2024 Model of Care Training

Ashley Ivill, RN

Director of Learning & Development

Background and Objectives

The Centers for Medicare & Medicaid Services (CMS) requires all Special Needs Plans (SNP) to provide Model of Care (MoC) training for all Care Team members who see the Plan's SNP members routinely.

This training will help you to:

- Review Medicare and Medicare Advantage
- Describe the different types of SNPs
- Understand the MoC key components
- Define your role in supporting the MoC

Original Medicare is limited to **two types** of coverage:

PART A

Helps pay for hospital stays and inpatient care

PART B

Helps pay for doctor visits and outpatient care

PART C

Medicare Advantage = Part A + Part B AND includes services not covered by Original Medicare

PART D

Prescription drug coverage (Included in our plan)

Get MORE with Medicare Advantage Special Needs Plans

Special Needs Plans

A type of Medicare Advantage plan

Who Qualifies?

Special Needs Plans (SNPs) offer additional services based on specific medical situations for those who qualify:

- Enrolled in Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Lives in plan service area (CMS approved counties)

Institutional Special Needs Plan (I-SNP)
Must reside (or plan to reside) in a qualifying facility for 90 or more days

Institutional-Equivalent Special Needs Plan (IE-SNP)
Meet institutional level of care but resides in other levels of care such as an assisted living or independent living

What is the Model of Care?

The Model of Care is the contract that the Plan submits to CMS clearly outlining who our members are, how we take care of them, how we demonstrate that care, and how we manage the quality of that care. We use this contract to individualize the unique needs of our members.

CMS requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care.

Key Sections:

- MOC 1: Description of the SNP Population
- ***MOC 2: Care Coordination (clinical team's focus)**
  - Health Risk Assessment (HRA)
  - Face to Face Encounters
  - The Individualized Care Plan (ICP)
  - The Interdisciplinary Care Team (ICT) Meetings
  - Care Transition Protocol
- MOC 3: Provider Network
- MOC 4: Quality Measurement and Performance Improvement

MoC 1:
Description of the SNP Population

Members living in Senior Living Communities:

- Skilled Nursing Facilities (SNF)
- Memory Care
- Assisted Living (AL)
- Independent Living (IL)
- Continuing Care Retirement Community (CCRC)

Members may have or require the following:

- Additional care coordination than the general population
- Has multiple co-morbid chronic conditions requiring close monitoring
- Likely prescribed high-risk medications
- May need help with 5 or more activities of daily living (ADLs)
- May have moderate to severe cognitive impairment

Key Plan Support Role

Advanced Plan Practitioner (APP)

- Performs the Health Risk Assessment (HRA)
- Completes a post-HRA visit within required timelines
- Works with the ICT to ensure every member has a complete and updated ICP that reflects the goals/preferences of the member and track progress towards goals
- Provides on-site primary care services
- Compliments and supports Primary Care group-led services; does not replace care by existing primary team
- Medication review and monitoring to avoid side effects
- Participates in the Facility ICT Meetings
- Oversight for all transition of care events
- Partners with the facility to proactively prevent hospital admissions
- Post-discharge visits including medication reconciliation
- Accountable for quality measures

MoC 2:
Care Coordination

- Health Risk Assessments (HRA)
- Face to Face Encounters
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT) Meetings
- Care Transition Protocols

For APPs Only:

To receive credit for the Model of Care activities completed, the Plan approved billing code must be submitted to the Plan. This is how the Plan will track your activities for compliance.

Approved codes are located in the **Quality Resource Guide** that is on the Plan's website under "Provider Documents." For questions, please reach out to Plan Management.

Health Risk Assessment (HRA)

The main objective of the HRA is to assess the Member's current health status, identify unmet health needs, estimate their level of health risk, and to use the information collected from the HRA to support the development of the Individualized Care Plan (ICP).

Requirements

- All new Plan members receive an HRA **within 90 days of enrollment** (start effective date). **Best practice is within 30 days.*
- Existing members should have an HRA annually (**within 364 days of their prior assessment**).

Reminder: If the annual HRA is not completed within 364 days of the previous HRA, the Plan must complete a second HRA during the next quarter (or within the calendar year) to ensure compliance. This is a CMS Part C requirement.

Example below:

Member Enrollment – 02/01/2021 to present

Member Initial Assessment – 03/1/2021

Member Reassessment (2022) – 02/20/2022

Member Reassessment (2023) – 03/15/2023- Not timely, 5/20/2023- Timely

Member Reassessment (2024)- due on/before 5/19/2024

Health Risk Assessment Outcomes

1. Results from the HRA directly contribute to a member's Individualized Care Plan (ICP).

2. Stratification of HRA responses set the timing of the post-HRA visit with the Advanced Plan Practitioner:

HRA Stratification Level	Post-HRA Visit
High	Within 14 days
Medium	Within 30 days
Low	Within 45 days

Health Risk Assessment (HRA)

HRA Unable to Contact (UTC) Protocol:

If the member is unable or unwilling to participate in the HRA, the HRA will be conducted with a caregiver, responsible party, Power of Attorney (POA), or other delegated entity as requested by the Member.

The Plan will make three documented attempts on different days and times and then will send an unable to contact (UTC) letter for Members or responsible parties who are unable to contact. The first three attempts should occur within 60 days of the Member's start effective date. The fourth attempt (letter) will occur within 90 days of enrollment.

Important: Contact the Plan Account Manager should an UTC letter need to be sent.

Face-to-Face Encounter

Advanced Plan Practitioner (APP)

- Conduct an initial member face-to-face encounter and HRA within 90 days of the Member's enrollment to the Plan.
- The result of the HRA sets the next face-to-face encounter (post-HRA visit) timeframe.
- The APP will conduct a face-to-face encounter with the member at a minimum **MONTHLY** (including members on hospice).
- Based on member needs, preferences, and clinician judgment the APP may determine that a member requires more frequent visits.
- Members who have recently experienced a care transition should be considered for weekly evaluation until clinically stable.

F2F Encounter Refusals

- The Plan's care team will make its best efforts to fully engage with Plan Members but also acknowledge that Members have the right to refuse a face-to-face encounter.
- The Plan's care team will document the reason why the face-to-face encounter is not feasible in the Plan's care management system.
- If the Member is unable to be reached, the Plan's care team will make multiple efforts to try and reach the Member to engage in case management services.
- Efforts to reach the Member include phone calls on different days.

Care Coordination

Individualized Care Plan (ICP)

- ICPs for all members are developed after the initial HRA is completed.
- Reviewed and updated, if needed, at minimum:
  - Nursing Home: **quarterly**
  - Other Levels of Care: **twice annually**
- Reviewed and updated, if needed, during ICT meetings or a significant change in member health status.
- A copy of the facility ICP is obtained and uploaded into the practice electronic medical record (EMR).

Interdisciplinary Care Team (ICT) Meetings

- Nursing home: **quarterly**
- Other levels of care: **twice annually**

- If the facility does not notify and/or invite the APP to the Facility ICT Meeting, the APP is responsible for coordinating an ICT Meeting with the member and/or caregiver, facility staff, and PCP.

ICT Meetings Documentation

ICT meeting documentation to include the following:

- Full name and credentials of those invited and attended
- PCP, APP and member and/or caregiver were invited to attend the meeting
- Description of the content of the ICT meeting discussion
- Description of care plan review and revisions made
- Evidence that the PCP was involved in coordination of care communications
    - Example: PCP was invited to meeting but did not attend. PCP was informed of ICT meeting discussion and ICP updates post meeting (i.e., verbally, fax)

Care Transitions

- The facility has the responsibility of notifying the APP before an unplanned care transition or, when a member requires immediate emergency services, right after (within 24 hours) contacting emergency services. The facility should also notify the Plan of transfers to hospital so that the Utilization Management team can ensure appropriate care level, engage in care coordination including exchange of patient information with the hospital, and begin discharge planning.

- If the Plan is notified of a potential care transition (i.e., inpatient or long-term acute care), the APP will make best efforts to meet with the member and/or caregiver/family **before** the transition to discuss goals of care and advance directives.

Care Transitions Protocols

Within 2 business days:

- The APP will perform a member outreach within two (2) business days of return from hospital inpatient stay or long term acute care (LTAC) stay to the facility. *Best practice is within one (1) calendar day.

Within 7 calendar days:

- The APP completes a face-to-face visit with the Member within seven (7) calendar days of the member's return to the facility and coordinates an updated ICP with the ICT.

Clinical Practice Guidelines can be found on the Plan website under the "For Provider" tab.

Post-discharge Visit

During the post-discharge visit, the APP may complete the following:

- Educate the member and/or caregiver on the reason(s) for hospitalization
- Provide instruction on who to contact for concerns at any point in time
- Educate the member and/or their caregiver on signs and symptoms or “red flags” (i.e., warning signs that indicate the condition is worsening and how to respond)
- *Perform medication reconciliation (required quality measure)
- Educate members living in Assisted Living who are managing their own medication on medication self-management, new medications, and dosing
- Review any new conditions or diagnoses
- Review the updated ICP
- Coordinate orders for post-hospital specialist visits, diagnostic testing, home health services and/or therapy

Care Transition Cont.

APP/Practice Group Reminder: Review the Quality Resource Guide to verify the provider is completing an approved encounter type and billing per the guidelines of the CPT code.

- This is how the Plan will verify the transition visit occurred within the compliant timeframe!
- Approved Billing Code:

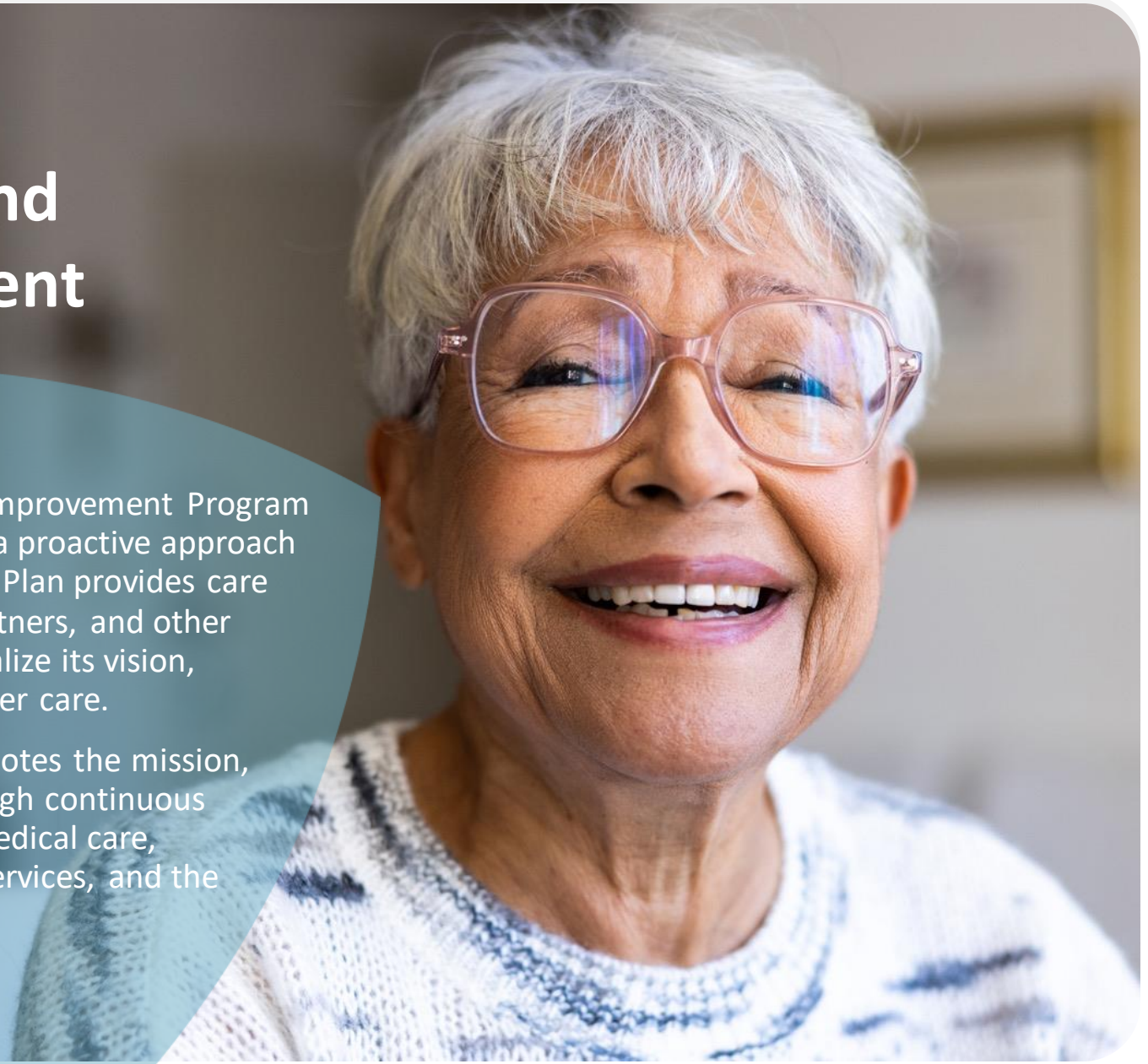
Measure	Detail	Code
Care Transitions	Interactive contact with the member or caregiver, as appropriate, within two (2) business days of hospital inpatient discharge or emergency room visit. The contact may be direct (face-to-face), telephonic or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit. Face to Face Visit must take place no later than seven (7) days from discharge.	99496

Quality Measure: Medication Reconciliation post-discharge is required within 30 days. Best practice is to complete this with the care transition visit. Report CPT II code 1111F on the claim, in addition to the visit code.

MoC 3: Provider Network

- The Plan provides a comprehensive contracted network of providers, facilities, ancillary service providers, specialist physicians, and acute care facilities with the specialized clinical expertise pertinent to the care and treatment of long-term senior housing residents.
- Primary care services through the APP and supportive ancillary services like therapy, rehab, selected diagnostic radiology and lab, and home health are provided within the member's senior housing residence and coordinated by the APP.
- The APP also coordinates visits and services provided outside of the facility including specialist visits, radiology, lab, and other diagnostic testing not available on site.
- Out of Network referrals may require prior authorization

MoC 4:
Quality Measurement and Performance Improvement



- The purpose of the Plan's Quality Improvement Program (QI Program) is to continually take a proactive approach to assure and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so that it may fully realize its vision, mission and commitment to member care.
- The QI Program supports and promotes the mission, vision, and values of the Plan through continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services to members.

Member Risk Prevention - PQI

Potential Quality Issues (PQI)

- A deviation or suspected deviation from expected provider performance, clinical care or outcome of care that cannot be determined to be justified without additional review. Examples of potential quality issues include:
  - Falls with injury/additional treatment required
  - Medication errors with injury/additional treatment required
  - Incident resulting in Death
  - Incident resulting in severe Brain or spinal damage to a patient

- All PQIs should be reported within three calendar days of the incident using the PQI form.
- Email completed form via secure email to pqireferral@allyalign.com or submit via the Provider Portal.
- The PQI will be reviewed to determine if there should be a change in procedure to prevent further incidences.

Member Risk Prevention – A&G

Appeal

An appeal is **the right to ask the Plan to change their decision**. An appeal only occurs if the Plan makes a decision to deny in whole or in part a service or claim. Member/Member Representatives and providers can file an appeal within the allowed CMS timeframe which is 60 days from date of denial.

- Members/member representative/providers reporting an appeal, should send a secure email with complete appeal details to: appeals@allyalign.com OR fax 1-833-610-2380.

Grievance

A grievance is **any complaint or dispute** (other than an organization determination) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. Grievances can be filed within 60 days of occurrence.

- In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.
- Members/member representative reporting a grievance, should send a secure email with complete grievance details to: grievances@allyalign.com OR fax 1-833-610-2380.

We are here to support you!

Training Department:

clinicaltraining@allyalign.com