Model of Care Training

Medica AccessAbility Solution Enhanced®

Medica DUAL Solution®

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Objectives

- Special Needs Plan Description
- Model of Care Overview and Requirements
- Complete training attestation

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Why do I need Model of Care Training?

- Centers for Medicare & Medicaid Services (CMS) Requirement
  - All Medicare Advantage Special Needs Plans (SNPs) must have a Model of Care (MOC) that describes the care and services to be provided to SNP members
  - The MOC is a detailed document (>100 pages) that provides the framework for how Medica identifies and addresses the unique needs of its SNP populations
  - CMS carefully reviews the MOC during an audit to make sure we are implementing all processes as described, including MOC training
- Medica Providers, Care Coordinators, member facing Support Staff who support the work of Care Coordinators (e.g., Case Aides, Community Health Workers), and member facing Medica staff who serve SNP members are required to complete annual training on the SNP MOC
- MOC training helps you:
  - Understand the unique characteristics and needs of SNP members
  - Understand the importance of your role
  - Understand the importance of collaborating with others involved in the member’s care, including the Interdisciplinary Care Team (ICT)

What is a Special Needs Plan (SNP)?

- A type of Medicare Advantage Plan that focuses on certain vulnerable groups of Medicare beneficiaries
- Three types of SNPs:

I-SNP

- Institutional Special Needs Plan
- Enrolls beneficiaries who are institutionalized or require an institutional level of care (LOC)

D-SNP

- Dual Eligible Special Needs Plan
- Enrolls beneficiaries who are eligible for both Medicare and Medicaid

C-SNP

- Chronic Condition Special Needs Plan
- Enrolls beneficiaries with certain chronic and disabling conditions

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Medica Plans

Plan Name	SNP Type
Medica DUAL Solution® (Minnesota Senior Health Options or MSHO)	D-SNP
Medica AccessAbility Solution Enhanced® (Special Needs BasicCare (SNBC) Special Needs Plan® or I-SNBC)	D-SNP

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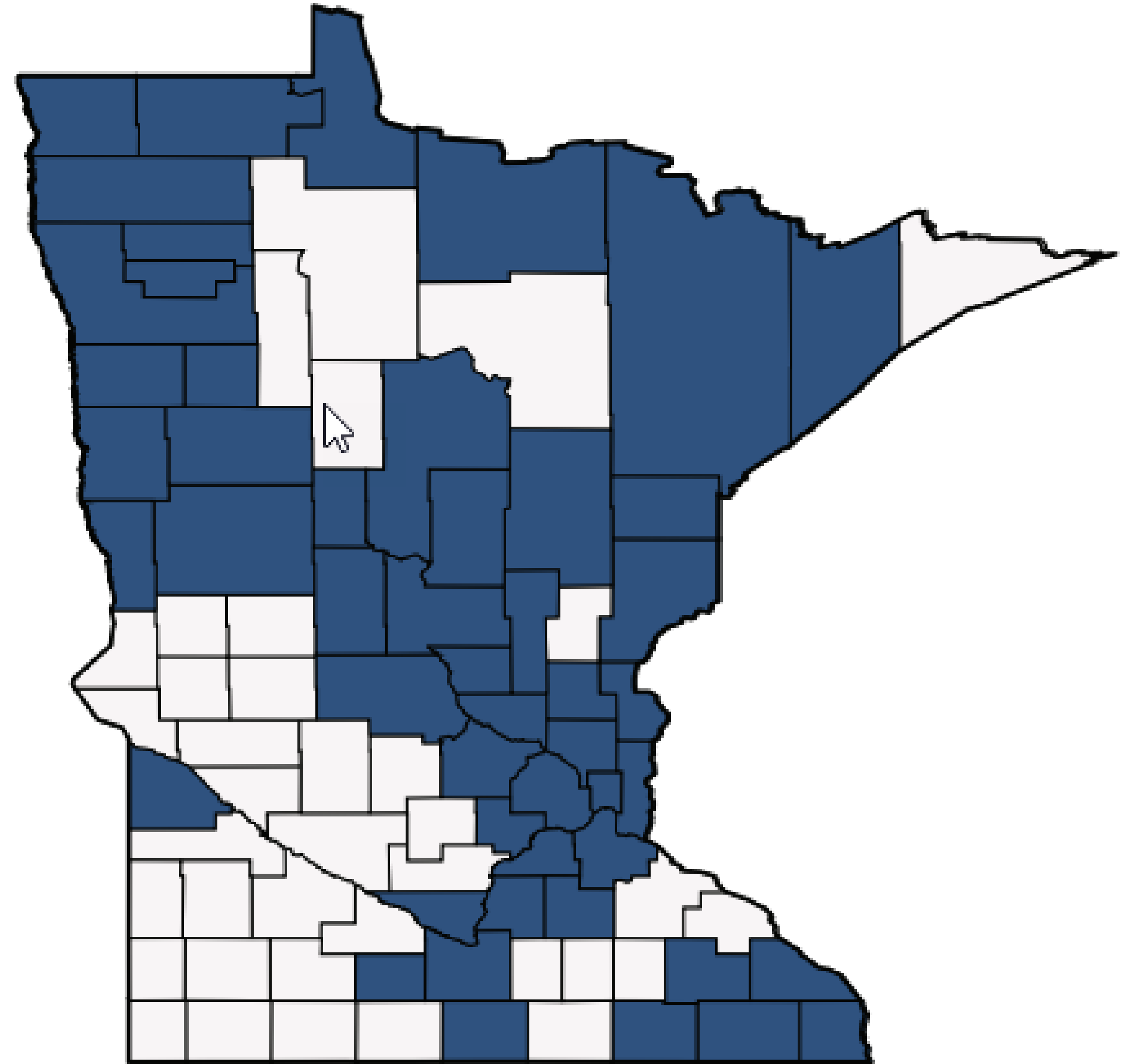
MSHO Eligibility



- Be 65 years or older
- Live in the Medica Dual Solution® service area
- Enrolled in Medicare Parts A & B
- Medicaid eligible

❖ ***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at www.medica.com***

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I-SNBC Eligibility

- Be at least 18 and under age 65
- Live in the Medica AccessAbility Solution® Enhanced service area
- Enrolled in Medicare Parts A & B
- Medicaid eligible
- Have a certified disability through the Social Security Administration or the State Medical Review team.

❖ ***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at*** www.medica.com

Model of Care

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Special Needs Plans and CMS Requirements

- Submission and Approval of Model of Care (MOC)
- CMS awards approval of MOC for 1 to 3 years
- CMS requires MOC Training be completed annually

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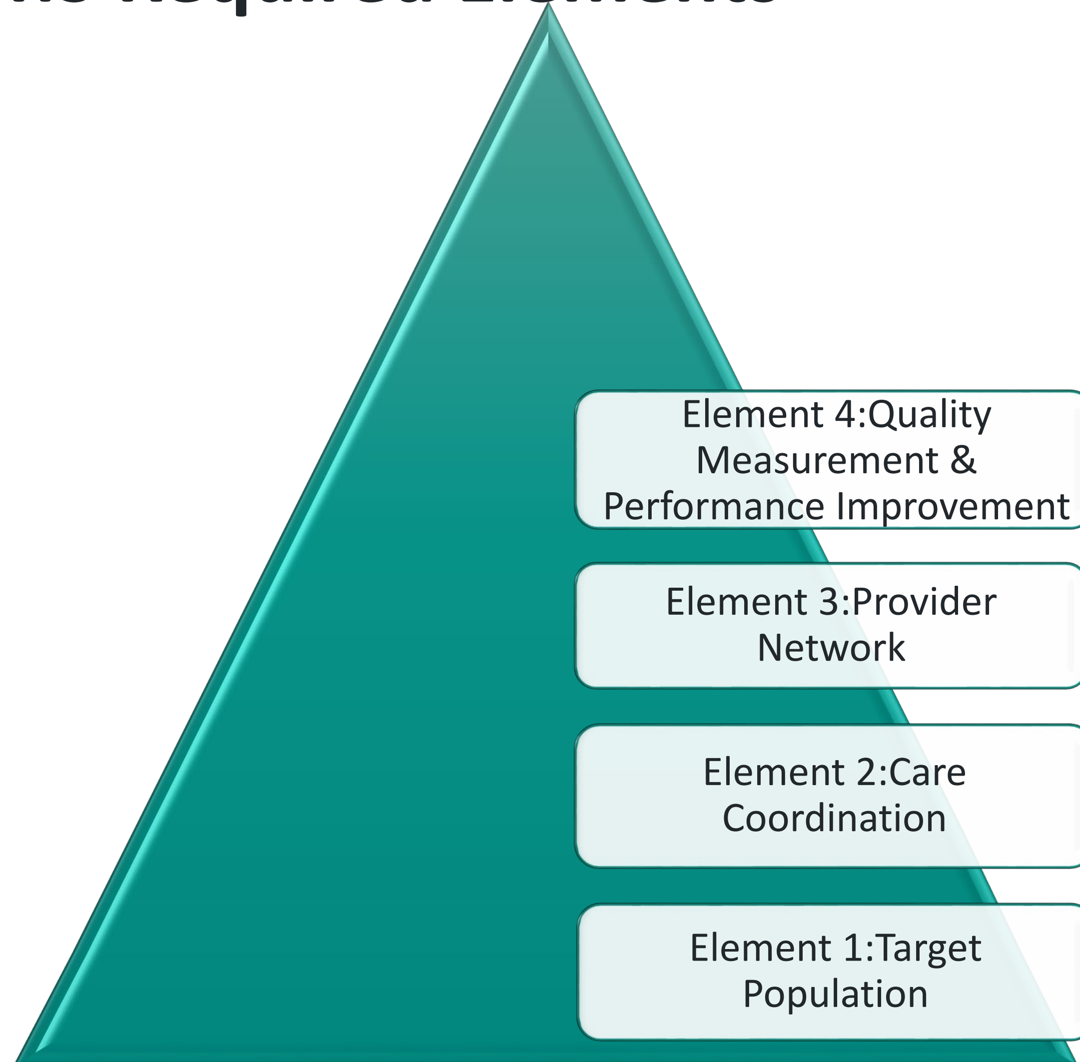
Model of Care: CMS Required Elements



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MOC 1: Description of Population

Medica AccessAbility Solution® Enhanced (I-SNBC) (D-SNP)	Medica DUAL Solution® (MSHO) (D-SNP)
Gender: 57% female and 43% male	Gender: 69% female and 31% male
Average age: 50	Average age:77
Ethnic breakdown: 66.4% White; 24.7% Black; 3.1% Asian; 1% American Indian or Alaska Native; 0.3% Native Hawaiian or Other Pacific Islander; 3.4% Unknown/Other	Race breakdown: 70.3% White; 13.1% Black; 9.4% Asian; 2% American Indian or Alaska Native; 0.2% Native Hawaiian or Other Pacific Islander; 5.1% Unknown/Other
Average number of chronic conditions: 7	Average number of chronic conditions: 8
Top Chronic Conditions: Depression, Hypertension, Hyperlipidemia, Low Back Pain, Persistent Asthma, Diabetes	Top Chronic Conditions: Hypertension, Hyperlipidemia, Depression, Diabetes, Low Back Pain, Chronic Renal Failure
98% live in the community; 2% live in an institutional setting	86% live in the community; 14% live in an institutional setting

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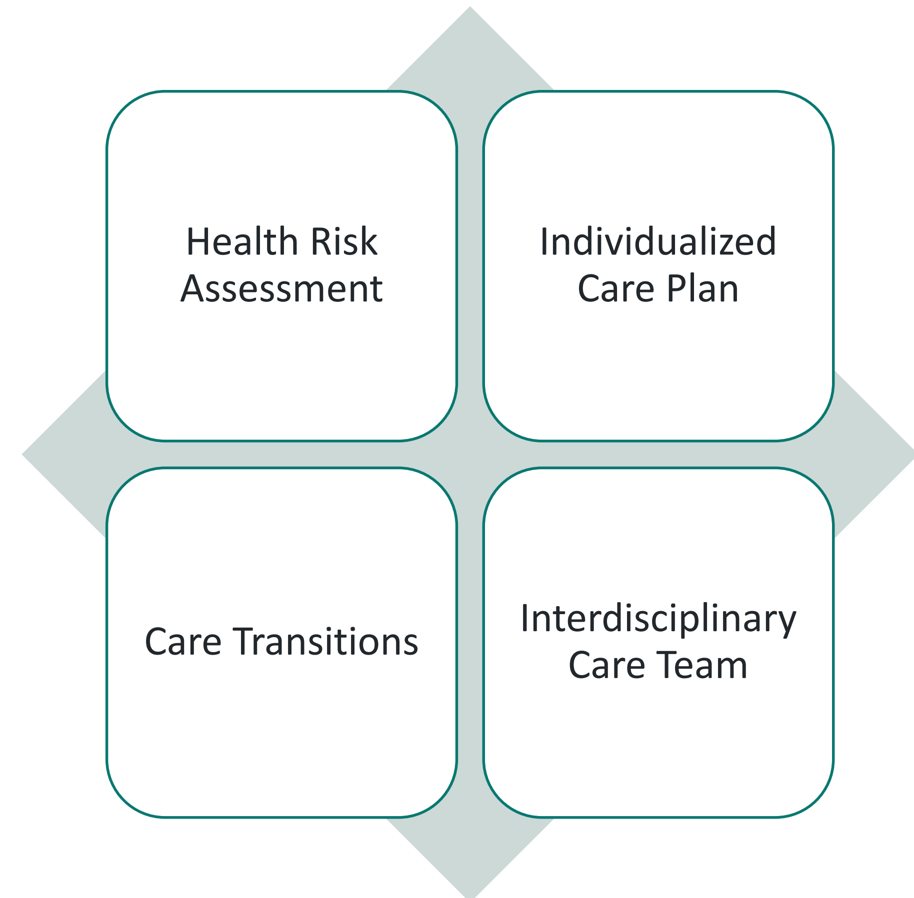
MOC 2: Care Coordination

- Every MSHO and I-SNBC member is assigned a Care Coordinator
- The Care Coordinator partners with the member and their Interdisciplinary Care Team (ICT)
- Primary Care Physicians are considered an integral part of the member's ICT
- The Care Coordinator is the primary point of contact to ensure there is ongoing communication between members of the ICT
    - This is true whether a member lives in the community, a skilled nursing facility, adult foster care, or customized living



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Care Coordinator Role

Conduct Health Risk Assessment and develop an Individualized Care Plan with the member based on their identified needs and preferences	Ensure the member's healthcare needs and preferences regarding their healthcare is shared across the ICT
Provide ongoing monitoring and updating of care plan, and education and advocacy	Connect the member to resources, health care, and services
Collaborate with different health and social services professionals and across settings of care	Work with the member to live in the least restrictive setting possible and that is the member's choice

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Care Coordinator Qualifications

Care Coordinator Qualifications	
MSHO D-SNP I-SNBC D-SNP	Registered nurses, social workers (either licensed social worker or social worker who meets the social work standards under the Minnesota State Merit System), public health nurses, physician assistants, nurse practitioners, or physicians. *See Appendix A & B for Care Coordinator qualification checklists

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Health Risk Assessment (HRA)

- Completed by Care Coordinator
    - Within 30 days of enrollment (MSHO); within 60 days of enrollment (I-SNBC)
    - With change of condition
    - Within 365 days of the last HRA completed
- An HRA provides the Care Coordinator with pertinent information about a member's medical, functional, cognitive, psychosocial, and mental health needs.
- The HRA provides insight into:
    - Determining and identifying a member's needs, wants, and concerns

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Care Plan/Support Plan

- Member Centered, addresses needs and concerns identified during HRA
- Includes member goals
- Completed by Care Coordinator and sent to member within 30 days of HRA
- Summary shared with Primary Care Provider (PCP) and other members of care team per member discretion
- Ongoing monitoring throughout the year with documentation of goal progress based on member-specific follow-up schedule

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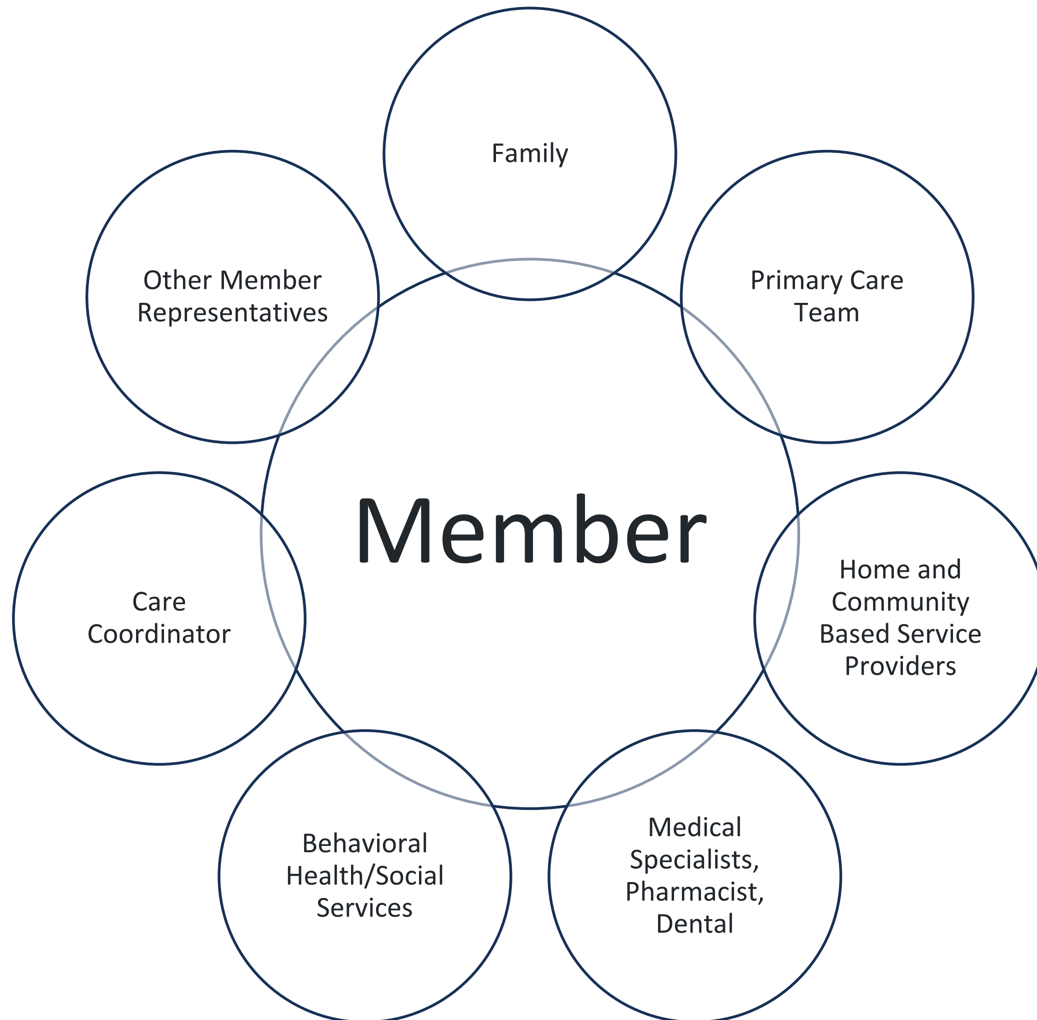
Interdisciplinary Care Team (ICT)



- ICT composition based on individual member needs and preferences
- Typically includes the member and/or their designee, PCP, and Care Coordinator, with other providers as appropriate (e.g., specialists, mental health providers, etc.)
- Care Coordinator is responsible for facilitating communication among the ICT
- Collaborative communication between the Care team members and the Care Coordinator is essential to best serve the member and their needs
- Primary Care providers (PCPs) have information that may be useful to the Care Coordinator and vice versa
- Care Coordinators send care plan information to the PCP at least annually, including a letter that has CC contact information

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Transitions of Care

- When members move from one care setting to another they are at risk of adverse outcomes due to fragmented care
- Care Coordinators follow up with the member throughout the transition to:
  - Discuss their health status changes and discharge instructions
  - Ensure follow up appointments have been scheduled
  - Ensure member understands any changes in their medication regimen
  - Ensure member is able to recognize warning signs and symptoms and how to respond
  - Determine if member requires any new services or supports upon discharge (and complete new assessment, as appropriate)
- Care Coordinators also facilitate communication with the receiving setting and other providers involved with the member's care
- The communication between the Care Coordinator, Providers and the member is critical to ensuring an effective transition from one care setting to another or back to home
- The Care Coordinator updates the member's care plan and shares this with the member and their Interdisciplinary Care Team, as needed

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MOC 3:Provider Network

Established provider network to meet the needs of its members and target population

Medica delegates management of mental health and substance use services to a behavioral health vendor, Medica Behavioral Health (MBH)

Medica's Provider Network

Medica's credentialing program, consistent with NCQA Guidelines, ensures that practitioners are licensed and provider sites meet Medica's requirements

Medica contracts with provider entities, titled as care systems or health delivery systems, to enhance coordination in the delivery of services

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MOC 4: Quality Measurement and Performance Improvement

- CMS requires SNPs to have a comprehensive Quality Improvement Program that evaluates the effectiveness of the MOC
- For each of the SNPs, Medica establishes process and outcome measures tied to MOC goals, such as:
  - Improving access and affordability
  - Ensuring coordination of care across the care continuum
  - Appropriate utilization of services for preventive health and chronic conditions
  - Implementation of the MOC
  - Improving member satisfaction

Examples of measures include:

- Health Risk Assessment completion rates
- Implementation of the Individualized Care Plan
- Implementation of Transitions of Care processes
- Member satisfaction with the Care Coordination Program
- Medication adherence
- Hospital readmission rates
- ER utilization rates
- Preventive care utilization

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Next Steps

Thank you for completing the Medica SNP Model of Care Training

To acknowledge completion and receive credit for this training, please go to the link below to complete the MOC Training Attestation (hold control + click to follow the link)

https://www.surveymonkey.com/r/SNPMOC_Attestations

*It is required that Medica follow up with any Care Coordination staff who has not taken the training within the calendar year

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Model of Care Questions?

Contact:

Courtney Chupurdy, SNP Program Manager

Courtney.Chupurdy@Medica.com

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APPENDIX A
MSHO Care Coordinator Qualification Checklist

<table>
<tr><th>Hiring Organization:</th><th>Candidate Name:</th></tr>
<tr><td>1) Is the CC candidate a RN, PHN, Licensed SW, County SW evaluated under the Minnesota Merit System, PA, NP, or Physician?</td><td>If yes and MnCHOICES is not live→ Candidate is qualified to be an MSHO/MSC+ CC (please enter Candidate’s credentials below)
If yes and MnCHOICES is live → Enter credentials below and go to question #4
Candidate’s Qualifying Credentials & License #: _________________________
If no → Go to question #2</td></tr>
<tr><td>2) Will the CC candidate be supervised by a RN, Licensed SW, PA, NP, or Physician?</td><td>If yes→ Enter Supervisor’s credentials below and go to question #3
Supervisor’s Qualifying Credentials: ____________________________________
If no → Candidate is not qualified to be an MSHO/MSC+ CC</td></tr>
<tr><td>3) Does the Candidate meet the DHS requirements for the provision of case management by virtue of meeting the social work standards under the Minnesota Merit System, which requires meeting the requirements in (a) or (b) <u>and</u> (c) below?
(a) a bachelor’s degree from an accredited four-year college or university with a major in social work, psychology, sociology, or a closely related field;* or
(b) a bachelor’s degree from an accredited four-year college or university with a major in any field and at least one year of experience as a social worker/case manager/care coordinator in a public or private social services agency; and
(c) the knowledge, skills and abilities necessary to perform the job
*A closely-related field includes occupational therapy, physical therapy, speech-language pathology, audiology, recreational therapy, dietician, special education, rehabilitation counseling, nursing, human services or other field in health or human services that involves the job duties of a care coordinator/case manager, including assessment and service planning.</td><td>If yes → Complete below questions and go to question #4
Candidate’s Qualifying Degree: _________________________________
Candidate’s Major: ____
If Candidate’s degree is not listed in 3(a), describe qualifying experience (i.e., one year as a social worker, case manager or care coordinator in a public or private social services agency):
If no → Candidate is not qualified to be an MSHO/MSC+ CC</td></tr>
<tr><td>4) (Effective once MnCHOICES is live): Has the Candidate: (i) completed DHS training and received DHS certification as a Certified Assessor; or (ii) will they do so before being assigned any MSHO or MSC+ members; or (iii) do they meet an exception (Candidate is a PA, NP or Physician acting as a CC for members in nursing homes)?</td><td>If yes → Candidate is qualified to be a MSHO/MSC+ CC (please complete below)
Date Certified Assessor Certification Obtained/Expected: ______________; or
Exception Met (Credentials & CC Setting): _______________________________
If no → Candidate is not qualified to be an MSHO/MSC+ CC</td></tr>
</table>

APPENDIX B
I-SNBC Care Coordinator Qualification Checklist

<table>
<tr><th>Hiring Organization:</th><th>Candidate Name:</th></tr>
<tr><td>1) Is the CC candidate a RN, PHN, Licensed SW, County SW evaluated under the Minnesota Merit System, PA, NP, or Physician?</td><td>If yes → Please enter Candidate’s credentials below and go to question #4
Candidate’s Qualifying Credentials & License #: ____________________________
If no → Go to question #2</td></tr>
<tr><td>2) Will the CC candidate be supervised by a RN, Licensed SW, PA, NP, or Physician?</td><td>If yes→ Enter Supervisor’s credentials below and go to question #3
Supervisor’s Qualifying Credentials: _____________________________
If no → Candidate is not qualified to be an SNBC/SNBC DSNP CC</td></tr>
<tr><td>3) Does the Candidate meet the DHS requirements for the provision of case management by virtue of meeting the social work standards under the Minnesota Merit System, which requires meeting the requirements in (a) or (b) <u>and</u> (c) below?
(a) a bachelor’s degree from an accredited four-year college or university with a major in social work, psychology, sociology, or a closely related field;* or
(b) a bachelor’s degree from an accredited four-year college or university with a major in any field and at least one year of experience as a social worker/case manager/care coordinator in a public or private social services agency; and
(c) the knowledge, skills and abilities necessary to perform the job
*A closely-related field includes occupational therapy, physical therapy, speech-language pathology, audiology, recreational therapy, dietician, special education, rehabilitation counseling, nursing, human services or other field in health or human services that involves the job duties of a care coordinator/case manager, including assessment and service planning.</td><td>If yes → Complete below questions and go to question #4
Candidate’s Qualifying Degree: _________________________________
Candidate’s Major: ____
If Candidate’s degree is not listed in 3(a), describe qualifying experience (i.e., one year as a social worker, case manager or care coordinator in a public or private social services agency):
If no → Candidate is not qualified to be an SNBC/SNBC D-SNP CC</td></tr>
<tr><td>4) Does the Candidate have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services?</td><td>If yes → Candidate is qualified to be an SNBC/SNBC DSNP CC
Describe qualifying experience:
If no → Candidate is not qualified to be an SNBC/SNBC DSNP CC</td></tr>
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