KeyCare ADVANTAGE

2024 Model of Care Training

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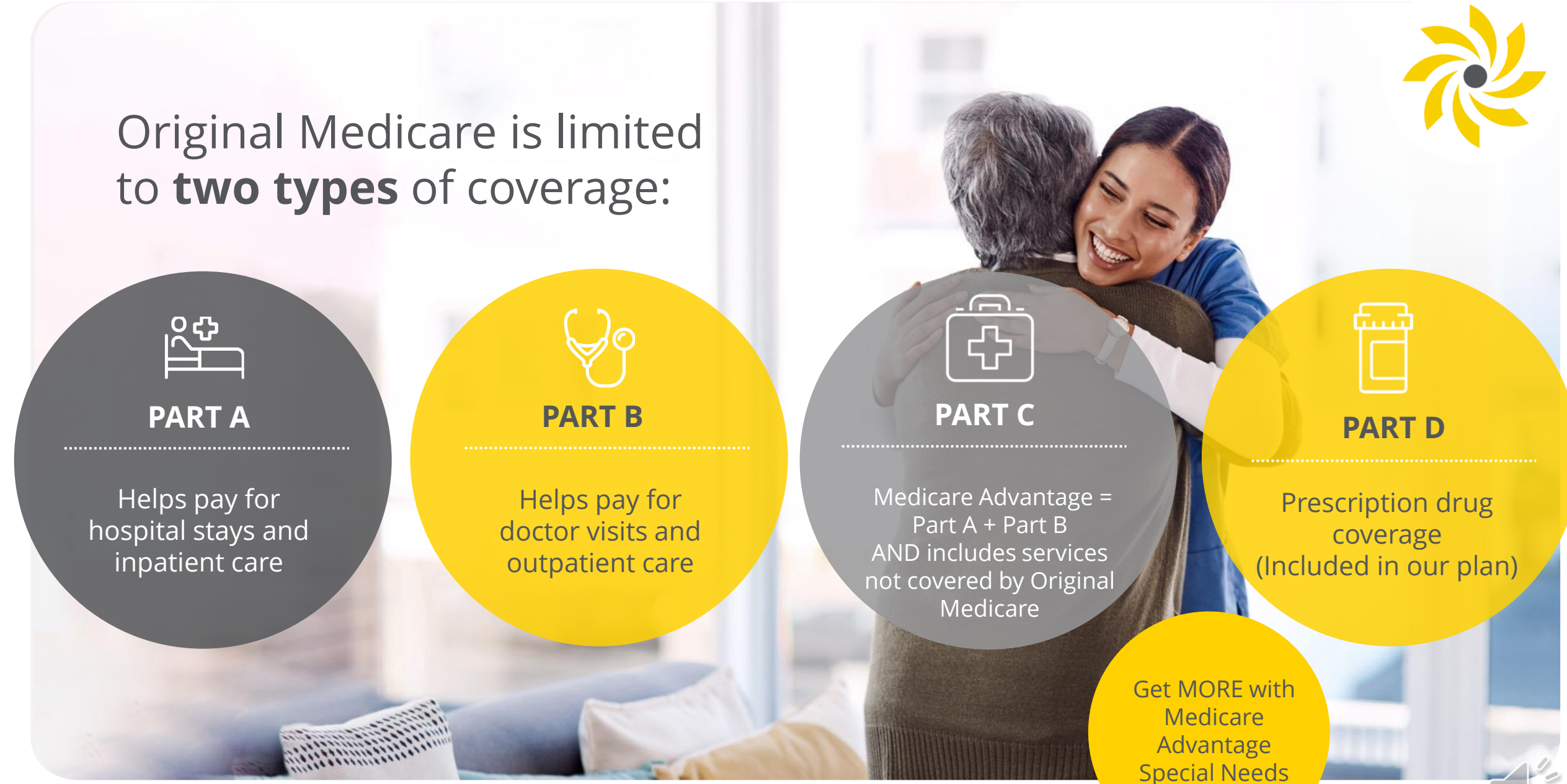
Background & Objectives

The Centers for Medicare & Medicaid Services (CMS) requires all Special Needs Plans (SNP) to provide Model of Care (MoC) training for all Care Team members who see the Plan's SNP members routinely.

This training will help you to:

- Understand Medicare and Medicare Advantage
- Describe the different types of SNPs
- Understand the MoC key components
- Define your role in supporting the MoC

Original Medicare is limited to **two types** of coverage:



PART A

Helps pay for hospital stays and inpatient care

PART B

Helps pay for doctor visits and outpatient care

PART C

Medicare Advantage = Part A + Part B AND includes services not covered by Original Medicare

PART D

Prescription drug coverage (Included in our plan)

Get MORE with Medicare Advantage Special Needs Plans

Special Needs Plans A type of Medicare Advantage plan

Who Qualifies?

Special Needs Plans (SNPs) offer additional services based on specific medical situations for those who qualify:

- Enrolled in Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Lives in plan service area (CMS approved counties)

Chronic Condition Special Needs Plan (C-SNP)
Documented diagnosis of at least one if the following:

- Diabetes mellitus
- Cardiovascular disorders limited to:
  - Chronic heart failure
  - Cardiac arrythmias
  - Chronic venous thromboembolic disorder
  - Coronary artery disease
  - Peripheral vascular disease

Institutional Special Needs Plan (I-SNP)
Must reside (or plan to reside) in a qualifying facility for 90 or more days

Institutional-Equivalent Special Needs Plan (IE-SNP)
Meet institutional level of care but resides in other levels of care such as an assisted living or independent living

What is the Model of Care?

The Model of Care is the contract that the Plan submits to CMS clearly outlining who our members are, how we take care of them, how we demonstrate that care, and how we manage the quality of that care. We use this contract to individualize the unique needs of our members.

CMS requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care.

Key Sections:

- MOC 1: Description of the SNP Population
- ***MOC 2: Care Coordination (clinical team's focus)**
  - Health Risk Assessment (HRA)
  - Face-to-Face Encounters
  - The Individualized Care Plan (ICP)
  - The Interdisciplinary Care Team (ICT) Meetings
  - Care Transition Protocol
- MOC 3: Provider Network
- MOC 4: Quality Measurement and Performance Improvement

MoC 1: Description of the SNP Population

Members living in Senior Living Communities:

- Skilled Nursing Facilities (SNF)
- Memory Care
- Assisted Living (AL)
- Independent Living (IL)
- Continuing Care Retirement Community (CCRC)

Members may have or require the following:

- Additional care coordination than the general population
- Has multiple co-morbid chronic conditions requiring close monitoring
- Likely prescribed high-risk medications
- May need help with 5 or more activities of daily living (ADLs)
- May have moderate to severe cognitive impairment

Key Plan Support Role

Advanced Plan Practitioner (APP)

- Completing and/or reviewing the Health Risk Assessments (HRA)
- Provides on-site primary and preventative care services
- Compliments and supports Primary Care group-led services; does not replace care by existing primary team
- Working with the ICT to ensure every member has a complete and updated ICP that reflects the goals/preferences of the member and track progress towards goals
- Participates in Facility ICT Meetings
- Medication review and monitoring to avoid side effects
- Oversight for all transition of care events
- Providing education for the member regarding health and medical conditions
- Partners with the facility to proactively prevent hospital admissions
- Post-discharge visits including medication reconciliation
- Accountable for quality measures

MoC 2:
Care Coordination

- Health Risk Assessments (HRA)
- Face-to-Face Encounters
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT) Meetings
- Care Transition Protocols

For APPs Only:

To receive credit for the Model of Care activities completed, the Plan approved billing code must be submitted to the Plan. This is how the Plan will track your activities for compliance.

Approved codes are located in the **Quality Resource Guide** that is on the Plan's website under "Provider Documents." For questions, please reach out to Plan Management.

Health Risk Assessment (HRA)

The main objective of the HRA is to assess the Member's current health status, identify unmet health needs, estimate their level of health risk, and to use the information collected from the HRA to support the development of the Individualized Care Plan (ICP).

Requirements

- All new Plan members receive an HRA **within 90 days of enrollment** (start effective date).
  **Best practice is within 30 days.*
- Existing members should have an HRA annually (**within 364 days of their prior assessment**).

Reminder: If the annual HRA is not completed within 364 days of the previous HRA, the Plan must complete a second HRA during the next quarter (or within the calendar year) to ensure compliance. This is a CMS Part C requirement.

Example below:

Member Enrollment – 02/01/2018 to present
Member Initial Assessment – 03/30/2018
Member Reassessment (2019) – 02/20/2019
Member Reassessment (2020) – No HRA completed
Member Reassessment (2021) – 02/01/2021- Not timely, 5/20/2021- Timely
Member Reassessment (2022)- due on/before 5/19/2022

Health Risk Assessment Outcomes

1. The APP is responsible for ensuring that needs or gaps identified through the HRA or in subsequent visits with the member are addressed by the ICP.

2. Stratification of HRA responses to set the timing of the initial comprehensive geriatric exam (**for new Plan Members**) or the next examination/ visit date with the APP.

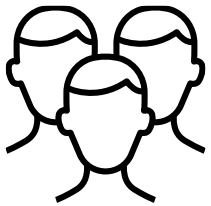
HRA Stratification Level	Post-HRA Visit
High	Within 14 days
Medium	Within 30 days
Low	Within 45 days

Health Risk Assessment (HRA)

HRA Unable to Contact (UTC) Protocol:

If the member is unable or unwilling to participate in the HRA, the HRA will be conducted with a caregiver, responsible party, Power of Attorney (POA), or other delegated entity as requested by the Member.

The Plan will make three documented attempts on different days and times and then will send an unable to contact (UTC) letter for Members or responsible parties who are unable to contact. The first three attempts should occur within 60 days of the Member's start effective date. The fourth attempt (letter) will occur within 90 days of enrollment.



Face-to-Face Encounter

- The APP will conduct an initial member face-to-face encounter and HRA within 90 days of the Member's enrollment to the Plan.
    - Best practice is within 30 days of enrollment or sooner based on clinical judgement.
- Subsequent face-to-face encounters will vary based on Member health status, needs, and preferences but will occur at minimum annually, including members on hospice.
    - Best practice is to complete a face-to-face encounter with the member at a minimum **MONTHLY**.
- Members who have recently experienced a care transition should be considered for weekly evaluation until clinically stable.
- Face-to face encounters may be completed in person or virtually via telehealth (video + audio). Member and or caregiver verbal consent to a telehealth visit will be obtained by the APP prior to conducting the telehealth visit and documented in the member's electronic medical record.

F2F Encounter Refusals

- The Plan's care team will make its best efforts to fully engage with Plan Members but also acknowledge that Members have the right to refuse a face-to-face encounter.
- The Plan's care team will document the reason why the face-to-face encounter is not feasible in the Plan's care management system.
- If the Member is unable to be reached, the Plan's care team will make multiple efforts to try and reach the Member to engage in case management services.
- Efforts to reach the Member include phone calls on different days.

Interdisciplinary Care Team

- Every member has access to an Interdisciplinary Care Team (ICT).
- The exact composition of the ICT working with members varies and is dependent on each member's unique circumstances, risk-level, and individual needs and preferences.
- The ICT is developed to ensure effective coordination of care, especially through the member's care transitions, and to improve health outcomes.
- The ICT reviews progress towards goals during clinical and monitoring visits with the member and during the ICT team meetings.
- The ICT improves access to needed services and support as gaps in care and outstanding needs are identified.

Care Coordination

Individualized Care Plan (ICP)

- ICPs for all members are developed after the initial HRA is completed (within 90 days of enrollment).
- ICPs should be reviewed and updated if needed:
    - Nursing Facility: quarterly
    - Other levels of care: twice a year
- Reviewed and updated, if needed, during ICT meetings or a significant change in member health status.

Interdisciplinary Care Team (ICT) Meetings

- The APP is required to attend ICT meetings, at minimum **annually** (including hospice).
- If the facility does not notify and/or invite the APP to the Facility ICT Meeting, the APP is responsible for coordinating an ICT Meeting with the member/caregiver and facility staff.

Care Transitions

- If the Plan is notified of a potential care transition (i.e., inpatient or long-term acute care), the APP will make best efforts to meet with the member and/or caregiver/family before the transition to discuss goals of care and advance directives.
- Upon notification of the member's discharge, the APP will make an interactive contact with the member/caregiver **within two (2) business days of the notification of discharge**.
- The APP will complete a post-discharge and/or change in condition visit with the member face-to-face and/or telehealth visit **within seven (7) calendar days of the discharge** and will update the treatment plan, as appropriate.

During the post-discharge visit, the APP may complete the following:

- Educate the member and/or caregiver on the reason(s) for hospitalization
- Provide instruction on who to contact for concerns at any point in time
- Educate the member and/or their caregiver on signs and symptoms or "red flags" (i.e., warning signs that indicate the condition is worsening and how to respond)
- *Perform medication reconciliation (required quality measure)
- Educate members living in Assisted Living who are managing their own medication on medication self-management, new medications, and dosing
- Review any new conditions or diagnoses
- Review the updated ICP
- Coordinate orders for post-hospital specialist visits, diagnostic testing, home health services and/or therapy

Clinical Practice Guidelines can be found on the Plan website under the "For Provider" tab.

Care Transition Cont.

APP/Practice Group Reminder: Review the Quality Resource Guide to verify the provider is completing an approved encounter type and billing per the guidelines of the CPT code.

- This is how the Plan will verify the transition visit occurred within 7 calendar days!
- Approved Billing Code:

Measure	Detail	Code
Care Transitions	Interactive contact with the member or caregiver, as appropriate, within two (2) business days of hospital inpatient discharge or emergency room visit. The contact may be direct (face-to-face), telephonic or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit. Face to Face Visit must take place no later than seven (7) days from discharge.	99496

Quality Measure: Medication Reconciliation post-discharge is required within 30 days. Best practice is to complete this with the care transition visit. Report CPT II code 1111F on the claim, in addition to the visit code.

MoC 3: Provider Network

- The Plan provides a comprehensive contracted network of providers, facilities, ancillary service providers, specialist physicians, and acute care facilities with the specialized clinical expertise pertinent to the care and treatment of long-term senior housing residents.
- Primary care services through the APP and supportive ancillary services like therapy, rehab, selected diagnostic radiology and lab, and home health are provided within the member's senior housing residence and coordinated by the APP.
- The APP also coordinates visits and services provided outside of the facility including specialist visits, radiology, lab, and other diagnostic testing not available on site.
- Out of Network referrals may require prior authorization

MoC 4:
Quality Measurement and Performance Improvement

- The purpose of the Plan's Quality Improvement Program (QI Program) is to continually take a proactive approach to assure and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so that it may fully realize its vision, mission and commitment to member care.
- The QI Program supports and promotes the mission, vision, and values of the Plan through continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services to members.

Member Risk Prevention - PQI

Potential Quality Issues (PQI)

- A deviation or suspected deviation from expected provider performance, clinical care or outcome of care that cannot be determined to be justified without additional review. Examples of potential quality issues include:
  - Falls with injury/additional treatment required
  - Medication errors with injury/additional treatment required
  - Incident resulting in death
  - Incident resulting in severe brain or spinal damage to a patient

- All PQIs should be reported within three calendar days of the incident using the PQI form.
- Email completed form via secure email to pqireferral@allyalign.com or submit via the Provider Portal
- The PQI will be reviewed to determine if there should be a change in procedure to prevent further incidences.

Member Risk Prevention – A&G

Appeal

An appeal is **the right to ask the Plan to change their decision**. An appeal only occurs if the Plan makes a decision to deny in whole or in part a service or claim. Member/Member Representatives and providers can file an appeal within the allowed CMS timeframe which is 60 days from date of denial.

- Members/member representative/providers reporting an appeal, should send a secure email with complete appeal details to: appeals@allyalign.com OR fax 1-833-610-2380.

Grievance

A grievance is **any complaint or dispute** (other than an organization determination) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. Grievances can be filed within 60 days of occurrence.

- In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.
- Members/member representative reporting a grievance, should send a secure email with complete grievance details to: grievances@allyalign.com OR fax 1-833-610-2380.

We are here to support you!

AllyAlign Health Training Department:

clinicaltraining@allyalign.com

Thank You