South Country HEALTH ALLIANCE

South Country Health Alliance Model of Care

Model of Care

Description

In accordance with Minnesota and federal managed care requirements, South Country maintains comprehensive Model of Care (MOC) programs: Fully Integrated Dual Eligible Special Needs Plan (SNP) SeniorCare Complete (MSHO, H2419) and Highly Integrated Dual Eligible SNP AbilityCare (SNBC, H5703). The MOC follows the National Committee for Quality Assurance (NCQA) standards and ensures that all SNP members receive initial and ongoing health risk assessments (HRAs), as well as an individualized care plan (ICP) to encourage the early identification of member health status, member choice, goal setting, and allow coordinated care to improve their overall health. SNP members receive care transition services as part of care coordination.

In February 2020, South Country submitted our MOCs to CMS for calendar years 2021, 2022 and 2023 for both SeniorCare Complete and AbilityCare. On Monday, April 13, 2020, we received confirmation that our MOCs were accepted, and we received the maximum of a three-year approval for both contracts.

Multiple departments at South Country contribute to the development, monitoring and training of the Model of Care as described in its four primary sections:

- Description of the SNP Population;
- Care Coordination;
- SNP Provider Network; and
- Quality Measurement and Performance Improvement.

Process

Underlying the SeniorCare Complete and AbilityCare program philosophies is a care coordination model driven by a member-centered, interdisciplinary care team (ICT) approach, of which the member, and their family or authorized representative, if applicable, is an integral participant. The ICT is focused on the member's needs, strengths, abilities, choices, and preferences for care, and is responsible for developing strategies in collaboration with the member's primary care provider(s), other health care providers, and in partnership with the member's care coordinator to meet the member's wishes and needs, with the result of better health outcomes. South Country primarily utilizes county-based care coordinators to provide the overall care coordination of the member's needs due to their wealth

of experience with service coordination and knowledge of the additional local resources and services available within the community.

The health risk assessment (HRA) is performed face-to-face in the community at a location of the member's choice. Due to the COVID-19 pandemic, HRAs were allowed to be completed by phone or video visit based on waivers and accommodations both from the Minnesota Department of Human Services (MN DHS) and CMS, but face-to-face assessments still occurred. This process continued into 2022. The health risk assessment tool utilized is either the Long-Term Care Consultation tool developed by the state of Minnesota, South Country's health risk assessment, or the skilled nursing facility (SNF) health risk assessment tool. Initial HRAs are completed within 30 days of the member enrolling onto SeniorCare Complete or AbilityCare. Reassessments are completed annually (no more than 365 days) from the member's previous HRA.

Members have the choice to complete the HRA. If a member refuses to complete the HRA, they continue to have an assigned care coordinator. The care coordinator will reach out to the member at least annually, within 365 days of enrollment or a completed HRA, for any hospitalization, or any changes in the member's utilization patterns.

At times, members are also unable to be reached. Care coordinators complete four attempts to reach the member. Typically, there are three phone calls and one unable to reach letter sent to the member. If the member is unable to be reached, they continue to have a care coordinator assigned to help them. The care coordinator will reach out to the member at least annually, within 365 days of enrollment or a completed HRA, for any hospitalization, or any changes in the member's utilization patterns.

South Country uses our electronic-based care plan in the South Country Care Plan Application for all products and programs, except members residing in the nursing home. The care plan in the Care Plan Application was built off the Collaborative Care Plan (CCP). The CCP has been approved by the Minnesota Department of Human Services (MN DHS) and is utilized by multiple health plans across the state. The care plans for members residing in the nursing home are completed in our electronic documentation system, TruCare. The individualized care plan is developed using evidence-based practice guidelines, is driven by the member, and incorporates the philosophy of person-centered planning. The written care plan is shared with the member and the member's ICT.

South Country's Model of Care/Care Coordination Workgroup is a subcommittee of the Public Health & Human Services Advisory Committee. The Model of

Care/Care Coordination Workgroup serves as a resource for the evaluation of policies and procedures of South Country's care coordination program. The workgroup reviews and implements the Model of Care for SeniorCare Complete, AbilityCare, MN DHS care coordination requirements and federal requirements. The primary responsibility of the group includes:

- Collaborating with South Country on the care coordination program design, changes, and ongoing review of processes;
- Recommending changes or improvement suggestions to South Country;
- Providing general feedback on the operations of South Country's care coordination program; and
- Bringing forward any county questions, concerns, and issues for discussion as they relate to the South Country Care Coordination Program.

The workgroup is made up of participants from each county with a variety of positions including a director of human services, supervisors, and care coordinators. South Country has individuals from the community engagement team, compliance team, and health services team present with a variety of positions including the director of community engagement, care systems managers, and the regulatory audit manager.

The overarching goals for South Country's Model of Care for both SeniorCare Complete and AbilityCare are listed below. We have multiple measures within each overarching goal to work on.

- Improve the ease of navigating the clinical and social system for the member and assure that the member has access to the right service, at the right time, from the right provider, and that it is affordable.

- Assure that members receive care and services from a system that is seamless for members across health care settings, providers and county health and social services.

South Country has a well-established MOC training plan for employees, county, and care system staff. Video training was completed due to COVID-19 pandemic restrictions for our annual care coordination conference in August of 2022. The annual care coordination conferences are attended by care coordinators, community care connectors, supervisors, and case aides who work with SeniorCare Complete and AbilityCare members. After the annual care coordination conferences, South Country cross-referenced the individuals who attended the annual training to the care coordinators who have access to TruCare. Any care coordinators who have SeniorCare Complete or AbilityCare

members on their caseload were provided with a one-page training document to review and an attestation to sign.

Internal South Country staff who interact with AbilityCare or SeniorCare Complete members review written MOC training materials each year and attest to their understanding of South Country's MOC. Written MOC materials are also shared with stakeholders and providers.

Analysis

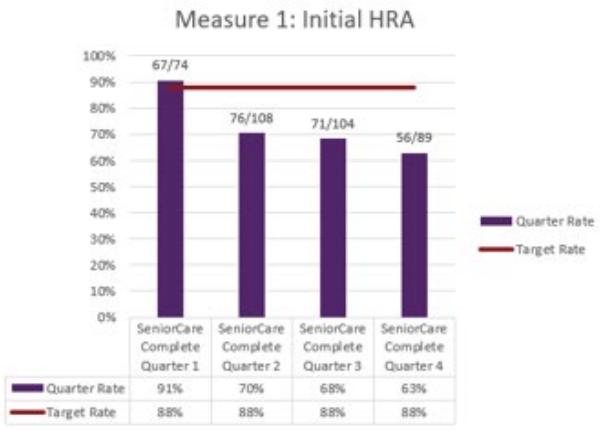
The current measurement period for the MOC analysis is January 1, 2022 – December 31, 2022, and utilizes data sources from TruCare, South Country's data warehouse, and South Country's BI Server reporting module.

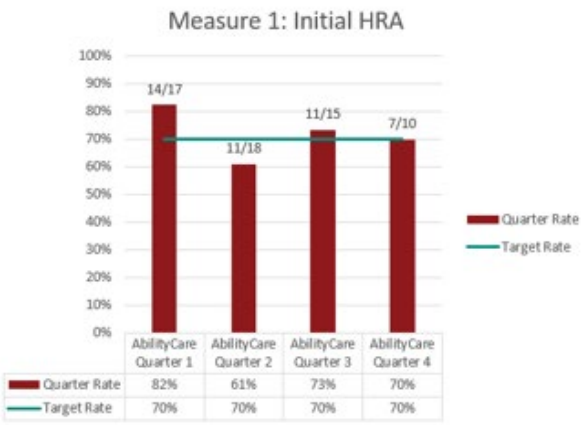
MOC goals and measurable outcomes are reviewed at least quarterly by the community engagement team and reported to South Country's Quality Assurance Committee (QAC) twice a year. The tables below show the measurable outcomes and processes used to evaluate the MOC goals. The data and analysis below review the second year of data for the 2021-2023 MOC.

Goal 1: Improve the ease of navigating the clinical and social system for the member and assure that the member has access to the right service, at the right time, from the right provider, and that it is affordable.

Members will receive integrated care coordination and service accessibility including preventive health services and comprehensive coordination of all services to meet their needs and wants across the continuum: social services, public health, medical and other community services. A health risk assessment will be completed, and an individual care plan will be developed collaboratively by the care coordinator and the enrollee, if the enrollee is willing, with input from the enrollee's interdisciplinary care team.

Measure 1: The percentage of enrollees who have a completed an initial health risk assessment within 30 days of enrollment.
SeniorCare Complete Annual Target Rate: 88%
AbilityCare Annual Target Rate: 70%



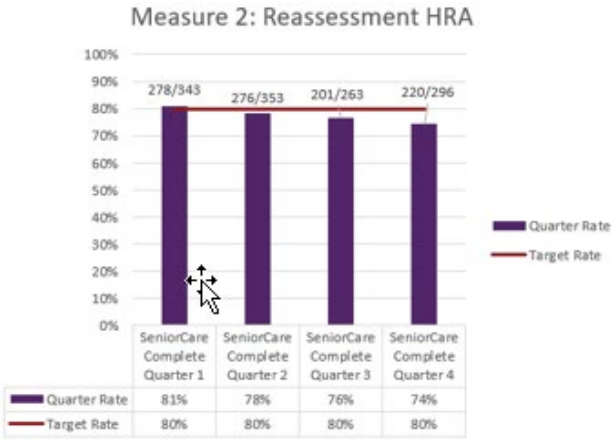


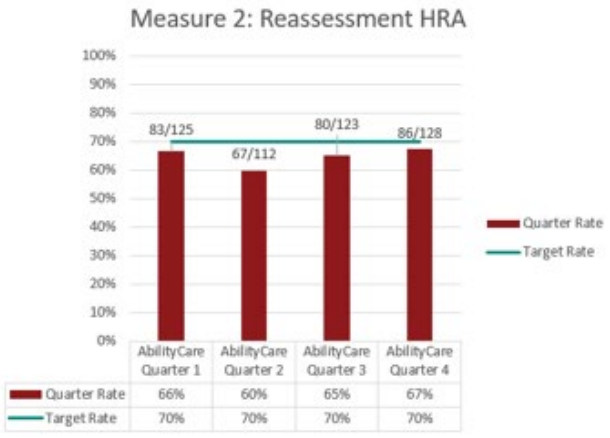
We experienced a downward trend in the completion of SeniorCare Complete health risk assessments throughout 2022. The health risk assessment completion for AbilityCare members was steady throughout the year. Both products were above benchmark for the first quarter, but below or at benchmark for the remainder of 2022. We had an increase in overall enrollment compared to the previous year, causing the total number of health risk assessments to increase.

Measure 2: The percentage of enrollees who have an annual health risk assessment completed no more than 365 days from the previous health risk assessment.

SeniorCare Complete Annual Target Rate: 80%

AbilityCare Annual Target Rate: 70%

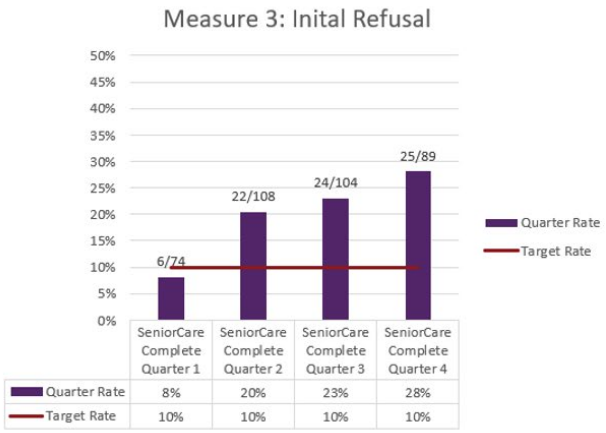


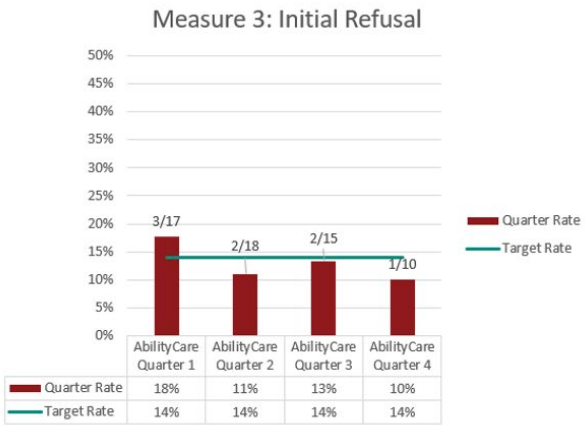


Overall, SeniorCare Complete and AbilityCare reassessment health risk assessments were near benchmark most of 2022.

Measure 3: The percentage of enrollees who actively refused to participate in an initial health risk assessment within 30 days of enrollment.

SeniorCare Complete Annual Target Rate: 10%
AbilityCare Annual Target Rate: 14%

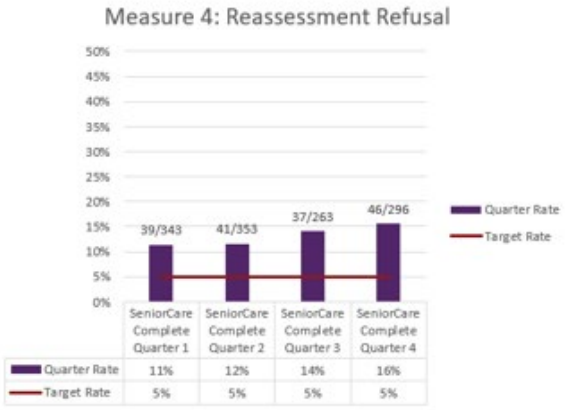


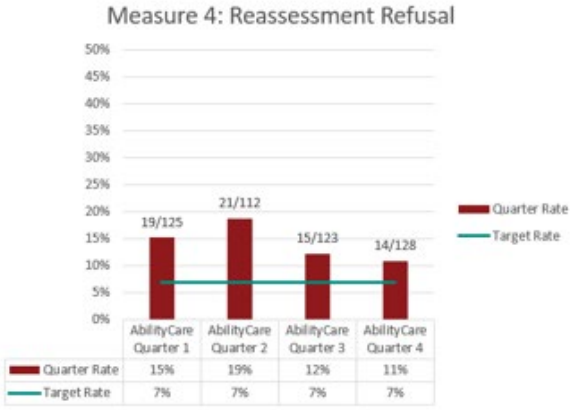


The SeniorCare Complete percentage of initial refusals for the health risk assessment was down in the first quarter, below the benchmark by 2%, but then grew as the year progressed to 18% above benchmark. There was a steady decrease in AbilityCare initial health risk assessment refusals. Overall, AbilityCare was below the benchmark by upwards of 4% in the last three quarters of 2022. This is a remarkable difference compared to last year's AbilityCare initial health risk assessment refusals, which averaged 23% in 2021.

Measure 4: The percentage of enrollees who actively refused to participate in an annual health risk assessment no more than 365 days from the previous health risk assessment or no more than 365 days from the enrollee's enrollment month.

SeniorCare Complete Annual Target Rate: 5%
AbilityCare Annual Target Rate: 7%

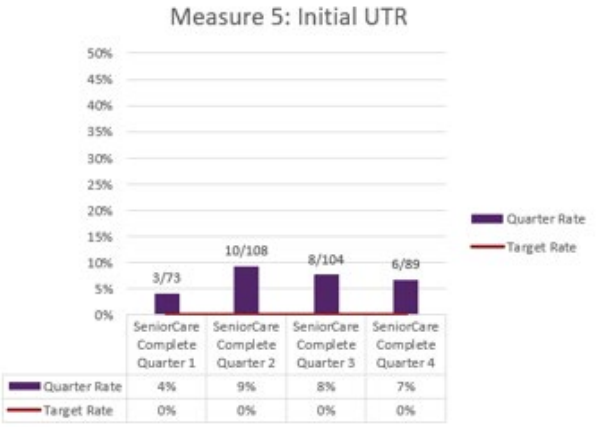


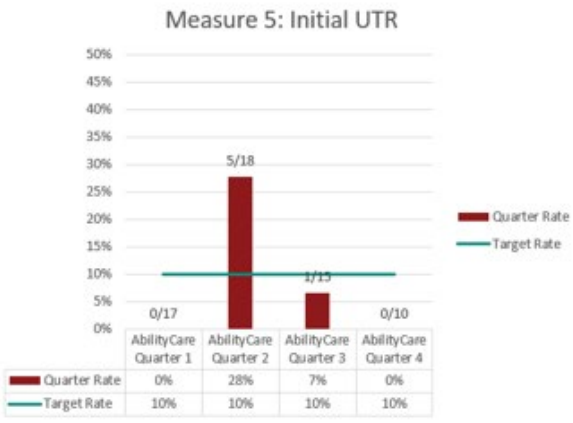


SeniorCare Complete showed an increase throughout 2022 of reassessment refusals. However, AbilityCare showed a steady decline in reassessment refusals after the second quarter. The AbilityCare data is similar to 2021.

Measure 5: The percentage of enrollees who are unable to be reached to participate in an initial health risk assessment within 30 days of enrollment.

SeniorCare Complete Annual Target Rate: 0%
AbilityCare Annual Target Rate: 10%

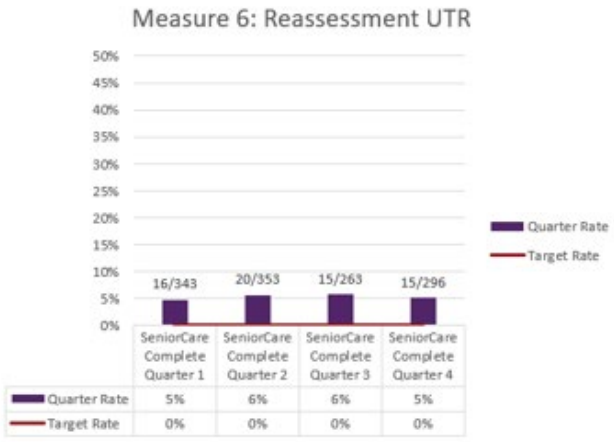


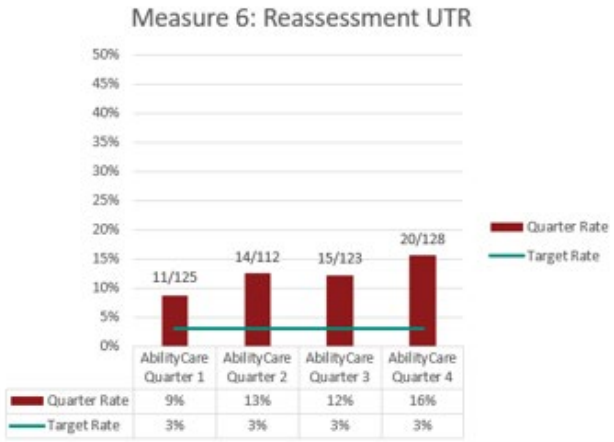


SeniorCare Complete had a higher rate of members who were unable to be reached in 2022 than in 2021, a 10% increase from last year. AbilityCare was lower than its benchmark of 10% for almost the entire year. In the second quarter there was an increase in AbilityCare members who were unable to be reached.

Measure 6: The percentage of enrollees who are unable to be reached to participate in an annual health risk assessment no more than 365 days from the previous health risk assessment or no more than 365 days from the enrollee's enrollment month.

SeniorCare Complete Annual Target Rate: 0%
AbilityCare Annual Target Rate: 3%





SeniorCare Complete was close to benchmark for the entire year of 2022. AbilityCare stayed consistently above benchmark with the first quarter being the lowest at only 6% over benchmark.

Measure 7: The percentage of enrollees who have developed, with the assistance of their care coordinator, an individual care plan (ICP) within 30 days of the completed health assessment.

SeniorCare Complete Annual Target Rate: 99%

AbilityCare data reflects that we met our target rate of 80% demonstrating most Care Coordinators were able to complete the transition of care log timely. A reason for this could be that members have been easier to reach, given the COVID-19 pandemic.

Measure 2: Percentage of enrollees who discharged from a hospital and had a completed medication reconciliation within 30 days of discharge following the HEDIS specification for Medication Reconciliation Post- Discharge.

SeniorCare Complete Annual Target Rate: 65%
AbilityCare Annual Target Rate: 65%

- **HEDIS MY 2020 Rate SeniorCare Complete: 43.18%**
- **HEDIS MY 2020 Rate AbilityCare: 53.41%**

Measure 3: (SeniorCare Complete Only) Percentage of enrollees with an acute inpatient stay and observation stays followed by an unplanned acute readmission for any diagnosis within 30 days based on HEDIS specification for Plan All Cause Remissions.

SeniorCare Complete Annual Target Rate: 7%

- **HEDIS MY 2020 Rate: 12%**

Next Steps

Each year, South Country reviews the appropriateness of the plan's monitoring and evaluation of the Model of Care (MOC) and reporting performance to the Quality Assurance Committee (QAC). Stakeholders on the QAC can respond and comment regarding the monitoring or suggest improvements to the MOC.

Next steps include:

- Review reporting template process and update as needed.
- Continue training counties regarding care transitions, timeliness of health assessments and care plan completion, and care coordinator assignment.
- Continue to review and update requirement documents as appropriate.
- Provide annual training on Senior Products and SNBC Products at Care Coordination Conference.
- Continue to provide guidance and monitor requirements based on COVID-19 and waivers through 2022.
- Adjust and communicate with counties regarding MnCHOICES/ transition for Health Risk Assessments and care plan into MnCHOICES.