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 Health Alliance (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 2023, South Country submitted our MOCs to the Centers for Medicare & Medicaid Services for calendar years 2024, 2025 and 2026 for both SeniorCare Complete and AbilityCare. On Monday, April 17, 2023, 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 in person in the community at a location of the member's choice. 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 completed 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.

Upon the phased launch of Minnesota Department of Human Services' (MN DHS) MnCHOICES Revision, South Country care coordinators have two systems to utilize: South Country's electronic-based care plan in the South Country Care Plan Application and the DHS MnCHOICES Revision 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 MN DHS and is utilized by multiple health plans across the state. The support plan (Support Plan-MCO MnCHOICES Assessment or Support Plan-HRA) in the MnCHOICES Revision Application was created by MN DHS and is designed to be the plan used after the phased launch approach timeline has been met. The care plans for members residing in the nursing home are completed in our electronic documentation system, TruCare. The individualized care plan or support 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 or support 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 Directors 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 responsibilities of the group include:

- 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, manager of community care coordination, 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 and county and care system staff. In person and video training was completed in August of 2023. 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 conference, 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, 2023 – December 31, 2023, and utilizes data sources from TruCare, South Country's data warehouse, Care Plan Application and Business Intelligence (BI) Server reporting module, and HEDIS.

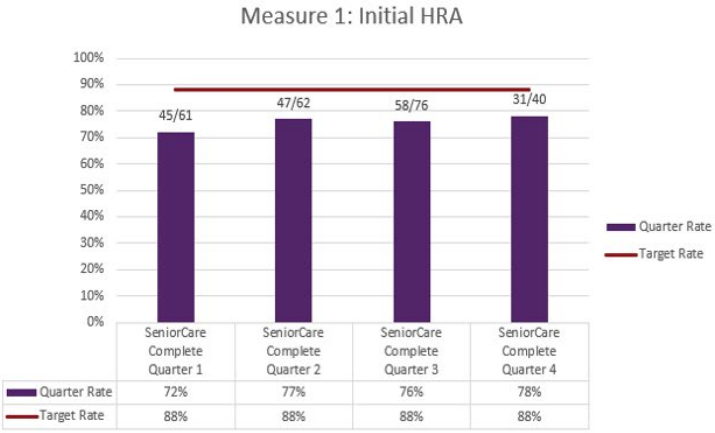
MOC goals and measurable outcomes are reviewed at least quarterly by the community engagement team and reported to South Country's Quality Assurance Committee (QAC) twice a year. The tables below show the measurable outcomes and processes used to evaluate the MOC goals. The data and analysis below review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

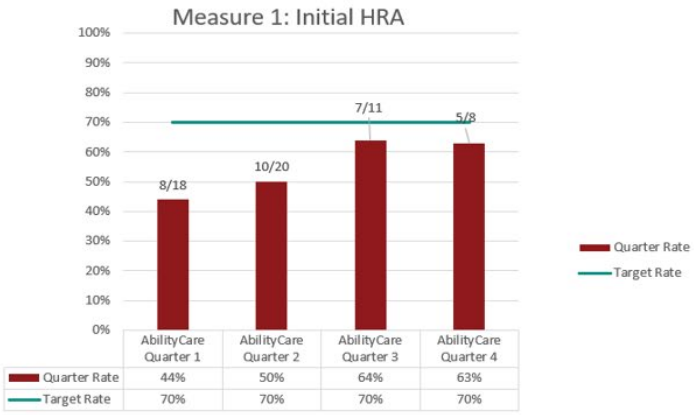
**Goal 1: Improve the ease of navigating the clinical and social system for the member and assure that the member has access to the right service, at the right time, from the right provider, and that it is affordable.**

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 completed an initial health risk assessment within 30 days of enrollment.

**SeniorCare Complete Annual Target Rate: 88%**
**AbilityCare Annual Target Rate: 70%**

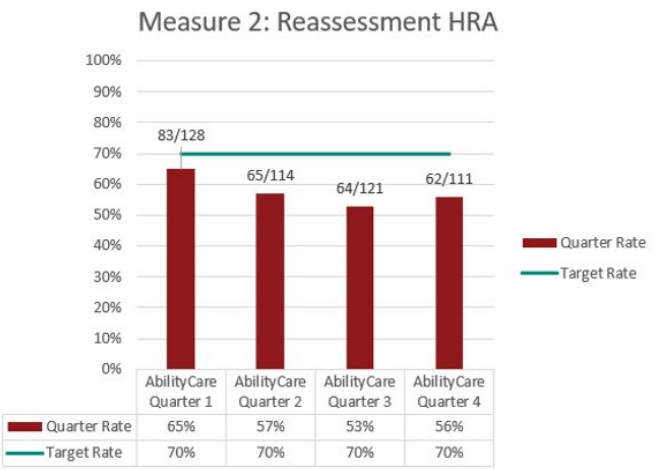



There was a decrease in enrollment from 2022 to 2023 for SeniorCare Complete. We had almost 400 new SeniorCare Complete enrollees in 2022 compared to just over 200 in 2023. The new health plans in our counties likely contributed to this decrease in enrollment. AbilityCare remained steady, hovering around 60 new enrollees in 2022 and 2023. SeniorCare Complete showed a slight increase of 4% more completed HRAs for 2023 compared to 2022, while AbilityCare had an approximate 20% decrease in completed HRAs.

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.

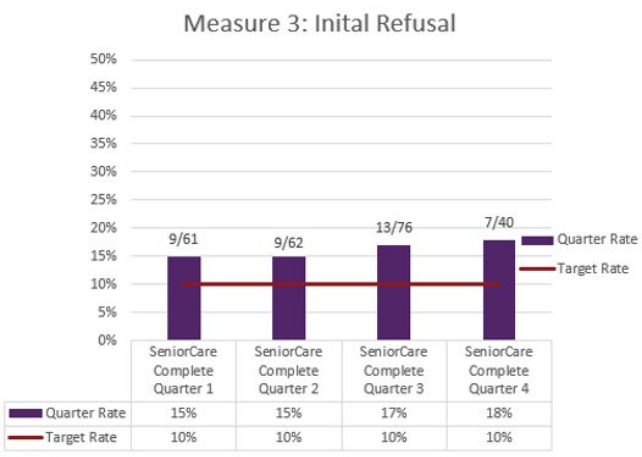
**SeniorCare Complete Annual Target Rate: 80%**
**AbilityCare Annual Target Rate: 70%**

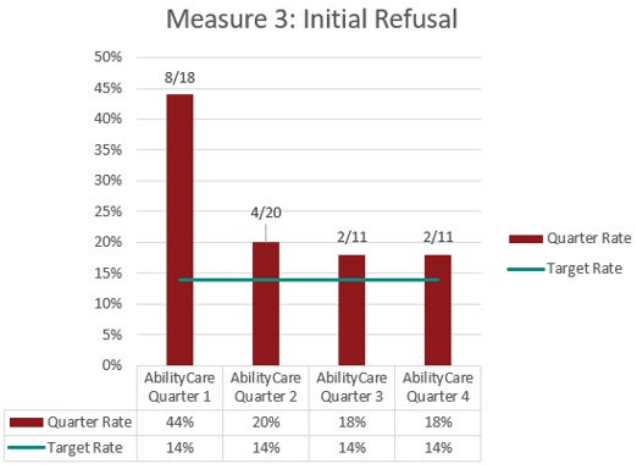



The total number of members due for reassessments remained near 500 for AbilityCare in 2022 and 2023 and around 1,200 for SeniorCare Complete for both years.

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%**

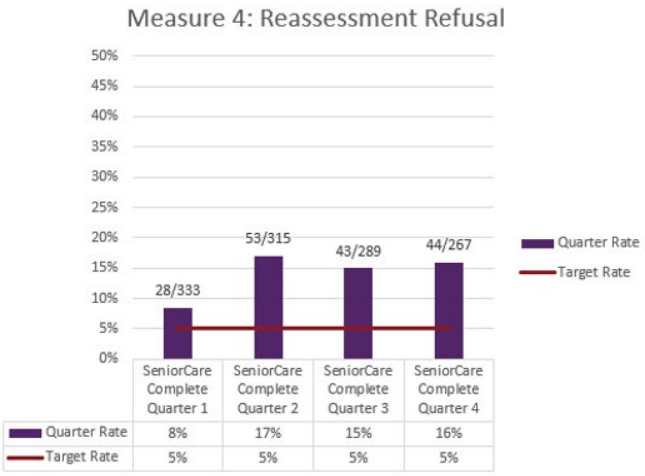


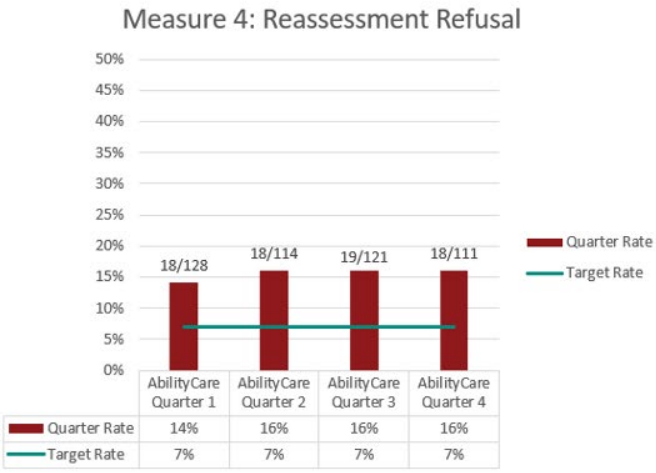




Even though SeniorCare Complete showed a significant decrease in overall enrollment for 2023, there was still a decrease in the number of total refusals for 2023 coming in at 16% versus 20% in 2022. AbilityCare had more than double from 13% total refusals in 2022 to 28% total refusals in 2023.

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%**

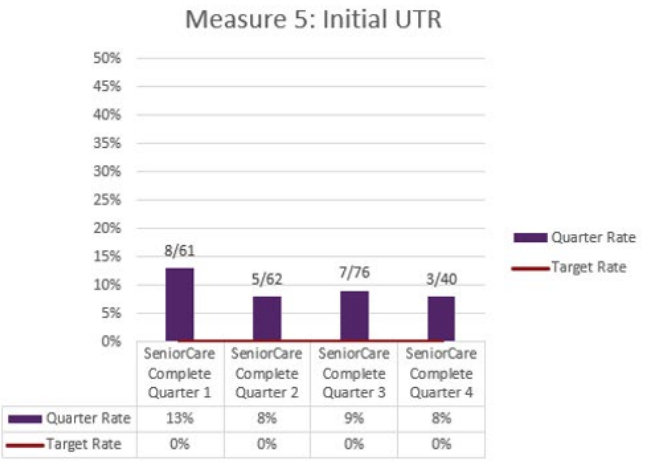


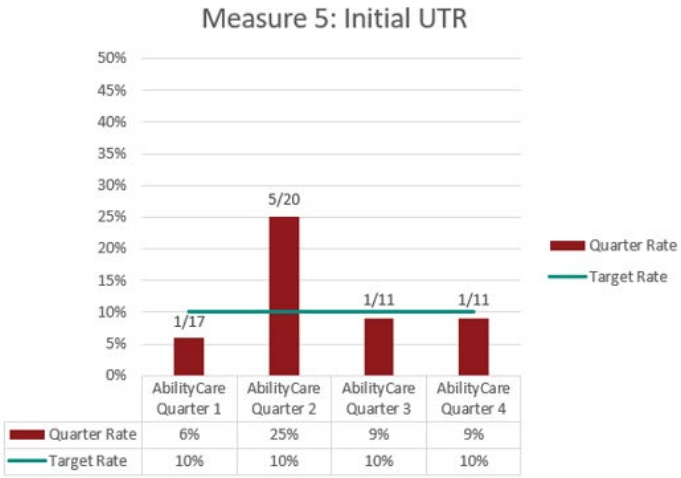




SeniorCare Complete and AbilityCare showed an increase throughout 2022 of reassessment refusals; 2023 data reflected the same trend for both products.

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%**



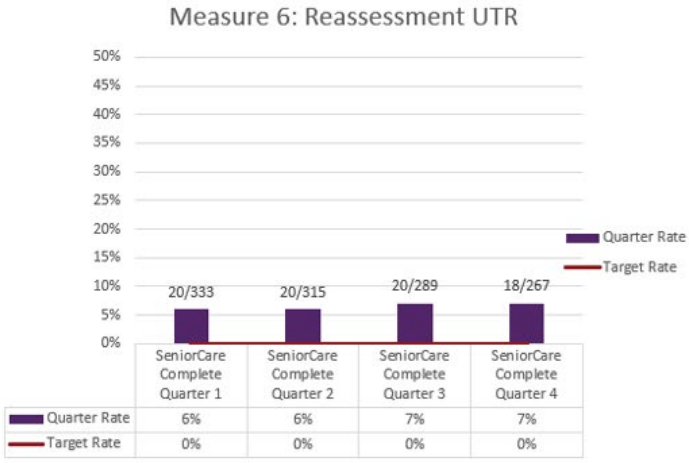



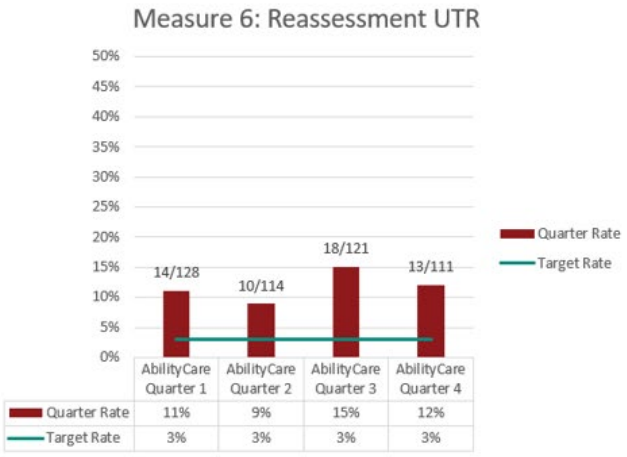

There were less unable to reach members in 2023 for SeniorCare Complete; however, the total enrollment was lower, causing the overall percentage for 2023 to be higher than in 2022. The

same is true for AbilityCare unable to reach members in 2023 compared to 2022. SeniorCare Complete had a 3% increase for 2023 and AbilityCare had a 4% increase in 2023 for 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%**

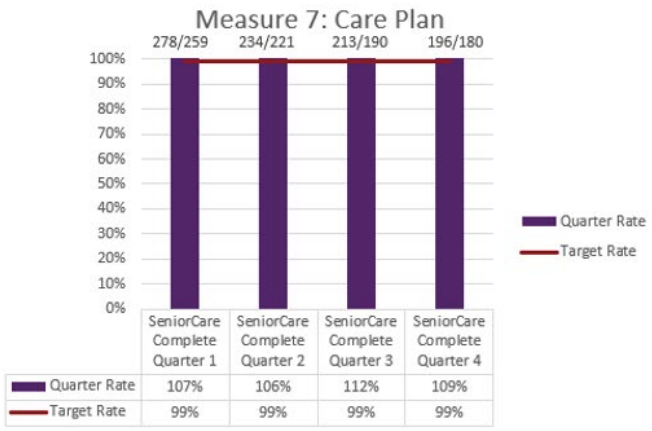


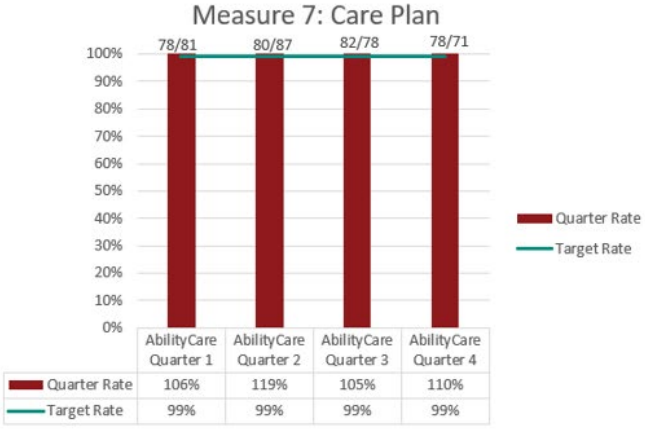




SeniorCare Complete and AbilityCare remained almost the same in 2023 as they did in 2022 for members eligible for a reassessment who were unable to be reached. SeniorCare Complete showed a slight increase of 1% in 2023 compared to 2022. AbilityCare was the same in 2022 as 2023 at 12%.

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 Annual Target Rate: 99%**



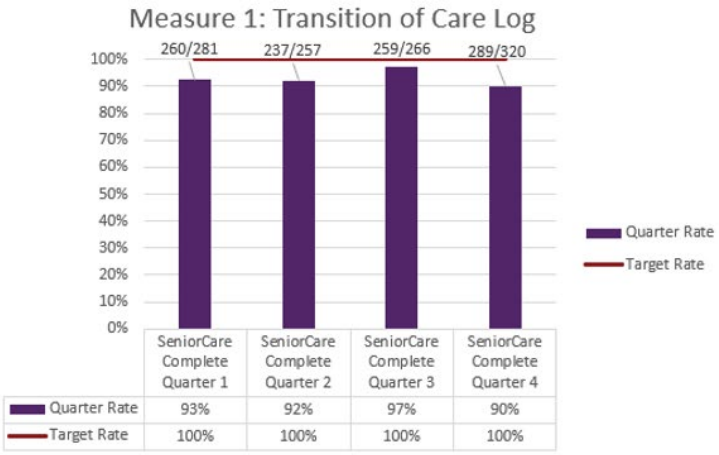

The care plan completion within 30 days of the completed HRA for SeniorCare Complete and AbilityCare surpassed the target rate for all four quarters of 2023. Care plan percentages are higher than the target rate due to the ability to count any care plan that meets criteria, even if the HRA did not, causing a higher rate of care plans completed compared to HRAs completed.

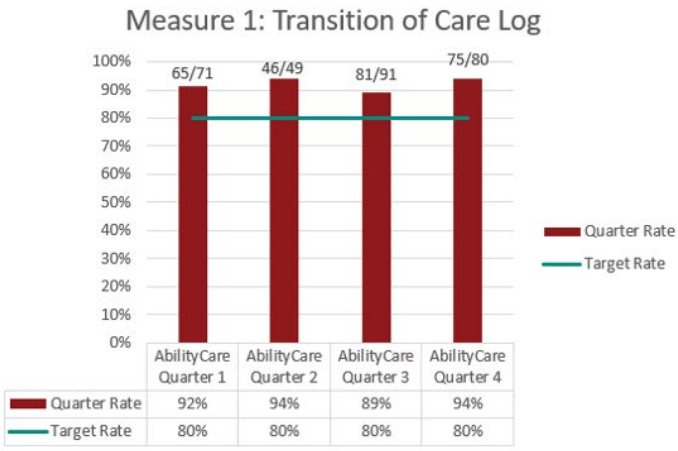
**Goal 2: Assure that enrollees receive care and services from a system that is seamless for enrollees across health care settings, providers, and health and social services.**

Members will experience seamless transitions of care across health care settings, providers, and health/social services. Care coordinators will be notified regarding a health care event (i.e., hospitalization or nursing facility placement) for follow up with the enrollee or most appropriate individual to assist the enrollee through the transition.

Measure 1: The percentage of enrollees, or most appropriate individuals to assist the enrollees, contacted within one business day for follow up by a care coordinator for a health care event when notified 14 days or less after the event.

**SeniorCare Complete Annual Target Rate: 100%**
**AbilityCare Annual Target Rate: 80%**

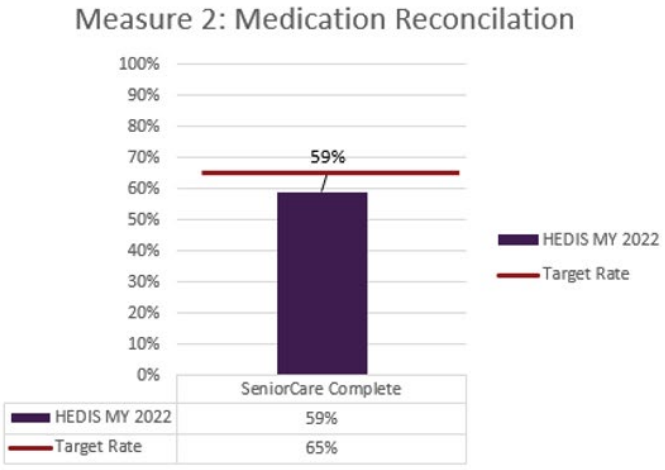


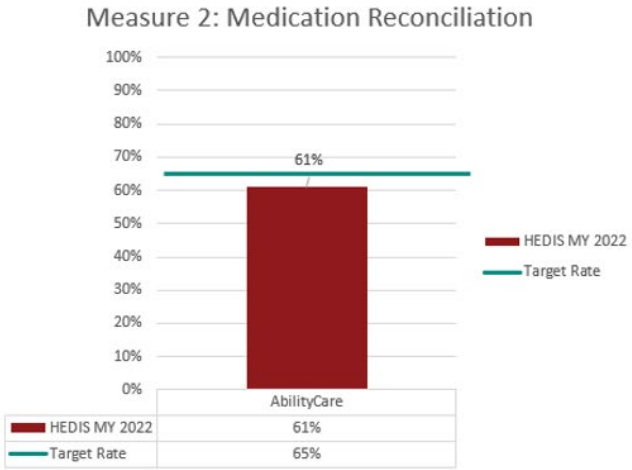




Transition of care data for 2023 reflects similar completion percentages, with just a 1% decrease in both products compared to 2022. SeniorCare Complete was 7% under the overall target rate of 100% in 2023. Quarter three showed the highest completion percentage at 97%. We did not achieve our target rate of 80% for AbilityCare in all four quarters.

Measure 2: The 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%**



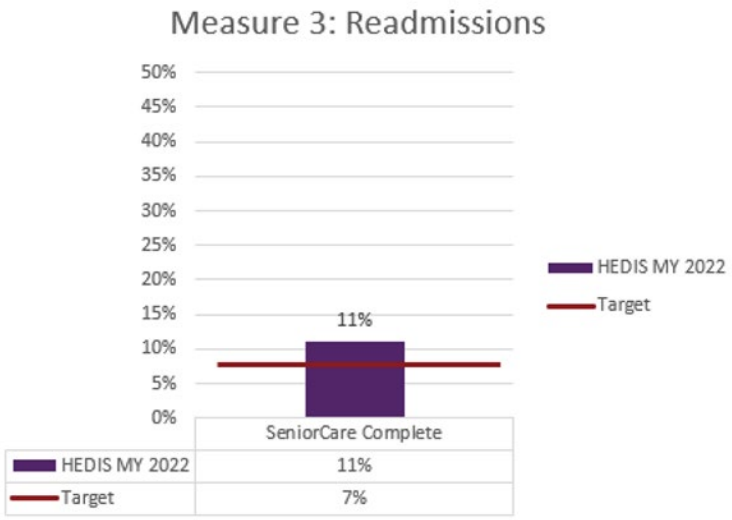



Fifty-nine percent of our SeniorCare Complete members who were discharged from a hospital completed medication reconciliation within 30 days of discharge. Sixty-one percent of our AbilityCare members who were discharged from a hospital completed medication reconciliation within 30 days of discharge. These results are increases from the prior-year levels (49% for SeniorCare Complete and 56% for AbilityCare).

Measure 3: (SeniorCare Complete Only) The 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 readmissions.

**SeniorCare Complete Annual Target Rate: 7%**

The percentage of SeniorCare Complete enrollees with an acute inpatient stay and observation stays followed by an unplanned acute readmission for any diagnosis was 11; therefore, we did not achieve our target rate.



*Next Steps*

Each year, South Country reviews the appropriateness of its monitoring and evaluation of the MOC and reports performance to the Quality Assurance Committee. Stakeholders on the committee can respond and comment regarding the monitoring or suggest improvements to the MOC.

*Next steps include:*

- We will continue to monitor our Model of Care goals;
- We will continue care coordinator training on care transitions, timeliness of health assessments and care plan completion;
- We will provide additional training on care plan completion;
- We will provide annual training on senior products and SNBC products at our care coordination conference; and
- We will adjust and communicate with our county delegates regarding the MnCHOICES transition for health risk assessments and care plans in MnCHOICES.