PPHP

PROVIDER PARTNERS HEALTH PLANS

PPHP Model of Care (MOC) Provider Training

2020

Overview – Regulatory Requirements

- The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to design and implement a Model of Care (MOC) that details how the Plan will provide specialized care to enrollees **§ 422.101 (f)**

- CMS requires all SNPs to conduct initial and annual training that reviews the major elements of the MOC for providers and staff **§ 422.101 (f)**

PPHP
PROVIDER PARTNERS HEALTH PLANS

Goals of Training

- Describe what an Institutional Special Needs Plan (I-SNP) is and the purpose of the MOC
- Show how PPHP's MOC can help you as a provider
- Help you understand your role in the MOC

PPHP
PROVIDER PARTNERS HEALTH PLANS

What is an I-SNP?

I-SNPs restrict enrollment to Medicare Advantage (MA) eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a:

- Skilled nursing facility (SNF)
- LTC nursing facility (NF)
- Intermediate care facility for the mentally retarded (ICF/MR)
- Inpatient psychiatric facility

PPHP
PROVIDER PARTNERS HEALTH PLANS

To be eligible for PPHP enrollment, nursing facility residents must:

- Reside in a PPHP contracted long term care facility for at least 90 days
- Be enrolled in Medicare Part A and Part B
- Not have ESRD diagnosis at time of enrollment

What is the MOC?

The MOC is PPHP's detailed, written commitment to CMS on how we will provide specialized care to enrolled I-SNP members.

**CMS will audit PPHP against the processes and commitments described in the MOC*

The MOC contains the following required components:

- Description of the Plan Population
- Care Coordination
  - Health Risk Assessment, Individualized Care Plan & Interdisciplinary Care Team
  - Care Transitions Protocols
- Specialized Provider Network and Use of Clinical Practice Guidelines and Protocols
  - MOC Training for Providers
- Quality Improvement and Performance Monitoring

PPHP
PROVIDER PARTNERS HEALTH PLANS

Goals of PPHP's MOC

The MOC is designed to:

- Reduce non-essential hospital admissions when care can safely be provided in the nursing facility
- Maintain the residents at an optimal level of function
- Increase compliance with appropriate screenings/testing
- Increase compliance with clinical practice guidelines
- Enhance identification and address problems earlier to optimize member function
- Improve communication related to member's care

PPHP
PROVIDER PARTNERS HEALTH PLANS

Advantages for Providers

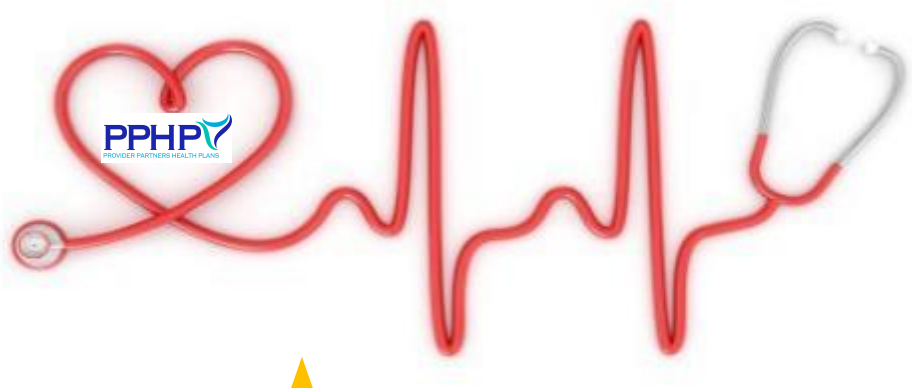
PPHP's MOC offers many advantages for providers, including:

- A local provider clinical team that provides case management and care coordination in consultation with you
- Better quality of care and health outcomes for patients as measured by HEDIS® scores and hospital use rates

In the following slides, look for the "star" symbol for quick tips and summaries of what providers can expect from the Plan

PPHP
PROVIDER PARTNERS HEALTH PLANS

Key SNP Staff

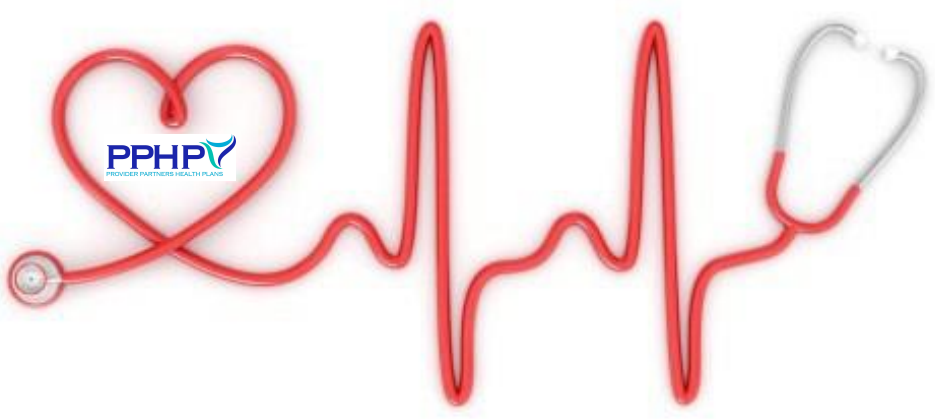


- Nurse Practitioner (NP)
  - Assigned to each nursing facility and all members in residence
  - Dedicated point of contact for providers, members and families/caregivers
  - Promotes continuity of care, coordinates care plan communications and implementation
  - Provides on-site primary care support
  - Visits/assesses each member at least monthly - and as often as daily, based on member condition and risk level

The NP will work closely with you to manage members' care and will keep you informed on their progress and changes in condition

PPHP
PROVIDER PARTNERS HEALTH PLANS

Key SNP Staff continued…



- RN Care Coordinator (RNCC)
  - Assigned to each nursing facility and dedicated to all members in residence
  - Liaison between the NP and facility staff
  - Rounds on each member daily and alerts NP to changes in member risk level or transitions
  - Partners with the NP to coordinate care and follow up for the member.

The RNCC may contact you on behalf of the NP to discuss services for the member or changes in condition

PPHP
PROVIDER PARTNERS HEALTH PLANS

CMS Care Coordination Requirements and PPHP's Approach

CMS MOC Regulatory Requirement		PPHP MOC Process
Health Risk Assessment (HRA) §42 CFR (f)(1)(i)	1) All SNP members must have an initial HRA within 90 days of enrollment and at least annually thereafter within 364 days of the previous HRA	• PPHP NP conducts a comprehensive HRA within 30 days of enrollment and at least annually thereafter. • NP conducts interim assessments at least monthly. • Member risk level assigned with each assessment and determines NP or RNCC visit frequency.
Individualized Care Plan (ICP) §42 CFR (f)(1)(ii)	2) All SNP members must have an ICP based on the needs identified in the HRA	• NP develops member's ICP after completing the HRA and in the same member visit. • ICPs reviewed/revised with each assessment
Interdisciplinary Care Team (ICT) §42 CFR (f)(1)(iii)	3) All SNP members must have an ICT that collaborates in care plan development and implementation	• NP is the "hub" of each member's ICT and coordinates communications with other participants. • The NP will contact you (the member's PCP or specialist) to discuss the member's HRA results and care plan along with revisions and updates.

All of these activities are documented centrally in each member's chart at the facility. You can also request a copy of the HRA, interim assessment or ICP any time.

PPHP
PROVIDER PARTNERS HEALTH PLANS

Health Risk Assessment (HRA)

- Conducted by the NP, the HRA identifies the medical, psychosocial, cognitive, functional and mental health needs and risk level of each member
- Risk level dictates the member's visit schedule by the NP or RNCC
  - High risk: members are seen at least every 14 days
  - Low risk: members are seen at least monthly
- The member is reassessed if there is a change in health condition or care transition
- HRA findings are used to develop/update the member's care plan

NP may contact you for assistance with the assessment especially if the member is cognitively impaired

PPHP
PROVIDER PARTNERS HEALTH PLANS

Individualized Care Plan (ICP)

- Tailored to the needs and preferences of the member as identified by the HRA
- Shared with member/responsible party, facility staff, the PCP and key specialists, as needed
- Clinical practice guidelines applied
- Reviewed/updated by the NP on a routine basis and at least monthly in accordance with member risk level

The NP will contact you to discuss your patient's ICP and will make any necessary edits based on your feedback. If you see a member outside of the facility, please send clinical notes to the facility for incorporation into the member's chart and care plan.

PPHP
PROVIDER PARTNERS HEALTH PLANS

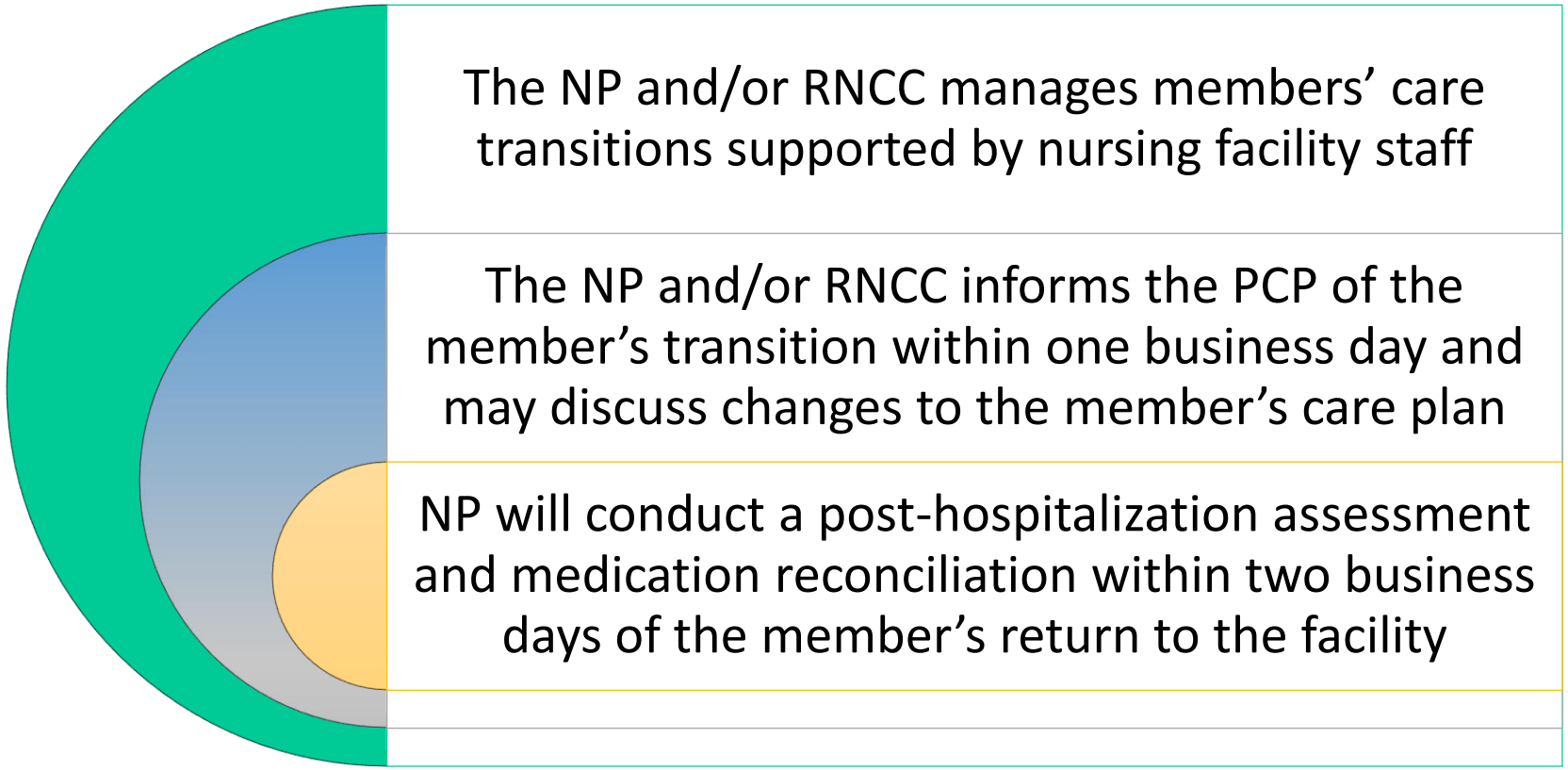
Individualized Care Team (ICT)

- Every member has an ICT tailored to the needs identified on the HRA and ICP
- The ICT oversees and coordinates the member's care plan
- Composition varies but, at a minimum, the ICT includes the NP, RNCC, facility staff and the PCP. Additional participants may be added by the NP.
- NP coordinates communications among ICT members and may request a formal meeting.

Please participate in ICT care planning meetings if requested and contact the NP to discuss changes to the member's care plan.

PPHP
PROVIDER PARTNERS HEALTH PLANS

Care Transitions Protocols



If your patient is at risk for a hospitalization, please contact the NP immediately!

PPHP
PROVIDER PARTNERS HEALTH PLANS

A Partnership For Care

Specialized Provider Network

- PPHP maintains a comprehensive network of primary care providers and specialists
    - Includes providers with specialized expertise in the long-term care population and who routinely care for members in network nursing facilities
- All contracted providers are credentialed
- A network adequacy report is completed annually to ensure that members have access to services

PPHP
PROVIDER PARTNERS HEALTH PLANS

Use of Clinical Practice Guidelines

- PPHP has approved and promotes the use of the American Medical Directors Association (AMDA) clinical practice guidelines among internal clinical staff and providers which are tailored to the long-term care population.
- They can be found here: https://paltc.org/product-store/full-set-clinical-practice-guidelines

The Plan also measures internal and external provider adherence to evidence-based guidelines via CMS-required HEDIS® reporting

amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

PPHP PROVIDER PARTNERS HEALTH PLANS

Expectations for Providers

- Get to know the NP and RNCC teams assigned to your PPHP patients
- Communicate! Actively oversee the member's care plan and participate in ICT meetings and activities
- Request copies of your patient's PPHP-conducted assessments and care plans if you have not seen them
- Call the assigned NP if your PPHP patient is at risk for a transition and follow authorization procedures for planned hospitalizations
- Deliver care in accordance with appropriate evidence-based guidelines
- Adhere to HEDIS® and other CMS-required Quality Measures

Please complete the attestation at the end of this training as the PPHP is required to track your completion!

PPHP
PROVIDER PARTNERS HEALTH PLANS

Model of Care Quality Measures

Measurable Goals and Health Outcomes	HEDIS®
	Chronic condition management
	Medication adherence
	Utilization
Compliance with CMS-required MOC processes	HRA and Care Plan completion rates
	Timely member visits
	Care transitions management
	Staff and Provider MOC Training
Member Satisfaction	PPHP-designed survey conducted once per year

PPHP
PROVIDER PARTNERS HEALTH PLANS

Evaluation of the Model of Care

- Data is collected, analyzed and evaluated on a monthly, quarterly and annual basis from each domain of care to monitor performance and identify areas for improvement and to ensure program goals have been met

- Annual Evaluation of the MOC
  - Formal evaluation of MOC effectiveness led by PPHP's Quality Improvement (QI) department.

You can request info on PPHP's quality measures and MOC performance data.

PPHP
PROVIDER PARTNERS HEALTH PLANS

Contact Information

Provider Partners Health Plan
785 Elkridge Landing Road Suite 300
Linthicum Heights, MD 21090

Beth Ann Martucci, DNP, CRNP
Vice President of Clinical Operations
bmartucci@pphealthplan.com

PPHP
PROVIDER PARTNERS HEALTH PLANS

Provider Attestation

I attest that I have received the 2020 Model of Care Training for PPHP:

_____ _____

Printed Name Organization Name (if applicable)

_____ _____

Signature Title

_____

Date

PPHP

PROVIDER PARTNERS HEALTH PLANS