Ascension Complete

Medicare: SNP Model of Care Training

Training Objectives

This course will describe how Ascension Complete and its contracted providers work together to successfully deliver the duals Model of Care (MOC) program.

After this training, attendees will be able to do the following:

- Outline the basic components of the Ascension Complete Model of Care (MOC)
- Explain how Ascension Complete medical management staff coordinates care for Special Needs members
- Describe the essential role of providers in the implementation of the MOC program
- Define the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT)

Special Needs Plan (SNP)

Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs. CMS has defined three types of SNPs that serve the following types of members:

Dual Eligible Special Needs Plan (DSNP)

Members must have both Medicare and Medicaid benefits

Chronic Condition Special Needs Plan (CSNP)

Members with chronic illness such as: Diabetes, COPD, Congestive Heart Failure

Institutional Special Needs Plan (ISNP)

Members who live in institutions such as: nursing homes or long term facilities

Health plans may contract with CMS for one or more programs. Currently, **Ascension Complete has Medicare Advantage Prescription Drug plans (MAPD)** and **DSNP.**

Specific Services

Ascension Complete provides members with services tailored to the needs of the SNP-population. These services can include, but are not limited to the following:

- Care coordination and complex care management
- Care transitions management
- Physician home visiting services
- Home health services
- Disease management and wellness services
- Clinical management in long-term care facilities as needed
- Medication Therapy Management and medication reconciliation
- Medicare and Medicaid benefit and eligibility coordination and advocacy

Model of Care Training

- The Model of Care (MOC) is a quality improvement tool that ensures the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed
- The Affordable Care Act requires the National Committee for Quality Assurance (NCQA) to review and approve all SNP MOCs using standards and scoring criteria established by Centers for Medicare and Medicaid (CMS)
- This course is offered to meet the CMS regulatory requirements for MOC Training for our SNPs
- It also ensures all employees and providers who work with our SNP members have the specialized training this unique population requires

What is a Model of Care?

The Model of Care (MOC) is Ascension Complete's comprehensive plan for delivering our integrated care management program for members with special needs. It is the architecture for promoting quality, care management policy and procedures and operational systems.

Model of Care

The Model of Care is comprised of four clinical and non-clinical elements:

Description of the SNP Population

2.
Care Coordination

3.
SNP Provider Network

4.
Quality Measurements & Performance Improvement

Element 1: Description of the Population

Description of Member Population

Element 1 includes characteristics related to the membership that Ascension Complete and providers serve including social factors, cognitive factors, environmental factors, living conditions and comorbidities.

The element also includes:

- Determining and tracking eligibility
- Specially tailored services for members
- How Ascension Complete works with community partners

Element 2: Care Coordination

Care Coordination

- The Care Coordination element includes a description of how the SNP will coordinate the care of health care needs and preferences of the member, and share information with the Interdisciplinary Care Team (ICT)
- Ascension Complete conducts care coordination using the Health Risk Assessment (HRA), an Individualized Care Plan (ICP) and providing an ICT for the member
- Care Coordination elements also includes the following:
  - Explanation of all the persons involved in care
  - Contingency plans to avoid disruption in care
  - Training and education assessment for all caregivers

Health Risk Assessment (HRA)

An HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks of members.

- Ascension Complete attempts to complete the initial HRA within 90 days of enrollment and annually, or if there is a change in the members condition or transition of care
- HRA responses are used to identify needs, are incorporated into the member's care plan and communicated to care team
- Members are reassessed if there is a change in health condition
- Change(s) in health condition and annual updates are used to update the care plan

Note: Physicians should encourage members to complete the HRA in order to better coordinate care and create an individual care plan.

Individualized Care Plan (ICP)

- An Individualized Care Plan (ICP) is developed by the Interdisciplinary Care Team (ICT) in collaboration with the member

- Case Managers and PCPs work closely together with the member and their family to prepare, implement and evaluate the Individualized Care Plan (ICP)

Individualized Care Plan (ICP)

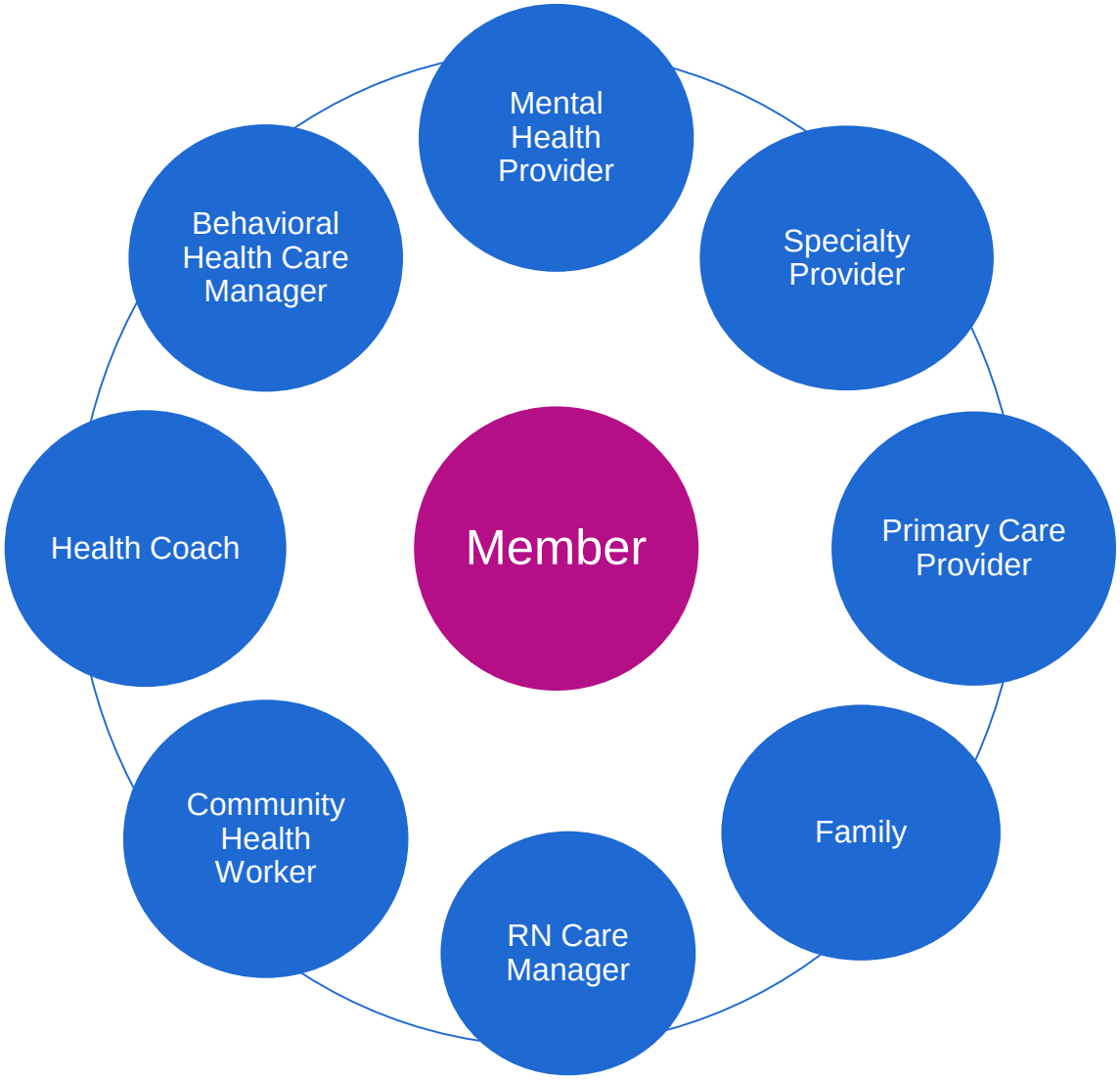
Members receive monitoring, service referrals and condition-specific education based on their individual needs.

ICPs include problems, interventions and measurable goals, as well as services the member will receive

- Medical condition management
- Transportation
- Skilled nursing, DME, home health
- Occupational therapy, physical therapy, speech therapy
- Behavioral health and substance use disorder
- Other services, as needed

Interdisciplinary Care Team (ICT)

- Ascension Complete's program is member centric with the PCP directing the care for the member
- The Care Manager (CM) serves as the single/one point of contact for the member and is responsible for care coordination



Interdisciplinary Care Team (ICT)

Ascension Complete Case Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) **based on the member's preference** of who they wish to be included. The ICT can include the following but not limited to:

- Appropriately involved Ascension Complete Staff
- The member and their family/caregiver
- External practitioners
- Vendors involved in the member's care
- PCP
- Specialty Providers
- Pastoral Care

ICT Responsibilities

Ascension Complete works with each member to manage the following:

- Develop their personal goals and interventions for improving their health outcomes
- Monitor implementation and barriers to compliance with the physician's plan of care
- Identify/anticipate problems and act as the liaison between the member and their PCP
- Identify Long Term Services and Supports (LTSS) needs and coordinate services as applicable

ICT Responsibilities Continued

- Coordinate care and services between the member's Medicare and Medicaid benefit
- Educate members about their health conditions and medications and empower them to make good healthcare decisions
- Prepare members/caregivers for their provider visits – Encourage use of personal health record
- Refer members to community resources as identified
- Notify the member's physician of planned and unplanned transitions

ICT Responsibilities Providers

- Accepting invitations to attend member's ICT meetings whenever possible
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record when received
- Collaborating and actively communicating with the following:
  - Ascension Complete Case Managers
  - Members of the Interdisciplinary Care Team (ICT)
  - Members and caregivers

Transition of Care

- During an episode of illness, members may receive care in multiple settings, often resulting in fragmented and poorly executed transitions

- Ascension Complete staff will manage transitions of care (TOC) to ensure that members have appropriate follow-up care after a hospitalization or change in level of care to prevent readmissions

Transitions of Care (TOC)

Managing TOC interventions for all discharged members may include, but is not limited to, the following:

- Face-to-face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan

- In-home visits or phone call within 48 hours post discharge to include:
  - Evaluate member's understanding of their discharge plan
  - Assess member's understanding of medication plan
  - Ensure follow up appointments have been made
  - Ensure home situation supports the discharge plan

- Ongoing education of members to include preventive health strategies in order to maintain care in the least restrictive setting possible for their health care needs

Element 3: Provider Network

Provider Network

Ascension Complete is responsible for maintaining a specialized provider network that corresponds to the needs of our members.

This element describes the following:

- How the network corresponds to the target population
- How Ascension Complete oversees network facilities
- How providers collaborate with the ICT and contribute to a member's ICP
- Ascension Complete coordinates care with and ensures that providers:
  - Collaborate with the Interdisciplinary Care Team
  - Provide clinical consultation
  - Assist with developing and updating care plans
  - Provide pharmacotherapy consultation

Provider Network

CMS expects Ascension Complete to do the following:

Prioritize contracting with board-certified providers	Monitor network providers to assure they use nationally recognized clinical practice guidelines when available	Assure network providers are licensed and competent through a formal credentialing process	Document the process for linking members to services	Coordinate the maintenance and sharing of member's health care information among providers and the ICT

Provider Network

- Medicare (Advantage) is always the primary payer and Medicaid is secondary payer, unless the service is not covered by Medicare or the Medicare service benefit cap is exhausted for DSNP members
- DSNP members have both Medicare and Medicaid but not always with Ascension Complete. Medicaid benefits may be via another Health Plan or the State
- It’s important to verify coverage before providing a service for the member

Element 4: Quality Measurement & Performance Improvement

Quality Measurement and Performance Improvement

- Element 4 requires plans to have performance improvement and quality measurement plans in place

- To evaluate success, Ascension Complete disseminates evidence-based clinical guidelines and conducts the following:
  - Measures member outcomes
  - Monitors quality of care
  - Evaluates the effectiveness of the Model of Care (MOC)

Model of Care Goals

Ascension Complete determines goals for the MOC related to improving the quality of care that members receive.

2022 goals are based on the following:

- Medicare Stars Measures
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Health Outcomes Survey (HOS)

Model of Care Goals may include:

- Access to care
- Access to preventative health services
- Member satisfaction
- Chronic care management

Summary

Ascension Complete values our partnership with our physicians and providers.

The Model of Care requires all of us to work together to benefit our members through:

- Enhance communication between members, physicians, providers and Ascension Complete
- Provide interdisciplinary approach to the member’s special needs
- Employ comprehensive coordination with all care partners
- Support the member's preferences in the plan of care
- Reinforce the member’s connection with their medical home