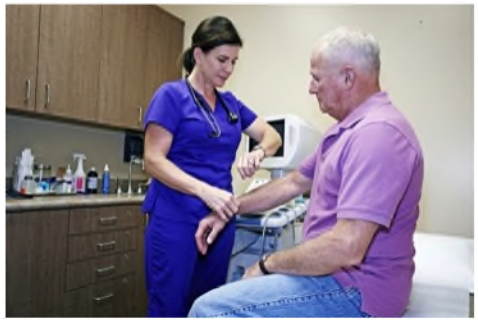
ArchCare Advantage

Model of Care Training for Special Needs Plans Care Providers



Agenda

Overview

Care Provider’s Role in Model of Care (MOC) Training

Identifying Special Needs Plan (SNP) Care Providers

SNP Background

What is a Model of Care?

Model of Care Design

- SNP Descriptions
- Care Coordination
- Accessing the Member’s Individualized Care Plan (ICP)
- SNP Provider Network
- Quality Measurement and Performance

Attestation of Training

Contract Information

Overview

The Centers for Medicare & Medicaid Services (CMS) requires all care providers who treat patients in Special Needs Plans (SNPs) to complete annual Model of Care (MOC) training.

SNPs are a type of Medicare Advantage plan that:

- Operate under a MOC structure and
- Ensures the unique health care needs of each SNP member are identified, met and measured

MOC training:

- Defines the SNP MOC and CMS' requirements
- Explains how you can support the SNP MOC

Care Providers’ Role in MOC Training

- You’re required to complete the initial and annual CMS-required MOC training.
- The training is available to clinical and non-clinical staff.
- You may share the training information with remaining personnel who can’t complete it online.

Exceptions

- None

Identifying SNP Care Providers

- ArchCare Advantage SNP care providers are identified through member claims history and network panels.

- If you see ArchCare Advantage members who have coverage through Medicaid, Medicare or both, you are likely a SNP care provider.

- Even if you just treat one member, you’re considered a SNP care provider.

SNP Background

A SNP is a type of Medicare Advantage plan such as:

- Preferred provider organization, or
- Health maintenance organization
- SNPs provide targeted care to members with special needs with targeted care, including improved coordination and continuity of care.

Members in a SNP may also have:

- Functional cognitive limitations
- Financial challenges
- Reside in a geographic area with limited resources

What is a Model of Care?

A Model of Care is a comprehensive document required by CMS that describes:

- Services provided to members enrolled in the SNP
- Framework to support the SNP to meet the needs of each enrolled member
- Foundation for promoting SNP quality, care management, and care coordination

Model of Care Design

There are four elements of the MOC design:

1. Description of the SNP population, which includes:

- Geographical and demographic information
- Services provided to the most vulnerable members within the SNP population

2. Care coordination includes:

- Staff involved in the SNP
- Administering the member's Health Risk Assessment Tool (HRAT)
- Creating and updating the member's Individualized Care Plan (ICP), and makeup of the Interdisciplinary Care Team (ICT)
- Care transition protocols required for SNPs

Model of Care Design (cont'd)

3. SNP Provider Network includes:

- Specialized expertise of the SNP providers
- Clinical practice guidelines and care transitions protocols MOC training for care providers

4. Quality Measurement and Performance Improvement includes:

- MOC quality performance improvement plan
- Measurable goals and health outcomes indicators Measuring SNP member satisfaction
- Ongoing performance improvement evaluation of the MOC
- Availability of SNP quality performance measures

SNP Description

Each Medicare Advantage SNP limits its membership to individuals in one of the following groups or subsets of them:

Chronic SNPs

- Individuals with one or more identified chronic conditions, such as cardiovascular disease, diabetes, heart failure, or chronic lung diseases

Dual Eligible and Fully Integrated Dual Eligible (FIDE) SNPs

- Individuals who are entitled to both Medicare and Medicaid assistance from a state plan
- A FIDE is a special type of DSNP for high-risk Medicare-enrolled members
- Dual Eligible and FIDE SNPs offer enhanced benefits by combining Medicare and Medicaid benefits.

SNPs Description (cont'd)

Institutional SNPs

Restricted to Medicare Advantage (MA)-eligible individuals who, for 90 days or longer, require services provided in on of the following:

- A long-term care (LTC) skilled nursing

  facility A LTC nursing facility
- An intermediate care facility for the

  intellectually disabled, inpatient

  psychiatric facility

Institutional Equivalent SNPs

Enroll MA eligible individuals living in the community, but require an institutional level of care, including residents of Assisted Living Facilities and other congregate settings.

SNPs Description (cont'd)

Institutional/Institutional Equivalent SNPs

- Individuals residing in a nursing homes or equivalent setting, such as an assisted living facility, for 90 days or longer

Medicare-Medicaid Plans

- Individuals enrolled in Medicare (Part A and/or Part B) and Medicaid managed under one health insurance plan

SNPs Description (cont'd)

Chronic SNPs

- Restrict enrollment to special needs individuals with specific severe or disabling chronic conditions
- Examples include diabetes, chronic heart failure, cardiovascular disease or chronic lung diseases

CSNPs help members:

- Monitor their health status
- Help them manage their chronic diseases
- Avoid inappropriate hospitalization
- Move from high risk to lower risk on the care continuum

CMS has approved 15 SNP-specific chronic conditions for enrollment; however, ArchCare Advantage doesn't currently offer plans for all of them.

SNPs Description (cont'd)

15 CMS-approved Chronic Condition SNPs

- Alcohol and drug dependence
- Autoimmune disorders
- Cancer (excluding pre-cancer conditions)
- Cardiovascular disorders*
- Chronic and disabling mental health conditions
- Chronic heart failure* Chronic lung disorders Dementia
- Diabetes mellitus*
- End-stage liver disease
- End-stage renal disease requiring any mode of dialysis
- HIV/AIDS
- Neurological disorders
- Severe hematological disorders Stroke

Care Coordination – Use the HRAT

Critical incidents affect care providers who have personal contact with Medicaid members receiving HCBS waiver and habilitation services.

The SNP must conduct an initial assessment of the member within 90 days of enrollment and a reassessment within a year for health status change or a care transition such as:

- Hospitalization
- Fall
- Change in medication

The quality and content of the HRAT is used to identify the following needs of each member:

- Medical
- Functional
- Cognitive
- Psychosocial
- Mental health

Care Coordination – Using the ICP

The HRAT results are used to create the member's Individualized Care Plan or ICP. Each MOC details:

- How the member and caregivers are involved in the ICP development
- The frequency that the ICP is reviewed by the member's care team
- Updating the ICP as the member's healthcare needs change

Additional MOC Requirements

- Members in SNPs are encouraged to share their ICP with their Primary Care Provider (PCP)
- CMS requires each health plan to send a copy of the ICP to the member's PCP via fax, mail, email, or the provider website.

You can use the HRAT information to assist you with managing/improving the beneficiary's health status.

Care Coordination – ICT

The Interdisciplinary Care Team (**ICT**) provides comprehensive care coordination and services to the member. The ICT typically includes but isn't limited to:

- Member
- Archcare Nurse Practitioners and other affiliated Nurse Practitioners provide monthly routine visits as well as acute visits to members in the community during episodes of care transitions
- Primary care physician
- Family members
- Caregivers, other treating physicians, nurses, behavioral health clinicians, pharmacies
- Social workers

As this is an interdisciplinary approach to providing care to our members, please Call your NP/Care Manager with any questions or concerns to discuss the needs of the members.

Care Coordination – ICT cont'd

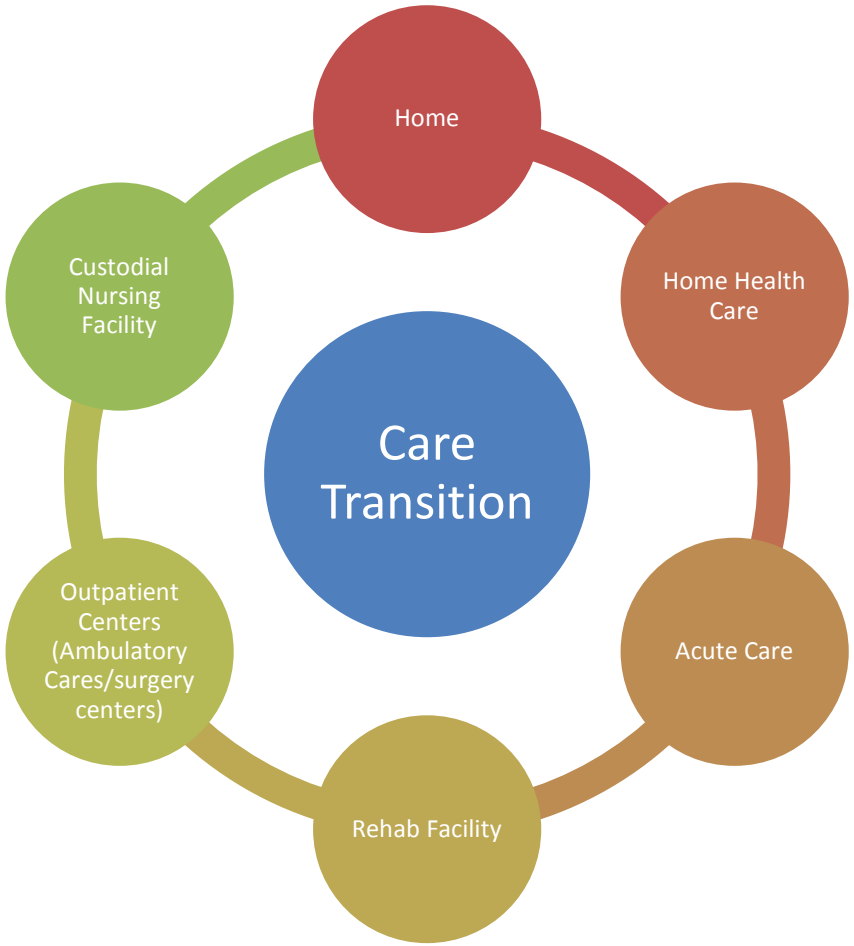
The MOC describes:

- Roles/responsibilities of the team
- How the expertise and capabilities of ICT support the identified clinical and social needs of SNP member
- How the ICT contributes to improving the health status of SNP member

As part of the ICT, your input and recommendations are vital to the member's continuity of care.

Care Coordination Care Transitions

Seven Care Transition Settings



Care Coordination – Care Transitions

When a SNP member has a care transition, ArchCare Advantage Transitional Case Management may:

- Provide a post hospital and transition management assessment and support for up to 30 days post discharge
- Develop interventions to meet the member's transition needs, including medication reconciliation
- Review and update the ICP with the member
- Call the member to reinforce the value and importance visiting their PCP within seven days of discharge

You also may receive discharge updates from ArchCare Advantage regarding
SNP members you've treated..

SNP Provider Network

The MOC includes details about:

- Specialized care provider expertise available to SNP beneficiaries
- Documentation that clinical practice guidelines and nationally-recognized protocols are used and followed

Care providers who treat members in SNPs don’t require special credentialing; however, we ask that you follow the credentialing and re-credentialing requirements of ArchCare Advantage.

Quality Measurement and Performance

The MOC includes details about the specific survey tools we use to measure:

- The MOC’s specific goals and how they meet the needs of SNP each member
- SNP member satisfaction
- Quality to continually evaluate and improve the SNP
- Routine SNP quality performance results

Quality Measurement and Performance cont’d

Some of the core MOC measurable goals include, but are not limited to:

Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population

- Improvements made in coordination care and appropriate delivery of services through the direct alignment of the HRAT, ICP and ICT;
- Enhanced care transitions across all health care settings and care providers for SNP members; and
- Ensuring appropriate use of services for preventive health and chronic conditions.

Attestation of Training

You have completed the Special Needs Plans Model of Care Provider Training.

The training fulfills the CMS MOC requirement.

Additional SNP and MOC Online Resources:

For SNPs:

- CMS website: **cms.gov**. Search Special Needs Plans

For MOCs:

- NCQA website: **ncqa.org**. Search Model of Care

Please note that you will not receive a certificate or confirmation of completion.

Contact Information

MOC Training Questions?

For SNPs:

Call the MOC Training Team at **800-373-3177** or

Email us at **vfama@archcare.org**

- **Thank You**

Annual SNP Model of 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

_____ _____

Name (please print) Practice or Company Name National Provider Identifier

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