Provider Training on the Model of Care for the Special Needs Plans (SNP-MOC)

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Objectives

Upon completion of this lesson, about the Introduction to the Model of Care, you will learn to:

Objective #1
Describe the Special Needs Plans (SNP) and the population of the MOC (C-SNP) y (D-SNP)

Objective #2
Define and recognize the 4 elements of the MOC

Objective #3
Recognize the essential components of the MOC's care coordination

CMS' Requirement

- ✓ Based on the requirement of CMS (Centers for Medicare and Medicaid Services), all employees, Providers and delegated entities must receive a training regarding the elements of the MOC, upon hiring and annually thereafter.

Definitions

- **CAHPS**: (Consumer Assessment of Healthcare Providers and Systems): Survey that collects, evaluates and informs about the member's experience (perception) in regards to the services received from the health plan and the providers.
- **CM** (Care Management): Care Management Program supported by nurses acting as Care Managers of the member's plan of care.
- **HEDIS**: (Healthcare Effectiveness Data and Information Set) Set of data and information regarding the effectiveness of the medical care and services.
- **HOS** (Health Outcomes Survey): Survey that collects valid and clinically significant data regarding the member's mental and health wellbeing.
- **HRA** (Health Risk Assessment): Evaluation made by the physician or Care Managers to identify the member's needs and risk factors.
- **ICP** (Individualized Plan of Care): Member's plan of care that is individualized based on the member's specific needs and risk factors.
- **ICT** (Interdisciplinary Care Team): Care team comprised of different specialties that are responsible of the coordination and execution of the plan of care.
- **PCP** (Primary Care Physician): Medical doctor that is primary responsible of the member's medical care under the Model of Care.

Background

The Special Needs Plans (SNPs) were created as part of the Medicare Modenization Act of 2003.

- In 2010, the *Patient Protection and Affordable Care Act (ACA)* reinforced the importance of the Model of Care (MOC) as a fundamental component for the SNPs. ACA requires that the National Council for Quality Assurance (NCQA) executes the review and approval of the MOC based on requirements and criteria established by CMS.
- Medicare Advantage plans must design benefit packages directed to the groups with different special needs. These packages, through improvements on care coordination, provide additional benefits, care improvement and reduction of costs to the most vulnerable.

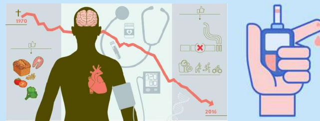
Regulation at 42 CFR 42.101(f) requieres that all MA organizations must implement a Model of Care for their Special Needs Plans to satisfy their care needs and improve their quality of life.

What is a special needs individual?

- May be one of the following:

Eligible for both Medicare and Medicaid (Government Health Plan) or Dual-SNP (Platino)

Person with a chronic or disabling condition, as specified by CMS* **or C-SNP**



TSS have a contract with Medicare and ASES to offer Platino plans to their eligible beneficiaries.

*Note: CMS *Centers for Medicare & Medicaid Services*, CMS, is part of the US Health and Human Services Department.

Dual-SNP Population

- This population is dually eligible for both Medicare and Medicaid.

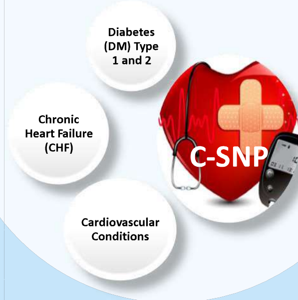
- ✓ These members are eligible to enroll in our Platino products.
- ✓ The most vulnerable enrollees are those with ESRD.

Product	Plan Code	January 2020 Membership
Platino Plus	024	23,431
Platino Ultra	025	9,729
Platino Advace	026	1,091
Platino Blindao	028	10,580
Platino Enlace	032	228
Total:45,059		

C-SNP Population

Certification of Condition

Through a provider's certification before enrollment



TSA C-SNP Product

Eligible conditions to this product and the most vulnerable population:

Diabetes (DM) Type 1 and 2

Chronic Heart Failure (CHF)

Cardiovascular Conditions

C-SNP

Contigo Plus (022): January 2020 membership: 1,257 enrollees

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Model of Care (MOC)

As established in Section 1859 (f) (7) of the Social Security Act, each SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance.

Provides the basic structure under which the SNP must satisfy the needs of each of the enrollees through care coordination.

Is a vital tool to improve the quality and an integral component to guarantee that the unique needs of each enrollee are identified by the SNP and that are managed through the care programs of each plan.

https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

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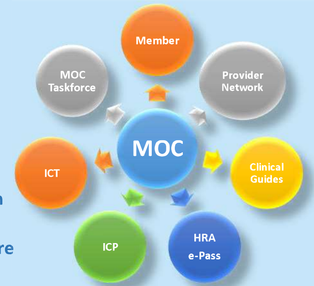
Components that support the MOC

- TSS' MOC have the structure to communicate and satisfy the needs of our SNP members.
- Regularly communicates with the member and its PCP about the medical, cognitive, mental, psychosocial and functional management and includes the caregiver as necessary.
- The initiatives facilitate the prior-authorization process, the transition of care and follow up of chronic conditions and the communication between the providers.
- The performance of the MOC and its components are regularly evaluated to guarantee the compliance with CMS requirements.



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Elements of the Model of Care (MOC)

The **Model of Care** consist of four principal elements:

1
Description of the SNP Population

2
Care Coordination

3
Provider Network

4
Performance and Quality Evaluation

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Element 1: Description of the SNP Population

The population of SNP members must go over an enrollment process where the eligibility is determined, verified and tracked.

Member or Legal Guardian

- Completes the enrollment form
- Form is sent to the Enrollment Department

Enrollment Department

- Receives and reviews the formulary
- Verifies and tracks the eligibility
  - ✓ Membes monitored to confirm that it had not been out of service área for more than 6 months
- Send transactions to CMS within 7 days
- CMS' response is received
- Welcome, rejection or disenrollmen letter is sent to the member

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Element 1: Most Vulnerable Population

- **The population with more risk or more vulnerable is identified to direct the resources towards the members with more need of services, for example, the care management.**

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Element 2: Care Coordination

- Regulations at 42 CFR§422.101(f)(ii)-(v) and 42 CFR§422.152(g)(2)(vii)-(x) requires that all SNP coordinate and evaluate the effectiveness of the services provided through the MOC.
- The care coordination guarantees that all the health needs and member preferences are covered.
- It also guarantees that the medical information is shared between the health professionals, maximizing the efficiency and high quality of the services and improving the member's health results.
- The MOC also describe the functions, responsibilities and oversight of the clinical and non-clinical personnel.
- The MOC establishes a contingency plan that guarantees the continuity of the critical functions during an emergency.
- It also requires that all personnel must be trained about the MOC upon hiring and annually thereafter.

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Element 2: Care Management Program

- All individuals eligible to a SNP product are eligible for the Care Management Program.
- They are notified through a phone call or letter to complete the health risk assessment (HRA).
- Cases are classified according the results of the HRA, the stratification and claims data.
- Members are informed about their particpation on the Care Management Program, in which the Interdisciplinary Care Team collaborate to create a care plan and the goals to achieve.

Element 2: Care Coordination

Health Risk Assessment (HRA)

Initial – is performed within the 90 days since the enrollment date.
Annual – is performed within the 365 days since the initial HRA.

Individualized Care Plan (ICP)

Is performed based on the individual needs of each member as identified through the HRA and it is updated when the member experiences a change in health status.

Interdisciplinary Care Team (ICT)

Provides the structure and necessary process to coordinate and offer the necessary healthcare services to the SNP population according to the results of the HRA.

Transition of Care (TOC)

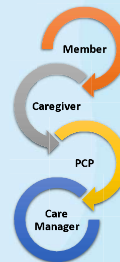
When a member experiences a change in health status and needs to go over one healthcare setting to another, it is a Transition of Care
Transition of care to a lower setting: Hospital to Home or
Transition of care to a higher setting: Home to Hospital

Element 2: Health Risk Assessment (HRA)

- The HRA is performed to identify the health risks and the medical, psychosocial, cognitive, functionals and mental needs of each member.
- It is completed within 90 days since the enrollment effectie date and 365 days therafter.
- The results of the HRA are shared with the PCP and are used to develop the care plan.
- If a change in health status occurs, the member is reassessed and the care plan is updated. For example: after hospitalizations, the member needs a reassessment to identify new needs.

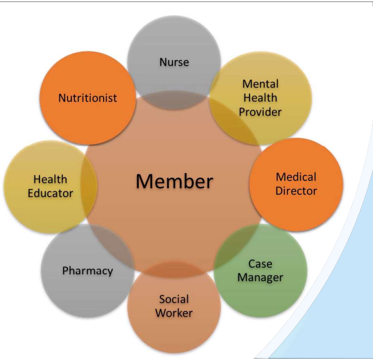
Element 2: Individualized Care Plan (ICP)

✓ The individualized care plans are developed by an interdisciplinary care team that includes:



The ICP must include:

- ✓ Objectives based on the identified needs and member preferences.
- ✓ Interdisciplinary care team interventions.
- ✓ Plans and goals of self-care adapted to the needs of the member.
- ✓ Barriers and progress towards the goals.

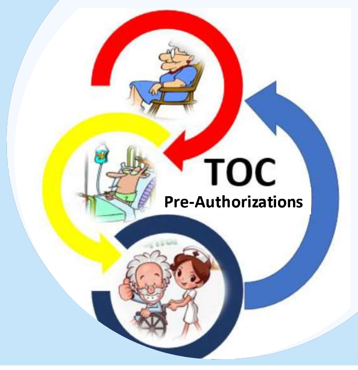


Element 2: Interdisciplinary Care Team (ICT)

- The interdiscinplinary care team provides the structure and improve the processeses to offer and coordinate the care services for the member and helps in preventing health complications.

Element 2: Transitions of Care Protocols (TOC)

- The transitions of care occurs when the member needs a transfer between one setting to another. The most common example is when a patient leaves the hospital to their home.
- In the MOC, the SNP members that experiences a transition of care receive coordination of services and pre-authorizations.
- After the discharge, the member or caregiver receives orientation through the phone about the transition process and the PCP is notified.



Element 3: Provider Network

Providers

- Primary Care Physician (PCP)
- Specialists (Endocrinologists, Cardiologists, among others)
- Mental/Behavioral Health Providers

Trainings

- Validation of credentials and with the provider trainings regarding the MOC.
- Includes Delegated Entities

Clinical Guidelines

- Diabetes
- Asthma/COPD
- Cancer
- Alzheimer
- Heart Conditions
- Among others

Element 3: Provider Network

Primary Care Physician's (PCP) Role

- ✓ Provide the necessary medical attention
- ✓ Encourage the member's participation in their medical care
- ✓ Offer timely and effective services and guarantee their quality
- ✓ Ensure the continuity of care and/or services and provide treatment follow up
- ✓ Offer preventive care and guide the enrollees to maintain a healthy lifestyle and comply with HEDIS measures
- ✓ Perform the HRA complying with the required timeframe
- ✓ Provide Access and include other specialties within the care management process, if necessary.

Element 3: Provider Network

Primary Care Physician's (PCP) Role

- ✓ Participate on the Interdisciplinary Care Team's meetings
- ✓ Maintain the communication with the Care Manager and the Interdisciplinary Care Team and/or caregiver and collaborate on the Individualized Care Plan (ICP)
- ✓ Revise and update the Care Plan and discuss the member's concerns and/or preferences
- ✓ Use the Clinical Guidelines adopted by TSA
- ✓ Notify the health plan about any barrier that may affect Access to services or the transition of care.

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Element 3: Provider Network

Specialist Physiciant's Role

- ✓ Provide services in a timely and effective manner and guarantee the quality of services
- ✓ Ensure the continuity of care and/or services and provide follow up to treatments
- ✓ Offer the necessary medical care and educate the member and/or caregiver about its condition
- ✓ Incorporate the PCP on the member's care
- ✓ Encourage the participation of the member in its care

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Element 3: Provider Network

Specialist Physiciant's Role

- ✓ Participate on the member's care planning and on the Interdisciplinary Care Team
- ✓ Offer preventive care and guide the member in maintain a healthy lifestyle
- ✓ Use the Clinical Guidelines adopted by TSA
- ✓ Notify the health plan about any barrier that may affect the access to services or the transition of care

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Element 3: Provider Network

TSA provides trainings regarding the MOC to Providers and Medical Groups, through:

- ✓ Presentations
- ✓ Brochures
- ✓ Magazines
- ✓ Mi Triple-S

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Element 4: Quality Performance Evaluation

Quality Improvement Evaluation Plan
- Design of an organizational plan to improve the ability of TSA to provide high quality services and better benefits.

Measurable Goals and Health Outcomes
- Indicators of measures such as HEDIS and CAHPS are used to establish the goals.

Member Satisfaction
- Member satisfaction surveys are conducted (CAHPS and HOS)

Performance Evaluation and Improvement
- Continuous monitoring and evaluation of quality indicators to identify opportunities for improvement.

Communication of the results of the evaluation
- The results are communicated to the Board of Directors, Management, Suppliers and others.

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Element 4: HEDIS Measures

Measures	
Diabetes Care: Eye Exam	Osteoporosis
Diabetes Care: Kidney Disease Monitoring	Plan of all Cause Readmission
Diabetes Care: Statins	COA: Medication Review
Breast Cancer Screening	COA: Functional
Colorectal Cancer Screening	COA: Pain screening
Medication Adherence: Oral Diabetes	Controlling Blood Pressure
Medication Adherence: Hypertension	Adult BMI
Medication Adherence: Cholesterol	Medication Review Post Discharge
Rheumatoid Arthritis - DMARD	

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Element 4: Quality Performance & Imrprovement Evaluation in TSA

Triple-S have a Chronic Care Improvement Program specifically to prevent members with Chronic Kidney Disease in Stage 4 reach Stege 5.

- Identify the members with CKD Stage 4
- The goal is to prolong the transition to Stage 5
- Perform interventions of:
  - Stage 4 assessment of needs
  - Education of management of comorbidities, such as diabetes, hypertension or health conditions
  - Schedule visits and follow ups with nephrologist
  - Coordinate the plan of care with the PCP

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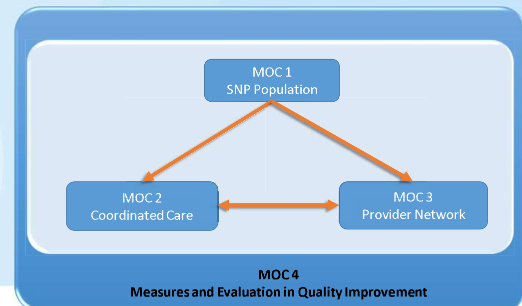
How the Model of Care elements work between them?



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Element 4: Communication of Quality Evaluation Results

- TSA discuss the performance, barriers, trends or patterns related to the Model of Care with the Clinical Quality Committee.
- The results are also shared with the Board of Directors, Executive Management, Employees, Providers, among others.

Remember!

The Model of Care allows to:

- Reinforce the collaboration between healthcare Providers for the benefit of each one of the members.
- Improve the communiction between the members, caregivers, Providers and TSA employees.
- Have an interdisciplinary approach to address the special needs of our members.
- Provide a comprehensive care and support the preverences of the care plan of the members.

References

Medicare Managed Care Manual, Chapter 5, Title 42, Part 422, Subpart D, 422.152 Special Needs Plan. (2016). Obtained from https://www.cms.gov/Medicare/HealthPlans/SpecialNeedsPlans/index.html

Model of Care Scoring Guidelines CY 2020. (2019). Obtained from https://snpmoc.ncqa.org/wp-content/uploads/MOC-Scoring-Guidelines_CY-2021-1.pdf

Chapter 16B Special Needs Plans of the Medicare Managed Care Manual. (2016). Obtained from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf

Provider Portal: https://providers.sssadvantage.com/

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