Elevate Medicare Choice (HMO D-SNP)

Special Needs Plan (SNP)

Model of Care (MOC) Training

2024

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Elevate Medicare Choice (HMO D-SNP)

Model of Care (MOC) Training Overview

This Model of Care (MOC) training manual meets the Centers for Medicare and Medicaid Services (CMS) regulatory requirements of MOC training for the Elevate Medicare Choice (HMO D-SNP) [H5608] Plan. It serves as DHMP's plan for delivering coordinated care and care management to special needs members with both Medicare and Medicaid.

The MOC is a very important quality improvement tool. It helps ensure that the unique needs of each dual eligible member are identified and addressed and meet DHMP's care management policy, procedures, and operational systems goals.

Through distribution of this training, and an attestation, DHMP will ensure all employees and providers who work with DHMP's dual eligible members have the specialized training this population requires.

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Elevate Medicare Choice (HMO-DSNP)

CMS requires all DHMP's HMO SNP staff and contracted medical providers to receive basic training about the MOC. This training will describe how DHMP, and its contracted providers work together to successfully deliver the MOC program for dual eligible members.

After reading this training, providers and care team members will be able to:

- Describe the basic components of the DHMP's MOC.
- Explain how DHMP's medical management staff coordinates care for dual eligible members.
- Describe the essential role of providers in the implementation of the MOC program.
- Explain the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT).

Special Needs Plans (SNPs)

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 members (D-SNP) – DHMP serves D-SNP members**,
- Individuals with chronic conditions (C-SNP)
- Individuals who are institutionalized or eligible for nursing home care (I-SNP)

Health plans may contract with CMS for one or more programs. Of the three types of SNPs, DHMP currently only contracts for D-SNP. DHMP's D-SNP product is called **Elevate Medicare Choice (HMO D-SNP)**, a Dual-eligible Special Needs Medicare Advantage Prescription Drug plan.

Special Needs Plans (SNPs) Coverage

It is important to verify coverage prior to serving the member. This is because D-SNP members may have both Medicare and Medicaid provided by DHMP, but not always. Providers may see members with Elevate Medicare Choice (HMO D-SNP) coverage who have their Medicaid under another health plan or traditional Fee-For-Service (FFS) Medicaid.

Acute care services for D-SNP members are paid as follows:

- The member's Medicare plan – Elevate Medicare Choice is always the primary payer.

- Colorado Medicaid (Health First Colorado) or Elevate Medicaid Choice is secondary.

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About Elevate Medicare Choice (HMO D-SNP) Plan

Elevate Medicare Choice (HMO D-SNP) is designed for Dual Eligible beneficiaries who are enrolled in Original Medicare (Parts A and B) and receive additional wrap benefits from Medicaid through Health First Colorado and Elevate Medicaid Choice. Eligible individuals may enroll in our plan at any time, year-round.

The plan has a highly qualified and compassionate group of in-network providers and specialists who collaborate to help our members stay healthy, active, and independent. Keep in mind, referrals made to out-of-network providers will increase Member cost. Members are provided with:

- Comprehensive medical, hospital coverage
- Prescription drug coverage, and
- Additional benefits not provided by Original Medicare or Medicaid.

While Members of the plan enjoy open access, they are highly encouraged to use in-network hospitals and PCPs for scheduled, routine and specialty care. In all cases, PCPs oversee, authorize, refer, and facilitate Member care except in a life-threatening situation or when there are provider access issues.

Model of Care (MOC) – Goals and Key Care Elements

What is the MOC?

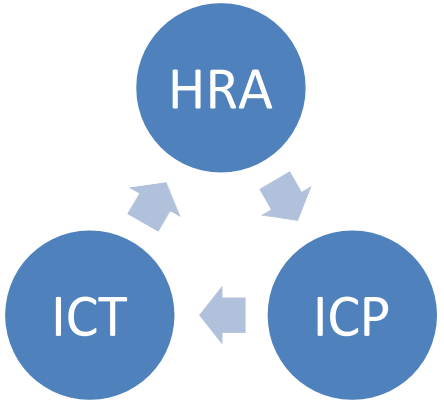
The Model of Care is Elevate Medicare Choice (HMO D-SNP)'s plan for delivering an integrated care management program for members with special needs. It is the architecture for care management policy, procedures, and operational systems.

MOC Goals:

- Improve access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across health care settings and providers
- Improve access to preventive health services
- Assure cost-effective service delivery
- Improve beneficiary health outcomes

MOC Key Elements:

- Completion of a Health Risk Assessment (HRA)
- Development of an Individualized Care Plan (ICP)
- Creation of an Interdisciplinary Care Team (ICT)



Health Risk Assessment (HRA) and Individualized Care Plan (ICP)

Health Risk Assessment (HRA)

Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment. Members are evaluated annually or more frequently with any significant change in condition or transition of care. The HRA collects information about the member's medical, psychosocial, cognitive, and functional needs, as well as medical and behavioral health history. Members are then triaged to the appropriate DHMP case management program for follow-up.

Individualized Care Plan (ICP):

An Individualized Care Plan (ICP) is developed with input from all parties involved in the member's care.

The DHMP ICP includes:

- Identified member-specific Problems, Goals, and Interventions, with measurable outcomes
- Integration of Medicare and Medicaid Services and benefits to be provided
- Documented coordination of care and transition of care efforts across care settings
- Coordination with community services and supports when appropriate
- Condition-specific education for the member and caregivers, and
- Documented collaboration between Case Managers and PCPs works closely together with the member and the member's family to prepare, implement and evaluate the ICP

Face to Face Encounters

DHMP Care Management staff or delegates conduct annual face-to-face encounters with enrollees of the DSNP to deliver healthcare, care management, and care coordination services in accordance with the MOC.

Face-to-face encounters will be performed either in person, or in a visual real time interactive tele-health encounter. (Voice only visits do not count.) Visits are documented in the Guiding Care system or the member's medical record.

During a face-to-face visit the following services may occur:

A. Engaging with the member to oversee their healthcare,
B. Annual wellness visits or physical,
C. Health Risk Assessment (HRA) completed in-person or via telehealth,
D. Care plan review or care coordination activities,
E. Health-related education,
F. Encounters may address behavioral health, social determinants of health (SDOH), gaps in care or overall health, including functional status,
G. Coordination of appropriate referrals to community services and other home-based services determined to be appropriate, and/or
H. Assisting with scheduling of follow-up appointments with providers as indicated.

Interdisciplinary Care Team (ICT)

DHMP's care managers coordinate the member's care with the ICT, which includes DHMP staff, the member, the member's family/caregiver and external practitioners and care teams involved in the member's care. The ICT participants are based on the member's unique needs.

DHMP's care managers work with the member to encourage self- management of the member's condition. They also communicate the members' progress toward these goals to the other members of the ICT.

DHMP's care managers are required to make two attempts to contact the primary provider and specialty provider (seen 3x or more a year) to participate in developing the care plan (ICP) and invitation to the care plan meeting (ICT). The ICT meetings are conducted weekly and one-off meetings are available to providers and members to accommodate schedules.

ICT Transitions of Care (TOC)

Transition of Care (TOC) coordinates the delivery of care for Members through an integrated and systematic care coordination process. This collaborative effort provides Members with continuity of care, thereby improving quality, access, and value.

Care Management staff will place an in-patient and post-discharge call to Members who are high-risk or have unresolved discharge needs. The call may include:

- Confirmation that follow-up appointments are made.
- Verification that prescriptions are filled.
- Confirmation that discharge services are completed.
- Care management goals are to support Members and providers across the continuum by:
    - Helping Members make transitions safely
    - Facilitating and supporting close connections to their PCP
    - Providing an ongoing nursing plan of care

Transitions of Care services are available to all plan Members who require a multidisciplinary approach to their care. Nurses and social workers assist Members with needs spanning various aspects of social services and the medical community. The DHMP Care Manager is the primary lead in coordinating the care transition process. In collaboration with facility discharge staff, primary care, specialty care and community-based services, the Member's Care Manager, through direct coordination and using supporting clinical and professional staff, leads all activities and communication with the Member/caregiver.

DHMP SNP MOC program is member-centric with the PCP being the primary ICT point of contact. DHMP staff works with all members of the ICT in coordinating the plan of care for the member.

ICT and Inpatient Care Coordination

- Coordinate with facilities to assist members in the hospital or in a skilled nursing facility to access care at the appropriate level and long-term services and supports as needed.
- Work with the facility and the member or the member's representative to develop a discharge plan, which will include various services and supports, including coordination with community providers.
- Proactively identify members with potential for readmission and enroll them in care management.
- Notify the Primary Care Provider (PCP) of the transition of care and anticipated discharge date and discharge plan of care.
- To prevent re-admissions, DHMP CM staff manages transitions of care to ensure members have appropriate follow-up care after a hospitalization or change in level of care.
- When members are ill, they may receive care in multiple settings, which often results in fragmented and poorly executed transitions.

Colorado Managed Long-Term Services and Supports

- MLTSS is a variety of programs that provide services to help individuals to remain living independently in the community or the most appropriate care setting of their choice. These services are covered under the Medicaid benefit.

- Assessment for MLTSS needs begins with the Health Risk Assessment (HRA). Ensuring members active participation in identifying their health needs, helps the care coordinator identify what services the member may benefit from.

- Face to face visits by qualified providers can also assist members in determining whether members qualify for certain waivers based on their conditions.

- A waiver is an extra set of benefits that members may qualify for based on their condition. Examples include: Developmental Disabilities (DD), Elderly,Blind and Disabled (EBD), Community Mental Health Supports (CMHS) and Brain Injury Waiver (BI).

Colorado Managed Long-Term Services and Supports

- During the care planning process, Care Managers can develop goals around these specific needs, and/or assist members in getting care and benefits provided by these waivers

- The Care Team includes participants from any home or community based services that the member is receiving, so that valuable input can be incporporated into the overall treatment plan for members.

- When assisting members through a Transition of Care (TOC), the Care Managers addressing primary, acute and long-term care needs before the member returns to the commnity

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DHMP and Provider Responsibilities

DHMP Responsibilities include:

DHMP CM Team works with each member to:

- Coordinate care and services between the member's Medicare and Medicaid benefit
- Develop personal goals and interventions for improving health outcomes
- Provide education about their health conditions and medications, while empowering the member to make good health care decisions
- Identify and anticipate problems, and act as the liaison between the member and the member's PCP
- Monitor implementation and barriers to comply with the physician's plan of care
- Identify member needs and coordinate services
- Make referrals to community resources as identified

ICT Provider Responsibilities include:

- Accepting invitations to attend member's ICT meetings whenever possible and actively communicating with DHMP (HMO-SNP) care managers, members of the ICT, the member, and their caregiver(s)
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record, when received
- Ensuring that STARs measures such as Functional Assessments, Advance Care Planning, Medication Reviews and Pain Assessments are completed and documented in member's medical record

Centers for Medicare & Medicaid Services (CMS)

Expectations of ICT and Provider Network

CMS expects the following related to the ICT:

- All care is based on member preference
- Family members and caregivers are included in health care decisions as the member desires
- Continual communication between all members of the ICT regarding the member's plan of care
- All team meetings/communications are documented and stored
- All team members are involved and informed in the coordination of care for the member
- All team members are advised on the ICT program metrics and outcomes
- All internal and external ICT members are trained annually on the current MOC

CMS expectations for Provider Network

DHMP is responsible for maintaining a specialized provider network that corresponds to member needs. DHMP coordinates care and ensures that providers:

- Collaborate with the ICT
- Provide clinical consultation
- Assist with developing and updating care plans
- Provide pharmacotherapy consultation

CMS Expectations of Elevate Medicare Choice (HMO D-SNP)

CMS expects the following of DHMP:

- 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

Summary

DHMP values provider partnerships. The MOC requires collaboration to benefit members in the following ways:

- Enhanced communication between members, caregivers, providers and DHMP
- Interdisciplinary approach to the member's special needs
- Comprehensive coordination with all care partners
- Support for the member's preferences in the plan of care
- Reinforcement of the member's connection with their medical home

Quick Check

- If you are completing this training in Workday there is no need to complete the attestation attached.

- If you are a DHMP employee or provider and did not complete training in Workday, **please complete the attestation on the next page. Email to DSNPCare@dhha.org or fax/scan to (303) 602-2146.**

- If you are a non-DHMP provider, please complete the attestation, on the next page, and **fax/scan back to the Care Management Department at (303) 602-2146. Email to DSNPCare@dhha.org.**

Attestation of Completion of DHMP SNP Model of Care Training for 2024 for Providers and Care Team

Non-DHMP Providers: Annual MOC Training is a CMS Regulatory Requirement. By signing below, you are attesting to the fact that this training has been reviewed and understood by you. **Please print and complete the form below then fax/scan this page back to DHMP Care Management Department at: (303) 602-2146. Email to DSNPCare@dhha.org.**

Date Training Completed: _____

Printed Name: Title: _____

Address: _____

Phone: _____

Provider Tax ID(s) if applicable: _____

Signature: _____

Practice Name if applicable: _____