2020 Model of Care Training

Medica DUAL Solution®
Medica AccessAbility Solution® Enhanced

MEDICA®

Model of Care Training for Providers

- Training Purpose:
  - Learn about the Center for Medicare and Medicaid Services (CMS) Model of Care requirements for Dual Special Needs Plans such as Medica DUAL Solution (MSHO) and Medica AccessAbility Solution Enhanced (DSNP SNBC)
  - Better understand Medica DUAL Solution (MSHO) and Medica AccessAbility Solution Enhanced (DSNP SNBC) products , its members and their needs
  - Understand the importance of your role as a member of the MSHO and DSNP SNBC interdisciplinary care team
  - Learn more about the role of the Care Coordinator (CC); how you may interface with them and benefits of coordinating with the Care Coordinator for your MSHO and DSNP SNBC member to better care for your member

MSHO = Medica DUAL Solution®

- Minnesota Senior Health Options (MSHO) is a Minnesota Department of Human Services program that provides health care for people who are age 65 and older and eligible for both Medicare and Medical Assistance (Medicaid).

- Medica DUAL Solution® is the Medica product name for Medica's MSHO plan.

To be eligible, members must :

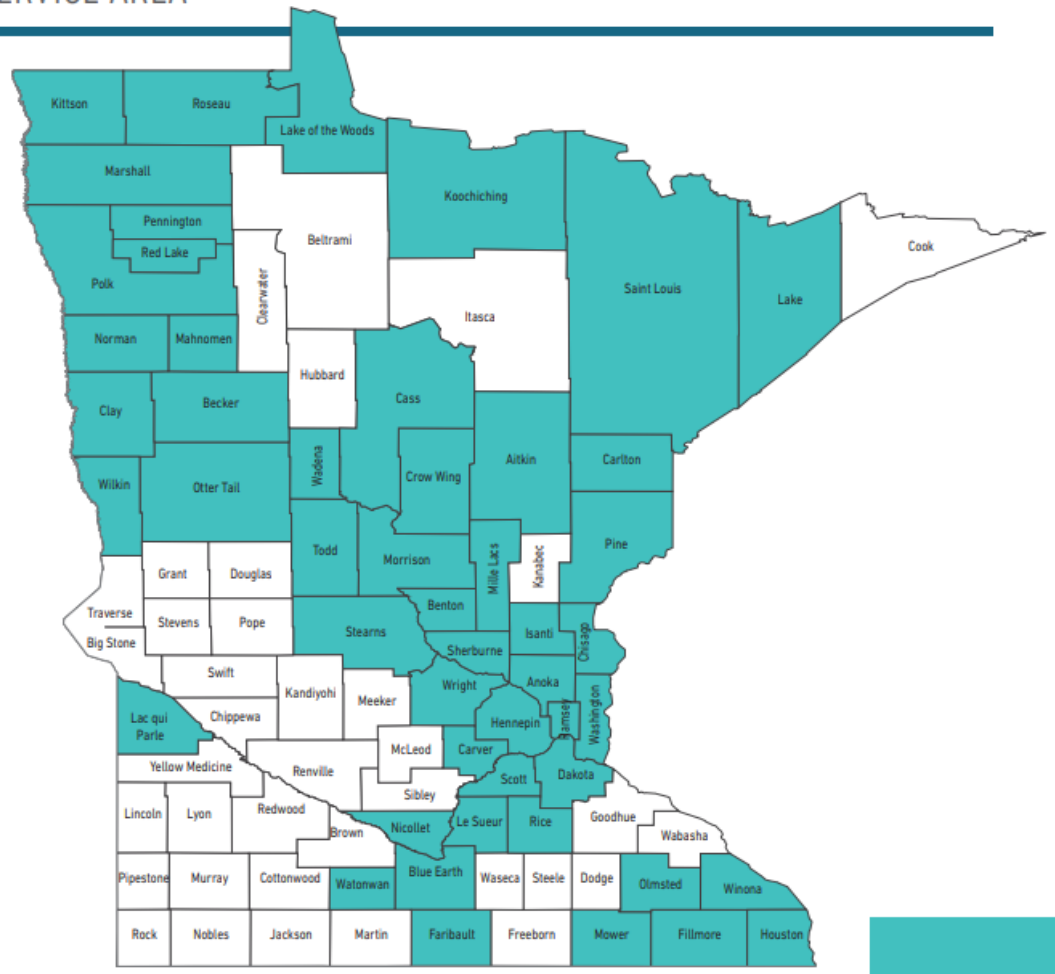
- ✓**Be Medicare and Medicaid eligible**
- ✓**Have Medicare Part A and B**
- ✓**Be 65+ years or older**
- ✓**Reside within the Medica service area**

Medica DUAL Solution® Service area

Medica Dual Solution® and Choice Care℠ MSC+

Minnesota Senior Health Care Options (MSHO) & Minnesota Senior Care Plus (MSC+)

SERVICE AREA



Effective January 1, 2019

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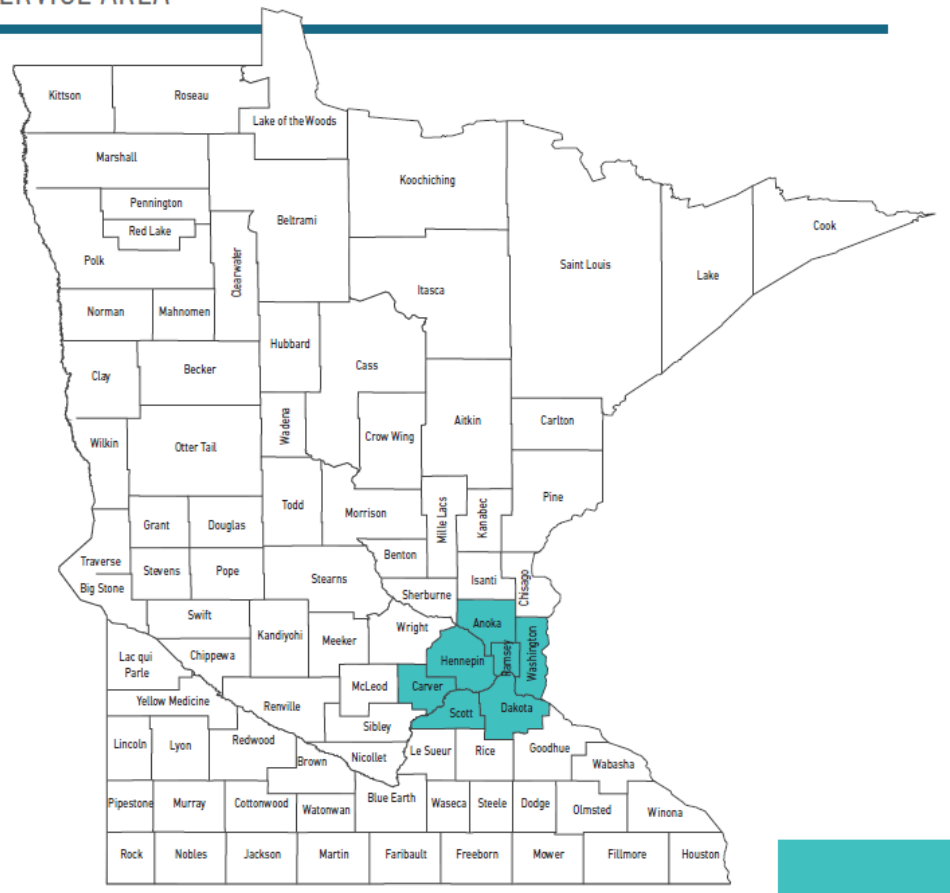
The Medica DUAL Solution® Service area extends to 50 counties across Minnesota

Medica AccessAbility Enhanced Service Area

Medica AccessAbility Solution® Enhanced (HMO D-SNP)

Special Needs BasicCare (SNBC SNP)

SERVICE AREA



Effective January 1, 2020

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The Medica AccessAbility Enhanced Service Area is metro counties Anoka, Hennepin, Ramsey, Dakota, Washington, Scott, and Carver County.

DSNP SNBC = Medica AccessAbility Solution® Enhanced

Special Needs Basic Care (SNBC) is a voluntary managed care program operated by the Minnesota Department of Human Services (DHS) for people with disabilities ages 18 through 64 who have Medicaid.

DSNP SNBC members are those who are both Medicaid ***and*** Medicare eligible are eligible for a Dual Special Needs Plan (DSNP) SNBC plan through Medica.

Medica AccessAbility Solution® Enhanced is the Medica product name for Medica's DSNP SNBC plan.

To be eligible, members must :

- ✓**Be Medicare and Medicaid eligible**
- ✓**Have Medicare Part A and B**
- ✓**Be aged 18 – 64**
- ✓**Certified Disabled**
- ✓**Reside within the Medica service area of Hennepin, Ramsey, Dakota, Scott or Carver County.**

Medica DUAL Solution® & Medica AccessAbility Solution® Enhanced

Medica DUAL Solution® and Medica AccessAbility Solution® Enhanced are fully integrated programs where the member receives one member card and all services and claims including Medicaid, Medicare, Part D, and Elderly Waiver benefits (*DUAL Solution only*) are managed by Medica.

As a Special Needs Plan (SNP), Centers for Medicare & Medicaid Services(CMS) requires Medica to submit and receive approval for our DUAL Solution® and Medica AccessAbility Solution® Enhanced Models of Care. CMS considers the Model of Care a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in a SNP are identified and addressed.

How Do Members Enroll in MSHO or DSNP SNBC?

- Enrollment is voluntary

  Ways to enroll:

  - ✓ Member's county financial worker
  - ✓ Medica Enrollment: 952-992-2030 or 800-266-2157
  - ✓ Senior Linkage Line: 1-800-333-2433 (for MSHO)

Benefits and Services

Medica Dual Solution and Medica AccessAbility Solution® Enhanced Members receive a wide array of benefits and services as part of their benefit set. Below highlights some of the benefits available to members. A complete benefit listing is found at:
DUAL Solution Benefits and Coverage and Medica AccessAbility Solution Enhanced Benefits and Coverage respectively.

- Medical
- Dental - managed for Medica by Delta Dental
- Behavioral Health
- Silver Sneakers
- Provide – A – Ride

✓ Transportation to medical appointments
✓ Special Transportation – Certificate of Need
✓ Transportation to Silver Sneakers

- 24/7 Nurse Line
- Health Coaching
- Disease Management
- Tobacco Cessation
- Pharmacy – Part D & OTC
- Medication Therapy Management
- Vision
- Care Coordination
- *Up to 180 day Institutional Care
- *Elderly Waiver Services (if applicable)
- *Waiver Transportation (if applicable)

* DUAL Solution Only

Model of Care

DUAL Solution and AccessAbility Solution Enhanced each have a Model of Care that describes the management, procedures, and operational systems that Medica has in place to provide access to services, coordination of care and the structure needed to best provide services and care for this special needs population.

- **The cornerstone of the Model of Care is the provision of an assigned Care Coordinator for each member. The Care Coordinator focuses on coordinating access and person centered delivery of all preventive, primary, specialty, acute, post acute and long term care services among different health and social service professionals and across settings of care.**

Model of Care - Required Elements

- Description of the population
- Care Coordination Overview
- Provider Network
- Quality Measurement and Performance Improvement

Medica DUAL Solution Member Demographics

- Average age: 78
- Age range: 65-108
- 69% Female /31% Male
- 40% Rural / 60% Metro
- Multiple chronic diseases
    - ✓Hypertension
    - ✓Diabetes
    - ✓Major Depressive Disorder
    - ✓Ischemic Heart Disease
    - ✓Chronic Renal Failure
- 65% meet nursing facility level of care
- 35% are “community well”

AccessAbility Solution Enhanced Member Demographics

- Gender: 53% female and 47% male
- Average age: 49
- Average number of chronic conditions: 5.8
- Ethnic breakdown: 42% Caucasian; 35% Black; 11.6% Unknown/Other; 5% Asian; 2% Hispanic; 2% American Indian
- The most prevalent conditions experienced by AccessAbility Solutions members include:

✓Depression	46.3%
✓Hypertension	39.4%
✓Hyperlipidemia	30.1%
✓Low Back Pain	28.6%
✓Diabetes	23.4%
✓Asthma	20.4%
✓Schizophrenia	18.8%
✓Bipolar Disorder	14.9%

Care Coordination

Every DUAL Solution and AccessAbility Solution Enhanced member has a Care Coordinator

- To find out who the Care Coordinator is for a member, call Medica Customer Service: 952-992-2580 or 888-347-3630

- The Care Coordinator partners with the member and their Interdisciplinary Care Team
  - ***All Primary Care Physicians are considered an integral part of the member's interdisciplinary care team***
- The Care Coordinator is the primary point of contact ensuring ongoing communication between members of the Interdisciplinary Care Team

Care Coordinator's Role

- MSHO Care Coordinators are Licensed Social Workers or Registered Nurses

DSNP SNBC Care Coordinators are typically Licensed Social Workers, or Registered Nurses or an individual with specialized expertise working with people with disabilities may be allowed to act as a CC if they have a four-year degree in a closely related field and two or more years of experience in home and community based services.

- Care Coordinator duties include:
  - ➢Conduct health risk assessments
  - ➢Develop an Individualized Care Plan with the member based on their assessed needs and preferences
  - ➢Provide ongoing monitoring and updating of care plan
  - ➢Connects the member to resources, health care, and services
  - ➢Provides education and advocacy
  - ➢Collaborates with different health and social services professionals and across settings of care
  - ➢Works with the member to live in the least restrictive setting possible and that is the members choice.
  - ➢Helps to ensure that the member's healthcare needs and preferences regarding their healthcare is shared across the interdisciplinary team.

Interdisciplinary Team

- Interdisciplinary Care Team is composed of the:
  - Member and/or appropriate family/caregiver
  - MSHO or DSNP SNBC Care Coordinator
  - *Primary Care Provider*
  - *Other providers appropriate to specific health needs (Specialists, Mental health providers, Palliative Care Team, Pharmacist, Dentist, etc.)*
  - Others are included as identified by the member and others on the team.

Interdisciplinary Care Team Communication

- Collaborative communication between the Care team members and the Medica Care Coordinator is essential to best serving the member and their needs
  - ✓ Primary Care providers have information that may be useful to the Care Coordinator
  - ✓ The Care Coordinator has information that may be helpful to the PCP
  - ✓ Care Coordinator's send information to PCP annually with member's care plan content included. This letter also includes CC contact information

- Each has a role in providing the most effective and efficient care for the member

Transitions of Care

- Care Coordinators assist members when they are moving from one care setting to another. The goal is to have a consistent person promoting smooth transitions and reducing incidents related to fragmented care and risk of potential readmission
- Care Coordinators follow up with the member to:
  - ✓Discuss their health status changes and discharge instructions
  - ✓Ensure that follow up appointments have been scheduled
  - ✓Ensure member understands any changes in their medication regimen
  - ✓Educate on the benefits of maintaining a personal health record
- 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. As a provider, your role providing follow-up care and communicating information back to the Care Coordinator regarding transition needs of the member is important to a successful transition plan.
- Care Coordinator updates the members care plan and shares with the member and their Interdisciplinary Care Team

Provider Network

- The provider network is composed of primary, specialty and dental care providers as well as a full-range of behavioral, geriatric, hospital, acute and post acute rehabilitation, long-term care services, home and community-based services and other specialty services.
- Members have access to a hardcopy provider directory annually.
- MnHelp.info has information related to available home and community based service providers
- Members have access to an online provider directory that is updated monthly
- Members can call Medica Customer Service for assistance
- The member's Care Coordinator can assist the member to locate providers and services
- Network specialists can be directly accessed, no referrals are required.

Quality Measurement & Performance Improvement

- Medica creates a corporate wide quality improvement plan that incorporates the DUAL Solution and AccessAbility Solution Enhanced quality and performance improvement activities.

- This plan addresses all levels of improvement including operational, clinical, regulatory and describes monitoring activities.

- Medica's Quality Improvement Subcommittee (QIS) directs, oversees and evaluates the Medica quality improvement program, with the goal of promoting and continually improving clinical quality, service quality, provider quality and patient safety

Quality Measurement & Performance Improvement cont.

- Examples of tools and sources used to measure plan performance include:
  - Claims, pharmacy utilization, demographic information from enrollment, HEDIS, CAHPS, and Star Ratings, predictive modeling, and Evidence Based Medicine analytic tools are used.
  - Complaints, grievances, appeals, and member surveys provide insight into member concerns and Medica's overall performance.
  - Medica uses the Plan, Do, Study, Act quality improvement process in it's quality improvement efforts.

Quality Measurement & Performance Improvement cont.

- Measurable Goals & Health Outcomes
  - Medica Care Coordination leadership team establishes annual goals for the DUAL Solution product
    - Metrics are used to monitor and measure performance
    - Based on key clinical, operational and member satisfaction areas of importance

  - Other areas measured/monitored: access and availability to primary and specialty care; Hospital admissions/readmissions, ER Use.

Quality Measurement & Performance Improvement cont.

- Quality Improvement information available to members and providers

- More information is available at medica.com
  - Medica | Quality Improvement Program
  - https://www.medica.com/providers/quality-and-cost-programs/quality-improvement-program

Model of Care Questions?

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Mission

To be the trusted health plan of choice for customers, members, partners and our employees.

Vision

To be trusted in the community for our unwavering commitment to high-quality, affordable health care.