Model of Care

2023 Provider Training

ALIGN SENIOR CARE

AllyAlign Health

Personalized healthcare for **you.**

Background

The Centers for Medicare & Medicaid Services (CMS) requires all Special Needs Plans to provide Model of Care (MoC) training for all in-network and out-of-network providers who see the Plan's SNP members routinely.

This training will help you to:

- Describe the different types of Special Needs Plans (SNP)
- Understand the MoC key components
- Define your role in supporting the MoC

What is the Model of Care?

- The Model of Care (MoC) is the contract that the Plan submits to Centers for Medicare and Medicaid Services (CMS) clearly outlining who our members are, how we take care of them, how we demonstrate that care, and how we manage the quality of that care.
- Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to develop and implement a Model of Care. The MoC is evaluated and approved by NCQA according to the CMS guidelines.

- <u>The MoC includes four elements:</u>
- **MoC 1**: Description of the SNP Population
- **MoC 2**: Care Coordination
- **MoC 3:** Provider Network
- **MoC 4:** Quality Measurement and Performance Improvement

What is a Special Needs Plan?

A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals.

I-SNP (Institutional Special Needs Plan)

- Entitled to Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Lives in Plan service area (facility)
- Must reside (OR is expected to reside) in a participating I-SNP nursing facility for greater than 90 days at time of enrollment

*Note: IE-SNPs (Institutional-Equivalent Special Needs Plans) For an I-SNP to enroll MA eligible individuals living in the community, but requiring an institutional level of care (LOC), the following two conditions must be met:

- Determination of institutional level of care based on the state assessment tool
- Assessment must be completed by an independent impartial party

C-SNP (Chronic Condition Special Needs Plan)

- Entitled to Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Live in plan service area (facility or home)
- Enrollees must have proof of Dementia or End Stage Renal Disease (ESRD) to be eligible

Who is AllyAlign Health / Align Senior Care?

AllyAlign Health (AAH) Overview

AAH is national leader in Medicare Advantage Special Needs Plans (SNPs) with clinical services designed for senior housing communities.

- National company specializing in developing care models and health plans for senior housing residents
- Founded in 2013 and advanced the senior-housing owned SNP model
- Viewed as market leader and innovator by CMS
- Experienced pioneers in the development and implementation of innovative Medicare Advantage strategies
- Excellent compliance record with Medicare
- Over $350 million in premium under management

Align Senior Care (ASC) is the Special Needs Plan owned by AllyAlign Health.

Our Mission

Improving the health, happiness and dignity of senior living residents.

Medicare Advantage - Special Needs Plans

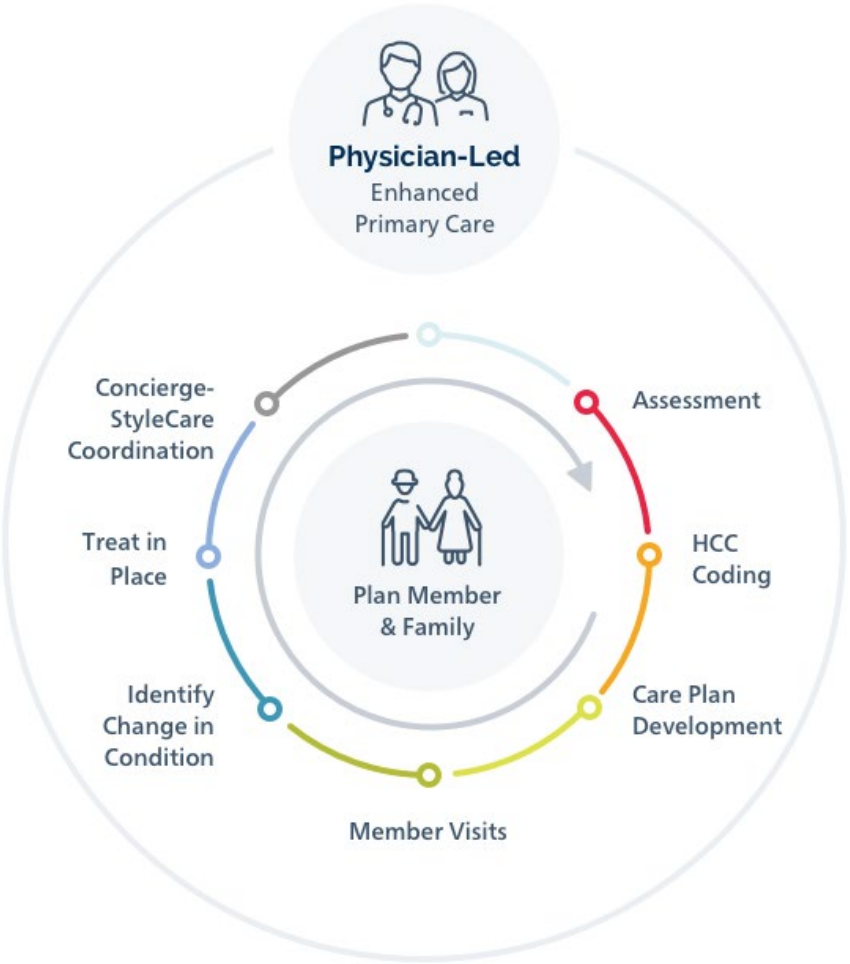
What makes us different?

- SNPs are unique because they target enrollment to “special needs” beneficiaries. To be eligible for a SNP an enrollee must meet specific criteria.
- SNPs focus more on specific care management needs with specialized expertise and benefits tailored to enrollee’s care.
- Special Needs Plans are also responsible to better manage the rising costs of Medicare.
- SNPs must provide prescription drug coverage.
- Plans may use an Advanced Plan Practitioner (APP) as an additional support for member's care. The APP is part of the primary care team.

Care Model

Members who enroll into our SNPs receive traditional Medicare benefits, in addition to personalized care.

- We believe in bringing the **right level of care**, right to the home of the members within our community.
- Our model of care delivers an **added level of support** to complement the services already being offered by the primary care team.



MoC 1: Description of the SNP Population

- **Seniors living in one of the following:**
  - Skilled Nursing Facilities (SNF)
  - Memory Care
  - Assisted Living (AL)
  - Independent Living (IL)
  - Continuing Care Retirement Community (CCRC)
  - Resides in the C-SNP Service Area
- **Seniors may have or require the following:**
  - Additional care coordination than the general population
  - Has multiple co-morbid chronic conditions requiring close monitoring
  - Likely prescribed high-risk medications
  - May need help with 5 or more activities of daily living (ADLs)
  - May have moderate to severe cognitive impairment

Plan Staffing & Functions Overview

- Health Plan Board of Directors
- Executive Director- Administration
- Compliance Officer- Compliance
- Plan Medical Director- Medical Leadership
- Behavioral Health Medical Director- Medical Leadership
- Care Team/Care Ally- Onsite Member Engagement
- Advanced Plan Practitioner (Nurse Practitioner, Physician Assistant, PCP)- Clinical Services
- Care Coordinator- Clinical Services Support
- Utilization Management Nurse- Validating medical necessity for services requested
- Customer Service- Centralized member and provider telephonic support

MoC 2:
Care Coordination

- Health Risk Assessments (HRA)
- Face-to-Face Encounter
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT) Meetings
- Care Transition Protocols

Health Risk Assessment Tool

The Plan's Health Risk Assessment Tool (HRAT) starts the **new member assessment** and care planning process for the Plan and provides an **annual checkpoint** and reassessment of key geriatric health metrics.

The HRAT is a screening tool used by the Plan to:

1. Collect member self-reported health status
2. Identify potential gaps (medical, functional, cognitive, psychosocial, and mental health) in existing care and treatment plans and immediate care need
3. Monitor changes in self-reported health status on an annual basis

Health Risk Assessment

Requirements

- All new Plan members receive an HRA **within 90 days of enrollment**.
- Existing members should have an HRA annually **(within 364 days of their prior assessment)**.
- The HRA **identifies immediate or overlooked health needs** and informs the care plan for the member.

Face-to-Face Encounters

- The Plan's Care Team will conduct an initial Member face-to-face encounter within 90 days of the Member's enrollment to the Plan and annually thereafter.

- The Plan's Care Team may conduct more frequent face-to-face encounters based on the Member's health status and care needs.
  - Face-to-face encounters may be completed in person or via telehealth (video + audio).
  - If a face-to-face encounter is performed via telehealth, the Plan will obtain Member and/or caregiver verbal consent and document the consent in the Plan's care management platform.

- The intended outcome of these face-to-face encounters is to establish and/or further enhance the relationship between the Member and their care team and to elicit additional concerns that may not be achieved by telephonic contact alone to promote successful coordination of care and improve health outcomes.

Individualized Care Plan

An Individualized Care Plan (ICP) is developed by the Interdisciplinary Care Team (ICP) in collaboration with the member and or their caregiver.

The Plan's care team works closely with the member and the senior housing community to create, implement and evaluate the ICP.

The ICP must include, but is not limited to:

- The beneficiary's self-management goals and objectives
- The beneficiary's personal health care preferences
- A description of services specifically tailored to the beneficiary's needs
- Identification of measurable goals and action taken if goals are not met

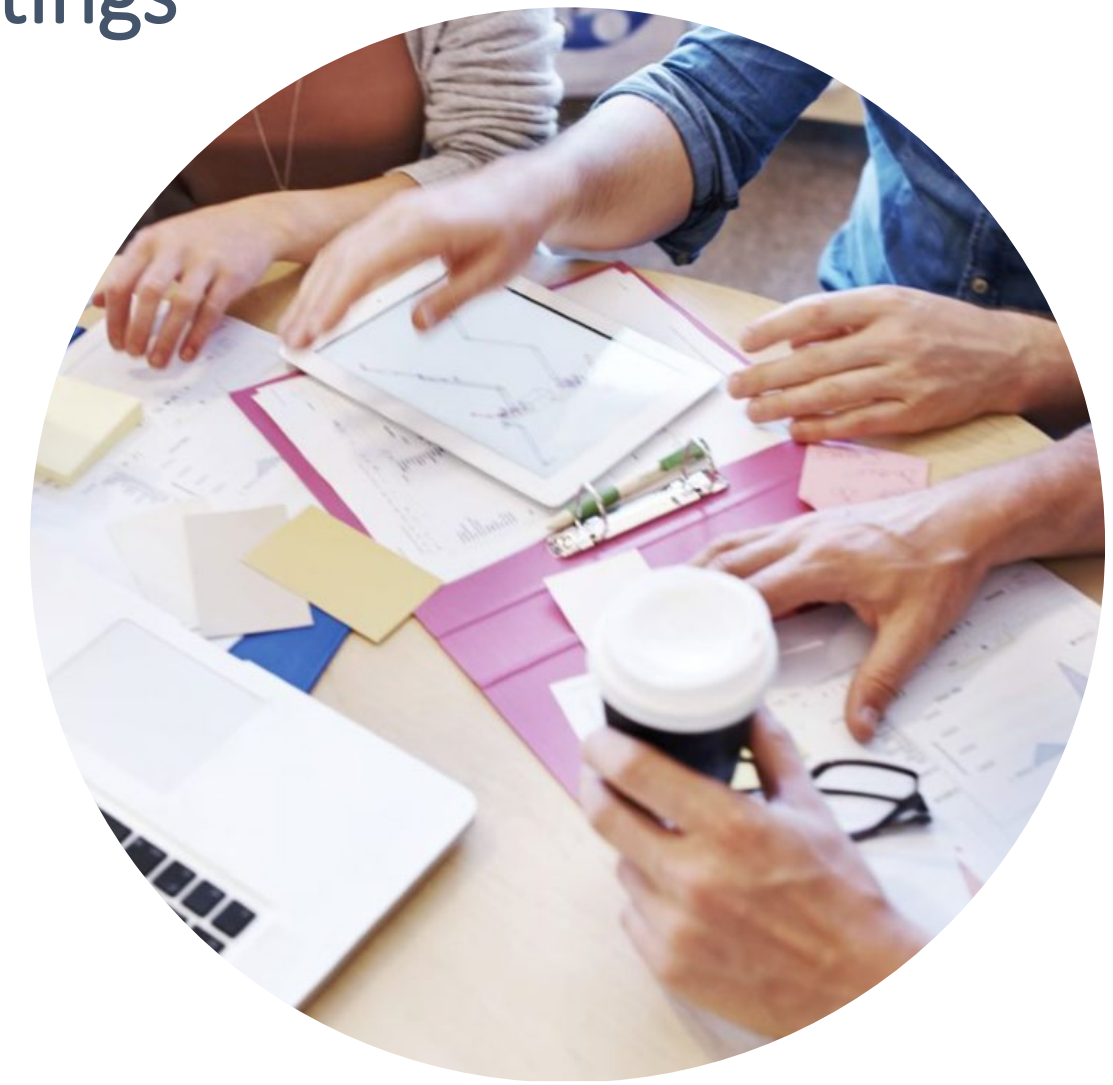
The ICP is shared with members of the ICT using various methods such as, but not limited to:

- Verbal communication during face-to-face or telephonic activities
- Written communication delivered in person, mail, email, facsimile
- Electronic communication through access to clinical documentation

Interdisciplinary Care Team Meetings

Requirements

- All SNP members have at least one Interdisciplinary Care Team (ICT) meeting annually or more often if:
  1. Updates are needed to the Individualized Care Plan
  2. The Senior Housing Community ICT schedule requires more regular updates:
     - Nursing Home: quarterly
     - Other Levels of Care: 2x annually



Care Transition Protocols

The Plan understands how **coordinated health care improves the care of its vulnerable membership**. The Plan incorporates care transition protocols to provide an integrated, proactive approach to safely transition members between levels of care and across care settings using evidence-based clinical practices and targeted strategies including (but not limited to):

- Ensuring that every member has a Care Team/Care Ally to serve as the centralized point of care coordination for members and families/caregivers for all care, including transitions.
- The Advanced Plan Practitioner or the Primary Care Team will be responsible for preventive and primary care services delivered in the facility.
- Minimizing the need for transitions outside of the facility through delivery of wellness, preventive, and monitoring services delivered in coordination with the ICT members.

Care Transition Protocols (cont.)

- Minimizing transitions outside of the senior housing community through a "**skill in place**" program.
- **Waiving the 3-day hospitalization requirement** for Skilled Nursing Facility services, enabling skill in place and encouraging appropriate ER and Observation combined with follow up skilled services in the SNF instead of an inpatient hospitalization.
- **Following members across care settings** during transitions (i.e., admission to a hospital) through the use of a Utilization Management Registered Nurse who coordinates discharge planning and post-discharge services with the hospital, and Plan Provider to ensure smooth transitions.
- **Identifying at-risk members** through the HRA and Most Vulnerable Member reports and notifying the Advanced Plan Practitioner of status or status changes.
- Requiring Plan Providers to provide **transitional care management visits** and communications.

MoC 3: Provider Network

- The Plan provides a comprehensive contracted network of providers, facilities, ancillary service providers, specialist physicians, and acute care facilities with the specialized clinical expertise pertinent to the care and treatment of long-term senior housing residents.
- Primary care services through the Plan Provider (MD, DO, NP, or PA) and supportive ancillary services like therapy, rehab, selected diagnostic radiology and lab, and home health are provided within the member's senior housing residence and coordinated by the Plan Provider.
- The Plan Provider also coordinates visits and services provided outside of the facility including specialist visits, radiology, lab, and other diagnostic testing not available on campus.
- Out of Network referrals may require prior authorization.

MoC 4: Quality Measurement and Performance Improvement

- The purpose of the Plan's Quality Improvement Program (QI Program) is to continually take a proactive approach to assure and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so that it may fully realize its vision, mission and commitment to member care.

- The QI Program supports and promotes the mission, vision, and values of the Plan through continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services to members.

- The Plan's QI Program is assessed annually and reviewed by the Quality Improvement Committee (QIC) to determine the overall effectiveness of the program, including the MOC, and appropriateness of care and services furnished to members. Enhancements are made to the QI Program based on the annual evaluation.

Member Risk Prevention - PQI

Potential Quality Issues (PQI)

- A deviation or suspected deviation from expected provider performance, clinical care or outcome of care that cannot be determined to be justified without additional review. Examples of potential quality issues include:
  - Falls with injury/additional treatment required
  - Medication errors with injury/additional treatment required
  - Incident resulting in Death
  - Incident resulting in severe Brain or spinal damage to a patient

- All PQIs should be reported within three calendar days of the incident using the PQI form located on the Plan's website.
- Email completed form via secure email to pqireferral@allyalign.com.
- The PQI will be reviewed to determine if there should be a change in procedure to prevent further incidences.

Member Risk Prevention

Grievance

- A grievance is **any complaint or dispute** (other than an organization determination) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. Grievances can be filed within 60 days of occurrence.
    - In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
    - Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.
    - Members/member representative reporting a grievance, should send a secure email with complete grievance details to: grievances@allyalign.com OR fax 1-833-610-2380.

Appeal

- An appeal is **the right to ask the Plan to change their decision**. An appeal only occurs if the Plan makes a decision to deny in whole or in part a service or claim. Member/Member Representatives and providers can file an appeal within the allowed CMS timeframe which is 60 days from date of denial.
    - Members/member representative/providers reporting an appeal, should send a secure email with complete appeal details to: appeals@allyalign.com OR fax 1-833-610-2380.

Why are We Unique?

Convenience

- A dedicated and responsive care team
- An Advance Plan Practitioner providing frequent visits, comprehensive exams
- Assigned Care Ally for onsite and personalized member support

Cost Savings

- Supplemental benefits beyond Medicare: Skill-in-Place, dental, vision, podiatry, etc.
- Cost-sharing and copayments designed to lower out of pocket costs for preventive care and services most used by senior housing residents

Great Service

- Personalized care facilitating all aspects of the care journey
- In-person enrollment and customer service support
- Transparent communication with members and families

"I love having you as my insurance provider because everyone has been so good to me. I never have to worry about anything because the plan takes care of it."

"Since joining the plan, my mom has 'come back to life' after losing her husband. Because of the services and great care, she's happier now and participates in activities."

"The plan Nurse Practitioner's quick intervention prevented an ER visit after my mom fell. She arranged for a mobile x-ray, and we had confirmation within an hour that there was no break."

ALIGN SENIOR CARE

Our Clinical Model Enhances Member Health and Satisfaction

Nurse Practitioner/ Physician Assistant/ Clinical Services	• 95% are satisfied with their courtesy, friendliness and level of respect. • 90% are satisfied with the amount of time spent with them.
Physician Services	• 97% are satisfied with their courtesy, friendliness and level of respect
Access to Health Services	• 96% report it was easy to get the needed care, tests, or treatment every time or almost every time. • 94% are satisfied with their/ their loved ones' access to hospitals during the last 6 months. • 90% were able to get an appointment to see a specialist as soon as needed

Summary

Finally, A Medicare Advantage plan that ***actually*** works for everyone.

Together, We…

- Offer a response-focused primary care team specialized in caring for seniors
- Use tools designed for use with our members to identify those most at risk for hospitalizations and complications
- Develop individualized care plans that pull together information from providers and caregivers within and outside of the community they live in
- Support the Individualized Care Teams through routine meetings to discuss member goals and outcomes

Desired Outcomes Include:

- Better health outcomes
- Reduced hospitalization rates
- Reduced cost of care
- Better resident experience
- Preserve direct resident/provider relationship

Additional Resources

- The Plan Website contains important information for Providers and Facility Staff!
  - Access the Plan website
  - Click For Providers
  - Folders shown the right will be available

- All Providers should be familiar with the **Provider Manual** (located within the Provider Documents folder). This manual includes information on key contacts, eligibility, benefits, referrals, billing/claims, credentialing, quality, reporting/monitoring, etc.

Thank you

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