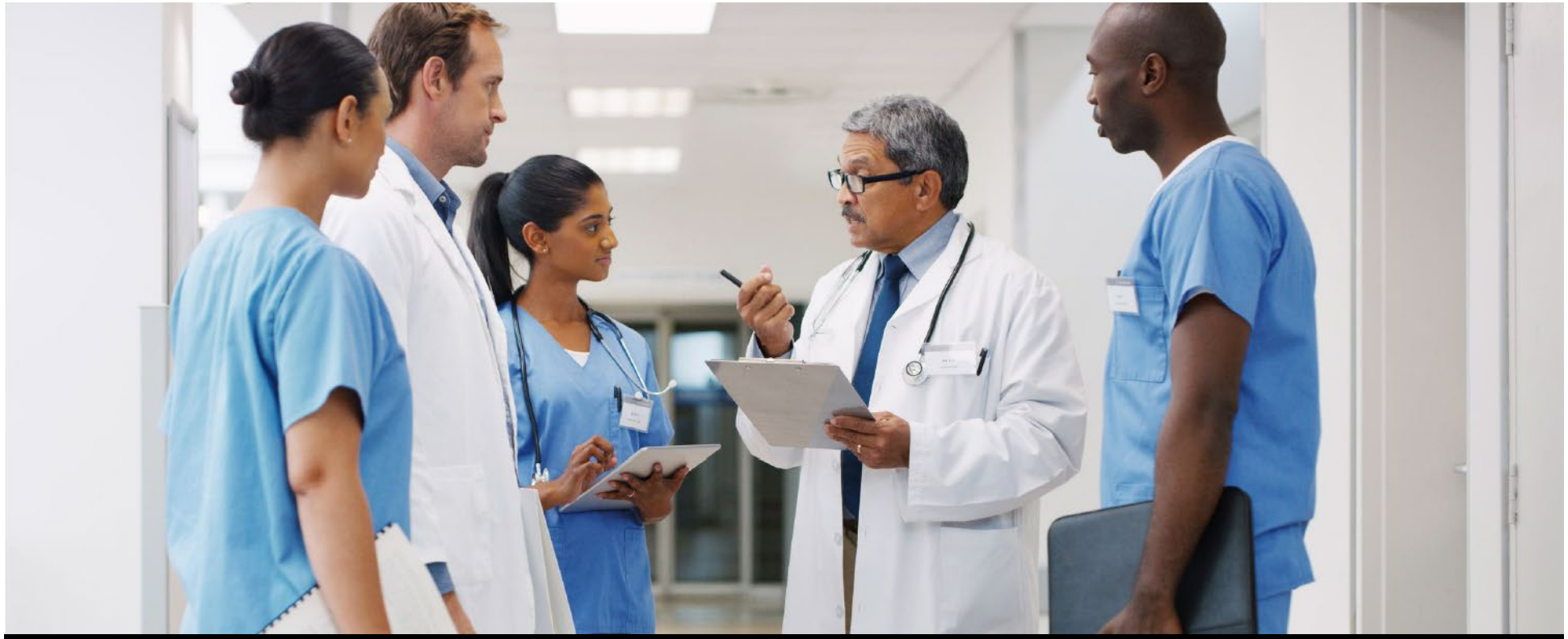


2024

Special Needs Plan (SNP) Model of Care Training

VillageCareMAX

What is the VillageCareMAX SNP Model of Care Training?

This training ensures providers have knowledge of the VillageCareMAX Model of Care

Model of Care Training is required for employed and contracted personnel who work with VillageCareMAX members

Center for Medicare and Medicaid Services (CMS) requires that the Model of Care Training be completed by Providers and VillageCare Staff

Training Objectives

At the end of this training, you will be able to recall specifics about the VillageCareMAX (VCMAX) Special Needs Plan (SNP) Model of Care as it pertains to:

- SNP Background
- VCMAX SNP Model of Care
- How does the MOC Work?
- Care Coordination
- Quality Measurement & Performance Improvement
- Role & Responsibilities of the Provider
- Member Experience & Satisfaction

Special Needs Plan (SNP) Background

Congress created Special Needs Plans (SNP) in the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan which focuses on certain vulnerable groups of Medicare beneficiaries.

SNPs are Medicare Advantage Plans with special benefit packages for populations with distinct health care needs.

The goal is to provide extra benefits and team-based care to improve outcomes and decrease costs for special need population through improved coordination.

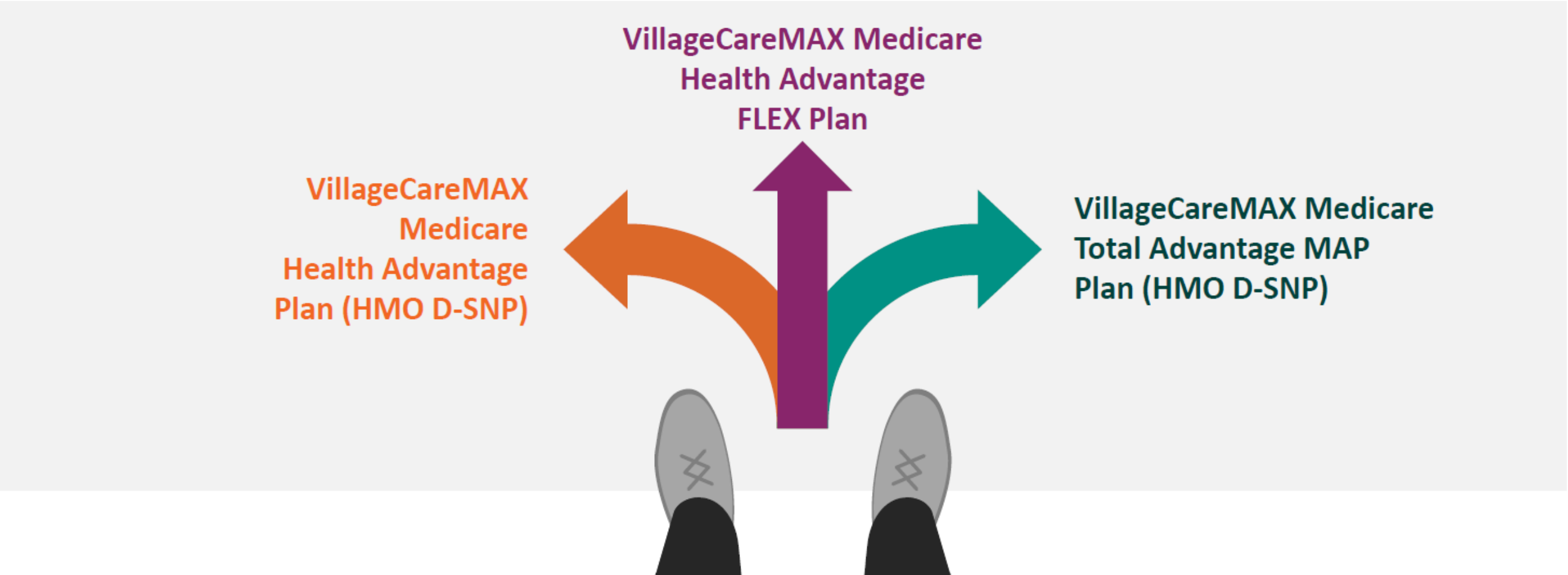
Foundation of the Model of Care

VillageCareMAX has implemented an evidenced-based Model of Care (MOC) for its Special Needs Health Plans. Model of Care refers to the framework for a comprehensive and collaborative care management delivery system to promote, improve, and sustain Member health outcomes across the care continuum in accordance with the requirements set forth by the CMS and DOH.

VillageCareMAX SNP Model of Care

The VCMAX SNP Model of Care strives to meet the specialized needs of its members and to optimize their health outcomes by using evidence-based practices with an appropriate network of providers and specialists.

VCMAX Special Needs Plans are:



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Model of Care Elements

Description of the SNP Population

Characteristics related to the membership that VillageCareMAX and its providers serve.

Care Coordination

How the Special Needs Plan will coordinate health care needs and preferences of the member and share information with the Interdisciplinary Care Team

Special Needs Plan Provider Network

The specialized provider network available to our members. It also describes how the network meets the needs of the target population.

Model Of Care Quality Measurement & Performance Improvement

VillageCareMAX determines goals for our Model of Care related to the improvement of the quality of care our members receive..

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How Does the Model Of Care Work?

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Model of Care Goals

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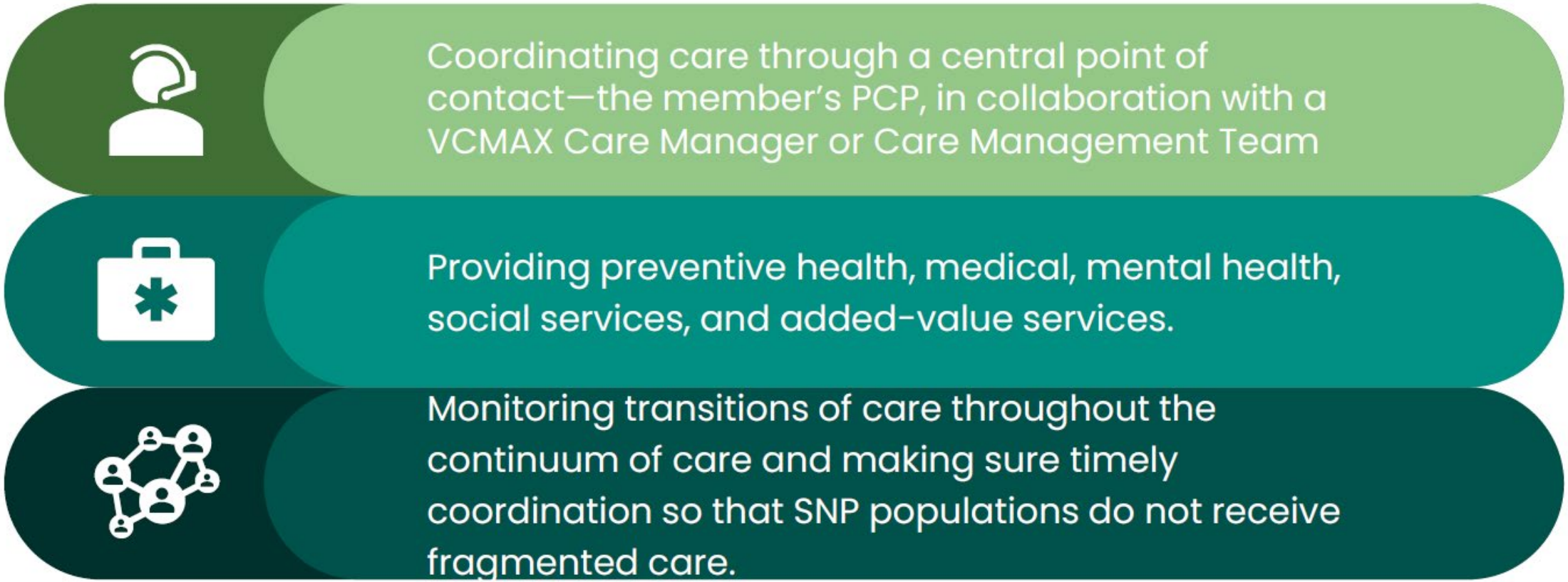
Model of Care Parts

How Does the MOC Work?

The VillageCareMAX Model of Care promotes quality care management and optimal health outcomes for members through facilitation of access to needed resources and care coordination, including:



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How We Support the Model of Care

- All SNP Members receive case management and are notified of their dedicated Care Manager by a welcome phone call
- Members are stratified according to their risk profile and/or Health Risk Assessment (HRA) to focus resources on the most vulnerable
- The Care Manager contacts the member based on risk level, change in status or transition of care needs
- Contingency planning is in place to avoid disruption of services for events such as natural disasters

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How Members Support the Model of Care

The Member is informed of and consents to Care Management

Member participates in the development of their Care Plan

The Member agrees to the goals and interventions of their Care Plan

The Member is informed of the Interdisciplinary Care Team (ICT) members and meetings

The Member either participates in the ICT meeting or provides input through the Care Manager and is informed of outcomes

Member satisfaction with the SNP is measured on an ongoing basis

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Providers Role in Supporting the Model of Care

- **Communication**:
  - Communicate pertinent information with the plan regarding member's care
  - Respond to communications from the Plan regarding member care
  - Including communicating with the following:
    - Members
    - Care Givers
    - Care Management Teams
    - Other members of the Interdisciplinary Care Team
- **Attend the Integrated Care Team (ICT) Meeting when invited**
- **Participate in the development of the ICP**
- **Maintain ICP and transition of care notices from Plan**
- **Completion of the Annual Model of Care Training Attestation Form**

Care Coordination

VCMAX conducts Care Coordination to meet the targeted needs of our members by utilizing the following strategies:

- Conducting a Health Risk Assessment (HRA) of the individual's physical, psychosocial , and functional needs, using assessment tools approved by CMS and other appropriate regulatory agencies.
- Creating an Individualized Care Plan (ICP) which is developed by the Interdisciplinary Care Team (ICT) and, in consultation with the member, identifying goals and objectives as well as specific services and benefits to be provided.
- Coordinating an ICT that manages the member's care and meets regularly to manage the medical, cognitive, psychosocial, and functional needs of the member.

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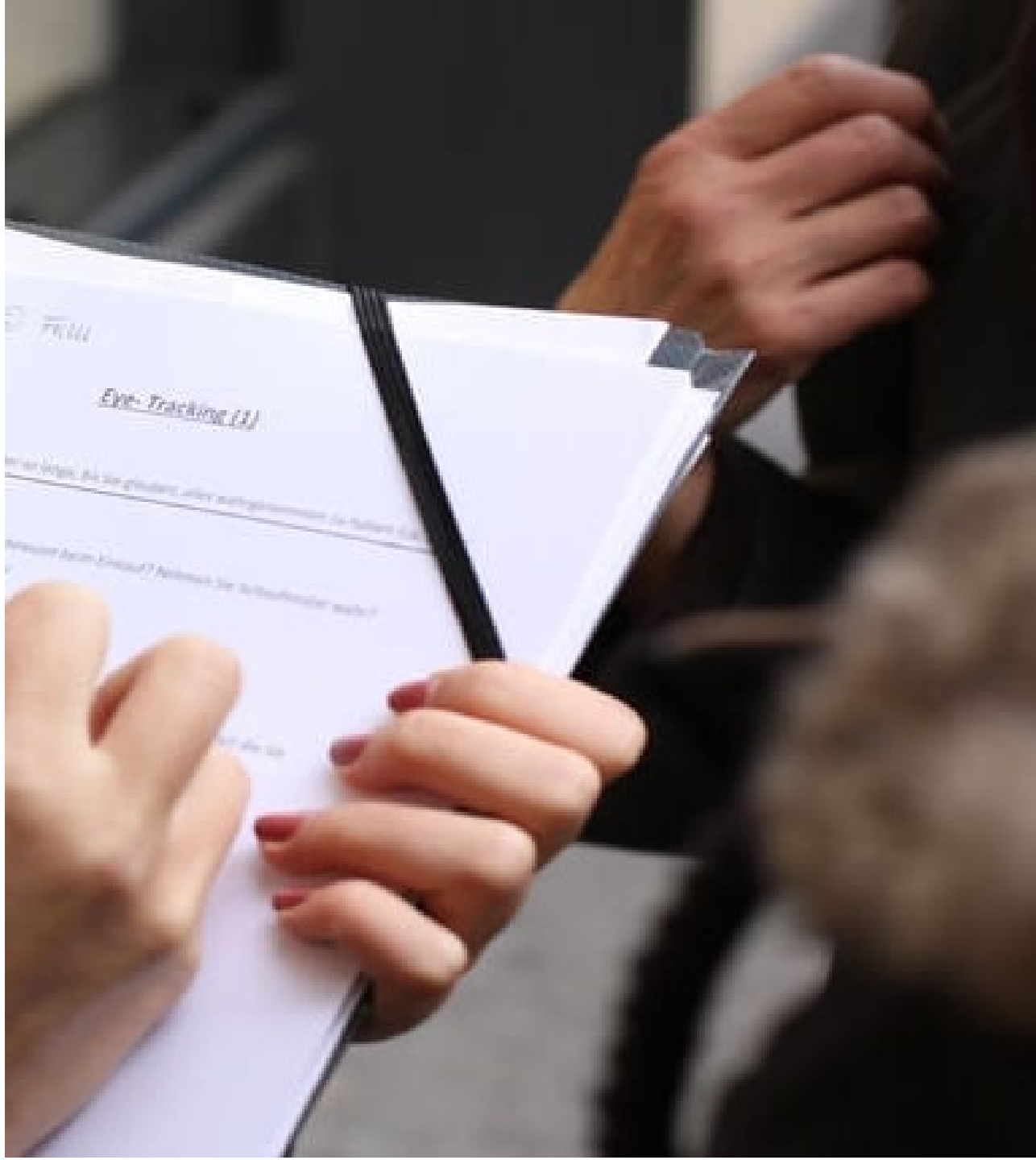
Health Risk Assessment (HRA)

A Health Risk Assessment (HRA) is a screening tool that helps individuals identify and understand their health risks and monitor health status over time. The Assessment includes a questionnaire, an assessment of health status, and personalized feedback about actions that can be taken to reduce risks, maintain health, and prevent disease. The tool assesses by a series of questions about the medical, functional, cognitive, psychosocial, and mental health needs of each member.

VCMAX conducts Care Coordination to meet the targeted needs of our members by utilizing the following strategies:

- Establishing an Individualized Care Plan (ICP) developed by the Interdisciplinary Care Team (ICT) and, in consultation with the member, identifying goals and objectives as well as specific services and benefits to be provided based on the HRA.
- Assessing members at enrollment and then reassessing members annually or after changes in condition.



Interdisciplinary Care Team (ICT)

- Each VillageCareMAX Member is assigned to a Care Manager and Interdisciplinary Care Team.
- The Interdisciplinary Care Team (ICT) includes the Care Manager, the enrollee, the enrollee's family, informal caregivers as requested, and the **Primary Care Provider (PCP)**.
- In addition, specialists, other providers, and staff are involved in the ICT, as needed, based on the member's care needs.
- The Interdisciplinary Care Team has ongoing responsibility for ensuring that the Member's health risks are identified on an ongoing basis and that the Member's healthcare needs and risks are appropriately addressed by the plan of care.
- **Providers are invited to the ICT and are encouraged to attend to support their member's care needs.**
- **If providers are unable to attend, they can send their clinical or navigation staff on behalf of the provider.**

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Individualized Care Plan

- Based on the results of the assessments, the Member is assigned a Nurse Care Manager
- Nurse Care Managers working with the Member, their caregivers, and the ICT, develop a Person-Centered Service Plan. A Person-Centered Service Plan is a written description in the care management record of Member-specific health care goals to be achieved and the amount, duration, and scope of the covered services to be provided to a Member in order to achieve such goals.

Nurse Care Manager

As the primary coordinator of care, the Nurse Care Manager's responsibilities include:

- Ensuring the ongoing identification of health risks by conducting in-home and telephonic assessments.
- Organizing and coordinating the Interdisciplinary Care Team (ICT).
- Developing a plan of care for the member and facilitating authorization of covered benefits.
- Implementing the Member's plan of care and coordinating services across the continuum of services.
- Monitoring the delivery of services for quality and effectiveness.
- Integrating feedback, observations, and recommendations of other professionals involved in managing the care of the Member, including Participating Providers, PCPs, Specialists and Providers of non-covered services.
- Collaborating with transition of care staff to coordinate discharge planning from hospital or nursing home stays and facilitate transitions of care.

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Behavioral Health (Carelon)

The high-risk most vulnerable beneficiaries have increased mental health burden, evidenced by more frequent behavioral health and medical admissions, high utilization of services, comorbid medical conditions that often receive inadequate medical care and high rates of substance abuse.

VillageCareMAX has selected Carelon as its Behavioral Health Organization. The partnership aims to ensure that beneficiaries, particularly high-risk beneficiaries, have care coordinated across both physical and behavioral health needs.

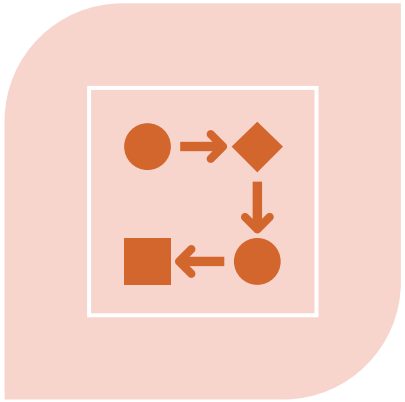
The Behavioral Health Team provides care managers with access to expertise in mental health and substance abuse. Carelon care managers participate in VillageCareMAX ICM rounds where cases are presented for feedback and discussion. In cases where members have both medical and behavioral health comorbidities, VillageCareMAX care managers remain the lead care manager and will case conference with the VCMAX Clinical Director of Behavioral Health. This model ensures integrated care coordination while leveraging the unique skills and expertise of the medical and behavioral health teams.

Member Services

Member Services Representatives serve as liaisons between the Member and their Care Manager and assist in facilitating communication across the Interdisciplinary Care Team.

Member Services Representatives Provide information about VillageCareMAX policies, available services, and Participating Providers, make and confirm service arrangements, and answer questions and resolve problems presented by Members.

Measurable Goals & Outcomes



VillageCareMax continuously reviews the progress that has been made toward meeting the goals of its Model of Care, and issues related to the MOC structure, provider network and communications mechanisms.

The Plan will review the results of its performance measures to assure that we continue to promote, improve and sustain Member health outcomes.

An annual member satisfaction survey serves as the method to reflect against the overall goals of the program and recalibrate whether the goals continue to be appropriate.

Transition of Care

- The Transition of Care Program is designed to bridge the gap for members who may receive care in multiple settings and deliver more comprehensive, coordinated and cost-effective care.
- For planned and unplanned transitions from the member's usual care setting to the hospital and transitions from the hospital to the next care setting, VillageCareMAX identifies and informs members' practitioners.
- The care transitions protocol is administered in alignment with VillageCareMAX SNP Model of Care (SNP MOC).
- Special effort is made to coordinate care when SNP members move from one setting to another, such as when they are discharged from a hospital, to reduce the risk of poor-quality care, risks to member's safety and to maximize health outcomes.
- Utilizing a multidisciplinary team approach to support the SNP member's medical, behavioral health, pharmacy, social and financial needs, case managers work with the member, provider, and community delivery systems to coordinate care and services.

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Clinical Practice Guidelines

Clinical Practice Guidelines

Clinical Practice Guidelines are systematically developed standards that help practitioners and Members make decisions about appropriate healthcare for specific clinical circumstances.

The use of clinical practice guidelines gives VillageCareMAX the ability to measure the impact of guidelines on outcomes of care and may reduce practice variations in diagnosis and treatment.

VillageCareMAX has adopted preventive care and practice guidelines that are based on nationally accepted guidelines.

Providers are informed of the Clinical Practice Guidelines through the Provider Manual, annual mailings, newsletters, and the VillageCareMAX website.

Please see Section 25 and Appendix 6 for a copy of the Clinical Practice Guidelines within the Provider Manual. VillageCareMAX adopts guidelines upon the recommendation and approval of the Internal Quality Review Committee.


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Quality

Quality Management & Performance Improvement Program

- VillageCareMAX maintains a Quality Management and Performance Improvement (QMPI) Program.
- The QMPI Program includes governance/accountability, quality improvement model and activities, member safety activities, and quality measures.
- The Quality Management Department develops goals, measures and benchmarks for assessing performance and identifying opportunities for improvement.
- Quality results are used by internal committees and program leaders, to identify and expand best practices, revise and initiate new programs and processes.

Quality Measurement

- Timely Access to Care
- Improvement of member health status through specific metrics such as HEDIS, PCP Visits, Medication Adherence, Behavioral Health Screening, etc.
- Completion of a comprehensive Health Risk Assessment
- Implementation of an Individualized Care Plan (ICP) for SNP beneficiaries.

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Role of Providers

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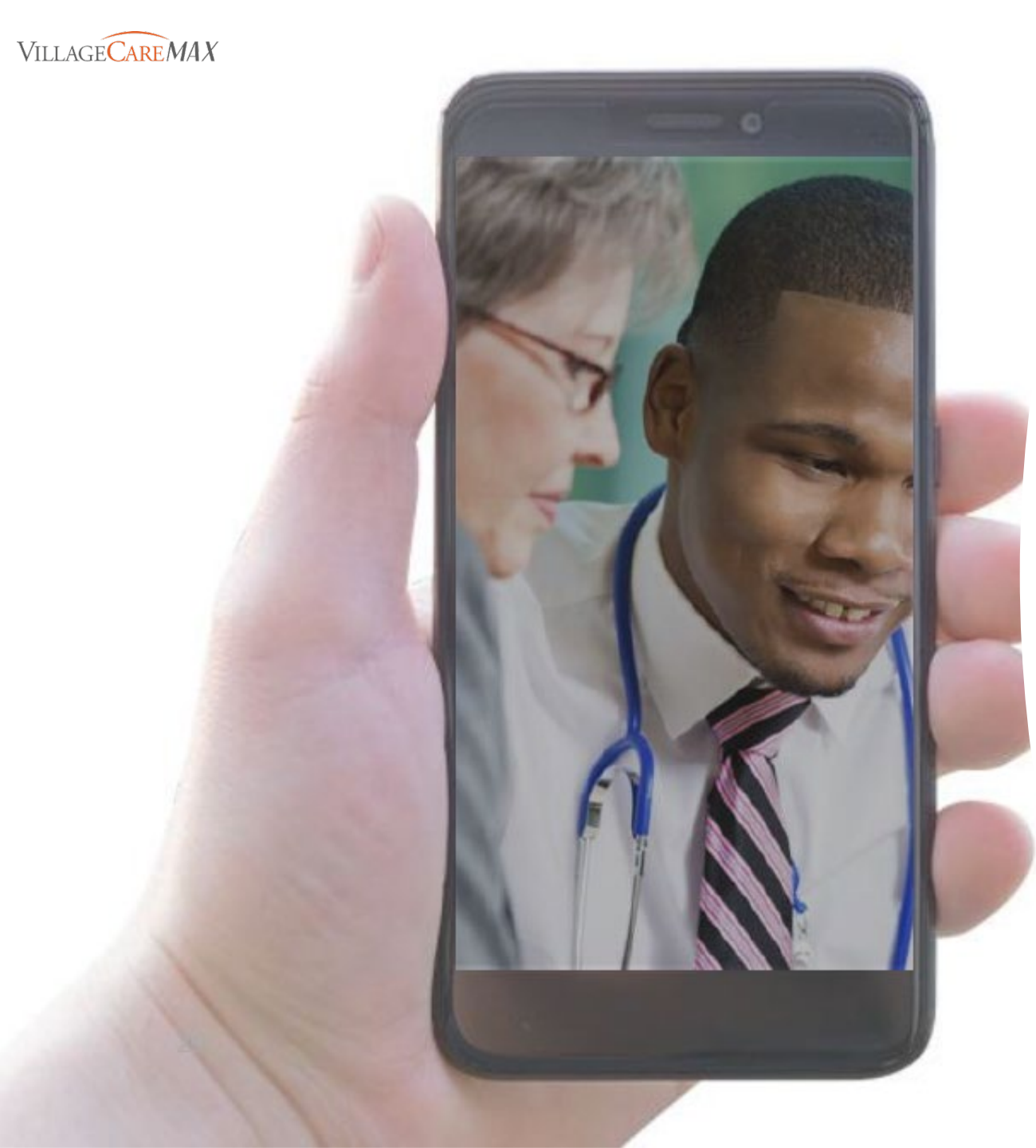

Who Are Our Providers?

- **Primary Care Physicians**
  - Preventive Care, Manage Chronic Conditions, Coordinate Care
- **Specialists**:
  - Can act as PCPs: Geriatricians, Nephrologists, Pain Management Specialists, Endocrinologists, Rheumatologists, Cardiologists, Oncologists, HIV Specialists
- **Other Practitioners**:
  - Nurse Practitioners, Physical Therapists, Occupational Therapists, Speech Therapists, >200 Behavioral Health & Mental Health Professionals, Specialty Clinic (e.g., dialysis, lithotripsy, endoscopy)
- **Long Term Care & Support Services**:
  - Personal Care Services, Adult Day Programs, Delivered Meals Programs, Consumer Directed Personal Assistant Services, Personal Emergency Response Systems
- **Ancillary Services**:
  - Home Infusion, Durable Medical Equipment (DME), Prosthetics, Orthotics, Diabetes Supplies, Diabetic Shoes, Transportation
- **Facilities**:
  - Hospitals, Urgent Care Centers, Ambulatory Surgery Centers, SNFs (Nursing Homes), Hospice, Rehabilitation Facility

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How We Support Our Providers

- Ensuring the appropriate types of providers are in the network.
- Support adequate access and availability.
- Credentialing and re-credentialing of providers.
- Provider communications and training in order to support provider involvement in the MOC.
- Community-based Programs/Organizations are also an important part of the VillageCareMAX provider network and are engaged in the continuum of care.

What Does This Mean for Providers?

VillageCareMAX Model of Care strives to enhance the medical and social health outcomes of our members while managing their comorbidities and reducing hospitalization rates.

To support the integrated delivery system all providers are engaged with involvement in the Interdisciplinary Care Team in order to:

- Collaborate with the case management team
- Update the Care Plan
- Ensure cost-effective, appropriate care for the right member at the right time.

Provider Collaboration

Communicating with VCMAX Care Managers, members and caregivers

Participating in the Interdisciplinary Care Team (ICT) and collaborating to develop the Individualized Care Plan (ICP)

Maintaining accurate members' health records and submitting documentation in a timely manner

Updating records as members' status changes or member transitions from one care setting to another

Encouraging and empowering members to continue treatments established in the ICP

Provider Responsibilities

Invitation

Once a member enrolls, their Care Manager contacts the member's Primary Care Provider (PCP) to invite their participation in the care planning meetings.

Coordination

Providers are responsible for coordinating or delivering care to members and attending the ICT.

Collaboration

The Individualized Care Plan (ICP) is mailed to the Primary Care Provider (PCP).

All updates to the ICP are recorded and appended as documents in the health plan Electronic Health Record (EHR).


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Measuring
Member
Satisfaction

Routine Member Survey

On an ongoing basis, member surveys are conducted to determine member satisfaction and the member experience.

- An example of a survey to measure member satisfaction is the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey. VillageCareMAX contracts with a CMS approved survey vendor to administer the CAHPS Survey.
- CMS selects a sample of eligible members to be surveyed. The survey can be completed online, via mail and telephone.
- The survey is sent out to members in their preferred written language, as appropriate, and special accommodations are made for disabled populations.

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Thank you!

We value your continued partnership in delivering high-quality cos-effective care to our members.

Your participation is greatly appreciated, and we look forward to working with you.

Resources:
VillageCareMAX Provider Manual
https://www.villagecaremax.org/provider-manual

Contact VillageCareMAX Network Management
1-718-517-2783
Monday – Friday, 9am-5pm

Updated 03/2024