Jefferson Health Plans

Dual Special Needs Plan (DSNP) Model Of Care Training

July 25, 2024

Mission, Vision and Core Values

Mission: To build healthier lives and stronger communities.

Vision: We connect with the hearts and minds of those we serve, improving the health outcomes for our members, operating with respect and dignity, while cultivating inclusivity and belonging.

Core Values: We serve our members and communities with integrity, commitment, compassion, excellence and inclusivity.

DSNP Model Of Care (MOC) Overview

Jefferson Health Plans

Purpose

- The Model of Care (MOC) training is conducted annually to ensure all contracted and non-contracted medical providers and staff receive training on the DSNPs MOC as required by the Centers for Medicare & Medicaid Services (CMS). Completion of the annual MOC training is mandatory for all providers who serve Jefferson Health Plans DSNP members.

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

- The goal of the training is to explain how Jefferson Health Plans and our provider partners (both contracted and non-contracted) can work cohesively together to deliver care.

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. SNP's members are individuals who are entitled to both Medicare (Title XVII) and medical assistance from the state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

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

Chronic Care
With specific types of chronic conditions

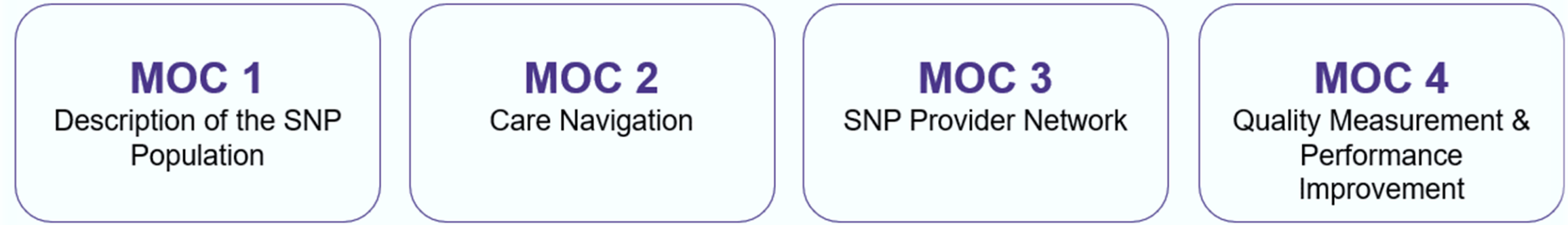
Dual Eligible*
Who receive both Medicare and Medicaid

Institutional
Live in an institution or require nursing care at home

- *** Jefferson Health Plans Medicare offers two Dual Eligible Special Needs Plans.**

What is the Model of Care (MOC)?

- The MOC provides the basic framework under which the SNP will meet the needs of each of its members.
- The MOC provides the foundation for promoting quality SNP care management and care coordination processes.
- All Medicare Advantage Organizations that offer SNPs are required to submit a MOC approved by the National Committee for Quality Assurance (NCQA).
- The MOC is comprised of 4 Elements outlined below:



MOC Eligibility

- Eligible members
  - Must reside within the plan service area
  - Must meet dual eligibility status requirements
- Primary coverage for DSNP members:
  - Medicare is always the primary payer
  - Medicaid is the payer of last resort and supplements Medicare coverage
  - Members are eligible for special election period to change health plans quarterly throughout the year

In 2024, Jefferson Health Plans offers two DSNP plans:

- **Special** is offered in the following 15 counties: Bucks, Berks, Carbon, Chester, Cumberland, Dauphin, Delaware, Lebanon, Lehigh, Lancaster, Montgomery, Northampton, Perry, Philadelphia and Schuylkill

- **Dual Pearl** is offered in the following 3 counties: Bucks, Montgomery and Philadelphia

MOC 1:Description of the SNP Population

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- Annually, Jefferson Health Plans performs a population assessment to determine the needs of our membership as well as the community we serve. Age, gender, 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 SNP Population

Service Area	Age (Years)	Gender	Race/Ethnicity	Language Spoken
Philadelphia County: 92% Delaware County: 3% Bucks County: 2% Montgomery County: 1% Others: 2%	<64: 32.83% 65-69: 21.94% 70-74: 21.70% 75-79: 12.19% 80-84: 6.47% 85-89: 3.28% +90: 1.59%	Male: 37% Female: 63%	Black: 31% White: 21% Hispanic: 11% Asian/Pacific Islander: 3% American Indian: .04% Other 34%	English: 71% Spanish: 28% Other: 1%

- **Service Area**: 92% of members live in Philadelphia
- **Age**: More than 66% of the members are 65 years of age or older
- **Gender**: 63% of members are female
- **Race/Ethnicity**: 31% are Black; 34% report other race/ethnicity
- **Language**: 71% speak English

MOC 1: Description of SNP Population-Most Vulnerable

Jefferson Health Plans has identified the following most vulnerable population (MVP) as Hypertensive members who have a high-risk score on their Health Risk Assessment and comorbidities of depression and/or obesity residing in Philadelphia County.

Co-Morbid Condition DSNP vs. MVP	DSNP		MVP	
	Depression	Obesity	Depression	Obesity
Percent	43%	56%	61%	70%

Brain Teaser 1

Description of the DSNP Population

Who are the most vulnerable DSNP Population?

A. All DSNP members are vulnerable.
B. DSNP members who live outside of Philadelphia County.
C. Only those 65 years or older.
D. Hypertensive members who have a high-risk score on their Health Risk Assessment and comorbidities of depression and/or obesity residing in Philadelphia County.

MOC 2: Care Navigation

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

- All DSNP members are assigned to a Care Coordinator upon enrollment to foster and maintain a strong relationship.

- The Care Coordinator, along with all clinical areas, educate DSNP members on self-management techniques and provide pharmacy consultation, behavioral health counseling and clinical oversight.

- The Care Coordinators core functions are to promote the highest level of physical, psychological and social functioning possible for the member and their caregivers.

MOC 2: Health Risk Assessment Tool (HRAT)

- The HRAT is a CMS approved tool that asks a series of questions designed to assess the medical, functional, cognitive, psychosocial and mental health needs of the member.

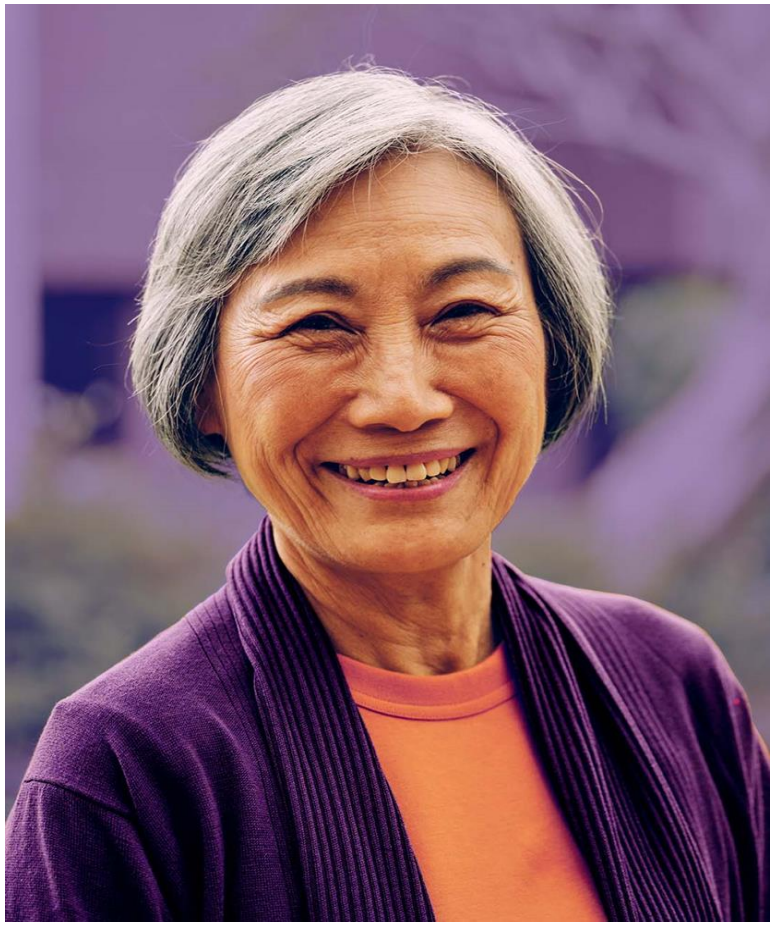
- This self-reported health risk assessment tool identifies member risk level of care for care coordination:
  - High
  - Low

- All DSNP beneficiaries are assessed initially within 90 days of effective date, within 365 days of the last HRAT and with any transition of care or change in condition.

- The HRAT is conducted telephonically by Health Assessment Outreach Coordinators and is reviewed by the team leads to evaluate the member's needs and assign to the appropriate Care Coordination team but can also be mailed to the member or completed in the member portal.

MOC 2: Individualized Care Plan (ICP)

- ICPs for members are created utilizing a combination of information available including:
  - Heath Assessments 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 their healthcare needs.



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MOC 2: Individualized Care Plan (ICP)

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

- 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 a Health Assessment, 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 Health Assessment 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 a 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)

Purpose: The ICT is a group of individuals from diverse fields who work together toward a common goal for the member, which is to improve care.

Composition is specific to the member but may include:

1. Core Team: Member and/or Representative, Primary Care Provider and Care Coordinator.
2. Ad hoc: Medical Director, Specialist, Clinical Supervisor, Pharmacy, Utilization Review Nurse, Behavioral Health Care Coordinator, etc.

MOC 2: Care Coordination ICT

- Member and/or caregiver, in collaboration with the care coordinator, identifies issues and barriers and then prioritizes the goals and set timelines to close these goals.
- PCPs are invited to participate in the ICT along with the ICP developed by the Care Coordinator and the member.
- Special accommodations will be made for members with hearing, visual impairments, language and literacy barriers, and/or cognitive deficits.
- Each member's ICP will be reviewed at least annually.
- Formal ICT meetings scheduled 3 days per week include members who have had a recent discharge from an acute inpatient stay or SNF, readmissions or any changes in condition that the care coordinator would like to discuss with the ICT.

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 plan establishes a provider network necessary to service the needs of a diverse member population to ensure all members receive quality care.
  - The plan ensures, through the credentialing and network adequacy processes, that providers are well trained and accessible in treating the needs of our member population.
  - 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 oversees how network providers use evidence-based medicine by:
    - Monitoring how network providers use appropriate clinical practice guidelines and nationally recognized protocols for target population, and if they need to be modified for vulnerable members.
    - Monitoring provider's adherence to clinical and preventive guidelines through the Quality and Clinical Review (QCR) program.

MOC 3: Provider Network Training

- The plan must provide initial and annual training for both in-network and out-of-network providers.
  - Training is available through live webinars and web-based self-led training modules.
- All provider training is documented and tracked.
- The training plan describes 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 ensures, through the credentialing and network adequacy processes, that providers are well trained and accessible in treating the needs of our member population.
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. A and C, but not B.
E. A, B and C.

MOC 4: Quality Measurement & Performance Improvement

MOC 4: Quality Measurement & Performance Improvement

- Jefferson Health Plans has a quality improvement plan in place to monitor the progress of the MOC to meet goals.
- To evaluate the effectiveness of the program, data is collected, analyzed, and evaluated.
- The 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

- 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 DSNP 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 DSNP member satisfaction through:
  - Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) results
  - Case management survey results
  - Grievance and appeals data

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

- The Board of Directors (BOD) is responsible for the oversight of the QMP, and they delegate responsibility for development, implementation, and evaluation of the QI program to the Quality Management Council (QMC)

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			

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 DSNP 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.

Conclusion

How can you help?

1. Reach out to the care coordinators if you identify an issue and want to update the member's ICP.
2. Participate in ICT, your input is valuable to the health of the member/patient.

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

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