Model of Care (MOC)

Arizona Priority Care

Table of Contents

- Learning Objectives
- Model of Care (MOC)
  - What is Model of Care?
  - Key Components
- Programs within the Model of Care
  - Complex Care Management (CCM)
  - Special Needs Plan (SNP)
- Goals of Model of Care (MOC)
- Implementing Model of Care
- Health Risk Assessments (HRAs)

Table of Contents (continued)

- Individual Care Plan (ICP)
  - Individual Care Plan Goals - SMART
- Interdisciplinary Care Team (ICT)
- Coordination of Care
- Care Transitions
- Behavioral Health Services
- Continuity of Care
- Responding to Critical Incident
- Provider Marketing

This overview contains all the required information to meet all health plan Model of Care information and education requirements for Arizona Priority 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.
  - List the three (3) overall goals of the SNP Model of Care
  - 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.

Model of Care (MOC)

What is Model of Care?

- The MOC is a comprehensive guide to how we care for our members, how we monitor effectiveness, improve quality of care, and communicate with stakeholders.
- It is an integrated, 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)

Model of Care (MOC)

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.
- Specialized Provider Network – comprehensive network of Primary Care Providers, facilities, specialists, behavioral health care providers, social service providers, community agencies and ancillary services to meet the needs of enrollees with complex social and medical needs.

Programs within the Model of Care

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.
- Members are managed holistically to encourage and maintain self-care and to improve member's state of wellness and decrease costs for unnecessary utilization.
- Members are followed upon discharge from an acute or skilled setting for the purpose of preventing a re-admission and maintaining a state of wellness.

Programs within the Model of Care (continued)

Special Needs Plan (SNP)

- SNPs are Medicare Advantage plans with special benefit packages for populations with distinct health care needs. The goal is to provide extra benefits and team-based care to improve outcomes and decrease costs for special needs population through improved coordination.

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

Programs within the Model of Care (continued)

Special Needs Plan (SNP)

There are three types of SNPs:

- Chronic Condition SNP (C-SNP) – Chronically ill members with targeted chronic conditions such as cardiovascular disease (Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Chronic Venous Thromboembolic Disorder), 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 (AHCCCS) 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 the Model of Care (continued)

Vulnerable SNP Sub-Populations

Populations at greatest risk are identified to direct resources towards members with increased need for team based care:

- Complex/multiple chronic conditions – require assistance with disease management and navigating health care systems
- Disabled – unable to perform key functional activities independently
- Frail – over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF
- Cognitively Impaired – at risk due to moderate/severe memory loss
- End-of-Life – those with terminal diagnosis
- Behavioral health – those in need of behavioral health care services

Programs within the Model of Care (continued)

Benefits to Meet Specialized Needs – Depends on the Heath Plan:

- Disease Management – whole person approach to wellness with comprehensive in-person, online and written educational and interactive heath resources
- Medication Therapy Management – pharmacist review of medication profile quarterly and communication with member/doctor when issues identified: duplications, interactions, gaps in treatment, adherence
- Transportation – covers medically related trips up to unlimited under the health plan or Medicaid benefit and vary according to the specific SNP and region
- In addition, SNP members may have benefits for Dental, Vision, Podiatry, Gym Membership, Hearing Aids, OTC allowance or lower costs for items such as Diabetic Monitoring supplies, Cardiac Rehabilitation – these benefits vary by region/SNP type.
- Diet and nutritional education
- Meal program – these benefits vary by region/SNP type

Programs within the Model of Care (continued)

Special Needs Plan (SNP)

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

- This D-SNP program has both Medicare and Medicaid (AHCCCS) 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.

Language and Communication Needs

SNP patients may have a greater incidence of limited English proficiency, health literacy issues and disabilities that affect communication with negative impact on health outcomes.

Services available through Health Plans to meet these needs include:

- Office interpretation services – in-person and sign-language with minimum 3-5 days notices
- Health Literacy – training materials and in-person training available
- Cultural Engagement – training materials and in-person training available
- Translation of vital documents
- 711 relay number for hearing impaired

Goals of Model of Care (MOC)

AZPC's MOC incorporates the CCM and SNP programs to achieve it's **Quadruple Aim** goals to:

- Increase member satisfaction of care.
- Increase quality outcomes of care.
- Improve provider quality of life.
- Decrease health care costs.

- Additional goals include:
  - Improving access to affordable medical, mental health, preventative care, social services, and other essential services such as Long Term Services and Supports (LTSS);
  - 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 (MOC)

- Additional goals include (continued):
  - 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 members to remain in their homes and communities with appropriate services and supports in lieu of institutional care, i.e. home and community-based services (HCBS);
  - 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).

Culturally Appropriate Care

Federal and state regulations, and national guidelines are in place to ensure that healthcare services being provided in a non-discriminatory manner and that they recognize the needs of our diverse membership.

Some examples include:

- Title VI of the 1964 Civil Rights Act
- Americans with Disabilities Act
- Affordable Care Act Section 1557
- Office of Minority Health Culturally and Linguistically Appropriate Standards
- National Committee for Quality Assurance Multicultural Healthcare Distinction

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)
  - Individualized Care Plan (ICP)
  - Interdisciplinary Care Team (ICT)
  - Coordination of Care
  - Care Transitions
  - Continuity of Care
  - Responding to Critical Incident
  - Additional Services

Culturally Appropriate Care

- Under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, federally conducted and assisted programs along with programs of state and local government are required to make their programs accessible to people with disabilities as well as provide effective communication.

- Effective communication means to communicate with people with disabilities as effectively as communicating with others. Alternative communications that support a patient encounter include Sign Language interpreters, captioning and assisted listening devices.

The benefits of culturally responsive communication and services are:

- Helps ensure equal access to appropriate health care services
- Improves heath outcomes by improving the quality of care
- Reduces healthcare costs by decreasing unwanted procedures
- Decreases malpractice risks
- Increases member and provider engagement and satisfaction
- Ensures compliance with state and federal regulations

Health Risk Assessment (HRA)

- Health Risk Assessments (HRAs) are conducted by the member's Health Plan 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 within 45 days from date of enrollment.
  - HRAs for low risk members or if the member is in a nursing facility are conducted within 90 days.
- Multiple attempts are made to contact the member by either telephone or mail, or face to face at the member's request (patients have the right to refuse to complete the HRA).
- Responses are reviewed by a licensed staff member from the Medical Group and are incorporated into the member's care plan, and are communicated to the member's primary care physician by mail or provider portal.

*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 ICP still needs to be completed if the member chooses to not participate/opt out. The member has the right to identify who they want to participate in care planning process.
- The member's goals and preferences must be included. Problems, barriers (lack of transportation, finances, etc.) and interventions should be documented.
- The ICP must have measurable objectives and timetables to meet the member needs.
- The timeframes for reassessment and updating of care plan must be done at least annually or more frequently if there are a significant changes in condition (i.e. transition of care).
- If member is receiving Behavioral Health (BH) 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.
- The member should receive the ICP when it is completed and whenever there are updates or changes. The care plan must be made available to the member at a 8th grade level, in alternative formats, and in the beneficiary's preferred written or spoken language.

Individual Care Plan (ICP) (Continued)

The ICP completed by the case manager includes:

- A review of clinical information from all available medical records, including a complete, current list of the member's medications.
- Integration of the Health Plan HRA into the overall care plan. Note: if the HRA is not received timely, the ICP must still be initiated and the Case Manager must document that there was no HRA at the time of ICP completion.
- Creation of the ICP in conjunction with the Interdisciplinary Care Team (ICT).
- Identification and referral to 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 carved-out and outside of plan such as referrals to community social services, specialty mental health or Medicaid services.
- Member and/or caregiver/authorized representative and members of the ICT must have access to the ICP upon request.
- ICPs will include the name and contact information for the current assigned care coordinator and name and contact information for the member's PCP and any specialists.

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 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 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 and others as needed.

Interdisciplinary Care Team (ICT) (Continued)

- Members have the ability to choose to limit or disallow all together any member on the ICT. They also have the right to not participate in/opt-out of the ICT meetings. The ICT still needs to be completed even if the member chooses to opt-out.
- 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 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) (Continued)

The ICT must be patient-centered and developed based on the needs and preferences of the member and will:

- Ensure integration of medical, LTSS, and coordination of Behavioral Health services when applicable.
- 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
    - Meet member's care plan goals
- Deliver services with transparency, individualization, respect, linguistic and cultural competence and dignity.

Interdisciplinary Care Team (ICT) (Continued)

- 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 SNP or 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. Ensuring 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.

- ICT meeting notes must be disseminated (or available at any time in the computer system) to all members of the ICT for that member.

Interdisciplinary Care Team (ICT) (Continued)

Role/Responsibilities	Position
Coordinate care management	Case Manager, Behavioral 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	Health Plans
Evaluate and analyze responses to HRA and assign enrollees according to risk level	Health Plans
Facilitate implementation of Care Plan	Case Manager, Behavioral Health Case Manager, Provider

Interdisciplinary Care Team (ICT) (Continued)

Role/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) (Continued)

Role/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
AZPC nurses, Medical Directors and delegated partners, 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. This team facilitates 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

Interdisciplinary Care Team (ICT) (Continued)

Each ICT has a composite of members that are knowledgeable on key competencies including, but not limited to:

- Person-centered planning processes
- Cultural competence
- Accessibility and accommodations
- Independent living and recovery, and
- Wellness principles

Care Coordination

Definition:

- An approach to health care in which all of a member's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the member and the member's caregivers and works with the member to make sure that the member gets the most appropriate treatment while ensuring that health care is not accidentally duplicated.

Goal:

- Help member regain optimum health or improve functional capability, in the right setting and in a cost-effective manner.

Support individual choice:

- Live in least restrictive environment
- Maintain independence
- Prevent functional decline

Care Coordination

- AZPC will coordinate member's care across the full 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 (Continued)

- 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 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.

Care Coordination (Continued)

The Case Manager:

- Performs an assessment of medical, psychosocial, cognitive and functional status
- Develops a comprehensive individualized care plan
- Identifies barriers to goals and strategies to address
- Provides personalized education for optimal wellness
- Encourages preventive care such as flu vaccines and mammograms
- Reviews and educates on medication regimen
- Promotes appropriate utilization of benefits
- Assists enrollee to access community resources
- Assists caregiver when enrollee is unable to participate
- 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.
- SNP and Dual enrollees experiencing or 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 Care Plan, assist with discharge needs, review medications and encourage 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.
- 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)

- A beneficiary with a pre-existing provider relationship who makes a COC request to the plan must be given the option to continue treatment with their current out-of-network provider and service authorization at the time of enrollment for :
  - A period up to 12 months for Medicare services if all of the following criteria are met under W&I Code §14132.275(k)(2)(A).

Continuity of Care (COC) (Continued)

- 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 HPN and Arizona Priority Care.

Continuity of Care (COC) (Continued)

- 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?
    - OIG exclusion list: http://oig.hhs.gov/exclusions/index.asp
    - SAM exclusion list: https://www.sam.gov/portal/SAM
    - Arizona Medicaid (AHCCCS) excluded provider list: https://www.azahcccs.gov/OIG/ExludedProviders.aspx

Continuity of Care (COC) (Continued)

- 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 under H&S Code Section 1373.96 apply.
  - 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

- AZPC PPGs must meet any diagnosis and encounter reporting requirements that are currently in place for Medicare Advantage and Medicaid plans.
- AZPC PPGs shall implement P&Ps to ensure the submission of complete, timely, reasonable and accurate encounter data for all services for which AZPC PPGs has incurred any financial liability, whether directly or through sub-contracts or other arrangements.
- AZPC PPGs 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 events 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,” Section 30.1.1
  - California Health & Safety Code, Section(s) 1368-1368.03
  - Title 42 Code of Federal Regulations (CFR) §422.152 (1)(3)
  - The Centers for Medicare and Medicaid (CMS) and the state of California: California Readiness review 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 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.
- The member's desire and ability to return to a home, or to a non-institutional housing environment, utilizing home and community based services will be assessed with the goal of returning the enrollee to independent living whenever reasonably possible.

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.
- Behavioral health services include inpatient and outpatient care, integrated with medical care and services:
  - Inpatient services (general acute, emergency services)
  - Partial hospitalization/intensive outpatient
  - Psychological testing
  - Psychiatric office visits
  - Outpatient psychotherapy (individual and group therapy)
- 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 County Mental Health Plans, as applicable*.
- If the enrollee's Health Risk Assessment identifies high risk behavioral health needs for any identified enrollee, the Interdisciplinary Care Team (ICT) will include behavioral health specialists who work in partnership with the enrollee and the team.
- *Some members may be at risk for some of the BH component(s).

Behavioral Health (BH)

- Participating providers may refer members, with routine behavioral health needs, directly to a Behavioral Health Provider. The member may find this information and number on the back of the members' insurance identification card.

- Members may also self-refer.

- AZPC's Participating Providers will be utilized, as AZPC is at risk for care and BH management. All coordination of care between Medical and BH will be documented in the members' care notes.

Member Rights

AZPC is dedicated to providing members with quality health care services so they may remain as independent as possible.

AZPC staff is committed to treating each and every member with dignity and respect, and ensuring that all members are involved in planning for their care and treatment.

Members have the right to know their rights and responsibilities. All AZPC members have the right to:

- Be treated with respect
- Protection against discrimination
- Information and assistance
- A choice of providers
- Access emergency services
- Have their health information kept private
- File a complaint
- Leave the program

There is no negative consequence to exercising a right.

Member Rights

- Members can choose their network and doctor.
- Members decide composition of and level of involvement in ICT in developing their ICP.
- All members have the right to select and delegate health care decisions to an authorized representative.
- Members can choose who can help with their health care decisions, such as family members, friends or others.
- A member can leave the plan, if they choose.
- Members have the same rights available to members in Medicare or Medicaid plans.

Quality Oversight of the MOC

As the Model of Care (MOC) is being implemented, the health outcomes will be monitored as follows:

- Identifying and defining measurable MOC goals and collecting data to evaluate annually if measurable goals are met
- Collect SNP/CMC specific HEDIS measures
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness
- Communicating MOC outcomes to stakeholders

Provider Marketing

Marketing materials include any informational materials that:

- Promote an organization;
- Provide enrollment for an organization;
- Explain the benefits of enrollment in an organization;
- Describe the rules that apply to enrollees;
- Explain how Medicare services are covered, including the conditions that apply to such coverage.

Regulations and Requirements

- No false, misleading or ambiguous information (42 CFR 422.2268(e));
- Written at 6th grade reading level or lower;
- Culturally and linguistically appropriate;
- Marketing materials shall include:
  - Year last updated
  - Source of representations, endorsements, or awards referenced
  - Entity responsible for producing the material
  - Correct usage of company and/or Health Plan logo
  - Prior to use, the Health Plan must first review and approve the use of their logo prior to producing/publishing.

Provider Marketing

Regulations related to Provider Based Activities

- Providers may provide the names of Plans/Part D sponsors with which they contract with and/or participate.
- Providers may provide information and assistance to a beneficiary applying for low income subsidy (LIS)
- Assist a beneficiary in an objective assessment of his/her needs
- Share information with beneficiaries from CMS' website (http://www.medicare.gov), including:
  - Medicare and You Handbook
  - Medicare Options Compare
  - Other documents written or approved by CMS

Provider Marketing

Regulations related to Provider Based Activities

Providers may NOT:

- Make any phone calls or directly urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider;
- Conduct health screenings as a marketing activity;
- Accept Medicare enrollment applications;
- Offer anything of value to induce enrollees to select them as a provider;
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization;
- Distribute materials/applications within an exam room setting.

Failure to comply with Medicare marketing guidelines may result in sanctions, including, but not limited to:

- Financial penalties
- Immediate suspension of use of marketing materials and promotional activities not exceeding 6 months
- Imposition of an enrollment or membership cap
- Contract termination

References

- www.cms.gov/Medicare/HealthPlans/SpecialNeedsPlans
- Medicare Managed Care Manual, Chapters 5, 16B
- Title 42, Part 422, Subpart D, 422.152

Arizona Priority Care™

One Goal. One Priority. Your Healthcare.

Please click the link below to start the test.

Model of Care Quiz