Our commitment to 5-Star remarkable service.

MOC Training
2021

Together, We Can
Be Remarkable
The mission of ArchCare, the Continuing Care Community of the Archdiocese of New York, is to foster and provide faith-based holistic care to frail and vulnerable people unable to fully care for themselves. Through shared commitments, ArchCare seeks to improve the quality of the lives of those individuals and their families.
Training Objective:
Educate all providers, delegated vendors, and appropriate staff on the ArchCare Special Needs Plan (SNP) Model of Care, the goal of which is to enhance member health outcomes through the use of an integrated care delivery system.

- SNP Background
- ArchCare SNP Model of Care
- How Does MOC Work?
- Care Coordination
- Quality Measurement and Performance Improvement
- Role and Responsibilities of Providers
SNP Background

What is a Special Needs Plan?
Congress created Special Needs Plans (SNP) in the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries.

What is Model of Care?
Model of Care (MOC) is the basic framework under which the SNP will identify and meet the needs of each of its enrollees.

The MOC requirements comprise the following clinical and nonclinical standards:

• Description of the SNP Population

• Care Coordination

• SNP Provider Network

• MOC Quality Measurement & Performance Improvement

SNP CLASSIFICATIONS

Chronic SNP (C-SNP) - for individuals with severe or chronic conditions

Institutional SNP (I-SNP) - for individuals who are institutionalized or eligible for nursing home care

Dual Eligible SNP (D-SNP) - for dual-eligible individuals
The ArchCare Model of Care strives to meet the specialized needs of its members and to optimize their health outcomes by using evidence-based practices with an appropriate network of providers and specialists.
ArchCare’s Model of Care promotes quality care management and optimal health outcomes for members through facilitation of access to needed resources and care coordination, including:

• Coordinating care through a central point of contact—the member’s PCP, in collaboration with a ArchCare Care Manager or Care Management Team

• Monitoring transitions through the timely coordination of care plans to ensure vulnerable SNP populations do not receive fragmented care

• Providing preventive health, medical, mental health, social services, and added-value services
ArchCare conducts Care Coordination to meet the targeted needs of our members by utilizing the following strategies:

- Conducting a Health Risk Assessment (HRA) of the individual’s physical, psychosocial, and functional needs, using a tool approved by CMS and other appropriate regulatory agencies

- Developing a member’s Individualized Care Plan (ICP) using the results of the HRA and the member’s input

- Each member has an Interdisciplinary Care Team (ICT) that manages the member’s care and meets regularly to manage the medical, cognitive, psychosocial, and functional needs of the member
Special Needs Plan Mode of Care Goals

- Improving access and affordability to medical, mental health, and social services
- Improving coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP and ICT
- Provide seamless transitions of care across all health care settings and providers
- Improve use of preventative health services
- Encourage appropriate utilization of services
- Improve member health outcomes
SNPs strive to continuously improve their performance.

ArchCare monitors the effectiveness of the Model of Care through ongoing evaluation of member health outcomes. The information is reported at the bimonthly meeting of the Model of Care Committee, which reports to the Quality Improvement Committee.

Evaluation of the Model of Care Committee includes collecting, analyzing, and reporting unique data related to each of ArchCare’s Special Needs Plans.

Model of Care metrics include:
- Access to care
- Improvement in member health status through specific metrics such as HEDIS, PCP Visits, Admission & Emergency Room utilization
- Completion of comprehensive Health Risk Assessment
- Implementation of an Individualized Care Plan (ICP) for SNP beneficiaries
Providers are integral in the execution of and compliance with the Model of Care elements

- Communicating with ArchCare Case Managers, members of the ICT, caregivers, and enrollees
- Participating in the ICT
- Collaborating with ArchCare to develop the ICP
- Maintaining the ICP in the member’s record
- Empowering the member to continue the treatment established in the ICP
- Updating the ICP as the member’s health status changes
- Submitting documentation in a timely manner
- Communicating the member’s plan of care before and after the member transitions from one care setting to another
- Utilizing the ArchCare evidence-based Clinical Practice Guidelines and Protocols, which are the foundation of the Care Management Program
What does this mean for providers?

It is important for SNP providers to understand:

The ArchCare Model of Care and its goal to enhance the medical and social health outcomes of our members.

Providers support the integrated care delivery system through:

- Active involvement with the ICT
- Collaboration with the ArchCare case management staff to:
  - maintain and update the member’s ICP
  - ensure cost-effective, appropriate care
SNP MOC Resources

What resources are available to help you participate with the SNP MOC?

Clinical Practice Guidelines via the ArchCare website’s Healthy Living section [www.ArchCare.org/live-healthy](http://www.ArchCare.org/live-healthy)


• Contact ArchCare Provider Services

1-800-373-3177

Monday to Friday, 9am–5pm
Thank you.

We value your partnership in delivering quality healthcare to our members.

Your participation is appreciated, and we look forward to working with you.

Please submit completion attestation online: https://www.archcare.org/forms/archcare-advantage-model-care-training
Course Attestation

In order to acknowledge your completion of this course, you must review the acknowledgement statement below and sign and date, attesting you have completed review of all text included in this course.

I have completed the Annual SNP Model of Care Training by reviewing all information in the training document.

_________________________________________  _________________________________
Date                                           Tax Identification Number

_________________________________________
Print Name of Practice or Company

_________________________________________
Signature