PROVIDER Bulletin

August 7, 2018

This Provider Bulletin applies to the lines of business and provider types checked below:

☒ **PHP (Medicare)**	☒ **Primary Care Physicians**	☒ **Specialists**
☒ **PHC (Medicaid)**	☒ **Ancillary**	☒ **Hospitals**

AHF/PHP/PHC Model of Care Summary 2018 - 2020

What's this Model of Care (MOC) all about?
Why do we have to have one?

- Medicare Special Needs Plans (SNPs) were created by Congress in the Medicare Modernization Act (MMA) of 2003, as a new type of Medicare managed care plan that focus on certain vulnerable groups of Medicare beneficiaries.
- PHP is a C-SNP (the "C" is for "chronic" condition) that focuses on the vulnerable group with HIV/AIDS.
- The Social Security Act requires that every Special Needs Plan must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA).
- Therefore, PHP has a MOC!

What is a MOC?

- The MOC is a written document which provides the basic framework under which the SNP will meet the needs of each of its enrollees.
- It must ensure the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.
- The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

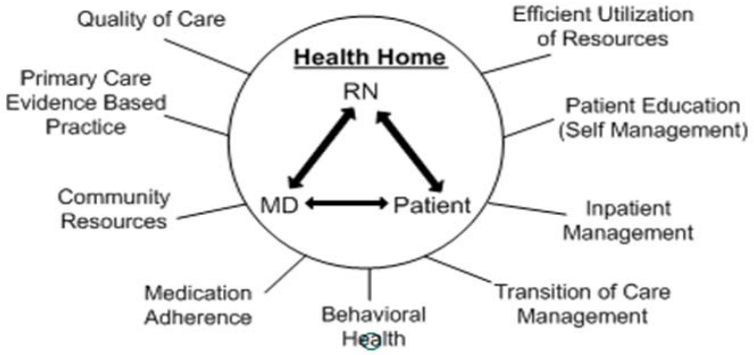
What must be in the written MOC?

- NCQA assess MOCs from SNP's according to detailed scoring guidelines published by CMS.
- The MOC requirements comprise the following standards:
  - Description of the SNP Population.
  - Care Coordination.
  - SNP Provider Network.
  - MOC Quality Measurement & Performance Improvement.
- PHP received a score of **100%** on its written SNP Model of Care Program from NCQA/CMS for its 3 year plan beginning January 2018.

PHP's MOC – What You Need to Know

- Every member in our Plans has at least one chronic condition HIV/AIDS.
- Staffing of the Plan and the Provider Network is based on the model of health service delivery described in the model of care.
- The model of health service delivery is Chronic Care Disease Management.
- QI produces an annual MOC Dashboard to measure our success with implementing the MOC for every member.
- It's teamwork by all staff at every level.

Care Coordination



- Starts with identifying chronic disease status by using the Health Risk Assessment (HRA) by RN Care Manager (RNCM)
- Severity Level (SL) calculated from HRA results (SL 1, 2 or 3 – 3 being most severe)
- Members assigned SL 3 are placed under complex care management – the rest are placed under chronic disease management
- Care Plan with member goals established & shared
- Interdisciplinary Care Team Meeting held to coordinate care & discuss best options for care and its delivery
- Ongoing support – working the care plan – teaching self-management to member
- Annual re-evaluation of member

MOC Quality Measurement & Performance Improvement

Model of Care Dashboard (Sample Section)

MOC Dashboard 2017 - Based on 2016 Data

Measure	Measure Definition	Data Source	Benchmark	Timeframe	Goal Met Determinant	2017 Result 2016 Data	
Appropriate Use of Services for Chronic Conditions						**CA**	**FL**
% members with Viral Load Suppression < 200mg	The percent of members with a viral load suppression < 200 mg.	Data Warehouse	≥ 80%	Quarterly & YTD	Run chart presented quarterly at QMC	**81%**	**81%**
% members with at least 3 visits per year	The percent of members with at least 3 provider visits, 90 days apart or more, annually.	Data Warehouse	≥ 80%	Quarterly & YTD	Run chart presented quarterly at QMC	**87%**	**90%**
ARV Adherence	Percent of member-years of enrolled beneficiaries 18 years or older with at least two fills of two unique products in the antiretroviral drug class during the period measured.	MedImpact	> 80%	Quarterly & YTD	Report presented at QMC	**83%**	**78%**
Percent of HIV patients not seen in a 6 month period	Percent of HIV patients who did not have a medical visit in the first 6 months of the measurement year.	Data Warehouse	<10%	First 6 mo's of measurement year	Report presented at QMC	**13%**	**8%**
Percent of HIV patients not seen in a 6 month period	Percent of HIV patients who did not have a medical visit in the last 6 months of the measurement year.	Data Warehouse	<10%	Last 6 mo's of measurement year	Report presented at QMC	**15%**	**12%**