

MSO Provider Education



Model of Care
(SNPs) 2018



Objectives

- Special Needs Plans and Model of Care Background

Products & Model of Care (MOC)

- Medicare y Mucho Más (MMM) SNP's
- PMC Medicare Choice (PMC) SNP's

Basic Components of the Model of Care

- MOC 1: Description of SNP Population
- MOC 2: Care Coordination
- MOC 3: SNP Provider Network
- MOC 4: Quality Measurement and Performance Improvement

Essential role of providers in the implementation of the Model of Care



Model of Care Training

Developed to meet the Centers for Medicare & Medicaid Services (CMS) guidelines.

It is mandatory that MAO's must conduct and document training on SNP Model of Care for all employed and contracted personnel and providers:

- Initial and annual training
- Methodology may be:
 - Face-to-face
 - Interactive (web-based, audio/video conference)
 - Self-study (printed materials, electronic media)



Background Coordinated Care



Provider Education

The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage (MA) Coordinated Care Plan (CCP) that was specifically designed to provide targeted care to individuals with special needs.

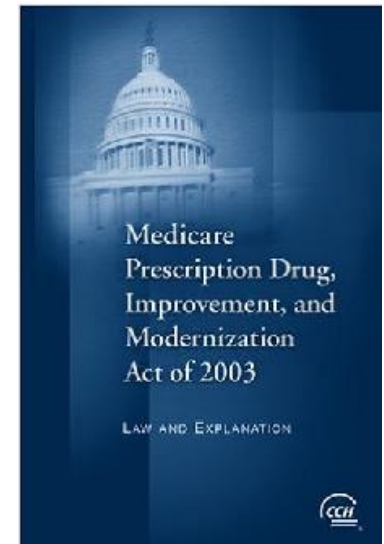
In the MMA, Congress identified "special needs individuals" as:

Dual eligible (D-SNP)

Members eligible for Medicare + Medicaid

Chronic conditions (C-SNP)

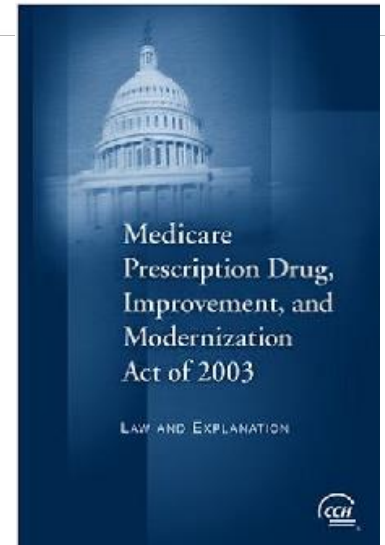
Members with severe or chronic conditions



Provider Education

Institutionalized (I-SNP)

- Institutionalized members:
- Live in an institution (like an elderly home) or need nursing services at home.
- They are capable of living in the community but require a level of attentions that equals the one of the instituionalized.
- (MMM does not have a product for patients in I-SNP)



SNP's Products

MMM Healthcare, LLC

<p>Coordinated Care Plan 2018</p>	<p>D-SNPs for members that are dually eligible for Medicare and Medicaid.</p>	<p>C-SNPs This coverage option is available for members that meet the following chronic or disabling conditions:</p> <ul style="list-style-type: none"> •Diabetes •Chronic Heart Failure (CHF) •Cardiovascular disease: <ul style="list-style-type: none"> Cardiac Arrhythmias Peripheral Vascular Disease Coronary Artery Disease Chronic venous thromboembolic disorder
<p>MMM Supremo (HMO – SNP)</p>		√
<p>MMM Diamante Choice Platino (HMO-SNP)</p>	√	
<p>MMM Diamante Excel Platino (HMO-SNP)</p>	√	
<p>MMM Diamante Choice Plus Platino (HMO-SNP)</p>	√	
<p>MMM Diamante Excel Plus Platino (HMO-SNP)</p>	√	
<p>PMC Premier Preferred Platino (HMO-SNP)</p>	√	



What is the Model of Care?



- MOC provides the structure for the implementation of processes and systems that allow the plan to give coordinated care to members with special needs.
- Models of Care (MOCs) are considered a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed.



MOC Elements

- The MOC is comprised of the following clinical and non-clinical elements:

Description of the SNP Population
(SNP)

Coordinated Care

- Mandated Health Risk Assessment and Re-assessment
- Individual Care Plan (ICP)
- Interdisciplinary Care Team (ICT)

Provider Network

Quality measures and improvements in performance



MOC 1: Description of the SNP Population



MOC 1: Description of the SNP Population

- MMM focuses on the unique characteristics of its target population(Dual and Chronic).
- Evaluates:
 - Social, environmental and cognitives factors
 - Medical and health conditions
 - Most vulnerable members



Establishes specific programs and benefits for these members.



Most-Vulnerable Sub-population

Identifies the populations at risk in order to coordinate care based on unique needs. Composed of members who are:

- Fragile
- Members with frequent visits to the ER (3 or more).
- Members with care gaps or uncontrolled laboratory results.
- Members with probability of admissions and readmissions (e.g. Congestive Heart Failure).
- Members with major trauma.
- Members with multiple admissions (3 or more in 6 months).
- Polypharmacy



Most-Vulnerable Sub-population

- Members with Chronic Conditions such as COPD, Asthma, CHF, Cardiovascular disease, Arteriosclerosis and HTN.
- Members with disabilities.
- Members who require complex procedures or transition of care:
 - Organ Transplant
 - Bariatric Surgery



MOC 2: Care Coordination



Coordinated Care

MMM:

- Ensures the health needs of beneficiaries of SNP and the information is shared among the interdisciplinary staff.
- Coordinates the delivery of services and specialized benefits that meets the needs of the most vulnerable population.
- Performs health risk assessments, Individualized Care Plan and has an established Interdisciplinary Team.



Care Management Program focus

Ensure accessibility of the available resources in the community.

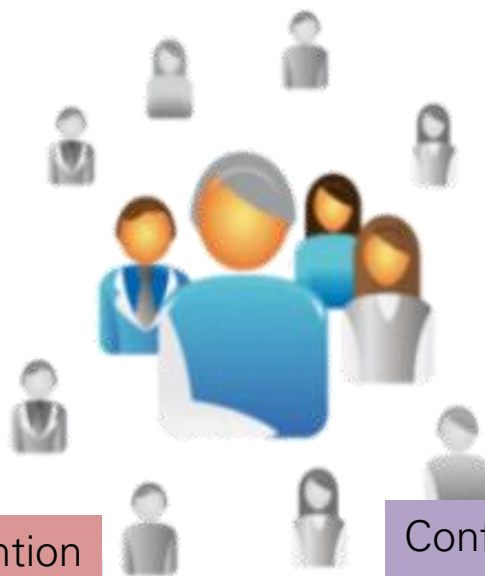
Provide medical benefit resources with effectiveness and efficiency at the same time the quality attention is guaranteed.

Ensure that all member's attention services are coordinated and receive the appropriate treatment in an efficient way.

Identify and classify members using established criteria los criterios establecidos to refer them to the programs.

Coordinate that all members have their comprehensive assessment.

Confirm that all members in the program have an individualized/personalized attention plan with orientations focused to satisfy the identified necessities.



Health Risk Assessment (HRA)

- The HRA assesses information about the members medical, psychosocial, cognitive, and functional needs of special needs individuals.
- Every SNP member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually.



Health Risk Assessment (HRA)

- Is performed by telephone and may be performed face-to-face, or paper-based.
- Results classify members in various risk categories. This way the automated referrals to the Care Management programs are generated.
- Results are communicated to members, interdisciplinary care team, and the primary physician.



Individualized Care Plan (ICP)

- Once the unique needs of the member have been identified, an individualized care plan (ICP) is generated, which is shared with the other members of the interdisciplinary team.
- The ICP is communicated to the member or caregiver and is shared with providers through our InnovaMD portal.



Equipo interdisciplinario

What is the Interdisciplinary Care Team (ICT)?

It is a member centered group that discusses the member's health status and interventions.

Providers Responsibilities in the ICT:

1. Participate in the ICP discussion.
2. Collaborate in goals setting.
3. Engage members in self management and provide follow-up.
4. Integrate other physicians and providers into the member's health care management.
5. Participate in ICT meetings when requested.
6. Communicate changes to the ICT members through ICT meetings or telephone calls.



Interdisciplinary Care Team

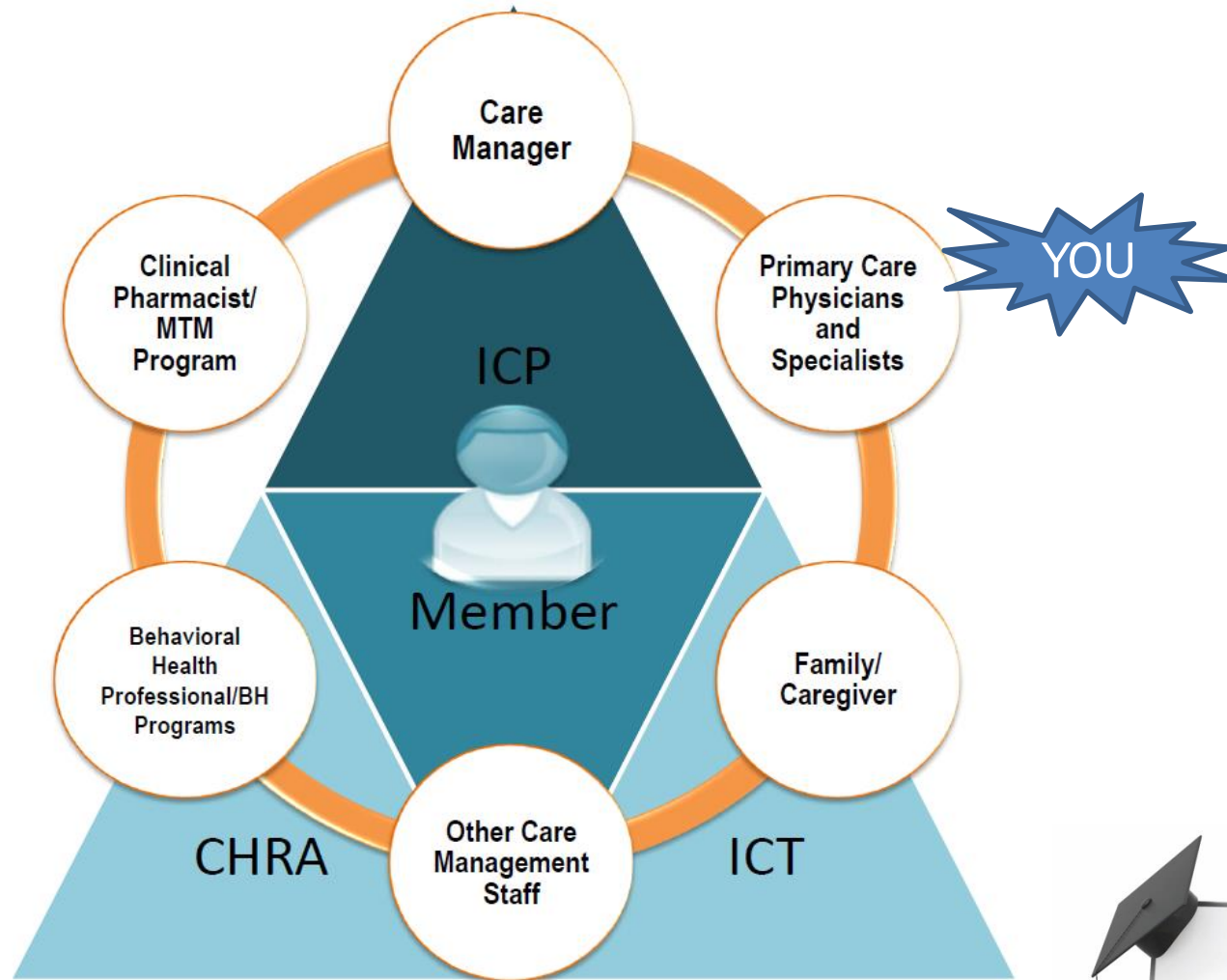


Care Transition

- Establish process and protocols to maintain continuity member's care.
- The different units work in collaboration with the primary physicians and providers to guarantee and support the necessary coordinated care.
- The Discharge Planning Unit (DPU) facilitates, communicates and coordinates the necessary services for the continuity of the member's care and shares information with the primary physician.



Protocols for care transition



Provider Role in our MOC



- Ensure that the health needs of the members and the necessary information are shared with the interdisciplinary team.
- Coordinate specialized services that meet the needs of the most vulnerable population.
- Promote the variety of Health Risk Assessment in order to develop the member/beneficiary Individualized Care Plan.
- Active participation in the Interdisciplinary Care Team.



MOC 3: SNP Provider Network



Provider Network Focus

- MMM is responsible for maintaining an adequate network of providers to meet the needs of our members being the primary link in their care.
- The Provider Network is monitors:
 - The use of clinical practice guidelines and protocols.
 - Ensure collaboration and active communication with the ICT.
 - Assure that network providers are licensed and competent through a formal credentialing process.



MOC 4: Quality Measurement and Performance Improvement



Quality Improvement Evaluation

The plans have a Quality Improvement Program established to monitor health outcomes and performance of the care model through:

- Collection of data to assess whether the objectives of the SNP program are met.
 - HEDIS and Clinics Programs, among others
- Conducting a Quality Improvement Project (QIP) that focuses on improving a clinical or service aspect that is relevant to the SNP population.
- Measure SNP member satisfaction.



Quality Improvement Evaluation

The plans have a Quality Improvement Program established to monitor health outcomes and performance of the care model through:

- Results are communicated to all stakeholders: members, employees, providers and the public.



Provider Education

Our Commitment to Quality



Thanks to your commitment we obtained excellent results in the last CMS audit

For additional information please contact us:
Monday through Friday
from 7:00 a.m. to 7:00 p.m.
787-993-2317 (Metro Area)
1-866-676-6060 (toll free)



Thank
You!

