Model of Care (MOC) Training

Provider Training

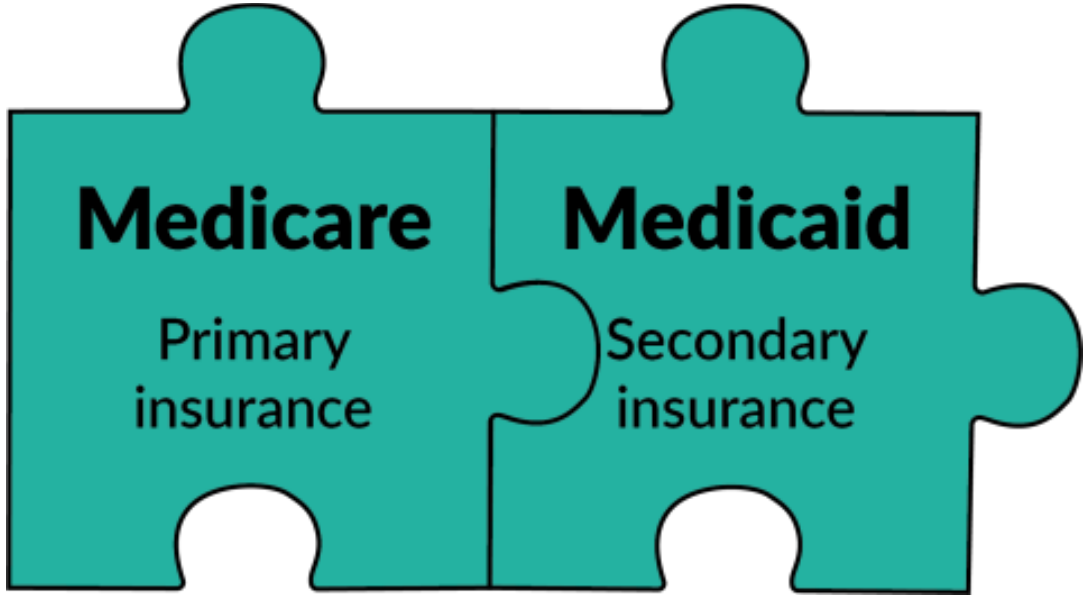
2024 Cooperative Advantage (HMO D-SNP)

group health Cooperative of eau claire | Cooperative ADVANTAGE

Cooperative Advantage (HMO D-SNP)

Group Health Cooperative of Eau Claire now offers a Dual Special Needs Plan, *Cooperative Advantage* (HMO D-SNP) that is designed specifically for people who are eligible for both Medicare and full Medicaid benefits (called dual-eligible).

Cooperative Advantage combines and coordinates benefits provided under Original Medicare (A and B) and part D prescription drug coverage with Wisconsin Medicaid benefits. Together, one cohesive plan.



Overview – Regulatory Requirements

Model of Care (MOC) Provider Training

- The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to design and implement a Model of Care (MOC) that details how the Plan will provide specialized care to members.

- CMS requires all SNPs to conduct initial and annual training that reviews the major elements of the MOC for all health plan employees, contracted and out-of-network providers seen by members on a routine basis.

Source: § 422.101 (f)

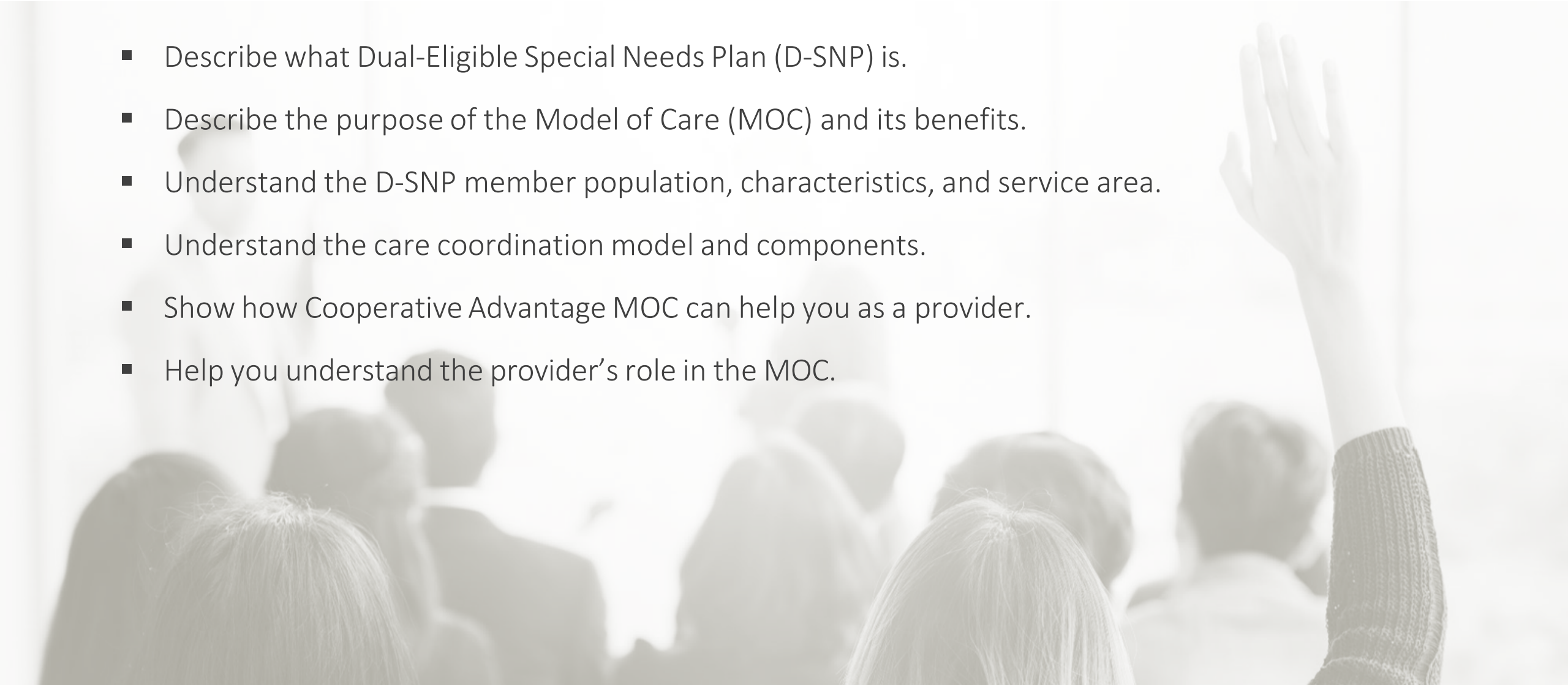
Based on a Model of Care review, Cooperative Advantage has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2025.

CMS Requirements and Cooperative Advantage Approach

CMS MOC Regulatory Requirement		Cooperative Advantage's MOC Process
Health Risk Assessment Tool (HRAT) §42 CFR (f)(1)(i)	1. All D-SNP members must have an initial HRAT within 90 days of enrollment and at least annually thereafter.	• A comprehensive HRAT within 30 days of enrollment and at least annually thereafter. • ICT meeting frequency determined by member health status and needs.
Interdisciplinary Care Team (ICT) §42 CFR (f)(1)(iii)	2. All D-SNP members must have an ICT that collaborates in care plan development and implementation.	• The Case Manager is the leader of each member's ICT and coordinates communications with other participants. • The Case Manager will contact the member's provider to discuss the member's HRAT results and care plan along with revisions and updated as needed.

Goals of Training

- Describe what Dual-Eligible Special Needs Plan (D-SNP) is.
- Describe the purpose of the Model of Care (MOC) and its benefits.
- Understand the D-SNP member population, characteristics, and service area.
- Understand the care coordination model and components.
- Show how Cooperative Advantage MOC can help you as a provider.
- Help you understand the provider's role in the MOC.



What is a D-SNP?

A Dual-Eligible Special Needs Plan (D-SNP): is a Medicare Advantage Plan for individuals who are eligible for both Medicare and Medicaid coverage, and together, provides a cohesive team to coordinate care and benefits to meet the needs of the member.

Medicare: a federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

Medicaid: a federal system of health insurance for those requiring financial assistance.

Special Needs: an integrated care model to improve the health of our most vulnerable members.

Plan: the plan is designed to coordinate care in a non-duplicative, collaborative manner, and improve overall quality of care for the member.

Model of Care Elements

- Description of the D-SNP Population
- Care Coordination
- Provider Network
- Quality Measurement & Improvement

Description of the D-SNP Population

Member Population Characteristics

Medical Conditions	Behavioral Health	Social and Economic Detriments
Endocrine/metabolic: diabetes, hyperlipidemia	Alzheimer's Disease/Dementia	Poverty
Musculoskeletal/Neuromuscular: osteoarthritis, rheumatoid arthritis, history of fracture, chronic pain	History of Mental Illness	Lack of consistent caregiver or family support
Cardiac: coronary artery disease, cerebral vascular accident	Depression/Anxiety	Housing and food insecurity
Respiratory: chronic obstructive pulmonary disease, history of pneumonia	Schizophrenia	Rural location-transportation and access to care

Description of the D-SNP Population

Service Area

The service area includes 44 counties in Southwestern, Central and Northwestern Wisconsin.

Cooperative Advantage Eligibility:

- Are entitled to Medicare Part A.
- Enrolled in Medicare Part B.
- Reside in the service area of Cooperative Advantage.
- Are a U.S. citizen or lawfully present in the United States.
- Eligible and enrolled in Wisconsin Medicaid (full benefit).

Care Coordination

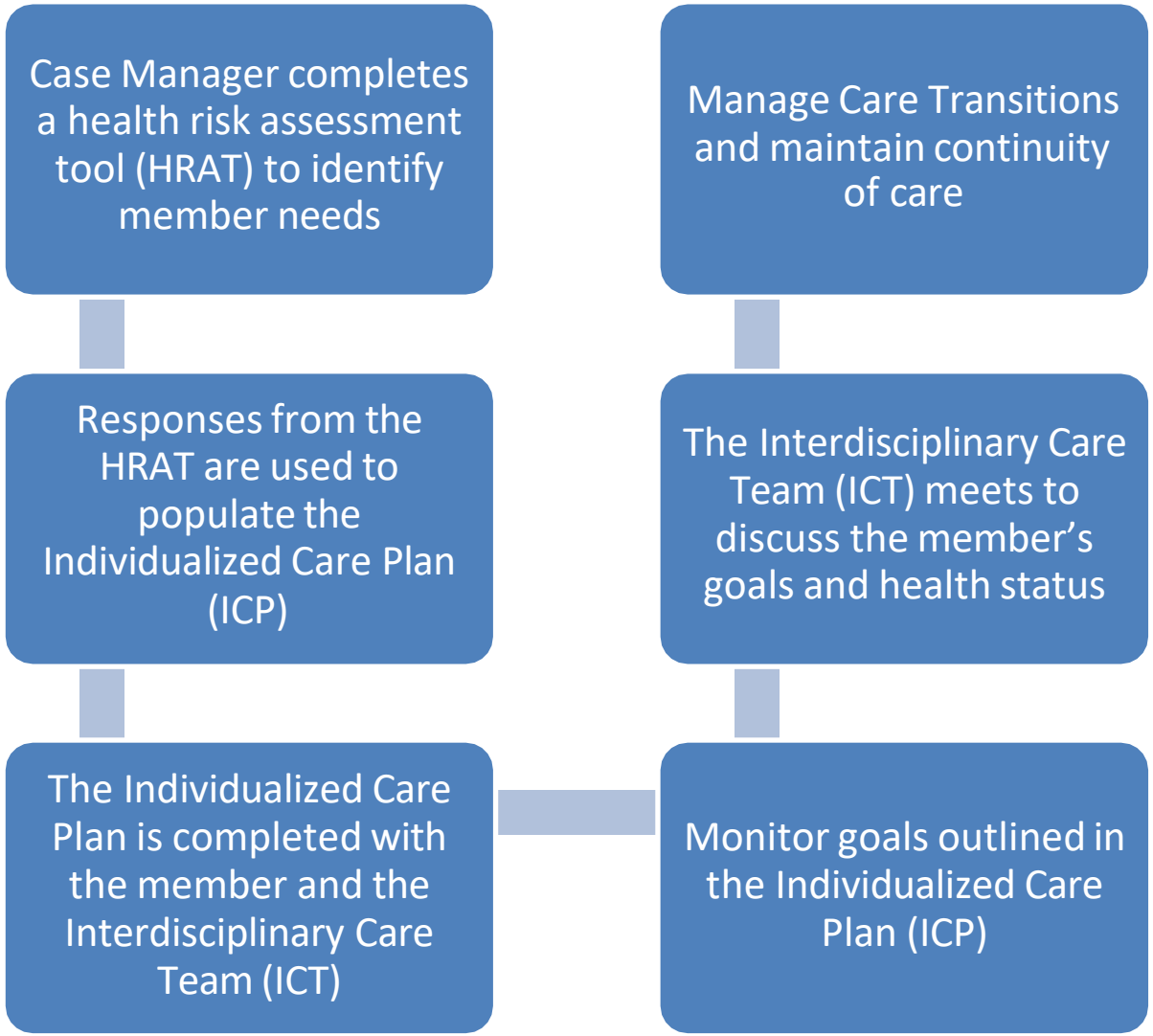
MOC Goals

The MOC is designed to:

- Reduce non-essential hospital admissions.
- Maintain members at an optimal level of function.
- Increase compliance with appropriate preventative screenings.
- Increase compliance with clinical practice guidelines.
- Enhance identification and address health care concerns earlier to optimize member health.
- Improve management of chronic disease through goal setting.
- Improve communication and collaboration related to member care.

Care Coordination

Care Model Management

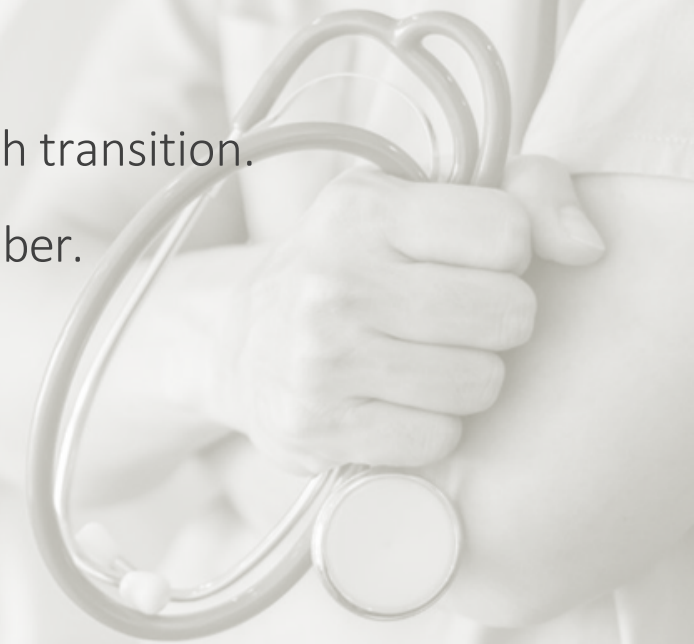


Care Coordination

Key Staff

CASE MANAGER

- Assigned to each member.
- Liaison between the provider and member.
- Monitors each member and alerts provider to changes in member health transition.
- Partners with the provider to coordinate care and follow-up for the member.



Care Coordination

Health Risk Assessment Tool (HRAT)

- Conducted by the Care Management Coordinator, the HRAT identifies the medical, psychosocial, cognitive, functional and mental health needs of each member.
- HRAT findings are used to develop and update the member's care plan.

Care Coordination

Individualized Care Plan (ICP)

- Tailored to the needs and preferences of the member as identified by the HRAT.
- Shared with member/responsible party, the Primary Care Physician and key specialists, as needed.
- Clinical practice guidelines applied.
- Reviewed/updated by the ICT on a routine basis and at least annually in accordance with member's changes.

Care Coordination

Individualized Care Team (ICT)

- Every member has an ICT tailored to the needs identified on the HRAT and the care plan.
- The ICT oversees and coordinates the member's care plan.
- The ICT includes the Case Manager, the PCP, Specialists, and member's support people and the member. Additional participants may be added as needed.
- Case Manager coordinates communications among ICT members and arranges care conferences.

Care Coordination

Care Transitions Protocols

Case Managers manage transitions of care for members in order to facilitate continuity of care and promote member safety. During care transitions, members can be provided with:

- Discharge care coordination, episodic case management, and pre-admission/post-discharge counseling.
- Education and guidance to mitigate condition risks and support for behavior change.
- Personalized outreach and engagement based upon attitudes, behaviors, and assessments.
- Reinforcement of provider instructions for care, diet, and activity.
- Assistance in finding a provider and helping schedule appointments.

Provider Network

- Cooperative Advantage Dual maintains a comprehensive network of primary care providers and specialists.
  - Includes providers with specialized expertise in chronic conditions that routinely affect the D-SNP population.
- All contracted providers are credentialed and recredentialed according to NCQA requirements.
- A network adequacy report is completed annually to ensure that members have access to providers.

Provider Network

Provider Responsibilities

Our provider partners respond to our members' needs by:

- Collaborate with the Case Manager and ICT assigned to your Cooperative Advantage member
- Involving family members and caregivers in healthcare decisions, as the member chooses
- Communicate! Actively oversee the member's care plan and participate in ICT meetings
- Completing physical exams
- Understanding the MOC for our members by completing this training
- Deliver care in accordance with appropriate evidence-based guidelines
- Reviewing and responding to patient-specific information
- Adhere to HEDIS and other CMS required Quality measures

Quality Measurement & Improvement

Use of Clinical Practice Guidelines

Cooperative Advantage has approved and promotes the use of the clinical practice guidelines among internal clinical staff and providers which are tailored to the D-SNP population.

Quality Measurement & Improvement

Model of Care Quality Measures

Measurable Goals and Health Outcomes	- HEDIS® - Chronic condition management - Medication adherence - Utilization
Compliance with CMS required MOC processes	- HRAT and Care Plan completion rates - Timely member visits - Care transitions management - Staff and Provider MOC Training
Member Satisfaction	- Cooperative Advantage satisfaction survey conducted once per year

Quality Measurement & Improvement

Evaluation of the Model of Care

Annual Evaluation of the MOC

- Formal evaluation of MOC effectiveness led by Cooperative Advantage Quality Improvement department.

Data is collected, analyzed, and evaluated regularly from each domain of care to monitor performance and identify areas for improvement and to ensure program goals have been met.

You can request information on Cooperative Advantage **quality measures** and **MOC performance data**.

Provider Attestation

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to conduct initial and annual training that reviews the major elements of the MOC for all contracted and out-of-network providers seen by members on a routine basis.

Once you have completed the training, please **click "Online Attestation"** to complete the online attestation in order for your training to be recorded as complete.

ONLINE ATTESTATION

Questions?

ATTN: Provider Relations
Group Health Cooperative of Eau Claire
2503 N. Hillcrest Parkway
Altoona, WI 54720
Phone: (715) 852-5706
Email: ProviderRelations@group-health.com