MMP Model of Care Matrix Upload Document

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2014 Medicare-Medicaid Plan Model of Care Matrix Upload Document

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Care Management Plan Outlining the Model of Care

In the following table, list the document, page number, and section of the corresponding description in your care management plan for each model of care element.

Model of Care Elements	Corresponding Document Page Number/Section
1. Description of the plan-specific Target Population (based on target population of full duals as defined by the State) The MCO's response to **Element #1** (Description of the Plan-specific Target Population) must include all **Virginia-specific** sub-populations of dual eligibles as follows: a. Individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver; b. Individuals with intellectual/developmental disabilities; c. Individuals with cognitive or memory problems (e.g., dementia and traumatic brain injury); d. Individuals with physical or sensory disabilities; e. Individuals residing in nursing facilities; f. Individuals with serious and persistent mental illnesses; g. Individuals with end stage renal disease; h. Individuals with complex or multiple chronic conditions; and, i. Individuals who have no reported medical, behavioral health, or long-term service and support (LTSS) needs but may have needs in the future. Responses to the Model of Care section should take into account the fact that many enrolled individuals will have co-occurring conditions and could be included in more than one sub-population. **Populations identified in items a – h are also**	

included as "Vulnerable Subpopulations" in Element #10.	
2. Measurable Goals a. Describe the specific goals including: • Improving access to essential services such as medical, mental health, and social services • Improving access to affordable care • Improving coordination of care through an identified point of contact (e.g., gatekeeper) • Improving seamless transitions of care across healthcare settings, providers, and health services • Improving access to preventive health services • Assuring appropriate utilization of services • Improving beneficiary health outcomes (specify organization selected health outcome measures) b. Describe the goals as measurable outcomes and indicate how the organization will know when goals are met c. Discuss actions the organization will take if goals are not met in the expected time frame The state has no further requirements beyond those listed above in **Element # 2**	
3. Staff Structure and Care Management Roles a. Identify the specific employed or contracted staff to perform **administrative** functions (e.g., process enrollments, verify eligibility, process claims, etc.) b. Identify the specific employed or contracted staff to perform **clinical** functions (e.g., coordinate care management, provide clinical care, educate beneficiaries on self-management techniques, consult on pharmacy issues, counsel on drug dependence rehab strategies, etc.) c. Identify the specific employed or contracted staff to perform **administrative and clinical oversight** functions (e.g., verifies licensing and competency, reviews encounter data for appropriateness and timeliness of services, reviews pharmacy claims and utilization data for appropriateness, assures provider use of clinical practice guidelines, etc.) The state has no further requirements beyond those listed above in **Element # 3**	
4. Interdisciplinary Care Team (ICT) a. Describe the composition of the ICT and how the organization determined the membership b. Describe how the organization will facilitate the participation of the beneficiary whenever feasible c. Describe how the ICT will operate and communicate (e.g., frequency of meetings, documentation of proceedings and retention of records, notification about ICT meetings, dissemination of ICT reports to all stakeholders, etc.) In addition to the elements described in **Element #4** above, additional state expectations include the following: If an enrollee is receiving Medicaid State Plan Targeted Case Management services, it is expected that the MCO's ICT will include the targeted case manager	

as a member of the ICT. Describe how the MCO will include the targeted case manager in the ICT.	
5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols a. Describe the specialized expertise in the organization's provider network that corresponds to the target population including facilities and providers (e.g., medical specialists, mental health specialists, dialysis facilities, specialty outpatient clinics, etc.) b. Describe how the organization determined that its network facilities and providers were actively licensed and competent c. Describe who determines which services beneficiaries will receive (e.g., is there a gatekeeper, and if not, how is the beneficiary connected to the appropriate service provider, etc.) d. Describe how the provider network coordinates with the ICT and the beneficiary to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it assures that specialized services are delivered to the beneficiary in a timely and quality way, how reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan, how services are delivered across care settings and providers, etc.) e. Describe how the organization assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols (e.g., review of medical records, pharmacy records, medical specialist reports, audio/video-conferencing to discuss protocols and clinical guidelines, written protocols providers send to the organization's Medical Director for review, etc.) The state has no further requirements beyond those listed above in **Element # 5**	
6. Model of Care Training for Personnel and Provider Network a. Describe how the organization conducted initial and annual model of care training including training strategies and content (e.g., printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, etc.) b. Describe how the organization assures and documents completion of training by the employed and contracted personnel (e.g., attendee lists, results of testing, web-based attendance confirmation, electronic training record, etc.) c. Describe who the organization identified as personnel responsible for oversight of the model of care training d. Describe what actions the organization will take when the required model of care training has not been completed (e.g., contract evaluation mechanism, follow-up communication to personnel/providers, incentives for training completion, etc.) The state has no further requirements beyond those listed above in **Element # 6**. However, state staff may attend MCO staff Model of Care trainings.	
7. Health Risk Assessment a. Describe the health risk assessment tool the organization uses to identify the specialized needs of its beneficiaries (e.g., identifies medical, psychosocial,	

functional, and cognitive needs, medical and mental health history, etc.) b. Describe when and how the initial health risk assessment and annual reassessment is conducted for each beneficiary (e.g., initial assessment upon enrollment, annual reassessment within one year of last assessment; conducted by phone interview, face-to-face, written form completed by beneficiary, etc.) c. Describe the personnel who review, analyze, and stratify health care needs (e.g., professionally knowledgeable and credentialed such as physicians, nurses, restorative therapist, pharmacist, psychologist, etc.) d. Describe the communication mechanism the organization institutes to notify the ICT, provider network, beneficiaries, etc. about the health risk assessment and stratification results (e.g., written notification, secure electronic record, etc.) In addition to the elements described in **Element #7** above, additional state expectations include the following. 1. Describe how the organization will ensure that initial HRAs are conducted for individuals who meet the criteria of a "**Vulnerable Subpopulation**" (as outlined in Element #10(a)) within 60 days of enrollment and for all other enrollees, within 90 days of enrollment. 2. Describe how the organization will ensure that annual reassessments for EDCD waiver participants are performed timely (minimum within one year of the last assessment) and describe the criteria for reassessment resulting from a health status change (the triggering events that precipitate a need for reassessment, including a change in the ability to perform activities of daily living and instrumental activities of daily living). The reassessment will include all the elements on the DMAS 99-C Level of Care (LOC) Review Instrument for individuals who are in the EDCD Waiver who have a change in status (available at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal). LOC reassessments must be performed by providers with the following qualifications: i) a registered nurse licensed in Virginia; ii) a social worker; iii) an individual who holds at least a bachelor's degree in social work or in a human services field, or has at least two years of experience working with individuals who are elderly and/or have disabilities. 3. Describe how the organization will communicate LOC reassessment data to DMAS in a timely manner.	
8. Individualized Care Plan a. Describe which personnel develops the individualized plan of care and how the beneficiary is involved in its development as feasible b. Describe the essential elements incorporated in the plan of care (e.g., results of health risk assessment, goals/objectives, specific services and benefits, outcome measures, preferences for care, add-on benefits and services for vulnerable beneficiaries such as disabled or those near the end-of-life, etc) c. Describe the personnel who review the care plan and how frequently the plan of care is reviewed and revised (e.g., developed by the interdisciplinary care team (ICT), beneficiary whenever feasible, and other pertinent specialists required by the beneficiary's health needs; reviewed and revised	

annually and as a change in health status is identified, etc.)

d. Describe how the plan of care is documented and where the documentation is maintained (e.g., accessible to interdisciplinary team, provider network, and beneficiary either in original form or copies; maintained in accordance with industry practices such as preserved from destruction, secured for privacy and confidentiality, etc.)

e. Describe how the plan of care and any care plan revisions are communicated to the beneficiary, ICT, organization, and pertinent network providers.

In addition to the elements described in **Element # 8** above, additional state expectations include the following.

The MCO shall develop a POC for each individual enrolled in the MCO. The POC will be tailored to individual needs, based on the MCOs method of stratification.

1. Describe the method of stratification, the person-centered and culturally competent POC development process, and how its POC development process will incorporate and not duplicate Targeted Case Management.
2. Describe how information from the Uniform Assessment Instrument and LOC will be incorporated into the plan of care for individuals in the EDCD waiver. [1]
3. Describe the organization's process for obtaining nursing facility MDS data and how it will be incorporated into the POC.
4. Describe how the organization will ensure that individuals in nursing facilities who wish to move to the community will be referred to the Money Follows the Person Program.
5. Describe how the POC will address health, safety (including minimizing risk), and welfare of the participant.

In addition to SNP Model of Care Element 8(b) listed above, describe the process the organization will use to include the following elements in the POC:

a. Prioritized list of concerns, needs, and strengths;
b. Attainable goals and outcome measures with target dates selected by the individual and/or caregiver;
c. Strategies and actions, including interventions and services to be implemented and the person(s)/providers responsible for specific interventions/services and their frequency;
d. Progress noting success, barriers or obstacles;
e. Enrollee's informal support network and services;
f. Back up plans as appropriate (for EDCD Waiver participants using personal care and respite services) in the event that the scheduled provider(s) is unable to provide services;
g. Determined need and plan to access community resources and non-

[1] The UAI may be found at http://www.dss.virginia.gov/files/division/dfs/as/as_intro_page/forms/032-02-0168-01-eng.pdf and the UAI User's Manual may be found at http://www.dss.virginia.gov/files/division/dfs/as/as_intro_page/manuals/uai/manual.pdf. Pre-admission screening criteria is available in the Preadmission Screening manual at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal).

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covered services; h. Enrollee choice of services (including consumer-direction) and service providers; and i. Elements included in the DMAS-97AB form, (which can be downloaded from https://www.virginiamedicaid.dmas.virginia.gov/wps/portal) for individuals enrolled in the EDCD Waiver.	
9. Communication Network a. Describe the organization's structure for a communication network (e.g., web-based network, audio-conferencing, face-to-face meetings, etc.) b. Describe how the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies c. Describe how the organization preserves aspects of communication as evidence of care (e.g., recordings, written minutes, newsletters, interactive web sites, etc.) d. Describe the personnel having oversight responsibility for monitoring and evaluating communication effectiveness In addition to the elements described in **Element #9(a)** above, the MCO shall include how its communication structure will accommodate the needs of individuals with communication impairments (e.g., hearing and vision limitations) and individuals with limited English proficiency.	
10. Care Management for the Most Vulnerable Subpopulations a. Describe how the organization identifies its most vulnerable beneficiaries b. Describe the add-on services and benefits the organization delivers to its most vulnerable beneficiaries For Element 10(a) **"Vulnerable Subpopulations"** shall include, at a minimum: a. Individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver; b. Individuals with intellectual/developmental disabilities; c. Individuals with cognitive or memory problems (e.g., dementia and traumatic brain injury); d. Individuals with physical or sensory disabilities; e. Individuals residing in nursing facilities; f. Individuals with serious and persistent mental illnesses; g. Individuals with end stage renal disease; and h. Individuals with complex or multiple chronic conditions.	
11. Performance and Health Outcome Measurement a. Describe how the organization will collect, analyze, report, and act on to evaluate the model of care (e.g., specific data sources, specific performance and outcome measures, etc.) b. Describe who will collect, analyze, report, and act on data to evaluate the model of care (e.g., internal quality specialists, contracted consultants, etc.) c. Describe how the organization will use the analyzed results of the performance measures to improve the model of care (e.g., internal committee, other structured mechanism, etc.) d. Describe how the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the model of care (e.g.,	

electronic or print copies of its evaluation process, etc.) e. Describe the personnel having oversight responsibility for monitoring and evaluating the model of care effectiveness (e.g., quality assurance specialist, consultant with quality expertise, etc.) f. Describe how the organization will communicate improvements in the model of care to all stakeholders (e.g., a webpage for announcements, printed newsletters, bulletins, announcements, etc.) In addition to the elements described in **Element #11** above, additional state expectations include the following. The following information does not require a separate response from the questions above. The MCO only needs to acknowledge its understanding that additional quality measures and evaluation will be required. **Quality Measurement and Evaluation** Participating plans will be required to report on quality indicators to allow an evaluation of the impact on quality of care for enrollees. The CMS-required Core Quality Performance Measures (as determined) and the EDCD Waiver Performance Measures. MCOs must also adhere to Medicaid managed care regulatory standards in 42 CFR 438.240. **All performance measures are subject to change per final three-way contract terms.** **EDCD Waiver Quality Oversight** MCOs will work with DMAS to monitor elements of the EDCD Waiver quality improvement strategy which must address assurances as required by CMS, including: (i) service plan, (ii) qualified providers, (iii) financial authority, (iv) health, safety, and welfare, and, (v) level of care.	
NOTE TO APPLICANT: THE FOLLOWING ROWS WILL CAPTURE ANY ADDITIONAL MOC ELEMENTS REQUIRED BY THE STATE IN WHICH YOUR MEDICARE-MEDICAID PLAN WILL OPERATE, IF APPLICABLE. CMS WILL NOT REVIEW THESE ADDITIONAL ELEMENTS BUT WILL SHARE THEM WITH THE STATE FOR STATE-ONLY REVIEW. ONLY POPULATE THESE ROWS IF THE STATE IN WHICH YOUR PLAN WILL OPERATE HAS SPECIFICALLY REQUIRED THAT YOUR MOC INCLUDE ADDITIONAL ELEMENTS BEYOND THE 11 ELEMENTS CMS WILL REVIEW.	
12. Additional Element #1: Hospital and Nursing Facility Transition Programs Describe the process, systems, and goals in detail for ensuring smooth transitions to and from hospitals, nursing facilities and the community, including: a. How the MCO will ensure that communication of an admission or discharge will be conveyed to the PCP, care manager and home and community-based providers within 24 hours; b. How the MCO will ensure that admissions and lengths of stay are appropriate to the individual's needs; c. How the MCO will ensure that there is timely and adequate discharge planning and medication reconciliation; d. How the MCO will work to reduce the need for hospital transfers and emergency department use; and, e. How the MCO will work with nursing facility staff (including obtaining MDS Section Q data), hospital staff, and the state Long-Term Care Ombudsman to facilitate transitions to the community. This shall include how individuals are referred to local contact agencies in order to facilitate transitions and are linked with other community resources that provide support to individuals and their families/caregivers, such as Centers for Independent Living, Community	

Services Boards, and local Area Agencies on Aging, and MFP.	
13. Additional Element #2: Enhanced Care Management for Vulnerable Subpopulations The MCO shall describe how it will provide care management functions for ***all*** enrollees. At a minimum, all enrollees shall have access to the following supports: 1. A single, toll-free point of contact for all questions; 2. Develop, maintain and monitor the POC; 3. Assurance that referrals result in timely appointments; 4. Communication and education regarding available services and community resources; and, 5. Assistance developing self-management skills to effectively access and use services. **Enhanced Care Management for Vulnerable Subpopulations** All individual's identified as a "Vulnerable Subpopulation" as described in **Element # 10(a)** must, at a minimum, receive Enhanced Care Management services. Describe how the organization will ensure that the following activities will be performed: 1. Ensure that individuals receive needed medical and behavioral health services, preventative services, medications, LTSS, social services and enhanced benefits; this includes setting up appointments, in-person contacts as appropriate, strong working relationships between care managers and physicians; evidence-based patient education programs, and arranging transportation as needed; 2. Monitor functional and health status; 3. Ensure seamless transitions of care across specialties and settings; 4. Ensure that individuals with disabilities have effective communication with health care providers and participate in making decisions with respect to treatment options; 5. Connect individuals to services that promote community living and help avoid premature or unnecessary nursing facility placements; 6. Coordinate with social service agencies (e.g. local departments of health, social services, and Community Services Boards) and refer enrollees to state, local, and other community resources; and, 7. Work with nursing facilities to include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the NF benefit.	
14. Additional Element #3: Partnering with Community Care Management Providers Describe any innovative arrangements the MCO will use to provide care management. MCOs are encouraged to partner and/or contract with entities that currently perform care management and offer support services to individuals eligible for the Demonstration. This flexibility includes the use of innovations such as health homes, sub-capitation, shared savings, and performance incentives. Entities can include, but are not limited to Community Services Boards (CSBs), adult day care centers, and nursing facilities.	