2015 Model of Care Training
Special Needs Plans

- Special Needs Plans (SNPs) were created by Congress through the Medicare Modernization Act of 2003
- SNPs are a type of Medicare Advantage Plan
- There are three forms of SNPs that limit membership to specific types of enrollees
Three Types of SNPs

- Chronic Care SNP – for enrollees with specific types of chronic conditions
- Institutional SNP – for enrollees who live in an institution or require nursing care at home
- Dual Eligible SNP – for enrollees who receive both Medicare and Medicaid
Mercy Care Advantage

- Mercy Care Advantage (MCA) is a Dual Eligible SNP
- MCA members have Medicaid coverage through one of three programs under Arizona Healthcare Cost Containment System (AHCCCS)
  - Arizona Long Term Care System (ALTCS),
  - Members enrolled in the AZ Division of Developmental Disabilities, or
  - Acute Care Program
Mercy Maricopa Advantage

- Mercy Maricopa Advantage (MMA) is also a Dual Eligible SNP
- This plan is available to members who have been diagnosed with a serious mental illness and are enrolled in Medicare and Medicaid.
Model of Care

The goal of this module is to describe MCA & MMA’s Model of Care and the role that contracted medical providers play in it’s delivery to members
The Centers for Medicare & Medicaid Services (CMS) requires each SNP to have a Model of Care.

The Model of Care is the architecture for care management policy, procedures, and operational systems.
Model of Care Elements

- The Model of Care includes the following elements:
  - Description of the SNP-specific Target Population
  - Measureable Goals
  - Staff Structure & Care Management Roles
  - Interdisciplinary Care Team
  - Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols
  - Model of Care Training for Personnel and Provider Network
Model of Care Elements (continued)

- Health Risk Assessment
- Individualized Care Plan
- Communication Network
- Care Management for the Most Vulnerable Sub-Populations
- Performance and Health Outcome Measurement
Model of Care Measurable Goals

- Improving beneficiary health outcomes
- Improving seamless transitions of care across healthcare settings, providers, and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving access to essential services such as medical, mental health, and social services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
Health Risk Assessment

- Every MCA and MMA member is outreached to complete a Health Risk Assessment (HRA), which is a standardized tool used to assess the medical, psychosocial, cognitive and functional needs of each enrollee.
- The outcome of the assessment will assist in the development of an individualized care plan.
Health Risk Assessment (continued)

- For those enrollees who are enrolled with MCA and ALTCS, the HRA is administered by our LTC staff within 12 working days of enrollment, and again every 90-180 days.

- The HRA’s for MCA Acute/DD and MMA are conducted:
  - Telephonically within 90 days of enrollment
  - Annually thereafter
  - Following a change in health status, such as a hospital admission
Individualized Care Plan

- An Individualized Care Plan (ICP) is a summary of the needs and service options identified during the assessment process.
- The ICP is developed to identify the enrollee’s health care goals and objectives, as well as the activities and services the enrollee agrees to pursue in order to attain optimal health outcomes.
- All members must receive a ICP.
Individualized Care Plan (continued)

- The ICP is developed by the case manager, enrollee and caregivers to meet the enrollee’s needs
- PCPs can provide feedback on the ICP via fax or phone call
- ICPs for all enrollees are also created utilizing a combination of information including:
  - HRA
  - Comprehensive medical evaluation
  - Review of medical records obtained
  - Provider diagnoses
  - Utilization data
Individualized Care Plan (continued)

- The ICP is developed with input from the member’s Interdisciplinary Care Team (ICT)
- The ICP is revised annually, or when the enrollee has a health status change
- For MMA members, the ICP does not replace the Individual Recovery Plan developed with the member at the Provider Network Organization
What is Case Management?

“Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost effective outcomes” (Case Management Society of America, 2002)
Case Management and Care Coordination (continued)

- All enrollees are eligible to receive case management or care coordination services
- MCA & MMA offer a range of case management and care coordination services to address enrollees’ needs
Case Management and Care Coordination (continued)

- The frequency and intensity of the interactions with Case Management varies based upon enrollee need
  - All MCA/ALTCS enrollees are placed in full case management
  - All other enrollees are assessed to determine what level of case management services are required and are placed accordingly
  - MCA & MMA enrollees who do not require intensive CM are contacted at least yearly for the HRA and are provided care coordination services as needed with their Interdisciplinary Care Team
What is Your Role as a Provider?

- Participate in the member’s Interdisciplinary Care Team
- Contribute to the Individualized Care Plan
- Assist with care coordination activities on the member’s behalf
How To Refer to Case Management or Disease Management

- Case Management Referral Line:
  602-586-1870

- All referrals are reviewed within 3-5 business days and assigned accordingly
Questions?

Contact Carol Turpin
Care Management Director
602-453-6033
Thank you