Model of Care Matrix Upload Document

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Care Management Plan Outlining the Model of Care		
In the following table, list the page number and section of the corresponding revision in your model of care for each model of care element. Enter N/A in the MOC Elements sections that are not revised.		

Model of Care Elements	Corresponding Document Page Number/Section
1. Description of the MMP Population:	
A. Description of the Overall MMP Population. The identification and comprehensive description of the MMP-specific population is an integral component of the MOC because all of the other elements depend on the firm foundation of a comprehensive population description. The organization must provide information about its local target population in the service areas covered under the contract. Information about national population statistics is insufficient. It must provide an overview that fully addresses the full continuum of care of current and potential MMP beneficiaries, including end-of-life needs and considerations, if relevant to the target population served by the MMP. Specific to South Carolina's Dual Eligible (SCDuE) Demonstration, the state defines the target population asfollows: o Full benefit dual eligible (Medicare-Medicaid) o 65 years of age and older o Non-institutional [including all home and community-based services (HCBS) waivers] at time of enrollment o No exclusions based on diagnosis or condition(s) o Excludes Program of All-Inclusive Care for the Elderly (PACE) participants The description of the MMP population must include, but not be limited to, the following:	
☐ Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of MMP beneficiaries.	
☐ A detailed profile of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with the MMP population in the plan's geographic service area.	
☐ Identification and description of the health conditions impacting MMP beneficiaries, including specific information about other characteristics that affect health such as, population demographics (e.g. average age, gender, ethnicity, and potential health disparities associated with specific groups such as: language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other).	
☐ Define unique characteristics for the MMP population served: What are the unique health needs for beneficiaries enrolled in an MMP? Include limitations and barriers that pose potential challenges for MMP beneficiaries.	

B. Sub-Population: Most Vulnerable Beneficiaries:
As an MMP, you must include a complete description of the specially-tailored services for beneficiaries considered especially vulnerable using specific terms and details (e.g., members with multiple hospital admissions within three months, "medication spending above $4,000"). The description must differentiate between the general MMP population and that of the most vulnerable members, as well as detail additional benefits above and beyond those available to general MMP members. Other information specific to the description of the most vulnerable beneficiaries must include, but not be limited to, the following:

☐ A description of the internal health plan procedures for identifying the most vulnerable beneficiaries within the MMP.	
☐ A description of the relationship between the demographic characteristics of the most vulnerable beneficiaries with their unique clinical requirements. Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factor(s) affect the health outcomes of the most vulnerable beneficiaries.	
☐ The identification and description of the established partnerships with community organizations that assist in identifying resources for the most vulnerable beneficiaries, including the process that is used to support continuity of community partnerships and facilitate access to community services by the most vulnerable beneficiaries and/or their caregiver(s).	

2. Care Coordination:

Care coordination helps ensure that MMP beneficiaries' healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the MMP's provider network as well as the care coordination roles and responsibilities overseen by the beneficiaries' caregiver(s). The following MOC sub-elements are essential components to consider in the development of a comprehensive care coordination program; no sub-element must be interpreted as being of greater importance than any other. All five sub-elements below, taken together, must comprehensively address the MMPs' care coordination activities.

A. MMP Staff Structure
Fully define the MMP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of beneficiaries enrolled in the MMP. This includes, but is not limited to, identification and detailed explanation of:

☐ Specific employed and/or contracted staff responsible for performing administrative functions, such as: enrollment and eligibility verification, claims verification and processing, other.	
☐ Employed and/or contracted staff that perform clinical functions, such as: direct beneficiary care and education on self-management techniques, care coordination, pharmacy consultation, behavioral health counseling, other.	
☐ Employed and/or contracted staff that performs administrative and clinical oversight functions, such as: license and competency verification, data analyses to ensure appropriate and timely healthcare services, utilization review, ensuring that providers use appropriate clinical practice guidelines and integrate care transitions protocols.	

□ Provide a copy of the MMP's organizational chart that shows how staff responsibilities identified in the MOC are coordinated with job titles. If applicable, include a description of any instances when a change to staff title/position or level of accountability was required to accommodate operational changes in the MMP.	
□ Identify the MMP contingency plan(s) used to ensure ongoing continuity of critical staff functions.	
□ Describe how the MMP conducts initial and annual MOC training for its employed and contracted staff, which may include, but not be limited to, printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing.	
□ Describe how the MMP documents and maintains training records as evidence to ensure MOC training provided to its employed and contracted staff was completed. For example, documentation may include, but is not limited to: copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, and electronic training records.	
□ Explain any challenges associated with the completion of MOC training for MMP employed and contracted staff and describe what specific actions the MMP will take when the required MOC training has not been completed or has been found to be deficient in some way.	
B. Health Risk Assessment Tool (HRAT) The quality and content of the HRAT should identify the medical, functional, cognitive, psychosocial and mental health needs of each MMP beneficiary. The content of, and methods used to conduct the HRAT have a direct effect on the development of the Individualized Care Plan and ongoing coordination of Interdisciplinary Care Team activities; therefore, it is imperative that the MOC include the following:	
□ A clear and detailed description of the policies and procedures for completing the HRAT including:	
▪ Description of how the HRAT is used to develop and update, in a timely manner, the Individualized Care Plan (MOC Element 2C) for each beneficiary and how the HRAT information is disseminated to and used by the Interdisciplinary Care Team (MOC Element 2D).	
▪ Detailed explanation for how the initial HRAT and annual reassessment are conducted for each beneficiary.	
▪ Detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable) the results of the HRAT, including the mechanisms to ensure communication of that information to the Interdisciplinary Care Team, provider network, beneficiaries and/or their caregiver(s), as well as other MMP personnel that may be involved with overseeing the MMP beneficiary's plan of care. If stratified results are used, include a detailed description of how the MMP uses the stratified results to improve the care coordination process.	
C. Individualized Care Plan (ICP)	

□ The ICP components must include, but are not limited to: beneficiary self-management goals and objectives; the beneficiary's personal healthcare preferences; description of services specifically tailored to the beneficiary's needs; roles of the beneficiaries' caregiver(s); and identification of goals met or not met.	
▪ When the beneficiary's goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions.	
□ Explain the process and which MMP personnel are responsible for the development of the ICP, how the beneficiary and/or his/her caregiver(s) or representative(s) is involved in its development and how often the ICP is reviewed and modified as the beneficiary's healthcare needs change. If a stratification model is used for determining MMP beneficiaries' health care needs, then each MMP must provide a detailed explanation of how the stratification results are incorporated into each beneficiary's ICP.	
□ Describe how the ICP is documented and updated as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, beneficiary and/or caregiver(s).	
□ Explain how updates and/or modifications to the ICP are communicated to the beneficiary and/or their caregiver(s), the ICT, applicable network providers, other MMP personnel and other stakeholders as necessary.	
D. Interdisciplinary Care Team (ICT)	
□ Provide a detailed and comprehensive description of the composition of the ICT; include how the MMP determines ICT membership and a description of the roles and responsibilities of each member. Specify how the expertise and capabilities of the ICT members align with the identified clinical and social needs of the MMP beneficiaries, and how the ICT members contribute to improving the health status of MMP beneficiaries. If a stratification model is used for determining MMP beneficiaries' health care needs, then each MMP must provide a detailed explanation of how the stratification results are used to determine the composition of the ICT.	
▪ Describe how the beneficiary's HRAT (MOC Element 2B) and ICP (MOC Element 2C) are used to determine the composition of the ICT; including those cases where additional team members are needed to meet the unique needs of the individual beneficiary.	
▪ Explain how the ICT uses healthcare outcomes to evaluate established processes to manage changes and/or adjustments to the beneficiary's health care needs on a continuous basis.	
□ Identify and explain the use of clinical managers, case managers or others who play critical roles in ensuring an effective interdisciplinary care process is being conducted.	
□ Provide a clear and comprehensive description of the MMP's communication plan that ensures exchanges of beneficiary information is occurring regularly within the ICT, including not be limited to, the following:	

▪ Clear evidence of an established communication plan that is overseen by MMP personnel who are knowledgeable and connected to multiple facets of the MMP MOC. Explain how the MMP maintains effective and ongoing communication between MMP personnel, the ICT, beneficiaries, caregiver(s), community organizations and other stakeholders.	
▪ The types of evidence used to verify that communications have taken place, e.g., written ICT meeting minutes, documentation in the ICP, other.	
▪ How communication is conducted with beneficiaries who have hearing impairments, language barriers and/or cognitive deficiencies.	
E. Care Transitions Protocols	
□ Explain how care transitions protocols are used to maintain continuity of care for MMP beneficiaries. Provide details and specify the process and rationale for connecting the beneficiary to the appropriate provider(s).	
□ Describe which personnel (e.g., case manager) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MOC Element 2A.	
□ Explain how the MMP ensures elements of the beneficiary's ICP are transferred between healthcare settings when the beneficiary experiences an applicable transition in care. This must include the steps that need to take place before, during and after a transition in care has occurred.	
□ Describe, in detail, the process for ensuring the MMP beneficiary and/or caregiver(s) have access to and can adequately utilize the beneficiaries' personal health information to facilitate communication between the MMP beneficiary and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network.	
□ Describe how the beneficiary and/or caregiver(s) will be educated about indicators that his/her condition has improved or worsened and how they will demonstrate their understanding of those indicators and appropriate self-management activities.	
□ Describe how the beneficiary and/or caregiver(s) are informed about who their point of contact is throughout the transition process.	

3. MMP Provider Network:

The MMP Provider Network is a network of healthcare providers who are contracted to provide health care services to MMP beneficiaries. The MMP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized health care needs of the target population as identified in MOC 1, and provide oversight information for all of its network types. Each MMP is responsible for ensuring their MOC identifies, fully describes, and implements the following for its MMP Provider Network:

A. Specialized Expertise

□ Provide a complete and detailed description of the specialized expertise available to MMP beneficiaries in the MMP provider network that corresponds to the MMP population identified in MOC Element 1.	
□ Explain how the MMP oversees its provider network facilities and ensures its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to MMP beneficiaries. Specialized expertise may include, but is not limited to: internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists, other.	
□ Describe how providers collaborate with the ICT (MOC Element 2D) and the beneficiary, contribute to the ICP (MOC Element 2C) and ensure the delivery of necessary specialized services. For example, describe: how providers communicate MMP beneficiaries' care needs to the ICT and other stakeholders; how specialized services are delivered to the MMP beneficiary in a timely and effective way; and how reports regarding services rendered are shared with the ICT and how relevant information is incorporated into the ICP.	
B. Use of Clinical Practice Guidelines & Care Transitions Protocols	
□ Explain the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols. This may include, but is not limited to: use of electronic databases, web technology, and manual medical record review to ensure appropriate documentation.	
□ Define any challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable MMP beneficiaries. Provide details regarding how these decisions are made, incorporated into the ICP (MOC Element 2C), communicated with the ICT (MOC Element 2D) and acted upon.	
□ Explain how MMP providers ensure care transitions protocols are being used to maintain continuity of care for the MMP beneficiary as outlined in MOC Element 2E.	
C. MOC Training for the Provider Network	
□ Explain, in detail, how the MMP conducts initial and annual MOC training for network providers and out-of-network providers seen by beneficiaries on a routine basis. This could include, but not be limited to: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the MMP plans' website.	
□ Describe how the MMP documents and maintains training records as evidence of MOC training for their network providers. Documentation may include, but is not limited to: copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, electronic training records, and physician attestation of MOC training.	
□ Explain any challenges associated with the completion of MOC training for network providers and describe what specific actions the MMP Plan will take when the required MOC training has not been completed or is found to be deficient in some way.	

4. MOC Quality Measurement & Performance Improvement:

The goals of performance improvement and quality measurement are to improve the MMP's ability to deliver healthcare services and benefits to its MMP beneficiaries in a high-quality manner. Achievement of those goals may result from increased organizational effectiveness and efficiency by incorporating quality measurement and performance improvement concepts used to drive organizational change. The leadership, managers and governing body of a MMP organization must have a comprehensive quality improvement program in place to measure its current level of performance and determine if organizational systems and processes must be modified based on performance results.

A. MOC Quality Performance Improvement Plan	
□ Explain, in detail, the quality performance improvement plan and how it ensures that appropriate services are being delivered to MMP beneficiaries. The quality performance improvement plan must be designed to detect whether the overall MOC structure effectively accommodates beneficiaries' unique healthcare needs. The description must include, but is not limited to, the following:	
▪ The complete process, by which the MMP continuously collects, analyzes, evaluates and reports on quality performance based on the MOC by using specified data sources, performance and outcome measures. The MOC must also describe the frequency of these activities.	
▪ Details regarding how the MMP leadership, management groups and other MMP personnel and stakeholders are involved with the internal quality performance process.	
▪ Details regarding how the MMP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan (MOC Element 4B).	
▪ Process it uses or intends to use to determine if goals/outcomes are met, there must be specific benchmarks and timeframes, and must specify the re-measurement plan for goals not achieved.	
B. Measureable Goals & Health Outcomes for the MOC	
□ Identify and clearly define the MMP's measureable goals and health outcomes and describe how identified measureable goals and health outcomes are communicated throughout the MMP organization. Responses must include but not be limited to, the following:	
▪ Specific goals for improving access and affordability of the healthcare needs outlined for the MMP population described in MOC Element 1.	
▪ Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT.	
▪ Enhancing care transitions across all healthcare settings and providers for MMP beneficiaries.	

▪ Ensuring appropriate utilization of services for preventive health and chronic conditions.	
□ Identify the specific beneficiary health outcomes measures that will be used to measure overall MMP population health outcomes, including the specific data source(s) that will be used.	
□ Describe, in detail, how the MMP establishes methods to assess and track the MOC's impact on the MMP beneficiaries' health outcomes.	
□ Describe, in detail, the processes and procedures the MMP will use to determine if the health outcomes goals are met or not met.	
□ Explain the specific steps the MMP will take if goals are not met in the expected time frame.	
C. Measuring Patient Experience of Care (MMP Member Satisfaction)	
□ Describe the specific MMP survey(s) used and the rationale for selection of that particular tool(s) to measure MMP beneficiary satisfaction.	
□ Explain how the results of MMP member satisfaction surveys are integrated into the overall MOC performance improvement plan, including specific steps to be taken by the MMP to address issues identified in response to survey results.	
D. Ongoing Performance Improvement Evaluation of the MOC	
□ Explain, in detail, how the MMP will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC, including how quality will be continuously assessed and evaluated.	
□ Describe the MMP's ability to improve, on a timely basis, mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation process.	
□ Describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.	
E. Dissemination of MMP Quality Performance related to the MOC	
□ Explain, in detail, how the MMP communicates its quality improvement performance results and other pertinent information to its multiple stakeholders, which may include, but not be limited to: MMP leadership, MMP management groups, MMP boards of directors, MMP personnel & staff, MMP provider networks, MMP beneficiaries and caregivers, the general public, and regulatory agencies on a routine basis.	
□ This description must include, but is not limited to, the scheduled frequency of communications and the methods for ad hoc communication with the various stakeholders, such as: a webpage for announcements; printed newsletters; bulletins; and other announcement mechanisms.	
□ Identify the individual(s) responsible for communicating performance updates in a timely manner as described in MOC Element 2A.	

NOTE: The following rows will capture any additional MOC elements required by the state in which your Medicare-Medicaid plan will operate, if applicable. **All participating organizations should meet the state and CMS requirements with one unified strategy for coordinating, providing, and monitoring beneficiaries' care. However, all information specific to the South Carolina demonstration should be located at the end of the document. Ensure that state reviewers can review this state-specific appendix without referencing the main MOC document. As such, information or brief sections from the main body of the MOC may be summarized or repeated as appropriate. The separation of the CMS and State requirements into different sections of the model of care document is meant only to expedite state review and should not affect the organization's ability to design or implement an integrated model of care.**	
2A. Staff Structure Identify and clarify care management roles of the employed or contracted staff of the organization and Patient-Centered Medical Home (PCMH) performing 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.).	
2B: Health Risk Assessment Tool (HRAT) Describe how the organization's assessment process, including both the initial assessment and regular updates, will interface with waiver assessments to identify potential HCBS/LTC service needs.	
2C: Individualized Care Plan Describe how the caregiver (e.g., family) is involved in the development of the plan of care.	
Describe specific transitional care services and/or directions incorporated in the plan of care.	
2D: Interdisciplinary Care Team Describe how reports on services delivered are shared with the care coordinator.	
Describe how the organization will facilitate the participation of the caregiver (e.g., family) as requested and/or needed.	
3A: Provider Network Describe the specialized expertise of geriatricians in the organization's provider network that corresponds to the target population.	
Specialized Expertise Describe how the organization will ensure PCMHs provide integrated care to this population and how the organization will work with those practices in the application phase to promote the development of recognized PCMHs.	
3C: MOC Training for the Provider Network Describe how the organization's model of care training will be coordinated with the state to ensure the following: • Consistent training related to integration of LTC Specialist/Waiver Case Manager in ICT;	
• Appropriate referrals to HCBS; and	
• Utilization of the state's LTC electronic care management system (i.e., Phoenix/Care Call) to ensure seamless entry and integration of HCBS into the plan of care and ICT.	

4B: Measureable Goals & Health Outcomes for the MOC Describe the organization's specific goals for improving access to long- term services and supports (LTSS).	
Describe the specific goals for assuring the appropriate utilization of LTSS. Within your description please address the following components: • Appropriate referrals to and coordination with HCBS;	
• Preventing and/or delaying avoidable admissions into nursing facilities or hospitals; and	
• Shortening the length of stay for nursing facilities or hospitals.	
Additional State Element #1 - Patient Centered Medical Home (PCMH) • Describe how the organization will ensure PCMHs provide integrated care to this population.	
• Describe specifically how the organization will support and monitor progress toward initiation and completion of the National Committee for Quality Assurance (NQCA) PCMH Recognition process for its provider network.	
Additional State Element #2 Describe how the organization would incorporate use of the state's existing LTC electronic care management system (Phoenix/Care Call) into care coordination and clinical management functions for beneficiaries needing and/or receiving HCBS.	
Additional State Element #3 Describe how the organization integrates the State Medicaid Agency in its communication network.	