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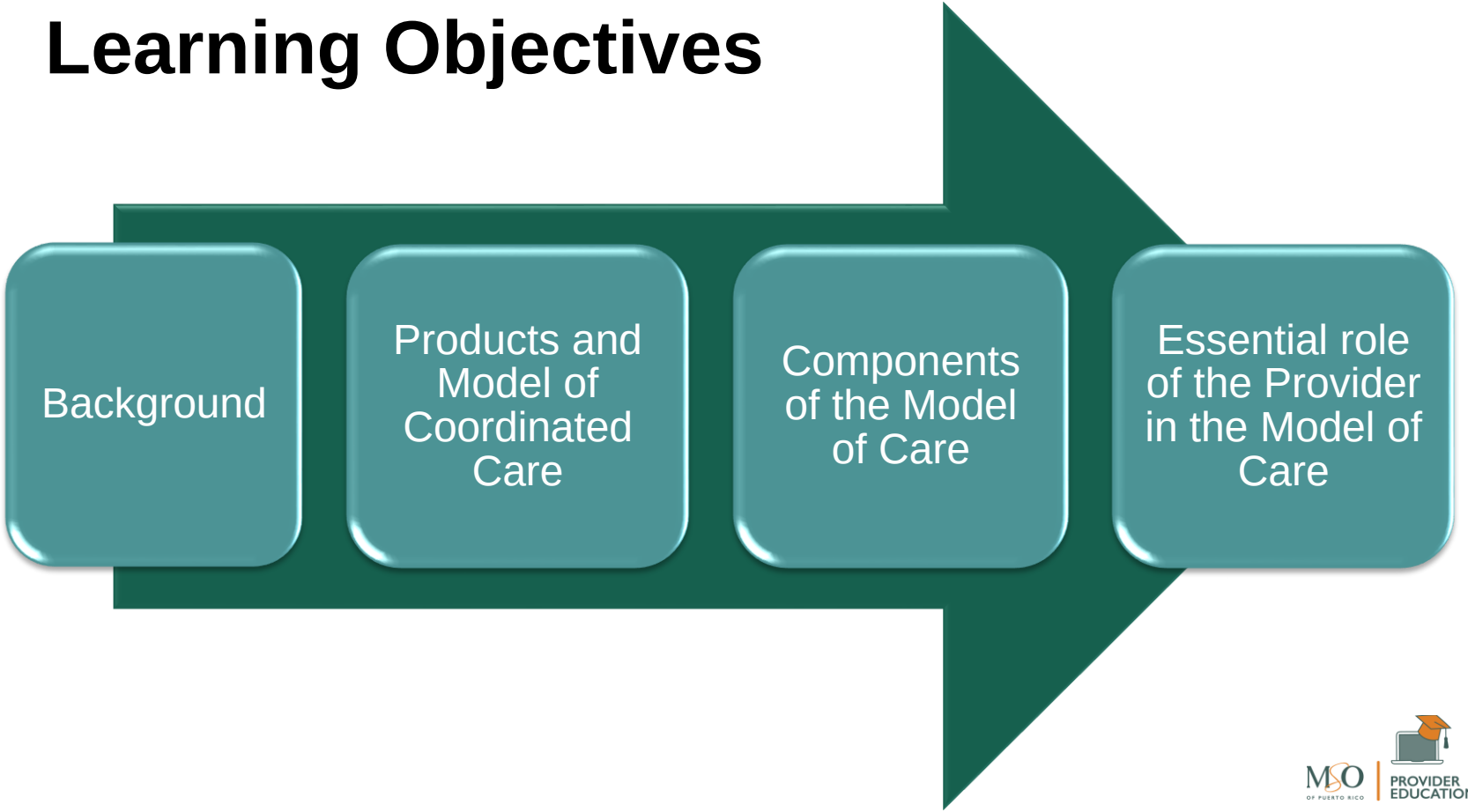
Model of Care 2023

Learning Objectives



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Model of Care

Training

Developed to meet the guidelines of the
Centers for Medicare and Medicaid Services*

Every MAO must conduct and document training on Model of Care for all employed and contracted personnel and providers:

- Initial and anual training
- Methodology or types of intervention:
  - Face-to-Face
  - Interactive (web-based, audio/video conference)
  - Self-study (printed materials, electronic media)

* CMS

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Background

MMM
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Incorporated in the year 2000

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

Focus:

Effective coordinated care
Prevention
Quality of life

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Background

MMM
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4.5 stars

We celebrate that one of our contracts has been rated 4.5 stars under the Medicare Star Rating Program **for six consecutive years.**

*** Contract H4004.**
Every year Medicare evaluates plans based on a 5-Star Rating System

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What is the Coordinated Model of Care?

- A structure to ensure coordinated care is performed efficiently
- Focused on beneficiaries with special needs

- Essential tool
- Improves quality
- Ensures that needs are met under SNP*

*SNP – Special Needs Plans

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SNP Products

2023

MMM

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Model of Care 2023

C-SNP	Members diagnosed with chronic or disabling conditions:
MMM Supremo (HMO-SNP)	• Diabetes • Chronic Heart Failure (CHF) • Cardiovascular diseases: ▪ Cardiac Arrhythmias ▪ Peripheral Vascular Disease ▪ Coronary Artery Disease ▪ Chronic Venous Thromboembolic Disorder
MMM Integral (HMO-SNP)	
MMM Vibrante (HMO-SNP) *	

*****Regional plan for members of the following municipalities: Aguadilla, Isabela, Quebradillas, Camuy, Hatillo, Arecibo, Aguada Rincón, Moca, Añasco, San Sebastián, and Utuado.

Model of Care 2023

D-SNP	
MMM Diamante Platino (HMO-SNP)	Members elegible for Medicare and Medicaid
MMM Relax Platino (HMO-SNP)	
MMM Dorado Platino (HMO-SNP)	
MMM Valor Platino (HMO-SNP)	
MMM Grande 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)
  - Medical Visits (Face-to-Face)
- 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 members with greater vulnerability.

Fragile.

Those with frequent visits to emergency rooms (3 or more).

With deficiencies in healthcare or uncontrolled laboratory results.

With probability of admissions and readmissions (eg, congestive heart failure).

With major traumas.

With multiple admissions (3 or more in 6 months).

Poly-pharmacy

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The most vulnerable

Members with chronic uncontrolled conditions:

- COPD (Chronic Obstructive Pulmonary Disease)
- Asthma
- CHF (Congestive Heart Failure)
- Cardiovascular Disease
- Arteriosclerosis
- HTN (Hypertension)

Members with disabilities

Members that require complex procedures or transition of care:

- Organ transplant
- Bariatric surgery

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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 members' **access** to **resources** available in the **community**.

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

Provide effective medical **benefit resources** while ensuring quality care.

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

Ensure that member care services are **coordinated** and provided with the **appropriate treatmen**t in an efficient manner.

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

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Health Risk Assessment (HRA)

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

Initial HRA - 90 days from membership to complete it. Annual HRA - starting 365 days after the initial or after the most recent 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 an interdisciplinary team.

HRA refers to→ Care Management Programs.

* Case Management, among others.

Care plan is shared with:

Member + PCP and Interdisciplinary Team.

Individualized Care Plan (ICP)

Interdisciplinary team develops an ICP for each SNP member, identifying the needs of the member based on the result obtained in the HRA.

ICP guarantees that needs are covered, the course of evaluation and coordination of services, and the member's benefits.

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Individualized Care Plan (ICP)

ICP is communicated to the member 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)

Group focused on the member. Discusses the health status and interventions for the patient.

Responsabilities of the providers in the ICT:

1. Participate in ICP discussion.
2. Collaborate in setting goals.
3. Involve members in the management of 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.
7. Refers to the care management programs available through the plan.

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Care Transition

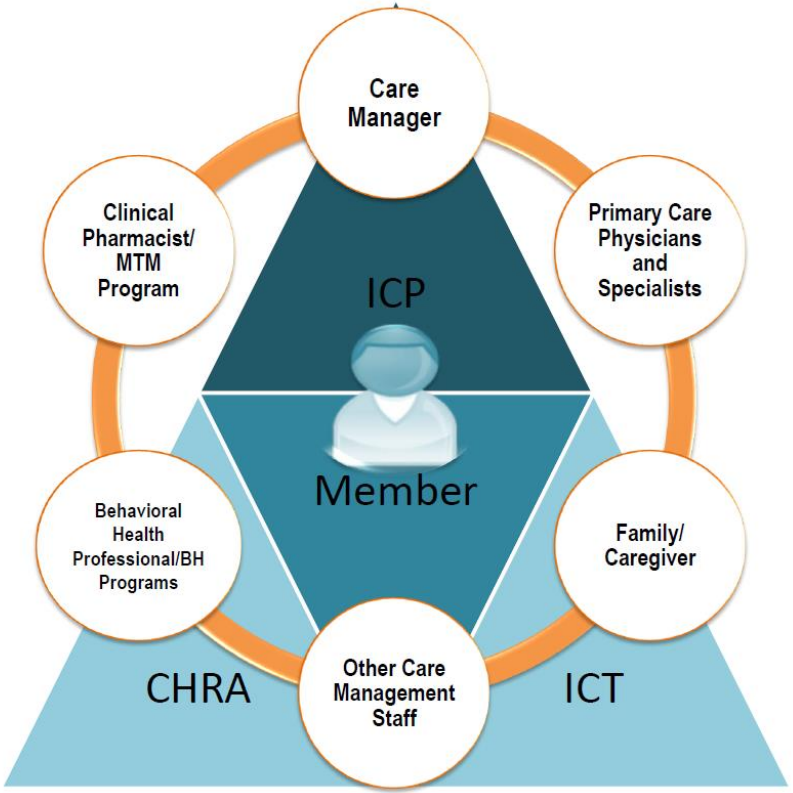
Transition processes and protocols are established to maintain continuity of care.

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

Staff available in the Discharge Planning Unit facilitates communication between care centers, primary physician and the member or their caregiver.

Member's ICP is shared with member 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 the continuous access to services and verifies what needs and information are shared among staff.
- Promotes follow-up visit seven days after patient is discharged from the hospital.
- Coordinates specialized services to the most vulnerable population.
- Promotes Health Risk Assessment for Individualized Care Plan.
- Actively participates as part of the Interdisciplinary Team.

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MOC 3:

Specialized Provider Network in the Care Plan

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Focus

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

The Provider Network monitors:

- The use of clinical practice guidelines and protocols.
- Collaboration and active communication between ICT and case administrators.
- Assistance in the preparation 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 establish a Quality Improvement Program 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, which focuses on improving the clinical aspect or service that is relevant to the SNP population.
- Measurement of SNP member satisfaction.

Quality Evaluation and Improvement

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

- Chronic Care Improvement Program (CCIP) for chronic disease, that identifies eligible members, and intervention to improve disease management and evaluate the effectiveness of the program.
- Collection of data to evaluate if the objectives of the SNP program are met.
- Sharing performance results every year with members, employees, vendors, and the general public.

References

1. *Model of Care Scoring Guidelines for Contract Year 2023*. Retrieved from: https://snpmoc.ncqa.org/static/media/MOCScrngGdlnsCY2023.78de7daf63ababaa3b9edd.pdf

2. *Medicare Managed Care Manual*. Chapter 5 - Quality Assessment, section 20.2 Additional Quality Improvement Program Requirements for Special Needs Plans (SNPs). Retrieved from: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326

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Our commitment to quality

Today we are proud to see that MMM special needs coverage will continue to improve the quality of life for 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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