Nascentia Health Plus Model of Care Training

2025

Overview

- Special Needs Plan Model of Care Requirements
- Our Member Characteristics
- Assessments
- Interdisciplinary Team
- Care Plans
- Care Management
- Monitoring and Measuring Results

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.
- Physicians and Providers are asked to encourage members to complete the HRA. This allows for better coordination of care and a more comprehensive individual care plan.

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 (including Physicians and Providers) 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.

Role and Responsibility of Providers, Physicians & Clinicians

- Communication:
  - Communicate relevant information with plan regarding member's care
  - Respond to communication from Plan regarding member's care
  - This includes communicating with multiple people
    - Members
    - Care Givers
    - Care Management Teams
    - Other members of the Interdisciplinary Care Team
- Participating in the development of the ICP
- Maintain ICP and transition of care notices from Plan
- Complete Model of Care Training Annually, and complete the Attestation form

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 ? ? ?