



# Medicare: 2018 Model of Care Training

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# Model of Care Training



- This course is offered to meet the CMS regulatory requirements for Model of Care Training for our Special Needs Plans.
- It also ensures all employees and providers who work with our Special Needs Plan members have the specialized training this unique population requires.



# Model of Care Training



- The Model of Care (MOC) is Sunshine Health's documentation of the CMS directed plan for delivering coordinated care and case management to members with both Medicare and Medicaid.
- The Centers for Medicare and Medicaid (CMS) require all Sunshine Health staff and contracted providers to receive basic training about the Sunshine Health duals program Model of Care (MOC).
- This course will describe how Sunshine Health and its contracted providers work together to successfully deliver the duals Model of Care (MOC) program.

# Training Objectives



After the training, attendees will be able to do the following:

- Describe the basic components of the Sunshine Health Model of Care (MOC).
- Explain how Sunshine Health medical management staff coordinates care for dual eligible members.
- Describe the essential role of providers in the implementation of the MOC program.
- Explain the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT).



Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs. CMS has defined three types of SNPs that serve the following types of members:

- Dually Eligible Members (D-SNP)
- Individuals with chronic conditions (C-SNP)
- Individuals who are institutionalized or eligible for nursing home care (I-SNP)

*Sunshine Health currently contracts for D-SNP only (Advantage by Sunshine Health).*

# SNP



- For D-SNP Members, Medicare is always the primary payer and Medicaid is secondary payer.
- Providers may see members with Medicare Advantage (Allwell from Sunshine Health) and their Medicaid is under another health plan or traditional FFS Medicaid or vice versa.

# What is the Model of Care?



The Model of Care is Sunshine Health's plan for delivering our integrated care management program for members with special needs. **It is the architecture for care management policy, procedures, and operational systems.**



# Model of Care Goals



The goals of the Model of Care are to:

- ✓ Improve access to medical, mental health, and social services.
- ✓ Improve access to affordable care.
- ✓ Improve coordination of care through an identified point of contact.
- ✓ Improve transitions of care across healthcare settings and providers.
- ✓ Improve access to preventive health services.
- ✓ Assure appropriate utilization of services.
- ✓ Assure cost-effective service delivery.
- ✓ Improve beneficiary health outcomes.

# Model of Care



CMS re-organized the 11 Model of Care elements to 4 in 2014 to:

- Integrate the related elements.
- Promote clarity and enhance the focus on care needs and activities.
- Highlight the importance of care coordination.
- Address care transitions as well as other aspects of care coordination, which were not explicitly captured in the 11 elements.

# Model of Care



The revised Model of Care elements are:

- Description of the SNP Population
- Care Coordination
- SNP Provider Network
- Quality Measurements & Performance Improvement

# Model of Care Process



- Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care.
- The Health Risk Assessment (HRA) collects information about the members medical, psychosocial, cognitive, and functional needs, and medical and behavioral health history.
- Members are then triaged to the appropriate Sunshine Health case management program for follow up.

# Individualized Care Plan (ICP)



- An Individualized Care Plan (ICP) is developed with input from all parties involved in the member's care.
- The Individualized Care plan includes:
  - Goals and Objectives
  - Specific services and benefits to be provided
  - Measureable Outcomes

# Individualized Care Plan (ICP)



- Members receive monitoring, service referrals, and condition specific education.
- Case Manager's and PCP's work closely together with the member and their family to prepare, implement and evaluate the Individualized Care Plan (ICP).
- Sunshine Health disseminates evidence-based clinical guidelines and conducts studies to:
  - Measure member outcomes
  - Monitor quality of care
  - Evaluate the effectiveness of the Model of Care (MOC)

# Interdisciplinary Care Team (ICT)



- Sunshine Health Case Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) which includes appropriately involved Sunshine Health staff, the member and their family/caregiver, external practitioners and vendors involved in the member's care **based on the member's preference** of who they wish to attend.
- Sunshine Health Case Managers work with the member to encourage self-management of their condition as well as communicate the member's progress toward these goals to the other members of the Interdisciplinary Care Team (ICT).

# ICT and Inpatient Care



## Sunshine Health's Case Managers:

- Coordinate with facilities to assist members in the hospital or in a skilled nursing facility to access care at the appropriate level.
- Work with the facility and the member or the member's representative to develop a discharge plan.
- Proactively identify members with potential for readmission and enroll them in case management.

# ICT and Inpatient Care



- Notify the PCP of the transition of care and anticipated discharge date and discharge plan of care.
- Sunshine Health staff manages transitions of care to ensure that members have appropriate follow-up care after a hospitalization or change in level of care to prevent re-admissions.
- During an episode of illness, members may receive care in multiple settings often resulting in fragmented and poorly executed transitions.

# ICT and Transition of Care



- Managing Transitions of Care interventions for all discharged members may include but not limited to:
  - Face to face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan.
- In-home visits or phone call within 1-2 days post discharge to evaluate member's:
  1. Understanding of their discharge plan
  2. Understanding of their medication plan
  3. Ensure follow up appointments have been made
  4. Home situation supports the discharge plan

# ICT and Transition of Care

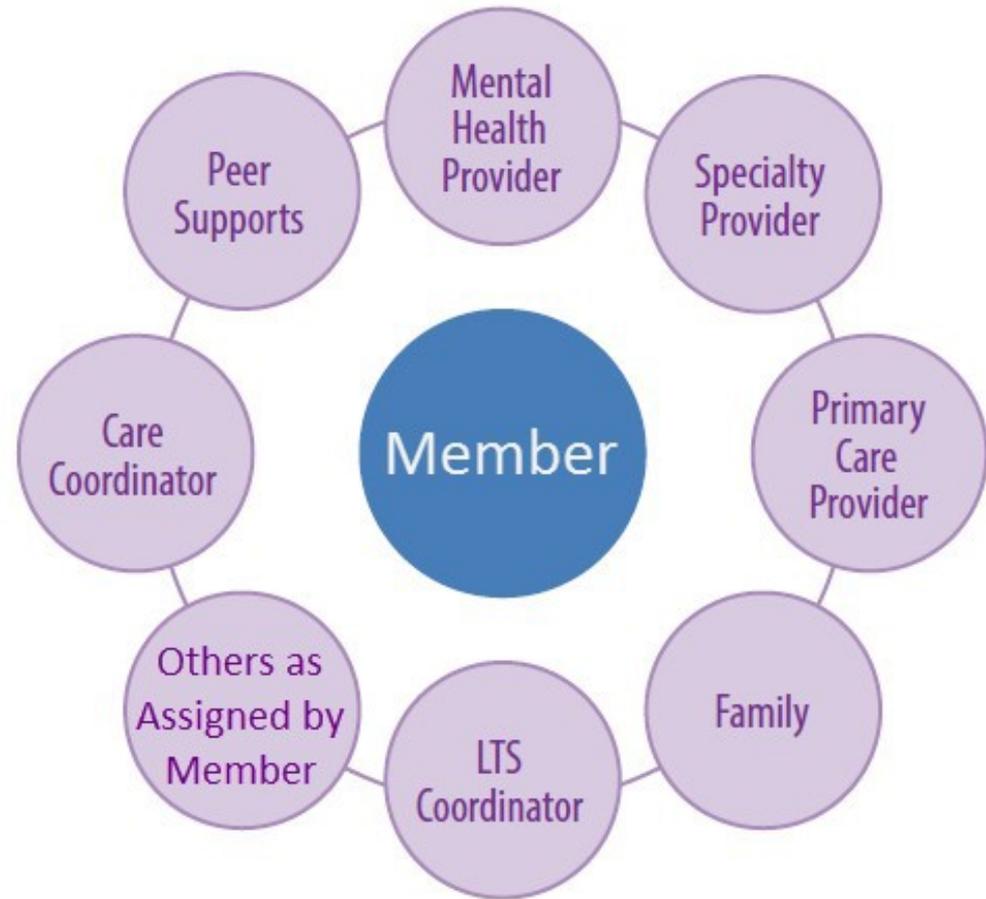


- Enrollment into the Case Management program
- Ongoing education of members to include preventive health strategies in order to maintain care in the least restrictive setting possible for their healthcare needs.

# Interdisciplinary Care Team



- Sunshine Health's program is member centric with the PCP being the primary ICT point of contact.
- Sunshine Health staff work with all members of the ICT in coordinating the plan of care for the member.



# ICT Member Responsibilities



Sunshine Health works with each member to:

1. Develop their personal goals and interventions for improving their health outcomes.
2. Monitor implementation and barriers to compliance with the physician's plan of care.
3. Identify/anticipate problems and act as the liaison between the member and their PCP.
4. Identify Long Term Services and Supports (LTSS) needs and coordinate services as applicable.

## ICT Member Responsibilities – *continued.*



5. Coordinate care and services between the member's Medicare and Medicaid benefit.
6. Educate members about their health conditions and medications and empower them to make good healthcare decisions.
7. Prepare members/caregivers for their provider visits-utilize personal health record.
8. Refer members to community resources as identified.
9. Notify the member's physician of planned and unplanned transitions.

# Provider ICT Responsibilities



Provider responsibilities include:

- Accepting invitations to attend member's ICT meetings whenever possible.
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record when received.
- Collaborating and actively communicating with:
  - Sunshine Health Case Managers
  - Members of the Interdisciplinary Care Team (ICT)
  - Members and caregivers

# CMS Expectations for the ICT



CMS expects the following related to the ICT:

- All care is per member preference.
- Family members and caregivers are included in health care decisions as the member desires.
- There is continual communication between all members of the ICT regarding the member's plan of care.
- All team meetings/communications are documented and stored.

# Provider Network



- Sunshine Health is responsible for maintaining a specialized provider network that corresponds to the needs of our members.
- Sunshine Health coordinates care and ensures that providers:
  - Collaborate with the Interdisciplinary Care Team
  - Provide clinical consultation
  - Assist with developing and updating care plans
  - Provide pharmacotherapy consultation

# Provider Network



CMS expects Sunshine Health to:

- Prioritize contracting with board-certified providers.
- Monitor network providers to assure they use nationally recognized clinical practice guidelines when available.
- Assure that network providers are licensed and competent through a formal credentialing process.
- Document the process for linking members to services.
- Coordinate the maintenance and sharing of member's health care information among providers and the ICT.

# Summary



- Sunshine Health values our partnership with our physicians and providers.
- The Model of Care requires all of us to work together to benefit our members by:
  - Enhanced communication between members, physicians, providers and Sunshine Health
  - Interdisciplinary approach to the member's special needs
  - Comprehensive coordination with all care partners
  - Support for the member's preferences in the plan of care
  - Reinforcement of the member's connection with their medical home

# Model of Care Attestation



After completion of the this training, please complete the [attestation](https://www.sunshinehealth.com/providers/resources/provider-training/model-of-care-provider-training.html):

<https://www.sunshinehealth.com/providers/resources/provider-training/model-of-care-provider-training.html>

**FOR OUR MEMBERS**    **FOR PROVIDERS**    **GET INSURED**

### Model of Care Provider Training

All Sunshine Health network providers are required to complete an annual Model of Care training. Click on the link below to review the Model of Care training presentation. Then, submit the form to verify the training was completed.

Provider Model of Care Training Presentation

#### Provider Model of Care Training Confirmation

Provider Group \*

County \*

Provider TIN(s) \*

Please provide any additional TINs that should be represented on this form.

TIN 2

TIN 3

TIN 4

TIN 5

Phone \*

Email \*

Form Completed By \*

Title \*

Date \*

Training Confirmation

The 2018 Provider Model of Care training has been completed by the Provider Group above.