Mercy Care Advantage

Model of Care Training and Attestation

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CMS Requirements

The Centers for Medicare and Medicaid Services (CMS) requires Special Needs Plans (SNP) to have a Model of Care and to provide Model of Care (MOC) training to its employees, contracted staff and providers within 90 days of hire or contracting and annually thereafter and any out-of-network providers seen by enrollees on a routine basis annually.

The Mercy Care Advantage (MCA) Model of Care is the plan for delivering coordinated care and case management to special needs members.

Who are we

MCA is a Medicare Advantage Prescription Drug (MA-PD), Dual Eligible Special Needs Plan (D-SNP) for people who are enrolled in both Medicare and Medicaid.

The MCA Contract with CMS includes all Mercy Care adult lines of business:

- ✓AHCCCS Complete Care (ACC)
- ✓AHCCCS Long Term Care (ALTCS)
- ✓Department of Developmentally Disabled (DDD)
- ✓Regional Behavioral Health Authority (RBHA)

Our Mission

MCA's MOC is designed to optimize the health and well-being of our aging, vulnerable and chronically ill members.

This course describes how (MCA) employees, contracted staff and providers can work together to coordinate and deliver the MCA Model of Care.

Our objectives

Describe the four elements of our MOC

MOC-1
Description of SNP Population

MOC 1-Description of SNP Population

Eligibility

MCA serves individuals who are eligible for both Medicare and Medicaid. To qualify for enrollment in MCA, individuals must meet the following eligibility requirements:

1. Have both Medicare Part A and Part B entitlements

2. Be eligible for Arizona Health Care Cost Containment System (AHCCCS) Medicaid

3. Live within the MCA geographic service areas approved by the CMS

4. Age 65 or over; turning age 65 within the month they are requesting enrollment; or are under the age of 65 and meet the criteria for Medicare eligibility to include qualifying disability.

MOC 1-Description of SNP Population

Overall Population

All MCA enrollees are dually eligible. Due to this nature they all have complex medical, behavioral and social needs. The most vulnerable enrollees are at higher risk of poor outcomes and increased service utilization. They may require additional services and specialized programs beyond those available to the MCA general enrollees to assist in management of their complex needs.

Based on demographics, enrollment information and information from other analysis, the following three groups are our most vulnerable sub population:

- Enrollees in ALTCS /FIDE-DSNP, diagnosis of serious mental illness (SMI) and in Core 2.0 (predictive analytical tool) High risk group
- Enrollees in in DD/HIDE-DSNP , and in Core 2.0 (predictive analytical tool) High risk group
- Enrollees in ACC/HIDE SNP, diagnosis of serious mental illness (SMI), in Core 2.0 (predictive analytical tool) High risk group and high disability index

MOC-2
Care Coordination

MOC 2-Care Coordination

SNP Staff Structure

MCA employs and contracts with staff and organizations to ensure that it meets all administrative and clinical oversight functions within the organizational structure regarding caring for all enrollees on the plan.

Employee MOC Training

All Mercy Care employees and contracted staff are required to complete MOC training using the technology-based training tool to develop their knowledge about the MOC objectives, goals and requirements so they can effectively assist enrollees and providers when performing their daily job responsibilities.

- New employees and contracted staff must complete MOC training within 90 days of hire.
- Existing employees and contracted staff must complete MOC training annually.

MOC 2-Care Coordination

Health Risk Assessment (HRA)

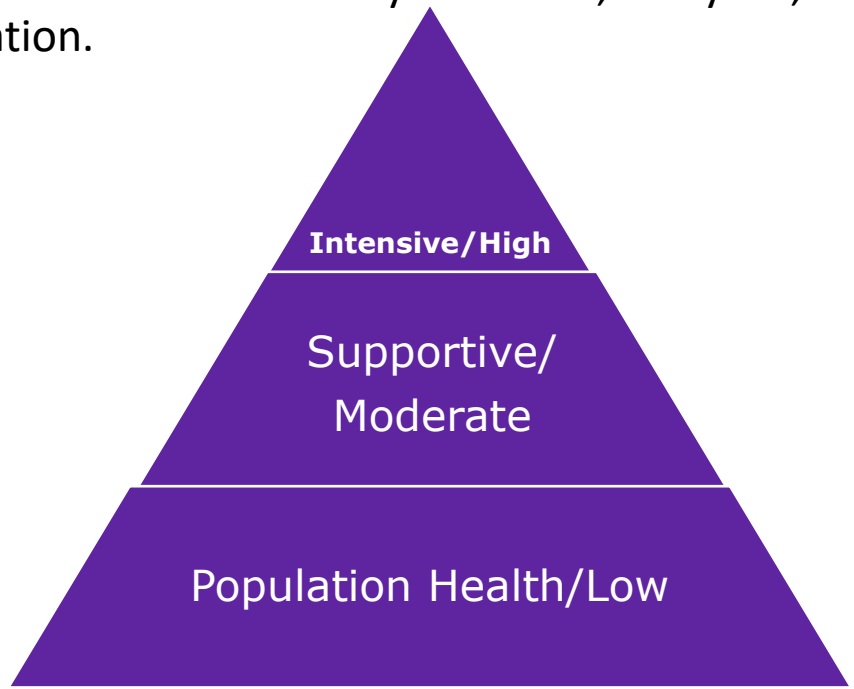
D-SNP plans are required to complete a HRA on every member within 90 days of enrollment and annually thereafter. The HRA results along with predictive model risk scores, claims, utilization, pharmacy, quality data etc. and information exchanged during enrollee and /or their caregiver/representative interactions with care management staff during initial assessments and reassessments are collectively reviewed, analyzed, and stratified to guide care management activities and ICP creation.

Every member is assigned a care manager.

Intensive/High: Require in-depth care coordination due to multiple complex health issues, high utilization or risk for future utilization

Supportive/Moderate: Require chronic condition management or moderate assistance with care coordination

Population Health/Low: Require minimal care coordination and are managing current conditions well



MOC 2-Care Coordination

Individualized care plans (ICP)

The ICP is developed by the care management staff with the involvement of the enrollee and/or their caregiver to the extent possible and input from the Interdisciplinary Care Team and HRA.

The ICP will include the beneficiary's self-management goals and objectives, personal healthcare preferences, caregiver(s) role, a description of services specifically tailored to the beneficiary's needs, and alternative actions if goals are not met.

The care management staff ensures that the care plan contains services and interventions that are consistent with the beneficiary's health care needs. The identified problems drive interventions and goal statements and facilitate enrollee/caregiver participation.

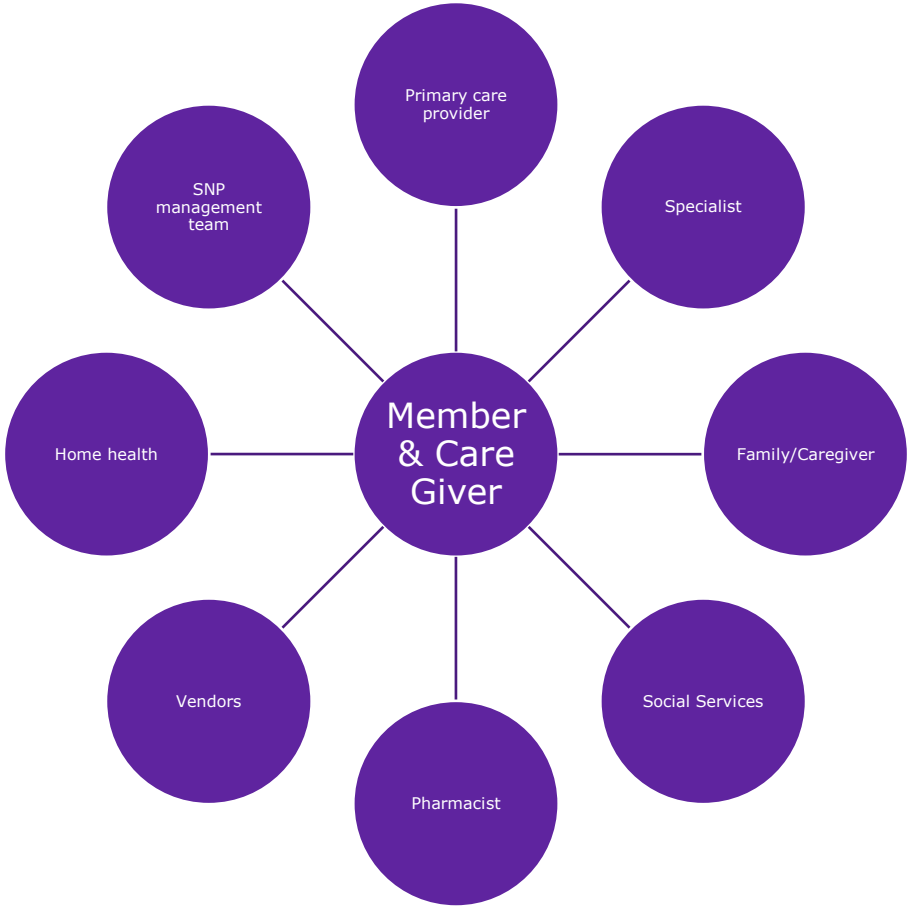
MOC 2-Care Coordination

Interdisciplinary Care Team (ICT)

In addition to the enrollee and family/caregivers, the ICT is comprised of various disciplines whose primary purpose is to coordinate the delivery of services and benefits that address the enrollee's clinical, social and other needs.

At a minimum, the ICT members include the enrollee family and or caregiver, care manager, primary care physician/practitioner, and a medical director. In addition, MCA has access to pharmacists, behavioral health specialists and medical management staff.

ICTs communicate in-person and via teleconference during regularly scheduled meetings.



MOC 2-Care Coordination

Care Transition Protocols

MCA uses care transitions protocols to ensure that all enrollees have a smooth and safe transition between health care settings both in network and out of network, before, during and after transitions. MCA maintains standardized practices and systems to ensure timely and thorough communications between and among internal staff and all involved providers to optimize support and minimize complications related to care setting transitions, and facility (hospital/skilled nursing facility) admissions and readmissions.

For Planned transitions of Facility placement (custodial and HCBS -Alternative Home and Community Based Facilities (Assisted Living Facility (ALF), Assisted Living Center (ALC), group home (GH)) services are based primarily on enrollee choice. Additional input in the decision making may come from the enrollee's guardian/significant other, caregivers, case manager's assessment, PCP and /or other service providers. The case manager in coordination with other Long Term Care staff assist with the process before, during and after transitions

MOC 2-Care Coordination

Face to Face Encounter

All MCA enrollees must have a face-to-face encounter for the delivery of the D-SNP enrollee health care, care management or care coordination on at least an annual basis, beginning within the first 12 months of the enrollee's enrollment in the D-SNP program to meet regulatory requirement set forth at 42 CFR § 422.101(f)(1)(iv) as feasible and with the enrollee's consent. The encounter will be either in-person or through a visual, real-time, interactive telehealth(virtual) encounter. The face-to-face encounter is part of the overall care management strategy to meet SNP goals.

MOC-3
Provider Network

MOC 3-Provider Network

MCA contracts with a comprehensive network of Primary Care Physicians, Specialists including but not limited to, internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists and other specialists, ancillary providers to provide coverage for all aspects of medical, behavioral and social needs.

Available facilities include, but not limited to acute care hospitals, dialysis centers, acute rehabilitation facilities, laboratory providers, skilled nursing facilities (SNF), pharmacies, and radiology facilities.

MCA uses the current "Medicare Advantage and 1876 Cost Plan Network Adequacy Guidance." This document is published by CMS and available in HPMS. The membership used to evaluate our network by CMS is based a sample of Medicare FFS members.

MOC 3-Provider Network

Collaboration with the ICT

Primary care physician (PCP) is the ICT member who determines which services the enrollee needs after ICT input. The PCP works collaboratively with the care management staff, who is the point of contact for all ICT members involved in the care of an enrollee. The enrollee's care management staff acts as the coordinator of services for the enrollee with ongoing input from the other ICT members. The care management staff helps to ensure enrollee access to specialists and other needed services. The other ICT members contribute to care planning and utilization as the enrollee's care needs change over time.

ALTCS/FIDE-DSNP:

The case manager is the key personnel for all enrollee's care coordination activities, ICT and ICP.

MOC 3-Provider Network

Clinical Practice Guidelines

MCA uses Clinical Policy Bulletins, Milliman Care Guidelines (MCG), evidence-based literature, clinical practice guidelines and nationally recognized protocols, NCD (National Coverage Determination) and LCD (Local Coverage Determination) to make appropriate clinical and coverage determinations.

MOC training

The Network Relations Consultants are responsible for provider education both at the time of initial contracting and on-going during their network participation. The Network Management staff conduct provider education via in-service visits, either face to face or via webinar. They utilize in-services as an opportunity to review the provider's responsibilities and provide education about the element of the MCA MOC and training requirements

MOC-4
MOC Quality Measurement & Performance Improvement Plan

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MOC Quality Improvement Program

MCA has developed a MOC that uses evidence-based practices and is continually reviewed for performance opportunities to meet enrollees' unique health needs.

The MOC Work Plan is the framework for monitoring, evaluating, and identifying opportunities for improving the quality and appropriateness of services provided to MCA enrollees. In order to carry out processes for continuous collections, analyses, evaluation and reporting, the Model of Care Committee (MOCC) has instituted a quarterly and annual MOC evaluation.

The Head of Medicare is primarily responsible for the oversight of the MOC. Medicare Product, with the assistance of other internal departmental SME's, is responsible for tracking, trending and reporting on the measurable goals and health outcomes measures via the MOCC.

The MOCC annually, submits an evaluation of the previous years' activities to the CBHICS, IHCS and to the Board of Directors. After evaluating the information, they may provide direction to the MOCC, make further recommendations and approves the MOC work plan.

MOC-4
MOC Quality Measurement & Performance Improvement Plan

Measurable Goals and & Health Outcomes

MCA's measurable goals and health outcome measures are included below. These measures are utilized by MCA to measure the overall MOC performance. The timeframe for meeting each goal is one measurement year.

1. **Improve access to health care.**
2. **Improve access to affordable care.**
3. **Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT.**
4. **Improve access to preventive health services and Chronic Conditions**
5. **Enhanced care transitions across all health care settings and providers for SNP enrollees**
6. **Delivery of Services to meet needs of the most vulnerable enrollees**

For each goal, a quantitative analysis is performed by the appropriate departmental to assess the plan's performance against prior performance, the plan goal and the benchmark for the measure, as applicable to track goal if met.

When goals are not met, analysis of barriers and identification of opportunities for improvement are completed by the respective department, as well as by the MOCC, who provide guidance on recommended corrective actions. The addition of or removal of MCA measurable goals must be reviewed and approved by the MOCC.

MOC-4
MOC Quality Measurement & Performance Improvement Plan

SNP Member Satisfaction

MCA utilizes the Consumer Assessment of Health Plans Survey (MA-PD CAHPS®) survey to assess our enrollee experience. The results are analyzed and reviewed to assist with improving enrollees experience of care.

Ongoing Performance Improvement Evaluation

The results of quality performance indicators are used to support ongoing improvement of the MOC and continually assess and evaluate performance no less than a quarterly basis.

Dissemination of Performance related to the MOC

As applicable, written documentation such as meeting minutes, presentations, etc. will be distributed and retained to support business operations. All operational departments, as determined by the MOC, have communication and reporting responsibility to the MOCC.

Summary of Provider Responsibilities

- Communicate and collaborate with MCA Case Managers, enrollees, care givers, and ICT members.
- Complete face-to-face encounters with all enrollees ,either in person or virtually annually
- Accept invitations to attend member's ICT meeting
- Review and respond to correspondence sent by MCA Case Managers including HRA results and ICPs.
- Maintain copies of the ICP, ICT and transition of care notifications in the member's medical record when received
- Follow Clinical practice guidelines (as referenced in provider manual) to provide high quality care for enrollees
- Participate in applicable quality measures.
- Complete the annual MOC provider training and return the attestation.

2024 Model of Care Attestation

I hereby attest that I have reviewed the **2024 Model of Care Training** which will complete the annual requirement.

I understand the Model of Care for MCA members and my role in improving health outcomes for our most vulnerable population.

I also understand this is an annual training requirement required of me by the Centers for Medicare and Medicaid Services (CMS) for all Medicare Advantage Special Needs Plan providers.

Disclaimers

It is the Office Manager/Administrator's responsibility to ensure that providers who care for Mercy Care Advantage (MCA) members have either a face-to-face training; an office meeting training; or have each individual practitioner complete a self-attestation. Please make sure we receive your annual attestation no later than December 31, 2024by clicking on the button on the next page.

2024 Model of Care Attestation

**By signing for the group, you are attesting that you have written evidence in your office that your providers have reviewed the power point training regarding Model of Care. In the event that Centers for Medicare and Medicaid Service requires Mercy Care Advantage (MCA) to provide proof of this training, MCA will request your documentation of the Model of Care training, i.e., staff meeting minutes documentation, sign in sheets, etc. This training is required to be completed by all contracted providers who see Mercy Care Advantage plan members. In addition, non-contracted providers treating Mercy Care Advantage members are encouraged to complete our Model of Care training.*

To begin, click the Submit Attestation button

To ensure you receive credit for this class, please be sure to include the following information in your attestation e-mail:

Printed Clinic/Practice Name

Tax ID# TIN

Individual Name (for the individual practitioner attestation)

Individual Provider NPI#

Administrator Name

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Thank you