



Model of Care

Institutional Special Needs Plan

Y0144_MOC23_C

Background

- MOC: CMS Requirement as an I-SNP
- AHP submits Model of Care to CMS (120 pages)
- Graded: year approval
- Model of Care – most often discussed clinical

Overview

- Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care (MOC)
- CMS requires all SNPs to conduct initial and annual training that reviews the major elements of the MOC for providers and staff
- Purpose of this training is to comply with the statutory requirements of CMS that all SNPs provide a general understanding of the requirements of the MOC

What is an Institutional Special Needs Plans (I-SNP)

I-SNPs are Medicare Advantage Prescription Drug Plans that restrict enrollment to Medicare eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a:

- Skilled nursing facility (SNF)
- LTC nursing facility (NF)
- Intermediate care facility (CMS)
- Inpatient psychiatric facility

OR

- Individuals living in the community or a contracted assisted living facility (ALF) but require an institutional level of care (LOC)*.

*As determined by a state assessment tool and evaluation. The tool is the same as that used for individuals residing in an institution.

Who is Eligible for an I-SNP?

- Entitled to Medicare Part A (Hospital Insurance)
- Enrolled in Medicare Part B (Medical Insurance)
- Live in Plan service area
- Must reside, or be expected to reside, in a participating I-SNP nursing facility for greater than 90 days at the time of enrollment, individuals living in the community or a contracted assisted living facility (ALF) but require an institutional level of care (LOC)

Learning Objectives – Four Elements of MOC

Model of Care – Element 1

Special Needs Plan (SNP) Population

- General Population
- Vulnerable Subpopulations

Model of Care – Element 2

Care Coordination

- I-SNP Staff Structure
- Health Risk Assessment (HRA)
- Individualized Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- Care Transition Protocols

Learning Objectives (cont.)

Model of Care – Element 3

Provider Network

- Specialized Expertise
- Use of Clinical Practice Guidelines
- Model of Care Training

Model of Care – Element 4

Quality Measurement and Performance Improvement

- Model of Care Performance Improvement
- Measurable Goals and Health Outcomes for the Model of Care
- SNP Member Satisfaction
- Evaluation of the Model of Care
- Dissemination of SNP Quality Performance Related to the Model of Care

Model of Care Element 1: Target Population / Subpopulation

- Institutionalized in a Long-Term Care (LTC) Facility or in the community and need institutional type of care usually provided in a long-term care facility
- Frail/vulnerable
- More likely to be Female
- Average age is 75 years old
- Clinical Risk Factors
  - Diabetes
  - Heart failure
  - Pressure injury
  - Respiratory conditions
  - Psychosis
  - Falls
  - Pressure ulcers
  - Urinary tract infections
  - Incontinence

Model of Care Element 2: Care Coordination

SNP Staff Structure

- The I-SNP has a care coordination team in place that includes an Advanced Practice Provider, Case Manager, Member Advocate, Clinical Pharmacist, and other providers
- APP (Advance Practice Practitioner) – APRN, PA-C
  - Frequency of APP visits is based on member stratification
- RN Case Manager: Care Coordination

Health Risk Assessment (HRA):

- HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks
- Initial HRA is completed within 90 days of enrollment and annually thereafter; findings are integrated into the member's care plan
- Stratification level dictates Advanced Practice Provider and Case Manager's intervention schedule

Model of Care Element 2: Care Coordination (cont.)

Individualized Care Plan (ICP):

- Includes goals that are member specific driven from clinical information obtained from HRAs and other Plan data

Interdisciplinary Care Team (ICT):

- The Interdisciplinary Care Team reviews and approves the ICP
- Composition varies and is dependent on each member's unique goals and member preferences
- Includes the member and any designated representative(s)

Model of Care Element 2: Care Coordination (cont.)

Care Transitions:

- Advanced Practice Provider conducts a care transition assessment, including comprehensive medication review post discharge. The Case Manager updates the ICP and communicates with ICT, as relevant

Model of Care Element 3: Provider Network

Specialized Expertise

- Comprehensive network of providers that collaborate with the I-SNP's ICP and ICT
- Comprehensive network of providers that meet CMS adequacy standards
- All contracted providers are credentialed

Clinical Practice Guidelines:

- Nationally developed and approved; reviewed minimally every two years, or significant change
- Available for provider reference

MOC Training is required for:

- Health Plan Staff
- Contracted Providers and Vendors
- Long Term Care Facility Staff

Model of Care Element 4: Quality Measurement

Quality Measurement & Performance Improvement:

- Continuous improvement and monitoring of medical care, patient safety, and delivery of services
- Data analysis and standard reporting is used in the Annual Quality Improvement Work Plan

Measurable Goals and Health Outcomes for the Model of Care

- Processes and procedures to determine health outcomes are met

Member Satisfaction:

- Assessed annually

Model of Care Element 4: Quality Measurement (cont.)

Model of Care Evaluation:

- Data is collected, analyzed and evaluated on a monthly, quarterly, and annual basis from each Model of Care domain to monitor performance, identify areas for improvement, and to ensure program goals have been meet

Dissemination of SNP Quality Performance Results

- Results shared within the organization and provider network

End of Training

- Thank you for completing the Model of Care Training, please proceed to the test and attestation.