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# MODEL OF CARE

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# Objectives

- Medicare/Medicare Advantage 101
- Outline the basic concepts of Special Needs Plans
- Identify the requirements for success
- Describe the purpose and key components of the Model of Care
  - Health Risk Assessments (HRA)
  - Individualized Plan of Care (IPOC)
  - Interdisciplinary Care Team (ICT) Meetings
  - Care Transition Protocols
- Plan communications

# Medicare/Medicare Advantage 101

## Medicare

- A federal system of health insurance for people over 65 years of age and for qualifying individuals younger than 65 years of age with disabilities
- **Part A (Hospital Insurance)**
  - Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
- **Part B (Medical Insurance)**
  - Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.
- **Part D (Prescription Drugs)**

## Medicare Advantage

- **Part C (Medicare Advantage)**
  - “All in one” alternative to Original Medicare. These “bundled” plans include Part A, Part B, and usually Part D.
- **Health Plan Options**
  - Approved by Medicare
  - Run by Private Companies
  - Available across the United States
- **Enrolled Members Receive Services Through the Plan**
  - All Part A and Part B Covered Services (A+B=C)
  - Some plans may provide additional benefits
- **Includes Prescription Drug Coverage (Part D)**
  - This is known as an MA-PD plan
- **Members are still in the Medicare Program**
  - Medicare pays the plan every month for the Member's care
  - Members have Medicare rights and protections

# Special Needs Plan



A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals.

A graphic consisting of two overlapping rounded squares. The background square is a solid light green. The foreground square is white with a thin green border. Inside the white square, the text "I-SNP" is written in bold black, followed by "(Institutional Special Needs Plan)" in a regular black font.

**I-SNP**  
(Institutional  
Special  
Needs Plan)

# Institutional Special Needs Plan (I-SNP)



## Who can join an I-SNP?

- Enrolled in Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Lives in Plan service area (facility)
- Must reside (OR is expected to reside) in a participating I-SNP nursing facility for greater than 90 days at time of enrollment

# What Creates Success?

- **Membership**
- **Medical Management**
  - Focus on Prevention:
    - *Routine Visits*
    - *Care Protocols*
    - *Skill in Place (for applicable Plans)*
  - Goals to Avoid:
    - *Avoidable Hospitalizations*
    - *ER Visits*
    - *SNF (post-acute part A services)*
    - *Unnecessary Specialist Visits*
  - *As the Payer (instead of Traditional FFS Medicare), the Plan can pay for the visits, activities, and work that directly contributes to better care.*
- **Quality**





# Model of Care Overview



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- ✓ Scored by National Committee for Quality Assurance (NCQA)
    - Score determines 1, 2, or 3-year approval timeline
  - ✓ Must be monitored, process documented, and changes updated
  - ✓ Must be approved by CMS

# What is the Model of Care?



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

Centers for Medicare and Medicaid Services (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
  - Health Risk Assessment Tool (HRAT)
  - The Individualized Plan of Care (IPOC)
  - The Interdisciplinary Care Team (ICT)
  - Care Transition Protocol
- **MOC 3:** Provider Network
- **MOC 4:** Quality Measurement and Performance Improvement



# A New Way of Delivering Care

- Uses Medicare Advantage Institutional Special Needs Plan platform to **modernize** Medicare benefits and their delivery.
- Employs Physician/Nurse Practitioner model that has been proven to deliver **improved clinical outcomes**.
- Transformational in nature and allowing care and services delivered to the most vulnerable to be optimized
- Prepares nursing facilities to **successfully manage** under other alternative payment models such as Accountable Care Organizations (ACOs) and Bundled Payments.
- Allows for significant **reinvestment** into facilities and staff.
- **Protects facilities** against outside managed care plan penetration as States move toward Managed Long-Term Services and Supports (MLTSS).



# MOC 1: Description of the SNP Population



Medicare beneficiary

Frail /vulnerable

More likely to be female

Typically 65 years and older

Typically widowed or single

Often unable to make care decisions and participate in their own care

May be confined to a bed or wheelchair

Has multiple co-morbid chronic conditions (e.g. high blood pressure, heart disease, depression, diabetes, COPD)

Likely prescribed one or more high-risk medications per month

May need help with 5 or more activities of daily living (ADLs) including bed, mobility, dressing, eating and toileting (depending on senior housing location)

High likelihood of reporting daily pain

Has moderate to severe cognitive impairment

Overall low health literacy

Has socioeconomic issues creating barriers to care

Lacks consistent, engaged caregiver / family support

\*List may vary. Please defer to your Plan's MOC for specific guidance.

# Vulnerable Beneficiaries

The Plan considers all members to be in the “vulnerable” category, as almost all members exhibit one or more characteristic of a vulnerable population at some point in time, such as:

- Having to face daily physical, mental, or environmental challenges that place at risk their health and/or ability to function, which includes those with severe chronic illnesses as well as physical, mental, and developmental disabilities.
- Experiencing more than one chronic condition (or multiple co-morbid conditions) and a recent exacerbation of one or more conditions requiring extensive coordination.
- One or more inpatient admissions over the preceding 12 months. Readmissions may be related to lack of follow through on discharge plans, acute exacerbation of chronic conditions, unaddressed lifestyle supports such as proper nutrition, or new acute diagnoses superimposed on chronic conditions.

# Most Vulnerable Beneficiaries

The Plan recognizes that a **subset of the overall population is particularly at risk for adverse outcomes** based on the below:

1. **Current clinical status:** All members in inpatient(IP)/skill stay are considered high risk based both on condition exacerbation, injury, or acute illness leading to the hospitalization and the care transitions related to an IP/SNF
2. **Utilization History:** High utilization of medical services results when chronic conditions are not stabilized and well-controlled, when there is an onset of a new chronic or acute illness, as the result of an injury, or when beneficiaries require significant daily living support.
3. **Functional Status:** Healthcare utilization (as evidenced by costs) significantly increase when “an underlying chronic condition accompanies the inability to care for oneself.”
4. **Medication Status:** Over-medication results in unnecessary costs but also can pose health threats to Medicare beneficiaries. High-risk medications like anticholinergic and CNS drugs or new prescriptions for antipsychotics increase the risk of falls, behavior changes, and other dangerous side effects for patients.
5. **Chronic Conditions:** The Plan understands that most (if not all) members will have one or more chronic conditions. The care model is designed to stabilize chronic conditions and prevent exacerbations while enhancing quality of life. New conditions or new symptoms like pain and signs of depression require additional monitoring, treatment titration, and stabilization efforts.

**The Plan will provide a report to assist the Plan Provider in identifying the most vulnerable beneficiaries. The Plan Provider will utilize this report, clinical judgement, and support from the Plan Medical Director in determining the frequency of member visits to best support member driven preventative care.**

*\*Best Practice: All members should be seen at minimum monthly, and more often based clinical judgement and transition protocols.*



# MOC 2: Care Coordination

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- Health Risk Assessments (HRA)
- Individualized Plan of Care (IPOC)
- Interdisciplinary Care Team (ICT) Meetings
- Care Transition Protocols



Please Note, the LHP NP/PA is provided free of charge to LHP members and they do not bill FFS for their services



# Role of the Advanced Practice Provider

- 1) Deliver evidenced based, collaborative Primary Care and preventive services
  - In coordination with member PCP
  - Treating in most appropriate setting
  - Coordinating with telehealth/on call services
- 2) Execute the LHP Model of Care activities
  - Complete HRAT-Initial and Annual
  - Develop/Implement member centric IPOC to included advanced care planning
  - Conduct ICT Meeting
  - Facilitate effective Care Transitions Management
- 3) Facilitate/Execute Clinical Operational Health Plan Functions
  - Accurate diagnoses documentation and coding
  - Facilitate access to network providers
  - Close HEDIS and STARs Quality gaps
  - Coordinate and ensure appropriate use of Part A and B services
  - Conduct MTM Reviews
  - Educating member/responsible party on health plan benefits
- 4) Trusted Advisor/Member Advocate
  - Effective communication of members goals of care
  - Advocates for member needs and goals
  - Understands nursing home regulatory environment and assists with compliance
  - Actively participates in NH meetings, quality projects
  - Provides effective NH staff training and assists with on quality programs, infection control program



# Health Risk Assessment Tool (HRAT)



The Plan's Health Risk Assessment Tool starts the **new member assessment** and plan of care development process for the Plan and provides an **annual checkpoint** and reassessment of key geriatric health metrics.

The Plan's Health Risk Assessment Tool is a screening tool used by the Plan to:

1. Collect member self-reported health status
2. Identify potential gaps (medical, functional, cognitive, psychosocial, and mental health) in existing care and treatment plans and immediate care need
3. Monitor changes in self-reported health status on an annual basis



# Health Risk Assessment (HRA)

## Requirements

- All new Plan members receive an HRA **within 90 days of enrollment** (start effective date).
- Existing members should have an HRA annually (**within 365 days of their prior assessment**).
- The HRA **identifies immediate or overlooked health needs** and informs the care plan for the member.

# Health Risk Assessment (cont.)



## Results from the Health Risk Assessment directly contribute to a member's Individualized Plan of Care (IPOC) in the following ways:

- The Plan will distribute the HRAT information to the ICT members and member/caregiver.
- Identification of potentially life-threatening conditions and/or conditions requiring an **immediate or near-immediate intervention** (i.e. thoughts of harming myself/others).
- Stratification of HRA responses set the **timing of the post-HRA visit** (for new Plan members) or the next examination/visit date from the Plan Provider (Physician, Nurse Practitioner, Physician Assistant).
- The Plan Provider (PP) schedules a visit with the member based on the total tallied score of the HRA.
- The Plan Provider will complete a post-HRA visit per the stratification timeline. Visit will include:
  - HRA review (***Provider visit notes should include documentation of HRA results/outcomes***)
  - Review of available historical hospital, specialist, and diagnostic information
  - Comprehensive exam
- Outcomes of the post-HRA visit (i.e. medication changes, therapy referrals, diagnostic tests, scheduling of next visit, etc.), will be included in the facilities EMR and incorporated into the ICP.

# Individualized Plan of Care (IPOC)

## Requirements:

- Needs identified in the HRA should be documented in the Individualized Plan of Care.
- All SNP members have an ICP that is updated with **significant changes in health status** and that is accessible to the member and with the Care Team for updates.
- Updated should be made, at minimum:
  - Nursing Home: quarterly



# Plan of Care Required Components:



## Medicare Managed Care Manual: (Chapter 5 Section 20.2.1)

### Designed to address the needs identified in the HRA.

Services specifically tailored to the member's need.

Roles/responsibilities of the member's caregiver(s).

### Should Contain SMART Goals:

**S= Specific** (direct, detailed, and meaningful)

**M= Measurable** (quantifiable to track progress or success)

**A= Attainable/Achievable** (realistic)

**R= Relevant** (aligns with the member and/or ICT's goals)

**T= Time-Based** (deadline)

### Measurable timelines and measurable outcomes.

Identification if goals are met/not met.

### Barriers should be documented.

### Beneficiary self-management goals & personal healthcare preferences.

Description of services specifically tailored to the beneficiary's medical, psychosocial, functional, and cognitive needs.

Describe how the ICP is **documented** and **updated** as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, beneficiary and/or caregiver(s).

Explain how updates to the ICP are communicated to the beneficiary/caregiver(s), the ICT, applicable network providers, other SNP personnel and other ICT members, as necessary.

# SMART GOAL/ICP EXAMPLE:

## SMART Goals:

S= Specific (direct, detailed, and meaningful)

M= Measurable (quantifiable to track progress or success)

A= Attainable/Achievable (realistic)

R= Relevant (aligns with the member and/or ICT's goals)

T= Time-Based (deadline)

Problem	Goal	Intervention
		Plan Provider will educate member, caregiver, and facility staff on increased risk of falls associated with medications (i.e. antihypertensive agents, diuretics, opiates, etc.).
Fall Risk	Member will remain free from falls for next 3 months	Facility staff will utilize assistive mobile devices (i.e. walker) while member ambulates.
		Facility staff, member, and caregivers will be educated on appropriate non-skid socks/shoes, appropriate fitting clothing (i.e. long pants, loose shoes, etc.) to prevent falls.
		Facility staff will toilet member prior to naps and bedtime.
		Facility staff will ensure bed alarm is activated when member is not under direct supervision.
		Facility staff will verify member has call bell within reach at each shift.
		Facility staff to relocate member to room close to nursing station for easier access to nursing staff.



# LHP Advanced Care Planning

- As part of the Individualized Plan of Care, the LHP NP will assess the members goals of care and ensure the IPOC incorporates the member's goals of care.
- LHP NPs will work with the member and their responsible party and PCP to obtain advanced directives and the associated legal paper-work in place to ensure their wishes and goals of care are implemented.
- Advanced care planning is an ongoing process and the LHP NP will have a series of conversations with the member/RP as the member's condition/health status changes
- Members eligible/inquiring about hospice will be referred to hospice
- LHP NPs can provide basic palliative care to LHP members and are willing to engage in NF palliative care programs upon request

# Interdisciplinary Care Team Meetings

## Requirements

All SNP members have at least one Interdisciplinary Care Team (ICT) meeting annually or more often if:

- Updates are needed to the Individualized Plan of Care
- The facility ICT schedule requires more regular updates:
  - Nursing Home: quarterly usually in conjunction with the facility MDS Review or Care Plan meetings



# Interdisciplinary Care Team Meeting (cont.)

- The Health Risk Assessment Tool is a **starting point** for the Plan to identify the different providers and support systems that the member has in place and the role they play in the member's overall care.
- The ICT is developed to ensure **effective coordination** of care, especially through the member's care transitions, and to improve health outcomes.
- The **continuity** and regular schedule of ICT meetings allows the Plan Provider to refine and re-evaluate the Member's ICP based on direct feedback from the ICT members.
- Ad hoc **meetings are scheduled as needed** with ICT members, the Plan Provider, and other pertinent clinical staff to review and address **urgent issues**.
- The **exact composition of the ICT working with members varies** and is dependent on each members' unique circumstances, risk-level, and individual needs and preferences.
- ICT **members are selected based on their functional roles**, knowledge, and/or established relationship with the member.
- The Plan Provider and the ICT reviews **progress towards goals** during clinical and monitoring visits with the member and during the ICT team meetings.

# Interdisciplinary Care Team (cont.)

An effective ICT contributes to **improving the health status** of SNP beneficiaries through:

- Minimized errors and potential adverse events
- Improved care coordination, including during transitions
- Improved communication and understanding of health status and treatment across the team and with the member and/or caregiver
- Improved management of the member's medical, cognitive, psychosocial, and functional needs of the Member through collaboration and revision of the ICP
- Improved access to needed services and support as gaps in care and outstanding needs are identified
- Member and/or caregiver satisfaction with care planning process

# Interdisciplinary Care Team (ICT) Responsibilities

## Member/Caregiver/ Responsible Party

- ICT process revolves around the member
- Member can identify specific individuals they would like to participate in the ICT
- Participation in all HRAs
- Participation in the development of the ICP
- Vocalize needs, barriers, and prioritize goals
- Contact MC /other ICT members for questions/concerns

## Plan Provider (Physician, Nurse Practitioner, Physician Assistant, or PCP)

- Responsible for ensuring that needs/gaps identified in the HRA or subsequent visits are addressed in the ICP
- Participates in the development of the ICP and ensures progress is being made to meet ICP goals
- Providing preventative services/primary care
- Conducts oversight for all transitions of care events
- Member education

## Facility

- May be various staff members (nurse, MDS coordinator, social worker, nutritionist, pharmacist, activity director, etc.)
- Communicate with all ICT members regarding changes in treatment or recommendations
- Provide input to the ICT for the ICP development and ongoing updates
- Ensure transition of care protocols are followed, including notification of transfers

## Other Medical Professionals /Specialist

- Each member of the ICT shares the responsibility for ensuring the member's needs in relation to their specialty are met
- Communicate updates regarding changes in treatment/recommendations
- Provide input to the ICT regarding the development and ongoing updating of the member's IPC
- Attend or provide input for ICT meetings, as appropriate

# Care Transition Protocols



The Plan understands how **coordinated health care improves the care of its vulnerable membership**. The Plan incorporates care transition protocols to provide an integrated, proactive approach to safely transition members between levels of care and across care settings using evidence-based clinical practices and targeted strategies including (but not limited to):

- Ensuring that every member has a Plan Nurse Practitioner to serve as a centralized point of care coordination for members and families/caregivers for all care, including transitions.
- The Plan NP will be responsible for preventive and primary care services delivered in the facility in partnership with the plan's PCP.
- Minimizing the need for transitions outside of the facility through delivery of wellness, preventive, and monitoring services delivered in coordination with the ICT members.
- Facilitating member information sharing with external providers/facilities to ensure coordinated care



# Care Transition Protocols (cont.)



- **Following members across care settings** during transitions (i.e. admission to a hospital) through the use of a Utilization Management Registered Nurse who coordinates discharge planning and post-discharge services with the hospital, and Plan Provider to ensure smooth transitions.
- **Identifying at-risk members** through the HRA and Most Vulnerable Member reports and notifying the Plan Provider of status or status changes.
- Requiring Plan Providers to provide **transitional care management visits** and communications.

# Care Transitions (cont.)



An important goal in **continuity** of care processes for the Plan is to **reduce the incidence of inappropriate care transitions**, particularly those resulting in unnecessary re-hospitalizations. As part of the Plan's approach to ensuring a safe care transition process, the Plan focuses on the following:

## 1. Member-Centered Care

- The Plan Provider oversees and approves all care transitions
- Educate member/caregiver as to the reasons for the transition
- Transitions consistent with the member's goals and advance care directives

## 2. Communication

- Peer to peer communication is established across sites of care
- Information about the member (i.e. medications and care plans) are collected prior, during, and post care transition

## 3. Safety

- Appropriate assessment of the member PRIOR to transition
- Prompt and consistent medication reconciliation at every transition point
- Accurate and timely transition of key information (i.e. functional/cognitive status, current problem list, allergies, advance directives, recent labs, consultations, diagnostic testing results, etc.)



## Typical Transitions Specific to the Plan's Population Include:

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- Facility to Emergency Department
- Facility to Hospital
- Emergency Department to facility/SNF
- Hospital to facility/SNF
- Facility to Hospice Care
- Facility to Skilled Care (may be in same facility, but care level change)
- Facility to community with home health
- Facility to a non-contracted facility
- Facility to Home

# Transition Follow-up Timeline



Plan Providers are required to provide transitional care management visits and communications with the ICT.

## Within 48 Hours:

The Plan Provider coordinates an **initial updated plan of care** with the facility within **48 business hours** of the members **return** to the ISNP nursing facility.

## Within 7 days

The Plan Provider provides a **visit to the Member** within **2 business days** of the Member's **return** to the facility, and coordinates an updated ICP with the ICT.

# Transition Coordination & Communication



## Plan Provider (PP)

- During the Interdisciplinary Care Team (ICT) meeting, the PP updates the ICT on the Member's status and transition plan.
- Post-discharge, the PP educates the Member and/or caregiver on the reason(s) for hospitalization/transition.
- Provides instruction on who to contact for concerns at any point in time.
- Provides instruction in recognition of warning signs for the disease processes and medications.
- Provides instruction on self-care to the degree possible.
- Discusses the next steps in the care management process (i.e. review updated ICP).
- Coordination of or orders for post-hospital specialist visits, diagnostic testing, home health services and/or therapy.
- Coordinates post-transition follow up for the Member (MC should also assist with this, for applicable Plans only).

# Care Transition Personnel

## The personnel responsible for coordinating the care transition process include:

- The **Plan Provider** (PP) should be notified of all planned or unplanned care transitions with every effort made to consult with the PP **before** a facility sends a member to the hospital.
- The **facility** has the responsibility of notifying the PP before an unplanned care transition or, when a member requires immediate emergency services, right after 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.
- The **Plan's Utilization Management (UM)** team takes over the care coordination role when members are admitting to a short term or long-term acute care hospital or when members are admitted to a non-contracted SNF.
  - Confirming the most appropriate level of care
  - Coordination and discharge planning upon admission to higher level of care
- The **Care Coordinator**, coordinates care for members who discharge from the contracted facility while the member is pending disenrollment from the Plan. They ensure the member received needed services and support (i.e. home health) during the transition, that the member established a visit with the community based primary care, and record sharing (i.e. medication list and care plan) are disseminated to the new physician/facility.



# 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.
- The Plan provides network of providers, specialists, and facilities with specialized expertise pertinent to the care and treatment of its members (i.e. cardiologist, pulmonologist, neurologist, endocrinologists, etc.).
- Primary care services through the Plan Provider (MD, DO, NP, or PA) 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 Plan Provider.
- The Plan Provider also coordinates visits and services provided outside of the facility including specialist visits, radiology, lab, and other diagnostic testing not available on campus.



# 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.
- The Plan's QI Program is assessed annually and reviewed by the Quality Improvement Committee (QIC) to determine the overall effectiveness of the program, including the MOC, and appropriateness of care and services furnished to Members. Enhancements are made to the QI Program based on the annual evaluation.

# MOC 4: Quality Measurement and Performance Improvement (cont.)



- The Quality Improvement (QI) Program provides the structure, framework, and governance used to guide the formal and informal processes for evaluating and improving the quality of care to members.
- The QI Work Plan and Annual Evaluation are important materials used to guide Quality Improvement efforts.
- The Board of Directors (BOD) is responsible for the establishment, implementation and oversight of the QI Program.
- The Plan Medical Director is accountable for oversight of the QI Program on an ongoing basis. The Plan Medical Director reviews and provided guidance on all QI activities.
- The Quality Improvement Committee reviews and provides oversight of the QI Program.
- The Plan educates its network on key performance measures and changes to the MOC.





Thank you!