Model of Care Training

Medicare Special Needs Plans

VNS Health Total (HMO D-SNP), D-SNP EasyCare Plus

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Health Plans

Education and Development

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CMS Requirements

What is a Model of Care?

As provided under section 1859(f)(7) of the Social Security Act, every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC provides the basic framework under which the SNP will meet the needs of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.

The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff to receive basic training about the Model of Care.

The Model of Care illustrates how the Health Plans will coordinate care and perform care management responsibilities.

This course will describe how the D-SNPs Health Plans from VNS Health and their contracted providers can work together to successfully deliver the Model of Care.

This course is required annually and upon new hire onboarding.

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Education Objectives

At the end of this module VNS Staff will be able to:

- Explain D-SNP Plans:
  - VNS Health Total (HMO D-SNP)
  - EasyCare Plus: D-SNP
- Describe which individuals qualify for these plans
- Describe the Model of Care key elements and goals
- Describe the covered benefits
- Describe the quality programs in place

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Model Of Care Design

The Model of Care training is designed to includes the following:

- **Assessment**
  - **Health Risk Assessment (HRA)-** EasyCare Plus: D-SNP
  - **Community Health Assessment (CHA)– VNS Health Total (HMO D-SNP) plan only**
- **Interdisciplinary care team (ICT)**
- **Individualized care plan (ICP)**
- **Face to Face Encounters**
- **Transition of Care protocols**
- **Care Management Team / Care Coordination**
- **Benefits**
- **Provider Network**
- **Quality Improvement Plan (QIP)**

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VNS Health Plans
VNS Health Total (HMO D-SNP)

A Dual Eligible Special Needs Plan (D-SNP), **VNS Health Total (HMO D-SNP)** whose features include:

- Enrollment limited to beneficiaries within the target SNP population:
  - Residing within the program's service area
  - Eligible for both Medicare and Medicaid
  - Eligible for long-term services and supports (LTSS)
  - Require community-based long-term care (CBLTC) services for more than 120 days
  - Eligible for Nursing Home Transition and Diversion waiver
- Benefit plans are **custom designed** to meet the needs of the target population
- Requires enrollment approval from CMS and DOH

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VNS Health Plans
EasyCare Plus

HMO Dual Special Needs Plan (D-SNP), or EasyCare Plus, designed to offer focused care management to individuals that have both Medicare & Medicaid.

- Enrollment limited to beneficiaries within the target SNP population
  - Residing within the program's service area
  - Eligible for both Medicare and Medicaid
- Benefit plans are custom designed to meet the needs of the target population who do not need long-term support services
- Requires enrollment approval from CMS

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Model Of Care
Assessment

Assessment

- The Health Risk Assessment (HRA) VNS Health D-SNP utilizes a customized Health Risk Assessment (HRA) tool that is part of the larger assessment and care planning process.
- The assessment focuses on multiple domains including: Medical, mental health, psychosocial, functional, cognitive, and nutritional needs. It also assesses the member's use of assistive devices, current living condition, and medication compliance.
- The assessment is also geared toward gathering information to understand the member's level of familiarity with their PCP as well as the date of the last appointment.
- The information gathered through the assessment, in conjunction with any claims data or additional information provided by the member, caregiver or provider all determine the physical health, behavioral health, social and lifestyle risk factors that may be impacting the member's overall health and functional status.

Process:

- When the HRA is completed, it is reviewed and an Individualized Care Plan (ICP) is created for the member by the Clinical Evaluation Manager (CEM).
- The CEM is responsible for communicating the ICP, which includes the results of the HRA to the Interdisciplinary Care Team (ICT) and monitoring of ICT responsibilities related to the ICP(Interdisciplinary Care Plan) delivery and action follow-up.
- When a member conducts an updated HRA their ICP is updated, and results may be shared with the ICT.
- During the creation of the ICP, the member's PCP and providers may be invited to provide information and input as necessary, based on member preference. The ICP can be shared telephonically, by secure email, regular mail, or by facsimile.

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Model Of Care
Assessment for
VNS Health Total (HMO D-SNP)

Community Health Assessment– New York (CHA-NY) Process for :

VNS Health Total (HMO D-SNP)

The Community Health Assessment-NY (CHA-NY) assessment is performed at the frequency set forth by the New York State Department of Health (NYS DOH) Model Contract

- Evaluates the following needs of an-enrollee's:
  - Health status
  - Strengths
  - Care needs
  - Preferences
- Assists with determining a more appropriate program eligibility if the home becomes unsafe
- Improves care coordination and facilitated service delivery
- Ensures enrollees with long term care needs receive the right care, within the right setting and at the right time

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Model Of Care
Interdisciplinary Care Team

Who are the members of the ICT?

- Care Managers / Utilization Managers
- Medical Director
- Behavioral/Mental Health experts
- Social Workers
- Primary Care Physician / Specialists
- Family/Caregiver
- Pharmacy
- Community Partners/Vendors

The Interdisciplinary Care Team will ensure:

- Participants of ICT are based on the member's needs
- Care managers will keep the team updated with information involving the member's care plan
- Staff participate in ICT meetings and rounds.

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Model Of Care
Individualized Care Plan (ICP)

- The Care Plan is the ongoing action plan to address the participant's care needs in conjunction with the Interdisciplinary Care Team (ICT) and enrollee
- Care Plans contain member-specific problems, goals and interventions, addressing issues found during the assessment and care management process
- An ICP is developed and maintained using:
  - Health risk assessment results
  - CHA-NY assessment results
  - Laboratory results, pharmacy, emergency department and hospital claims data
  - Care manager interaction
  - Interdisciplinary care team input
  - Enrollee preferences and personal goals
- The care plan is based on information obtained from the communication with the member, their caregiver, claims data, their providers, ancillary providers, facilities, or other sources the ICP is assessed and updated as needed. Sentinel events can trigger the need for a new ICP and new ICPs can generate the need for ICT composition changes.

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Model Of Care
Face to Face Encounter

- Face-to-Face Encounter
  - Regulations at 42 CFR §422.101(f)(1)(iv) require that all SNPs must provide, on at least an annual basis, beginning within the first 12 months of enrollment, as feasible and with the individual's consent, for face-to-face encounters for the delivery of health care or care management or care coordination services and be between each enrollee and a member of the enrollee's ICT or the plan's care management and coordination staff, or contracted plan healthcare providers.
  - A face-to-face encounter must be either in-person or through a visual, real-time, interactive telehealth encounter.

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Model Of Care
Care Management

Care Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation of an enrollee's needs.

Comprehensive Care Management includes advocacy for options and services to meet the enrollee and their caregiver's comprehensive health needs.

Care Managers facilitate this through communication and promoting available resources to ensure enrollee safety, quality of care and cost-effective outcomes.

Care Managers are healthcare professionals like nurses and social workers trained to meet healthcare needs by assisting the enrollee to navigate the healthcare system, collaborate with providers, utilize their social support system, their community, and other professionals associated with their care.

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Care Coordination

Integrate and coordinate care across specialties:

- The health plan integrates and coordinates care for enrollees across the care continuum through a central point of contact. The care manager (CM) functions as this central contact across all settings and providers.

To **improve** coordination of care:

- The **Primary Care Physician (PCP) is the gatekeeper** and responsible for identifying the needs of the beneficiary.
- The **Care Management Team coordinates care** with the enrollee, the enrollee's PCP and other participants of the enrollee's ICT.

Through **seamless transitions** between care settings the CM will**:**

- **Notifying the enrollee's PCP** of the transition
- **Sharing the enrollee's ICP** with the PCP, the hospitalist, the facility, and/or the enrollee/caregiver (where applicable)
- **Contacting the enrollee** prior to a planned transition to provide educational materials and answer questions related to the upcoming transition

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Care Management and Transitions

Enrollees are at risk of adverse outcomes when transitioning between settings (hospital, nursing home, rehabilitation center, outpatient surgery centers or home health)

- Enrollees experiencing inpatient transitions are identified/managed (pre-authorization, facility notification, inpatient census)
- Important elements (diagnoses, medication reconciliation, treatments, providers and contacts) of care plan are transferred between care settings before, during and after a transition
- Enrollees can communicate their health information to healthcare providers in different settings
- Enrollee is educated on health status and self-management skills: Discharge needs, medications, follow-up care, how to recognize and respond to issues, discharge instructions, and post-discharge calls

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Care Coordination and Transitions

- **Post Hospitalization Transitions of Care:**
  - The **post-hospitalization** program for enrollees includes multiple phone calls after hospitalization with the goal of preventing readmission within thirty days

- **During these calls, the Care Team:**
  - Helps the enrollee understand discharge diagnosis and instructions
  - Facilitates follow-up appointments
  - Assists with needed home health and equipment
  - Resolves for barriers in obtaining medications
  - Educates the enrollees on new or continuing medical conditions

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Model Of Care
Benefits

- **Disease Management**–whole person approach to wellness with comprehensive online and written educational and interactive health materials

- **Medication Therapy Management**–a pharmacist reviews medication profile quarterly and communicates with enrollee and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues

Additional benefits may include: (subject to eligibility for each)

- Medication Therapy Management
- Diet and nutritional education
- Behavioral health services
- End-of-life support services
- Social work support
- Home and community-based services partnerships
- Nonemergency transportation
- Meal programs
- Over-the-counter allowance

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Model of Care
Provider Network

Provider partners are an **invaluable part** of the interdisciplinary care team. Our Model of Care offers an opportunity to work together for the benefit of **enrollees** by:

- Enhanced **communication**
- Focusing on each individual **enrollee's special needs**
- Delivering **care management** programs to assist with the **enrollees** medical and non-medical needs
- **Supporting** the enrollee's plan of care

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Provider Role

- **Communicate** with Care Managers, Interdisciplinary Care Team (ICT) members as well as **enrollees** and Caregivers
- **Collaborate** on the Individual Care Plan (ICP)
- **Review and respond** to enrollee specific communication
- Participate in the Interdisciplinary Care Team **(ICT)**
- Remind enrollee of the importance of the **HRA and/or CHA-NY assessment(s)**, which is essential in the development of the ICP
- **Encourage** the **enrollee** to work with their Care team
- Participate in routine audits

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Model of Care
Quality Improvement Plan (QIP)

We implement a Quality Improvement Program to monitor health outcomes while implementing our Model of Care:

- Collect HEDIS measures data
- Annual Quality Improvement Project focuses on a clinical or service aspect relevant to our enrollees.
- Provide an Advanced Illness Management Program

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How to report Compliance Concerns and Fraud, Waste & Abuse

Website: www.vnshealth.ethicspoint.com

VNS Health Compliance Hotline: (888) 634-1558

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Summary

This presentation outlines the different components of our D-SNPs' Model of Care.

It is intended to provide a broad overview of how the Health Plans from VNS Health addresses the enrollee's needs and achieves positive outcomes.

Kindly attest to having received this training by using this link: 2024 Model of Care Attestation Form - Form by Asana

(Able click link with CNTRL button or copy and paste into a browser for completion)

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Thank you for attending!