# *Annual Medicare Model of Care Training*

## *Health Choice Generations*

# Introduction

- The Medicare Act of 2003 established a Medicare Advantage coordinated care plan that is designed to provide targeted care to individuals with special needs.
- The Centers for Medicare and Medicaid (CMS) require all Health Choice staff and contracted medical providers to receive basic training about the D-SNP Model of Care (MOC).
- The Health Choice Model of Care (MOC) includes an overview of our general approach to care coordination, describes the guiding principles we apply to drive improved outcomes for the members that we serve.
- Case Management in conjunction with Quality Management review the MOC annually.

# Goals of the Special Needs Plan

- Health Choice Generations HMO Special Needs plan is a URAC accredited Dual Eligible Special Needs Plan (D-SNP). The MOC is designed to ensure the provision and coordination of specialized services that meet the needs of the dual eligible beneficiaries by:
- Improving member Health Outcomes
- Improving Seamless Transitions of Care Across Healthcare Settings, Providers, and Health Services
- Improving Access to Preventive Health Services
- Assuring Appropriate Utilization of Services

# MOC Elements

- There are 4 elements to the MOC of which each contain multiple sub-elements.
- The 4 elements are:
    1. Description of the SNP Population;
    2. Care Coordination;
    3. SNP Provider Network; and
    4. Quality Measurement and Performance Improvement.

# Element 1 – SNP Population

- As a dual eligible plan, the MOC includes both Medicare and Medicaid characteristics of the population.
- The identification and description of the SNP specific population is an integral foundation on which the other elements are built. This description includes:
  - Detailed profile of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with our members.
  - Identification and description of health conditions including the unique health needs for our members.
  - Identification of barriers that may pose potential challenges for those members such as language barriers, health literacy and cultural beliefs.

# Vulnerable Sub-Populations

- Using claims data to identify health conditions, in our D-SNP population we see the following:
- 62% of members have been diagnosed with Hypertension (HTN)
- 13% have Chronic Obstructive Pulmonary Disease (COPD)
- 10% have an asthma diagnosis
- 12% have a diagnosis  of major depression diagnosis and 5.5% have a schizophrenia diagnosis
- 5% of the population suffers from drug and/or alcohol dependence

- Health Choice Generations has programs specifically tailored for vulnerable beneficiaries.  Currently in place are disease management programs such as diabetes, heart disease, asthma, hepatitis C, and HIV programs.  Still, the overall characteristics of these beneficiaries make them particularly vulnerable, requiring both specialty disease management programs and collaboration with behavioral health and community resources.

# Element 2 – Care Coordination

- Care coordination helps ensure that our members healthcare needs are met over time using high quality services that ultimately lead to improved health outcomes.
- This care coordination element contains 5 sub-elements:
    - Staff Structure
    - Health Risk Assessment Tool (HRA)
    - Individualized Care Plan (ICP)
    - Interdisciplinary Care Team (ICT)
    - Care Transition Protocols

# Health Risk Assessment (HRA)

- As a sub-element, the MOC describes the process for conducting the HRA which may be completed by phone or by written survey.
- The plan is required to conduct a HRA on each new member within 90 days of their enrollment and conduct a reassessment at a minimum of annually, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the members' medical, psychosocial, cognitive, and functional needs, and medical and behavioral health history.
- Members are then evaluated for their health risk level and referred to a case management program when appropriate.
- Providers may request a copy of the completed HRA by emailing the request to HCA_CaseManagement@iasishealthcare.com

# Individualized Care Plan (ICP)

- Another a sub-element of the MOC describes the process for developing an Individualized Care Plan based on information received from the HRA.
- The ICP is a summary of the needs and service options identified in the assessment process.
- The ICP is developed to identify the member's health care goals and objectives, as well as the activities and services the member agrees to pursue in order to attain optimal health outcomes.
- ICPs are developed by the member, their assigned case manager and the member's preference on who will participate in the development of the ICP.
- The ICP is tailored to meet the member's needs and preferences.
- The ICP is communicated with all members of the care team.
- ICPs are revised annually, or when the member has a health status change

# Interdisciplinary Care Team (ICT)

- Health Choice Case Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) which includes appropriately involved Health Choice staff, the member and their family/caregiver, external practitioners and vendors involved in the member's care based on the member's preference of who they wish to attend

- The Interdisciplinary Care Team (ICT) offers member-centric delivery of care that focuses on the needs of the member by encouraging and incorporating the member's active participation which includes personal preferences and feedback into the creation of an individualized care plan.

- All members of the ICT, which includes the member, receive a copy of the ICP to ensure everyone is following the same plan for continuity of care purposes.

# Element 3 – Provider Network

- As a SNP plan, Health Choice is responsible for ensuring the MOC identifies, describes, and implements an extensive network of qualified healthcare providers with demonstrated clinical expertise to meet the needs of our target populations' specialized needs and who do not discriminate against our most vulnerable beneficiaries.
- Health Choice's network is comprised of over 2,000 primary care providers and more than 10,000 specialists.
- Health Choice providers are trained and capable of meeting the special needs of patients with AIDS, Hepatitis C, Diabetes and a variety of other chronic/complex diseases difficult to effectively treat in rural and/or underserved Arizona.

# Element 4 – Performance and Health Outcome Measurement

- The goal of performance improvement and outcome measurement as it relates to the MOC is to improve the plan's ability to deliver healthcare services and benefits to its members in a high quality manner.
- The Health Choice Quality Committee meets monthly to review the performance of our population.
- Through this analysis, goals are developed and targeted strategies are deployed. Once deployed, metrics are monitored monthly to determine the effectiveness. If no positive change is seen, the Committee evaluates the need to redefine actions.
- Health Choice utilizes the Plan, Do, Study, Act (PDSA) for all quality improvement initiatives.

# Element 4 Continued

- Through analysis, Health Choice has established priorities for clinical and case management through a series of sources including the QIP, Star Metrics, CCIP, and internal Quality Improvement Programs:

- Care for Older Adult Focus: Pain Screening, Functional Status Assessment, and Medication Review
- Member Satisfaction
- Use of High Risk Medications
- Early detection of chronic diagnoses
- Reducing hospital readmissions
- Medication Adherence
- Appropriate timely and proactive medical services

# Member Satisfaction

- Health Choice acknowledges that our members face complexities in navigating the Medicare and Medicaid systems, so our teams strive to provide the best service to enhance the member experience.

- Health Choice focuses on member satisfaction from an internal and external perspective. Specifically, Health Choice analyzes our annual CAHPS survey results and identifies areas of improvement.

# Model of Care Audit

- CMS has created a separate audit specific to the Model of Care and the processes described in the document.
- The CMS review includes but is not limited to:
  - Completion and timeliness of the initial and annual HRAs;
  - Completion and communication of an ICP for each member;
  - Whether or not the ICP was managed by the Care Team;
  - Evidence of care and case management documentation for the ICP;
  - Evidence of provider and employee training;
  - Evidence of whether or not the plan collected, analyzed, and evaluated the MOC;
  - Review of the analyzed results used to improve the MOC;
  - Evidence of a corrective action implemented based on the evaluation; and
  - Evidence of a Final/Annual MOC report submitted to the Board

Thank you for participating in the MOC training.

The NCQA approved Model of Care may be found on the Intranet under the Medicare Compliance Department page, in the Documents section.