

Annual Model of Care Training for Providers (2017)



Model of Care Training

- Mandated by CMS to be completed annually and relates to Affinity's Medicare Advantage Dual Eligible Special Needs Plans (SNP): Affinity Medicare Ultimate and Affinity Medicare Solutions
- This training allows providers to gain an enhanced understanding of how Affinity is expected to meet the unique needs of the SNP population

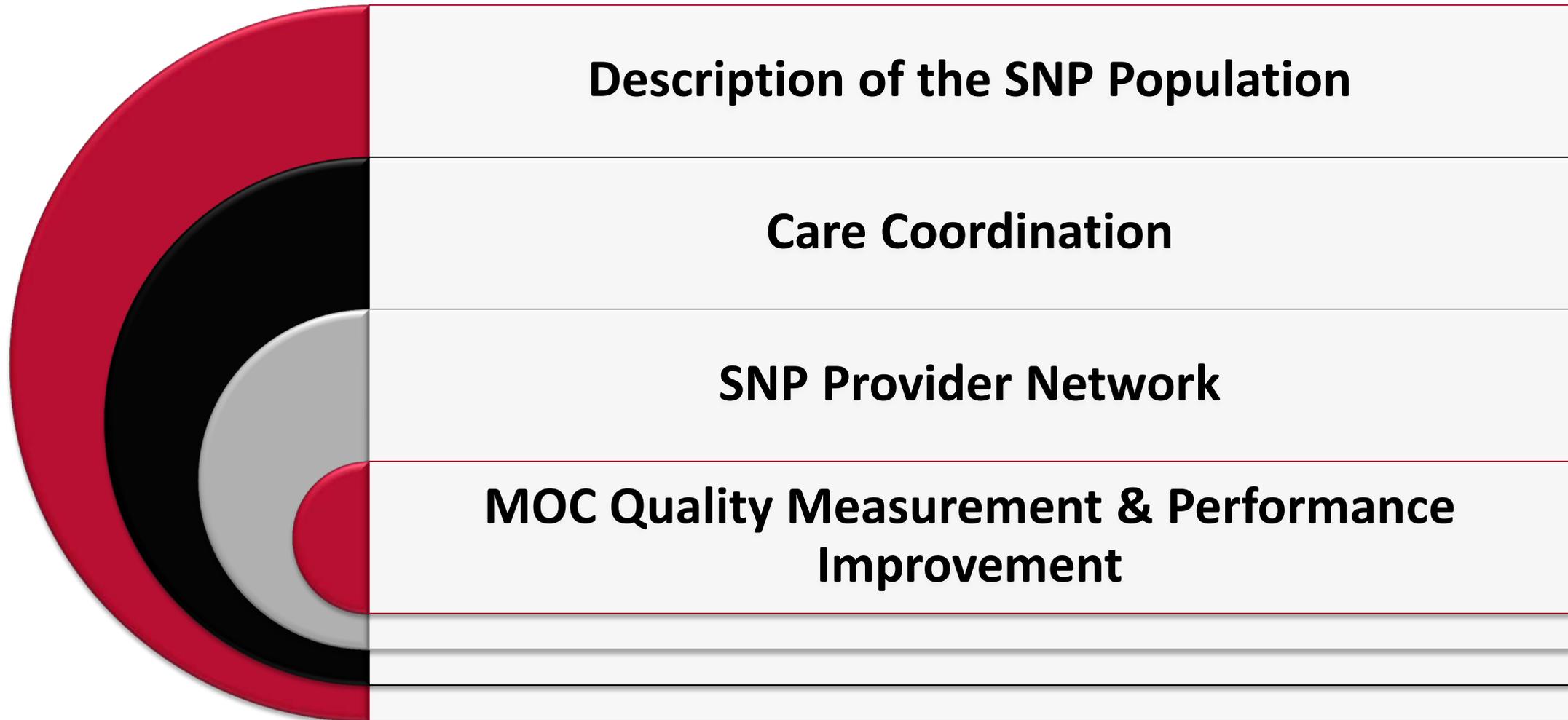
In this module, you will learn to:

- Summarize the four components of the Model of Care and Affinity's plan for delivering our care management program to SNP members
- Introduce and define the three types of Medicare Advantage SNPs
- Connect the Model of Care goals to members in Affinity's SNP plans



What are the Four Components of the Model of Care

The MOC is comprised of clinical and non-clinical elements under the following four (4) main sections:



Background of SNPs

SNPs were created by CMS to provide:

- Improved Access
- Care Coordination
- Continuity of Care

Focus of SNP:

- Monitor health status of targeted population
- Identify needs
- Improving access to quality healthcare services and benefits
- Manage chronic diseases
- Avoid inappropriate hospitalizations
- Decrease members' medical, mental and social risk

Special Needs Plan Types

Institutional SNP (I-SNP)

For people with Medicare who require an institutional level of care

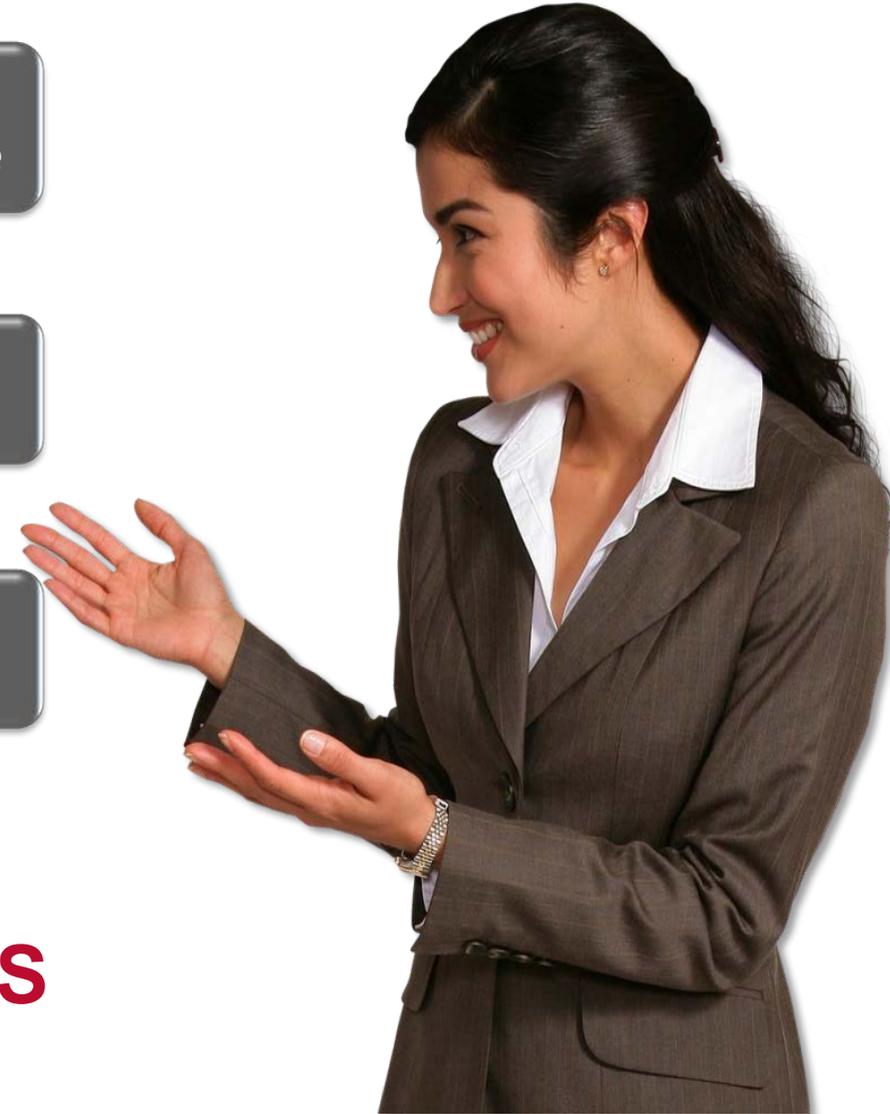
Chronic Conditions SNP (C-SNP)

For people with Medicare and certain types of chronic conditions

Dual Eligible SNP (D-SNP)

For people with Medicare and Medicaid

AFFINITY OFFERS D-SNP PLANS





Description of the SNP Population

- D-SNP members are dually eligible for Medicare and Medicaid
- Every D-SNP member is evaluated with a comprehensive health risk assessment (HRA) within 90 days of enrollment and annually thereafter
- Members may be evaluated more frequently as their health conditions require
- The HRA collects information about the members' medical, psychosocial, cognitive and behavioral needs and health history

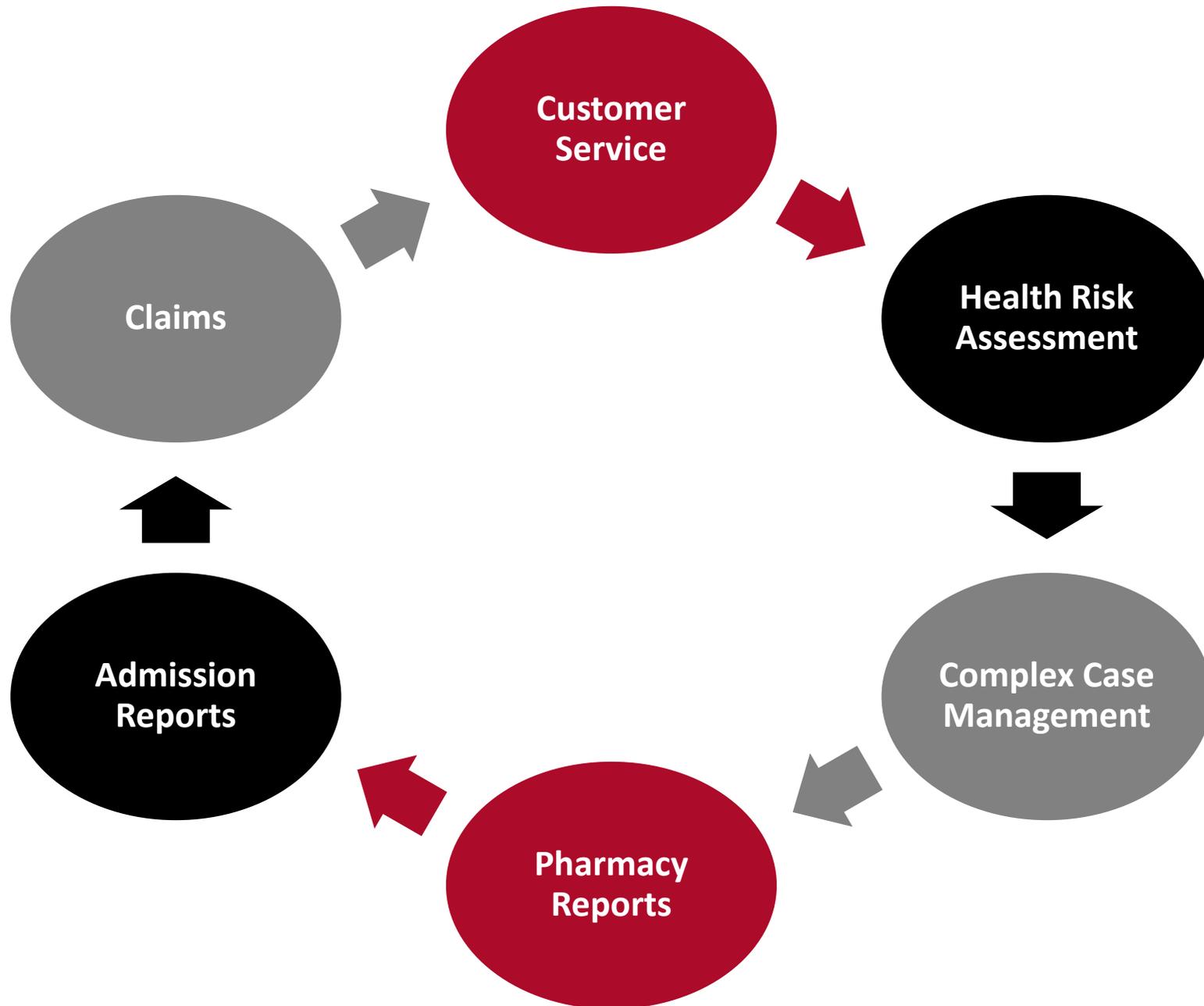
The Role of the Care Manager

The Care Manager is central to Affinity's care management process and is responsible for:

- Reviewing results of the HRA with the member, both within 90 days of enrollment and annually thereafter
- Sharing the Individualized Care Plan with members, which is developed using results from the HRA, pharmacy reports and lab and claims data, if available
- Connecting members to their interdisciplinary care team at Affinity
- Coordinating services as needed
- Helping to prevent unnecessary hospital readmissions by proactively working with members at risk
- Ensuring members have appropriate follow up care after a hospitalization
- Facilitating improved access to benefits and services



Care Coordination



Interdisciplinary Care Team (ICT)

Affinity's ICT includes Affinity care managers, staff, the member, his/her family/caregiver, external practitioners and vendors involved in the member's care.

Care Managers work with the ICT and the member to communicate goals related to their condition(s), encourage self management and communicate progress toward goals to other members of the ICT.

The ICT works with each member to:

- Develop personal goals and interventions for improving health outcomes
- Coordinate services on behalf of the member, including those covered by both Medicare and Medicaid
- Refer members to community resources as needed
- Notify the member's physician of planned and unplanned transitions

D-SNP Provider Network

Affinity maintains a network of providers with specialized expertise who are contracted to provide health care services to Affinity's Medicare SNP members.

Affinity provider's responsibilities include:

- Care and coordination for the member
- Participation in ICT
- Responsiveness and cooperation with the Care Manager
- Communicating with the member's family or legal representative
- Timely submission of documentation



Provider Network

CMS Expects Affinity to:

- Contract with Board-certified providers
- Monitor network providers to ensure they use nationally recognized clinical practice guidelines when available
- Verify licensing and competency of network providers through a credentialing process
- Facilitate the sharing of members' healthcare information among providers and the ICT
- Provide annual training on its Model of Care to its provider network

Quality Measurement (QM) & Performance Improvement (PI)

QM & PI include the following:

- Quality Performance Improvement plan
- Measurable goals and health outcomes
- Measuring SNP Member Satisfaction
- Supporting ongoing improvement of the MOC
- Communicating quality improvement performance results

CMS expects Affinity will:

- Implement quality improvement projects that focus on enhancing our ability to deliver healthcare services and benefits to its D-SNP beneficiaries in a high-quality manner
- Establish, meet and monitor goals through quality measurement and performance improvement initiatives





Performance and Health Outcomes Measurement

Affinity monitors data quarterly to ensure we are achieving our measurable goals, complying with our Model of Care and identifying opportunities for improvement.

Data sources include but are not limited to:

- Authorizations
- Medical Record Review
- Claims
- Enrollment
- Member Services Calls and Surveys
- Pharmacy Reports
- Provider Appointment Availability Studies
- Health Risk Assessments
- Health Outcome Surveys
- Health Outcome Data

Summary

The Model of Care requires us to work together to benefit our members by:

- Enhancing communication between the plan, members and providers
- Interdisciplinary approach to the members' special needs
- Care coordination appropriate for each member
- Support for member preference in the plan of care



Thank you for completing the Annual Model of Care Training for Providers (2017)

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