Title: Individualized Care Plan Policy			**Policy Number:** CM-005
Primary Department: Care Management	**LOB:** Medicare Advantage		**Author:** Ileana Havrilla and Hannah Beal
Effective Date: 10/28/2022	**Original Date:** 10/27/2022	**Review Date(s):**	**Archive Date:**
Interactive Related Department(s)			
☐All Departments ☐Compliance ☒Medical Management ☐Provider Operations ☐Sales and Marketing	☐Appeals and Grievances ☐Pharmacy ☐Member Services ☐Quality Management ☐Utilization Management	☐Care Management ☐Enrollment ☐Plan Administration ☐Claims ☐Other _____	

POLICY PURPOSE

Troy Health, Inc. is committed to comply with all regulations and requirements for Medicare Advantage Plans.

The purpose of this policy is to describe the process by which Troy Health completes Individualized Care Plans for all Medicare beneficiaries enrolled in the Dual Eligible Special Needs Plan (SNP) as required by regulatory requirements set forth by the Centers of Medicare and Medicaid Services (CMS) as well as Model of Care Guidance issued by the National Committee for Quality Assurance (NCQA).

SCOPE

This policy applies to all employees in Medical Management and Care Management at Troy.

REFERENCES

- 42 CFR § 422.101(f)
- Medicare Managed Care Manual Chapter 5, Section 20.2.1
- Model of Care Scoring Guidelines for Contract Year 2023

RESPONSIBLE PARTIES

- Vice President of Health Services
- Chief Medical Officer

DEFINITIONS

- **Attempt Cycle**- The process for when a member is contacted for follow-up, HRA completion, or when they experience a transition of care. Attempt cycle includes 3 documented phone attempts and a letter sent to the member prior to the outreach completion due date.
- **Health Risk Assessment (HRA)-** an objective tool used to collect information on a beneficiary's health status, health risk factors, social determinants of health, and functions of daily living.
- **Individualized Care Plan (ICP)-** the member plan that includes health goals, barriers, and interventions based on HRA results. This is a living document that is updated with changes in the members needs and is used as map for the member in improving their health care.
- **Interdisciplinary Care Team (ICT)-** a group of healthcare professionals that work together to provide members with the health care they need. Some examples of ICT members include the member's PCP, any specialists a member sees, and the member's Care Manager
- **Model of Care (MOC)-** provides the basic framework under which Troy Medicare SNP plan has protocols to ensure members have the right health care to improve their health.
- **Risk Stratification**- The process by which members are placed into low, medium, or high-risk level, which determines the frequency of outreach and follow up made to the member is based on the risk category assigned.

POLICY

CMS requires all Special Needs Plans (SNPs) to create an Individualized Care Plan (ICP) for all SNP members. The ICP is the plan that Troy Health uses to document the member's health care needs and set goals to improve their health status. All SNP members will receive a copy of the Individualized Care Plan as it is updated when the member's health needs change.

SNPs must implement an evidence-based Model of Care, that is approved by the National Committee for Quality Assurance (NCQA). The NCQA works to improve the quality of health care through the administration of evidence-based standards, measures, programs, and accreditation.

Based on the Model of Care, Troy Care Management starts with the Initial Health Risk Assessment (HRA) in collaboration with the new SNP member to evaluate their current health status. From the HRA, the Care Manager develops a comprehensive Individualized Care Plan (ICP). Then the Troy Care Manager discusses the ICP with the member telephonically to develop specific goals meant to improve their health and identify their risk stratification level.

The ICP is sent to the member and the Interdisciplinary Care Team (ICT) within 45 days of the HRA completion, and when any changes are made. The Care Manager ensures that any feedback from the ICT is included in the ICP.

The ICP is required to address all issues identified in health risk assessments (HRAs) and any needs or goals that the member wishes to include in it. The ICP includes attainable goals and measurable outcomes including preventive services, care preferences, and management of chronic conditions.

The Care Manager must review and revise the member's ICP consistent with its Model of Care (MOC) as warranted by a change in the member's health status or care transition. The frequency of review of the ICP is determined by the risk stratification level. For low-risk members this review occurs every 6 months, for moderate risk members this occurs every 3 months, and for high-risk members this occurs every 2 months. The ICP is also reviewed after each transition of care or change in health care status.

PROCEDURE
Individualized Care Plan (ICP) Completion

1. After the Care Manager completes the HRA with the member and risk stratification to determine the outreach schedule, the Care Manager refers to the Care Plan Discussion Template to review and addressing of HRA identified risks, member goals, barriers, and goal preferences.

2. The care planning conversation is documented in the members chart as "HRA and Member Care Plan Discussion". For example, If the member declines a goal, the Care Manager includes it in the documentation of the telephone conversation for ICP creation.

3. The Care Manager creates the ICP with the member, then documents the goals in "TruChart" system. Members must have always at least (2) open goals that they are working towards and ensure there is always an active care plan for members.

4. Within 45 days of the completion of the HRA, a paper copy of the ICP is sent to the member and PCP requesting review and feedback.

5. If feedback is received from either the member or the PCP, it is incorporated into the ICP.

6. After the initial ICP is sent by the Care Manager, the outreach schedule is followed based on the member's Risk Stratification Level.

7. Individualized Care Plan follow up with the member is then documented by the Care Manager in the "TruChart" care management system.

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

- None

APPROVALS

Chief Medical Officer	**Committee Approval**
10 / 28 / 2022	10 / 28 / 2022
Date:	**Date:**