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 members' 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 offered to be performed in person in the community at a location of the member's choice. The health risk assessment tool utilized for members residing in a nursing home is the skilled nursing facility (SNF) health risk assessment tool within TruCare. For all other members, the assessment is completed within the Minnesota Department of Human Services' (MN DHS) MnCHOICES Application. 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 members. 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 care coordinators have two systems to utilize for care plans: For members residing in a nursing home, the care plan is completed in our electronic documentation system, TruCare. For all other members, the support plan is completed in the DHS MnCHOICES Application. The support plan (Support Plan-MCO MnCHOICES Assessment or Support Plan-HRA) in the MnCHOICES Application was created by MN DHS. 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, county relations coordinator 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 also have multiple measures within each overarching goal.

- Improve the ease of navigating the clinical and social system for the member and ensure that the member has access to the right service, at the right time, from the right provider, and that it is affordable.
- Ensure 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 were completed in July of 2025. 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, 2025 – December 31, 2025, and utilizes data sources from TruCare, South Country's data warehouse 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. South Country is in the final year of our three-year Model of Care approval for calendar years 2024, 2025 and 2026. The data and analysis below review the second year of data.

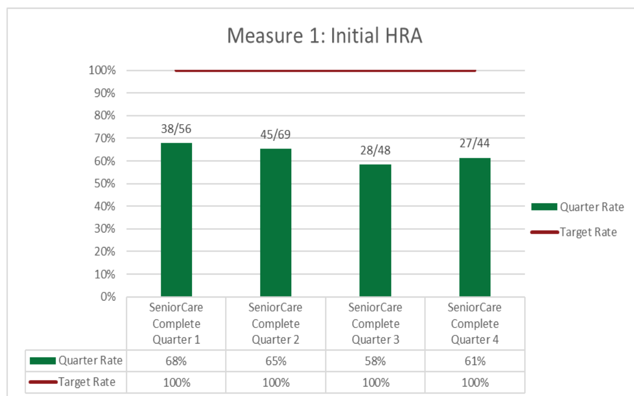
Goal 1: Improve the ease of navigating the clinical and social system for the enrollee and ensure that the enrollee has access to the right service, at the right time, from the right provider, and that it is affordable.

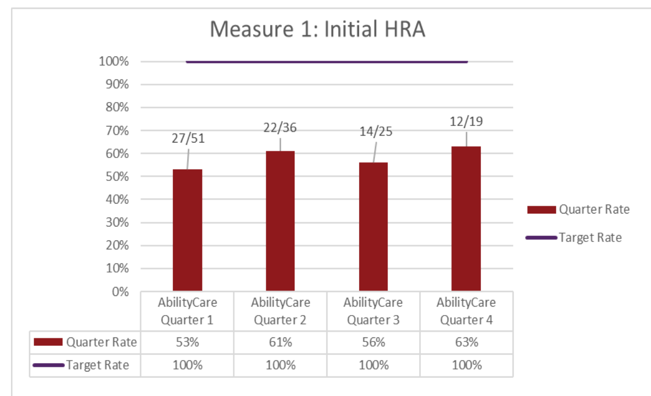
Members will receive integrated care coordination and service accessibility including preventive health services and comprehensive coordination of all services to meet their needs and wants across the continuum: social services, public health, medical, and other community services. A health risk assessment 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 (ICT).

Measure 1: Percentage of enrollees who have a completed initial health risk assessment within 30 days of enrollment for SeniorCare Complete and 60 days of enrollment for AbilityCare.

SeniorCare Complete Annual Target Rate: 100%

AbilityCare Annual Target Rate: 100%

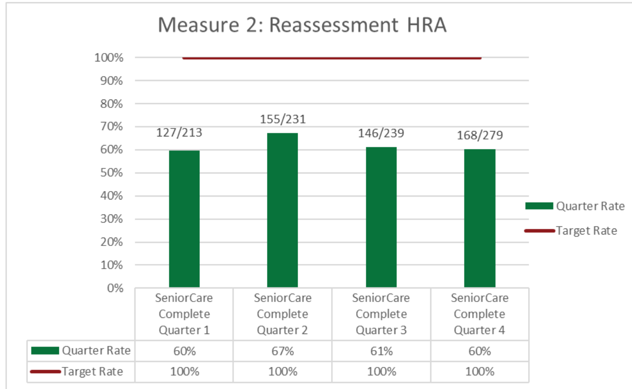


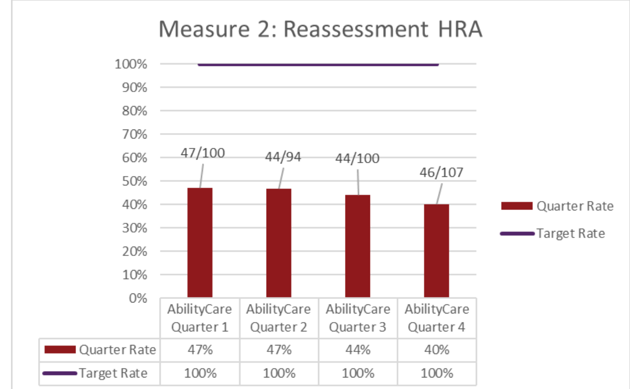


Measure 2: Percentage of enrollees who have an annual health risk assessment completed no more than 365 days from the previous health risk assessment.

SeniorCare Complete Annual Target Rate: 100%

AbilityCare Annual Target Rate: 100%





The percentages shared below are important to understand the difference between our benchmark goal of 100% for these measures and actual member results for the completed initial and reassessment HRA data above.

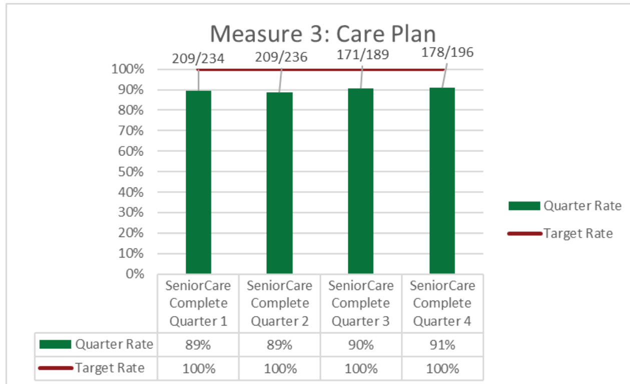
Data shows initial refusals at 23% for Q1, 23% for Q2, 23% for Q3, and 23% for Q4, and initial unable to reaches (UTRs) at 2% for Q1, 6% for Q2, 6% for Q3, and 7% for Q4 for SeniorCare Complete members. Data also shows initial refusals at 33% for Q1, 19% for Q2, 24% for Q3, and 21% for Q4 and initial UTRs at 10% for Q1, 11% for Q2, 16% for Q3, and 16% for Q4 for AbilityCare members.

Data shows reassessment refusals at 14% for Q1, 11% for Q2, 15% for Q3, and 11% for Q4, and reassessment UTRs at 9% for Q1, 8% for Q2, 3% for Q3, and 3% for Q4 for SeniorCare Complete members. Data also shows reassessment refusals at 27% for Q1, 29% for Q2, 21% for Q3, and 25% for Q4, and reassessment UTRs at 12% for Q1, 9% for Q2, 10% for Q3, and 7% for Q4 for AbilityCare members.

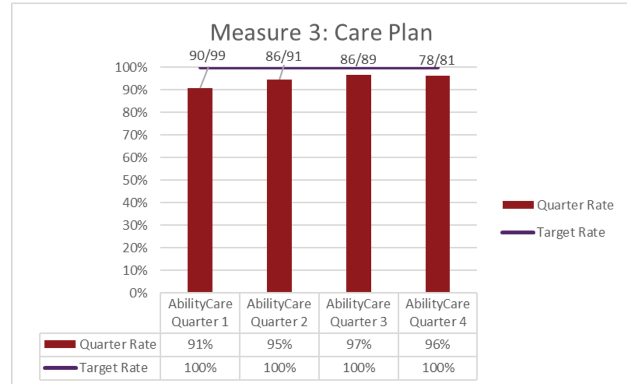
Measure 3: Percentage of enrollees who have developed, with the assistance of their care coordinator, an individual care plan (ICP) within 30 days of the completed health assessment, which identifies their ICT.

SeniorCare Complete Annual Target Rate: 100%

AbilityCare Annual Target Rate: 100%



	SeniorCare Complete Quarter 1	SeniorCare Complete Quarter 2	SeniorCare Complete Quarter 3	SeniorCare Complete Quarter 4
Quarter Rate	89%	89%	90%	91%
Target Rate	100%	100%	100%	100%



	AbilityCare Quarter 1	AbilityCare Quarter 2	AbilityCare Quarter 3	AbilityCare Quarter 4
Quarter Rate	91%	95%	97%	96%
Target Rate	100%	100%	100%	100%

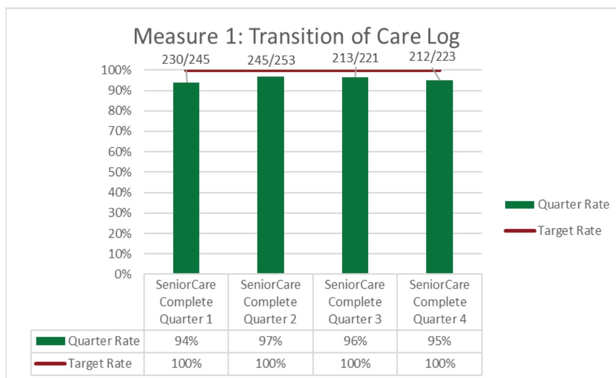
Goal 2: Ensure that enrollees receive care and services from a system that is seamless for enrollees across health care settings, providers and health and social services.

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.

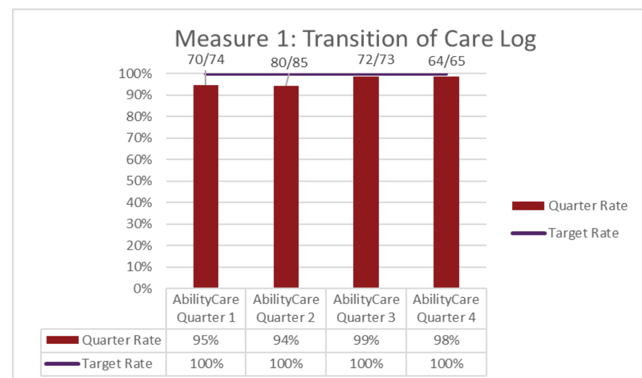
***Measure 1*:** Percentage of enrollees (or most appropriate individual to assist the enrollees) contacted within one business day for follow up by a care coordinator for a health care event when notified 14 days or less after the event.

SeniorCare Complete Annual Target Rate: 100%

AbilityCare Annual Target Rate: 100%



	SeniorCare Complete Quarter 1	SeniorCare Complete Quarter 2	SeniorCare Complete Quarter 3	SeniorCare Complete Quarter 4
Quarter Rate	94%	97%	96%	95%
Target Rate	100%	100%	100%	100%

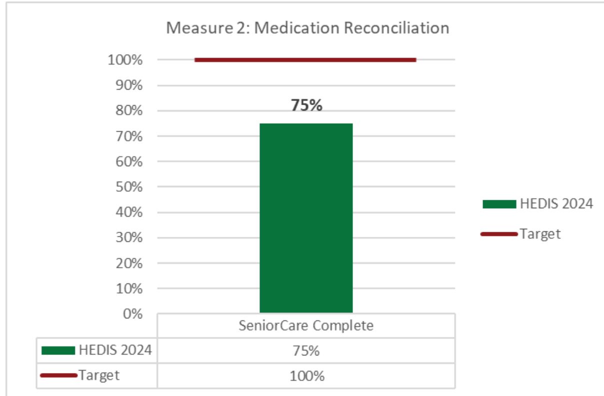


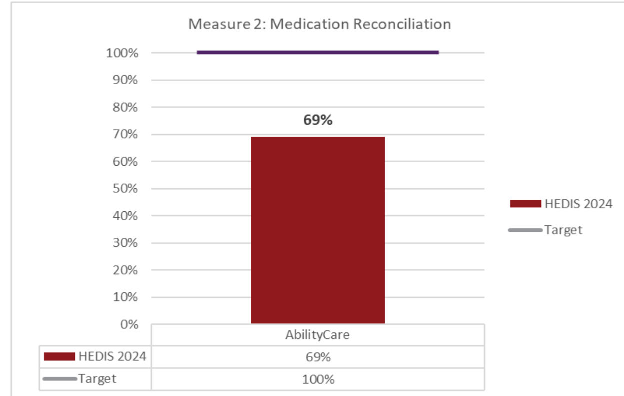
	AbilityCare Quarter 1	AbilityCare Quarter 2	AbilityCare Quarter 3	AbilityCare Quarter 4
Quarter Rate	95%	94%	99%	98%
Target Rate	100%	100%	100%	100%

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

SeniorCare Complete Annual Target Rate: 100%

AbilityCare Annual Target Rate: 100%



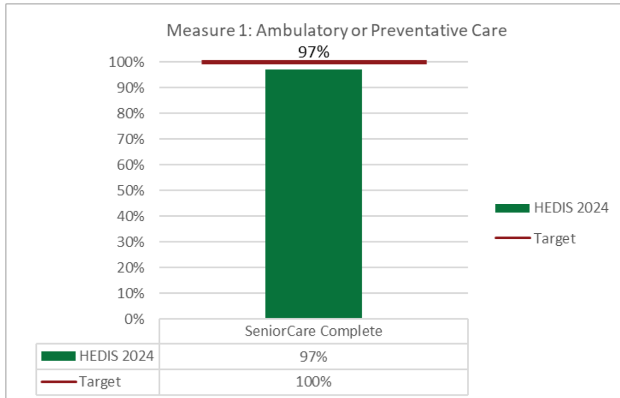


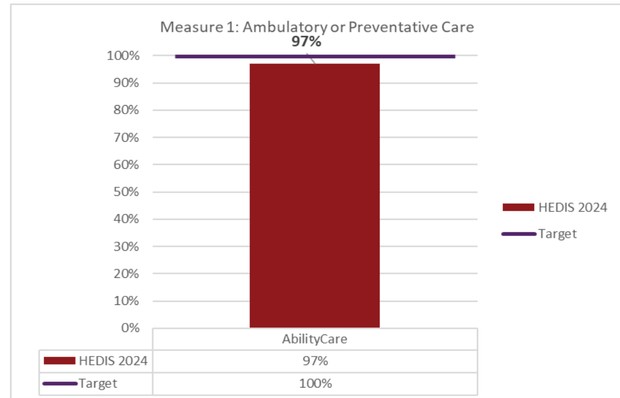
Goal 3: Ensure that enrollees receive preventive or ambulatory services annually and to help control diabetes and hypertension.

***Measure 1*:** The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.

SeniorCare Complete Annual Target Rate: 100%

AbilityCare Annual Target Rate: 100%

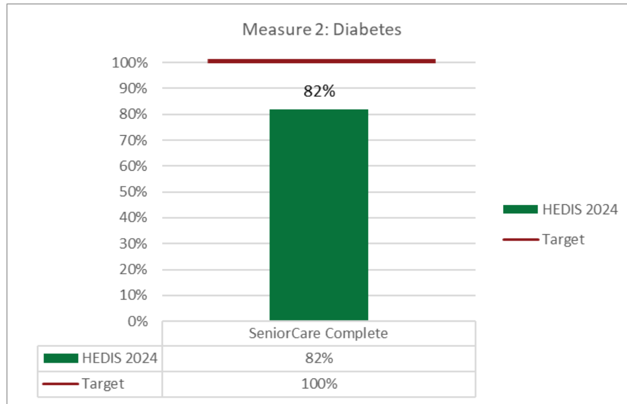


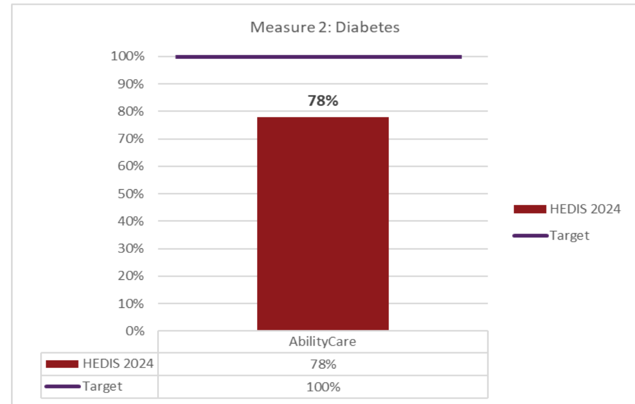


Measure 2: The percentage of members with diabetes (Types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: HbA1c <9.0%.

SeniorCare Complete Annual Target Rate: 100%

AbilityCare Annual Target Rate: 100%

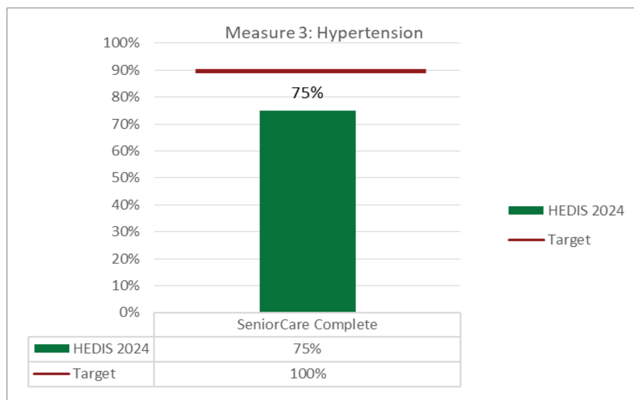


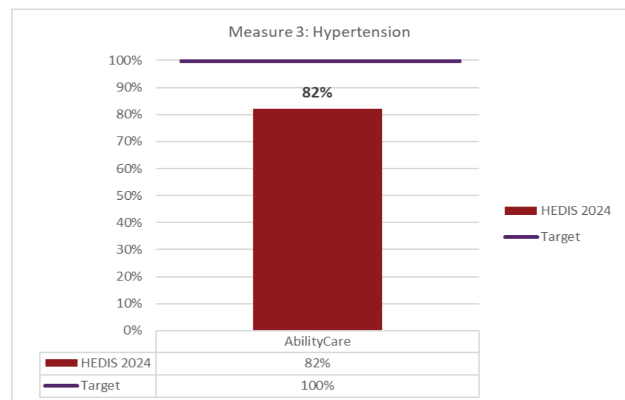


Measure 3: The percentage of members who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

SeniorCare Complete Annual Target Rate: 100%

AbilityCare Annual Target Rate: 100%





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.

- We are in the process of developing our new Model of Care goals and measures for our next span and will monitor accordingly;
- We will continue care coordinator training on requirements and regulations around care transitions, timeliness of health assessments and care plan completion; and
- We will provide annual training on senior products and SNBC products at our care coordination conference.