Model of Care for Special Needs Plan FY 2019

Regular & temporary employees, Contractors, Sub-Contractors and Board of Directors

Objectives

- Know Model of Care (MOC) statutory and regulatory background.
- Identify plans and criteria for a Special Needs Plan.
- Identify the basic components of a Special Needs Plan.

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Objectives

- Learn about the elements of the Model of Care for 2019.
- Understand the MMM and PMC Models of Care.

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Model of Care Training

It is mandatory that MAO's must conduct and document training on SNP Model of Care for all employed and contracted personnel and Providers:

- Initial and annual training.

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Model of Care Training

- Methodology may be:
  - Face-to-face
  - Interactive (web-based, audio/video conference)
  - Self-study (printed materials, electronic media)

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Model of Care
Historical Background

- 2003: Medicare Modernization Act (MMA) establishes SNP Plans.
- 2008: Medicare Improvements for Patients and Providers Act of 2008" (MIPPA), PL110-275 required all SNPs to submit an evidence based **Model of Care** for CMS review during the MA application cycle.

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Model of Care
Historical Background

- 2008: Medicare Improvements for Patients and Providers Act (MIPPA) – Established requirement to conduct a Health Risk Assessment (HRA), care plan, interdisciplinary team care for beneficiaries and assess care effectiveness.

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Model of Care
Historical Background

- 2008: Call Letter - Established trainings
  for providers.
- 2008-2010: Health plans are required to comply with the requirements established by The National Committee for Quality Assurance (NCQA).

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Model of Care
Historical Background

- Upon its enactment in 2011, the Patient Protection and Affordable Care Act (the ACA) extended the SNP program through December 31, 2013, and mandated further SNP program changes such as:
  - Require all SNPs to submit Models of Care (MOCs) that comply with an approval process based on CMS standards; these MOCs must be reviewed and approved by the National Committee for Quality Assurance (NCQA) beginning January 1, 2012.

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Model of Care
Historical Background

- 2013 CMS Memo (February): CMS issued a notice clarification regarding expectations for Medicare Advantage Special Plans based on independent audits in 2012.
- 2013 CMS Memo (April): CMS issued a notice indicating the Audit Protocol for Model of Care "MOC" 2013.

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Model of Care
Historical Background

- In March 5, 2014, the Centers for Medicare & Medicaid Services (CMS), Medicare Part C and D Oversight and Enforcement Group (MOEG), responsible for conducting program audits for Medicare Advantage (MA) and Prescription Drug (Part D) plans (hereinafter sponsors) to ensure compliance with CMS requirements; release the 2014 audit process documents and protocols that will be utilized to measure outcomes in the following areas.

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Model of Care
Historical Background

- Part D Formulary and Benefit Administration.
- Part D Coverage Determinations, Appeals, and Grievances.
- Part C Organization Determinations, Appeals, and Grievances.
- **Special Need Plans (SNP) – Model of Care (SNP-MOC).**
- Part C and Part D Compliance Program Effectiveness.

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Special Needs Plan (SNP)

- Provide a plan for people who require health services tailored to their specific needs and conditions.
  - Vulnerable
  - **Most** vulnerable

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Special Needs Plan (SNP)

- Provide plans available for beneficiaries that have chronic, severe diseases or are disabled.
- Also offers services to beneficiaries who are elegible for Medicare and Medicaid and beneficiaries who live in certain types of institutions. (example: nursing homes).

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Special Needs Plans "SNP"

Dual Eligible Special Needs Plans (D-SNPs)

Enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

Dual Plans

- MMM Diamante Platino
- MMM Relax Platino
- MMM Completo Platino
- PMC Premier Platino

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Special Needs Plan (SNP)

Chronic Conditions MMM Supremo

Medical Certification

- **Cardiovascular disorders**
- **Diabetes**
- **Congestive heart failure**

Chronic Special Needs Plans (C-SNP) Requirement

CMS provides a period of 60 days to evidence the conditions of the beneficiary. If the beneficiary does not evidence the condition eligible under coverage an automatically disenrollment from the Medicare Advantage will take effect

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MMM SNP for Chronic Conditions

MMM SUPREMO

Recommended for beneficiaries:

- **With chronic conditions:**
  - Cardiovascular disorders
  - Diabetes
  - Congestive heart failure
- **That do not have Medicaid**

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MMM/PMC SNP for Dual Eligible Members

MMM Diamante Platino

MMM Relax Platino

MMM Completo Platino

PMC Premier Platino

Recommended for beneficiaries:

- Have Part A and Part B of Medicare.
- They have their certified Medicaid plan.

Model of Care (MOC) 2019

- A minimum score of 70% is considered passing and scores of 75 or more qualify the SNP's MOC for multi-year approval, either two or three years. The MOC summaries are intended to provide a broad overview of each SNP's MOC and are intended to provide the reader with a general overview of how each SNP addresses beneficiary needs.

MMM and PMC Models of Care were approved for 3 years.

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MOC Elements

MOC 1: SNP Population

MOC 2: Care Coordination

MOC 3: Provider Network

MOC 4: Quality Measurement and Performance Improvement

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MOC 1: Description of the SNP Population

- Focuses on the target population in the SNP.
- Includes overall general targeted population as well as most vulnerable beneficiaries.
- Targets the unique health needs of all beneficiaries including the most vulnerable.

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MOC 2: Care Coordination

- Ensures SNP beneficiaries' healthcare needs, and information is shared across healthcare staff and facilities over time.
- Coordinates the delivery of services and specialized benefits that meets the needs of the most vulnerable population.
- Requires a Health Risk Assessment, Individualized Care Plan, and Interdisciplinary Care Team.

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MOC 2: Care Coordination

Includes the following key elements:

- **Health Risk Assessment (HRA)**
  - Initial
  - Re-assessment
- **Individualized Care Plan (ICP)**
  - Initial
  - Enhance/Change of Health Status
- **Interdisciplinary Care Team (ICT)**
  - Steering
  - Virtual
  - Case Rounds
- **Care Transitions**

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MOC 2: Care Coordination

Health Risk Assessment (HRA)

MIPPA of 2008 mandated that MAO's conduct initial and annual health risk assessments for EACH beneficiary.

- The HRA assesses medical, psychosocial, cognitive, and functional needs of special needs individuals.
- The HRA is performed by telephone and may be performed face-to-face, or paper-based.

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MOC 2: Care Coordination

Health Risk Assessment (HRA)

- MMM/PMC utilizes a homegrown Health Risk Assessment (HRAT) tool called MSO's Health Risk Assessment which is an instrument developed by the Steering Interdisciplinary Care Team Committee.
- The HRA is conducted within 90 days from the date of enrollment, within 365 days of the last HRA and/or when there are changes in members health status.

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MOC 2: Care Coordination

Health Risk Assessment (HRA)

- The results classify the member in different categories of risks. This way the automatic referrals are generated to the Care Management programs such as *Complex Case Management etc.*
- Results are communicated to beneficiaries, interdisciplinary care team, and member's usual practitioners.

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MOC 2: Care Coordination

Individualized Care Plan (ICP)

- MMM/PMC develops an ICP to each SNP beneficiary.
- The ICP ensures that needs are addressed, on-going evaluation and coordination of services and benefits in which the beneficiary unique needs.
- Developed for each beneficiary by the respective interdisciplinary care team using the member's needs identified in the HRA.

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MOC 2: Care Coordination
Individualized Care Plan (ICP)

- ICP is communicated to the beneficiary and/or caregiver and provider.
- Revised annually or when health status changes.
- Maintain care plan records to assure access by all members of the Interdisciplinary Care Team.

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MOC 2: Care Coordination
Interdisciplinary Care Team (ICT)

MIPPA Mandate the MAO must assign EACH beneficiary to an interdisciplinary care team.

- MMM/PMC ICT is comprised but not limited to the Care Manager, Social Worker, Nutritionist, Member’s usual practitioner or primary care physician and member or their caregiver.

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MOC 2: Care Coordination
Interdisciplinary Care Team (ICT)

- This team is responsible for:
  - ✓Analyzing initial and annual results of a health risk assessment.
  - ✓Collaborating to develop an ICP for each beneficiary.
  - ✓Managing a beneficiary's medical, cognitive, psychosocial, and functional needs.
  - ✓Staying in constant communication to coordinate a Plan of Care for each beneficiary.

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MOC 2: Care Coordination
Interdisciplinary Care Team (ICT)

- The ICT has different three approaches to discuss and manage members needs and these are through Case rounds, virtual ICT and Steering ICT.

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MOC 2: Care Coordination
Care Transitions

- Transition is a movement of a member from one care setting to another as the members health status changes. *E.g. Moving from hospital to home.*

- MMM/PMC has processes to coordinate and support members through transitions in order to maintain continuity of care.

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MOC 2: Care Coordination
Care Transitions

- MMM/PMC has staff available in their Care Management Program for coordinating care transitions who facilitates communication between healthcare settings, member’s usual practitioner and the member or their caregiver.
- The member’s ICP is shared across settings when a care transitions occurs.

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MOC 3: SNP Provider Network

- MMM/PMC ensures that the provider network has specialized clinical expertise that fulfills the SNP Plan target population.
- Ensure Use of Clinical Practice Guidelines & Care Transitions Protocols
- MMM/PMC educates the SNP Provider Network and out-of-network providers of the plan's Model of Care.

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MOC 4: Quality Measurement and Performance Improvement

- SNP Specific Quality Performance and Improvement Plan.
- MMM/PMC measures goals and health outcomes for SNP.
- MMM/PMC measures SNP member satisfaction.

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MOC 4: Quality Measurement and Performance Improvement

- Supporting ongoing improvement of the MOC
- On an annual basis the SNP MOC quality improvement performance results are communicated to all stakeholders: *members, employees, providers, Board of Directors and the public.*

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To clarify questions related to the

Model of Care for Special Needs Plan 2019, (MOC), contact your direct supervisor.

Thank You

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