

Navigating the New Healthcare Economy



## **Medicare: Model of Care Training**



01/2020

# Model of Care Training



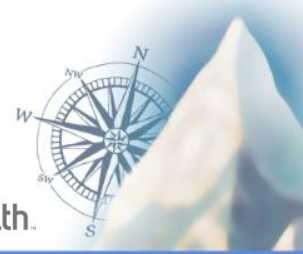
- This course is offered to meet the CMS regulatory requirements for Model of Care Training for our Special Needs Plans.
- It also ensures all employees and providers who work with our Special Needs Plan members have the specialized training this unique population requires.

# Model Of Care Training



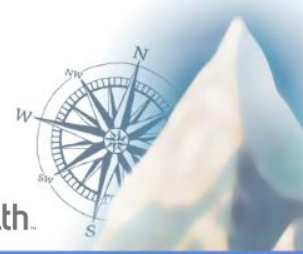
- The Model of Care (MOC) is Michigan Complete Health's documentation of the CMS directed plan for delivering coordinated care and case management to members with both Medicare and Medicaid.
- The Centers for Medicare and Medicaid (CMS) require all Michigan Complete Health staff and contracted medical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

# Training Objectives



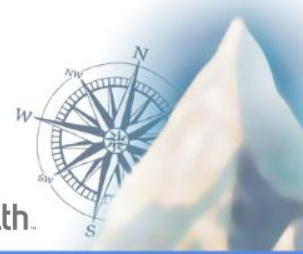
- After the training, attendees will be able to do the following:
  - Describe the basic components of the Michigan Complete Health Model of Care (MOC)
  - Explain how Michigan Complete Health medical management staff coordinates care for dual eligible members
  - Describe the essential role of providers 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-Medicaid Plan (MMP)



- Duals or Medicare-Medicaid Plan (MMP) is a new 3-way program as of 01/01/14 between CMS, Medicaid and Michigan Complete Health as defined in Section 2602 of the Affordable Care Act.
  - Purpose: Improve quality, reduce costs, and improve the member experience
    - ✓ Ensure dually eligible members have full access to the services to which they are entitled
    - ✓ Improve the coordination between the federal government and state requirements
    - ✓ Develop innovative care coordination and integration models
    - ✓ Eliminate financial misalignments that lead to poor quality and cost shifting

# Medicare-Medicaid Plan (MMP)



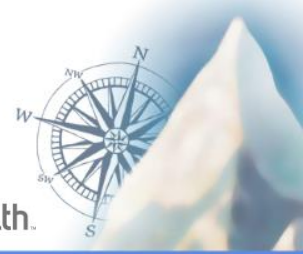
- Eligibility rules vary from state to state, but general eligibility guidelines must be met:
  - Eligibility for Medicare
  - Eligibility for Medicaid
  - No private insurance
- For MMP the Medicare and Medicaid benefits are rolled up as one benefit with Michigan Complete Health coordinating services and payment.
- MMP members have full Medicare and Medicaid benefits.

# What is the Model of Care?

- The Model of Care is Michigan Complete 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.**



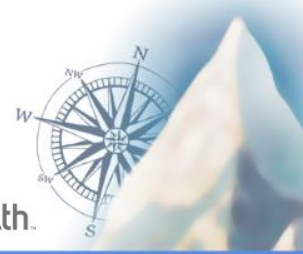
# Model of Care Goals



- The goals of the MOC 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



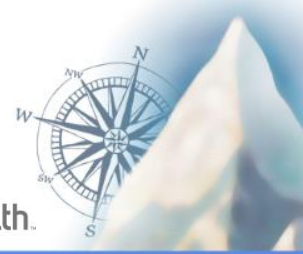
# Model of Care



CMS re-organized the 11 MOC elements to 4 in 2014 to:

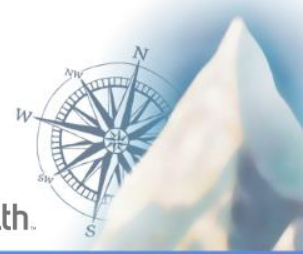
- Integrate the related elements
- Promote clarity and enhance the focus on care needs and activities
- Highlight the importance of care coordination
- Address care transitions as well as other aspects of care coordination, which were not explicitly captured in the 11 elements

# Model of Care



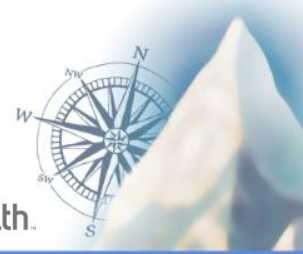
- The revised Model of Care elements are:
  - Description of the SNP Population
  - Care Coordination
  - SNP Provider Network
  - Quality Measurements & Performance Improvement

# Model of Care Process



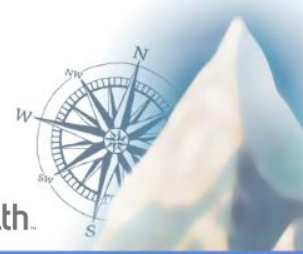
- Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 60 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the members' medical, psychosocial, cognitive, and functional needs, and medical and behavioral health history.
- Members are then triaged to the appropriate Michigan Complete Health case management program for follow up.

# Individualized Care Plan (ICP)



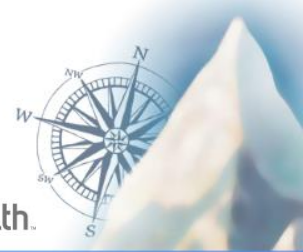
- An Individualized Care Plan (ICP) is developed with input from all parties involved in the member's care.
- The Individualized Care plan includes:
  - Goals and Objectives
  - Specific services and benefits to be provided
  - Measureable Outcomes

# Individualized Care Plan (ICP)



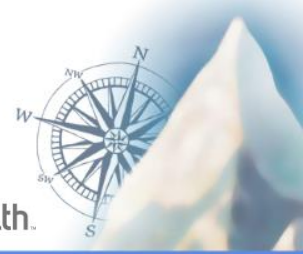
- Members receive monitoring, service referrals, and condition specific education.
- Case Managers and PCPs work closely together with the member and their family to prepare, implement and evaluate the Individualized Care Plan (ICP).
- Michigan Complete Health disseminates evidence-based clinical guidelines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

# Interdisciplinary Care Team (ICT)



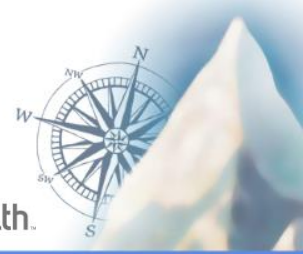
- Michigan Complete Health Case Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) which includes appropriately involved Michigan Complete Health staff, the member and their family/caregiver, external practitioners and vendors involved in the member's care **based on the member's preference** of who they wish to attend.
- Michigan Complete 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 ICT.

# ICT and Inpatient Care



- Michigan Complete 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

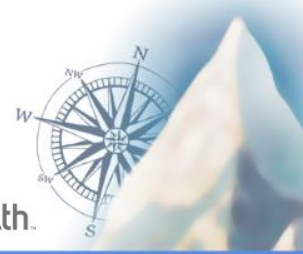
# ICT and Inpatient Care



- Notify the PCP of the transition of care and anticipated discharge date and discharge plan of care
- Michigan Complete Health staff manage 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

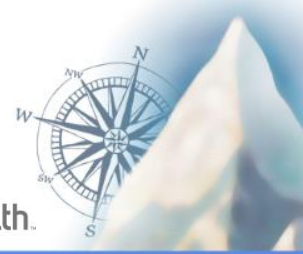


# ICT and Transition of Care

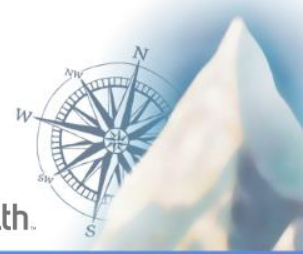


- Managing Transitions of Care interventions for all discharged members may include but not limited to:
  - Face-to-face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan

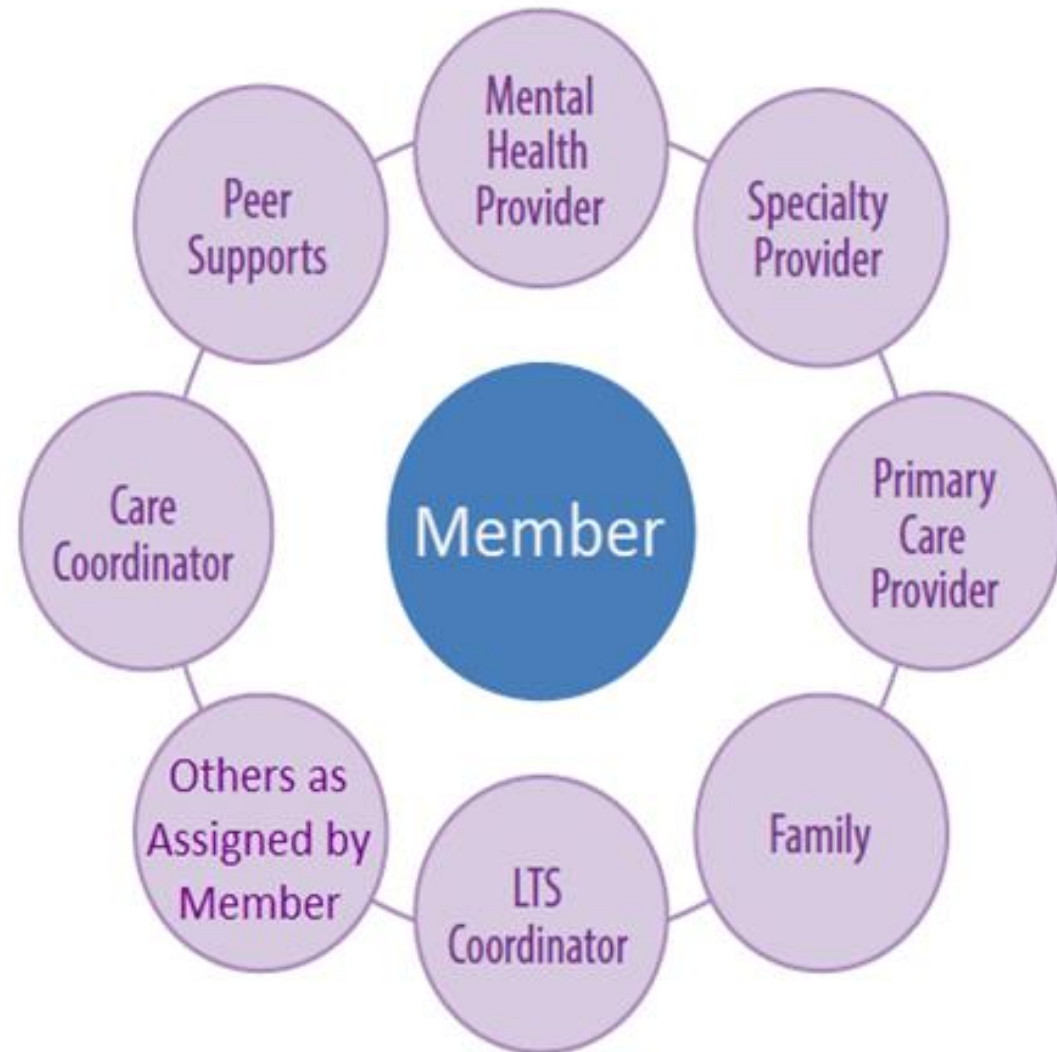
# ICT and Transition of Care



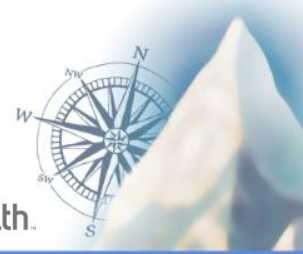
- In-home visits or phone call within 1-2 days post discharge to evaluate member's:
  1. Understanding of their discharge plan
  2. Understanding of their medication plan
  3. Ensure follow up appointments have been made
  4. Home situation supports the discharge plan
- Enrollment into the Case Management program
- Ongoing education of members to include preventive health strategies in order to maintain care in the least restrictive setting possible for their health care needs



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

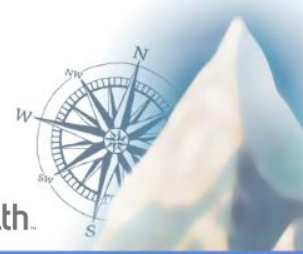


# ICT Member Responsibilities



- Michigan Complete 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



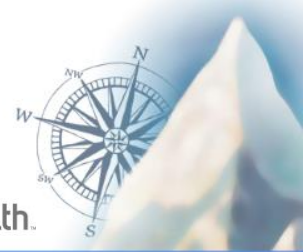
5. Coordinate care and services between the member's Medicare and Medicaid benefit
6. Educate members about their health conditions and medications and empower them to make good healthcare decisions
7. Prepare members/caregivers for their provider visits-utilize personal health record
8. Refer members 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:
    - Michigan Complete 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

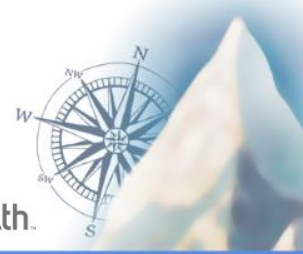
# Provider Network



- Michigan Complete Health is responsible for maintaining a specialized provider network that corresponds to the needs of our members.
- Michigan Complete 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



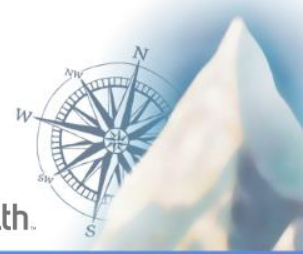
- CMS expects Michigan Complete Health to:
  - Prioritize contracting with board-certified providers
  - Monitor network providers to assure they use nationally recognized clinical practice guidelines when available
  - Assure that network providers are licensed and competent through a formal credentialing 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

# CMS Expectations



- All team members are involved and informed in the coordination of care for the member
- All team members must be advised on the ICT program metrics and outcomes
- All internal and external ICT members are trained annually on the current Model of Care

# Summary



- Michigan Complete 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 Michigan Complete 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