

▶ Nascentia Health Plus Model of Care Training

2022

Overview

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Model of Care Requirements

- ▶ Unlike a “regular” Medicare Advantage Plan, a Special Needs Plan(SNP) must offer extra help to members in managing their needs.
- ▶ CMS requires all SNPs to submit a “Model of Care” prior to opening.
 - ❑ The model of care must outline a comprehensive approach to care management
 - ❑ CMS prescribes a range of elements that must be included in the Model of Care
 - ❑ The plan is required to use data to measure and monitor the Model of Care’s effectiveness
- ▶ Nascentia’s model of care received the highest level of approval from CMS.
- ▶ As we implement the model of care, it is important that all staff understand the key elements.

Nascentia Health Plus D-SNP

Special Needs Plan (SNP) for dual eligible individuals

- ▶ Enrolls people with both Medicare and Medicaid
- ▶ Including people with Medicare savings plans (e.g. QMB, SLMB)
- ▶ Characteristics of Dual eligible individuals:
 - ❑ Low income
 - ❑ Higher frequency of chronic illnesses
 - ❑ Behavioral health, substance abuse, and/or family issues
 - ❑ Frequent needs due to social determinants, such as lower health literacy, poor housing, inadequate access to care
- ▶ Because Nascentia will enroll its MLTC members, we can also expect:
 - ❑ Elderly members
 - ❑ Members with functional deficits and cognitive impairment

Nascentia Health Plus I-SNP

Special Needs Plan (SNP) for nursing home residents

- ▶ Enrolls people who are permanent residents of a nursing facility
- ▶ SNF length of stay must be greater than 100 days
- ▶ Characteristics of nursing home residents:
 - ❑ Many are dual eligible
 - ❑ Multiple chronic illnesses
 - ❑ Functional deficits
 - ❑ Cognitive impairment
 - ❑ Risk for hospitalization and further decline
- ▶ **Note:** *In the future, Nascentia will introduce a third SNP that combines Medicare benefits with comprehensive Medicaid benefits (including LTSS services).*
 - ❑ *This plan will enroll only dual eligibles who are also nursing home eligible.*

Assessments

- ▶ Each new member will be assessed in the first 90 days of enrollment.
- ▶ Initial assessments are conducted by telephone.
- ▶ If the assessment raises concerns, a follow up in-person assessment may be conducted in the member's home by a nurse.
- ▶ The assessment is an important building block to develop the member's plan of care.
- ▶ It becomes part of the care management record
- ▶ Assessments are conducted annually
 - In addition, assessments may take place if there has been a change in condition, due to hospitalization, a new medical diagnosis, the loss of a caregiver, or other significant event.

Interdisciplinary Care Team

- ▶ Nascentia will deploy an interdisciplinary care team (IDT) to ensure that each member's needs are met.
- ▶ The team is led by the care manager - a nurse for most members.
 - ❑ Care manager may be a social worker for a member with significant behavioral health issues
- ▶ The member's physician is a member of the IDT.
 - ❑ He/she will be invited to participate in care planning and IDT meetings
 - ❑ In most cases, his/her input will be obtained by the care manager by phone
- ▶ Other team members may include:
 - ❑ Utilization Management nurse
 - ❑ Social Worker
 - ❑ Pharmacist

The Role of the IDT

- ▶ IDT members are expected to:
 - ▶ Share information about the member's health and other factors that can have an impact on his/her health
 - ▶ Participate in the assessments, as appropriate
 - ▶ Participate in IDT meetings, when the member's strengths and needs are discussed. IDT meetings will include discussion of:
 - ❑ member's medical care, and connection to primary care
 - ❑ medication adherence
 - ❑ housing and financial issues
 - ❑ family dynamics and potential for domestic violence
 - ❑ need for palliative care or hospice, as appropriate
 - ▶ Participate in care planning for the member
 - ▶ The care manager documents all IDT meetings in the care management record.

Care Planning

- ▶ Each member will have a care plan that outlines his/her problems, goals, and interventions. This includes:
 - ❑ Short term goals and long term goals
 - ❑ Barriers
 - ❑ Member self-management
- ▶ When developing the care plan, the care manager will obtain input from:
 - ❑ PCP and other physicians
 - ❑ Member
 - ❑ Caregiver(s)
 - ❑ Claims data
 - ❑ Prescription drug data

Care Planning

- ▶ The Care Plan is a “living” document, and is updated as needs are identified or goals are achieved.
 - ❑ The care plan is reviewed and updated if there is a change in condition, such as a hospitalization
 - ❑ The care plan is reviewed and updated at least annually, following the annual health risk assessment
- ▶ A copy of the care plan is shared with the member and his/her physician.
- ▶ The care plan is maintained in the care management record.

Care Management

- ▶ The care manager coordinates the member's care across all health care settings.
 - ▶ Periodic phone contacts with the member and/or caregiver
 - ▶ Contacts, as appropriate, with the member's physician(s)
 - ▶ Monitoring the member's needs through the use of data
 - ❑ Utilization management data
 - ❑ Pharmacy data
 - ▶ Member education
 - ❑ About the role of the PCP (and ensuring the member has a PCP)
 - ❑ About his/her diagnoses, and management of chronic illnesses
 - ❑ About his/her medications
 - ▶ Linkages
 - ❑ To covered services and other community services
 - ▶ All care management contacts and documented in the care management record.

Management of Transitions

- ▶ Care management is critical at times when the member changes health care setting (e.g. to/from hospital or skilled nursing facility).
- ▶ Transitions are times of high risk, when members are vulnerable to complications and re-admission.
- ▶ Transitional care planning includes:
 - ❑ Ensuring that the member and/or caregiver understands the discharge plan
 - ❑ Ensuring that supportive services are in place when the member returns home
 - ❑ Ensuring that the member has any new prescriptions and understands when to take them. This includes understanding that some previous prescriptions may have been discontinued.
 - ❑ Ensuring that the member has an appointment for follow-up care by his/her physician
- ▶ As appropriate, the care plan is updated to reflect the change in the member's needs.

Using Data to Monitor and Measure Results

- ▶ Nascentia will use a broad range of data to measure the effectiveness of its model of care.
 - ❑ The model of care is an important focus of the Quality Management Committee, and data is analyzed and reported at each quarterly meeting.
- ▶ Utilization measures, including:
 - ❑ Hospital admissions and re-admissions
 - ❑ ER visits
 - ❑ PCP utilization
 - ❑ Pharmacy data
 - ❑ Medical Loss Ratio (MLR)
- ▶ HEDIS measures and gaps in care
- ▶ Satisfaction measures
 - ❑ From member surveys (CAHPS, HOS, and plan surveys)
 - ❑ Grievance data

Using Data to Monitor and Measure Results

- ▶ Process measures, including:
 - ❑ Completion rate for HRA and care plans
 - ❑ Measures to monitor transitional care management
- ▶ Administrative measures, including:
 - ❑ Member services - average speed to answer, hold time, dropped calls
 - ❑ Claims payment - timeliness and accuracy
 - ❑ Access to providers and use of out-of-network providers

▶ Questions ? ? ?