Provider Partners™
Health Plans

Model of Care(MOC) Facility
IE-SNP Training 2024

Overview – Regulatory Requirements

Provider Partners Health Plans

- The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to design and implement a Model of Care (MOC) that details how the Plan will provide specialized care to enrollees § 422.101 (f)

- CMS requires all SNPs to conduct initial and annual training that reviews the major elements of the MOC for providers and staff § 422.101 (f)

Goals of Training

Provider Partners Health Plans

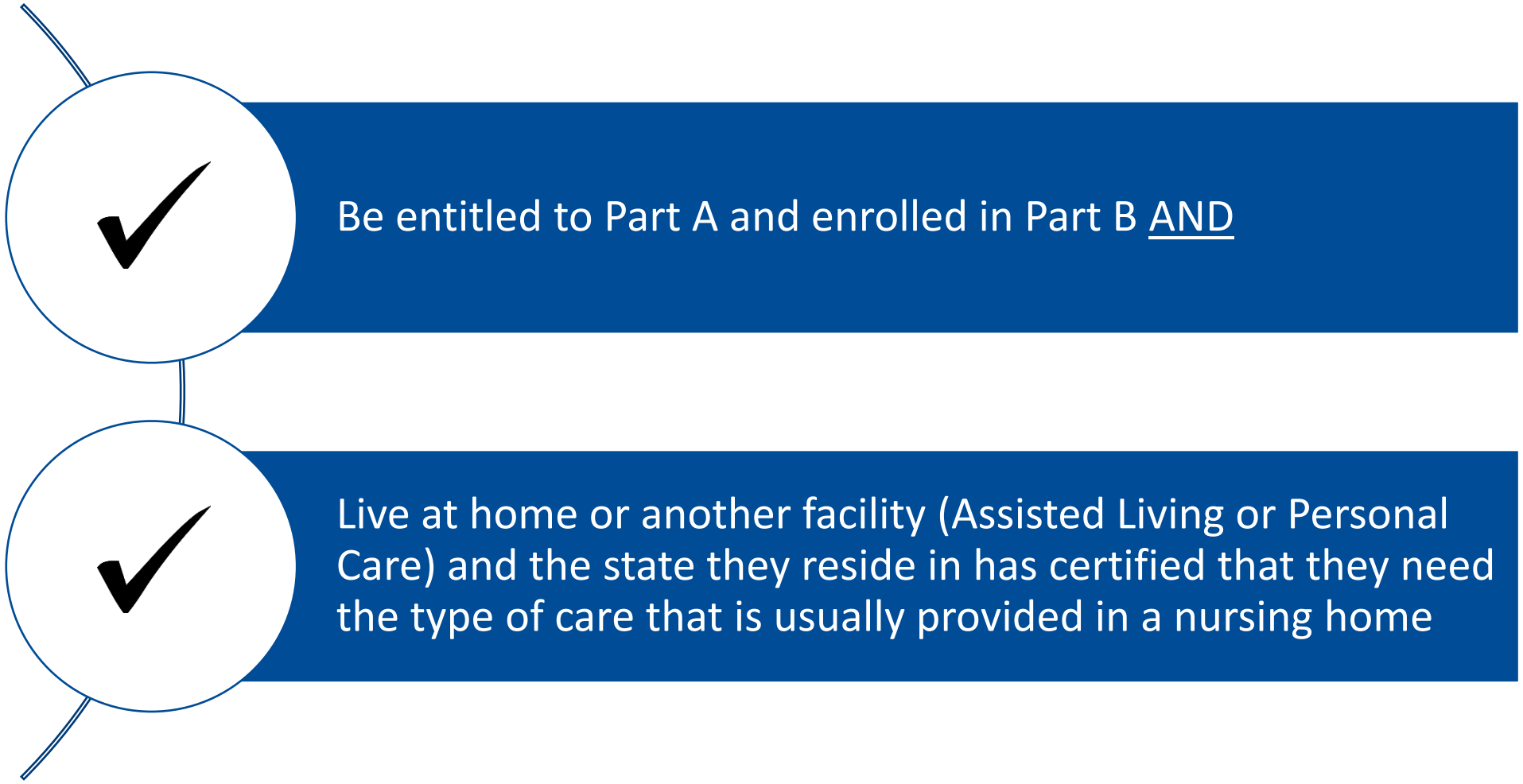
- Describe what an Institutional Equivalent Special Needs Plan (IE-SNP) is and the purpose of the MOC
- Show how the Provider Partners MOC can help you as facility staff
- Help you understand your role in the MOC

What is an IE-SNP?

AN IE-SNP is a type of I-SNP plan. IE-SNPs offer benefits tailored to the unique medical, social, and emotional needs of members who need the level of care given in a long-term care facility who can remain at home. Some members also live in:

- Group home setting
- Assisted Living Residences
- Personal Care Communities

To be eligible for Provider Partners enrollment, beneficiaries must:



What is the MOC?

Provider Partners Health Plans

The MOC is Provider Partners detailed, written commitment to CMS on how we will provide specialized care to enrolled IE-SNP members.

**CMS will audit Provider Partners against the processes and commitments described in the MOC*

The MOC contains the following required components:

- Description of the Plan Population and identification of "Most Vulnerable"
- Care Coordination
  - Staff Structure and MOC Training
  - Health Risk Assessment (HRA), Individualized Care Plan (ICP) & Interdisciplinary Care Team (ICT)
  - Care Transitions Protocols
- Specialized Provider Network and Use of Clinical Practice Guidelines and Protocols
  - MOC Training for Providers and Facilities
- Quality Improvement and Performance Monitoring

Goals of Provider Partners MOC

Provider Partners Health Plans

The MOC is designed to:

- Identify and address changes in condition to optimize member function
- Reduce non-essential hospital admissions when care can safely be provided where the member resides (SNF/ ALF/ PCH)
- Maintain members at an optimal level of function
- Ensure preventative and quality measures are completed as appropriate
- Utilize clinical practice guidelines to deliver safe evidence-based interventions
- Coordinate care to ensure interdisciplinary approach across all care continuums

Advantage for Facilities

Provider Partners MOC offers many advantages for facilities, including:

- A dedicated Nurse Practitioner and/or RN Care Coordinator that collaborates and communicates with the facility both onsite/ telephonically to provide an interdisciplinary approach to care
- Coordination of planned and unplanned care transitions between the facility, hospital or other care settings as necessary
- Improved quality of care and health outcomes for residents as measured by HEDIS® scores and hospital use rates

In the following slides, look for the “star” symbol for quick tips and summaries of what facilities can expect from the Plan

MOC Staff and Roles

Provider Partners Health Plans

The MOC contains the following required components:

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  - Health Risk Assessment, Individualized Care Plan & Interdisciplinary Care Team
  - Care Transitions Protocols
- Specialized Provider Network and Use of Clinical Practice Guidelines and Protocols
  - MOC Training for Providers and Facilities
- Quality Improvement and Performance Monitoring

Key Teams: Partner Development/Sales, Enrollment, Analytics, Clinical Operations

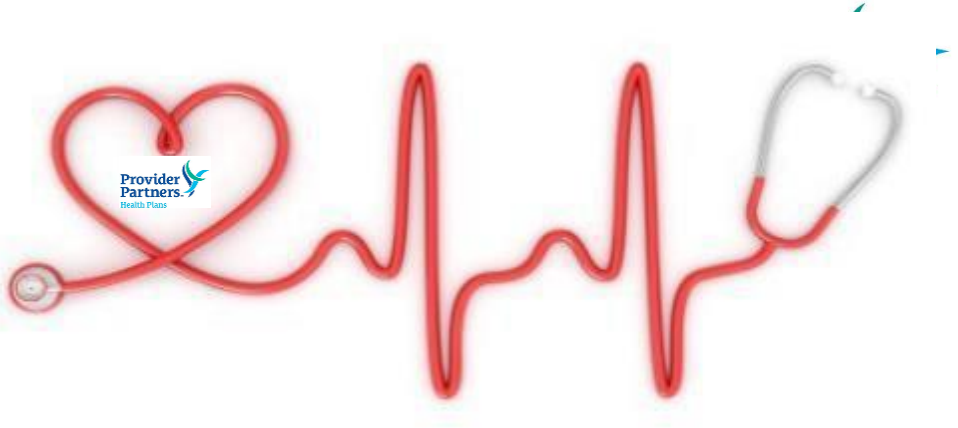
Key Teams: Clinical Operations, Partner Development, Utilization Management, Pharmacy

Key Teams: Network Operations, Partner Development, Clinical Operations, Quality, Credentialing

Key Teams: Quality Improvement, Analytics, Clinical Operations, Network Operations, Member Services, Operations, Pharmacy, Utilization Management

SNP members and MOC processes are also supported by: Executive Leadership, Compliance, Information Technology, Member Services/Call Center, Pre-certification, Claims, Appeals and Grievances.

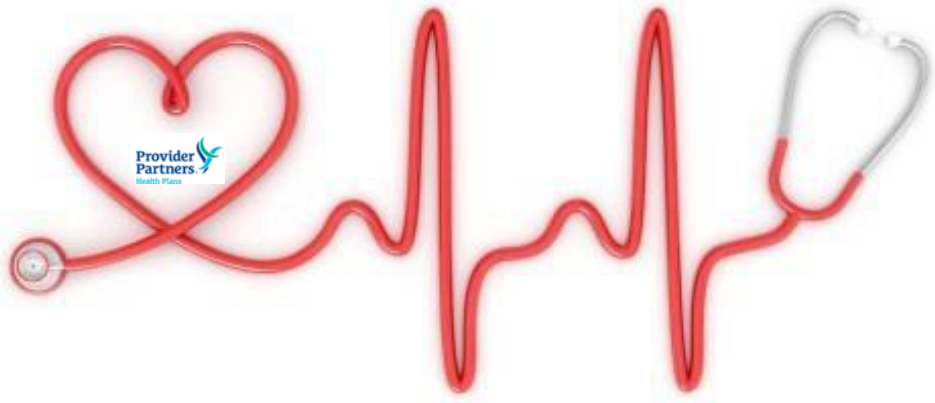
Key Care Coordination Staff



- Nurse Practitioner (NP)
  - Assigned to each facility and all members enrolled
  - Dedicated point of contact for providers, members and families/caregivers
  - Promotes continuity of care, coordinates care plan communications and implementation
  - Provides on-site and telephonic primary care support
  - Visits/assesses each member based on member condition and risk level

The NP will work closely with you to manage members' care and will keep you informed on their progress and changes in condition

Key Care Coordination Staff continued…



- RN Care Coordinator (RNCC)
  - Assigned to each facility and dedicated to all members enrolled
  - Liaison between the NP/ Provider and facility staff
  - Assesses and monitors members' conditions and coordinates care based on their needs with the member and care team

Contact the RNCC or the NP if you have any concerns with a Provider Partners member. A Provider Partners provider is on call 24/7.

Key Care Coordination Staff continued

- Provider Relations Team
  - Knowledgeable about covered benefits under Medicare, Coordination of Benefits (COB) issues, MOC and administrative processes
  - Support members by focusing on member experience and promoting positive facility and provider relationships.

CMS Care Coordination Requirements and Provider Partners Approach

CMS MOC Regulatory Requirement		Provider Partners MOC Process
Health Risk Assessment (HRA) §42 CFR (f)(1)(i)	1) All SNP members must have an initial HRA within 90 days of enrollment and at least annually thereafter within 364 days of the previous HRA	• Provider Partners NP or RNCC conduct a comprehensive HRA within 90 days of enrollment and at least annually thereafter. • Interim assessments conducted as needed based on members' condition. • Member risk level assigned with each assessment and determines NP or RNCC visit frequency.
Individualized Care Plan (ICP) §42 CFR (f)(1)(ii)	2) All SNP members must have an ICP based on the needs identified in the HRA	• NP/RNCC develops member's ICP after completing the HRA and in the same member visit. • ICPs reviewed/revised based on members' goals and condition.
Interdisciplinary Care Team (ICT) §42 CFR (f)(1)(iii)	3) All SNP members must have an ICT that collaborates in care plan development and implementation	• The NP and the RNCC are the "hub" of each member's ICT and coordinates communications with other participants. • The NP or RNCC will talk to you about the member's HRA results and care plan along with revisions and updates.

All of these activities are documented centrally in the member's chart at the facility as well as in the Provider Partners electronic medical record.

Provider Partners™ Health Plans

Health Risk Assessment (HRA)

Provider Partners Health Plans

- Conducted by the RNCC or NP, the HRA identifies the medical, psychosocial, cognitive, functional and mental health needs and risk level of each member.
- Risk level dictates the member's visit schedule by the NP or RNCC
  - For IE-SNP Members:
    - High risk: members are seen at least monthly
    - Low risk: members are seen at least quarterly
- The member is reassessed if there is a change in health condition or care transition.
- HRA findings are used to develop/update the member's care plan and shared with the member, Care Team and are available in facilities Provider Partners electronic medical record.
- Face to face encounters are conducted in person or via HIPPA secure telemedicine platform.

NP or RNCC may contact you for assistance with the assessment especially if the member is cognitively impaired.

Individualized Care Plan (ICP)

Provider Partners Health Plans

- Tailored to the needs and preferences of the member as identified by the HRA
- Shared with member/responsible party, facility staff, the PCP and key specialists, as needed
- Clinical practice guidelines applied
- Reviewed/updated by the NP or RNCC on a routine basis and at least monthly in accordance with member risk level

The NP or RNCC will contact you to discuss the ICP and the best ways to care for the member.

Individualized Care Plan (ICP) Goals

Provider Partners Health Plans

ICP goals must be based on the SMART Measurable Goal Model

- Specific – Exactly what is to be learned/accomplished by the member
- Measurable – A quantifiable goal and specific result that can be captured, reported and documented in the ICP.
- Attainable – Goal is achievable by the member.
- Relevant – Goal is clearly linked to health status.
- Time-Bound – The deadline or time period to motivate and evaluate is specific in terms of specific date, number of days/weeks/months or calendar year.

Goals and objectives are tailored to a member's unique and individual needs

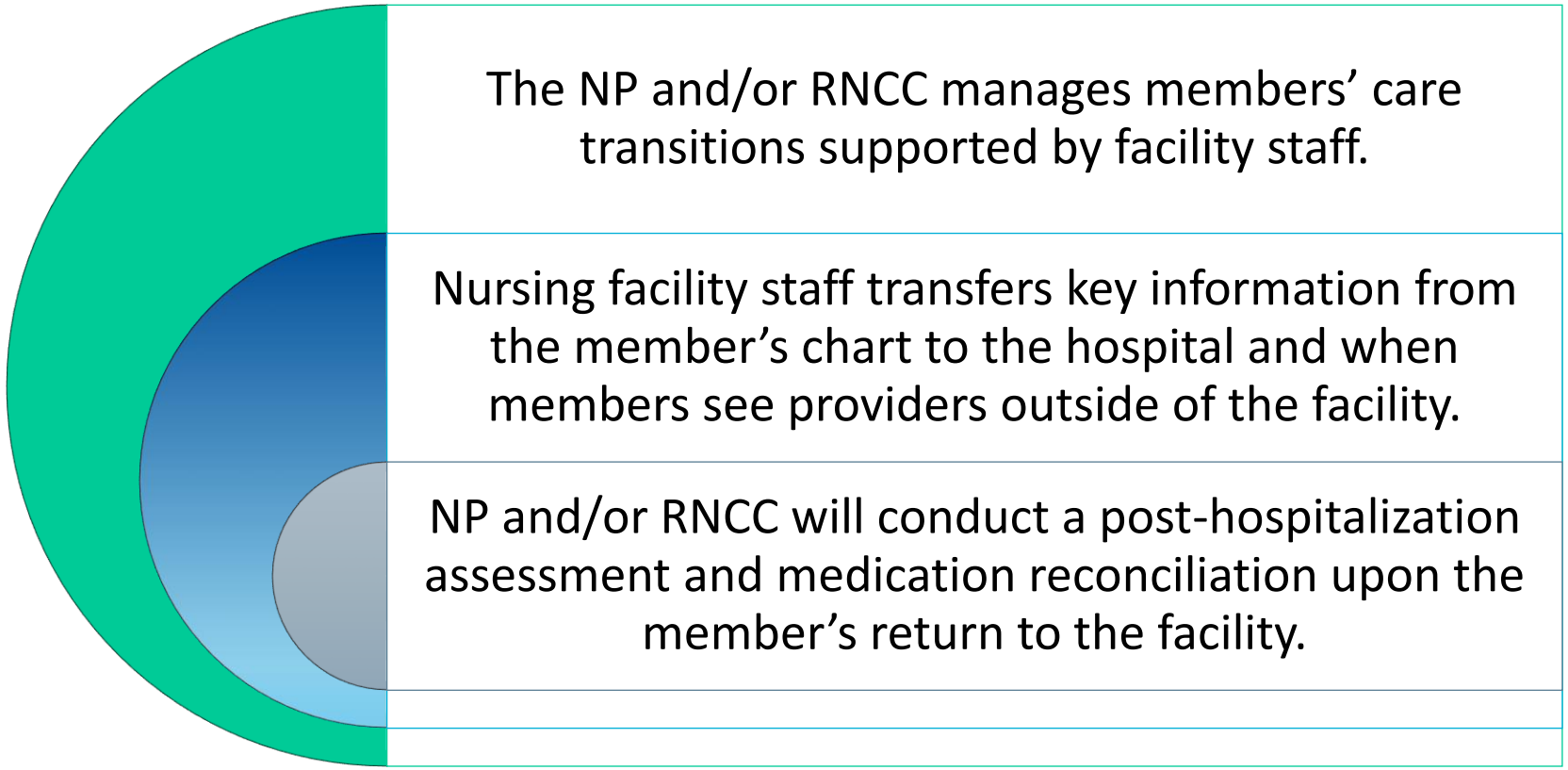
Individualized Care Team (ICT)

Provider Partners Health Plans

- Every member has an ICT tailored to their needs identified on the HRA and ICP
- The ICT oversees and coordinates the member's care plan
- Compositions varies but at a minimum, the ICT includes the NP, RNCC, facility staff and the PCP. Additional participants may be added by the NP or RNCC.
- NP or RNCC coordinates communications among ICT members and may request a formal meeting.

Please participate in ICT care planning meetings if requested and contact the NP or RNCC to discuss changes to the member's care plan.

Care Transitions Protocols



If you see that a Provider Partners member is at risk for a hospitalization, please contact the NP or RNCC immediately!

A Partnership For Care

Provider Partners Health Plans

Specialized Provider Network

- Provider Partners maintains a comprehensive network of primary care providers and specialists
  - Includes providers with specialized expertise in the long-term care population and who routinely care for members in network nursing facilities
- All contracted providers are credentialed
- A network adequacy report is completed annually to ensure that members have access to services

Use of Clinical Practice Guidelines

Provider Partners Health Plans

- Provider Partners provides the Nurse Practitioners access to reputable platforms that provide evidence-based guidelines such as:
  - Up to Date
  - American Medical Directors Association (AMDA) clinical practice guidelines
  - They can be found here:
    - https://www.uptodate.com/login
    - https://paltc.org/product-store/full-set-clinical-practice-guidelines-and-7-pocket-guides

The Plan also measures internal and external provider adherence to evidence-based guidelines via CMS-required HEDIS® reporting.

UpToDate®

amda The Society For Post-Acute And Long-Term Care Medicine™

Expectations for Nursing Facilities

- Get to know the NP and RNCC teams assigned to Provider Partners members. We are here to help you!
- Communicate!
- Review the member's care plan and participate in ICT meetings and activities.
- Call the NP or RNCC if a Provider Partners member is at risk for a transition.
- Notify the NP or RNCC as soon as the member returns from a hospital stay.
- Deliver care in accordance with appropriate evidence-based guidelines.

Please complete the attestation at the end of this training as Provider Partners is required to track your completion!

MOC Training Requirements

- Model of Care training is conducted to ensure special needs plan model of care (SNP MOC) training is administered in accordance with the requirements and guidelines sent forth by the Centers for Medicare & Medicaid (CMS).
- Employees, Board members, and contracted consultants are required to complete the MOC training and attest to training completion within 60 days of hire, appointment or contracting and annually thereafter.
- Network providers are required to complete Provider Partners MOC training and attest to training completion within 90 days of contracting and annually thereafter. Out- of- network providers that treat our members on a routine basis will be contacted by their Provider Network Manager to complete the training via the company's website.

Model of Care Quality Measures

Measurable Goals and Health Outcomes	HEDIS®
	Chronic condition management
	Medication adherence
	Utilization
Compliance with CMS-required MOC processes	HRA and Care Plan completion rates
	Timely member visits
	Care transitions management
	Staff and Provider MOC Training
Member Satisfaction	Provider Partners designed survey conducted once per year

Evaluation of the Model of Care

Provider Partners Health Plans

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

- Annual Evaluation of the MOC
  - Formal evaluation of MOC effectiveness led by Provider Partners Quality Improvement (QI) department.
  - Significant changes to the MOC must be approved by the QIC.

Provider Partners reports performance data to CMS via required annual reporting and makes MOC performance results available to key stakeholders including Plan leadership and staff, providers and members.

Facility Attestation

I attest that I have received the 2024 Model of Care Training for Provider Partners:

_____ _____

Printed Name Organization Name (if applicable)

_____ _____

Signature Title

_____

Date

Contact Information

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