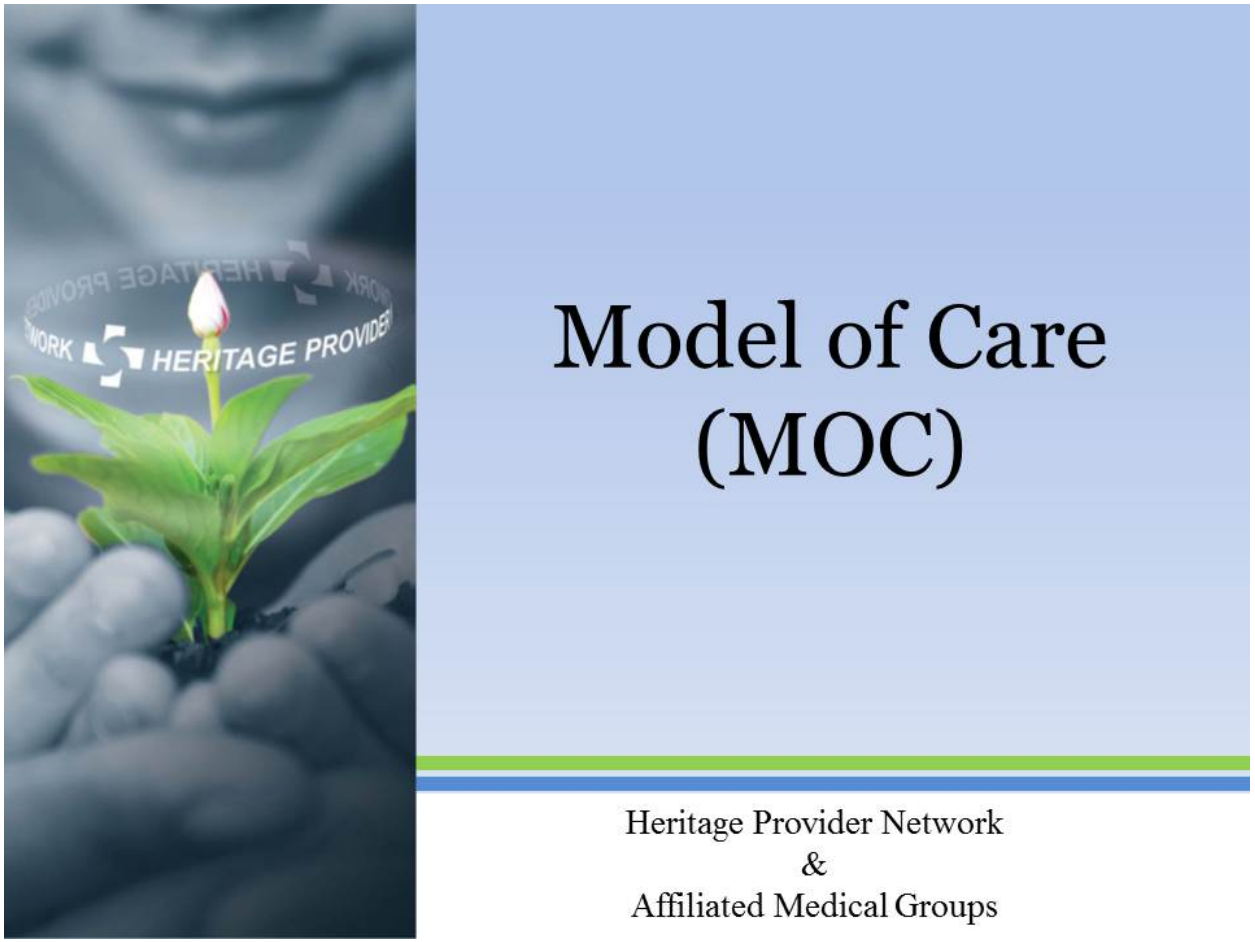
Model of Care



Learning Objectives

Program participants will be able to:

- List two differences between the Complex Care Management (CCM), and Special Needs Program (SNP) programs.
- Identify the three types of Special Needs Programs.
- Describe which entity is responsible for the Health Risk Assessment.
- Describe the member's role in the development of the Individualized Plan of Care.
- Describe the purpose of the Interdisciplinary Care Team and the three mandatory participants.
- Identify two processes that improve coordination of Care Transitions.

What is Model of Care (MOC)?

- The MOC is a guide to how we care for our members, how we monitor effectiveness, improve quality of care, and communicate with stakeholders.
- It is a member-centric program to support member health and health care decisions.
- Benefits are managed via care coordination, health management and planning.
- Programs within the Model of Care:
  - Complex Care Management (CCM)
  - Special Needs Plan (SNP)

Key Components

- Health Risk Assessment (HRA) – member's health status information used to improve the care process and offer providers actionable information.
- Case Manager – specialized staff assigned to facilitate care and serve as a point of contact for members.
- Interdisciplinary Care Team (ICT) – team in which all participants coordinate their effort to benefit the member.
- Individual Care Plan (ICP) – an actionable plan of care developed by the ICT and delivered to the member with a focus on cultural differences, languages, alternative formats and health literacy.

Programs within MOC - CCM

Complex Care Management (CCM)

- Medicare Advantage Health Plans were required to develop care management programs for members with complex health care needs. This includes both acute and chronic issues a member may have, and encompasses the disease management process as well.
- Members are managed holistically to encourage and maintain self-care and to improve member's state of wellness and decrease costs for unnecessary utilization.
- For the purposes of preventing an admission and maintaining a state of wellness, members are followed upon discharge from an acute or skilled setting, at the request of their Primary Care Physician, Caregiver, and/or Health Plan representative, or because of a noted increase in utilization of services.

Programs within MOC - SNP

Special Needs Plan (SNP)

- In 2003 Special Needs Plans (SNPs) were created under the Medicare Modernization Act as a type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries:
  - the institutionalized;
  - persons who are dual-eligible (eligible for both Medicare and Medicaid); and,
  - individuals with severe or disabling chronic conditions.

- These beneficiaries are typically older, with multiple co-morbid conditions, and therefore more challenging and costly to treat.

- Medicare Advantage Health Plans were required to develop special benefit packages for members with special health care needs. These packages included extra benefits to improve care and decrease costs for the frail and elderly using improved coordination.

Programs within MOC - SNP

Needs Plan (SNP)

There are 3 types of SNPs:

- Chronic Condition SNP (C-SNP) – Chronically ill beneficiaries with targeted chronic conditions such as cardiovascular disease, diabetes, congestive heart failure, osteoarthritis, mental disorders, ESRD, or HIV/AIDS.

- Dual Eligible SNP (D-SNP) – Dual Eligible members who qualify for both Medicare and Medicaid coverage and who have severe or disabling conditions.

- Institutional SNP (I-SNP) – Members who reside, or are expected to reside, for 90 days or longer in a long term care facility – defined as skilled nursing facility, nursing facility, intermediate care facility, or inpatient psychiatric facility OR those who live in the community but require an equivalent level of care to those who reside in a long term care facility.

Programs within MOC - SNP

Special Needs Plan (SNP)

- The health plans contract with AZPC to manage these members. AZPC manages the Care Coordination and Interdisciplinary Care processes as part of our delegated responsibility.

- This program has both Medicare and Medicaid benefits and the member is considered a managed care member for both.

- These members have had to actively enroll in a managed care program for both lines of business and meet the necessary criteria to be a SNP member.

Who Pays for What Benefits?

MEDICARE

- People 65 or older
- People under 65 with certain disabilities
- ESRD & ALS

MEDICAID

- Low-income individuals

Which Programs Pay For What Service?

- Hospital care
- Physician & ancillary services
- Short-term skilled nursing facility care
- Hospice
- Home health care
- Durable medical equipment
- Medicare cost sharing
- Long-term nursing home (after Medicare benefits are exhausted)
- Long-term services and supports
- Prescriptions and durable medical equipment, and supplies not covered by Medicare

What are the Goals for SNP & CCM?

AZPC's MOC incorporates the CCM and SNP programs to achieve it's Triple Aim goal to:

- Increase beneficiary/member satisfaction of care
- Increase quality outcomes of care
- Decrease health care costs

Additional goals include:

- Improving access to affordable medical, mental health, preventative care, and social services
- Improving coordination of care through an identified point of contact
- Creating seamless transitions across the health care setting, health care providers and health services

Goals of Model of Care

Additional goals include (continued):

- Improving the appropriate utilization of services;
- Facilitating delivery of cost-effective health services;
- Improving members' health outcomes through reduction of admissions, improved self-management, functional status, improved pain management and improved quality of life;
- Maximizing the ability of beneficiaries/members to remain in their homes and communities with appropriate services and supports in lieu of institutional care;
- Minimizing Potential Avoidable Hospitalizations;
- Coordinating benefits and access to care; and
- Enhancing the ability of a member to self-direct their care (beneficiary/member-centric).

Implementing Model of Care

AZPC incorporates the following elements in its MOC to achieve its goals in improving member satisfaction and health outcomes, and in decreasing health care costs:

- Health Risk Assessments (HRAs)
- Individual Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- Coordination of Care
- Care Transitions
- Continuity of Care
- Responding to Critical Incidents
- Additional Services

Health Risk Assessment (HRA)

- Health Risk Assessments (HRAs) are conducted to identify medical, psychosocial, cognitive, and functional risks.

- A risk stratification (based on historical data received from CMS is completed by the Health Plans to identify high and low risk members.
  - HRAs for high risk members are conducted face to face.
  - HRAs for members in Special Needs Facilities or Long Term Care are also done face to face and are completed within 45-90 days.
  - HRAs for low risk members are completed within 45-90 days by either telephone or mail, or face to face at the member's request.

- Responses are incorporated into the member's care plan, are maintained in the patient portal, and are communicated to the member's primary care physician.
- The HRA does not include the initial health assessment which is completed by the attending physician at the time of the initial visit.

*AZPC follows the requirements in accordance with all applicable Federal and State laws, and the CMS Model of Care.

Individual Care Plan (ICP)

- An Individual Care Plan (ICP) is an integrated, member centric care plan developed by the Case Manager and must be conducted for every member.
- The member and/or representative must participate in the development of a care plan and the member retains the right to refuse participation.
- The member's goals and preferences must be included.
- The ICP must have measurable objectives and timetables to meet the member needs.
- The timeframes for reassessment and updating the care plan must be done at least annually or if there is a significant change in condition (i.e. transition of care).
- If the member is receiving Behavioral Health services the care plan must include:
  - Name and contact number of provider;
  - Attestation that the BH provider and PCP have reviewed and approved the ICP;
  - Record of one case meeting that included the BH provider; and
  - If member/beneficiary has opted-in to care coordination for BH.
- Records of the ICP are stored per HIPAA and professional standards.

Individual Care Plan (ICP)

The ICP conducted by the case manager includes:

- A review of clinical information from all available medical records.
- Integration of the Health Plan HRA into the overall care plan.
- Creation of the ICP in conjunction with the Interdisciplinary Care Team (ICT).
- Identification and referral to the appropriate providers and facilities such as medical, rehabilitation, support services, long term services and supports, behavioral health, and for covered and non-covered services, as applicable.
- Direct communication with member, member's providers and family.
- Member and family education, including self-maintenance and lifestyle changes.
- Coordination of services outside of plan such as referrals to community social services, specialty mental health or drug services.
- Member and/or caregiver/authorized representative and members of the ICT must have access to the ICP upon request.

Individual Care Plan Goals - SMART

Individual Care Plan goals need to be:

- **S**pecific: clear with a targeted result to be achieved.
- **M**easurable: includes quantifiable criteria of how the result will be measured such as quantity, frequency, and time period.
- **A**chievable: realistic, clinically appropriate, and credible (Case Manager, Medical Director, enrollee, or provider is confident that s/he has the ability to attain the goal).
- **R**esults-oriented: stated in terms of an outcome that must be achieved and requires focused interventions and effort.
- **T**ime-bound: includes specific deadline by which the goal must be achieved that focuses attention and effort on achieving the goal results.

Interdisciplinary Care Team (ICT)

- The ICT team works together to optimize the member's quality of life and outcomes, and to support the member and/or family to meet health goals in the ICP.

- The ICT is responsible for overseeing, coordinating, and evaluating the care delivered to enrollees to address medical, cognitive, psychosocial, and functional needs; and meets regularly to review these needs of the members.

- The ICT team is comprised of professional, knowledgeable, and credentialed personnel within the provider network to include:
  - Primary Care Physician and Care Coordinator.
  - Member and/or authorized representative, family and/or caregiver, as approved by the member.
  - Other personnel as applicable such as: hospital discharge planner, social worker, specialized providers, IHSS or CBAS providers, if approved by member, Behavioral Health providers, nutritionist or others as needed.

Interdisciplinary Care Team (ICT)

- Members have the ability to choose to limit or disallow all together any member on the ICT.

- The ICT will be offered to every member when a need is demonstrated, or if an member, or member authorized representative, family member and/or caregiver requests one.

- AZPC defines a "demonstrated need" for an ICT as any of the following:
  - Any member who has a care level of “High”.
  - Any member who has undergone a care transition, such as, a change in level of care, an unplanned inpatient admission, etc.
  - Any member who has been identified by the ICT pharmacist as high risk.
  - Any member who has experienced as significant change in health status.
  - Any member and/or case manger experiencing barriers to achieving goals requiring support of the ICT.
  - Any member whose assessment identifies needs requiring support of the ICT.

Interdisciplinary Care Team (ICT)

- The ICT must be patient-centered and developed based on the needs and preferences of the member.
- Will ensure integration of medical, LTSS, and coordination of Behavioral Health services when applicable.
- Will facilitate care management to include: utilization of Health Plan completed HRA, care planning, authorization of services, transitional care issues, and working closely with providers to:
  - Stabilize medical conditions
  - Increase compliance with care plans
  - Maintain functional status, and
  - Meet member's care plan goals
- Deliver services with transparency, individualization, respect, linguistic and cultural competence and dignity.

Interdisciplinary Care Team (ICT)

- If the member's/beneficiary's primary diagnosis is a Behavioral Health disorder, the BH specialist will lead the ICT and coordinate the member's treatment.

- An Interdisciplinary Care Team (ICT) will be developed for each Dual Eligible member/beneficiary. The ICT is minimally composed of a medical expert, a behavioral health expert, and a social services expert. The ICT collectively manages the medical, cognitive, psychosocial, and functional needs of beneficiaries, and ensures the incorporation of the Health Plan HRA results into the member's individualized care plan. Additional team members may be added based on issues identified through assessment.

- The purpose of the ICT meeting is to review the member's/beneficiary's medical, cognitive, psychosocial, and functional needs, and to incorporate the findings from assessments and any care plan for the member/ beneficiary into the member's/beneficiary's individual treatment plan.

Interdisciplinary Care Team (ICT)

Roles/Responsibilities	Position
Coordinate care management	Case Manager, Behavior Health Case Manager, Provider
Advocate, inform, and educate enrollees on services and benefits	Case Manager, enrollee Service Associate, Provider, Behavioral Health Case Manager, Care Coordinator, Public Program Coordinator
Identify and facilitate access to community resources	Case Managers, Behavioral Health Case Manager, Provider, Care Coordinators, Public Program Coordinator
Triage care needs	Case Manager, Behavioral Health Case Manager, Provider
Facilitate HRA	Case Manager, Behavioral Health Case Manager, enrollee Service Associate, Survey vendor, Care Coordinator, Public Program Coordinator
Evaluate and analyze responses to HRA and assign enrollees according to risk level	Data Analysis, Case Manager, Behavioral Health Case Manager
Facilitate Implementation of Care Plan	Case Manager, Behavioral Health Case Manager, Provider

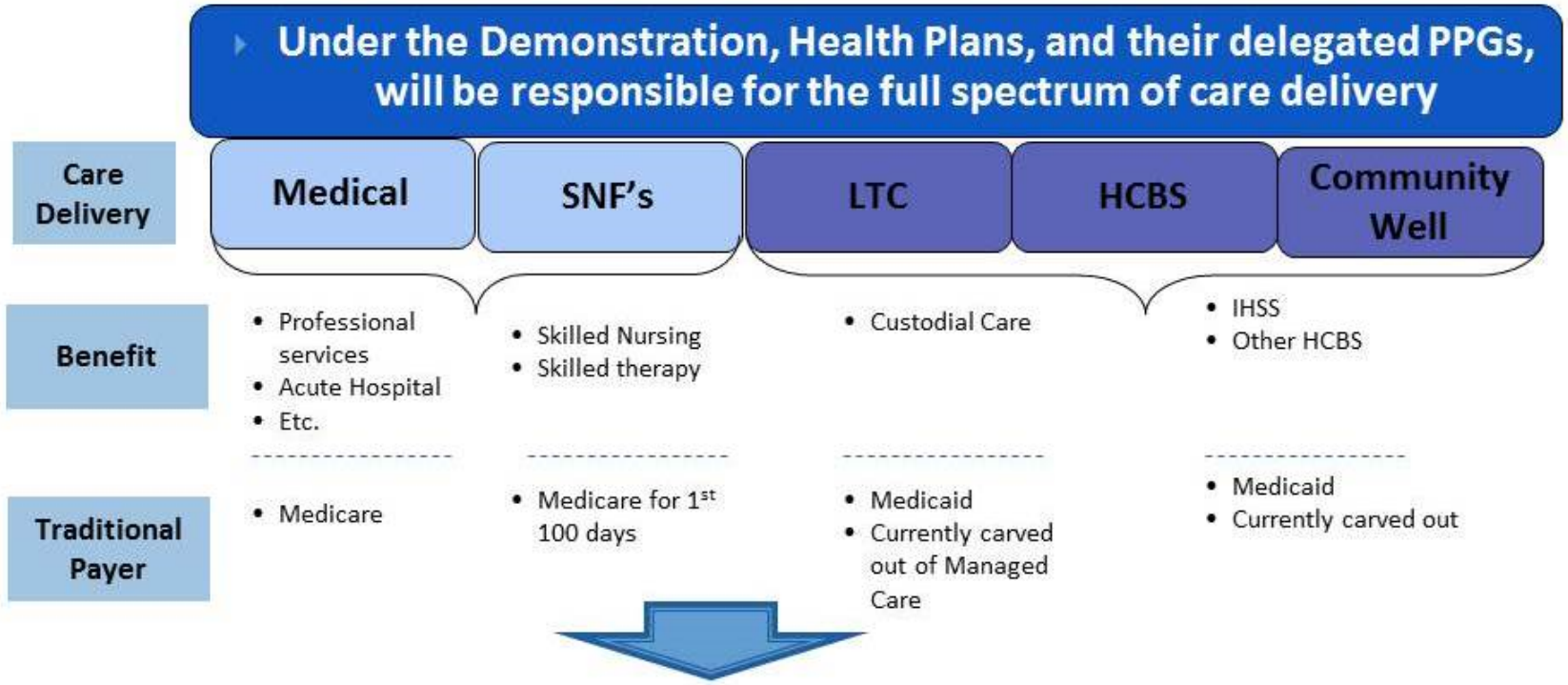
Interdisciplinary Care Team (ICT)

Roles/Responsibilities	Position
Educate enrollees in disease and behavioral health self-management	Case Managers, Behavioral Health Case Managers, Disease Management Specialist, Provider, Health Educator
Consult on pharmacy issues	Pharmacist
Authorize or facilitate access to services	Provider, Pre-authorization Specialist, Concurrent Review Nurse, Case Manager, Behavioral Health Case Manager, Care Coordinator, Public Program Coordinator
Obtain consultation and diagnostic reports	Case Manager, Pre-authorization Specialist, Concurrent Review Specialist, Behavioral Health Case Manager, Provider
Facilitate translation services	Director and Manager of Cultural and Linguistics Services, enrollee Service Associate, Case Manager, Behavioral Health Case Manager, Provider
Facilitate transportation, dental, vision and other add-on services	Case Manager, Behavioral Health Case Manager, Provider, Care Coordinator, Public Program Coordinator

Interdisciplinary Care Team (ICT)

Roles/Responsibilities	Position
Provide Medical and Mental Health Care	Provider
Counsel on Substance Abuse and rehab strategies	Behavioral Health Provider, Behavioral Health Case Manager, Social Worker
Coordinate Social Services	Case Manager, Behavioral Health Case Manager, Social Worker, Provider, Care Coordinator, Public Program Coordinator
Conduct medication reviews	Pharmacist, Provider
Conduct onsite or telephonic concurrent review of enrollees admitted to hospitals, rehabilitation units, or skilled nursing facilities. The review monitors medical necessity, levels of care, and evaluates alternatives to inpatient care. Facilitate discharge planning and coordinates care transitions to promote continuity and coordination of care in conjunction with the provider, enrollee, and enrollee's family to ensure a timely and safe discharge.	Nurses and Medical Directors
Facilitate care transitions related to behavioral health services including: facility admissions, facility admission diversions, discharge to home or other living arrangement, and step down to alternate clinical care setting (i.e., residential treatment, Partial hospital, Intensive Outpatient Treatment).	Behavioral Health Provider, Plan Behavioral Health Case Manager, County Behavioral Health Case Manager, Social Worker

Compliance - Model of Care (AZPC)



Interdisciplinary Care Teams (ICT) provide one point of accountability for the delivery coordination, and management of the member's benefits and services. The ICT is comprised of any combination of the following, as needed: *Member, caregivers, *PCP, Nurses, *BH Clinician, Pharmacist, Care Coordinator, and *Social Worker/Designee.

Care Coordination

- AZPC will coordinate member's care across the continuum of service providers, including medical, Behavioral Health, and Long Term Services and Support.
- AZPC will focus on providing services in the least restrictive setting.
- Care coordination will be led by the Care Coordinator with participation by members of the ICT.
- AZPC shall ensure effective communication of clinical and management systems among Network Providers. Such communication shall include policies for sharing of information, especially during transitions of care.
- Policies and procedures shall clarify all communications and reporting protocols related to coordination of services including, but not limited to, how AZPC oversee all such coordination activities.
- AZPC will ensure that care coordination services:
  - Reflect a person-centered, outcome-based approach, consistent with the CMS model of care.
  - Maintain a member’s right to self-direct his or her IHSS, in addition to the right to hire, fire, and manage the IHSS provider.

Care Coordination

- Follow a member's direction about the level of involvement of his or her caregivers or medical providers.
- Incorporate medical and LTSS delivery systems, including IHSS, with a focus on transitions.
- Assist in coordination with county agencies and direct contractors, as applicable, for Behavioral Health services.
- Include development of an integrated Individual Care Plan (ICP) with members.
- Care Coordination is performed by nurses, social workers, primary care providers, if appropriate, other medical, Behavioral Health, or LTSS professionals, and health plan care coordinators, as applicable; and
- Demonstrate access to appropriate community resources, and monitoring of skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between the facilities and community.

** Health Plans have the responsibility of obtaining and making available existing care plans/information from IHSS, MSSP, CBAS and other LTSS providers to share with the AZPC PPGs regarding these members.

Care Coordination

The Care Coordinator:	
• Performs an assessment of medical, psychosocial, cognitive and functional status	• Reviews and educates on medication regimen
• Develops a comprehensive individualized care plan	• Promotes appropriate utilization of benefits
• Identifies barriers to goals and strategies to address	• Assists enrollee to access community resources
• Provides personalized education for optimal wellness	• Assists caregiver when enrollee is unable to participate
• Encourages preventive care such as flu vaccines and mammograms	• Provides a single point of contact during care transitions

Care Transitions

Management of Care Transitions

- Enrollees are at increased risk of adverse outcomes when there is a transition from one care setting to another such as admission or discharge from a hospital, skilled nursing, rehabilitation center or home health.

- Dual enrollees experiencing or who are at-risk of an inpatient transition are identified (via pre-authorization, facility notification, surveillance).

- Inpatient stays (acute, SNF, rehab) are monitored including the establishment of the Care Plan by the physician within 1 business day of admission.

- When the enrollee is discharged home, the Case Manager conducts post-discharge calls within 2 business days of notification to review changes to the Care Plan, assists with discharge needs, reviews medications and encourages follow-up care with provider.

Care Transitions

- Care Transitions are delegated to the groups and AZPC's goal is to prevent care transitions whenever possible by identifying at risk members and preemptively managing these members to reduce possible hospitalizations.

- The care transition record* Transitions of Care Log (TOC Log): Reports the percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility, PCP or other health care professional for follow-up care within 24 hours of the discharge.

- Transition Record* with Specified Elements Received by Discharged Patients:
  - Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregivers(s), who received a transition record at the time of discharge including, at a minimum, all of the specified elements.

- The Health Plan may provide specific templates in which to document this process. AZPC CS will develop a singular template to be able to report this to ALL Health Plans who require this data.

Continuity of Care (COC)

- AZPC is not required to provide continuity of care for services not covered by Medicaid or Medicare. In addition, the following providers/vendors are not eligible for continuity of care: providers of durable medical equipment (DME), transportation, other ancillary services, or carved-out services.

- AZPC may choose not to provide continuity of care with an out-of-network provider when:
  - The ability to demonstrate an existing relationship between the beneficiary and provider does not occur.
  - The provider is not willing to accept payment from AZPC based on the current Medicare or Medicaid fee schedule, as applicable, and
  - AZPC would otherwise exclude the provider from its provider network due to documented quality of care concerns.

Continuity of Care will be the responsibility of AZPC.

Continuity of Care (COC)

A quality of care issue means that, AZPC can document concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other AZPC members.

- Where can you check for quality of care?
  - Medical Board: http://azmd.gov/doctorsearch/doctorsearch
  - OIG exclusion list: http://oig.hhs.gov/exclusions/index.asp
  - Arizona Medicaid (AHCCCS) excluded provider list: https://www.azahcccs.gov/fraud/providers/

Continuity of Care (COC)

- If the member **does not** qualify for continued access to a non-participating provider or the non-participating provider does not agree to Medicare or the Medicaid FFS rate, AZPC must:
  - Arrange for another provider to render the member's care.
  - Inform the member of the determination in a timely manner appropriate for the member's clinical condition, not to exceed thirty days from the date of the request.

- AZPC should determine whether existing transition of care requirements apply based on Centers for Medicare & Medicaid (CMS) 42 CFR 42.112(b), Chapter 4 of the Medicare Managed Care Manual.
  - Transition of care applies in cases of pregnancy/care of a newborn, serious chronic illness, acute condition, terminal illness or scheduled surgery or procedure.
  - **The COC rate requirements do not apply in transition of care cases.**

Reporting Requirement Changes

- All groups participating in Medicaid must submit to Health Plans all facility admissions on a weekly basis. The template is provided by the Health Plans.

- AZPC must meet any diagnosis and encounter reporting requirements that are currently in place for Medicare Advantage and Medicaid plans.

- AZPC shall implement P&Ps to ensure the submission of complete, timely, reasonable and accurate encounter data for all services for which AZPC has incurred any financial liability, whether directly or through sub-contracts or other arrangements.

- AZPC shall have in place mechanisms, including edits in reporting systems sufficient to ensure encounter is complete, timely, reasonable and accurate prior to submission to health plans no less than on a monthly basis.

New Monthly Reporting Requirements

Enhanced SNP (Special Needs Population) reports are to include the following:

- Number of members not participating (these are members that refused to participate or were unable to be located – bad phone number or address with three attempts being made in the month).

- Number of members with initial assessments within 30, 60 and 90-days for first wave of passive enrollment and then 90-days of enrollment going forward (how many members were seen by the MD and had a full initial assessment (IHA) and at what point in the first 90-days. The number who had these done at these initial increments over the actual number of members assigned).

- Number of care plans developed within 90-days of receipt of HRA (number of care plans versus the number of members assigned).

Responding to Critical Incidents

Critical incidents are, but not limited to:

- Abuse
- Unexpected death
- Disappearance
- Neglect
- Exploitation
- Serious life threatening events
- Suicide attempts
- Inappropriate restraints or seclusion

You may become aware of a critical incident when:

- A member tells you
- A member is admitted for a suicide attempt
- A caregiver or family member with knowledge of the member's situation tells you

Responding to Critical Incidents

Critical incidents must be documented and reported to the appropriate authorities and as required by the health plans.

Authorities:

- Medicare Managed Care Manual (MMCM), Ch. 5 “Quality Assessment”
- Title 42 Code of Federal Regulations (CFR) §422.152 (1)(3)
- The Centers for Medicare and Medicaid (CMS) criteria

Additional Services Associated with MOC

AZPC maintains a comprehensive network of providers, facilities, specialists, behavioral health care providers, social service providers, community agencies, and ancillary services to meet the needs of its members, especially those with complex social and medical needs.

AZPC coordinates with the following programs as necessary to meet the needs of its members and to assist them with their goal to remain independent in their homes.

- Long Term Services and Support (LTSS)
- In Home Support Services (IHSS)
- Multi-Purpose Senior Services Program (MSSP)
- Community Based Adult Services (CBAS)
- Long Term Care (LTC)
- Skilled Nursing Facility (SNF)
- Behavioral Health (BH)

Long Term Care (LTC) and Skilled Nursing Facility (SNF)

Definition of Long Term Care (LTC) & Skilled Nursing Facility (SNF):

- Long-Term Care (**LTC**) is the provision of medical, social, and personal care services (above the level of room and board) that are not available in the community, and are needed regularly due to a mental or physical condition. This is considered a custodial level of care.
- LTC is generally provided in a facility-based setting such as a Skilled Nursing Facility (**SNF**), the member has to demonstrate a skilled need, such as PT, ST, OT, etc.

Behavioral Health (BH)

- Behavioral Health services will be provided through an integrated network of private, contracted behavioral health specialists and county mental health and substance abuse programs.

- Some health plans, such as Health Net provide their beneficiaries with Managed Health Network (MHN) Behavioral Health benefits where they may obtain these services directly through MHN's extensive behavioral health and substance abuse network.

- Dual Eligible beneficiaries who have been assessed and identified as needing specialty mental health services and/or alcohol/drug services and related specialty consultations will be referred to the AHCCCS, as applicable*.

*Some members may be at risk for some of the BH component(s).

Behavioral Health (BH)

- Participating providers may refer beneficiaries, with routine behavioral health needs, directly to participating health plan contracted BH entities. Who will offer a referral to a behavioral health provider. The member may find this information and number on the back of the member's insurance identification card.
- AZPC is not at risk for care and management. All coordination of care between Medical and BH will be documented in the members' case notes.