MSO Provider Education

Model of Care 2021

Learning Objectives

- Background
- Products and Model of Coordinated Care
- Components of the Model of Care
- Essential role of the Provider in the Model of Care

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Model of Care
Training

Developed to meet the Centers for Medicare & Medicaid Services* guidelines

Every MAO 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)

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* CMS

Background

Incorporated on the year 2000

2001: Approved by CMS to begin providing services as the first Medicare Advantage plan in Puerto Rico.

Focus:

Quality service
Prevention
Quality of life

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Background

The only Medicare Advantage plan in Puerto Rico, with:

4.5 stars under the Medicare Star Rating Program *

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* Each year, Medicare evaluates plans based on a 5 Star Rating System.

What is the Coordinated Model of Care?

* Structure for processes and systems
* Beneficiaries with special needs

* Essential tool:

-Improves quality

-Ensures that needs are met under SNP

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SNP Products 2021

MMM

Model of Care 2021	D-SNPs
	
	Beneficiaries eligible for Medicare and Medicaid.
		C-SNPs
		
		Beneficiaries that meet the following chronic or disabling conditions:
		
		• Diabetes
		• Chronic Heart Failure (CHF)
		• Cardiovascular disease:
		  ○ Cardiac Arrhythmias
		  ○ Peripheral Vascular Disease
		  ○ Coronary Artery Disease
		  ○ Chronic venous thromboembolic disorder

MMM Supremo (HMO-SNP)		√
MMM Diamante Platino (HMO-SNP)	√	
MMM Conectado Platino (HMO-SNP)	√	
MMM Relax Platino (HMO-SNP)	√	
MMM Valor Platino (HMO-SNP)	√	
MMM Bienestar Platino (HMO-SNP)	√	
PMC Premier Platino (HMO-SNP)	√	

MOC Elements

- Special Needs Population (*SNP*) Description
- Coordinated Care
  - Mandatory assessment of health risks and reevaluation (HRA)
  - Individual Care Plan (ICP)
  - Interdisciplinary Team (ICT)
- Provider network
- Quality metrics and Performance improvements

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MOC 1:

Description of the Special Needs Population (SNP)

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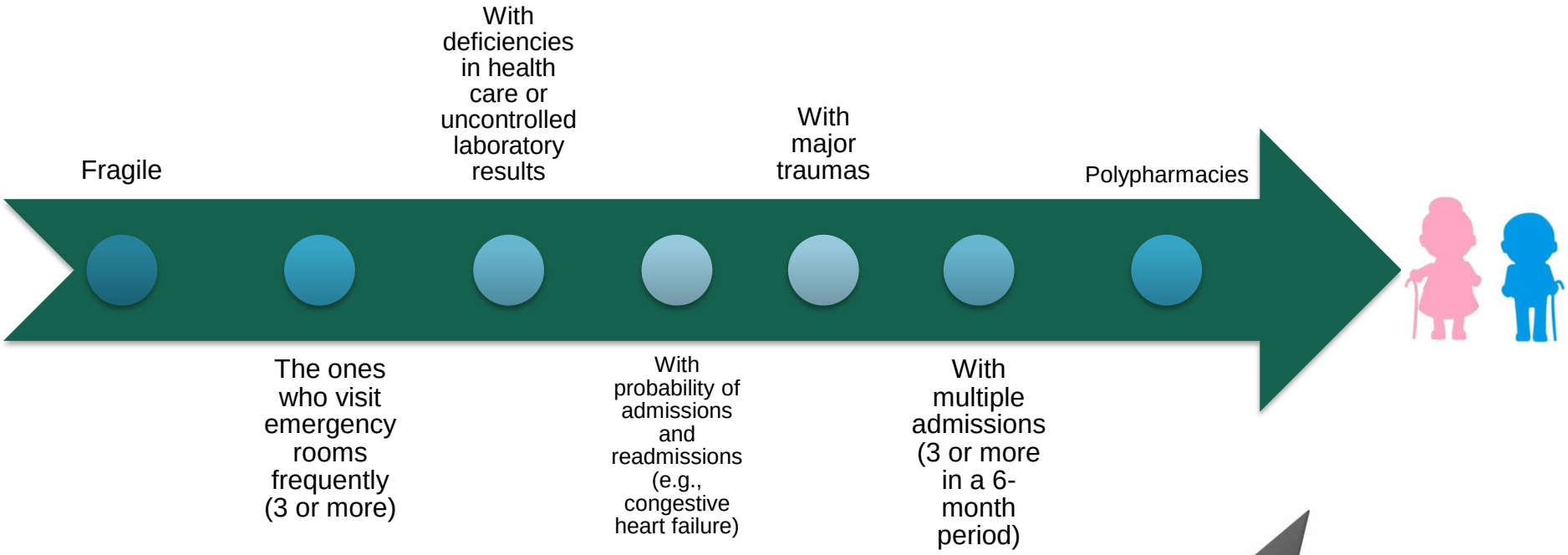
The most vulnerable

Identify those beneficiaries with greater vulnerability.



The most vulnerable

Beneficiaries with chronic uncontrolled conditions:

- COPD
- Asthma
- CHF
- Cardiovascular Disease
- Arteriosclerosis
- HTN

Beneficiaries with disabilities

Beneficiaries that require complex procedures or transition of care:

- Organ transplant
- Bariatric surgery

MOC 2:

Service Coordination

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Coordinated Care

Ensures the health needs of beneficiaries of an SNP; information is shared among the interdisciplinary staff.

Coordinates the delivery of specialized services that meet the needs of the most vulnerable population.

Performs health risk assessments, Individualized Care Plan and has an established Interdisciplinary Team.

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Care Management Program Focus

Guarantee beneficiaries **access** to **resources** available in the **community**.

Ensure that beneficiaries **identify** and qualify for the program using established criteria.

Provide **resources** of effective medical **benefits** while ensuring quality care.

Ensure that all program beneficiaries have a **comprehensive** needs **assessment**.

Ensure that beneficiary care services are **coordinated** and given the **appropriate treatmen**t in an efficient manner.

Ensure that all active beneficiaries of the program have an **individual and personalized attention plan** with targeted interventions, to meet identified needs.

Health Risk Assessment (HRA)

HRA is performed to identify medical, psychosocial, cognitive and functional needs of special needs people.

Initial HRA/90 days from enrollment to complete.
Annual HRA/starting 365 days from the initial HRA.

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Health Risk Assessment (HRA)

HRA is done by phone or on paper.

Results → Individualized Care Plan:

* Problems, goals and interventions with interdisciplinary team

HRA refers to→ Care Management Programs

* Case Management, among others.

Care plan is shared with:

Beneficiary + interdisciplinary team (including PCP)

Individualized Care Plan (ICP)

An ICP is developed for each SNP beneficiary by the respective interdisciplinary team, identifying the beneficiary's needs based on results obtained in the HRA

The ICP guarantees the needs that will be covered, the course of evaluation, coordination of services, and the beneficiary's benefits.

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Individualized Care Plan (ICP)

ICP is communicated to the beneficiary or caregiver, and shared with the provider through our InnovaMD portal.
Review annually or when health status changes.

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Interdisciplinary Team (ICT)

Beneficiary-focused group, discusses health status and interventions for the patient.

ICT Provider Responsibilities::

1. Participate in ICP discussion.
2. Collaborate in goal setting.
3. Involve beneficiaries in self-management and follow-up.
4. Integrate other doctors and providers.
5. Participate in ICT meetings.
6. Communicate changes to ICT components through meetings or phone calls.

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Care Transition

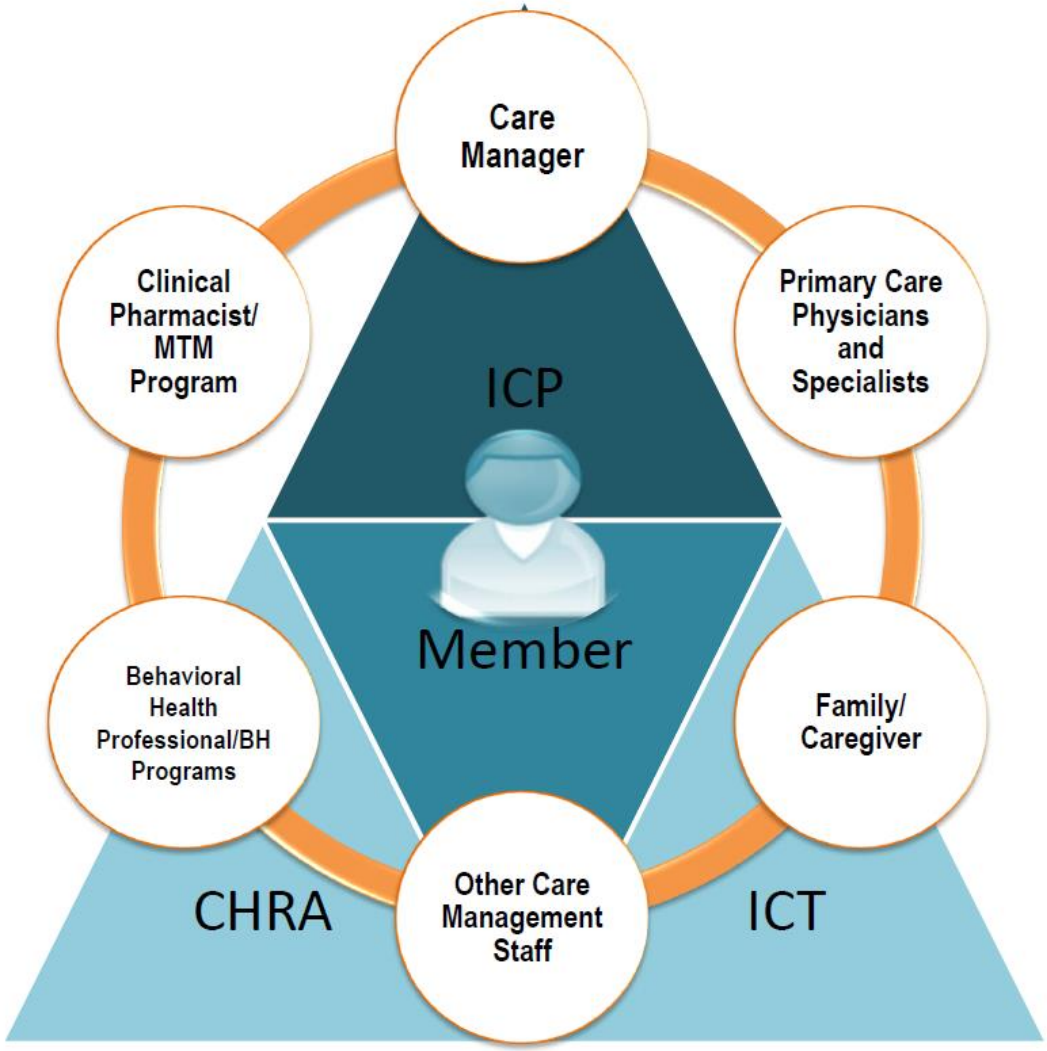
Transition processes and protocols are established to maintain continuity of care.

Different units work in collaboration with primary care doctors and providers to guarantee and support the coordinated care the beneficiary deserves.

Staff available in the discharge planning unit facilitates communication between care centers, primary care physician and the beneficiary or his/her caregiver.

Beneficiary's ICP is shared with beneficiary and primary care physician when a transition of care occurs.

Care Transition Protocols



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Provider's Role in the Model of Care

- Ensures continuous access to services, and what needs and information is shared among staff.
- Coordinates specialized services to the most vulnerable population.
- Promotes Health Risk Assessment for Individualized Care Plan.
- Active participation as part of the Interdisciplinary Team.

MOC 3:
Specialized providers network in the care plan

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Focus

Maintain a network of specialized providers to meet the needs of our beneficiaries by being the primary link in their care.

The provider network monitors:

- Use of clinical practice guidelines and protocols.
- Active collaboration and communication with ICT administrators and case managers.
- Development and updating of care plans.
- That all network providers are evaluated and qualified through a credentialing process.

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MOC 4:

Quality Measurement and Performance Improvement

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Quality Evaluation and Improvement

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

- Data collection and follow-up of the specific SNP Five Stars Program measures (HEDIS).
- Implementation of the Annual Quality Improvement Project that focuses on improving the clinical aspect or service that is relevant to the SNP population.
- Measuring SNP beneficiary satisfaction.

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Quality Evaluation and Improvement

- Chronic Care Improvement Program (CCIP) for chronic disease identifies eligible beneficiaries, intervenes to improve disease management and evaluates the effectiveness of the program.
- Collects data to evaluate if SNP program objectives are being met.
- Performance results are shared with beneficiaries, employees, vendors, and the general public on an annual basis.

Our commitment to quality

We’re proud to see that MMM’s special needs coverage will continue to improve the quality of life of thousands around the island.

For more information:

787-993-2317 (Metro Area)

1-866-676-6060 (Toll Free)

Monday through Friday from 7:00 a.m. to 7:00 p.m.

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Questions?

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Thanks

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