Model of Care Training: 2022 Employee and Provider Training

Tania Barriere-Perez, LCSW

VP, Clinical Operations

MMM
Medicare and Much More

Objectives

Special Needs Plans and Model of Care Background

Products & Model of Care (MOC)

- MMM of Florida, Inc. (MMM) Special Needs Plan (SNP)

Basic Components of the Model of Care

- MOC 1: Description of SNP Population
- MOC 2: Care Coordination
- MOC 3: SNP Provider Network
- MOC 4: Quality Measurement and Performance Improvement

Essential Role of Providers in the Implementation of the Model of Care

Model of Care Training

- Developed to meet the Centers for Medicare & Medicaid Services (CMS) guidelines.

- **MMM of Florida, Inc. (MMM) must conduct and document training on the SNP Model of Care for all employed and contracted personnel and providers:**

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

Background Coordinated Care

Model of Care Training

The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage (MA) Coordinated Care Plan (CCP) that was specifically designed to provide targeted care to individuals with special needs.

In the MMA, Congress identified “special needs individuals” as:

Dual eligible (D-SNP)

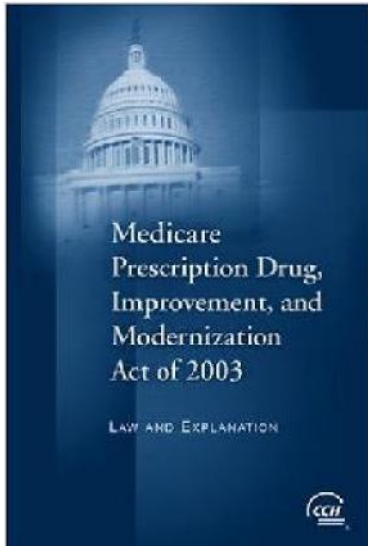
- Members eligible for Medicare + Medicaid

Chronic conditions (C-SNP)

- Members with severe or chronic conditions

Institutionalized (I-SNP)

- Living in an institution for 90 days or longer (like an elderly home or a long-term care skilled nursing facility) OR
- Are living in the community but require an institutional level of care (LOC), a level of attention that equals to the one received in an institution



MMM
Medicare and Much More

Dual Eligible Special Needs Plan (D-SNP)

- MMM operates as a Medicare Advantage Plan in Miami-Dade, Broward and Palm Beach Counties.
- MMM offers a dual eligible Special Needs Plan (D-SNP) called ***MMM Platinum and MMM More***.
- D-SNP members qualify for Medicare because they are either aged and/or disabled (title XVIII).
- D-SNP members are also eligible for medical assistance from a state plan under Medicaid (title XIX).
- MMM's D-SNP member must reside within the Plan's services areas.

MMM
Medicare and Much More

What is Model of Care (MOC)?

- MOC provides the structure for the implementation of processes and systems that allow the plan to give coordinated care to members with special needs.

- The MOC is considered a vital quality improvement tool and integral component for ensuring that the unique needs of each member enrolled in a Special Needs Plan (SNP) are identified and addressed.

MOC Elements

The MOC is comprised of the following clinical and non-clinical elements:

Description of the SNP Population

Coordinated Care

- Mandated Health Risk Assessment and Annual Re-assessment
- Individualized Care Plan (ICP)
- Interdisciplinary Care Team (ICT)

Provider Network

Quality Measures and Improvements in Performance

MOC 1: Description of the SNP Population

SNP Population

- MMM focuses on the unique characteristics of its target population (Dual SNP).
- Evaluates:
  - Social, environmental and cognitive factors
  - Medical and health conditions
  - Most vulnerable members
- Establishes specific programs and benefits for these members.

Most Vulnerable Sub-Population

- MMM identifies the population at risk in order to coordinate care based on unique needs. When members become eligible for a D-SNP, it means that they fall on the lower end of the economic scale as well as being either disabled and/or elderly and often medically fragile.

Characteristics of D-SNP members in Miami-Dade, Broward and Palm Beach	
Average age 65-70	Equal chance of English vs Spanish Speaking
Slightly higher prevalence of being a female vs male	Low socioeconomic status living at or be poverty level
Probability of having one or more chronic condition and high probability of having heart disease	High probability of not receiving appropriate medical care nor accessing medical services
High probability of living in a community setting	Low probability of having a chemical health concern
Potential for physical and emotional problems affecting social activities	Multiple prescriptions due to complexity of health needs
Probability of having caregiver support	High probability of needing transportation services
High probability of low health literacy	Lack of affordability of healthy food

Most Vulnerable Sub-Population (cont.)

- Due to the characteristics of D-SNP members, these members:
  - Have frequent ER visits
  - Use the ER as their primary care
  - Have multiple admissions
  - Require complex procedures and transition of care services (organ transplant, bariatric surgery)
  - Have gaps in care
  - Have polypharmacy issues

MOC 2: Care Coordination

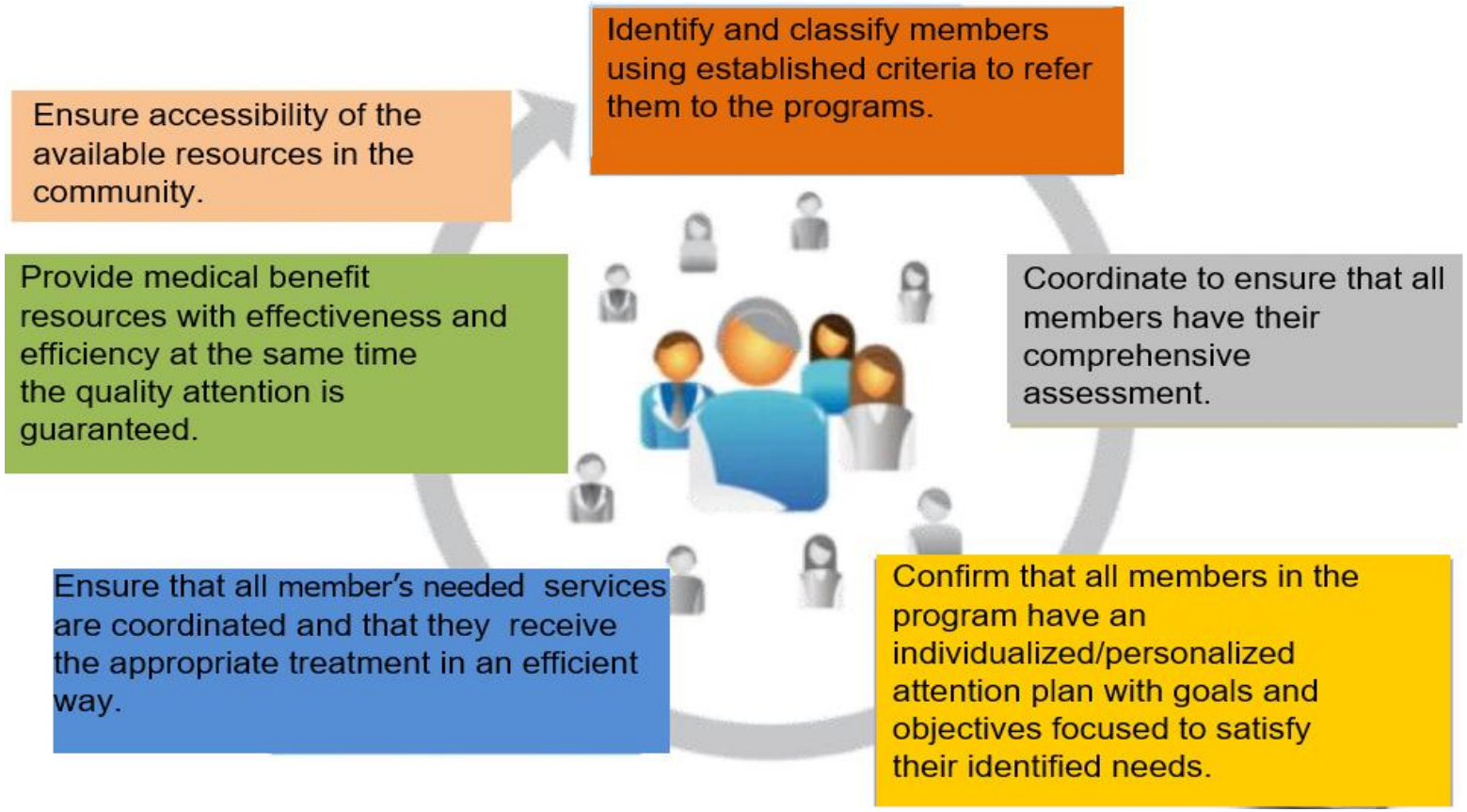
MMM
Medicare and Much More

Coordinated Care

MMM:

- ✓Ensures the health needs of beneficiaries of SNP and the information is shared among the interdisciplinary staff.
- ✓Coordinates the delivery of services and specialized benefits that meets the needs of the most vulnerable population.
- ✓Performs health risk assessments, Individualized Care Plan and has an established Interdisciplinary Team.

Care Management Program Focus



MMM
Medicare and Much More

Health Risk Assessment (HRA)

- The HRA assesses information about the members medical, psychosocial, cognitive, and functional needs of special needs individuals.
- Every SNP member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually.
- Is performed by telephone and may be performed face-to-face or paper-based.
- Results classify member in various risk categories. This way the automated referrals to the Care Management programs are generated.
- Results are communicated to members, interdisciplinary care team, and the primary physician.

MMM
Medicare and Much More

Individualized Care Plan (ICP)

- Once the unique needs of the member have been identified, an individualized care plan (ICP) is developed with input from the interdisciplinary team.
- The ICP ensures that the member's needs and preferences are addressed.
- ICPs are reviewed and updated with each successful member contact according to the level of intervention needed as appropriate however, it is updated/revised at least annually or when the member's health status changes through ongoing member evaluation and coordination of services and benefits.
- The ICP is provided to and reviewed with the member or caregiver and updates can be viewed real-time and shared with providers through our InnovaMD portal.

Interdisciplinary Care Team (ICT)

What is the Interdisciplinary Care Team (ICT)?

An ICT is a member centered group that identifies care interventions, provides expertise, and coordinates the delivery of services and benefits.

Providers' Responsibilities in the ICT:

- Participate in the ICP discussion
- Collaborate in goal setting
- Engage members in self-management and provide follow-up
- Integrate other physicians and providers into the member's health care management
- Participate in ICT meetings when requested
- Communicate changes to the ICT members through ICT meetings or telephone calls.

Interdisciplinary Care Team

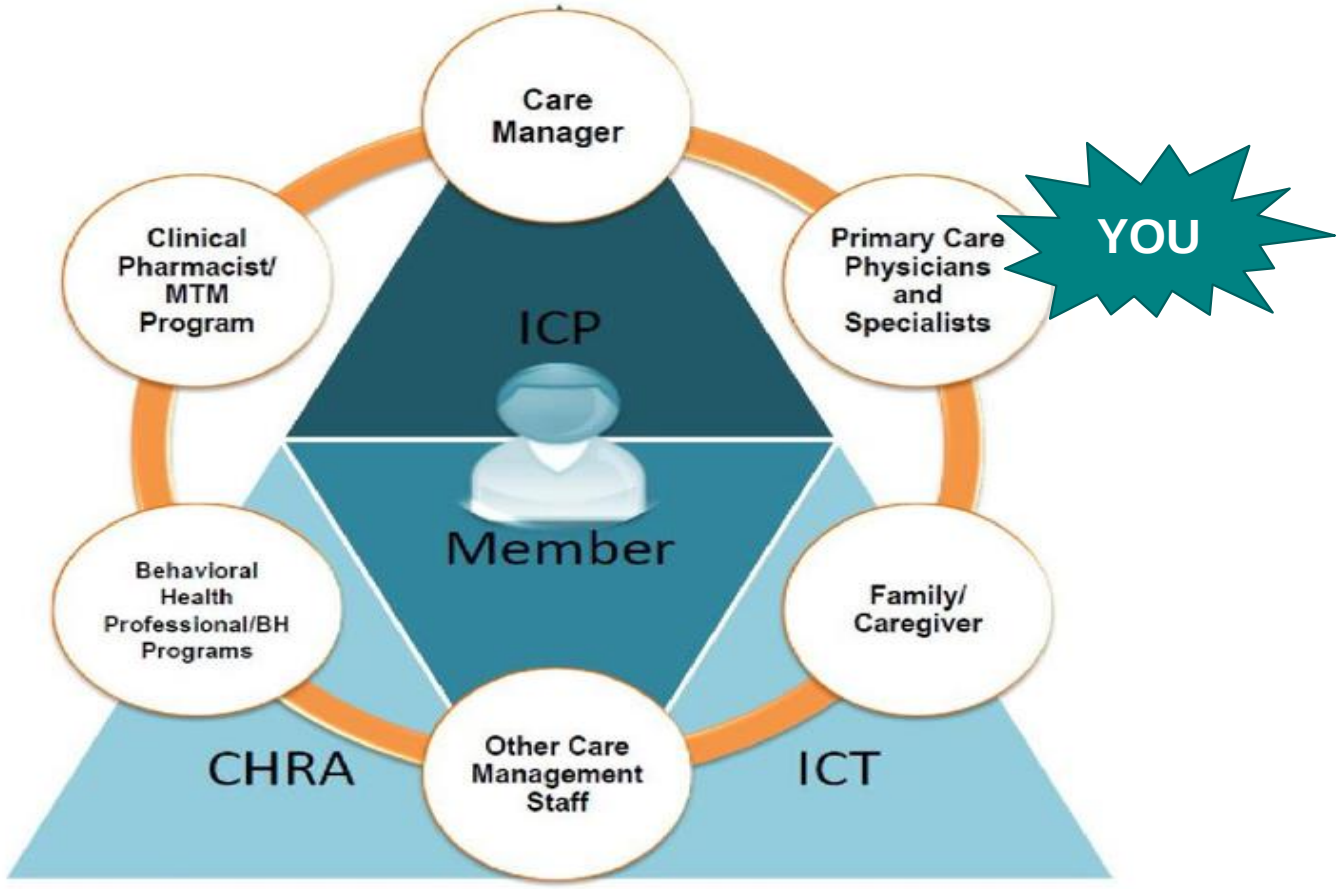
Care Transition

- Established process and protocols to maintain continuity of member's care.
- The different units work in collaboration with the primary physicians and providers to guarantee and support the necessary coordinated care.
- The Discharge Planning Unit (DPU) staff facilitates, communicates and coordinates the necessary services for the continuity of the member's care and shares information with the primary physician.

Providers Role in Care Transition

- Re-asses the member as soon as possible after an inpatient discharge.
- Work with the Plan's Clinical Care Manager to facilitate delivery of newly identified needed services or to ensure continuation of services post discharge.

Protocols for Care Transition



MMM
Medicare and Much More

Provider's Role in our MOC

- Provide a face-for-face encounter (either in-person or through a visual, real-time, interactive telehealth encounter) on at least an annual basis, beginning within the first 12 month of enrollment with the Plan.
- Re-assess members to identify health status changes.
- Coordinate specialized services that meet the needs of the most vulnerable population.
- Ensure that the health needs of the members and the necessary information are documented in the member's record and shared with the interdisciplinary team which includes Plan staff.
- Promote the variety of Health Risk Assessment in order to develop the member Individualized Care Plan.
- Actively participate in the Interdisciplinary Care Team.
- Support MMM's Quality Initiatives

MMM
Medicare and Much More

MOC 3: SNP Provider Network

Provider Network

- MMM is responsible for maintaining an adequate network of providers to meet the needs of our members as the primary link in their care.

- The Provider Network:
  - Monitors the use of clinical practice guidelines and protocols by practitioners.
  - Ensures collaboration and active communication with the Interdisciplinary Care Team (ICT).
  - Assures that network providers are licensed and competent through a formal credentialing and re-credentialing process.
  - Provides and tracks that all network providers and out-of-network providers seen by members on a routine basis receive the required MOC training.

MOC 4: Quality Measurement and Performance Improvement

Quality Measurement and Performance Improvement

- MMM has a Quality Performance Improvement Plan designed to detect whether the overall MOC structure effectively accommodates members' unique healthcare needs.
- The MOC goals include:
  - Improving access and availability of services for our D-SNP population;
  - Improving coordination of care across specialty and multi-setting care continuum through a central point of contact through the direct alignment of the Health Risk Assessment (HRA), Individual Care Plan (ICP), and Interdisciplinary Care Team (ICT) structure;
  - A seamless transition of care across settings, health care providers, and services;
  - Maintaining appropriate utilization of health services for preventive health and chronic conditions;
  - Improving health outcomes through the reduction of hospitalizations, emergency room use, readmissions, improved member health/functional status, and overall quality of life;
  - Maintaining an open communication with departments, delegates, vendors and provider network to collaboratively promote and ensure continuous quality improvement and compliance with regulatory and accreditation standards.

Quality Measurement and Performance Improvement (cont.)

- MMM's Quality Improvement Program will use the following process to evaluate the effectiveness of the D-SNP Model of Care:
  - Analysis of member population
  - Annual Surveys – Consumer Assessment of Health Plan Study (CAHPS) survey, SNP Member Satisfaction Survey, Health Outcome survey (HOS)
  - Focus Studies
  - Quality Performance Indicators
  - Quantitative Analysis
  - Barrier and Root Cause Analysis


MMM
Medicare and Much More