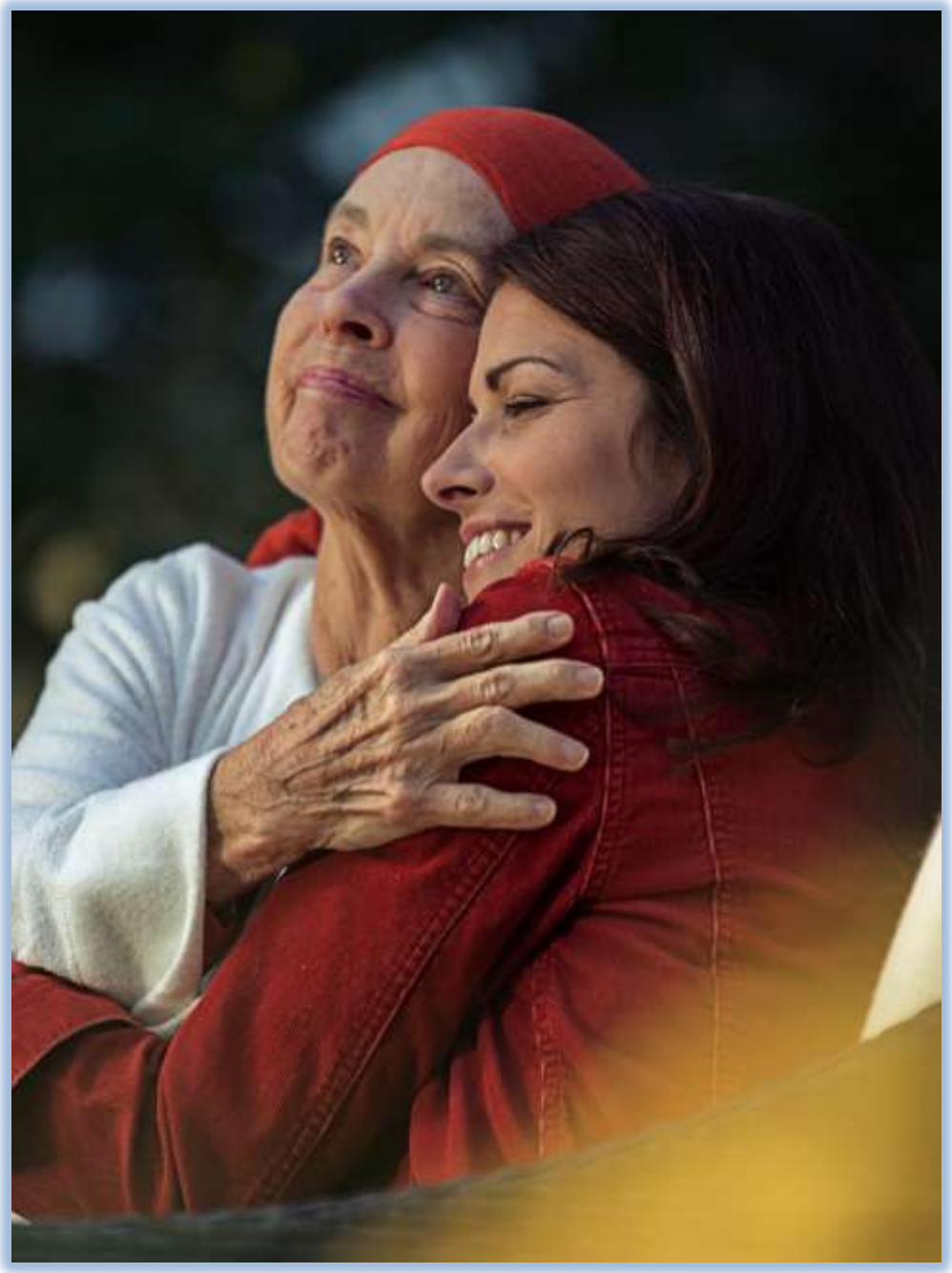

2023

Special Needs Plan (SNP)

Model of Care (MOC)

Training

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Training Objectives

- Understand key elements of the MOC and Center for Medicare and Medicaid Services (CMS) requirements
- Understand the goals of the MOC
- Understand key components described in the MOC

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Training Requirement

- CMS Requires that initial and annual MOC Training is provided to all Special Needs Plan (SNP) staff and providers.
  - SNP staff include all employed and contracted staff across all health plan functions as well as staff who directly or indirectly affect care coordination of SNP members
  - SNP providers include all in-network providers and out-of-network providers that see SNP members on a routine basis

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West Virginia Senior Advantage's Model of Care

A Model of Care provides structure for care management and coordination of SNP members. The WVSA MOC details the health plan's processes for delivering a unique level of customized clinical care and services to the frail and vulnerable institutionalized population it serves.

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MOC Focus Areas

- Description of the SNP Population
- Care Coordination
- Provider Network
- MOC Quality Measurement and Performance Improvement

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Description of the Population

- WV Senior Advantage's target population will be Institutional Special Needs Plan (ISNP) members
- Institutional Special Needs Plan members are Medicare Advantage (MA) eligible individuals that have an actual or expected stay of 90 days or longer in a nursing facility or skilled nursing facility
- Within the overall ISNP population, there is an identified sub-population, described as the most vulnerable due to the number of comorbidities, stages of disease processes, utilization patterns related to services and/or identified barriers of maintaining health
- Members are assigned a risk level based on identified needs, service utilization, functional status, frailty and/or disease trajectory

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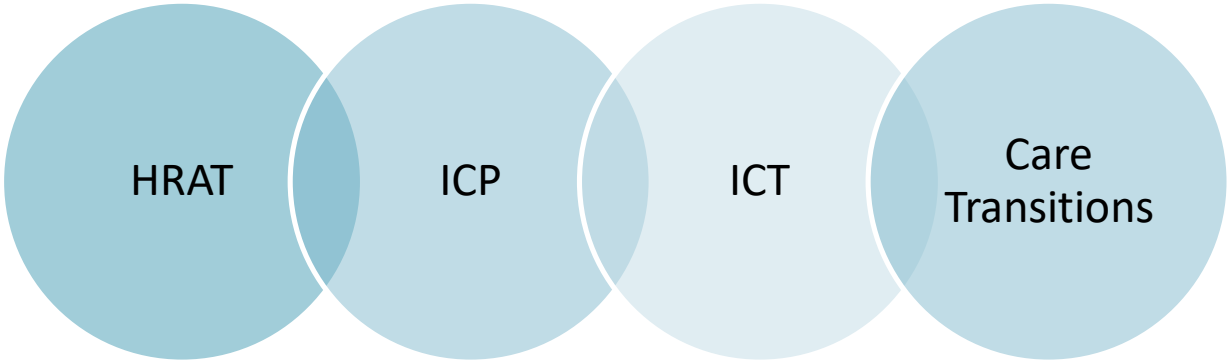
Care Coordination



Primary Care Providers (PCPs) and other specialists play a key role in care coordination. As part of the Interdisciplinary Care Team (ICT), the PCP is responsible for contributing and/or collaborating to develop the member's Individualized Care Plan (ICP). The PCP also plays a critical role in the member's medical management, especially during care transitions.

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Health Risk Assessment Tool (HRAT)

Assesses medical, functional, cognitive, mental health and psychosocial needs of the member

Results are utilized to determine risk stratification and develop the members Individualized Care Plan

Must be shared with the member and disseminated to the Interdisciplinary Care Team

Must be completed for each member within 90 days of enrollment or within 90 days of a contract change and every 365 days thereafter

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Individualized Care Plan (ICP)

- Begins with the completion of the HRAT
- The ICP is developed by the APC and/or the RN
- ICP identifies the interventions that support the member's goals of care
- Elements of the ICP include: member needs, goals of care, preferences, services and individualized measurable goals
- Reviewed and updated according to the approved Model of Care
- ICP is communicated to all ICT members
- The ICP is kept in the EMR for ICT to review

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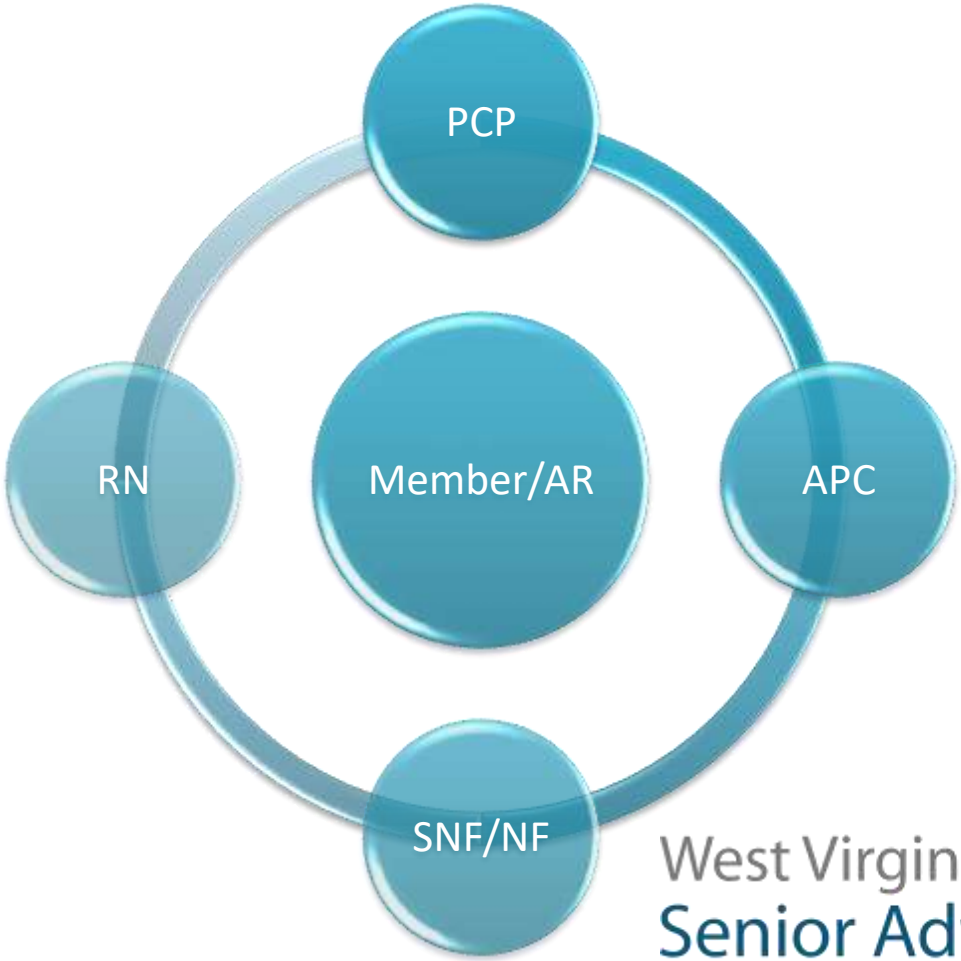
Interdisciplinary Care Team (ICT)

At minimum, the ICT is comprised of the member, family or authorized representative (AR), the Advanced Practice Clinician (APC), the Registered Nurse that supports the APC, the Skilled Nursing Facility (SNF) or Nursing Facility (NF) and the PCP.

PCP Responsibilities include:

- Providing medical treatment and collaborating with the APC, RN and other members of the ICT
- Reviewing the ICP and providing feedback
- Providing updates regarding the member's needs and recommended treatment



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Care Transitions

- Care transition refers to the movement of a member from one care setting to another as the member's health status changes.
- The ICT collaborate during care transitions to effectively manage, coordinate, and monitor transitions
- The SNF/NF caregivers are educated and instructed to contact the APC in addition to the PCP, when a transition occurs. During transitions, the SNF/NF staff provides elements of the ICP to the receiving facility
- The APC and PCP collaborate to clinically manage the member and support goals of treatment in the most appropriate setting of care
- After an inpatient admission or emergency department visit, the PCP and/or SNF/NF staff notify the APC of the members return to the facility. The APC with RN support, resumes management of care in collaboration with the PCP
- The goal during any care transition is to ensure continuity of care

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Provider Network

WV Senior Advantage will provide a comprehensive network of providers, specialists, and facilities with the specialized clinical expertise pertinent to the care and treatment of long-term nursing facility residents. A thorough credentialing and re-credentialing process is followed to ensure that providers are competent with active licenses.

- Provider expectations:
  - Collaborate closely with the assigned APC and/or RN and the entire ICT in an effort to improve care, outcomes and satisfaction, and developing and updating the ICP
  - Utilize nationally recognized and accepted practices for providing care (Clinical Practice Guidelines, Preventive Health Recommendations, etc.)
  - Provide ongoing primary care services and refer members for specialty and other health services as appropriate
  - Complete initial Model of Care training and annually thereafter

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MOC Quality Measurement and Performance Improvement

WVSA employs a comprehensive overall quality performance improvement plan across all functions.

The Quality Performance Improvement Plan ensures the health plan's ability to measure and evaluate the effectiveness of the MOC. Through this process we identify and address barriers to meeting MOC goals. MOC goals are measurable and evaluated on an ongoing basis.

Annual quality improvement activities and performance results are made available to members and providers on the West Virginia Senior Advantage website.

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MOC Goals

- Improving access and affordability of the healthcare needs
- Improving coordination of care and appropriate delivery of services
- Enhance care transitions across settings
- Ensure appropriate utilization of services for preventive health and chronic conditions
- Ensuring adequate utilization of behavioral health services
- Continuously improving care for seniors

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Resources

- Centers for Medicare and Medicaid. Medicare Managed Care Manual Chapter 5 – Quality Assessment (Rev 117, Issued 08-08-14): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf

- Centers for Medicare and Medicaid. Medicare Managed Care Manual Chapter 16B – Special Needs Plans (Rev 126, Issued 3-31-2023): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf

- National Committee of Quality Assurance. Special Needs Plan: Model of Care Approval: https://snpmoc.ncqa.org/resources-for-snps/

West Virginia Senior Advantage

MOC Questions

If you have any questions please contact:

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