



2018 Model of Care Training



Special Needs Plans

- **Special Needs Plans (SNPs) were created by Congress through the Medicare Modernization Act of 2003.**
- **SNPs are a type of Medicare Advantage Plan.**
- **There are three types of SNPs that limit membership to specific types of enrollees:**
 - **Chronic Care SNP – for enrollees with specific types of chronic conditions,**
 - **Institutional SNP – for enrollees who live in an institution or require nursing care at home, or**
 - **Dual Eligible SNP – for enrollees who receive both Medicare and Medicaid**

Mercy Care Advantage

- **Mercy Care Advantage (MCA) is a Dual Eligible SNP.**
- **MCA members have Medicaid coverage through one of three programs under Arizona Healthcare Cost Containment System (AHCCCS):**
 - **Arizona Long Term Care System (ALTCS),**
 - **Members enrolled in the AZ Division of Developmental Disabilities, *or***
 - **Acute Care Program**

Model of Care

The goal of this module is to describe MCA's Model of Care and the role that contracted medical providers play in its delivery to members.



Model of Care

- **The Centers for Medicare & Medicaid Services (CMS) requires each SNP to have a Model of Care.**
- **The Model of Care is the architecture for care management policy, procedures, and operational systems.**

Model of Care Elements

- **The Model of Care includes the following elements:**
 - **Description of the SNP-specific Target Population**
 - **Measureable Goals**
 - **Staff Structure and Care Management Roles**
 - **Description of the Interdisciplinary Care Team**
 - **Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols**
 - **Model of Care Training for Personnel and Provider Network**
 - **Health Risk Assessment**

Model of Care Elements (continued)

- **Individualized Care Plan**
- **Communication Network**
- **Care Management for the Most Vulnerable Sub-Populations**
- **Performance and Health Outcome Measurement**

Model of Care Measurable Goals

- **Improving beneficiary 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**
- **Improving access to essential services such as medical, mental health, and social services**
- **Improving access to affordable care**
- **Improving coordination of care through an identified point of contact**

Health Risk Assessment

- **All MCA enrollees are outreached to complete a Health Risk Assessment (HRA), which is a standardized tool used to assess the medical, psychosocial, cognitive and functional needs of each enrollee.**
- **The outcome of the assessment will assist in the development of an individualized care plan for enrollees.**
- **For MCA enrollees who are enrolled in ALTCS as their Medicaid plan, the HRA is administered by our LTC staff within 12 working days of enrollment, and again every 90-180 days.**

Health Risk Assessment (continued)

- **The HRA's for MCA enrollees with Acute/DD Medicaid is conducted by our acute care management staff:**
 - **Telephonically within 90 days of enrollment; and**
 - **Annually thereafter, unless the enrollee cannot be reached or the enrollee requests that we mail the HRA to them for completion; or**
 - **Whenever an enrollee experiences a significant change in health status, such as an inpatient stay.**

Interdisciplinary Care Team

- **The Interdisciplinary Care Team (ICT) is a group of health plan staff and care providers who meet regularly to discuss HRA results and other information available on each enrollee to develop a care plan that is individualized to their specific health care needs.**
- **The enrollee and their PCP are invited to attend the ICT to provide input.**

Individualized Care Plan

- **An Individualized Care Plan (ICP) is a summary of the needs and service options identified during the assessment process.**
- **The ICP is developed to identify the enrollee's health care goals and objectives, as well as the activities and services the enrollee agrees to pursue in order to attain optimal health outcomes.**

Individualized Care Plan (continued)

- **ICPs for all enrollees are created utilizing a combination of all information available including:**
 - **HRA results**
 - **Utilization and claims data**
 - **Preventive health information, according to the enrollee's age and gender**

Individualized Care Plan (continued)

- **Both the PCP and/or the enrollee can request a meeting to further discuss the ICP.**
- **The results are communicated to enrollees and their Primary Provider during the ICT and via the ICP.**
- **The ICP is revised annually, or when the enrollee has a significant change in health status, such as an inpatient admission.**

Case Management and Care Coordination

- **What is Case Management?**

“Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost effective outcomes.” (Case Management Society of America, 2002)

Case Management and Care Coordination (continued)

- **All MCA enrollees are eligible to receive high risk case management or care coordination services.**
- **MCA offers a range of case management and care coordination services to address enrollees' clinical and non-clinical needs**

Case Management and Care Coordination (continued)

- **The frequency and intensity of the interactions with Case Management vary based upon enrollee need:**
 - **All MCA/ALTCS enrollees are placed in full case management**
 - **MCA/Acute and MCA/DD enrollees are assessed to determine what level of case management services are required and are placed accordingly**

How to Refer to MCA Case Management

- **If you feel an enrollee requires case management, please contact our Case Management Referral Line at 602-586-1870.**
- **All referrals are reviewed within 3-5 business days by a triage nurse.**

Condition Management

- **Condition Management (formerly referred to as disease management) is now incorporated into care management so all the enrollee's bio-psychosocial needs can be assessed as a whole.**

Questions?

If you have questions about any information in this Model of Care Training, please call 602-586-1870.

2018 Model of Care Attestation

I hereby attest that I have reviewed the **2018 Model of Care Training** which will complete the annual requirement.

I understand the Model of Care for MCA members and my role in improving health outcomes for our most vulnerable population.

I also understand this is an annual training requirement required of me by the Centers for Medicare and Medicaid Services (CMS) for all Medicare Advantage Special Needs Plan providers.

Disclaimers

It is the Office Manager/Administrator's responsibility to ensure that providers who care for Mercy Care Advantage (MCA) members have either a face to face training; an office meeting training; or have each individual practitioner complete a self-attestation. Please make sure we receive your annual attestation no later than January 31, 2019 by clicking on the button on the next page.

2018 Model of Care Attestation

**By signing for the group, you are attesting that you have written evidence in your office that your providers have reviewed the power point training regarding Model of Care. In the event that Centers for Medicare and Medicaid Service requires Mercy Care Advantage (MCA) to provide proof of this training, MCA will request your documentation of the Model of Care training, i.e., staff meeting minutes documentation, sign in sheets, etc. This is required for all Specialists and Primary Care Providers, including MDs, DOs, PAs, and NPs, who see MCA members.*

To begin, click the Submit Attestation button



**Submit
Attestation**

To ensure you receive credit for this class, please be sure to include the following information in your attestation e-mail:

- **Individual Name (for individual practitioner attestation)**
- **Or**
- **Contract Holder/Administrator Name (when conducting group training)***
- **Printed Clinic/Practice Name**
- **Tax ID (TIN)**

Thank you

