Jefferson Health Plans

D-SNP Plan MOC Medicare Training

D-SNP MOC Overview

Purpose

- The Model of Care (MOC) training is conducted annually to ensure all Jefferson Health Plans employed and contracted staff involved with our Dual Special Needs Plan (DSNP) members have a complete understanding of the program.

- Successful completion of this training module is mandatory for providers serving Health Partners Medicare's DSNP members.

- At least one member of a care team location is required to take the annual online training course, complete the attestation and distribute the training material to all D-SNP care team members.

- Annual MOC training is mandatory for all employed and contracted staff involved with the D-SNP population and must be completed within 45 days of hire. Additionally, HRAT, ICP and ICT training is required for Medicare Clinical Staff.

Special Needs Plans (SNPs)

- Special Needs Plans (SNPs) were created by Congress through the Medicare Modernization Act of 2003. SNPs are a type of Medicare Advantage Plan.

- There are three types of SNPs that limit membership to specific types of enrollees:

Chronic Care
With specific types of chronic conditions

Dual Eligible*
Who receive both Medicare and Medicaid

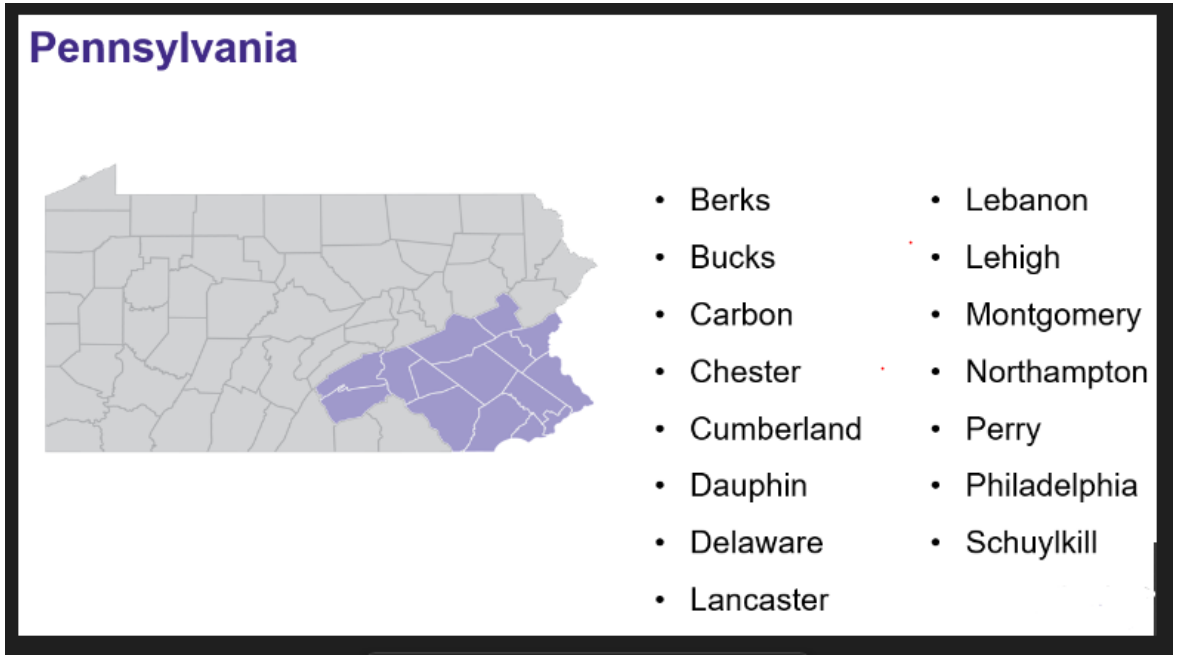
Institutional
Live in an institution or require nursing care at home

- * Health Partners Medicare (part of Jefferson Health Plans) offers a Dual Eligible Special Needs Plan.

Background

- All Medicare Advantage Organizations that offer Special Needs Plans are required to submit a Model of Care for CMS approval.

- To the right is a map of our service area



What is the Model of Care (MOC)?

- The Health Partners Medicare Model of Care (MOC) is designed to meet the specific health care needs of our dual eligible beneficiaries by providing and coordinating services.

MOC 1
Description of the SNP Population

MOC 2
Care Navigation

MOC 3
SNP Provider Network

MOC 4
Quality Measurement & Performance Improvement

MOC 1: Description of the D-SNP Population

MOC 1: Description of the D-SNP Population

- Annually, the Health Partners Medicare team performs a population assessment to determine the needs of our membership as well as the community we serve. Age, gender, claims, disease prevalence in the region, food sources and other social determinants of health are reviewed.

- Using this information, we determine if all resources including community, practitioner and provider partners are in place to meet the beneficiaries' health and social needs.

MOC 1: Description of the D-SNP Population

Culture and Gender

- 48% Black
- 29% White
- 13% Hispanic
- 9% Other
- 75% Female
- 25% Male

Education, Health Literacy, and income

- 49% Did not graduate high school
- 30% Annual household income is less than $10,000
- 26% Speak a language other than English (with Spanish most prevalent)
- 40% Have diabetes

MOC 1: Description of the D-SNP Population

Per CMS, the MOC must include:

- Methodology for determining, verifying and tracking member eligibility.
- Profile of medical, social, cognitive, environmental and living conditions and comorbidities associated with SNP population.
- Health conditions impacting SNP, as well as issues such as language barriers, health literacy deficits, socioeconomic status, and cultural beliefs.
- Community partnerships providing resources to most vulnerable members.

Brain Teaser 1

Description of the D-SNP Population

What must the description of the D-SNP Population, per CMS include?

A. Methodology for determining, verifying and tracking member eligibility.
B. Profile of medical, social, cognitive, environmental and living conditions and comorbidities associated with SNP population.
C. Health conditions impacting SNP, as well as issues such as language barriers, health literacy deficits, socioeconomic status, and cultural beliefs.
D. Community partnerships providing resources to most vulnerable members.
E. All of the above

MOC 2: Care Navigation

MOC 2: Care Coordination-Resources to Meet Member's Needs

- All D-SNP members are assigned to a Care Coordinator upon enrollment to foster and maintain a strong relationship.
- The Care Coordinator works with all clinical areas to educate D-SNP members on self-management techniques and provide pharmacy consultation, behavioral health counseling and clinical oversight.
- Examples include:
  - Transportation vendor: an enhanced benefit that includes unlimited rides per year to doctor appointments, pharmacies and other plan-approved locations.
  - Food resources: all staff have a list of food resources to direct beneficiaries to locations in their zip codes.
  - Pharmacy: home delivery and pre-packaging provided by participating pharmacies for those members who have difficulty accessing and/or managing their prescriptions.

MOC 2: Health Assessment Tool (HAT)

- This self-reported health assessment identifies member risk level of care for care coordination:
  - High
  - Low

- A completed HAT provides our Care Coordinators with a clearer understanding of our members needs.

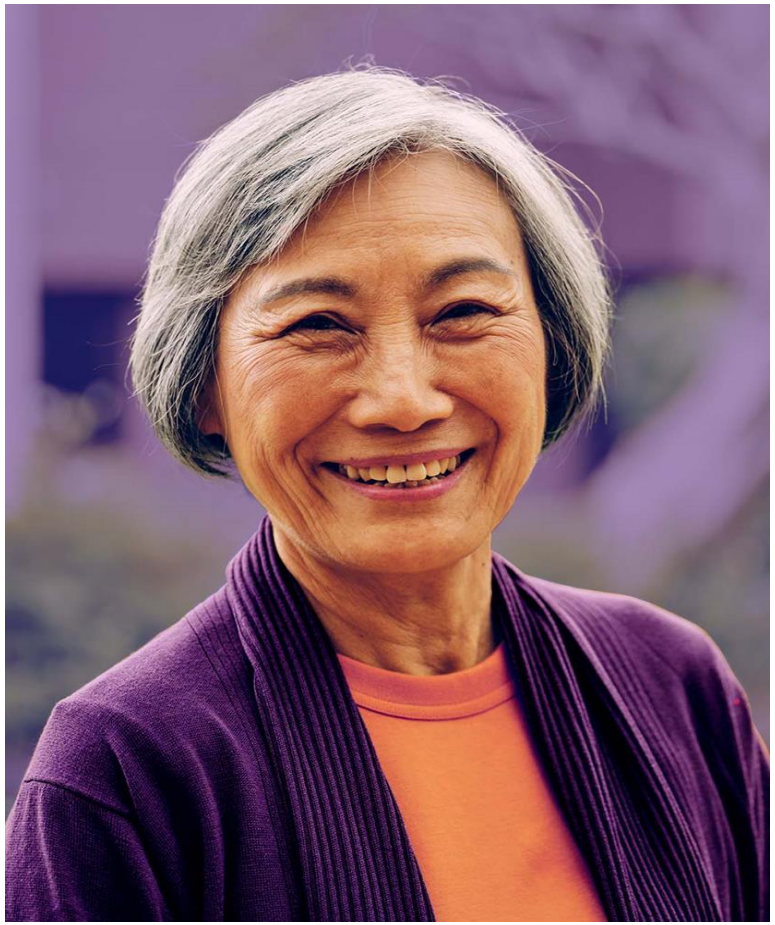
- Case management uses a CMS-approved HAT that assesses the medical, cognitive, functional, psychosocial and mental health of each DSNP beneficiary.

- All DSNP beneficiaries are assessed initially within 90 days of effective date and annually thereafter.

- The HAT is conducted telephonically by HA Outreach Coordinators and reviewed by the team leads to evaluate the member's needs and assign to the appropriate Care Coordination team.

MOC 2: Individualized Care Plan (ICP)

- ICPs for members are created utilizing a combination of all information available including:
  - HA results
  - Utilization and claims data
  - Preventive health information, according to the member's age and gender
- The ICP is revised at least annually, or when the member has a significant change in health status, such as an inpatient admission.
- The goal is to educate and empower the member and/or caregiver to take an active role in managing healthcare needs.



16

MOC 2: Individualized Care Plan (ICP)

- CMS requires that an Individualized Care Plan (ICP)* be completed for each D-SNP member within 30 days of HA completion. A revised ICP will be completed within 30 days of a revised HA.

- The ICP includes:
  - Member-specific identified goals
  - Medical, pharmacy, preventive and behavioral health interventions
  - Information/access to community resources

- *If a member could not be reached or chose not to create an HA, the ICP will be based on historical claims data.

MOC 2: Individualized Care Plan (ICP)

- All members and their PCPs receive a copy of the ICP with clear action steps for the year
- ICPs are based on issues, interventions and goals:
  - Issues are identified using the member's answers on the HA and other communication with member.
  - Interventions are tailored to each member's needs. The ICP will address member-specific barriers to complying with the plan.
  - Goals are reassessed at least annually and adjusted accordingly.

Transition of Care

- Transition of Care protocols maintain continuity of care for members, reducing complications and readmissions.
  - The Care Coordinator may work with the hospital discharge planner and transitional care managers to identify member's health care needs and address barriers/environmental concerns.
  - The member and/or caregivers are educated about member's health status to assist with self-management.

- Other events that would trigger an ICP include a practitioner referral, member self-referral and inappropriate use of resources.
  - Both the PCP and/or the member can request a meeting to further discuss the ICP.
  - The results are communicated to members and their PCP during the Interdisciplinary Team (ICT) Meeting and via mail after the ICT.

MOC 2: Care Coordination Interdisciplinary Care Team (ICT)

- Composition is specific to the member but may include:
  - Member or Member's family caregivers, if requested.
  - Member's identified PCP or specialists.
  - Member's ancillary providers such as occupational therapy (OT), physical therapy (PT) and home care.
  - Our health care management staff that includes a pharmacist, Medical Director, behavioral health provider and Certified Registered Nurse (CRNP).
  - Member's identified community-based agencies.

MOC 2: Care Coordination ICT

- The ICT meeting takes place within 30 days of the completed ICP.
  - Additional ICT meetings will be completed within 30 days of a revised ICP.

- The ICT meeting takes place telephonically for all outside participants.

- Members, caregivers, PCPs and specialists are all invited to participate in the ICT.
  - However, all members are required to have an ICT whether or not the member and/or their provider choose to participate in the meeting.

- At the ICT meeting:
  - The ICP is presented, recommendations are made and an updated ICP is mailed to the member and the assigned PCP if changes are made to the member's goals.
  - All privacy rules apply, and all documentation is maintained in the care management system.

Brain Teaser 2

Individualized Care Plan (ICP)

Which of the following events will trigger an ICP?

A. An inpatient event
B. Practitioner referral
C. Beneficiary self-referral
D. Inappropriate use of resources without a PCP visit
E. All the above

MOC 3: Provider Network

MOC 3: Provider Network

- The MOC must establish a provider network with specialized expertise that describes how:
  - The plan chooses providers and ensures that they are competent and credentialed.
  - The plan documents, updates and maintains accurate provider information.
  - Providers collaborate with the ICT and contribute to the ICP to provide specialized services.
  - The plan must oversee how network providers use evidence-based medicine by:
    - Monitoring how network providers use appropriate clinical practice guidelines and nationally recognized protocols for target population.
    - Identifying how these may be inappropriate or need to be modified for vulnerable members.
    - Monitoring provider's adherence to clinical and preventive guidelines through the Quality Care Plus (QCP) program.

MOC 3: Provider Network Training

- The plan must provide initial and annual training for network providers.
- All provider training must be documented and tracked.
- Training plan must describe actions to be taken when training is not completed timely.

Brain Teaser 3

Provider Network

How does the MOC establish a provider network with specialized expertise?

A. The plan chooses providers and ensures that they are competent and credentialed.
B. The plan documents, updates and maintains accurate provider information.
C. Providers collaborate with the ICT and contribute to the ICP to provide specialized services
D. None of the above
E. All of the above

MOC 4: Quality Measurement & Performance Improvement

MOC 4: Quality Measurement & Performance Improvement

- Jefferson Health Plans has a quality improvement plan that is in place to monitor the progress of the MOC to meet goals.
- Jefferson Health Plans collects, analyzes and evaluates data to evaluate the effectiveness of the program.
- Jefferson Health Plans' quality management elements are consistent with CMS' Triple Aim:
  - Better care
  - Healthier people/healthier communities
  - Lower costs through improvements

MOC 4: Quality Measurement & Performance Improvement-Data Source

Measurements include HEDIS Rates for:			
Diabetic Star Measures:	Eye Exams	Kidney Disease Monitoring	Blood Sugar Control
Care of Older Adults (COA):	Functional Status	Medication Review	Pain Screening
HEDIS and CAHPS Metrics for Screening Tests and Vaccines:	Breast Cancer	Colorectal Cancer	Reducing Fall Risk & BMI Assessment
HEDIS and HOS Measures for Management of Chronic Conditions			

MOC 4: Quality Measurement & Performance Improvement

- Jefferson Health Plans' Quality Management Program (QMP) includes:
  - Program goals and processes for data retrieval and analysis.
  - Reassessment if goals are not met.

- The MOC evaluation goals and metrics include:
  - Specific goals for improving access and affordability of the healthcare needs of D-SNP members.
  - Improvements in care coordination and delivery of services through HRA, ICP and ICT.
  - Enhanced care transitions across all health care settings and providers.
  - Appropriate utilization of services for preventive health and chronic conditions.

MOC 4: Quality Measurement & Performance Improvement

- Jefferson Health Plans monitors D-SNP member satisfaction through:
  - Medicare CAHPS results
  - Case management survey results
  - Grievance and appeals data

MOC 4: Quality Measurement & Performance Improvement

- Ongoing Performance Improvement Evaluation and Data Sharing

- Performance indicators are tied to benchmarks such as:
  - Chronic Care Improvement Program (CCIP)
  - CMS Star Ratings

- The Quality Management Committee (QMC) is responsible for QMP development, implementation and evaluation. QMC shares information with Board of Directors and other stakeholders.

Brain Teaser 4

Quality Measurement & Performance Improvement

Which of the following MOC evaluation goals and metrics are included?

A. Specific goals for improving access and affordability of the healthcare needs of D-SNP members.
B. Improvements in care coordination and delivery of services through HRA, ICP and ICT.
C. Enhanced care transitions across all health care settings and providers.
D. Appropriate utilization of services for preventive health and chronic conditions.
E. All of the above

How Can You Help?

- Refer members to our Care Coordinators when case management services are identified.
- Participate in the ICTs when requested. Your input is valuable!
- Let us know if you need more information about the MOC.
- Contact the Care Coordination unit with questions or suggestions to enhance MOC.

Conclusion

Thank you for joining the DSNP MOC Medicare training!

Please complete your DSNP Attestation using the link below.

- https://www.healthpartnersplans.com/providers/provider-education-attestation?tot=DSNP

Get in Touch with Us!

- Contact us via the Jefferson Health Plans Provider Services Helpline:1-888-991-9023

Jefferson
Health Plans

JeffersonHealthPlans.com