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Provider Model of Care Training

2025

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Model of Care Training

- This course is offered to meet The Centers for Medicare and Medicaid (CMS) regulatory requirements for Model of Care (MOC) Training for our Special Needs Plan.

- It also ensures all employees and providers who work with our Special Needs Plan members have the specialized training that the Dual Special Needs Plan (DSNP) population requires.

- The MOC is Alterwood Advantage's documentation for the CMS requirement of delivering coordinated care and case management to its members within a DSNP plan.

- CMS requires all Alterwood Advantage staff and contracted medical providers to receive basic training about Alterwood Advantage's MOC.

- This course will describe how Alterwood Advantage and its contracted providers work together to successfully deliver the DSNP MOC program.

Training Objectives

After the training, attendees will be able to:

- Describe the basic components of the Alterwood Advantage MOC.
- Explain how medical management staff coordinates care for dual eligible members.
- Describe the essential role of providers in the implementation of the MOC program.
- Explain the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT).

Special Needs Plans (SNPs)

- Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs. CMS has defined three types of SNPs that serve the following types of members:
  - **Dually eligible members with both Medicare and Medicaid (D-SNP)**
  - Individuals with chronic conditions (C-SNP)
  - Individuals who are institutionalized or eligible for nursing home care (I-SNP)

- Health plans may contract with CMS for one or more programs. Under the SNP plan options, Alterwood Advantage offers health plan options for the D-SNP population.

- For D-SNP members, Medicare is always the primary payer and Medicaid is secondary payer.

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What is the SNP Model of Care (MOC)?

- The SNP MOC is the plan for delivering case management and services for members with special needs. It sets guidelines for:
  - Staff structure and care management roles
  - The interdisciplinary care team
  - Provider network having special expertise and use of Clinical Practice Guidelines
  - A member health risk assessment (HRA)
  - Annual face to face visit with a care team provider
  - Assessment and case management of members
  - Communication among members, caregivers, and providers
  - Integration of the primary care physician (PCP)
  - Model of Care training
  - Measurable program goals

What are the SNP MOC Goals?

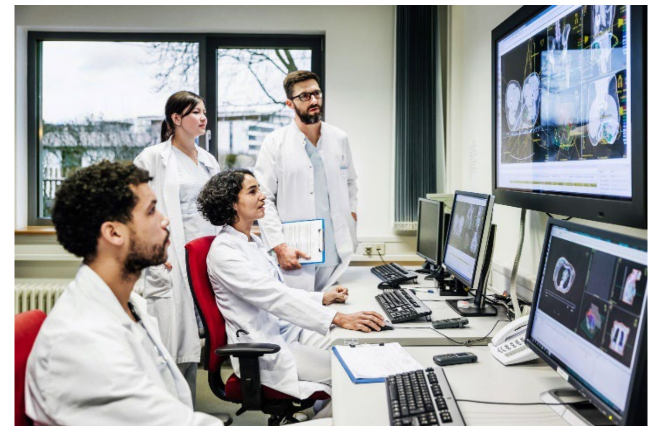
The SNP MOC Goals for our members fall into six categories:

1. Improve access to medical, mental health, and social services
2. Improve coordination of care through an identified point of contact
3. Improve transitions of care across health care settings and practitioners
4. Improve access to affordable care and preventative health services
5. Assure appropriate utilization of services
6. Improve member health outcomes

Interdisciplinary Care Team Goals

The goals of the MOC are achieved by the coordinated efforts of the Interdisciplinary Care Team (ICT).

- The ICT, together with input from the member, collaborates to develop and update their individualized care plan.
- The team manages the medical, cognitive, psychosocial and functional needs of the member.
- The team communicates on the coordination of the care plans. The care plan is available to member and provider on the portal – can be mailed or faxed upon request.
- Through the team, problems/opportunities can be identified, and possible resolutions can be presented to assist the member in achieving solutions to health or care issues.

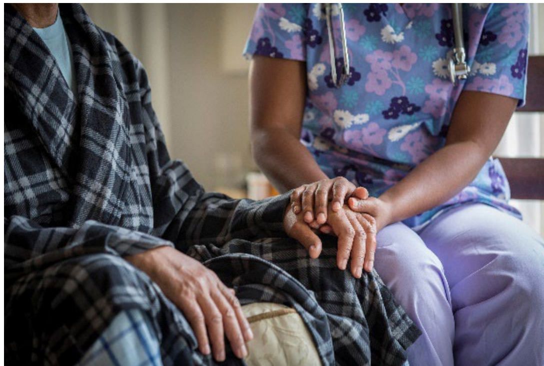


ICT Functions

- Support care planning, implementation, and monitoring of the individualized care plan (ICP)
- Assessment and management of the medical, cognitive, psychosocial and functional needs of the member
- Regular monitoring of the patient’s health status, needs, and services
- Manage and revise the ICP based on changes in the member’s status or progress toward the goals; ICT plays a critical role in ensuring the member’s desired health outcomes are met.
- Data collection and analysis of program goals
- Regular care coordination and case roundtable meetings to discuss healthcare needs of members requiring care coordination.
- ICT members include: The member/primary care giver, nurses, physicians, pharmacists, licensed clinical social workers and health coordinators. Additional health care disciplines may be included as appropriate.

Alterwood Advantage works to support and collaborate with our providers and members with the goal of moving our members toward their optimal health status.

How does our SNP MOC operate?



- Every SNP member is evaluated annually with a Health Risk Assessment (HRA)
- An Alterwood Advantage case manager develops an individualized care plan (ICP) with input from the member, the member's interdisciplinary care team (ICT) and the member's caregiver/family
- Case managers and the PCPs work closely together to monitor the ICP
- ICPs are made available to ICT members via portal (can be sent via mail/fax per request)

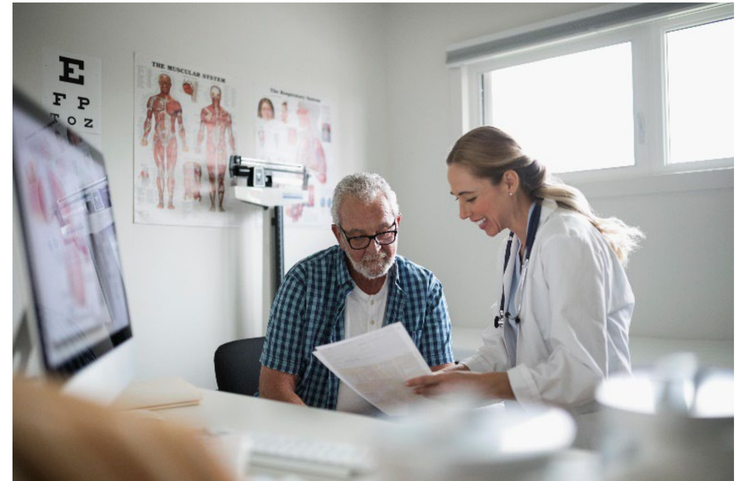
Role of the Provider in the ICT

Provider responsibilities include:

- Collaborating and actively communicating with:
  - Alterwood Advantage case managers
  - Members of the Interdisciplinary Care Team (ICT)
  - Members and caregivers

- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record when received

- Facilitating and completing annual face to face visits/encounters to enable a full assessment of the member and their immediate environment.
  - The intended outcome is more comprehensive care planning.
  - Face-to-face encounters can provide a timely opportunity for real time clinical intervention.
  - They also result in more immediate intervention if there is a need due to concerns about the member's safety and wellbeing.



Face to Face Visit/Encounter Components

The face-to-face visit may include any of the following components:

- Vital signs and any other routine measurements as deemed appropriate
- Medical and family history including a list of risk factors and conditions for which interventions are recommended including mental health and cognitive impairment
- Review of the individual's potential for depression, including current or past experiences with depression or other mood disorders, based on the use of appropriate screening tools.
- Review of the individual's functional ability and level of safety, based on direct observation or the use of appropriate screening tools
- Health education, preventive counseling, and review of health screenings schedule
- Review of medication and medication reconciliation, including review of opioids and risk factors for substance abuse
- Assessment of communication needs, demographic data, self-assessment of health status, frailty, physical functioning, psychosocial risk, behavioral risks, activities of daily living, instrumental activities of daily living, and pain, along with treatment plans
- Review of HRAT and resulting ICP, if completed

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Face to Face Visit/Encounter Outcomes

During the face-to-face encounter, the provider is expected to analyze the member's responses to the assessments and physical evaluation, address findings, and identify opportunities for member education.

Examples may include, but are not limited to, the following:

- Review medications and provide resources/education
- Review health conditions and provide resources/education
- Identify care gaps and provide resources/education
- Identify needs based on social determinants of health and provide resources/education
- Identify barriers to health management and provide resources/education
- Referrals to appropriate specialists
- Review of adherence to and modification of treatment plan

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CMS Expectations for ICT

CMS expects the following related to the ICT:

- All care is per member preference
- Family members and caregivers are included in health care decisions as the member desires
- There is continual communication between all members of the ICT regarding the member's plan of care
- All team meetings/communications are documented and stored
- All team members are involved and informed in the coordination of care for the member
- All team members must be advised on the ICT program metrics and outcomes

All internal and external ICT members are trained annually on the current Model of Care.

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Provider Network

Alterwood Advantage is responsible for maintaining a specialized provider network that corresponds to the needs of our members.

Alterwood Health coordinates care and ensures that providers:

- Collaborate with the Interdisciplinary Care Team
- Provide clinical consultation
- Assist with developing and updating care plans
- Provide pharmacotherapy consultation
- Facilitate and complete annual face to face visits/encounters

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Alterwood Advantage's Case Management Programs

Identification for Care Management	Identification of Member Needs	Case Management Programs
• Inpatient Status • HRA • Risk Stratification • Community Referrals • Physician/Specialist Referrals	• Comprehensive Health Assessments • Individualized Care Plan (ICP)	• Care Transitions • Care Coordination • Pharmacy Medication Therapy Management • Gaps in Care • Health Education/Wellness • Referrals/Community Resources

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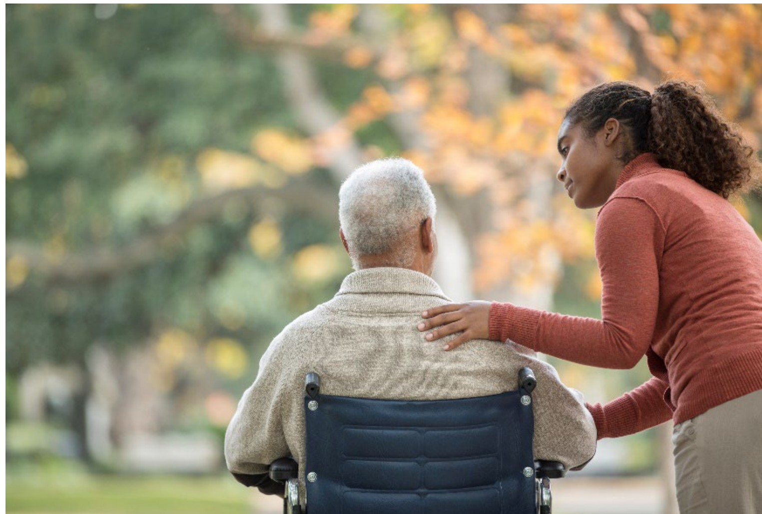
Individualized Care Plan (ICP)

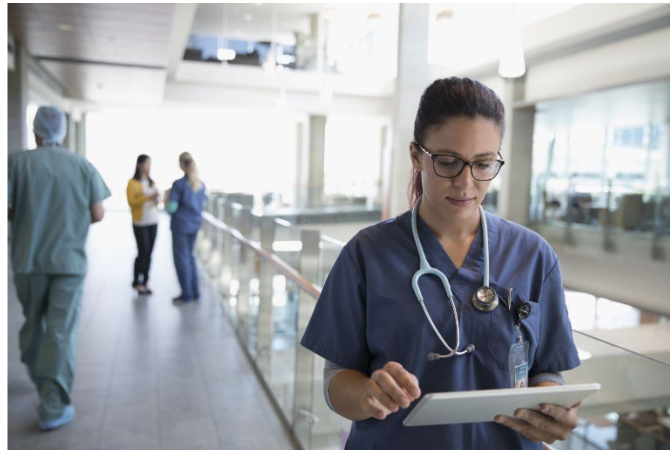
- The individualized care plan is the initial and ongoing mechanism of evaluating the member's current health status and formulating an action plan to address care needs and gaps in care in conjunction with the ICT and member.
- The individualized care plan is re-evaluated on a regular basis or if the member's health status has a substantial change, such as hospitalization.



Care Transitions

Alterwood's Utilization and Case Management teams:

- Coordinate with the hospital interdisciplinary team to ensure a smooth transition through the continuum of care.
- Identify and facilitate discharge planning and transition of care needs and barriers
  - IE: Setting up home health, delivery of DME, delivery of healthy meals, additional benefits available, etc
- Assist with scheduling post-acute/SNF follow-up appointments
- Ensure communication continuity with PCP



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How Do We Know If We Achieved Our Goals?

Monitoring of :

- Provider network, appointment availability, and provider engagement
- Reduction in hospitalizations, ED usage and SNF placements
- Improvement in transition of care metrics
  - Discharge follow-up
  - Medication reconciliation
- Increase in medication adherence rates
- Improvement in member reported self-management and independence
- Improving member quality of life and satisfaction with health services and health status
- Reduction in the number of outstanding care gaps
- HRA completion and member engagement with Alterwood’s case management services

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Our Mission

Alterwood Advantage's mission is to optimize our members' health and well-being. Our compassion and integrity drive change for enhanced quality as well as accessible and affordable care. Our partnerships with network providers and community resources build healthier populations.

You have NOT completed the training until you have attested HERE. Please be sure to click through and complete the 2025 Model of Care Attestation.

Thank you for being a valued Alterwood Advantage provider.

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