AGERIGHT ADVANTAGE

2024 Model of Care Training

Background & Objectives

The Centers for Medicare & Medicaid Services (CMS) requires all Special Needs Plans (SNP) to provide Model of Care (MoC) training for all Care Team members who see the Plan's SNP members routinely.

This training will help you to:

- Understand Medicare and Medicare Advantage
- Describe the different types of SNPs
- Understand the MoC key components
- Define your role in supporting the MoC

Original Medicare is limited to **two types** of coverage:

PART A

Helps pay for hospital stays and inpatient care

PART B

Helps pay for doctor visits and outpatient care

PART C

Medicare Advantage = Part A + Part B AND includes services not covered by Original Medicare

PART D

Prescription drug coverage (Included in our plan)

Get MORE with Medicare Advantage Special Needs Plans

Special Needs Plans

A type of Medicare Advantage plan

Who Qualifies?

Special Needs Plans (SNPs) offer additional services based on specific medical situations for those who qualify:

- Enrolled in Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Lives in plan service area (CMS approved counties)

Institutional Special Needs Plan (I-SNP)

Must reside (or plan to reside) in a qualifying facility for 90 or more days

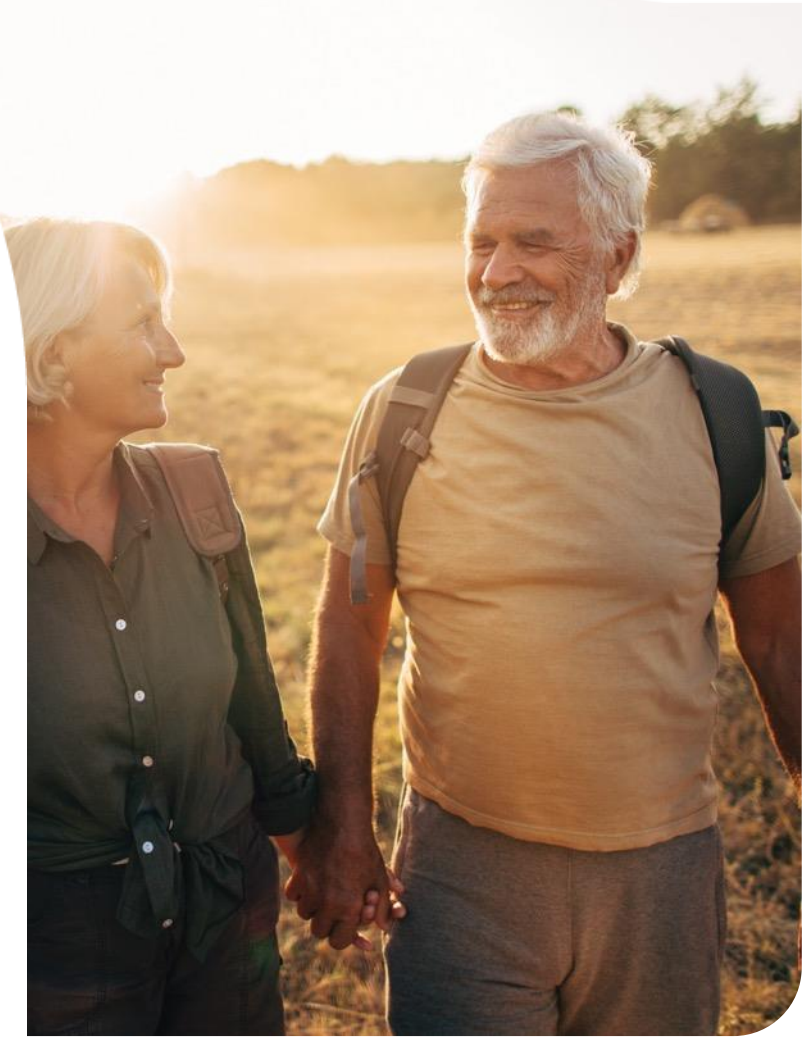
Chronic Condition Special Needs Plan (C-SNP)

Documented diagnosis of at least one if the following:

- Diabetes mellitus
- Cardiovascular disorders limited to:
  - Chronic heart failure
  - Cardiac arrythmias
  - Chronic venous thromboembolic disorder
  - Coronary artery disease
  - Peripheral vascular disease

Institutional-Equivalent Special Needs Plan (IE-SNP)

Meet institutional level of care but resides in other levels of care such as an assisted living, independent living



What is the Model of Care?

The Model of Care is the contract that the Plan submits to CMS clearly outlining who our members are, how we take care of them, how we demonstrate that care, and how we manage the quality of that care. We use this contract to individualize the unique needs of our members.

CMS requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care.

Key Sections:

- MOC 1: Description of the SNP Population
- ***MOC 2: Care Coordination (clinical team's focus)**
  - Health Risk Assessment (HRA)
  - Face-to-Face Encounters
  - The Individualized Care Plan (ICP)
  - The Interdisciplinary Care Team (ICT) Meetings
  - Care Transition Protocol
- MOC 3: Provider Network
- MOC 4: Quality Measurement and Performance Improvement

MoC 1: Description of the SNP Population

Members living in Senior Living Communities:

- Skilled Nursing Facilities (SNF)
- Memory Care
- Assisted Living (AL)
- Independent Living (IL)
- Continuing Care Retirement Community (CCRC)

Members may have or require the following:

- Additional care coordination than the general population
- Has multiple co-morbid chronic conditions requiring close monitoring
- Likely prescribed high-risk medications
- May need help with 5 or more activities of daily living (ADLs)
- May have moderate to severe cognitive impairment

MoC 2:
Care Coordination

- Health Risk Assessments (HRA)
- Face-to-Face Encounters
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT) Meetings
- Care Transition Protocols

For APPs Only:

To receive credit for the Model of Care activities completed, the Plan approved billing code must be submitted to the Plan. This is how the Plan will track your activities for compliance.

Approved codes are located in the **Quality Resource Guide** that is on the Plan's website under "Provider Documents." For questions, please reach out to Plan Management.

Key Plan Support Role

Care Navigator

- May helps arrange PCP and specialist appointments
- Coordinates DME and approved services
- Responds to non-urgent clinical and benefit questions
- May complete the Health Risk Assessments (HRA)
- Supports the development and maintenance of the care plan
- Participates in Facility ICT Meetings as applicable

Advanced Plan Practitioner (APP)

- Completing/reviewing the Health Risk Assessments (HRA); may delegate to Care Navigator
- Provides on-site primary and preventative care services
- Compliments and supports Primary Care group-led services; not replacing existing primary care
- Working with the ICT to ensure every member has a complete and updated ICP that reflects the goals/preferences of members and tracks progress towards goals
- Participates in Facility ICT Meetings
- Medication review and monitoring to avoid side effects
- Oversight for all transition of care events
- Providing education for the member regarding health and medical conditions
- Partners with the facility to proactively prevent hospital admissions
- Post-discharge visits including medication reconciliation
- Accountable for quality measures

Health Risk Assessment (HRA)

The main objective of the HRA is to assess the Member's current health status, identify unmet health needs, estimate their level of health risk, and to use the information collected from the HRA to support the development of the Individualized Care Plan (ICP).

Requirements

- All new Plan members receive an HRA **within 90 days of enrollment** (start effective date).
  **Best practice is within 15 days.*
- Existing members should have an HRA annually (**within 364 days of their prior assessment**).

Reminder: If the annual HRA is not completed within 364 days of the previous HRA, the Plan must complete a second HRA during the next quarter (or within the calendar year) to ensure compliance. This is a CMS Part C requirement.

Example below:

Member Enrollment – 02/01/2018 to present
Member Initial Assessment – 03/30/2018
Member Reassessment (2019) – 02/20/2019
Member Reassessment (2020) – No HRA completed
Member Reassessment (2021) – 02/01/2021- Not timely, 5/20/2021- **Timely**
Member Reassessment (2022)- due on/before 5/19/2022

Health Risk Assessment Outcomes

1. The at the completion of the HRA, it provides a Stratification Level. This informs the APP how soon they need to performs the “Post-HRA Visit” or also known as the initial comprehensive geriatric exam with the member.
    - The HRA Stratification Level only applies to new members.

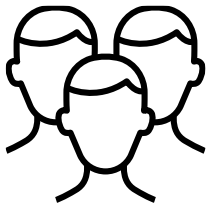
HRA Stratification Level	Post-HRA Visit
High	Within 14 days
Medium	Within 30 days
Low	Within 45 days

2. The APP is responsible for ensuring that needs and/or gaps identified through the HRA and/or in subsequent visits with the member are addressed in the members Individualized Care Plan (ICP).

Health Risk Assessment (HRA)

HRA Unable to Contact (UTC)/Complete Protocol:

- If the member is unable or unwilling to participate in the HRA, the HRA will be conducted with a caregiver, responsible party, Power of Attorney (POA), or other member delegated entity.
  - Three documented attempts on different days and times will be documented
    - In first 60 days of enrollment
  - Fourth attempt will include sending an unable to contact (UTC) letter to Members or responsible parties.
    - Within 90 days of enrollment



Face-to-Face Encounter

- The APP and or Care Navigator (in some cases) will conduct an initial comprehensive face-to-face encounter with the member based the HRA result (15, 30, 45)
    - Must be completed within 90 days of the Member's effective date on the Plan.
- Subsequent face-to-face encounters will be conducted with the member at least monthly, and more frequently based on the Member's health status, needs, and preferences.
    - This includes members on hospice
- Members who have recently experienced a care transition should be considered for weekly evaluation until clinically stable.
- Face-to face encounters may be completed in person or virtually via telehealth (video + audio). Member and or caregiver verbal consent to a telehealth visit will be obtained by the APP prior to conducting the telehealth visit and documented in the member's electronic medical record.

F2F Encounter Refusals

- The Plan's care team will make its best efforts to fully engage with Plan Members but acknowledge that Members have the right to refuse.
- If the Member is unable to be reached, the Plan's care team will make multiple efforts to reach the Member and engage in case management services.
- The Plan's care team will document, in the care management system, the reason why the face-to-face encounters and case management services were not feasible.

Interdisciplinary Care Team (ICT) & Meetings

- The HRA is the starting point in identifying ICT members. ICT members are selected based on functional roles, knowledge, established relationships with the member, members unique circumstances, risk-level, individual needs and preferences.
  - Example of an ICT includes the member/caregiver/responsible party, APP, PCP, facility staff (Nursing, Therapy, Pharmacy, Dietary, Activities, etc.), other medical professionals and/or other individuals as needed/member preferred.
- The ICT helps improve access to needed services and support as gaps in care and outstanding needs are identified. Each member of the ICT shares the responsibility for ensuring the member's individualize care plan (ICP) is developed, executed, and updated as needed.
- Regularly scheduled ICT meetings allows the APP/Care Navigator to refine, re-evaluate and contribute to the member's ICP based on direct feedback from the ICT members.
- ICT meetings will be held quarterly at a minimum and more often as needed to address urgent concerns. (Including hospice)
  - Resident/responsible party/caregiver, PCP and other ICT members are to be invited
  - Best practice is to attend the meetings hosted by the facility
  - If the APP/Care Navigator is unable to attend the facility scheduled ICT meeting, the APP/Care Navigator is responsible for coordinating an ICT meeting with appropriate ICT members, three ICT members at a minimum. (PCP to be invited/included)
  - The member's PCP will be informed of care plan reviews/changes with these quarterly meetings and as needed

Care Coordination – (ICT) Meetings Documentation

ICT meeting documentation to include the following:

- Full name and credentials of people invited and attended
- PCP, APP and member and/or caregiver were invited to attend the meeting
- Description of the content of the ICT meeting discussion
- Description of care plan review and revisions made
- Evidence that the PCP was involved in coordination of care communications
    - Example: PCP was invited to meeting but did not attend. PCP was informed of ICT meeting discussion and ICP updates via fax post meeting
    - Reminder: ICT meetings are to also be conducted for hospice enrollment members

Care Coordination – Individualized Care Plan's (ICP)

- The care planning process starts with the HRA and continues with subsequent visits, changes in health status, etc.
- Initial care plan will be developed within 90 days of the member being enrolled
- Needs and gaps identified will be addressed and incorporated in the ICP
- Members and/or caregivers (family/POA/Representatives) are to play an active role in developing their ICP
- ICP will be, minimally, reviewed and updated on a quarterly basis with ICT meetings, with each care transition/change in health status and as needed
- ICP's are to be tailored specifically to the member's needs. ICP's will include roles/responsibilities of the members caregivers, measurable timelines and outcomes, whether goals are met/not met (barriers will be documented if not met), member self-management goals and healthcare preferences, services tailored to member's medical, psychosocial, functional, and cognitive needs.

Care Transitions

Leaves facility to:	**ED/ER visit, Hospital extended stay, Hospital for observation, Planned procedures with admission/observation.**
Level of care change within facility:	ICF to SNF (SIP), Hospice to ICF/AgeRight

- The facility has the responsibility of notifying the APP before an unplanned care transition or, when a member requires immediate emergency services, right after (within 24 hours) contacting emergency services. The facility should also notify the Plan of transfers to hospital so that the Utilization Management team can ensure appropriate care level, engage in care coordination including exchange of patient information with the hospital, and begin discharge planning.
- If the Plan is notified of a potential care transition or change in condition, the APP will make best efforts to meet with the member and/or caregiver/family before the transition to discuss goals of care, possible treatments in place, advance directives, etc.
- For unplanned care transitions, the APP in conjunction with the facility team, Care Navigator, etc. communicates with the Member and/or caregiver/family throughout the transition and explains their role throughout the stay, at discharge, and post discharge.
- Upon notification of the member's discharge, the APP will make an interactive contact with the member/caregiver within two (2) business days of discharge.
- The APP will complete a post-discharge and/or change in condition visit with the member face-to-face and/or telehealth visit within seven (7) calendar days of the discharge and will update the treatment/care plan with the interdisciplinary care team, as appropriate.

★ Clinical Practice Guidelines can be found on the Plan website under the "For Provider" tab.

Care Transitions

During the post-discharge visit:

- Educate the member and/or caregiver on the reason(s) for hospitalization
- Provide instruction on who to contact for concerns at any point in time
- Educate the member and/or their caregiver on signs and symptoms or “red flags” (i.e., warning signs that indicate the condition is worsening and how to respond)
- *Perform medication reconciliation (required quality measure: CPT ll code 1111F)
- Educate members who are managing their own medication on medication self-management, new medications, and dosing
- Review any new conditions or diagnoses
- Review and update the ICP and treatment plan
- Coordinate orders for post-hospital specialist visits, diagnostic testing, home health services and/or therapy

Clinical Practice Guidelines can be found on the Plan website under the “For Provider” tab.

Care Transition Cont.

- Encounter visit coding for a care transitions:

Measure	Detail	Code
Care Transition/Trigger Event	Interactive contact with the member or caregiver within two (2) business days post hospital inpatient discharge or emergency room visit. The contact may be direct (face-to-face), telephonic or be electronic means. Medication reconciliation and management must occur no later than date of the face-to-face visit. Face-to-face visits must take place no later than seven (7) days from discharge.	99496

★ Quality Measure: Medication Reconciliation post-discharge is required within 30 days. Best practice is to complete this with the care transition visit. Report CPT II code 1111F on the encounter, in addition to the CPT visit code.

MoC 3:
Provider Network

- The Plan provides a comprehensive contracted network of providers, facilities, ancillary service providers, specialist physicians, and acute care facilities with the specialized clinical expertise pertinent to the care and treatment of its members.
- Primary care services through the APP and supportive ancillary services like therapy, rehab, selected diagnostic radiology and lab, and home health are provided and coordinated collaboratively with the APP/Care Navigator/facility teams.
- The APP/Care Navigator with the facility teams help coordinate services provided outside of the facility including specialist visits, radiology, lab, and other diagnostic testing not available on site.
- Out of Network referrals may require prior authorization.

MoC 4:
Quality Measurement and Performance Improvement

- The purpose of the Plan's Quality Improvement Program (QI Program) is to continually take a proactive approach to assure and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so that it may fully realize its vision, mission and commitment to member care.
- The QI Program supports and promotes the mission, vision, and values of the Plan through continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services to members.

Member Risk Prevention - PQI

Potential Quality Issues (PQI)

- A deviation or suspected deviation from expected provider performance, clinical care or outcome of care that cannot be determined to be justified without additional review. Examples of potential quality issues include:
    - Falls with injury/additional treatment required
    - Medication errors with injury/additional treatment required
    - Incident resulting in death
    - Incident resulting in severe brain or spinal damage to a patient

- All PQIs should be reported within three calendar days of the incident using the PQI form.
- Email completed form via secure email to pqireferral@allyalign.com or submit via the Provider Portal
- The PQI will be reviewed to determine if there should be a change in procedure to prevent further incidences.

Member Risk Prevention – Appeals & Grievances

Appeal

An appeal is **the right to ask the Plan to change their decision**. An appeal only occurs if the Plan makes a decision to deny in whole or in part a service or claim. Member/Member Representatives and providers can file an appeal within the allowed CMS timeframe which is 60 days from date of denial.

- Members/member representative/providers reporting an appeal, should send a secure email with complete appeal details to: appeals@allyalign.com OR fax 1-833-610-2380.

Grievance

A grievance is **any complaint or dispute** (other than an organization determination) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. Grievances can be filed within 60 days of occurrence.

- In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.
- Members/member representative reporting a grievance, should send a secure email with complete grievance details to: grievances@allyalign.com OR fax 1-833-610-2380.

We are here to support you!

AllyAlign Health Training Department:

clinicaltraining@allyalign.com