Banner Plans & Networks

Banner Medicare Advantage Dual HMO D-SNP Model of Care Training

What is a Model of Care?

- Special Needs Plan(SNP) Model of Care (MOC) - Provides the basic framework under which the SNP will meet the needs of each of its enrollees.
- The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.
- SNPs are unique from regular Medicare Advantage plans because they focus on members who have special needs.
  - The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

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Special Needs Plan: Description of Terms

AHCCCS: Arizona Health Care Cost Containment System

CMS: Centers for Medicare and Medicaid Services

BMA Dual: Banner Medicare Advantage Dual HMO D-SNP

ALTCS: Arizona Long Term Care System

FIDE: Fully Integrated Dual-Eligible

PCSP: Person-Centered Service Planning

Special Needs Plan: Description of Terms

- **ICT**: Interdisciplinary Care Team
- **ICP**: Individualized Care Plan
- **HRA**: Health Risk Assessment
- **ACC**: AHCCCS Complete Care
- **SNP**: Special Needs Plan
- **MOC**: Model of Care

SNP Model of Care Training Learning Objectives

After this training participants will be able to:

- Describe what type of SNP is offered by BMA Dual
- Describe the basic components and services included in the BMA Dual Model of Care
- List three priorities in 2024 to improve the Model of Care
- List important characteristics of our BMA Dual populations
- Describe the roles and responsibilities of key staff and our contracted providers in delivering the MOC

Special Needs Plan: Definition and Background

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Special Needs Plans (SNPs) were created by the Medicare Modernization Act (MMA) of 2003.

- BMA Dual is a Dual-Eligible SNP
  - **Medicare SNPs** are a type of **Medicare** Advantage Plan (like an HMO or PPO).
  - **Medicare SNPs** limit membership to people with specific diseases or characteristics.
  - **Medicare SNPs** tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.
- BMA Dual members qualify for both AHCCCS Complete Care and Medicare
  - Members must reside in our service area which includes Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, or Yuma Counties to enroll.

Special Needs Plan: Definition and Background- Cont.

- Arizona Long Term Care System (ALTCS) provides nursing facility services to AHCCCS members in a home or nursing home.
  - BMA Dual now includes a FIDE (Fully Integrated Dual Eligible) SNP for our ALTCS members who also have Medicare.
    - BMA Dual's status as a FIDE-SNP was approved by CMS concomitant with BUHP's contract award, effective October 1, 2017.
- What BMA Dual beneficiaries receive by enrolling in our SNP:
  - Model of Care (MOC) module based on CMS Guidelines
  - Customized benefit plan that is designed to meet the enrollees needs
  - Additional election periods to change their Medicare coverage

Special Needs Plan: Definition, Elements and Goals

What is the SNP Model of Care?

- Medicare mandates all SNPs have a MOC designed to help vulnerable beneficiaries receive the care and services necessary to manage and improve their specific health needs.
- The MOC is the framework for Care Management policies, procedures and operational systems designed to meet the specific needs of our Dual-Eligible SNP enrollees.
- BMA Dual received a one-year approval for the MOC starting in 2024 and regularly monitors the program's progress through the MOC Workgroup.

Model of Care Standards and Elements

- BMA Dual SNP MOC is a service delivery mechanism that contains the following required four standards:
  - Description of the SNP Population
  - Care Coordination
  - SNP Provider Network
  - Quality Measurement and Performance Improvement

- Each MOC standard contains elements that comprise individual factors against which SNPs are assessed.
    - In total, there are 16 elements across the four standards.

Model of Care Goals

BMA Dual SNP MOC Goals-

- Facilitate delivery of care in most appropriate setting, including the home setting
- Link health care services around enrollee, including community-based programs addressing barriers associated with SDoH
- Maximize enrollees' health status
- Enhance enrollees' quality of life
- Link health care services around enrollee, including community-based services to address SDoH-related barriers
- Identify enrollees at risk for depression
- Prevent gaps in service, close quality gaps in care and ensure follow-through on referrals
- Assist with obtaining preventive care as indicated
- Prevent gaps in clinical services
- Educate enrollee in self-care measures
- Assist enrollee and their caregivers in developing an adequate, resilient support system
- Early identification of destabilization of medical or psychological status
- Empowering enrollees to develop a self-care plan as part of their ICP
- Special focus on medication adherence
- Special focus on assisting enrollee to build a resilient healthy support system

Special Needs Plan:
Description of SNP Population

Vulnerable Enrollees within BMA Dual Population

- BMA Dual identifies vulnerable populations through two primary strategies:
  1) Identifying enrollees with complex healthcare needs as evidenced by specific high-risk conditions, multiple co-morbidities, or excessive utilization patterns
  2) Identifying enrollees at vulnerable moments in their lives, such as care transitions

- Unique characteristics of BMA Dual population are best summarized as:
  - High disability rate, especially due to a serious mental illness
  - High rate of multiple co-morbid conditions
  - Low literacy
  - Low engagement in self-care and case management; and general challenges associated with living in rural areas with poor access to specialty care

Social Characteristics

- BMA-Dual Enrollees - Plan Population Includes:
  - Low Literacy
  - High Rate of Poverty
  - Nutritionally Challenged
  - Lack of Social Supports
  - Low Education Level
  - Low Employment Level
- FIDE SNP enrollees with ALTCS are particularly fragile:
  - FIDE SNP enrollees qualified for ALTCS because of their frailty and disability

SNP Provider Network

Provider Network

- Annual Assessment:
  - Providers are contracted to see both Medicaid and Medicare members.
  - Sustain utilization of evidence-based clinical practice guidelines and nationally recognized protocols consistent with policies and procedures.
- BMA Dual has a robust network of primary care and specialists contracted to provide specialized clinical expertise pertinent to our target population
  - SNP populations also have access to the full spectrum of Banner Health hospitals and delivery systems which include:
    - Behavioral health, cancer centers, surgery centers, imaging, home health, pharmacy, labs, urgent care centers and behavioral health integrated urgent care centers
    - The network includes practitioners specializing in geriatric medicine, internists/primary care physicians (PCP) and endocrinologists to manage diabetes as well as specialists to manage enrollee comorbidities such as cardiologists, nephrologists, and orthopedic surgeons.

MOC Training for the Provider Network

- Provider Network receives initial and annual Model of Care (MOC) training
- BMA Dual MOC and expectations or requirements related to the health risk assessment, ICP, coordination of care or participation in the ICT.
  - This training is required at the time of employment or within 60 days of contracting through the new provider orientation meetings, online access, and on an annual basis.
- The provider manual contains a condensed version describing the MOC for our providers review and use:
  - Reviewed for updates on a quarterly basis and the updated version is offered to providers in either a paper or electronic version available on the banneruhp.com and bannerhealth.com/Medicare websites.
  - Bi-annually virtual, or face-to-face provider education sessions are conducted for all service areas.
  - Providers, and their staff who attend, receive information and materials regarding special requirements related to dual eligible enrollees.
  - Providers receive MOC information in the MOC Provider Training slides, Provider Manual, virtual or in face-to-face office visits and group education sessions such as our Provider Forums held throughout our service areas on an on-going basis, but at least yearly.

Care Coordination

Health Risk Assessment (HRA) and Person-Centered Service Plan (PCSP)

- BMA Dual conducts an initial health assessment within 90 days of enrollment and annually thereafter
- Health Risk Assessment (HRA) Tool -
  - Measures all aspects of the enrollee's status such as physical health, cognitive status, medical history, behavioral health status, cultural preferences, linguistic needs, pregnancy state, nutrition status, functional needs, and health related social factors such as housing, transportation, and availability of food to identify enrollee needs and properly assess their risk level
- Person Centered Service Plan (PCSP) -
  - The PCSP is primarily conducted during face-to-face encounters between the enrollee and LTSS case manager
    - PCSP may be conducted by phone under exceptional circumstances if needed
- Social Determinates of Health (SDoH) are also evaluated

Health Risk Assessment (HRA) and Person-Centered Service Plan (PCSP) Cont.

- The results of each assessment are used to develop an Individualized Care Plan (ICP) for each enrollee

- The assessment is completed by:
  - The enrollee mailing in the HRA or PCP
  - Telephonic outreach
  - Face-to-Face interview/meeting

The Interdisciplinary Care Team (ICT)

The Interdisciplinary Care Team (ICT) includes health care professionals such as:

- Physicians (Primary Care and Specialty Providers)
- Case Managers
- Pharmacists
- Therapists
- Social Workers
- Disease Managers
- Health Educators

The ICT assists in care coordination for a high-risk enrollees and assisting in the development of their Individualized Care Plan (ICP).

The Individualized Care Plan (ICP)

- The Individualized Care Plan (ICP) is the initial and on-going mechanism used to impact positive change in the enrollee's health conditions
- The ICP is generated in the Case Management System and is based upon the identified needs of the enrollee through the assessment process
- The ICP is reviewed and revised annually or when the enrollee's health status changes
- The ICP is shared with the enrollees PCP, the enrollee and relevant ICT members as needed

Quality Measurement and Performance Improvement

Quality Improvement Plan

BMA Dual uses standardized quality improvement outcome and process measures to assess the performance of the Model of Care and measure enrollee health improvements. Sources for this data include but is not limited to:

- Completion rate of the HRAs/PCSP
- Appointment availability
- Utilization Management measures
- CAHPS (Consumer Assessment of Healthcare Providers and Systems)
- Utilization Metrics
- HOS (Health Outcomes Survey)
- Complaint and grievance tracking analysis
- HEDIS (Healthcare Effectiveness Data and Information Set) measures

Quality Improvement Plan- Cont.

- BMA Dual developed an integrated comprehensive quality improvement plan that includes the continuous monitoring, evaluation, and improvement of health care service rendered to our enrollees.
  - The quality improvement plan analyzes performance trends associated with: Performance Measures (NCQA HEDIS measures), Chronic Care Improvement Program (CCIP), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcome Survey (HOS), Utilization of Services, and Customer Care measures

Summary

As provided under section 1859(f)(7) of the Social Security Act (the Act), every Medicare Special Needs Plan (SNP) must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

Questions & Support with Model of Care:

If you have any questions or need support, please contact your
Care Transformation Specialist or Consultant.

If you are not sure who your assigned Care Transformation Specialist or Consultant is, please contact the Provider Experience Center by phone (877) 874-3930 x 2

Or email: providerexperiencecenter@bannerhealth.com

Additional information on the Model of Care can be found in our Provider Manual at www.BannerHealth.com/Medicare

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Attestation

After receiving your Model of Care Training, please complete your attestation online at:

https://bannerhealth.formstack.com/forms/moc_attestations

Thank you