Valor Health Plan

Insurance focused on you.

2026 Model of Care Training

For Providers contracted with Valor Health Plan (HMO-ISNP)

H1119_MOC26_C

Overview

- The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care (MOC) and to conduct initial and annual training that reviews the major elements of the MOC for contracted providers and staff.
- The MOC describes how the health plan will identify and address the needs of enrolled members.
- This training will review the MOC for Valor Health Plan's Institution-Special Needs Plan (I-SNP).

This training is offered to comply with the statutory requirements of CMS that all SNPs provide a general understanding of the requirements of the MOC. (§1859(f)(7) of the Social Security Act)

Training Objectives

The Purpose of this training is to:

- Describe the basic components of the Valor Health Plan MOC
- Explain how Valor Health Plan manages care coordination activities for eligible members
- Describe the essential role providers play in implementing the MOC
- Review Clinical Practice Guidelines
- Outline Valor's continuous quality improvement and monitoring efforts

Basic Components of the MOC

Valor Health Plan's MOC is our detailed, written commitment to CMS on how we will provide care to enrolled members.

MOC is designed to:

- Reduce non-essential hospital admissions when care can safely be provided in the nursing facility
- Maintain the residents at an optimal level of function
- Reduce avoidable admissions
- Increase compliance with appropriate screening/testing/immunizations
- Increase compliance with clinical practice guidelines
- Enhance identification and address problems earlier to optimize member function
- Decrease redundancy and confusion of medical care for this vulnerable population
- Improve communication

Service Area Population

- Medicare eligible Ohio residents
- Frail and/or vulnerable
- 2/3 female
- Average age over 75 years old
- Primarily Caucasian
- Prevalent clinical conditions
  - Diabetes
  - Congestive Heart Failure
  - Psychoses
  - Chronic Obstructive Pulmonary Disease
  - Pressure wounds
  - Urinary Tract Infections
  - Falls
  - Incontinence

Additional criteria to identify highly vulnerable/high risk members:

- Six or more Hierarchical Condition Category (HCC) diagnoses
- Two or more emergency room visits in past 30 days
- Two or more inpatient readmissions within 30 days

CMS I-SNP Requirements

- Expected to follow Medicare Advantage program rules, including MA regulations at 42 CFR 422
- Must provide Part D prescription drug coverage
- Focus on:
  - Enrollment
  - Care Coordination
    - Assigned Case Manager and Nurse Practitioner (NP)
    - Completed Health Risk Assessment (HRA) within first 90 days and then annually thereafter
    - Individualized Care Plan (ICP) completed and shared with all vested parties as requested
    - Interdisciplinary Care Team (ICT) meets as needed to review ICP and member goals and health outcomes
    - PCP-chosen by member or assigned if needed
  - Quality
    - Reduction in avoidable hospital visits
    - Reduction in ED utilization
    - Improved overall health outcomes and chronic condition management

Care Coordination Staff Structure

- **Case Manager**
  - Schedules and completes Health Risk Assessments (HRAs) for new members and annually thereafter
  - Creates Care Plan (ICP) collaboratively with NP
  - Communicates HRA and ICP with all vested providers
  - Coordinates Interdisciplinary Care Team Meeting (ICT)
  - Assists with Transitional Assessment within 72 hours of discharge from hospital
  - Promotes member engagement through education and encouragement
- **Nurse Practitioner**
  - Collaborates with Case Manager to create ICP
  - Reviews completed HRA and ICP to determine frequency of rounding on member
  - Rounds on members as needed and as determined by risk level
  - Participate in ICT
  - 24/7 On-call coverage
  - Provide clinical care to promote early diagnosis, intervention, communication, and delivery of services
  - Works collaboratively with other vested providers

Additional Provider Requirements

Network

- All contracted providers are credentialed

Clinical Practice Guidelines

- Nationally developed and approved clinical practice guidelines are reviewed every two years, or when there is a significant change
- Guidelines are available for providers to reference

Annual MOC Training

- All contracted providers attest to the MOC training, annually

Valor Health Plan is required to maintain a comprehensive network of primary care providers and specialists that meet CMS adequacy standards.

Clinical Practice Guidelines

- Please refer to our website for the most current list of our Clinical Practice Guidelines: https://www.valorhealthplan.com/providers/

Communication is Key to Collaboration

- We ask that the PCP or specialist participate in Interdisciplinary Care Team Meetings when available either in person or via phone
- Valor commits to communicate any transition of care of member, we ask the provider to do the same (open line of communication)
- Valor's Clinical Team (Case Manager and Nurse Practitioner (NP)) will communicate any episodic concerns or change in status in a timely manner
- There will be a NP on call 24/7 365 days a year for any changes in the Member's health status and addressing needs based on that change
- Members will have access to a local, hands-on clinical team that is integrated in the facility, that will communicate with the member, the PCP, specialist, and family to ensure high quality, continuity of care

Quality Measurement and Performance Improvement

- Measurable goals and health outcomes
- Evaluation of the Model of Care
  - Data from multiple sources is collected, analyzed, and evaluated on a monthly, quarterly, and annual basis from each Model of Care domain to:
    - Monitor performance
    - Identify areas for improvement
    - Ensure that program goals have been met
- Continuous quality improvement and monitoring efforts

In addition to measurement through claims data, visit encounter data, member surveys and other sources, plans are also asked to implement a Chronic Care Improvement Program (CCIP)-Valor's focused is on heart failure.

Attestation

- **Please complete attestation by 12/1/2026**
- Please go to the following link to attest to receiving and reviewing Valor Health Plan's 2026 Model of Care Training:
  - https://aproposystems.com/Attestation/Index/H1119

Contact Information

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