mercy care advantage HMO SNP

2021 Model of Care Training

Special Needs Plans

- **Special Needs Plans (SNPs) were created by Congress through the Medicare Modernization Act of 2003 and was permanently authorized by the Bipartisan Budget Act of 2018.**
- **SNPs are a type of Medicare Advantage Plan.**
- **There are three types of SNPs that limit membership to specific types of members:**
  1. **Chronic Care SNP – for members with specific types of chronic conditions,**
  2. **Institutional SNP – for members who live in an institution or require nursing care at home, or**
  3. **Dual Eligible SNP – for members who receive both Medicare and Medicaid**

Mercy Care Advantage

- **Mercy Care Advantage (MCA) is a Dual Eligible SNP.**
- **MCA members have Medicaid coverage through one of four programs under Arizona Healthcare Cost Containment System (AHCCCS):**
    1. **Arizona Long Term Care System (ALTCS)**
    2. **Members enrolled in the AZ Division of Developmental Disabilities (DDD)**
    3. **Acute Care Program (ACC), or**
    4. **Regional Behavioral Health Authority (RBHA)**

Model of Care

The goal of this module is to describe MCA's Model of Care and the role that contracted medical providers play in its delivery to members.

Model of Care

- **The Centers for Medicare & Medicaid Services (CMS) requires each SNP to have a Model of Care.**

- **The Model of Care is the architecture for care management policy, procedures, and operational systems.**

Model of Care Elements

❖ **The Model of Care includes the following elements:**

- Staff Structure and Care Management Roles
- Description of the Interdisciplinary Care Team
- Provider Network having Specialized Expertise and Use
- of Clinical Practice Guidelines and Protocols
- Model of Care Training for Personnel and Provider Network
- Measurable Goals
- Description of the SNP-specific Target Population
- Health Risk Assessment
- Individualized Care Plan
- Communication Network
- Care Management for the Most Vulnerable Sub-Populations
- Performance and Health Outcome Measurement

Model of Care Goals

1. **Improve access to care/essential services**
2. **Improve access to affordable care**
3. **Improve coordination of care**
4. **Provide seamless transition across healthcare settings**
5. **Improve access to preventative care**
6. **Ensure appropriate utilization and cost effectiveness**
7. **Improve member health outcomes**

Health Risk Assessment

- All MCA members are outreached to complete a Health Risk Assessment (HRA), which is a standardized tool used to assess the medical, psychosocial, cognitive and functional needs of each member.
- The outcome of the assessment will assist in the development of an individualized care plan for members.
- HRA's for MCA members are conducted within 90 days of enrollment and annually thereafter.

Interdisciplinary Care Team

- **The Interdisciplinary Care Team (ICT) is a group of health plan staff and care providers who meet regularly to discuss HRAT information and any other information available to develop a care plan that is individualized to their specific health care needs.**

- **The member and their PCP are invited to attend the ICT to provide input.**

Individualized Care Plan

- An Individualized Care Plan (ICP) is a summary of the needs and service options identified during the assessment process.
- The ICP is developed to identify the member's health care goals and objectives, as well as the activities and services the member agrees to pursue in order to attain optimal health outcomes.
- ICPs for all members are created utilizing a combination of information from the following sources:
  - HRA results
  - Utilization and claims data
  - Preventive health information as recommended based on the member's age, gender and medical history

Individualized Care Plan (continued)

- The results are communicated to the member/Provider via the ICP
- Both the member/Provider can request a meeting to further discuss the ICP
- The ICP is revised annually, or when the member has a significant change in health status

Case Management and Care Coordination

- **What is Case Management? "*Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensivehealth needs through communication and available resources to promote quality cost effective outcomes.*" (Case Management Society of America, 2002)**

- **All MCA members are eligible to receive high risk care management or care coordination services**

- **MCA offers a range of care management and care coordination services to address members' clinical and non- clinical needs**

Care Management and Care Coordination (continued)

- **The frequency and intensity of the interactions with Care Management vary based upon member need:**
  - **All MCA/ALTCS members are placed in full case management**
  - **MCA/Acute and MCA/DD members are assessed to determine what level of care management services are requiredand are placed accordingly**
  - **Integrated Behavioral Health Program members are assessed to determine level of care management services are needed and placed accordingly.**

How to Refer to MCA Care Management

- If you feel a member requires care management, please email referral to MCACMReferral@mercycareaz.org or contact our Case Management Referral Line at 602-586-1870.

- All referrals are reviewed within 3-5 business days by care management staff.

Condition Management

- **Condition Management (formerly referred to as disease management) is now incorporated into care management so all the member's bio-psychosocial needs can be assessed as a whole.**

Questions?

If you have questions about any information in this Model of Care Training, please call your assigned Network Management representative.

2021 Model of Care Attestation

I hereby attest that I have reviewed the **2021 Model of Care Training** which will complete the annual requirement.

I understand the Model of Care for MCA members and my role in improving health outcomes for our most vulnerable population.

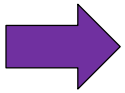
I also understand this is an annual training requirement required of me by the Centers for Medicare and Medicaid Services (CMS) for all Medicare Advantage Special Needs Plan providers.

Disclaimers

It is the delegated entities responsibility to ensure that all staff who are involved with Mercy Care Advantage (MCA) members have reviewed the Model of Care training. Please ensure your client relationship manager submits the annual attestation to Mercy Care Advantage no later than January 31, 2022 by clicking on the "Submit Attestation" button on the next page.

2020 Model of Care Attestation

By submitting this attestation, you are attesting that you have evidence to show that your staff have reviewed the power point training regarding theMCAModel of Care. In the event that the Centers for Medicare and Medicaid Service (CMS) requires Mercy Care Advantage (MCA) to provide proof of this training, MCA will request your documentation of the Model of Care training, i.e., reporting show staff completion. This is required for all delegated entities who are involved with MCA members.

To begin, click the Submit Attestation button 

Submit Attestation

To ensure you receive credit for this course, please be sure to include the following information in your attestation e-mail:

- **Individual Name (for individual practitioner attestation) Or**
- **Contract Holder/Administrator Name (when conducting group training)***
- **Printed Clinic/Practice Name**
- **Tax ID (TIN)**

Thank you

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