



# Nascentia Health Plus

- ▶ **Model of Care Training**

2026

# 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 ? ? ?