Medicare Model of Care

Provider Training

PRV 24.053

Metro Plus Health

OBJECTIVES

At the end of this course you should be able to:

- Describe the Medicare model of care
- Explain the requirements of the Medicare model of care
- Explain who the interdisciplinary care team (ICT) members are & their roles in the development of the individualized care plan (ICP)
- Describe the role of the care manager & provider in the transition of care (TOC)
- Describe food programs & other benefits for Medicare members

BACKGROUND

Why do we provide this training?

The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff, who provide services to our Special Needs Population, to receive Model of Care training.

What are SNPs?

A SNP is a Medicare Advantage coordinated care plan that is limited to individuals with special needs and is specifically designed to provide targeted care to plan members.

- D-SNP members are individuals who are dually eligible for Managed Medicare and have Medicaid
- Both the Medicare Advantage and Medicaid Advantage Plans are D-SNPs

This training covers both our MetroPlusHealth Advantage Plan and our MetroPlus UltraCare Plan.

What is a Model of Care?

Every SNP must have a Model of Care (MOC) approved by CMS. The MOC provides the basic framework under which the Plan will meet the needs 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.

SPECIAL NEEDS PLAN

A Special Needs Plan (SNP) is for individuals who are dually eligible for Medicare and Medicaid.

- **Full duals**: Individuals who have Medicare benefits and receive full Medicaid benefits.
- **Partial duals**: Individuals who have full Medicare benefits but do not qualify for full Medicaid because of their income. These individuals are eligible for Medicare Advantage but not integrated plans like Medicaid Advantage Plus Plan (UltraCare).

CARE MANAGEMENT SERVICES FOR MEDICARE MEMBERS

- MetroPlusHealth Care Management coordinates services to meet the medical, behavioral, psychosocial, and functional needs of the dual eligible members.
- MetroPlusHealth care managers are either registered nurses or social workers
- Medicare Advantage and UltraCare (MAP) members are assigned a care manager
  - For MAP, the care manager is always a registered nurse
- Members are assessed using the Health Risk Assessment (HRA) for Medicare Advantage and the Uniform Assessment System (UAS-NY) for UltraCare members
- Following the assessment, an Individualized Care Plan (ICP) is developed with participation of the member, care manager, PCP, behavioral health provider, and others as needed

WHO ARE THE INTERDISCIPLINARY CARE TEAM (ICT) MEMBERS?

The ICT functions as a multidisciplinary team to support the member and to improve the members' health conditions. The member is the central focus of the team.

The purpose of the ICT is to:

- Assist the member with care coordination
- Assist the member with managing transitions of care after an acute care admission; or discharge from rehab facility, skilled nursing facility, and from home care services
- Mediate identified barriers to care
- Facilitate and coordinate the course of treatment prescribed by the PCP, specialist or behavioral health provider

While the core members of the ICT are the member, care manager, PCP, and behavioral health provider (as applicable), other members such as a pharmacist, physical therapist, specialist, etc. can participate as needed.

WHAT IS A PLAN OF CARE (POC)?

A plan of care (POC) identifies member-specific goals that address the member's needs.

The Individualized Care Plan (ICP) addresses the following:

- Short- and long-term goals
- Issues identified in the annual assessment
- Gaps in care
- Medication reconciliation/review
- Educational needs

For MAP, the Individualized Care Plan considers other elements such as residential setting and supports.

The Individualized Care Plans are shared with the member and the provider.

HEALTH RISK ASSESSMENT (HRA)

The Health Risk Assessment (HRA) is an objective tool used to collect information on a beneficiary's health status, health risk factors, social determinants of health, and functions of daily living

- Social determinants of health questions relate to food insecurity, transportation, homelessness, and utilities

The HRA is conducted upon enrollment and annually.

For MAP, the HRA is the Uniform Assessment System of NY (UAS-NY).

HEALTH RISK ASSESSMENT

Includes questions about:

- Preferred language
- Appointments
- Transportation
- Public assistance
- Need for support with activities of daily living
- Pain
- Chronic conditions
- Medications

METROPLUSHEALTH MEMBER ANNUAL HEALTH ASSESSMENT FORM | TELL US HOW YOU'RE DOING.

PLEASE COMPLETE IN FULL AND MAIL BACK TO US AT:
MetroPlus Health Plan · 50 Water Street, 7th Floor · New York, NY 10004

First, Last Name: _____ Member ID#: _____

Mailing Address: _____

Phone: _____ Date of Birth: _____ Height: ____ft. ____ in. Weight: ____lbs.

Preferred Language: ❑ English ❑ Spanish ❑ Chinese ❑ Creole ❑ Urdu ❑ Bengali ❑ Other: _____

Race: ❑White ❑American Indian ❑Alaskan Native ❑Asian ❑Black / African American
❑ Native Hawaiian / Pacific Islander ❑ Two or More Races ❑ Other: _____ ❑ Decline to answer

Ethnicity: ❑ Hispanic or Latino ❑ Non Hispanic or Latino ❑ Decline to answer

In general, would you say that your health is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Would you like us to call you to help you with any urgent health problem? ❑ Yes ❑ No

Do you have a doctor you see regularly? ❑ Yes ❑ No

If Yes, has your doctor advised you to start, increase, or maintain some level of exercise or physical activity? (for example, start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program)? ❑ Yes ❑ No

Do you have any of the following? ❑ Diabetes ❑ Heart problems ❑ High blood pressure ❑ Cancer
❑ Breathing problems (asthma or COPD) ❑ Memory problems ❑ Hearing problems ❑ Vision problems
❑ Mental / emotional problems ❑ Urinary Incontinence ❑ HIV ❑ Drug or alcohol problems
❑ Other medical problems: _____

How many different medicines do you take a day? ❑ None ❑ 1-3 ❑ 4-7 ❑ 8 or more

Do you need help with your basic activities (such as getting dressed, taking a bath, eating, getting in / out of a chair)? ❑ I'm able to do this without help ❑ I need help, and get the help I need
❑ I need help, and do not get the help I need

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TRANSITION OF CARE (TOC)

Upon admission to a hospital, the member's current ICP is sent to the admitting facility and an admission and discharge notification letter is mailed to the provider

Upon discharge from the hospital, a care manager will reach out to the member to:

- Conduct a transition of care (TOC) assessment
- Ensure the member's discharge plan is in effect
- Develop a new ICP
- Send the new ICP to the provider of record for feedback, if needed
- Contact the member weekly for up to 30 days

YOUR ROLE AS A PROVIDER

- See your patients for their annual wellness visit
- Schedule an appointment within 7 days of discharge from a hospital, rehabilitation or skilled nursing facility
- Review medications with your patient
- Review the member's individualized care plan (ICP) and submit feedback where applicable
- Contact us at healthpromotion@metroplus.org

RESOURCES

Contact the MetroPlusHealth Care Management Department for assistance with care coordination.

- Email: **healthpromotion@metroplus.org**
- Phone: 212.908.8445
- Additional information is available on the Provider website, in the Provider Newsletters, and the Provider Manual.

You are our partner in caring for our members!

Social Determinants of Health (SDoH)

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. For example:

- Safe housing and reliable transportation
- Exposure to racism, discrimination, and violence
- Access to quality education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Exposure to polluted air and water
- Language and literacy skills

MetroPlusHealth has programs to address SDoH:

- Housing, food, and transportation
- Staff can link members to community-based organizations (CBOs) and services through FindHelp

Source: https://health.gov/healthypeople/priority-areas/social-determinants-health

WHAT WE KNOW

In 2023, the top member health-related social needs among Medicare members were:

Food insecurity (22%)

Poor housing quality (10%)

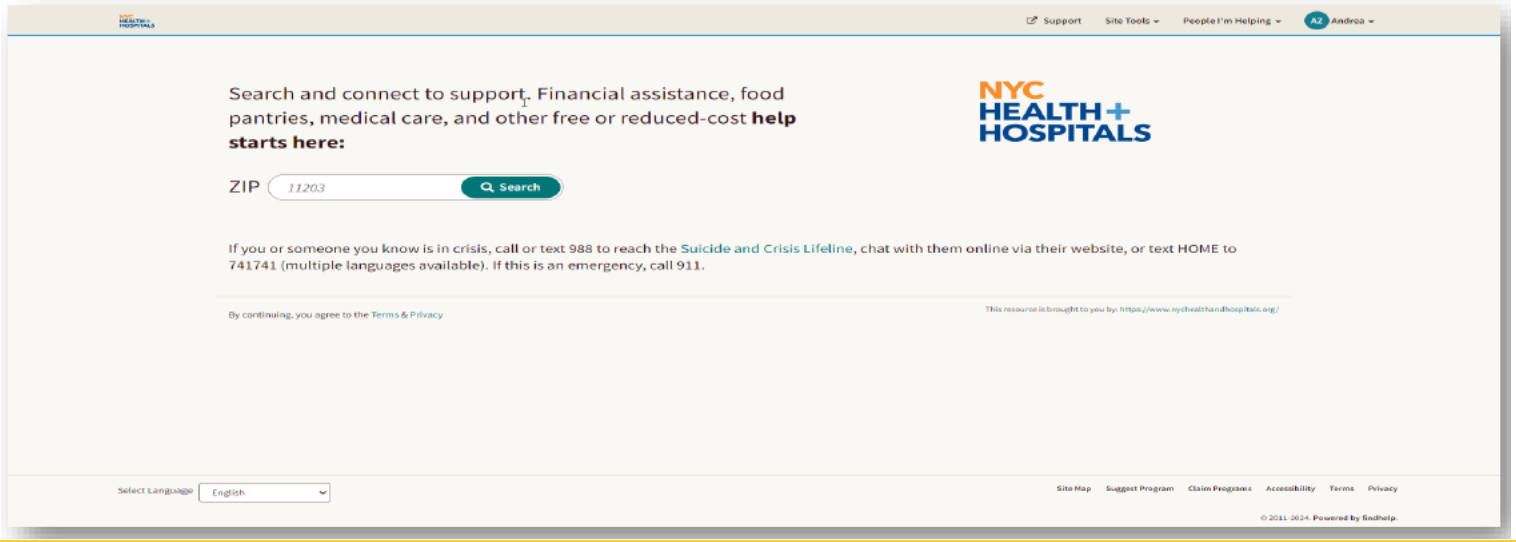
Transportation (8%)

A total of 14,694 members in all lines of business were in Department of Homeless Services (DHS) shelters during 2023

FINDHELP

FindHelp is an online community resource referral platform that immediately allows staff to provide members with community resources within their ZIP code.

Staff can use FindHelp to assist members in finding food pantries, community organizations that can assist with SNAP/WIC applications or provide diapers, birthing classes, etc.



FINDHELP SEARCH TERM & REFERRAL DATA

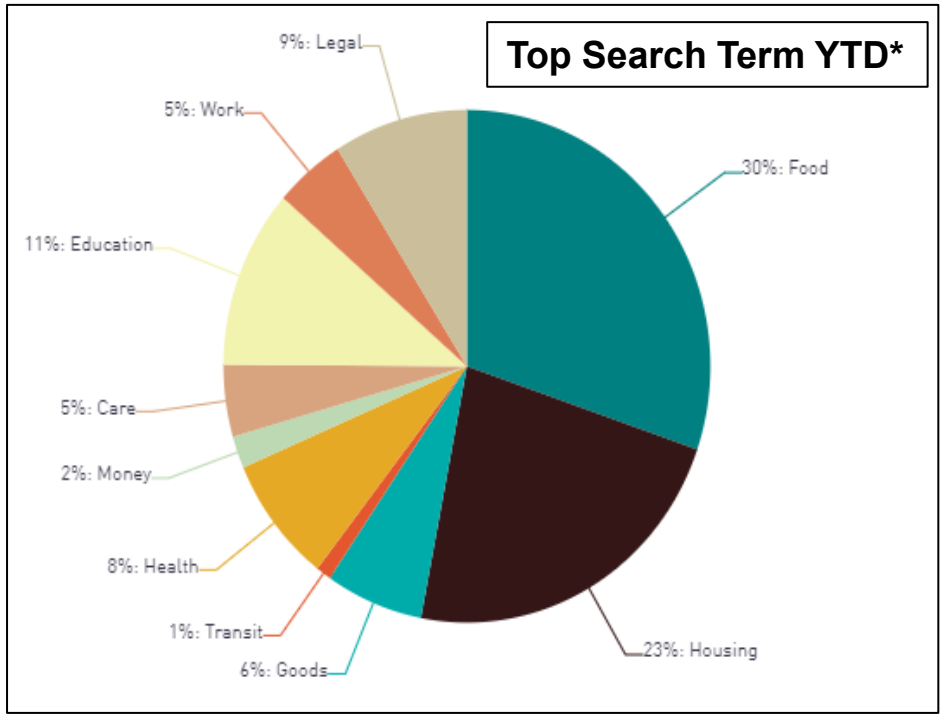
FindHelp is an online platform designed to connect members to resources in their community.

Care managers and support staff can send information to members and complete closed-loop referrals to participating community-based organizations (CBOs).

There were 4,828 searches between 01/01/2024 – 07/31/2024.

Top 6 most referred programs

- Lasagna Love (Prepared meal delivery)
- Med Source (DME products)
- My Housing Search (Housing locator call center)
- True Connect (Affordable connectivity program)
- Esusu (Rent relief fund)
- NYS Office of Temporary and Disability Assistance



Data as of 07/31/2024

Food Programs for Medicare Members

FOOD PROGRAMS WE OFFER

- **NationsBenefit Flex Card:** Medicare Advantage and UltraCare members receive $155/month worth of Flex Card benefit that can be used to purchase groceries
- **Nutritional/Dietary counseling benefit:** 6 visits per year with a registered dietician
- **Discharge Medically Tailored Meals (Discharge MTM):** Partnership with God's Love We Deliver (see next slide)

DISCHARGE MEDICALLY TAILORED MEALS

Overview of benefit: Members receive 10 days worth of pre-made nutritious meals post hospital discharge (20 meals total, lunch and dinner)

Qualifying plans: MetroPlusHealth Medicare Advantage and UltraCare

Qualifying condition: Chronic disease

Eligibility requirements

- Discharged from the hospital within the last 30 days
- Additional screening criteria: refrigerator to store meals, stove or microwave to heat meals

Members are required to choose one of the following pre-made options: standard, dialysis, or vegetarian

*Contact us at foodprograms@metroplus.org

Non-Emergency Transportation

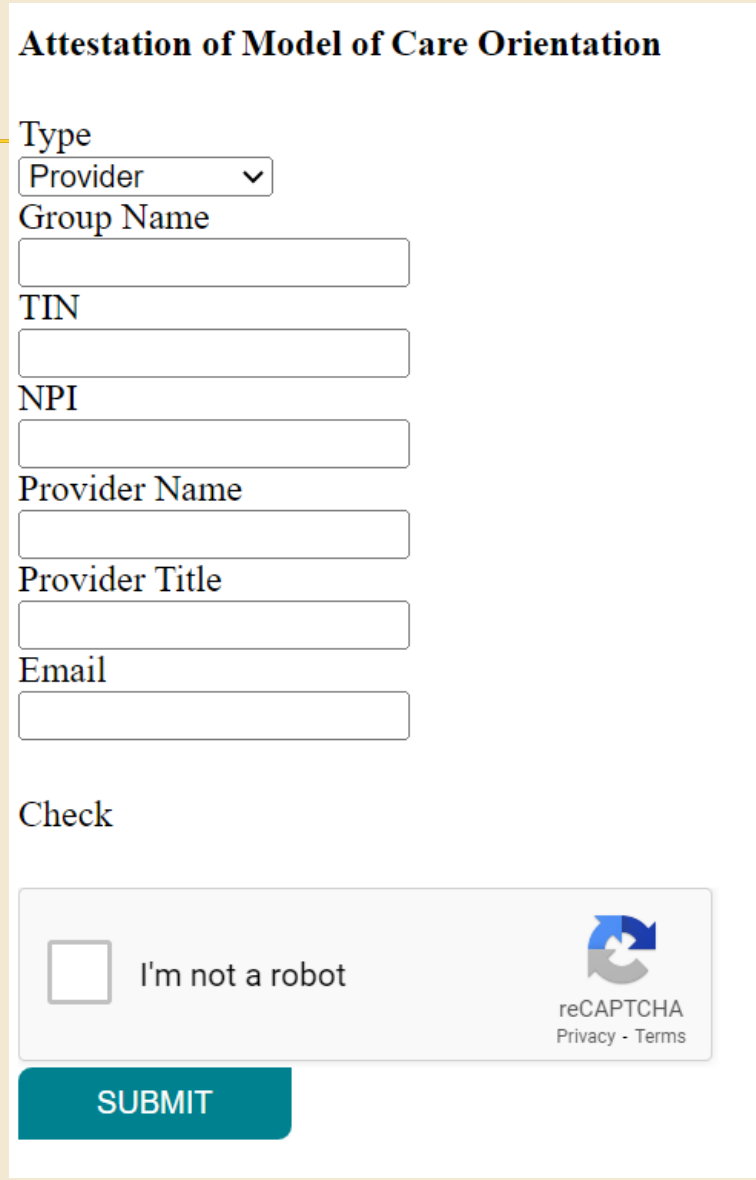
NON-EMERGENCY TRANSPORTATION

In 2024, our Medicare plans offer 48 one-way trips for non-emergency transportation for plan-approved health-related locations

- This is an increase of 34 trips over 2023 benefit (14 trips offered in 2023)

ATTESTATION

Please click the Attestation Link to attest that you have completed the annual Model of Care training.



Thank you!

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