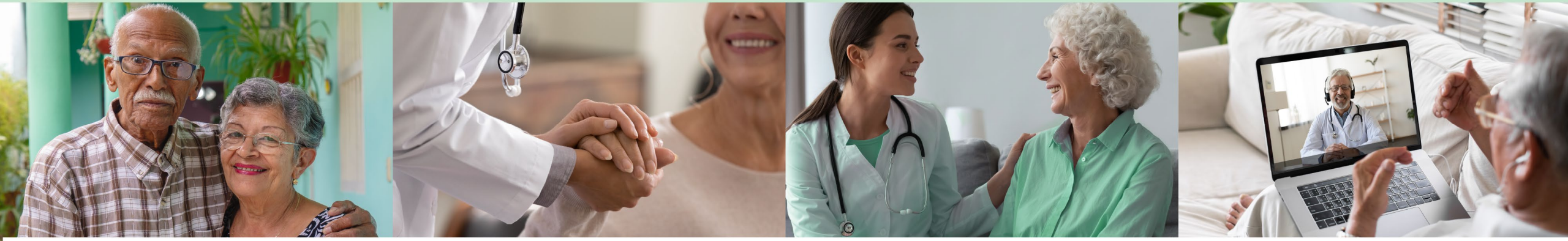
MODEL OF CARE
FOR SPECIAL NEEDS PLANS
TRAINING 2024

January
2024



MCS Classicare (HMO)

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Objectives

At the end of the training, you will be able to:

- ❖ Identify the four (4) Model of Care elements.
- ❖ Describe the Model of Care that MCS offers to its dual eligible members with special needs (D-SNP) or members with chronic conditions (C-SNP).
- ❖ Define the Interdisciplinary Care Teams for the D-SNP and C-SNP population.
- ❖ Explain the integrated role of employees and providers in the Model of Care of MCS.

Definitions

- **C-SNP MOC** (Chronic Conditions Special Needs Plan Model of Care): Model of care for members with certain chronic conditions.
- **CAHPS** (Consumer Assessment of Healthcare Providers and Systems): Survey that collects, evaluates, and reports about the experience (perception) of members in relation to services received from health plan and providers.
- **CHRAT** (Comprehensive Health Risk Assessment Tool): Assessment performed by clinicians to identify member's needs and risk factors.
- **CM** (Care Management): Care Management Program/Care Manager.
- **SDOH** (Social Determinants of Health): Describe the range of social, environmental, and economic factors that can influence health status conditions that can often have a greater impact on health outcomes than the actual delivery of health services.
- **D-SNP MOC** (Dual eligible Special Needs Plan Model of Care): Model of care for members with dual eligibility.
- **HEDIS** (Healthcare Effectiveness Data and Information Set): Is a set of standardized performance measures related to care and service developed by the National Committee on Quality Assurance (NCQA).
- **HOS** (Health Outcomes Survey): Is the first patient-reported outcomes measure used in Medicare managed care.
- **ICP** (Individualized Care Plan): Individualized Care Plan created for the member.
- **ICT** (Interdisciplinary Care Team): Care team for SNP members composed of at least the PCP and the member and other health experts, if applicable.
- **PCP** (Primary Care Physician): Physician who is mainly responsible for the member's care under the Model of Care.

Special Needs Plans Background (SNP)

It is important to know that the CMS regulation **42 CFR §422.101(f)** requires that all Medicare Advantage (MA) organizations implement a Model of Care for its special needs members, have an appropriate provider network, and specialists designed to meet the members' health needs and improve their quality of life.

2003

Under the *Medicare Modernization Act*, the U.S. Congress developed the Special Needs Plan (SNP) as part of the requirements for *Medicare Advantage plans (MA)*.

SNPs are classified in three categories:

1. Dual Eligible (D-SNP)
2. Chronic Diseases (C-SNP)
3. Institutionalized Individuals (I-SNP)

2012

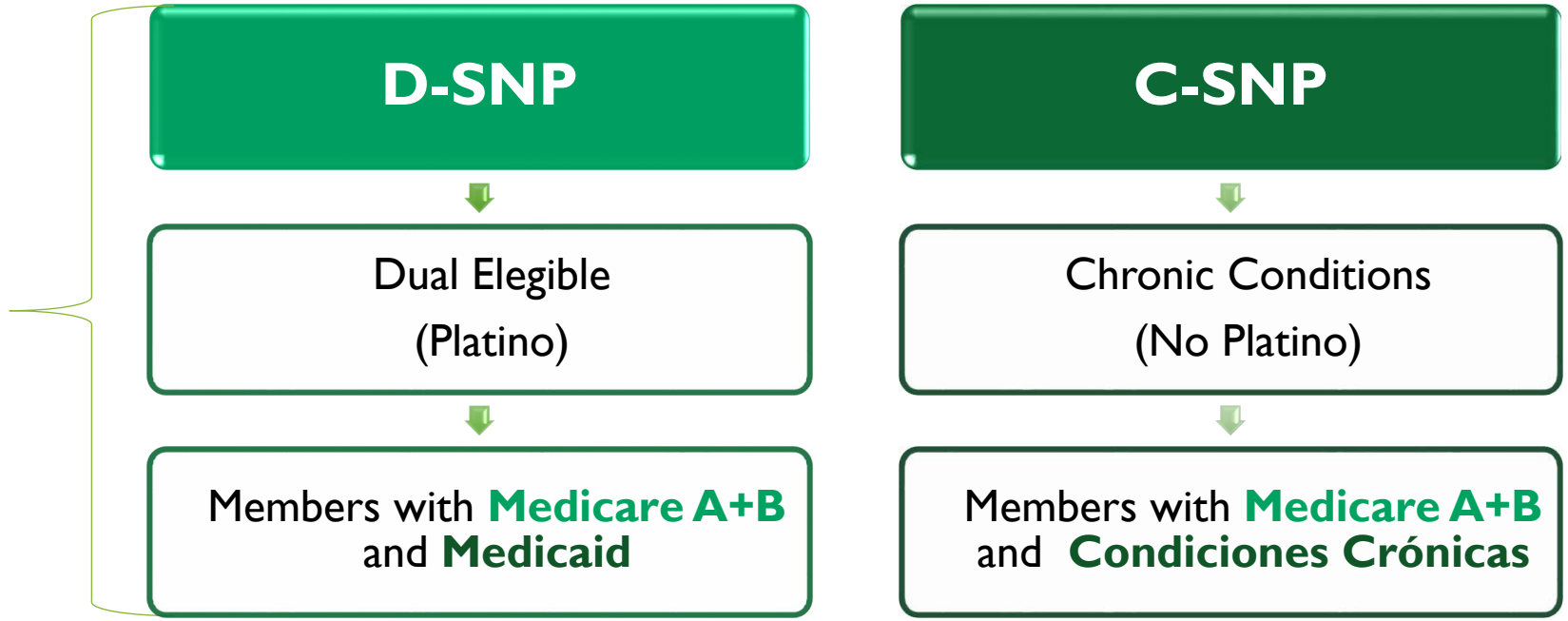
The Affordable Care Act amended Section 1859(f)(7) of the Social Security Act

Requires that all MA plans offering SNPs plans submit a **Model of Care (MOC)** to CMS for the evaluation and approval of NCQA (*National Committee for Quality Assurance*) that ensures compliance with CMS guidelines.

Model of Care (MOC)

CMS describes the Model of Care as a vital quality improvement tool that integrates components to ensure that the unique needs of each enrolled member are identified and addressed through the plan's care management practices. The MOC provides the necessary infrastructure to promote quality, care management and care coordination processes for SNPs members.

MCS has **two (2) models** of care in health plans for eligible individuals, these are:



2024 MCS Classicare SNP Plans

For **2024**, MCS Classicare has six Platino plans for the D-SNP population and one plan for the population with chronic conditions C-SNP.

MCS Classicare		
Plan's name	**Contract number**	**Número de grupo**
Platino Ideal (HMO D-SNP)	H5577-002 (Renewal)	850614
Platino Progreso (HMO D-SNP)	H5577-017 (Renewal)	850717
Platino MásCa$h (HMO D-SNP)	H5577-029 (Renewal)	850723
Platino Total (HMO D-SNP)	H5577-046 (Renewal)	850749
Platino Máximo (HMO D-SNP)	H5577-054 (New)	850752
Platino Del Sur (HMO D-SNP)	H5577-055 (New)	850753
Primero (HMO C-SNP)	H5577-038 (Renewal)	850728

Total MCS Classicare Population as of January 1, 2024:
D-SNP **103,149** enrolles | C-SNP **12,841** enrolles.

Model of Care (MOC)

The Model of Care (MOC) is composed of **four (4) elements**. These are:

MOC 1

Description of SNP population

MOC 2

Care coordination

MOC 3

Provider network

MOC 4

Quality measures and performance improvement

MOC I

DESCRIPTION OF SNP POPULATION

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MOC 1: Description of SNP Population

Most vulnerable population D-SNP and C-SNP

The most vulnerable **D-SNP** and **C-SNP** population is part of the total **MCS Classicare** population identified as having complex health risks that require intervention by a **care manager** to assist them with their needs.

- Eligibility
- Social, cognitive and environmental factors
- Living conditions
- Comorbidities
- Physical and mental health conditions
- Specific characteristics identified in the population

MOC 1: Description of SNP Population

Specialized services for D-SNP and C-SNP population

- Transportation services for medical appointments.
- Health education for members with chronic conditions.
- Special supplemental services:
  - Transportation to non-health related locations (in-network)
  - Allowance to purchase healthy food, and to pay for electricity, water, telephone, internet bills, among other services
  - Home Assistance:
    - ✓ Simple repairs and services: simple yard clean-up, hairstyling (wash, cut, and dry), plumbing, electrical repairs, locksmith services, preventive home cleaning/disinfection, pest control, and technology assistance.

- Zero cost-sharing for dental services covered, recognizing the link between dental health and management of chronic conditions.
- Some coverages include the In-home foot care benefit, which includes nail trimming and filing, foot cleaning, callus exfoliation, among other services.
- Comprehensive health risk assessment, which includes:
  - Skin integrity assessment
  - Assessment of social determinants of health and the need for community services and/or non-clinical services
  - Assessment of knowledge of their health conditions
  - Medication reconciliation

MOC 2

CARE COORDINATION

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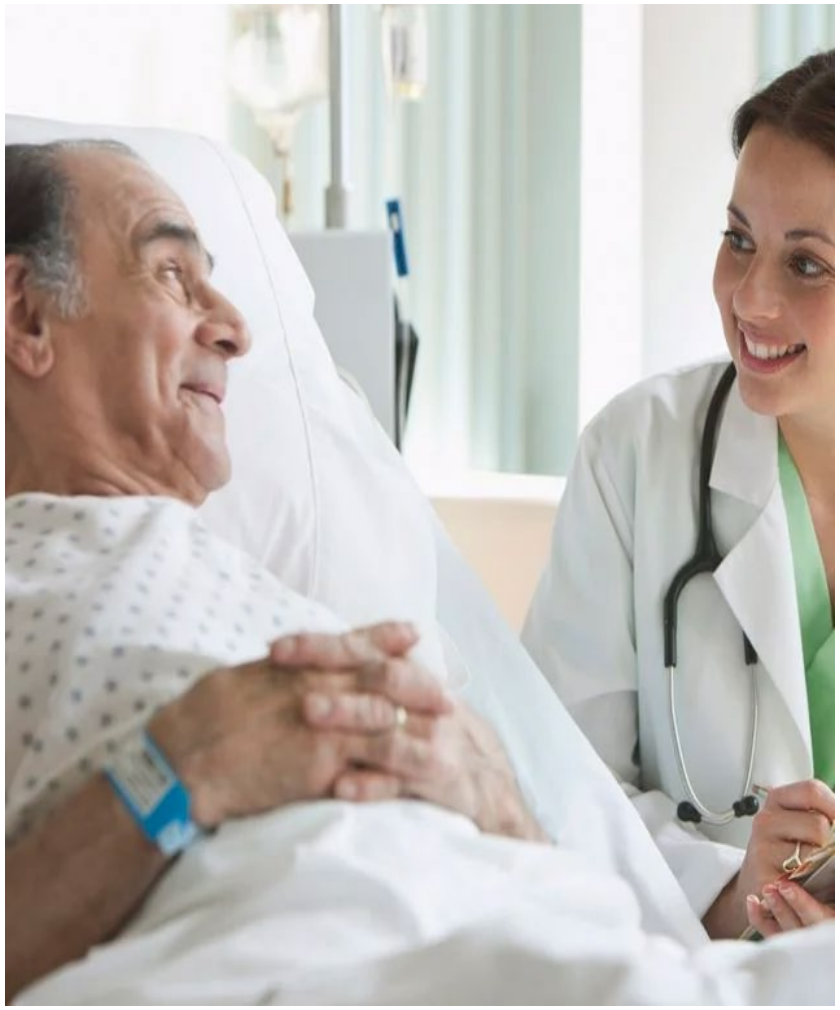
MOC 2: Care Coordination

Care coordination establishes the following:

Coordinate and evaluate the effectiveness of the provision of services contemplated in the MOC.

Ensure that all health needs and service preferences of SNPs members are met.

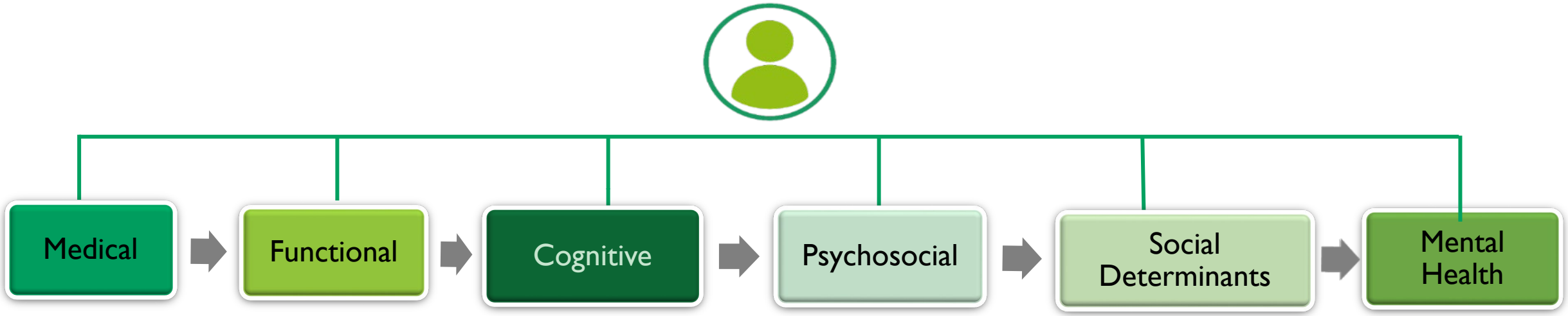
To ensure that medical information is shared among health professionals maximizing effectiveness, efficiency, high quality services and improving health outcomes for members.



MOC 2: Care Coordination

Health Risk Evaluation identified in the CHRAT

The **Comprehensive Health Risk Assessment Tool** (CHRAT) is a tool designed to collect all the elements that help identify the needs of our members, these are:



CHRAT sections are carefully selected by the Interdisciplinary Care Team (ICT) to evaluate member's possible risks and needs, both clinical and non-clinical.

The needs identified in the CHRAT determine the SNP member's level of health risk, in one of the following three (3) categories: **Mild, Moderate or Severe**. The Individualized Care Plan is also generated and shared with the member and his/her PCP.

MOC 2: Care Coordination

Health Risk Evaluation

The Comprehensive Health Risk Assessment Tool (CHRAT) is administered by the PCP and is inclusive of the ICT.

The CHRAT process allows the PCP or physician to obtain an updated health profile for their patient and develop the Individualized Care Plan (ICP) with the beneficiary, at the time of administration.

The CHRAT provides a complete and current health profile of each MCS beneficiary (D-SNP & C-SNP and MA), to identify specialized needs for the development of the ICP, to guide care management and account for health status changes.

An initial and annual CHRAT may be administered face-to-face or via a telehealth medical appointment between PCP/physician and the beneficiary and documents the health assessment, including clinical and non-clinical findings.

The care plan is stored in the system for ICT members to view and updated care plans are sent to the members.

MOC 2: Care Coordination

Face-to-Face Encounters

CMS regulation 42 CFR § 422.101(f)(1)(iv) requires that the entire SNP population receive a face-to-face encounter to facilitate the member's participation in services such as:

- Health care, care management, or health care coordination services.
- These encounters must occur with the member's consent, at least annually within the first 12 months of enrollment.
- These encounters may be provided to the SNP member through visits to their Primary Care Physician (PCP), telemedicine services (videoconference), among others.

The purpose of the face-to-face encounter is to assess the member's current health status and healthcare concerns as well as to foster discussion of available treatment options, the availability of community resources, and the establishment of the members health care goals.

MOC 2: Care Coordination

Interdisciplinary Care Team (ICT)

The Interdisciplinary Care Team (ICT) provides the structure and processes needed to ensure the coordination of health care services for our Special Needs Plan members, according to their health status and identified needs.

The primary care physician (PCP) and the member or the member's representative are the ICT. The ICT is responsible to develop and implement the member's Individualized Care Plan (ICP).

Alternative ICT:

- The member and the PCP are the ICT. If for some reason the member and the PCP cannot meet to discuss the ICP, then an alternative ICT will meet on behalf of the PCP and the member.
- This alternative ICT is composed of an MCS physician and a care manager.
- The alternative ICT may discuss multiple members ICPs in a meeting.

ICT Complex:

- Responsible for the development and implementation of individualized care plans for the members who meet the criteria for severe health risk stratification level according to their CHRAT and who participate from one of the Complex Management Programs.

MOC 2: Care Coordination

Interdisciplinary Care Team (ICT)

The member or member's representative, along with his/her primary care physician (PCP), are the ICT.

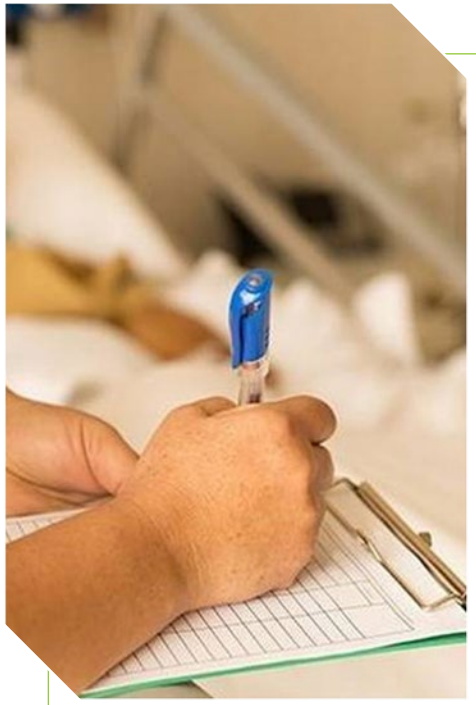
In addition to the beneficiary and family/caregivers and the member's PCP, other team members may be added from the various disciplines that deliver or coordinate services that address specific chronic care needs.

The ICT is responsible for developing an ICP that includes measurable goals/objectives, measurable outcomes, as well as all appropriate services for the beneficiary based upon assessments, discussions with the beneficiary, recommendations by Care Management or any input from providers as applicable.

Considering the medical, functional, cognitive, psychosocial, and mental health needs of members, MCS uses an integrated approach to coordinate care that may incorporate any of the following: the MCS Care Management Team, various components of the provider network, as well as programs and resources that are available in the community.

MOC 2: Care Coordination

Individualized Care Plans (ICP)



All MCS members receive an Individualized Care Plan, at least, annually or if there are major changes in the member's health status.

- The responses from the Health Risk Assessment Tool (HRAT) are used to develop the initial Individualized Care Plan for each enrollee. After the initial Individualized Care Plan is generated (which normally takes 60 to 90 business days after the completion of the HRAT), it is updated no less than annually through the HRAT or if the member's health status warrants an ICP update.
- The ICP is distributed to both the member and the PCP by postal mail.
- The individualized care plans for D-SNP and C-SNP include interventions and goals for chronic conditions such as: diabetes, chronic heart failure, cardiovascular disorders, arthritis, among others.

MOC 2: Care Coordination

Individualized Care Plan (ICP)

ICPs provide a structure to organize health goals and to document results. These include, but are not limited to, the following essential components:

- The member's self-management goals and objectives.
- The member's personal healthcare preferences.
- A description of services specifically tailored to the member's needs.
- Role of the member's caregiver if applicable.
- Identification of goals (met or not met).
    - If the member's goals are not met, the ICT will reassess the current ICP and determine the appropriate alternative actions.

The Individualized Care Plan is the tool used to document the health recommendations based on the diagnoses that have been identified in the member's health status evaluation by the member and PCP to encourage him/her to meet goals. For members that met with the PCP for the HRAT, the ICP will be developed in the same visit.

MOC 2: Care Coordination

Care Transition

It is identified as a transition/movement of the member from one health care setting to another, in which the member receives health care and services due to a change in health status. In either scenario, a designated provider has continuing responsibility for the member's medical care.

Care transition to a lower level:

- Example: from the hospital setting to a rehab facility and then to the member's home

Care transition to increase level:

- Example: from the member's home to a hospital setting

MOC 2: Care Coordination

Transition of Care

MCS Classicare integrates the member, the caregiver and the primary care physician (or regular physician) in the transition process that occurs before, during and after the change from one level of care to another, as the member's health status changes.

Coordination of care for transitions ensures all beneficiaries experiencing a transition are connected to the appropriate provider based on the unique circumstances of the enrollee.

Notification of PCP:

- Once aware of a member's transition, MCS informs the member's PCP of the transition.
- For acute care events, the notification occurs through the Provider Portal.
- For post-acute care events, MCS notifies the determination to the receiving setting, patient's PCP, and beneficiary.

Once the transition concludes (i.e., the enrollee is not expected to have any further movement from one health care setting to another because the member's health has stabilized), the care plan is reviewed and updated, when indicated, based on ongoing needs resulting from the transition. Care plan updates are shared with the beneficiary and PCP.

MOC 3

PROVIDER NETWORK

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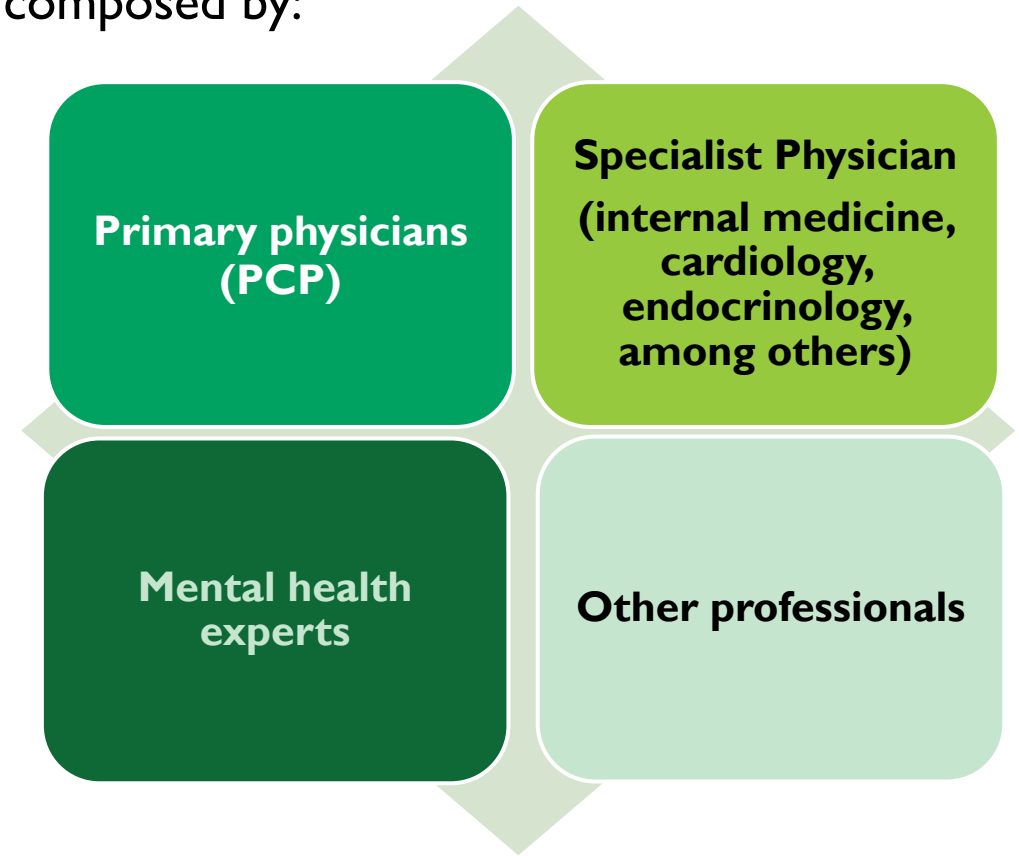
MOC 3: Provider Network

The network of Providers contracted by MCS is composed by:



The MCS Provider Network must meet the following MOC requirements:

Use of clinical guidelines and transition of care protocols

- Clinical guides example:
  diabetes, asthma, cancer, among others

Participate in required MOC training

- Participant providers
- Non-participant providers that assist MCS members routinely
- Providers contracted by the delegated entities

MOC 3: Providers Networks

Role of primary care physician and specialist physicians

Integrate the primary care physician or other providers in the member's care management.

Use the clinical practice guidelines adopted by MCS (available in Provinet).

Review and update the Individual Care Plan. Communicate, update, and address concerns or preferences with member.

Provide services on time guaranteeing quality in the continuity of care, treatment, and services to the member.

Notify the health plan of any barrier that affects access to services or the care transition process.

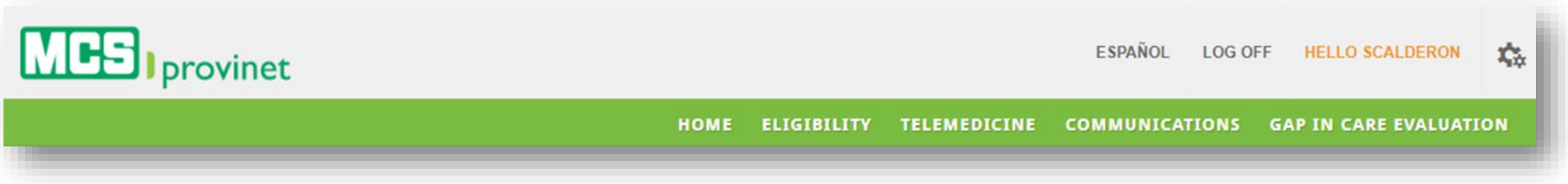
Participate in the patient's care planning and encourage their participation in the care process.

Participate as a member of the Interdisciplinary Care Team and maintain communication with the team and the caregiver.

Lead the member to a healthy lifestyle offering preventing care and providing education about their condition.

MOC 3: Providers Network

Provinet: Tool for providers



The provider is accessible through Provinet:

- Assistance to the PCP to coordinate the member's care and evaluate their patient's compliance with preventive care and HEDIS measures.
- Clinical Guidelines such as: Diabetes, Asthma, Cancer, among others.
- MOC Training
- Referral for Care Management Programs
  - Can be sent to fax: 787.620.1336

MOC 4

QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

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MOC 4: Quality Measurement and Performance Improvement

The requirements to be met on quality and performance improvement measures for both models of care are:

- MCS Classicare current **MOC-Dual** is renewed every three (3) years.
- MCS Classicare current **Chronic-MOC** is renewed annually.
- Requires annual presentation and/or approval of the MCS Board of Directors, Utilization Management Committee, and Quality Improvement Committee.
- The MOC Task Force composed of leaders from the areas impacted by the MOC, including delegated entities, meet at least six (6) times a year to discuss and monitor the operational compliance with MOC requirements including measures aligned to STARS, HEDIS, CAHPS, HOS, and those of its own departments.

MCS Quality Department is responsible for **overseeing, monitoring and evaluating** actions related to the MOC.

MOC 4: Quality Measurement and Performance Improvement

The quality measures and performance improvement report as required in the MOC must contain the following:

A. Quality measurement and performance improvement plan

Data sources:

- ✓Electronic Care Management system, CHRAT data base, and PMHS application
- ✓MCS leader's participation in the internal quality process

B. Measurable goals and health outcomes

Metrics indicators:

- ✓STARS
- ✓HEDIS
- ✓Regulatory reports
- ✓Operational reports

C. Measurement of patient experience of care

Satisfaction surveys:

- ✓CAHPS
- ✓HOS
- ✓Internal surveys of members' satisfaction:
  - Focus groups

D. The MOC is presented for Program Evaluation in the MCS Quality Committee

Ongoing performance improvement and evaluation of the MOC:

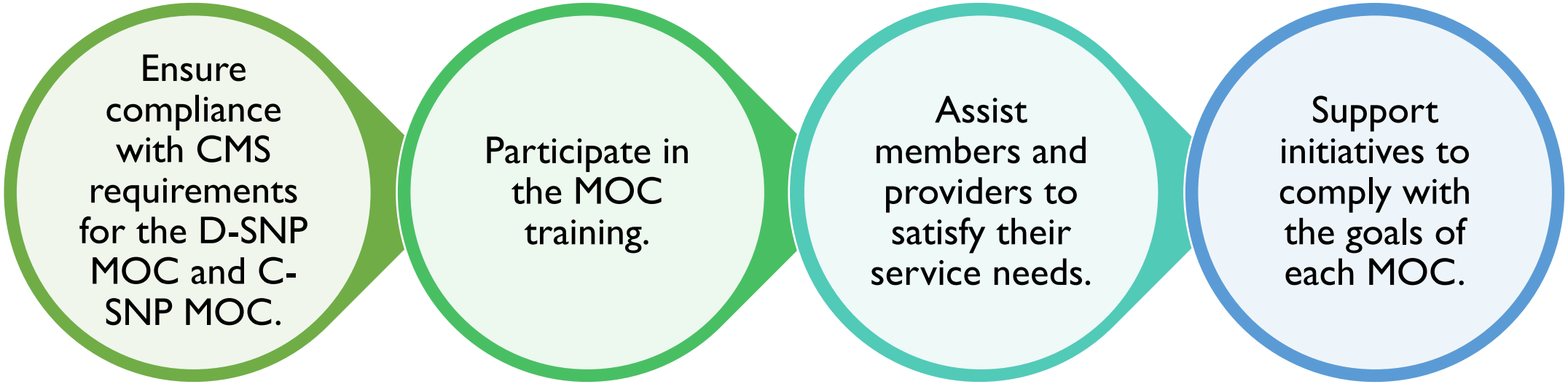
- ✓ Monitor and analyze the quality indicators to identify improvement opportunities
- ✓ Hold MOC Taskforce meetings

E. Communication of the SNP MOC performance

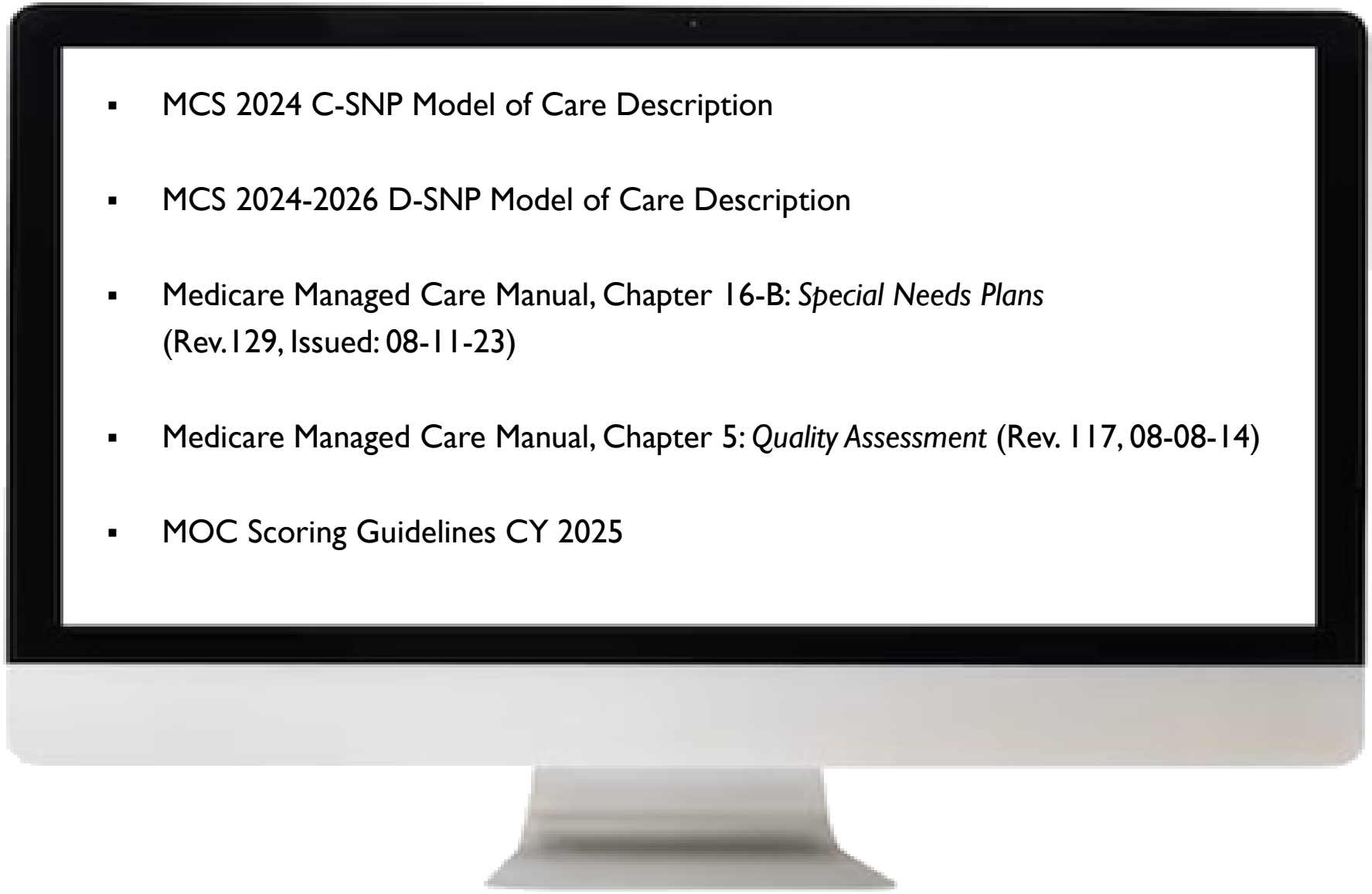
MCS communicates the obtained information to:

- ✓Board of Directors
- ✓Employees
- ✓Providers
- ✓Among others

We all have a very important integral role, and we must:



References



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Any further information you can contact:

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MCS Classicare

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MCS Classicare is an HMO plan subscribed by MCS Advantage, Inc. Every year, Medicare evaluates plans based on a 5-star rating system.

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