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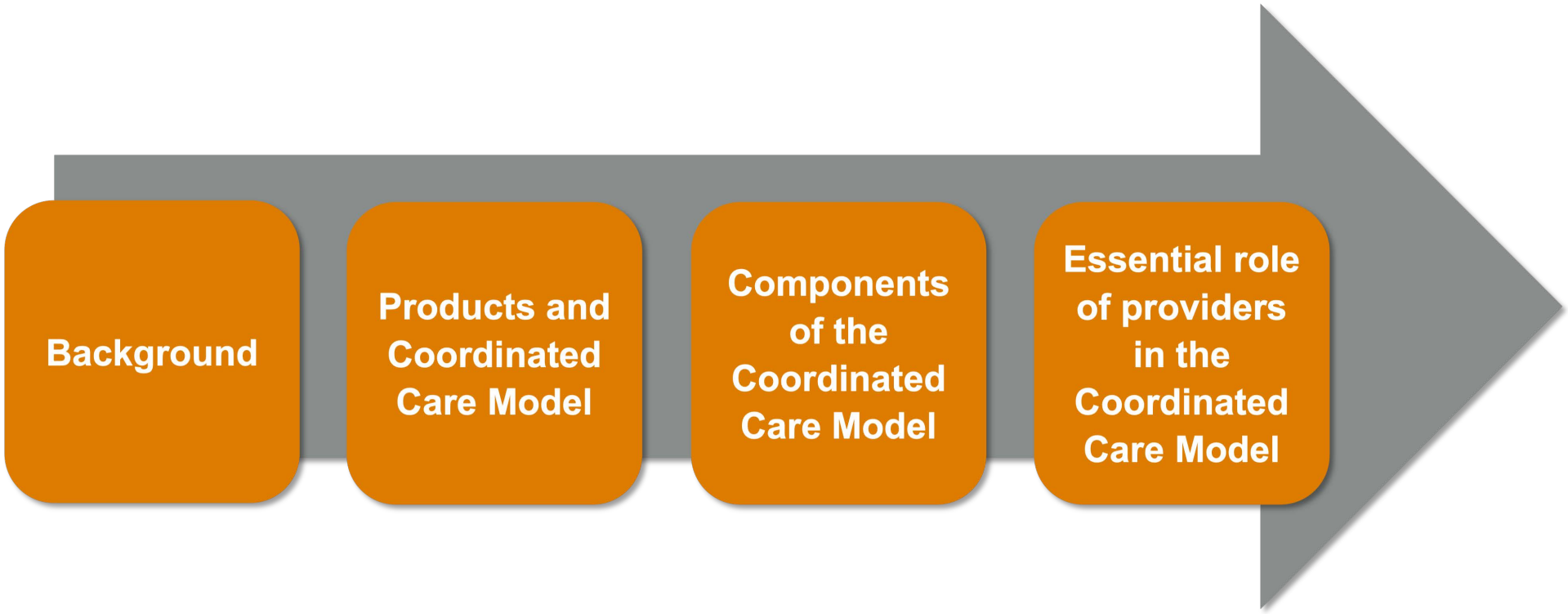
Coordinated Care Model 2025

Objectives


Background
Products and Coordinated Care Model
Components of the Coordinated Care Model
Essential role of providers in the Coordinated Care Model

Model of Care: Training

Developed to comply with the guidelines of the Centers for Medicare and Medicaid Services*.

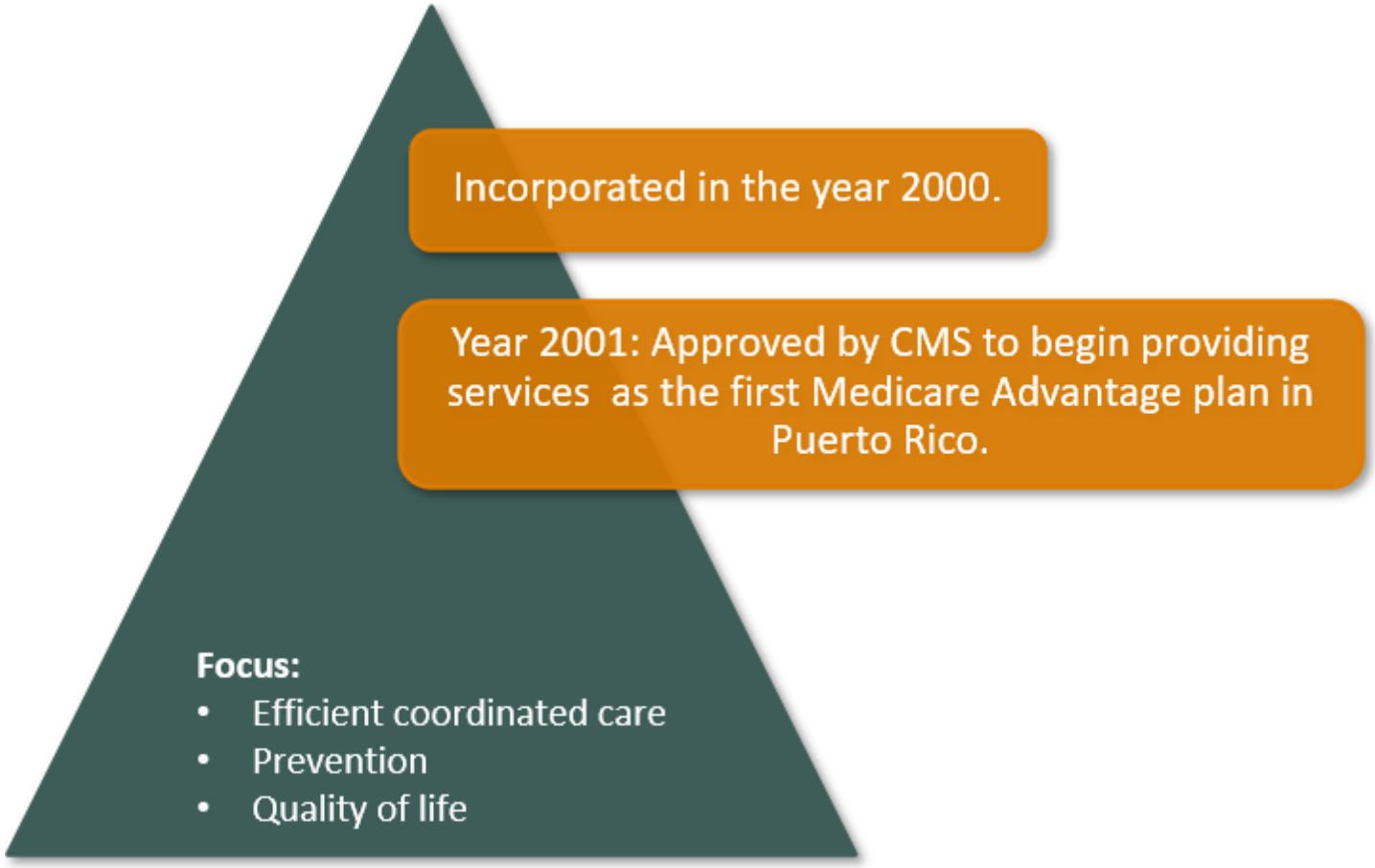
Every Medicare Advantage insurer must provide and document training on the Coordinated Care Model** to all employees, contracted personnel, and providers.

It is an annual requirement.

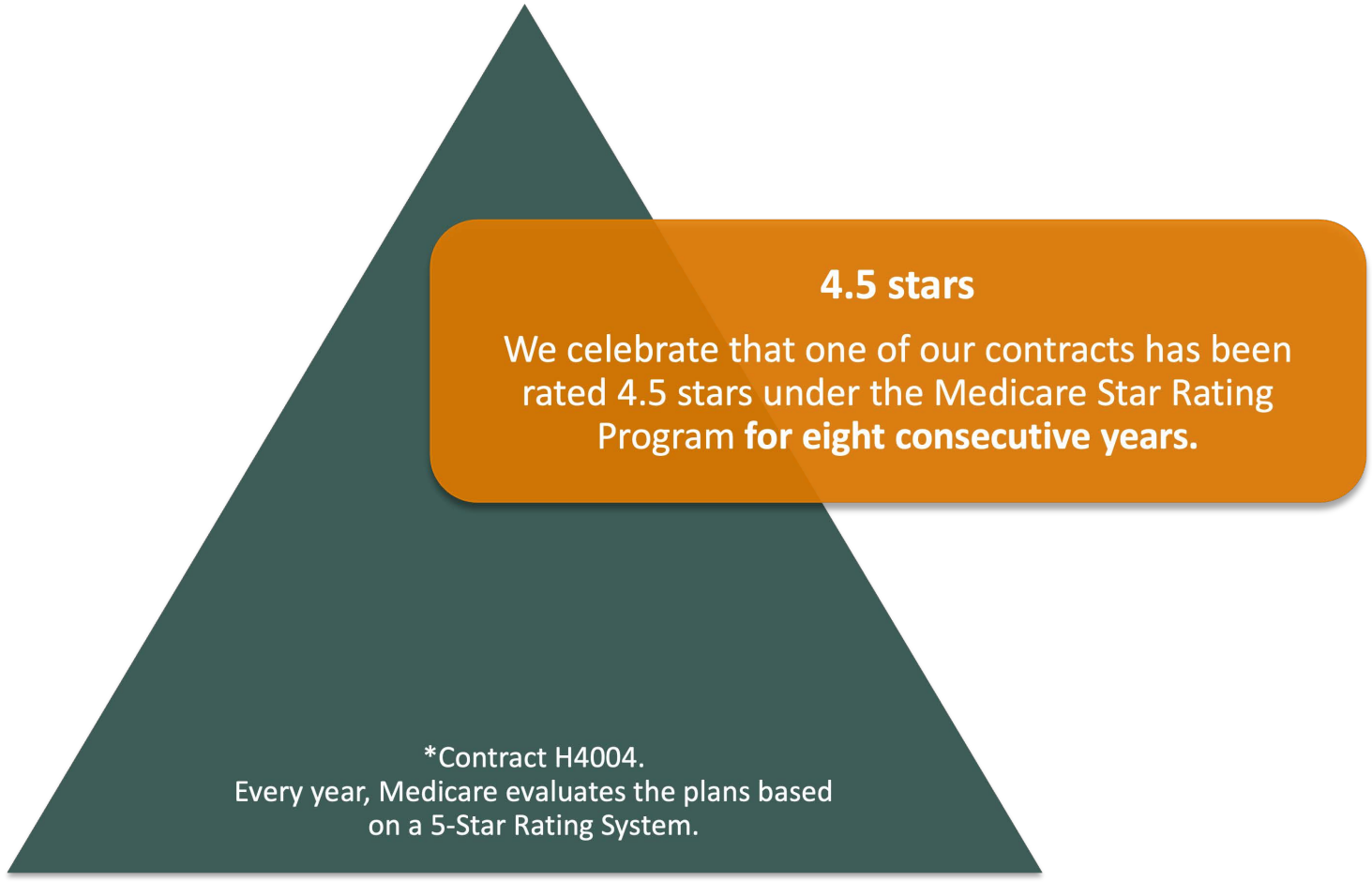
- Methodology or types of intervention:
  - ❑ Face-to-face
  - ❑ Interactive (Internet, audio/video)
  - ❑ Self-study (printed material or electronic media)

* CMS **MOC

Background


Incorporated in the year 2000.
Year 2001: Approved by CMS to begin providing services as the first Medicare Advantage plan in Puerto Rico.
Focus:
• Efficient coordinated care
• Prevention
• Quality of life

Background


4.5 stars
We celebrate that one of our contracts has been rated 4.5 stars under the Medicare Star Rating Program **for eight consecutive years.**
*Contract H4004.
Every year, Medicare evaluates the plans based on a 5-Star Rating System.

What is the Coordinated Care Model?

- Structure to carry out coordinated care efficiently
- Focus on beneficiaries with special needs

- Vital tool
- Improve the quality
- Ensure that needs are met under SNP*

*SNP –Special Needs Plan


MMM
COVERAGE
2025

Special Needs Plans

C-SNP (Chronic Condition Special Needs Plan)	

MMM Supremo (HMO-C SNP)	Members with chronic or disabling conditions:
	• Diabetes
	• Chronic Heart Failure (CHF)
	• Cardiovascular diseases:
	  ○ Cardiac arrhythmia
	  ○ Peripheral vascular disease
	  ○ Coronary artery disease
	  ○ Chronic Venous Thromboembolic Disorder

Special Needs Plans

D-SNP (Dual Eligible Special Needs Plan)	
MMM Diamante Platino (HMO-SNP)	Members eligible for Medicare and Medicaid.
MMM Relax Platino (HMO-SNP)	
MMM Dorado Platino (HMO-SNP)	
MMM Combo Platino (HMO-SNP)	
MMM Flexi Platino (HMO-SNP)	
PMC Premier Platino (HMO-SNP)	

Elements of the MOC

Description of Special Needs Population (SNP)

Coordinated care

- Mandatory assessment of Health Risks and Reassessment (HRA)
- Medical Visits (Face-to-Face)
- Individual Care Plan (ICP)
- Interdisciplinary Team (ICT)

Provider Network

Quality Metrics and Performance Improvement

MOC 1:
Description of the Special Needs Population (SNP)

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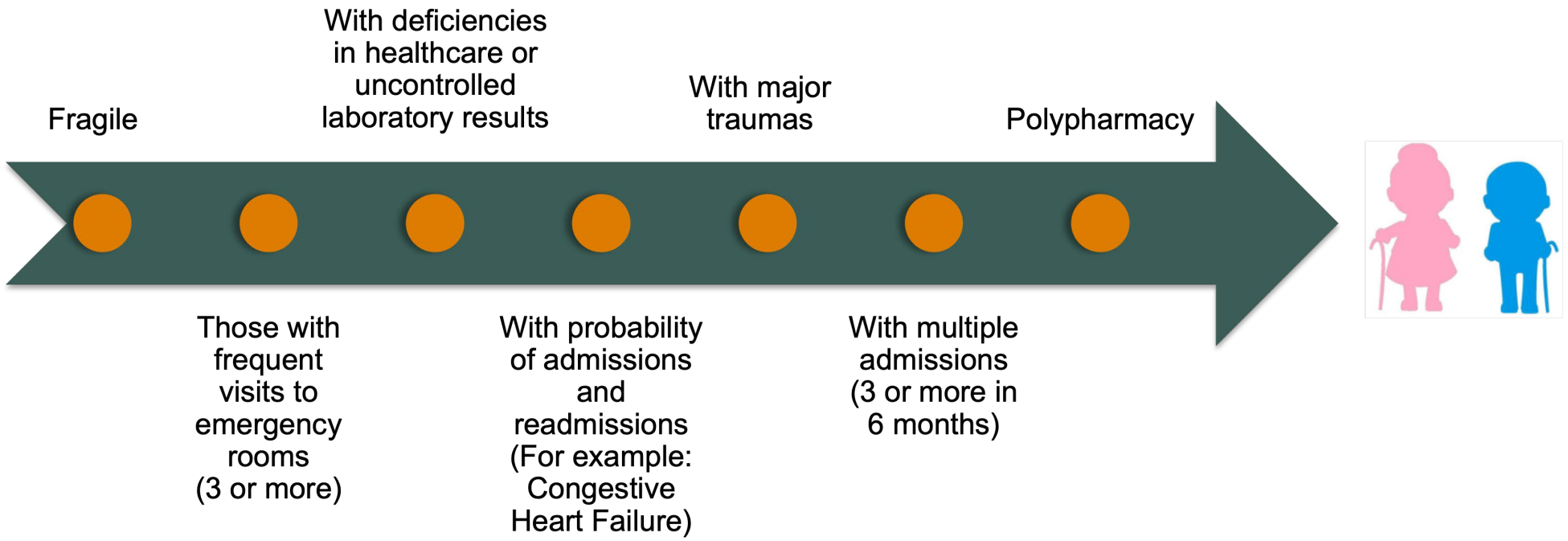
The Most Vulnerable

- **Identify those Members with the greatest fragility.**



The Most Vulnerable

Members with uncontrolled chronic conditions:

- COPD (Chronic Obstructive Pulmonary Disease)
- Asthma
- CHF (Congestive Heart Failure)
- Cardiovascular disease/ Arteriosclerosis
- HTN (Hypertension)
- Diabetes

Members with disabilities

Members that require complex procedures and/or care transition:

- Organ transplant
- Bariatric surgery

MOC 2:
Coordination of services

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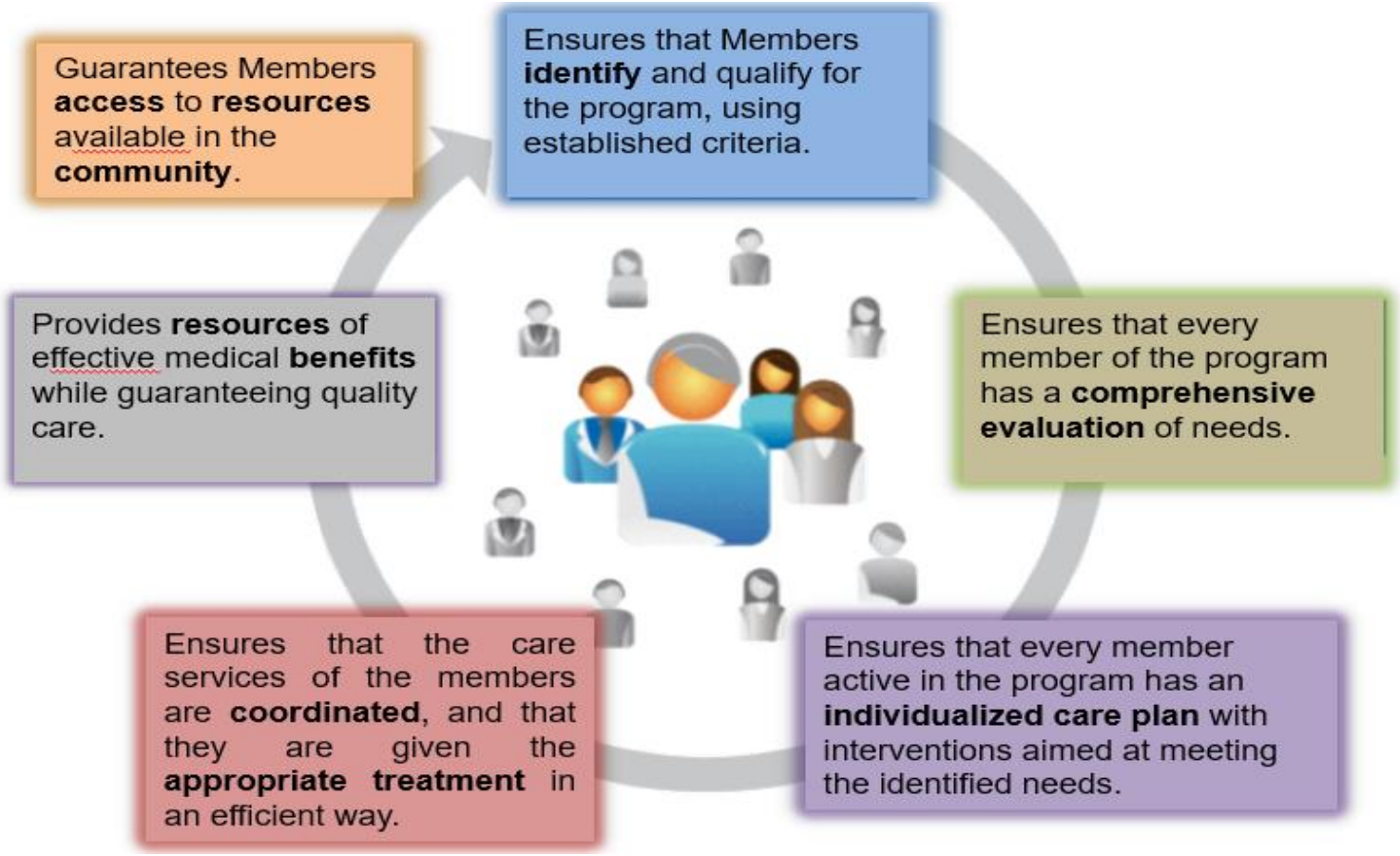
Coordinated Care

Ensures the attention of the health needs of beneficiaries of an SNP. The information is shared among interdisciplinary staff.

Coordinates the delivery of specialized services and benefits that meet the needs of the most vulnerable population.

Carries out Health Risk Assessments and Individualized Care Plan and has an established Interdisciplinary Team.

Focus of the Program



Health Risk Assessment (HRA)

It is done to identify medical, mental, psychosocial, cognitive, and functional needs of people with special needs.

Initial HRA – 90 days after the affiliation to complete it. Annual HRA from 365 days after the initial or last HRA.

Health Risk Assessment (HRA)

It is done by phone or on paper.

Results → Individualized Care Plan:

* Problems, goals and interventions with an interdisciplinary team.

HRA refers to→ Care Management Programs

* Case management, among others.

Shared care plan with:

member + PCP and Interdisciplinary Team

Medical Visits (Face-to-Face)

Essential elements:

- Effective management of preventive care.
- Establish treatment plans to control chronic diseases and improve overall health.
- Support members in the active participation of their medical care.
- Identify members who can qualify and benefit from case management programs established by the medical plan.
- Promote effective coordinated care.

Individualized Care Plan (ICP)

- The interdisciplinary team develops an ICP for each SNP coverage member, identifying the needs of the member from the results obtained in the HRA.

- The ICP guarantees that the needs are met, the course of evaluation and coordination of services, and the benefits of the member.

Individualized Care Plan (ICP)

- ICP is communicated to the member or caregiver and is shared with the Provider through our InnovaMD portal.

- Review annually or when state of health changes.

Interdisciplinary Team (ICT)

Group focused on the member. Discusses the state of health and interventions for the patient

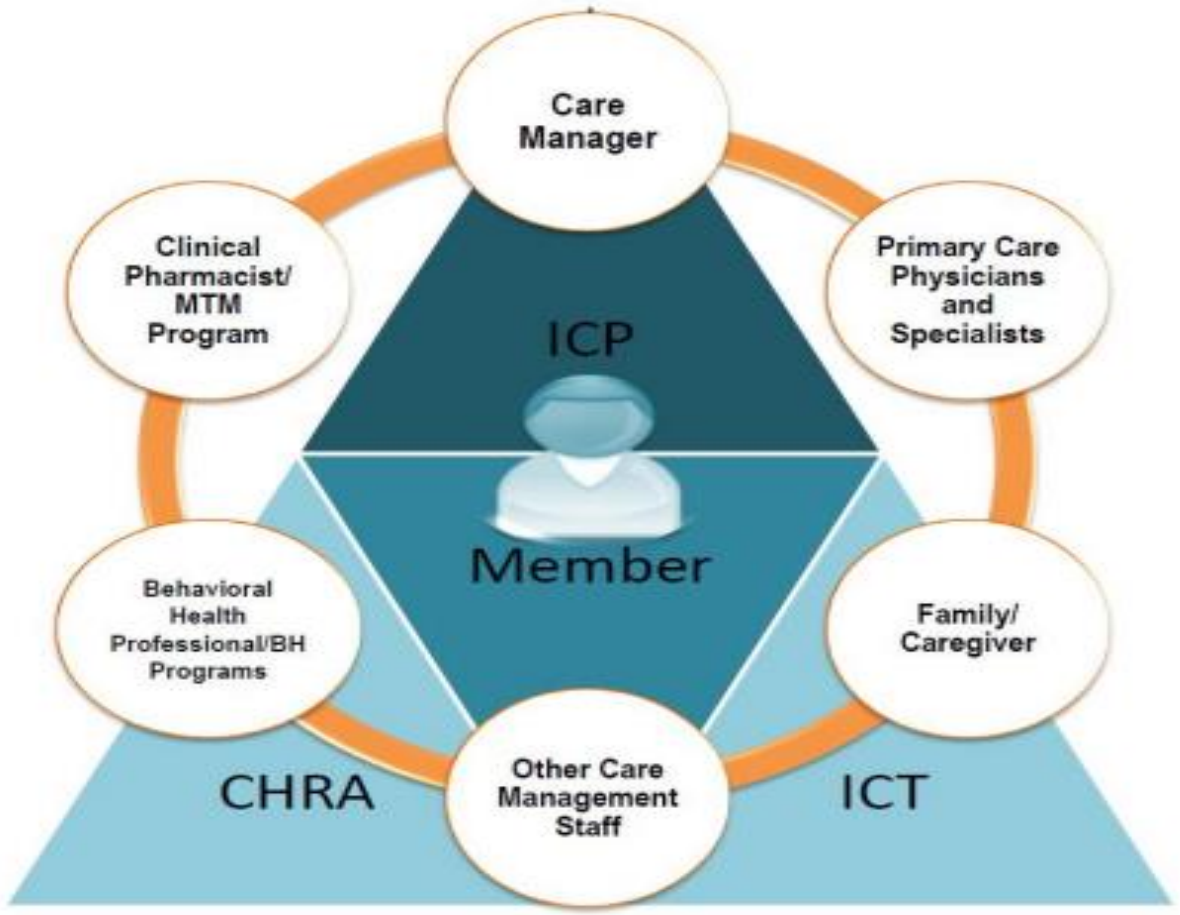
Responsibilities of providers in the ICT:

1. Participate in ICP discussion.
2. Collaborate in setting goals.
3. Involve members in the management of self-management and follow up.
4. Integrate other physicians and providers.
5. Participate in ICT meetings.
6. Communicate changes to ICT components through meetings or phone calls.
7. Refer to the management programs available through the plan.

Transition of Care

- Transition processes and protocols are established to maintain continuity of care.
- The different units work in collaboration with primary doctors and providers to guarantee and support the coordinated care that the member deserves.
- Staff available in the discharge planning unit facilitates communication between care centers, the primary physician, and the member or their caregiver.
- The member's ICP is shared with member and their primary physician, when a care transition occurs.

Protocols for Care Transition



Role of the Provider in the Model of Care

- Ensures continuous access to service and verify what needs and information are shared among staff.
- Promotes the post-discharge visit in a period within seven days after hospitalization.
- Coordinates specialized services to the most vulnerable population.
- Promotes health risk assessment for the Individualized Care Plan.
- Actively participates as part of the interdisciplinary team.
- Performs an annual health assessment.

MOC 3:
Specialized Provider Network in the Care Plan

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Focus

Maintain a network of specialized providers to meet the needs of our members, as the primary link in their care.

The Provider Network monitor:

- ✓Use of clinical practice guidelines and protocols.
- ✓Collaboration and active communication with ICT and case administrators.
- ✓Assistance in the preparation and updating of care plans.
- ✓Guarantee that all network providers are evaluated and qualified through a credentialing process.

MOC 4:
Quality Measurement and Performance Improvement

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Quality Measurement and Improvement

The plans establish a Quality Improvement Program to monitor health outcomes and performance of the care model through:

- Data collection and monitoring measures of the Five Star Program, SNP specific. (HEDIS, Healthcare Effectiveness Data and Information Set).
- The carrying out of an Annual Quality Improvement Project, which focuses on improving the clinical aspect or service that is relevant for the SNP population.
- Measurement of SNP member satisfaction.

Quality Evaluation and Improvement

The plans establish a quality improvement program to monitor health results and performance of the care model through:

- Chronic Care Improvement Program (CCIP) for chronic disease, which identifies eligible members, and intervention to improve disease management and evaluates the effectiveness of the program.
- The collection of data to evaluate if the objectives of the SNP program are met.
- Share annual performance results with members, employees, vendors, and the general public.

References

1. *Model of Care Scoring Guidelines for Contract Year 2024*. Obtained from: https://snpmoc.ncqa.org/static/media/CY2025SNP_MOC_Scrng_Gdlns_508.4c71d8c17b37b33ff079.pdf

2. *Medicare Managed Care Manual*. Chapter 5 - Quality Assessment, section 20.2 Additional Quality Improvement Program Requirements for Special Needs Plans (SNPs). Obtained from:

   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326

Our commitment to quality

Today we are proud to see that MMM special needs coverage will continue to improve the quality of life for thousands around the island.

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