# Mercy Care Advantage

2025 Model of Care Training and Attestation

# Purpose of the Model of Care (MOC) Training

- Understand Special Needs Plans (SNP) and Dual SNP requirements.
- Description of the Model of Care (MOC) Elements:
  - ❖ MOC 1-Description of the SNP Population
  - ❖ MOC 2-Care Coordination
  - ❖ MOC 3-Provider Network
  - ❖ MOC 4-Quality Measurement and Performance
- Summary of provider responsibilities and Provider Collaboration
- Attestation process to document compliance with annual MOC training

# 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 is Mercy Care Advantage?

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:

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

# 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

- Documentation of how the health plan will determine, verify and track eligibility
- Detailed profile of medical, social, environmental conditions, and related issues associated with SNP population
- Health conditions impacting clients/ beneficiaries & plan for especially vulnerable clients/ beneficiaries

### MOC 2

- SNP staff structure, roles and training defined
- HRA –Health Risk Assessment tool description and plan for analyzing results
- F2F -Face-to-Face encounter:–in-person or via telehealth
- ICP -Individualized Care Plan development process, beneficiary goals & health preferences
- ICT-Interdisciplinary Care Team composition, member selection, health care outcomes evaluation
- TOC -Care Transitions: Transition of Care (TOC) practices

### MOC 3

- Specialized expertise available to SNP beneficiaries & how health plan evaluates competency of network
- Use of clinical practice guidelines & care transition protocols by providers
- Provider Training: -MOC training for provider network

### MOC 4

- MOC Quality Performance Improvement (QPI) Plan process to collect and analyze data
- Measurable goals& health out comes for the MOC
- Measure patient experience of care survey and analyze integrated results
- Disseminate SNP quality performance to stakeholders, regulatory agencies & general public

# MOC-1 Description of SNP Population

**Eligibility**

- Documentation of how the health plan will determine, verify and track eligibility

**SNP Population**

- Detailed profile of medical, social, environmental conditions, and related issues associated with SNP population

**Health Conditions**

- Health conditions impacting clients/ beneficiaries & plan for especially vulnerable clients/ beneficiaries

# MOC 1-Description of SNP Population

To be eligible for MCA members must meet the following requirements:

- Medicare A and B entitlements
- AHCCCS Eligible
- Live within MCA's approved geographic service area
- 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

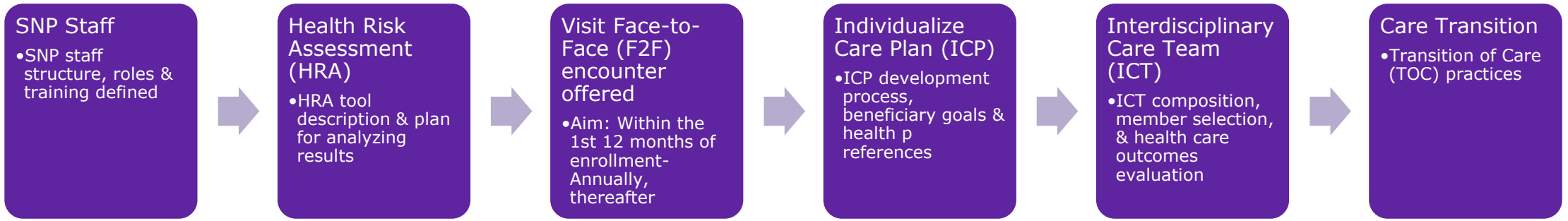
## Overall Population

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 | In the 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 the MOC training within 90 days of hire |
| Existing employees and contracted staff | Must complete the MOC training annually |

# MOC 2-Care Coordination

**Health Risk Assessment (HRA)**

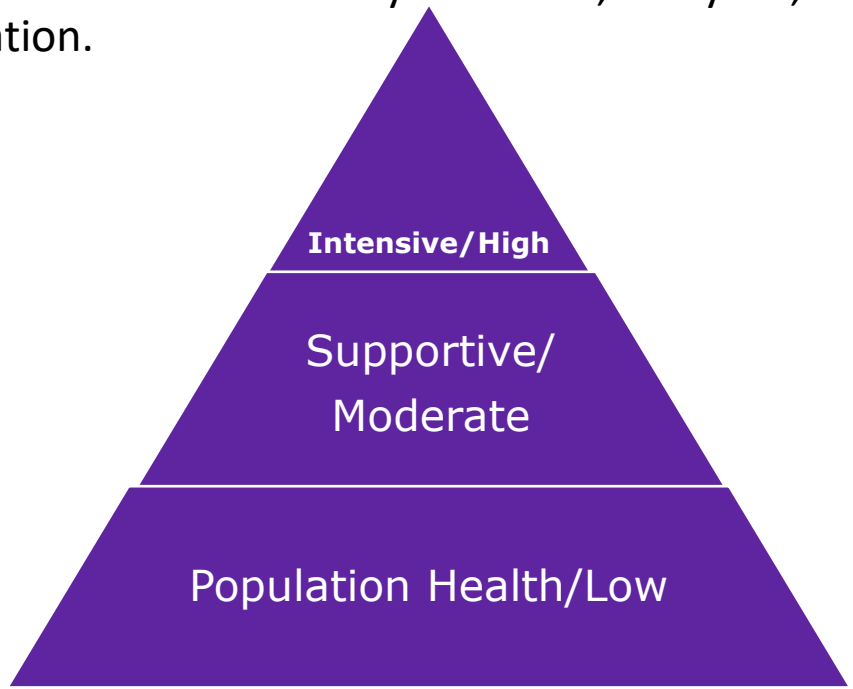
D-SNP plans are required to complete a HRA on every member within 90 days of enrollment and annually thereafter. The HRA results along with predictive model risk scores, claims, utilization, pharmacy, quality data etc. and information exchanged during enrollee and /or their caregiver/representative interactions 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

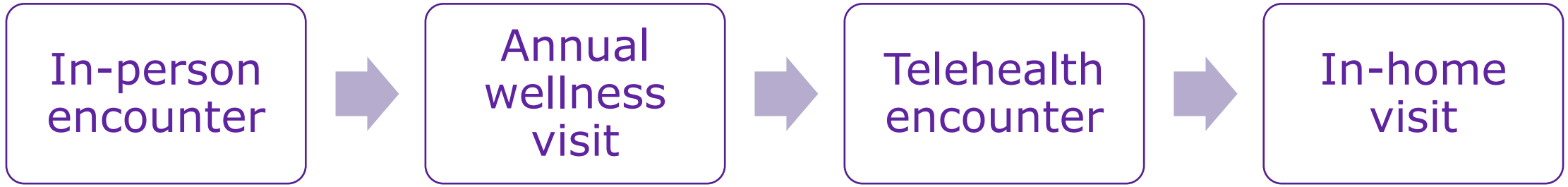
Population Health/Low: Require minimal care coordination and are managing current conditions well



# MOC 2-Care Coordination

**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 as feasible and with the enrollee's consent. The face-to-face encounter is part of the overall care management strategy to meet SNP goals. Types of face-to-face encounters include but are not limited to:



# 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.

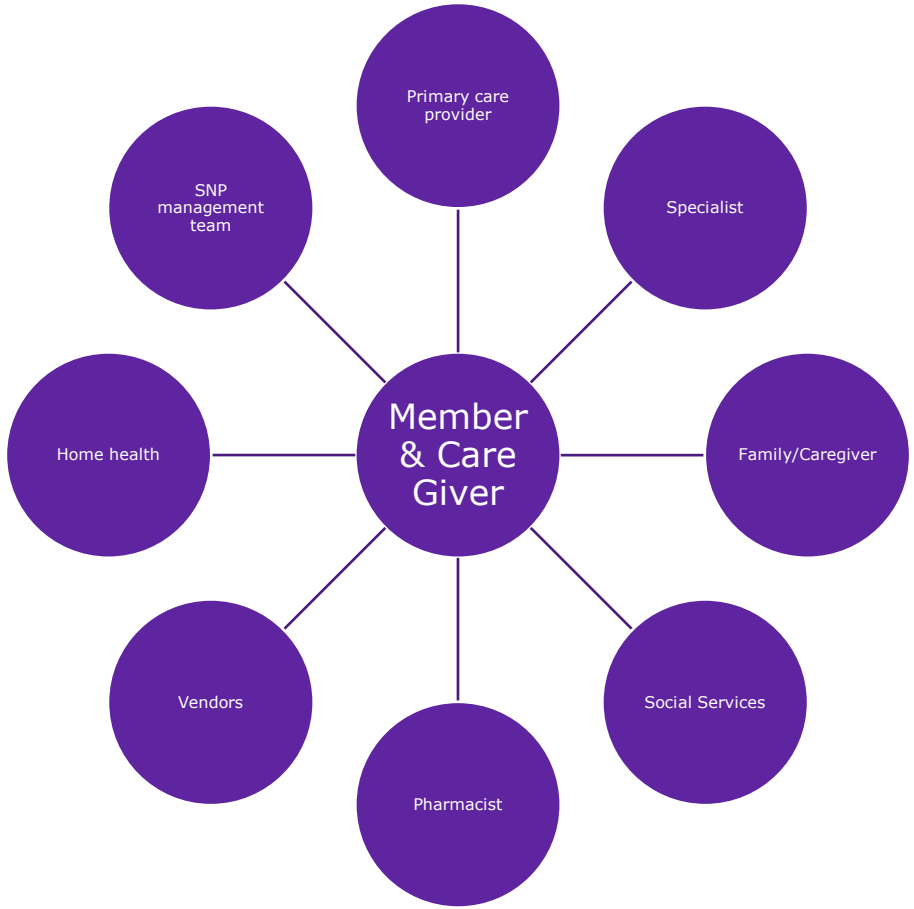
# MOC 2-Care Coordination

## 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-3 Provider Network

**Network:**

- Specialized expertise available to SNP beneficiaries & how health plan evaluates competency of network

**Practice Guidelines & Protocols:**

- Use of clinical practice guidelines & care transition protocols by providers

**Provider Training:**

- MOC training for the provider network & out-of-network providers frequently seen by members

# MOC 3-Provider Network

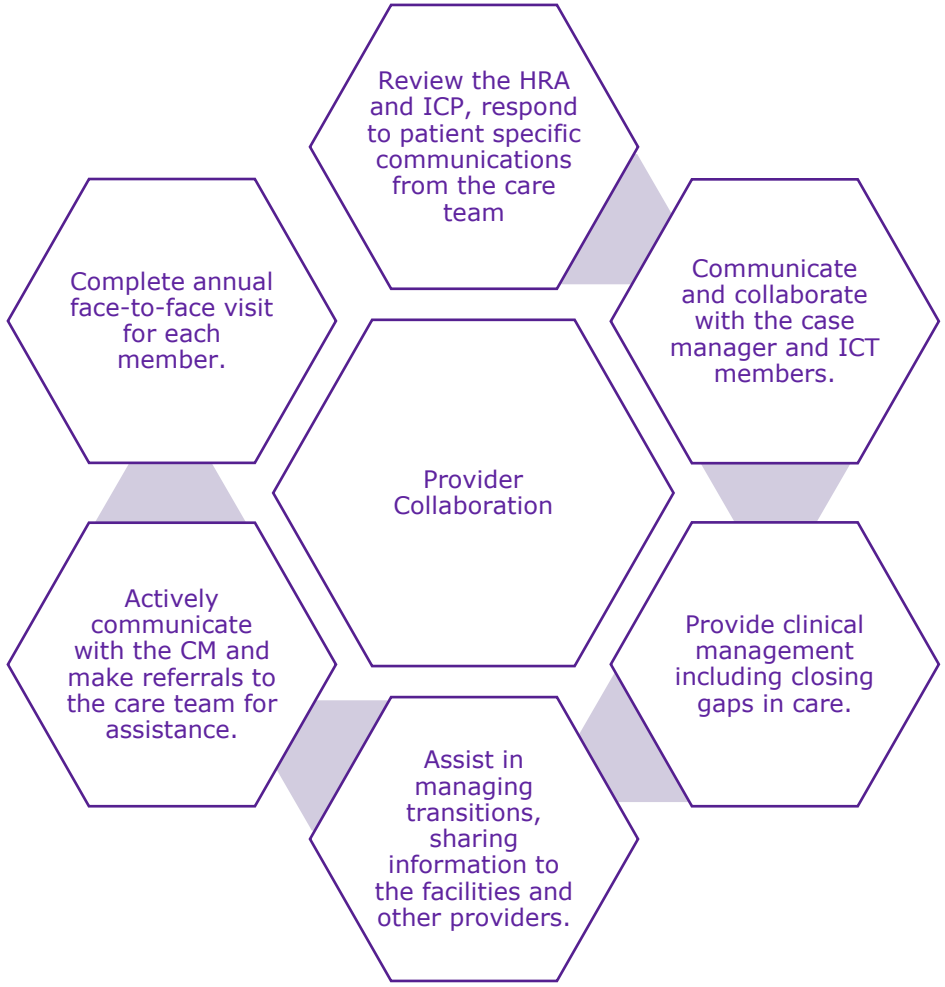
MCA contracts with a comprehensive network of Primary Care Physicians, Specialists including but not limited to, internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists and other specialists, ancillary providers to provide coverage for all aspects of medical, behavioral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

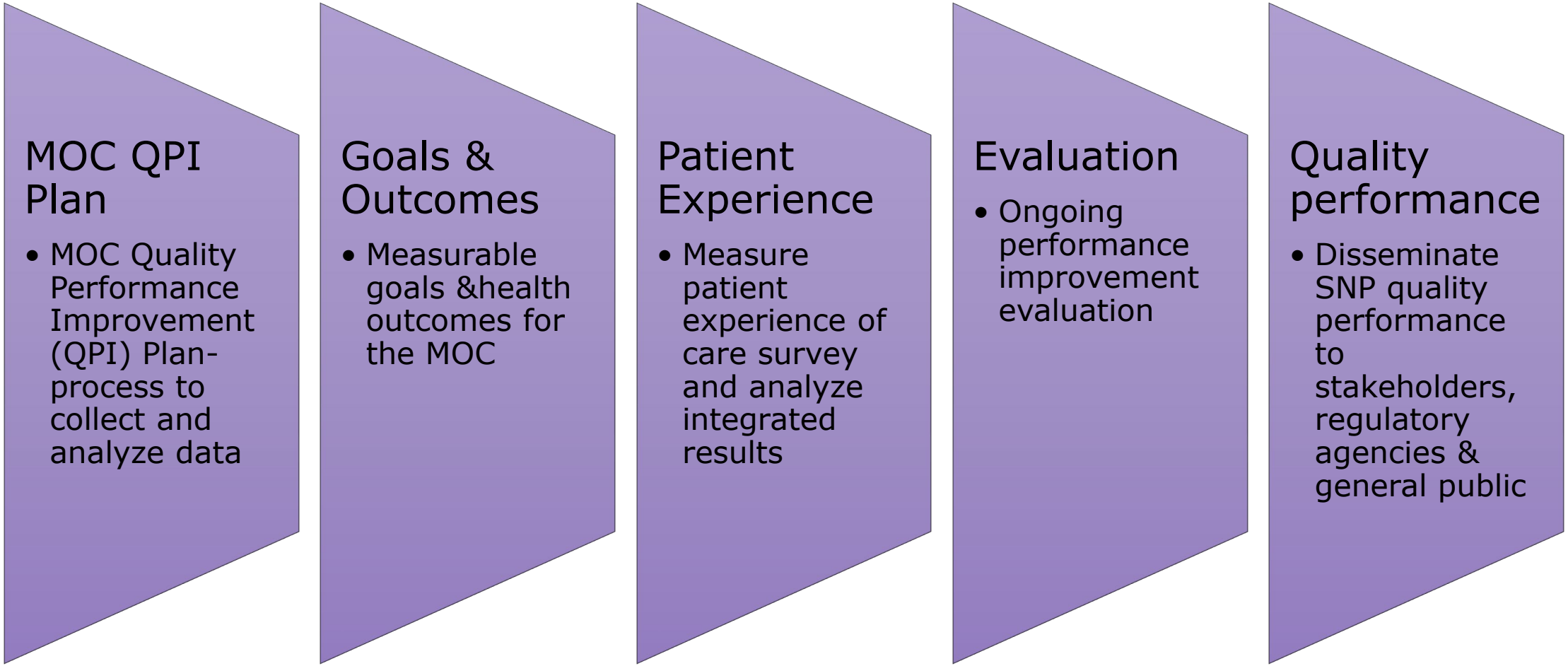
**Provider collaboration with the ICT**



# Summary of Provider Responsibilities

- Communicate and collaborate with MCA Case Managers, members, care givers, and ICT members.
- 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.

# MOC-4 MOC Quality Measurement & Performance Improvement Plan



# MOC 4 - Quality Measurement & Performance Improvement Plan

MCA creates an annual quality improvement plan that focuses on our membership and includes identifying measurable goals and outcome objectives.

Data is collected, analyzed and evaluated throughout the year to monitor and measure the overall performance.

Each year, an evaluation is performed, and improvement actions are identified and incorporated into the next year's quality improvement 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 - Quality Measurement & Performance Improvement Plan

**SNP Member Satisfaction**

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

# 2025 Model of Care Attestation

I hereby attest that I have reviewed the **2025 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.*

# 2025 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**

# Thank you for your ongoing care and support for our members!

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