Medicare: 2019 Model of Care Training

Provider Training

Training Objectives

This course will describe how Home State Health Plan (HSH) and its contracted providers work together to successfully deliver the duals Model of Care (MOC) program.

After the training, attendees will be able to:

- Outline the basic components of the Home State Model of Care (MOC)
- Explain how Home State's medical management staff coordinates care for Special Needs members
- Describe the essential role of providers in the implementation of the MOC program
- Define the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT)

Model of Care Training

- The Model of Care (MOC) is a quality improvement tool that ensures that the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed
- The Affordable Care Act requires the National Committee for Quality Assurance (NCQA) to review and approve all SNPs MOC using standards and scoring criteria established by Centers for Medicare and Medicaid (CMS)
- This course is offered to meet the CMS regulatory requirements for MOC Training for our SNPs
- It also ensures all employees and providers who work with our SNP members have the specialized training this unique population requires

Current Medicare Plans

Centene provides different types of Medicare Advantage plans all over the country. It is important to note that **only** D-SNP plans require a Model Of Care.

Dual Special Needs Plans (D-SNP)

- Arizona (AZ) - Health Net
- California (CA) - Health Net
- Florida (FL) - Sunshine State Health Plan
- Georgia (GA) - Peach State Health Plan
- Kansas (KS) – Sunflower Health Plan
- Missouri (MO) – Home State Health Plan
- Ohio (OH) - Buckeye Community Health Plan
- Oregon (OR) - Trillium Community Health Plan
- Pennsylvania (PA) - Health and Wellness – Pennsylvania

Dual Special Needs Plans (D-SNP) – cont.

- Texas (TX) - Superior Health Plan
- Wisconsin (WI) - MHS
- South Carolina (SC) - Absolute Total Care

Chronic Condition Special Needs Plans (C-SNP)

- Arizona (AZ) - Health Net

Current Medicare Plans

Medicare Advantage Prescription Drug Plans (MAPD)

- Arizona (AZ) - Health Net
- Arkansas (AR) - Arkansas Health & Wellness
- California (CA) - Health Net
- Florida (FL) - Sunshine Health
- Georgia (GA) - Peach State Health Plan
- Indiana (IN) - MHS
- Kansas (KS) - Sunflower Health Plan
- Louisiana (LA) - Louisiana Healthcare Connections
- Mississippi (MS) - Magnolia Health Plan
- Missouri (MO) - Home State Health
- Ohio (OH) - Buckeye Health Plan
- Pennsylvania (PA) - PA Health & Wellness
- South Carolina (SC) - Absolute Total Care
- Texas (TX) - Superior Health Plan
- Washington (WA) - Coordinated Care

Current Medicare Plans

Medicare – Medicaid Plans (MMP)

- California (CA) - Health Net
- Illinois (IL) - IlliniCare Health Plan
- Michigan (MI) - Michigan Complete Health
- Ohio (OH) - Buckeye Health Plan - MyCare Ohio
- South Carolina (SC) - Absolute Total Care - Healthy Connections Prime
- Texas (TX) - Superior Health Plan STAR+PLUS

What is a Model of Care?

- The Model of Care (MOC) is HSH's comprehensive plan for delivering our integrated care management program for members with special needs
- It is the architecture for promoting quality, care management policy and procedures and operational systems

Model of Care

The Model of Care is comprised of four clinical and non-clinical elements:

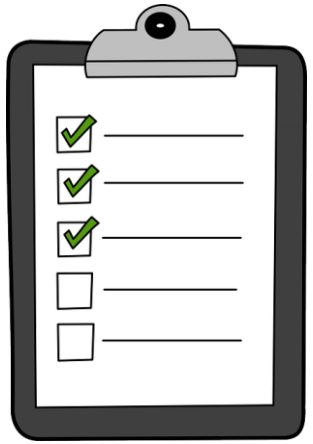
- ✓ Description of the SNP Population
- ✓ Care Coordination
- ✓ SNP Provider Network
- ✓ Quality Measurements & Performance Improvement

Element 1:

Description of the Population

Description of Member Population

- Element 1 includes characteristics related to the membership that Home State and providers serve including social factors, cognitive factors, environmental factors, living conditions and co-morbidities
- The element also includes:
  - Determining and tracking eligibility
  - Specially tailored services for members
  - How Home State Health works with community partners



Special Needs Plan (SNP)

- Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs. CMS has defined three types of SNPs that serve the following types of members:

  Dual Eligible Special Needs Plan (D-SNP)
  Members must have both Medicare and Medicaid benefits

  Chronic Condition Special Needs Plan (C-SNP)
  Members with chronic illness such as: Diabetes, COPD, Congestive Heart Failure

  Institutional Special Needs Plan (I-SNP)
  Members live in institutions such as: Nursing homes or long term facility

- Health plans may contract with CMS for one or more programs. Currently, Home State Health only offers **Dual SNP** plans.

Special Needs Plan (SNP)

- Medicare is always the primary payer and Medicaid is the secondary payer, unless the service is not covered by Medicare or the Medicare service benefit cap is exhausted for D-SNP members

- D-SNP members have both Medicare and Medicaid, but not always with Home State Health. Medicaid benefits may be via another Health Plan or the State

- It’s important to verify coverage prior to servicing the member

Medicare-Medicaid Plans (MMP)

- A Medicare-Medicaid Plan (MMP), sometimes referred to as a “Duals” plan, is a demonstration that combines Medicare and Medicaid. It’s a three-way contract between CMS, Medicaid and the health plan as defined in Section 2602 of the Affordable Care Act.
- The purpose of the MMP plan is to improve quality, reduce costs and improve the member experience. This is accomplished by:
    - Ensuring dually eligible members have full access to the services they are entitled
    - Improving coordination between the federal government and state requirements
    - Developing innovative care coordination and integration models
    - Eliminating financial misalignments that lead to poor quality and cost shifting

Medicare-Medicaid Plans (MMP)

- Eligibility rules vary from state to state; however, general eligibility guidelines must be met. Members must be eligible for Medicare and Medicaid, and have no private insurance
- MMP members have full Medicare and Medicaid rights and benefits
- The Medicare and Medicaid benefits are integrated as one benefit with the health plan coordinating services and payment

Note: Missouri does not offer MMPs.

Specific Services

Home State provides members with services tailored to the needs of the SNP and MMP populations. These services can include, but are not limited to:

- Care coordination and complex care management for high risk and most vulnerable members
- Care transitions management
- Physician home visiting services
- In-home wound care
- Disease management services
- Clinical management in long term care facilities as needed
- Medication Therapy Management and medication reconciliation
- Medicare and Medicaid benefit and eligibility coordination and advocacy

Element 2:

Care Coordination

Care Coordination

- The Care Coordination element includes a description of how the SNP will coordinate the care of health care needs and preferences of the member, and share information with the Interdisciplinary Care Team (ICT)
- Home State conducts care coordination using the Health Risk Assessment (HRA), an Integrated Care Plan (ICP) and providing an ICT for the member
- Care Coordination elements also includes:
  - Explanation of all the persons involved in care
  - Contingency plans to avoid disruption in care
  - Training that is required of all involved in member care and how it is administered

Care Coordination: HRA

An HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks of members.

- Home State attempts to complete the initial HRA telephonically within 90 days of enrollment and annually, or if there is a change in the members condition or transition of care
- HRA responses are used to identify needs, are incorporated into the member's care plan and communicated to care team
- Members are reassessed if there is a change in health condition
- Change(s) in health condition and annual updates are used to update the care plan

Note: Physicians should encourage members to complete the HRA in order to better coordinate care and create an individual care plan.

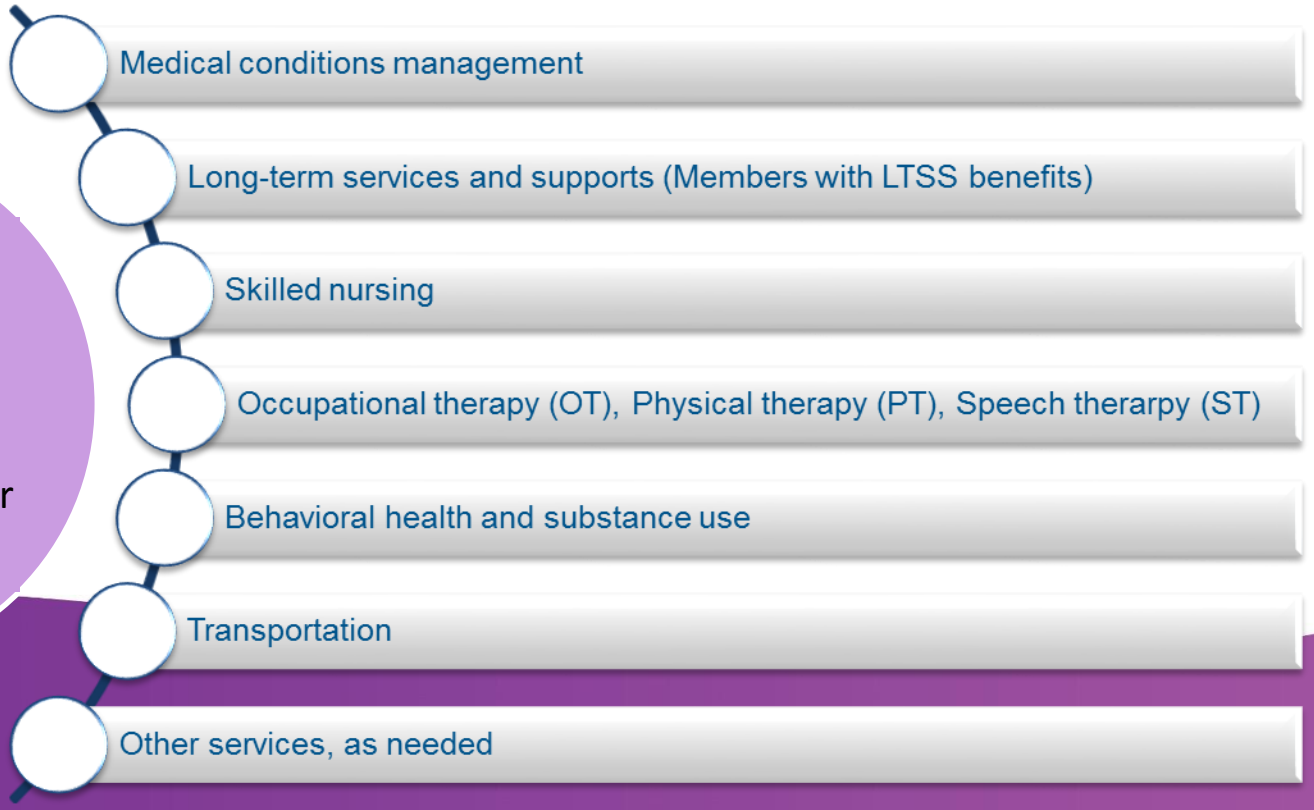
Individualized Care Plan (ICP)

- An Individualized Care Plan (ICP) is developed by the Integrated Care Team (ICT) in collaboration with the member
- Case Managers and PCPs work closely together with the member and their family to prepare, implement and evaluate the Individualized Care Plan (ICP)

Individualized Care Plan (ICP)

Members receive monitoring, service referrals and condition specific education based on their individual needs.

ICPs include member-centric problems, interventions and goals, as well as services the member will receive.

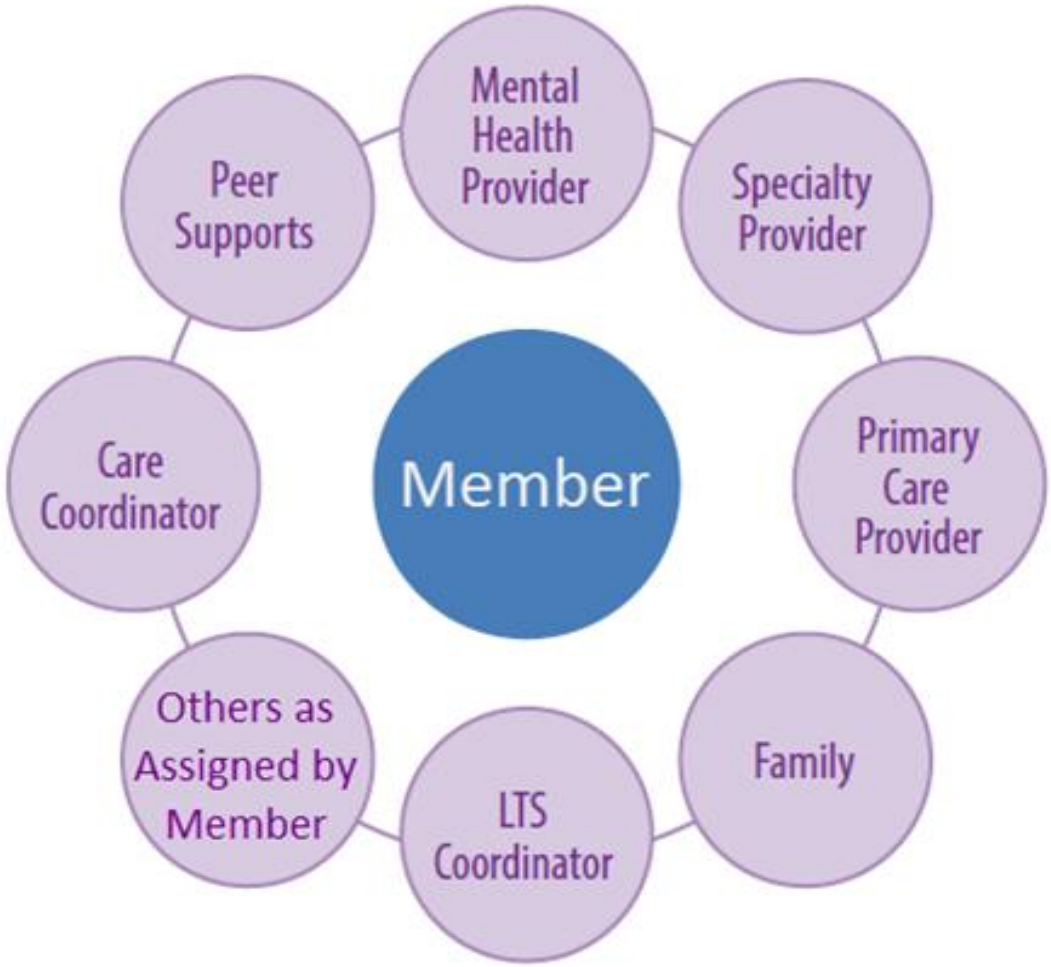


Integrated Care Team (ICT)

- Home State Health Case Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) **based on the member's preference** of who they wish to attend. The ICT includes:
  - Appropriately involved Home State staff
  - The member and their family/caregiver
  - External practitioners
  - Vendors involved in the member's care
- Home State Case Managers work with the member to encourage self-management of their condition, as well as communicate the member's progress toward these goals to the other members of the ICT

Integrated Care Team (ICT)

- Home State's program is member centric with the PCP being the primary ICT point of contact
- Home State staff works with all members of the ICT in coordinating the plan of care for the member



ICT and Inpatient Care

- During an episode of illness, members may receive care in multiple settings, often resulting in fragmented and poorly executed transitions

- Home State staff will manage transitions of care to ensure that members have appropriate follow-up care after a hospitalization or change in level of care to prevent re-admissions

ICT and Inpatient Care

Home State's Care Managers:

Coordinate with facilities to assist members in the hospital or in a skilled nursing facility to access care at the appropriate level	Work with the facility and the member or the member's representative to develop a discharge plan	Proactively identify members with potential for readmission and enroll them in case management	Notify the PCP of the transition of care and anticipated discharge date and discharge plan of care

ICT and Inpatient Care

Managing Transitions of Care interventions for all discharged members may include, but is not limited to:

- Face-to-face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan
- In-home visits or phone call within 72 hours post discharge
- Enrollment into the Case Management program
- Ongoing education of members to include preventive health strategies in order to maintain care in the least restrictive setting possible for their health care needs

ICT and Inpatient Care

In-home visits or phone calls are done to:

- Evaluate member's understanding of their discharge plan
- Assess member's understanding of medication plan
- Ensure follow up appointments have been made
- Make certain home situation supports the discharge plan

ICT Responsibilities

Home State works with each member to:

- Develop their personal goals and interventions for improving their health outcomes
- Monitor implementation and barriers to compliance with the physician's plan of care
- Identify/anticipate problems and act as the liaison between the member and their PCP
- Identify Long Term Services and Supports (LTSS) needs and coordinate services as applicable

ICT Responsibilities

- Coordinate care and services between the member's Medicare and Medicaid benefit
- Educate members about their health conditions and medications and empower them to make good healthcare decisions
- Prepare members/caregivers for their provider visits – Encourage use of personal health record
- Refer members to community resources as identified
- Notify the member's physician of planned and unplanned transitions

Provider ICT Responsibilities

Provider responsibilities include:

- Accepting invitations to attend member's ICT meetings whenever possible
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record when received
- Collaborating and actively communicating with:
  - Home State Case Managers
  - Members of the Interdisciplinary Care Team (ICT)
  - Members and caregivers

CMS Expectations

CMS expects the following related to ICT:

- All care is per member preference
- Family members and caregivers are included in health care decisions as the member desires
- There is continual communication between all members of the ICT regarding the member's plan of care
- All team meetings/communications are documented and stored

CMS Expectations

Natural disasters or emergencies can occur at any time. CMS requires each health plan to have a contingency plan to avoid disruption in care and services for their members.

Disruption can be avoided if:

- Corporate or regional office personnel will fulfill the duties of administrative staff
- Clinical employees are crossed-trained to ensure continuity and have the ability to work remotely using a web-based program on a secure network
- During an emergency, calls are diverted to other regional health plans within the Home State network

Element 3:

Provider Network

Provider Network

Element 3 explains the specialized expertise that is made available to members in Home State's provider network.

This element describes:

- How the network corresponds to the target population
- How Home State oversees network facilities
- How providers collaborate with the ICT and contribute to a beneficiary's ICP
- Home State is responsible for maintaining a specialized provider network that corresponds to the needs of our members
- Home State coordinates care with and ensures that providers:
  - Collaborate with the Interdisciplinary Care Team
  - Provide clinical consultation
  - Assist with developing and updating care plans
  - Provide pharmacotherapy consultation

CMS Expectations

CMS expects Home State Health Plan to:

- Prioritize contracting with board-certified providers
- Monitor network providers to assure they use nationally recognized clinical practice guidelines when available
- Assure that network providers are licensed and competent through a formal credentialing process
- Document the process for linking members to services
- Coordinate the maintenance and sharing of member's health care information among providers and the ICT

Element 4:

Quality Measurement & Performance Improvement

Quality Measurement & Performance Improvement

- Element 4 requires plans to have performance improvement and quality measurement plans in place
- To evaluate success, Home State disseminates evidence-based clinical guidelines and conducts studies to:
  - Measure member outcomes
  - Monitor quality of care
  - Evaluate the effectiveness of the Model of Care (MOC)

Model of Care Goals and Data Sources

- Home State determines goals for the MOC related to improvement of the quality of care that members receive
- The 2019 goals are in alignment with the Medicare and Medicaid regulatory agencies performance measurement systems:
  - Stars
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - Health Outcomes Survey (HOS)

Model of Care Goals may include:

- Access to care
- Access to preventative health services
- Member satisfaction
- Chronic care management

Summary

- Home State Health Plan values our partnership with our physicians and providers
- The Model of Care requires all of us to work together to benefit our members by:
  - Enhanced communication between members, physicians, providers and Home State
  - Using an interdisciplinary approach to the member’s special needs
  - Employing comprehensive coordination with all care partners
  - Supporting the member's preferences in the plan of care
  - Reinforcing the member’s connection with their medical home

MOC Attestation

After completing this training, please complete the attestation by clicking here:

https://www.homestatehealth.com/providers/allwell-provider-materials.html