Model of Care Training

Special Needs Plans (SNP)
Medicare/Medicaid Plans (MMP)

Presentation for:

LIBERTY Dental Plan Employees

Dental Provider Network

Training Objectives

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

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

- Outline the basic components of Model of Care (MOC)
- Explain how Case/Care 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)

Model of Care Training Requirement

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 Interdisciplinary Care Team (ICT)

This course is offered to meet the CMS regulatory requirements for MOC Training for ours and our Health plan Partners' SNPs

What is Model of Care?

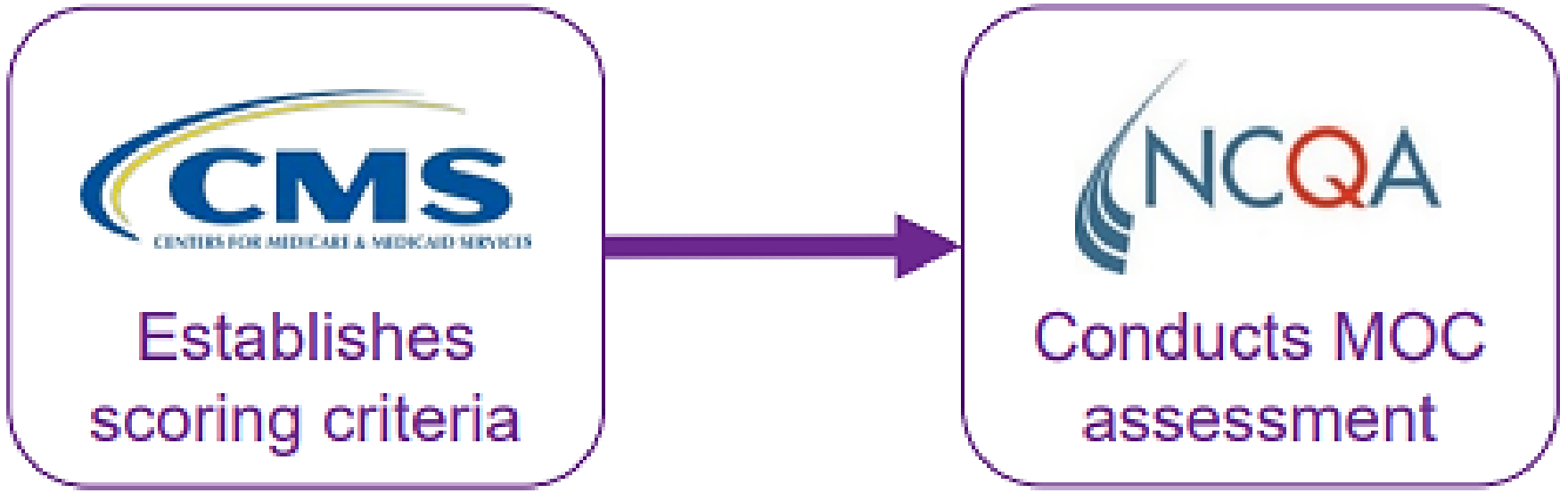
The Model of Care (MOC) is a quality improvement tool that ensures the unique needs of each member enrolled in a Special Needs Plan (SNP) are identified and addressed

A 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 Special Needs Plan Model of Care using standards and scoring criteria established by Centers for Medicare and Medicaid (CMS).



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 disabling condition

Institutional Special Needs Plans (ISNP)

- Members who live in institutions such as nursing homes or long-term care facilities or members who live in the community but require institutional level of care (LOC).

What is DSNP?

A Medicare Advantage plan available to member who are eligible for both Medicare and Medicaid. Members must:

01

Be entitled to Medicare Parts A (hospital), B (medical) and eligible for Part D (drugs)

02

Be eligible for Medicaid

03

Reside in the DSNP's service area

What is CSNP?

A Medicare Advantage plan available to members with a specific chronic illness or disabling condition. CMS has identified the following 15 eligible chronic conditions for CSNP.

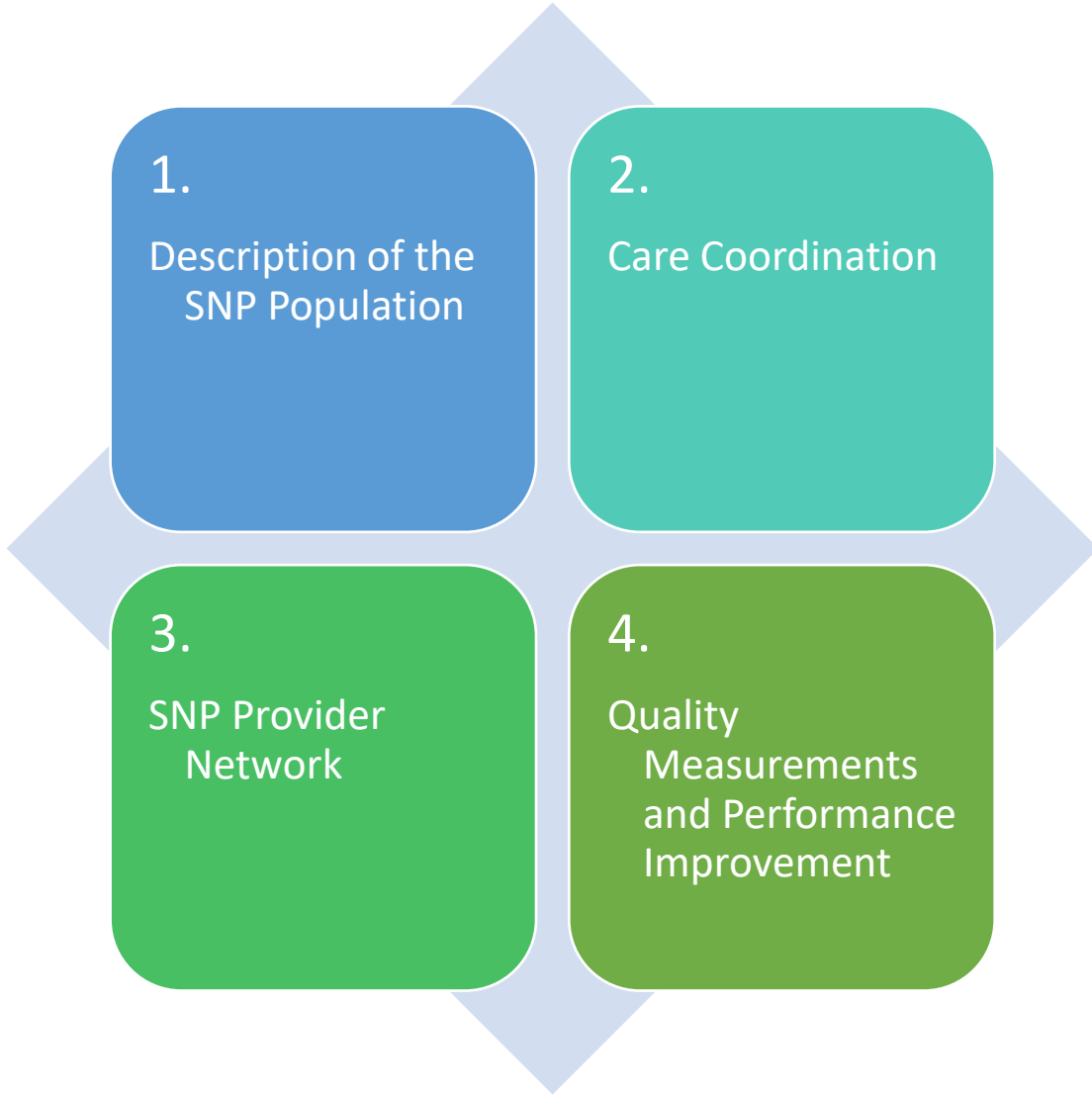
- Chronic Alcohol & Other Drug Dependence
- Certain Autoimmune Disorders
- Cancer
- Certain Cardiovascular Disorders (CVD)
- Congestive Heart Failure (CHF)
- Dementia
- Diabetes Mellitus
- End-stage Liver Disease
- End-stage Renal Disease (ESRD)
- Certain Severe Hematologic Disorders
- HIV/AIDS
- Certain Chronic Lung Disorders
- Certain Chronic & Disabling Mental Health Conditions
- Certain Neurologic Disorders
- Stroke

CSNP may focus on one chronic condition or a group of co-morbidities and clinically linked conditions.

What is ISNP

A Medicare Advantage plan available to member who are reside in **institutions** such as nursing homes or long-term care facilities with no immediate plans for discharge members who live in the community but require institutional level of care (LOC).

Model of Care is comprised of clinical and non-clinical elements



Description of SNP Population

Element 1

Description of Member Population

MOC includes characteristics related to the membership that the Plan 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 plans works with community partners

Care Coordination

Element 2

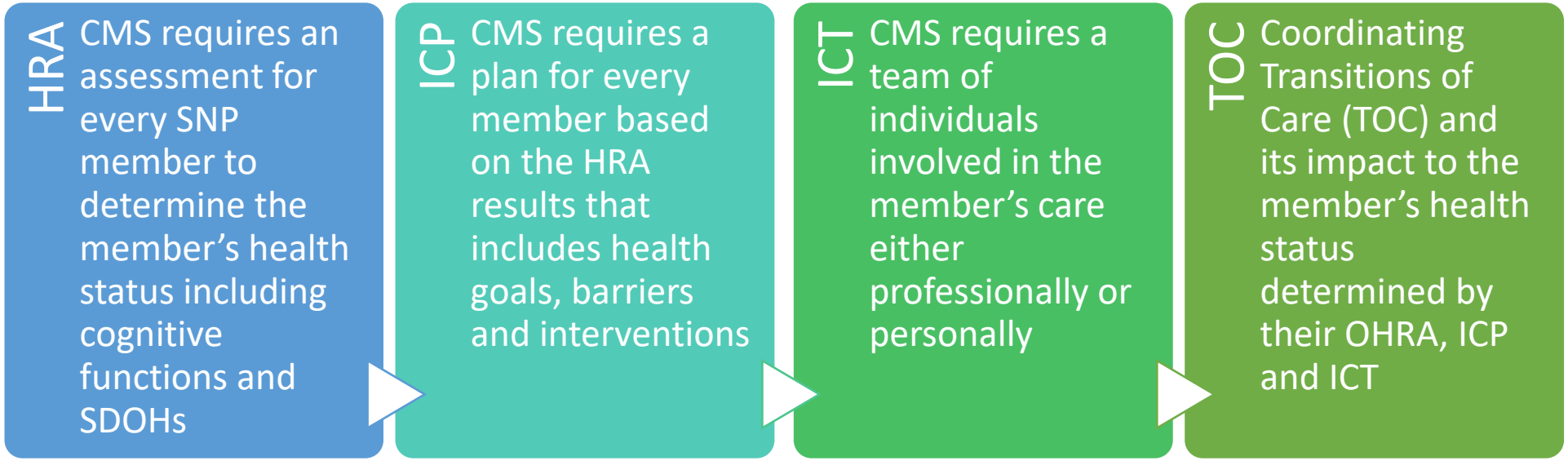
Care Coordination

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

Plans conduct care coordination using a Health Risk Assessment (HRA), and Individualized Care Plan (ICP) and participating in an Interdisciplinary Care Team (ICT). Basic components of care coordination are:



Oral Health Risk Assessment (OHRA)

An OHRA is conducted to identify a member's medical, psychosocial, cognitive, functional and mental health needs and risks.

- LIBERTY attempts to complete the initial OHRA within 90 days of enrollment and annually, or if there is a change in the members condition or transition of care
- OHRA responses are used to identify needs that 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

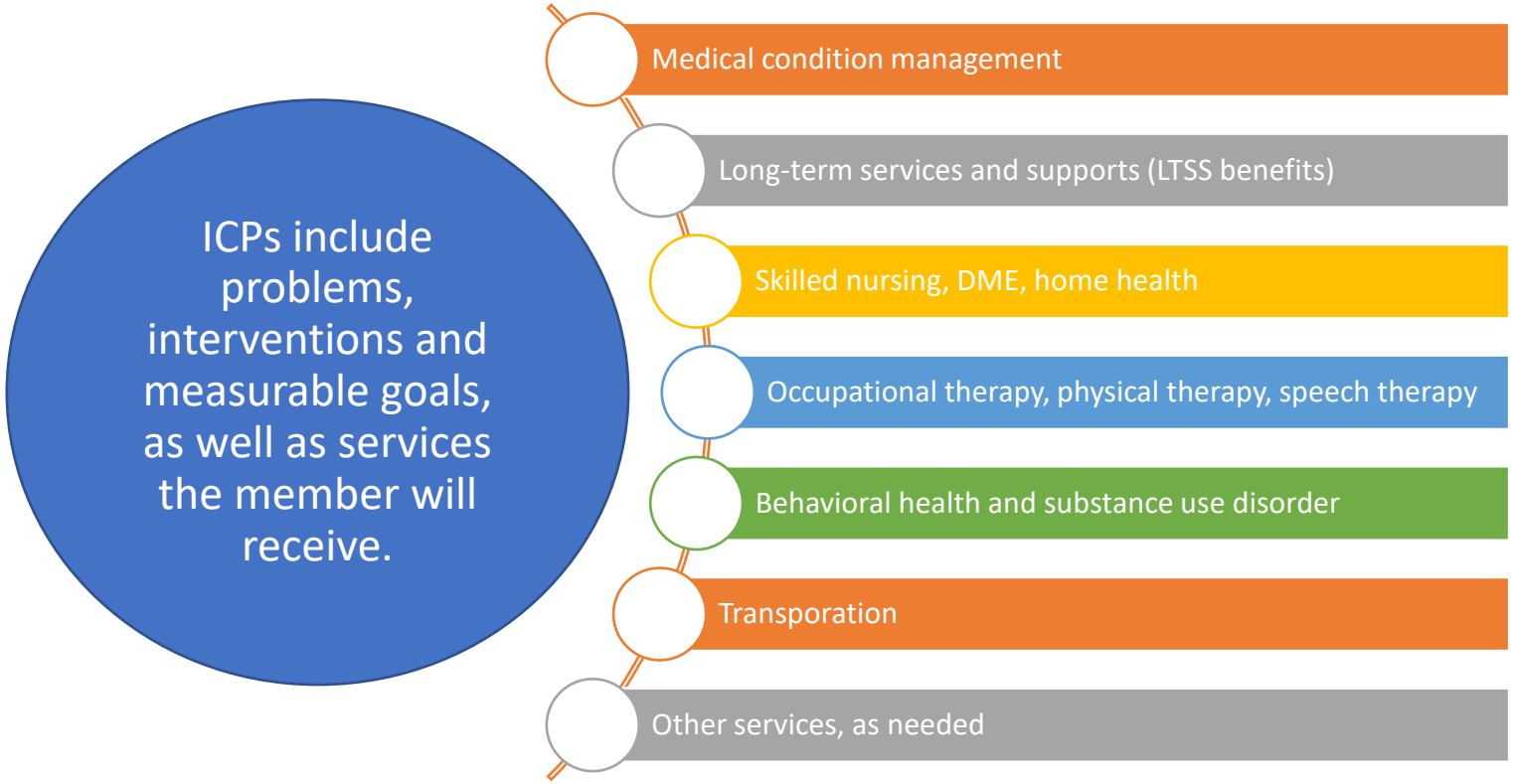
NOTE: health providers should encourage members to complete the OHRA in order to better coordinate care and create an individual care plan

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 health care providers work closely together with the member and their family to prepare, implement and evaluation the ICP

Members receive monitoring, service referrals and condition-specific education based on their individual needs.



Interdisciplinary Care Team (ICT)

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

The Model of Care 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

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

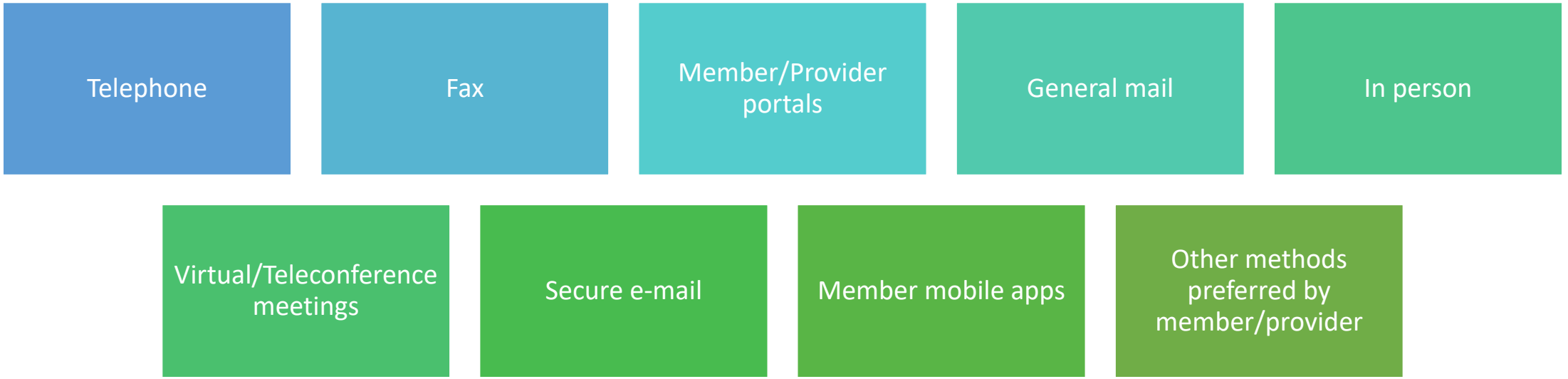
ICT Responsibilities

We 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
- 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
- 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:
    - 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 though a variety of methods:



Transition of Care (TOC)

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

Staff will manage Transitions of Care (TOC) to ensure that members have appropriate follow-up care, hospitalization or change in levels of care to prevent re-admission

TOC Intervention

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
- 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

Provider Network

Element 3

Provider Network

MOC explains the specialized expertise in the provider network that is made available to SNP members.

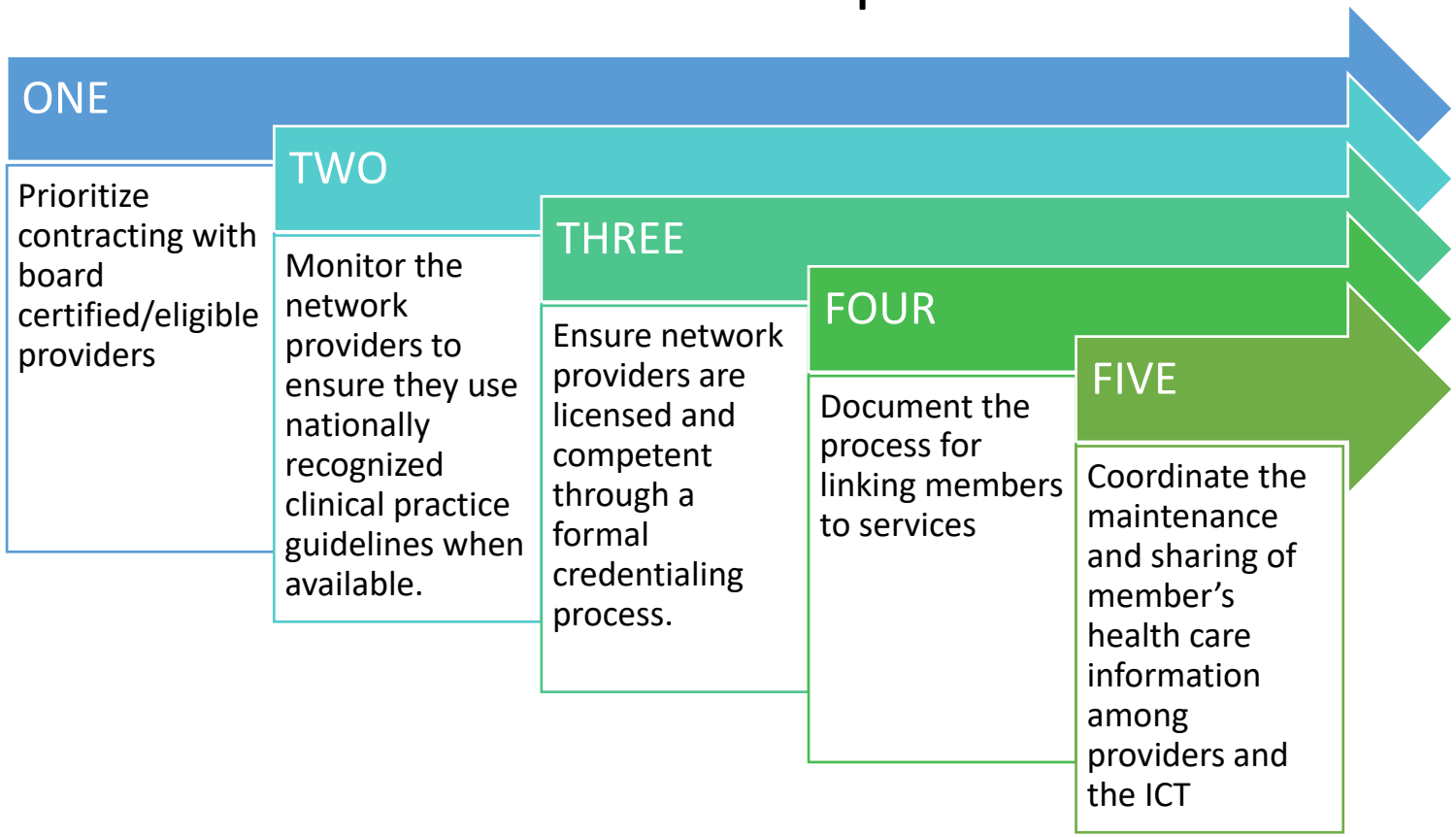
LIBERTY is responsible for maintaining a specialized dental provider network that corresponds to the needs of members.

This element describes the following:

- How the network corresponds to the target population
- How plans oversee network facilities and providers
- How providers collaborate with the ICT and contribute to a member’s ICP
- How care is coordinated with providers

Provider Network

CMS and our Health Plan Partners are expected to do the following:



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

DNSP members have both Medicare and Medicaid but not always with the same LIBERTY Health Plan Partner. 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 plan it is:

- Fully integrated DSNP plans (FIDE)
- Highly integrated DSNP plans (HIDE)

It is important to verify coverage prior to providing any services

Quality Measurements and Performance Improvement

Element 4

Quality Measurement and Performance Improvement

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

To evaluate success, Plans 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

Plans determine 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) surveys
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Health Outcomes Survey (HOS)

Model of Care Goals May Include:

- Access to Care
- Member Satisfaction
- Access to Preventive Services
- Chronic Care Management

Summary

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

Enhanced communication between members, physicians, providers and LIBERTY

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 plan of care

The member's self-management capabilities and connections with providers and support services.