The Comprehensive Health Risk Assessment tool* (CHRAT) is a tool designed to gather all the elements that help to identify our members' needs.
- Consists of a risk evaluation conducted by clinical personnel during the first 90 days of affiliation and annually before the 12 months of the last CHRAT.
- CHRAT 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 CHRAT or General Assessment (GA) should be updated.

MOC 2: Care coordination
Health Risk Evaluation identified in the CHRAT



MOC 2: Care coordination
Comprehensive Health Risk Assessment Tool (CHRAT)

Clinical Information Section



MCS Classicare — Comprehensive Health Risk Assessment — *Confidential*

Patient name: | Contract #: | Service Date:

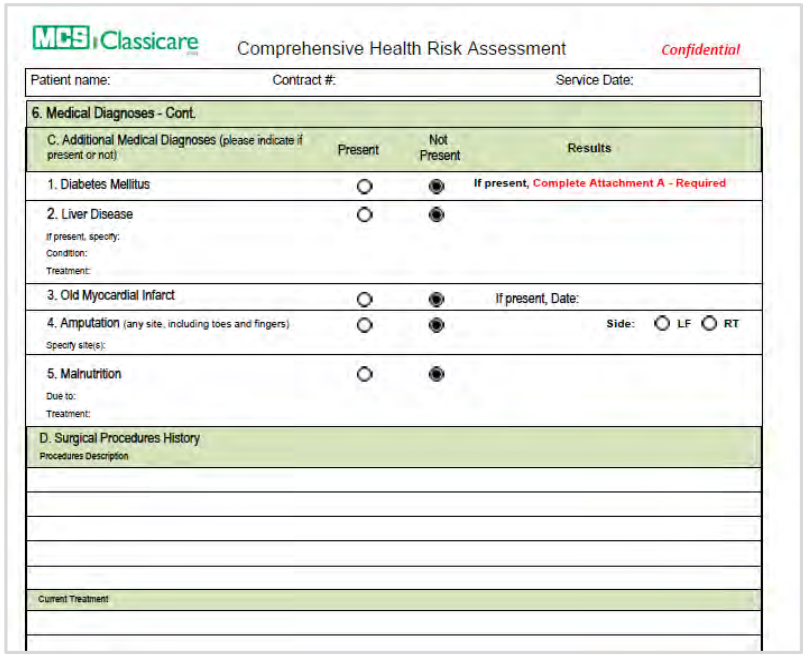
6. Medical Diagnoses - Cont.

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) Specify site(s):	○	◉	Side: ○ LF ○ RT
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:

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) Specify site(s):	○	◉	Side: ○ LF ○ RT
5. Malnutrition Due to: Treatment:	○	◉	

D. Surgical Procedures History
Procedures Description

Current Treatment

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

low-moderate-severe

MOC 2: Care coordination

Comprehensive Health Risk Assessment Tool (CHRAT)

Health levels based on the score obtained in CHRAT

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

Low

> 65 points

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

Moderate

Between 20 to 65 points

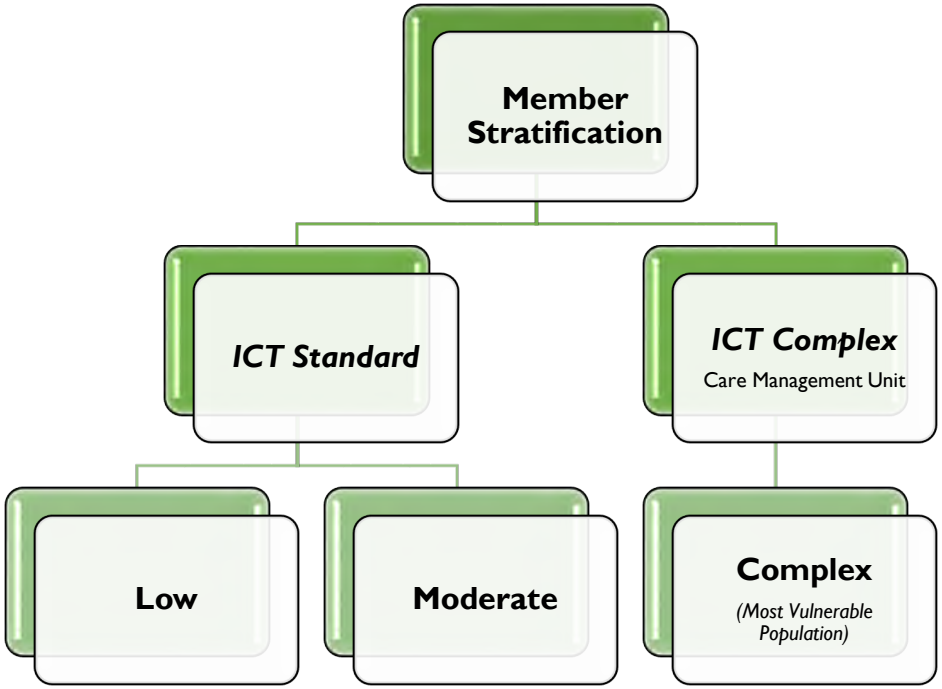
Individualized Care Plan is required for **Complex** and Care Management intervention. **(every six months)**

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 CHRAT.



MOC 2: Care coordination D-SNP

Interventions and recommendations established in the D-SNP 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 C-SNP

Interventions and recommendations established in the C-SNP 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
- Arthritis
- Osteoporosis
- CKD
- ESRD
- Infectious disease
- 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.

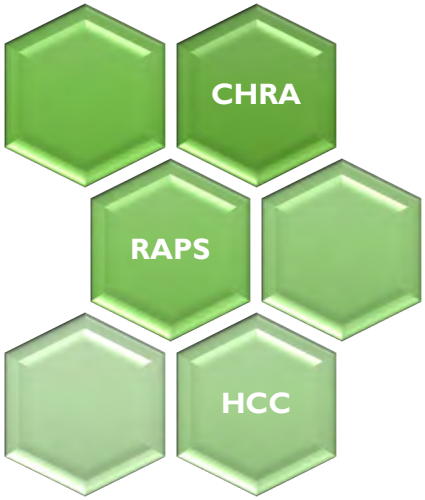
ICT Complex

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

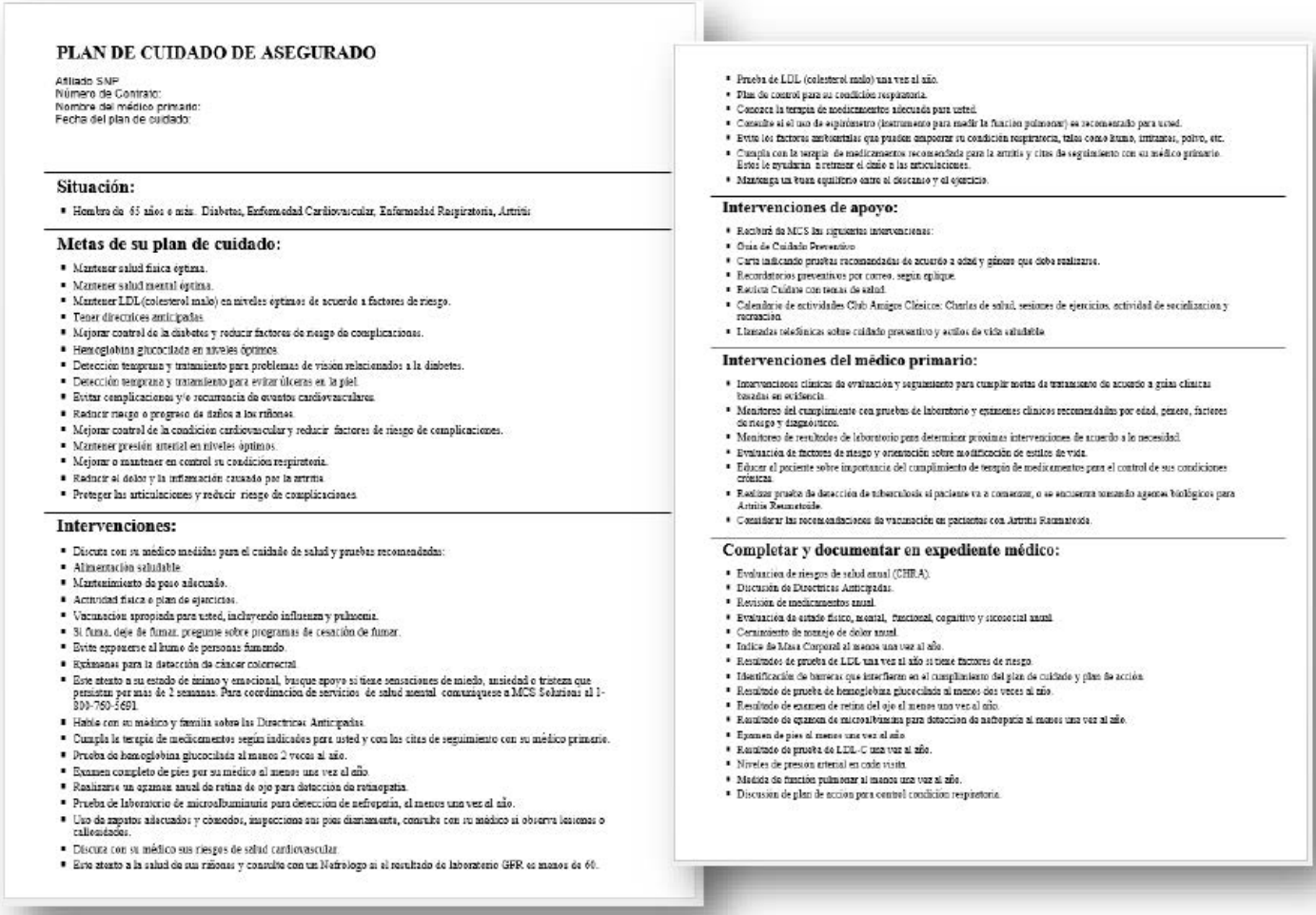
- Member's name
- Contract number
- Primary care physician's name

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 optima.
- Mantener salud mental óptima.
- Mantener LDL (colesterol malo) en niveles optimos de acuerdo a factores de riesgo.
- Tener directrices anticipadas.
- Mejorar control de la diabetes y reducir factores de riesgo de complicaciones.
- Hemoglobina glucosilada 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 condicion 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.
- Vacunacion apropiada para usted, incluyendo influenza y pulmonia.
- 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 animo y emocional, busque apoyo si tiene sensaciones de miedo, ansiedad o tristeza que persistan por mas de 2 semanas. Para coordinación de servicios de salud mental comuníquese a MCS Soluciones 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 glucosilada al menos 2 veces al año.
- Examen completo de pies por su medico al menos una vez al año.
- Realizarse un oftalmo anual de rutina 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 comodos, 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 Nefrologo 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 al el uso de espirómetro (instrumento para medir la función pulmonar) es recomendado 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 recomendados por edad, genero, factores de riesgo y diagnósticos.
- Monitoreo de resultados de laboratorio para determinar proximas 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.
- Coordinar 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 psicosocial anual.
- Cernimiento de manejo de dolor anual.
- Indice 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 interfieren en el cumplimiento del plan de cuidado y plan de acción.
- Resultado de prueba de hemoglobina glucosilada al menos dos veces al año.
- Resultado de examen de retina del ojo al menos una vez al año.
- Resultado de examen de microalbuminuria para detección 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 presion arterial en cada visita.
- Medida de funcion pulmonar al menos una vez al año.
- Discusión de plan de accion para control condicion respiratoria.

MOC 2: Care coordination

Updating and communication process of the Care Plan

Low and 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 six 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

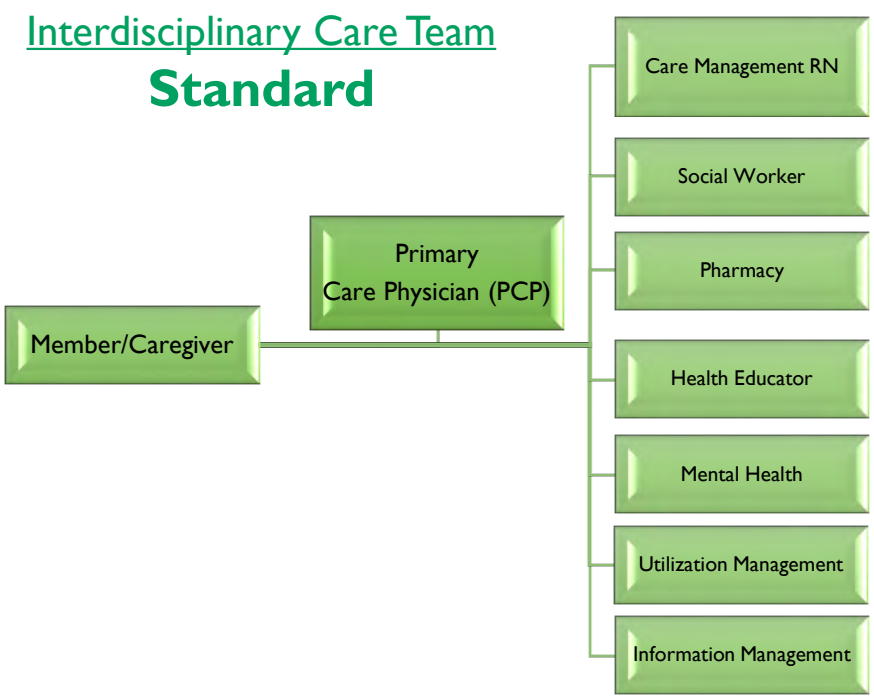
- Individual Care Management interventions with members with severe risk
- Preventive care and chronic management conditions reminders
- Clinical Management warning letters
- Educational campaigns
- Shipment of educational material and self-care guide
- Chronic conditions management workshops
- Health talks
- Cuídate Magazine
- MCS *Tu Ruta al Bienestar*

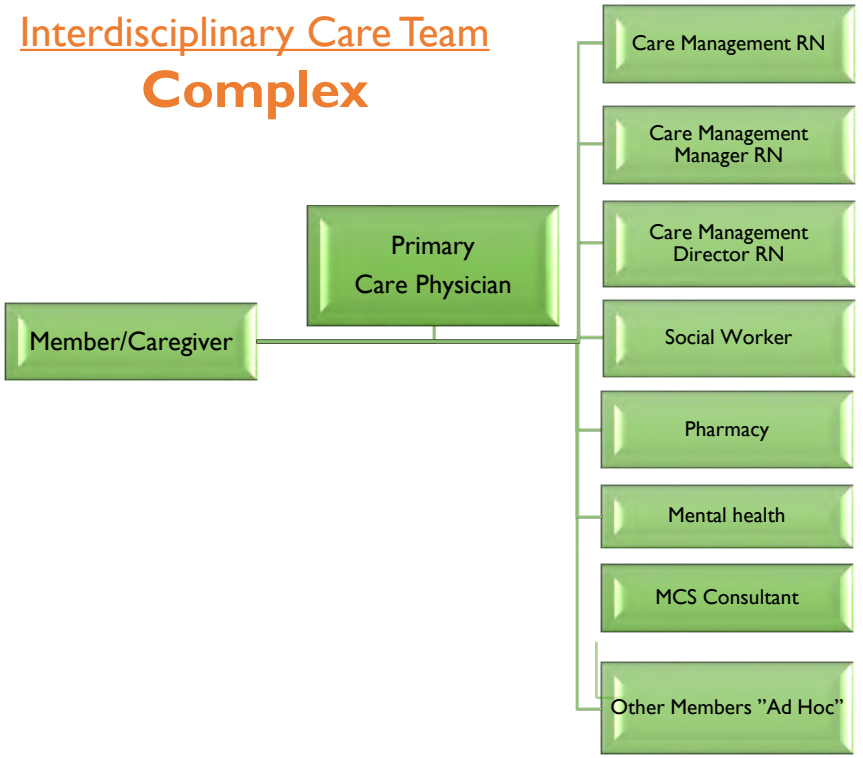
With PCP

- 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 status and identified needs.





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

The two types of care transition

Non planned 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 the care transition process we educate our members through:

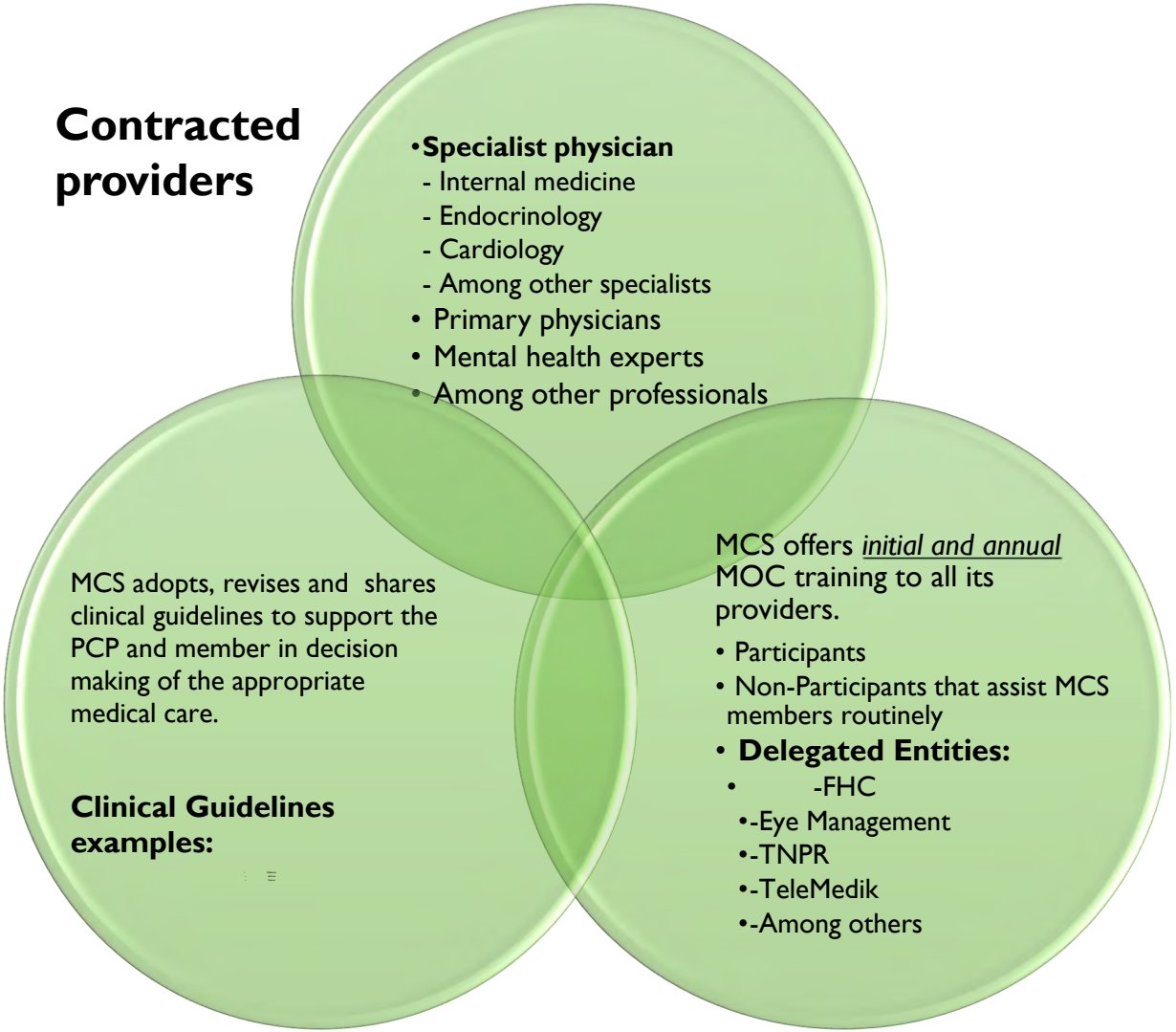
- Care transition letter to the member and its PCP
- Medilínea 24/7
- Educational self-care material

  (Cuídate Magazine, preventive reminders for diabetes, cardiovascular conditions, among others)
- Phone call from a nursing professional

Model of Care (MOC)

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



MOC 3: Providers network

Role of primary care physician and specialist physicians

- 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 physicians

- 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 physicians

- 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

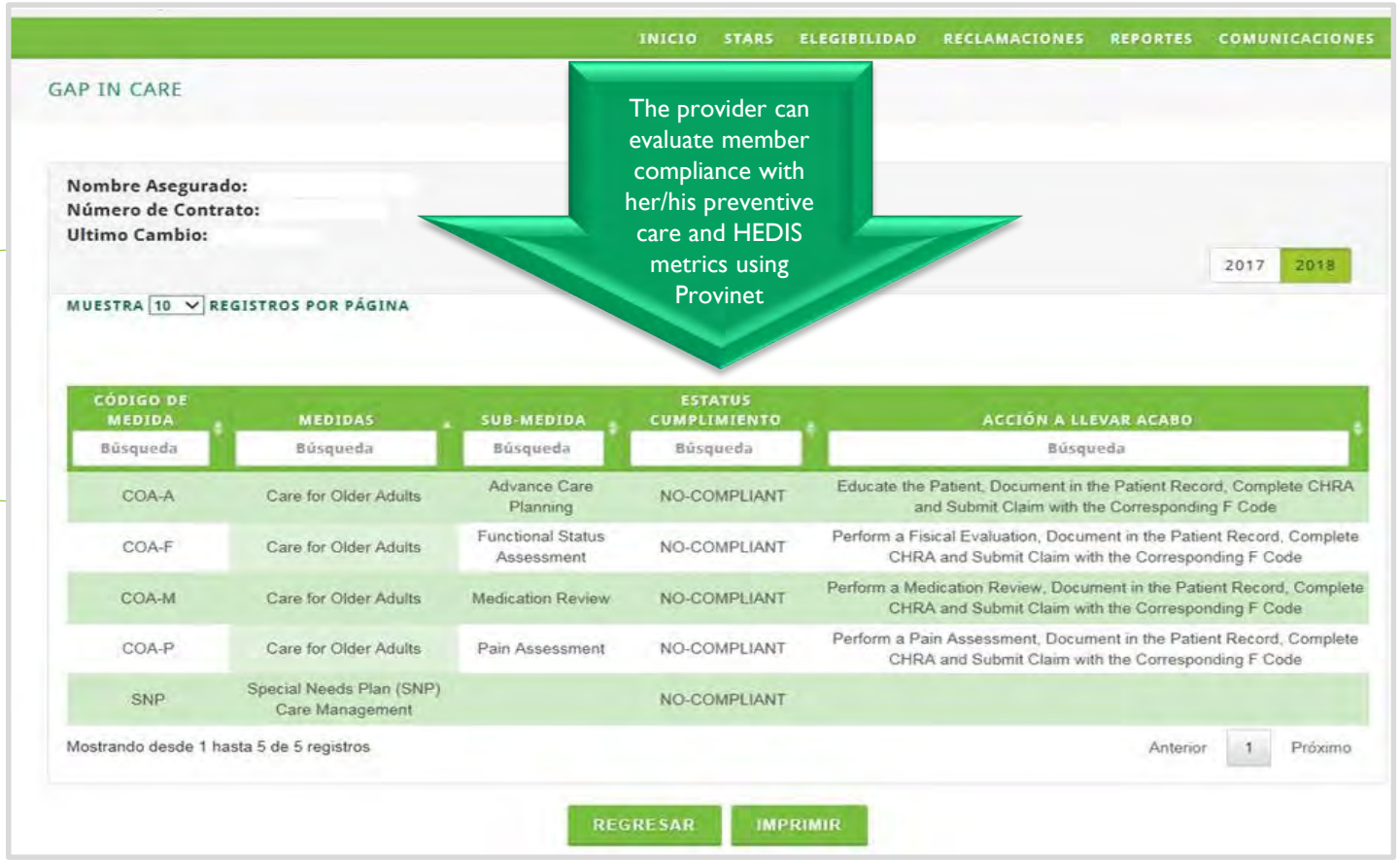
MOC 3: Providers network

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

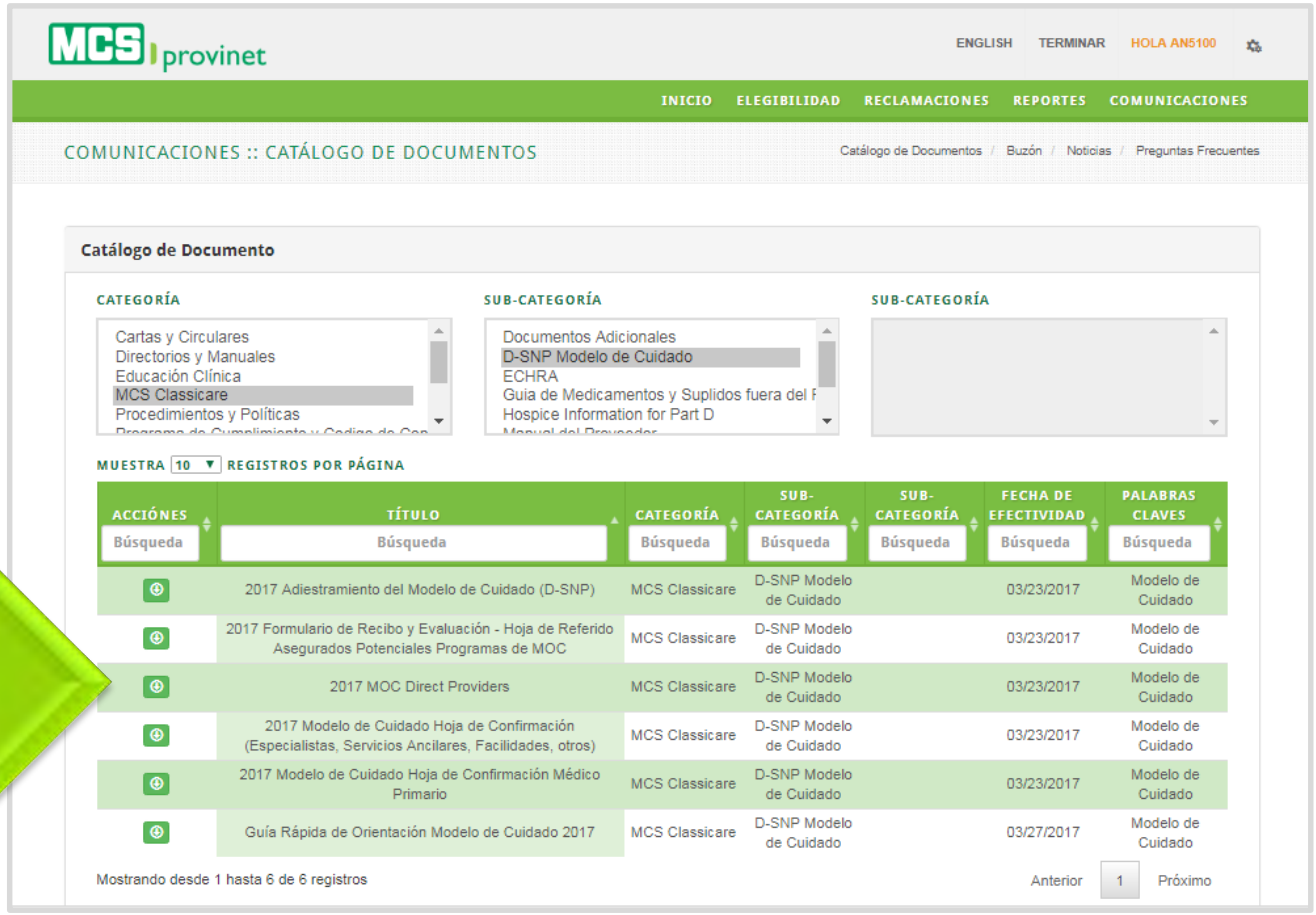
The ***Clinical Guidelines*** are available in Provinet

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



MOC 3: Providers network

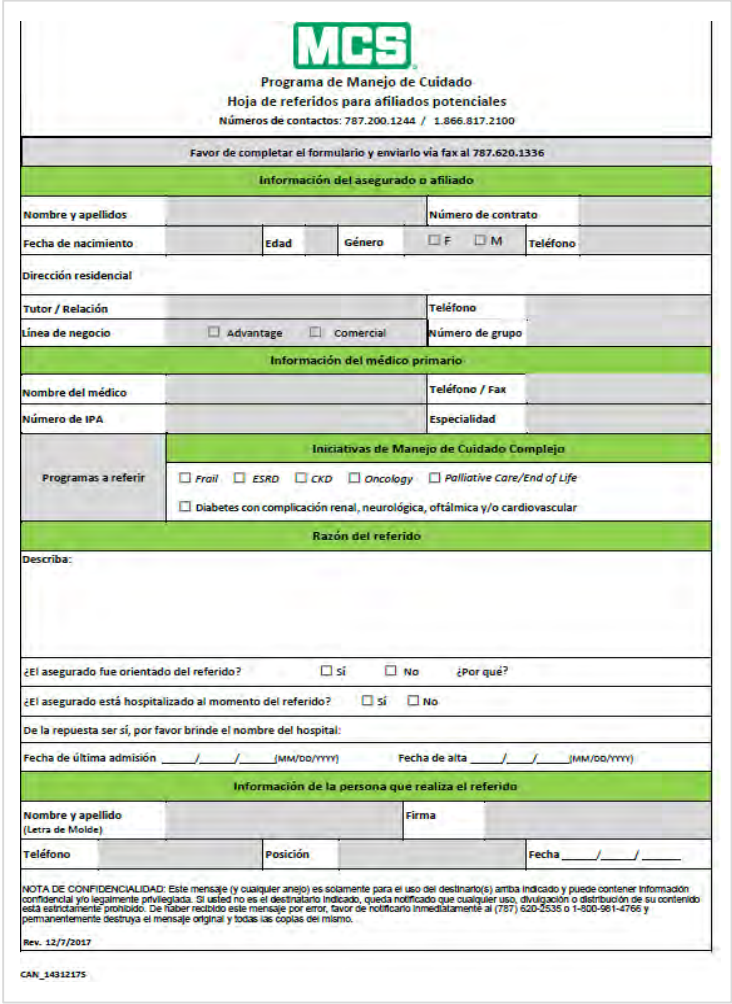
Care Management Programs Referral

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 destinatario(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.

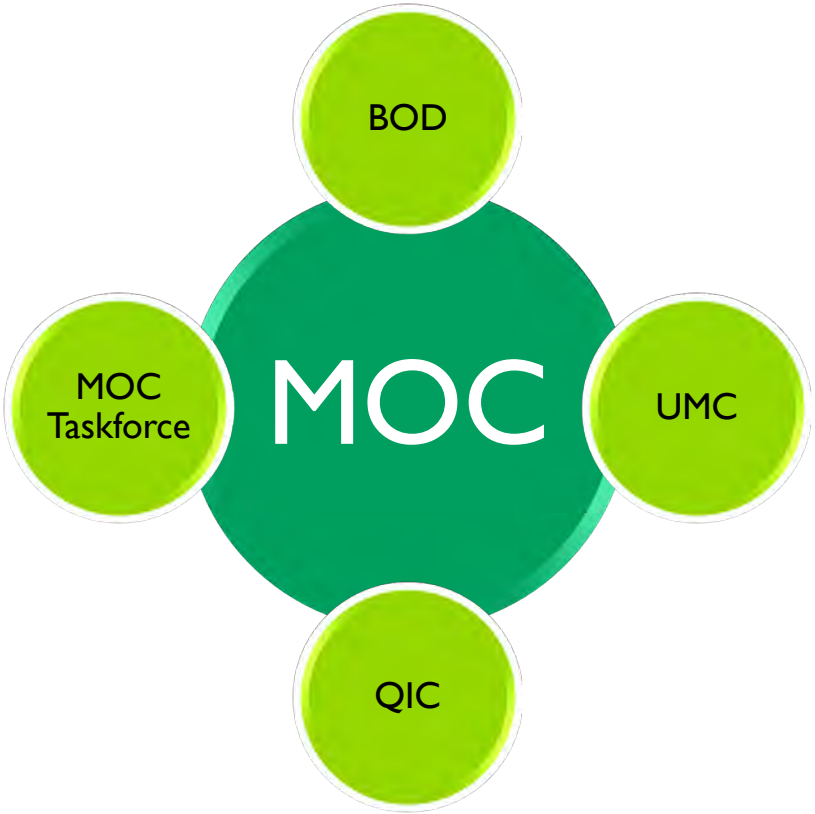
Rev. 12/7/2017

CAN_14312175

Model of Care (MOC)

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 D-MOC is currently approved for a cycle of three years (2018-2020).
- MCS's C-MOC is currently approved for one year (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 as required for the MOC

A. Quality measurement and performance improvement plan

- Data sources:
- CM, CHRA, PMHS applications
- MCS leaders participation in the internal quality process

B. Measurable goals and health outcomes

- Metrics Indicators
  - STARS
  - HEDIS
  - Regulatory reports
  - Operational reports

C. Measurement of patient experience of care

- Satisfaction Surveys
  - CAHPS
  - HOS
  - Internal surveys of members satisfaction
  - Focus Groups

D. Ongoing performance improvement and evaluation of the MOC

- Monitor and analyze the quality indicators to identify improvement opportunities
  - Hold MOC Taskforce meetings
  - The MOC is presented for Program Evaluation in the MCS Quality Committee.

E. Communication of the SNP MOC performance

- MCS communicates the obtained information to:
- Board of Directors
- Employees
- Providers
- Among others

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:

PROVIDER SERVICE CALL CENTER

Phone: 1-800-981-4766

787-620-2535

Monday – Friday: 8:00am a 5:00pm

Saturday: 8:00am a 1:00pm

MCS ALWAYS WINS!