Medicare: Model of Care Training 2021

4/22/2021

Training Objectives

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

After this training, attendees will be able to do the following:

- Outline the basic components of the Centene Model of Care (MOC)
- Explain how Centene medical management staff coordinates care of 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)

What is a Model of Care?

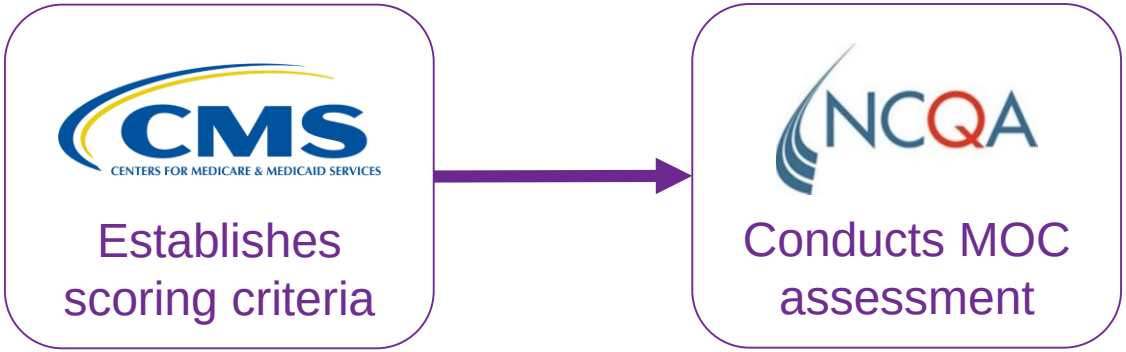
- ✓ The Model of Care (MOC) is a quality improvement tool that ensures the unique needs of each member enrolled in a Special Needs Plan (SNP) are identified and addressed

- ✓ It is Centene's comprehensive plan for delivering our integrated care management program for members with special needs

- ✓ It promotes quality measures, care management policy and procedures and operational systems

Model of Care

The Affordable Care Act requires the National Committee for Quality Assurance (NCQA) to review and approve all SNP MOCs using standards and scoring criteria established by Centers for Medicare and Medicaid (CMS)



Model of Care Training

- All **employees** and **providers** who interact with SNP members are required by CMS to complete annual MOC training. This also includes all members of the Interdisplinary Care Team (ICT)
- This course is offered to meet the CMS regulatory requirements for MOC Training for our SNPs

What is a 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 Special Needs Plans (DSNP)

- Members must have both Medicare and Medicaid benefits

Chronic Condition Special Needs Plans (CSNP)

- Members with a specific chronic illness or illnesses

Institutional Special Needs Plans (ISNP)

- Members who live in institutions such as: Nursing homes or long term facility

All Medicare SNP plans consist of DSNPs and CSNPs; Home State Health Plans presently do not have ISNP plans.

Model of Care

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

1. Description of the SNP Population
2. Care Coordination
3. SNP Provider Network
4. Quality Measurements & Performance Improvement

MOC Element 1

Description of SNP Population

Description of Member Population

MOC Element 1 includes characteristics related to the membership that Centene and providers serve including demographics, social factors, cognitive factors, environmental factors, living conditions and co-morbidities.

This element also includes:

- Description of most vulnerable population
- Determining and tracking eligibility
- Specially tailored services for members
- How Centene works with community partners

MOC Element 2

Care Coordination

Care Coordination

The Care Coordination element includes detailed descriptions of the following:

- How the SNP will coordinate the care of health needs and preferences of the member, and how care coordination information is shared with members of the Interdisciplinary Care Team (ICT)
- Listing and explanation of roles of all the persons involved in the care of the member
- Contingency plans to avoid disruptions in care
- Training for all involved in member care and how it is administered

Coordinating Care

Centene conducts care coordination using the Health Risk Assessment (HRA), an Individualized Care Plan (ICP) and providing an Interdisciplinary Care Team (ICT). Basic components of care coordination are:

HRA

CMS required assessment for every SNP member to determine member's health status including cognitive functions and SDOHs

ICP

CMS required plan for every member based on HRA results that includes health goals, barriers and interventions

ICT

CMS required team of individuals involved in the member's care either professionally or personally

TOC

Coordinating Transitions of Care (TOC) and its impacts to the member's health status determined by their HRA, their ICP and ICT

Health Risk Assessment (HRA)

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

- Centene attempts to complete the initial HRA 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 that 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 Interdisciplinary 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 problems, interventions and measurable goals, as well as services the member will receive.

- Medical condition management
- Long-term services and supports (LTSS benefits)
- Skilled nursing, DME, home health
- Occupational therapy, physical therapy, speech therapy
- Behavioral health and substance use disorder
- Transportation
- Other services, as needed

Interdisciplinary Care Team (ICT)

Centene Care Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) and operate as the single point-of-contact for all ICT members

Centene's SNP program is member centric. The ICT is **based on the member's decision** of who should participate

The ICT is designed to provide the expertise needed to manage the member's care. The PCP, member/caregiver and the Care Manager make up the core members of the ICT

Centene staff work with members of the ICT in coordinating the plan of care with the member and to encourage self-management of their condition

ICT Responsibilities

Centene works with each member to manage the following:

- 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 Cont'd

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

ICT Responsibilities Providers

- Communicate with, and respond to communication from the plan regarding the member's care, including accepting meeting invitations when applicable
- Maintaining copies of the ICP and transition of care notifications in the member's medical record when received
- Collaborating and actively communicating with the following:
    - Centene Case Managers
    - Members of the Interdisciplinary Care Team (ICT)
    - Members and caregivers

ICT Communications

Members of the ICT engage in discussions related to the member's health status and care coordination activities through a variety of methods:

- Telephone
- General mail
- Secure e-mail
- Fax
- In person
- Member apps
- Member/Provider Portals
- Virtual/ Teleconference Meetings
- Other methods preferred by member/provider

Transition of Care (TOC)

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

Centene staff will manage Transitions of Care (TOC) to ensure that members have appropriate follow-up care after hospitalization or change in level of care to prevent re-admissions.

Transition of Care (TOC)

Managing TOC interventions for all discharged members may include, but is not limited to, the following:

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 to evaluate member's understanding of their discharge plan, medication plan if applicable, ensure follow-up appointments have been made, and make certain the home supports the discharge plan

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

MOC Element 3

Provider Network

Provider Network

MOC Element 3 explains the specialized expertise in Centene's provider network that is made available to SNP members.

Centene is responsible for maintaining a specialized provider network that corresponds to the needs of our members.

This element describes the following:

- How the network corresponds to the target population
- How Centene oversees network facilities and providers
- How providers collaborate with the ICT and contribute to a member's ICP
- How Centene coordinates care with and ensures that providers:
  - Provide clinical consultation
  - Assist with developing and updating care plans

Provider Network

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CMS Expects Centene to do the following:

1	2	3	4	5
Prioritize contracting with board-certified providers	Monitor network providers to ensure they use nationally recognized clinical practice guidelines when available	Ensure 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

Provider Network – Who Pays?

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

- DSNP members have both Medicare and Medicaid but not always with Centene. Medicaid benefits may be via another Health Plan or the State, unless the DSNP is one of the following. It's important to know what type of DSNP your plan is:
    - Fully Integrated DSNP plans (FIDE)
    - Highly Integrated DSNP plans (HIDE)

- It's important to verify coverage prior to providing any services

MOC Element 4

Quality Measurement & Performance Improvement

Quality Measurement & Performance Improvement

- MOC Element 4 requires SNPs to have performance improvement and quality measurement plans in place.

- To evaluate success, Centene disseminates evidence-based clinical guidelines and conducts the following studies:
  - Measure member outcomes
  - Monitor quality of care
  - Evaluate the effectiveness of the Model of Care (MOC)

Model of Care Goals

Centene determines goals for the MOC related to improvement of the quality of care that members receive.

Goals are based on the following:

- Medicare Stars Measures
- 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:

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

Summary

The Model of Care requires all of us to work together to benefit our members through:

- Enhanced communication between members, physicians, providers and Centene
- Provide an interdisciplinary and clinically based approach to the member’s special needs
- Employ comprehensive coordination with all partners involved in the member’s care
- Support the member's preferences in the plan of care
- Reinforce the member’s self-management capabilities and connections with providers and support services

Health Plan Information

Medicare Product/Operations:	**Beth Johnson, Sr. Director of Medicare Operations** *elizabeth.a.johnson@homestatehealth.com*
Provider Relations:	**Allwell HMO: 855-766-1452** **Allwell D-SNP: 833-298-3361**
Medical Management (CM & UM):	**Jennifer West, Manager, Case Management** *jennifer.l.west@homestatehealth.com*
Quality:	**Dr. Jennifer Wessels, Chief Medical Director** *jennifer.wessels@homestatehealth.com*

For questions or additional information, please contact Provider Relations Representative.