Medicare: Model of Care Training

2019

7/1/2019
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 the 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 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)
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 (DSNP)**
  Members must have both Medicare and Medicaid benefits

  **Chronic Condition Special Needs Plan (CSNP)**
  Members with chronic illnesses such as: Diabetes, COPD, Congestive Heart Failure

  **Institutional Special Needs Plan (ISNP)**
  Members who live in institutions such as: Nursing homes or long term facilities

- Health plans may contract with CMS for one or more programs. Currently, Centene has **MAPD, DSNP, CSNP** and **MMP** plans

- Many of Centene’s Medicare Health Plans are DSNP
Medicaid-Medicare 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 Centene 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 the following:
  • Ensuring dually eligible members have full access to the services they are entitled to
  • 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
Medicaid-Medicare Plans (MMP) cont.

- 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 Centene coordinating services and payment

- MMPs do not require a Model of Care!
Specific Services

Centene 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
- 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
Model of Care Training

• The Model of Care (MOC) is a quality improvement tool that ensures 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 SNP MOCs 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.
What is a Model of Care?

- The Model of Care (MOC) is Centene’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.
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
Element 1: Description of the Population
Description of Member Population

• Element 1 includes characteristics related to the membership that Centene 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 Centene works with community partners
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)

- Centene conducts care coordination using the Health Risk Assessment (HRA), an Individualized Care Plan (ICP) and providing an ICT for the member

- Care Coordination elements also include the following:
  - 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
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, are incorporated into the member’s care plan and communicated to the 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 support (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’s program is member centric with the PCP being the primary ICT point of contact.
- Centene staff work with all members of the ICT in coordinating the plan of care with the member.
Interdisciplinary Care Team (ICT)

- Centene 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 the following but not limited to:
  - Appropriately involved Centene staff
  - The member and their family/caregiver
  - External practitioners
  - Vendors involved in the member’s care
- Centene 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
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.

• 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
ICT Responsibilities

Providers

• 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 the following:
  • Centene Case Managers
  • Members of the Interdisciplinary Care Team (ICT)
  • Members and caregivers
Transition of Care

• 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 a hospitalization or change in level of care to prevent re-admissions
Transitions 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
- Ongoing education of members to include preventative health strategies in order to maintain care in the least restrictive setting possible for their health care needs
- In-home visits or phone calls are conducted for the following:
  - 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 situations support the discharge plan
Element 3: Provider Network
Provider Network

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

This element describes the following:

- How the network corresponds to the target population
- How Centene oversees network facilities
- How providers collaborate with the ICT and contribute to a member’s ICP
- Centene is responsible for maintaining a specialized provider network that corresponds to the needs of our members
- Centene 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 expects Centene to do the following:

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

- 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 DSNP members.

- DSNP members have both Medicare and Medicaid but not always with Centene. Medicaid benefits may be via another Health Plan or the State.

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

The 2019 goals are based on the following:

• 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:

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

• Centene values our partnership with our physicians and providers

• 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 interdisciplinary approach to the member’s special needs
  • Employ comprehensive coordination with all care partners
  • Support the member's preferences in the plan of care
  • Reinforce the member’s connection with their medical home
Health Plan Information

• For questions or additional information, please contact Compliance and Vendor Oversight

Contact:
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2019 Medicare Plans

Dual Special Needs Plans (DSNP): Model of Care is required

• Arizona (AZ) – Arizona Complete Health
• California (CA) – Health Net
• Florida (FL) – Sunshine Health
• Georgia (GA) – Peach State Health Plan
• Indiana (IN) – MHS
• Kansas (KS) – Sunflower Health Plan
• Mississippi (MS) – Magnolia Health
• Missouri (MO) – Home State Health
• New Mexico (NM) – Western Sky Community Care
• Ohio (OH) – Buckeye Health Plan
• Oregon (OR) – Trillium Advantage
• Pennsylvania (PA) – PA Health & Wellness
• South Carolina (SC) – Absolute Total Care
• Texas (TX) – Superior Health Plan
• Wisconsin (WI) – MHS Health Wisconsin
2019 Medicare Plans

Chronic Condition Special Needs Plans (CSNP)
Model of Care is required annually
- Arizona (AZ) – Arizona Complete Health
- California (CA) – Health Net

Medicare-Medicaid Plans (MMP)
Model of Care is not required
- California (CA) – Health Net
- Illinois (IL) – IlliniCare Health
- 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
2019 Medicare Plans

Medicare Advantage Prescription Drug Plans (MAPD)
Model of Care is not required

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