# 2023 Provider Model of Care Training

# Training Topics

- Training Objectives
- Dual Special Needs Plan (D-SNP) – Member Benefit Overview
- What is the D-SNP Model of Care (MOC)?
- Model of Care Requirements and Provider Roles and Responsibilities
    - Description of L.A. Care's DSNP Population
    - Care Coordination
    - Provider Network
    - Quality Measurements and Performance Improvement

# MOC Training Objectives

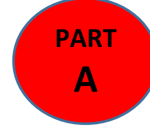
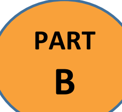
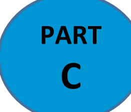
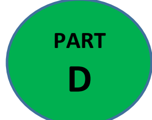
**Objectives:**

- Overview
- Outline the basic components of L.A. Care's D-SNP Model of Care (MOC), including Member Benefits
- Describe L.A. Care's MOC
- Describe the essential **role of L.A. Care Providers** in the implementation of the MOC, including participation in the member's:
  - Health Risk Assessment (HRA)
  - Individualized Care Plan (ICP)
  - Interdisciplinary Care Team (ICT)
  - Face to Face Encounter

# CMS Requirements Overview

- The Centers for Medicare & Medicaid Services (CMS) requires all contracted and non-contracted network providers seen by members on a routine basis receive training about the D-SNP Model of Care (MOC).
- The MOC provides the framework for how the SNP will identify and address the unique needs of its members
- The SNP's Model of Care is the plan for delivering coordinated care and care management to special needs members.
- To meet the requirement, this training will explain the MOC and also describe how L.A. Care and their contracted providers can work together to successfully deliver the MOC.

# The ABCs of Medicare

| PARTS OF MEDICARE | WHAT's COVERED | |
|---|---|---|
| <br>**Original Medicare (CMS)** | <br>**Partial Coverage**<br>Inpatient Hospital Stay<br>Skilled Nursing Care<br>Hospice<br>Home Care | |
| <br>**Original Medicare (CMS)** | **Partial Coverage**<br>Doctor Visits<br>Surgery<br>Lab Tests<br>Medicare Equipment<br>Preventative Exams | |
| <br>**Private Insurers and Plans** | Similar to Part A & B with predictable out-of-pocket costs and more coverage<br><br>**Often Fully Covers**<br>Wellness Services<br>Vision Exams<br>Hearing Exams<br><br>**Often Partly Covers**<br>Eye Glasses<br>Hearing Aids | |
| <br> <br>**Private Insurers and Plans** | Helps with the costs of prescriptions drugs not covered by Original Medicare.<br><br>**Covers Some**<br>Prescriptions Drugs | |

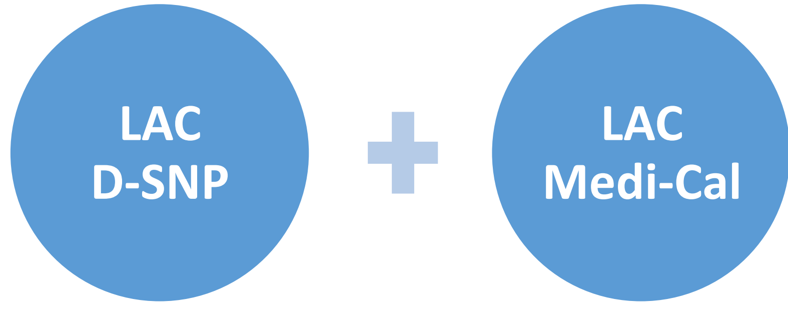
# Dual Special Needs Plan (D-SNP)

- D-SNPs are a type of Medicare Advantage (MA) that enroll individuals who are entitled to both Medicare and medical assistance from a state plan under Medi-Cal.
- The state covers some Medicare costs, depending on the state and the individual's eligibility. D-SNPs are required to administer Medicare benefits and assist/coordinate access to the covered Medi-Cal services on behalf of the member.

# Exclusively Aligned Enrollment (EAE)

Under the California Advancing and Innovating Medi-Cal (CalAIM) Initiative:

- Exclusively Aligned Enrollment (EAE) Mandate
  - Enrollment of Duals into a single Manage Care Organization for Medicare and Medi-Cal
  - Medicare will be the "Lead Plan" aligning with Medi-Cal Plan Enrollment



# L.A. Care's D-SNP Product

# L.A. Care Medicare Plus Plan Benefits

## Plan Benefits for CY2023

- L.A. Care benefits are outlined in the Contracted Provider Reference Guide located in the provider portal: https://www.lacare.org/providers/provider-resources/forms-manuals
- L.A. Care Medicare Plus will provide covered Medicare benefits and coordinate access to covered Medi-Cal services through L.A. Care's Medi-Cal Managed Care plan.

# Who can enroll in L.A. Care's D-SNP?

- An eligible member must meet all the following requirements to be enrolled:
  - Enrolled in Medicare Part A (Hospital)
  - Enrolled in Medicare Part B (Medical)
  - Lives in Los Angeles County
  - Meets the California Medicaid requirements for QMB+, SLMB+ or FBDE
  - Enrolled in L.A. Care Medi-Cal Managed Care Plan

- Enrollment begins during the Annual Election Period (October 15 – December 7)

# Ongoing Eligibility Verification

L.A. Care Medicare Plus members will be disenrolled due to the following:

- **Loss of Medi-Cal** eligibility or **"Deeming Period"**. L.A. Care will continue to provide all D-SNP plan-covered Medicare benefits up to 3 months before being dis-enrolled. During this time, member is placed on Medi-Cal Fee-For-Service. If Medi-Cal is regained within 3 month period then member will remain on D-SNP and placed back on L.A. Care's Medi-Cal Managed Care Plan.

**Out of L.A. Care's Service Area**

- Member is temporarily out of service area up to 6 months or;
- Confirms member permanently moved outside of service area which disenrollment occur the beginning of the following month

# D-SNP Member Billing

- L.A. Care Medicare Plus D-SNP members are entitled to Medicare and Full Medi-Cal benefits including Medicare cost sharing assistance covered by Medi-Cal.
- Cost Share Protections - D-SNP members shall not be balanced billed for any Medicare cost sharing amounts, including deductibles, coinsurance, and copayments, in accordance with Section 1902(n)(3)(B) of the Social Security Act.
- Medicare is always the primary payor and Medi-Cal is the secondary. For services covered under both programs, such as Skilled Nursing Facility, Medicare benefits must be exhausted prior to Medi-Cal coverage.

# L.A. Care’s Model of Care Requirements

# Provider Model of Care (MOC) Training Requirements

- L.A. Care must maintain training attestation records for all providers (in and out-of-network) managing L.A. Care D-SNP members as evidence they have successfully completed MOC training

- In addition, MOC training is required to be completed by all employed, contracted, and temporary staff participating in a D-SNP member's management of care upon initial enrollment and annually thereafter

- L.A. Care's D-SNP MOC training is accessible via the Provider website and can be used as a resource as well as for meeting the initial and annual MOC training requirements

# What is the L.A. Care Model of Care (MOC)?

- The MOC is L.A. Care's **plan for providing members with comprehensive coordination** of their care needs and services. This plan focuses on those members who are most vulnerable, fragile, or "at-risk" for changes in their health status due to potential exacerbations of chronic health conditions or impact from social drivers of health.
- The MOC is a **vital quality improvement tool** and integral to ensuring the unique needs of each D-SNP member are identified and addressed.
- The MOC is the **roadmap** for promoting quality health care, encompassing L.A. Care's care management policy and procedures, and operational systems.
- The MOC **reinforces L.A. Care's mission** by assisting members to receive the right health care, in the right setting, at the right time.
- The MOC is a **requirement**. Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage SNPs to have a MOC.

# Why is the Model of Care (MOC) important?

The MOC assists Providers in delivering effective care and coordination to:

- Improve quality
- Increase access
- Create affordability
- Integrate care across specialties and settings
- Provide seamless transitions of care
- Improve use of preventive health services
- Encourage appropriate utilization and cost effectiveness
- Improve member health

# Model of Care Provider Roles and Responsibilities

# Model of Care Provider Roles and Responsibilities: PCP

The member's Primary Care Provider (PCP) is the gatekeeper and responsible for identifying the needs of the member.

L.A. Care PCP partners are an invaluable part of the Interdisciplinary Care Team (ICT). Our D-SNP Model of Care offers opportunities to work together for the benefit of the member by:

1. Enhancing Communication:
   - With the Member
   - With the Member's Care Manager
   - With the Member's ICT participants
2. Focusing on each individual member's special needs

# Model of Care Provider Roles and Responsibilities: PCP (Cont.)

Our D-SNP Model of Care offers opportunities to work together for the benefit of the member by:

3. Supporting the member's care management through participation in:
    - Review of member's Health Risk Assessment (HRA)
    - Identifying members who are most vulnerable, fragile, and/or at-risk for health complications
    - Performing Face-to-Face encounters or tele-visits with Members every 12 months
    - Assistance with the development, execution and communication of a member's Individualized Care Plan (ICP)
    - Use of appropriate evidence-based clinical practice guidelines
    - Attendance and participation in the member's Interdisciplinary Care Team meetings
    - Participation in Quality-of-Care initiatives such as but not limited to completing AWEs that include Pain and Functional assessment, Cognitive and Psychosocial evaluation, Medication Reconciliation, and Advance Care planning
    - Assessment of Member condition after care transitions or other changes in condition

# Coordination of Medicare/Medi-Cal

It is important to understand the following about D-SNP benefits:

- Both benefits offered by Medicare and Medi-Cal must be coordinated
- Provider staff are required to have knowledge of both programs
- Assistance for Members to maintain Medi-Cal eligibility is expected
- Cost-sharing may be an important part of care coordination
- Members have rights to pursue appeals and grievances through both Medicare and Medi-Cal

# Model of Care Roles and Responsibilities: PPG

L.A. Care’s D-SNP Model of Care offers an opportunities for PPG partners to support the member by:

1. Enhancing communication
   - With the Member
   - With the PCP
   - With the Member’s Interdisciplinary Care Team (ICT)
   - With L.A. Care covered Medi-Cal Services
2. Delivering Care Management to low risk members through:
   - Review of the member’s Health Risk Assessment (HRA) and any additional assessments
   - Identifying Members most vulnerable, fragile, and/or “at-risk” for health complications
   - Creation, execution, and communication of Individualized Care Plans (ICP) to address each Member’s needs and barriers
   - Holding regular ICT conferences to review the Member’s needs and ensure participants are in alignment with the ICP including communication to all participants and execution of all action items
   - Completion of care transition support with Members
   - Tracking and encouraging each Member to complete an annual Face-to-Face encounter

# Model of Care Sections

# Four Sections of the Model of Care

The Model of Care (MOC) is comprised of four sections:

- MOC 1: Description of the D-SNP Population
- MOC 2: Care Coordination (through a dedicated care management team and program)
- MOC 3: Provider Network
- MOC 4: Quality Measurements and Performance Improvement

Each element has corresponding factors L.A. Care must meet when implementing the MOC. Those factors will be outlined within this training.

# MOC 1: Description of the Population

# Description of Member Population

The D-SNP Population for whom L.A. Care provider partners are responsible to support are:

- Individuals who are age 21 and older and eligible for both Medicare and Medi-Cal
- Adults with disabilities
- Aged, blind, or disabled (ABD) populations

Many D-SNP members have:

- Comorbidities
- Complex Care Needs
- Cognitive Conditions
- Behavioral Health Conditions
- Limited Health Literacy
- Insufficient Coordination in Care

## Description of Most Vulnerable Members

L.A. Care's most vulnerable members include many of the following characteristics:

- Complex or multiple chronic conditions
- Disabled
- Frail
- Socioeconomic challenges
- Dementia related disorders
- Near End-of-Life; or
- Polypharmacy

# Description of Most Vulnerable Members

- L.A. Care identifies the D-SNP member population at greatest risk (through indicators such as intensive health care utilization, multiple chronic conditions, etc.) and directs resources towards them through care management services.
- L.A. Care takes into consideration the member's social factors, cognitive factors, functional and behavioral status, environmental factors, living conditions and co-morbidities.

# MOC 2: Care Coordination

# Care Coordination

D-SNP members are required to have the following elements completed:

# Care Coordination Overview

**Care Coordination** is the process by which L.A. Care coordinates the health care needs and preferences of the member and shares this information with the member's Interdisciplinary Care Team (ICT). Care coordination involves:

- Completion of the **Health Risk Assessment** (HRA) for each member
    - Risk stratification of members in Low/High/Complex
- Development and implementation of the **Individualized Care Plan** (ICP)
    - PPGs are responsible for members who are identified as:
        - Low risk, or
        - Unable to be reached, or
        - Unwilling to participate in high or complex care management programs.
    - L.A. Care's Care Managers will be responsible for members identified as:
        - High or complex risk, and
        - Willing to participate in high or complex care management programs

# Care Coordination Overview (continued)

Care coordination involves:

- Performing a **Face-to-Face encounter** with each member.
- Establishing an **Interdisciplinary Care Team** (ICT) for each member and holding ICT meetings to ensure alignment of the member's needs, services, and preferences.
- Following protocols for **Transitions of Care** (TOC) and **Continuity of Care** (COC).

# HRA Components

L.A. Care will conduct HRAs to identify medical, psychosocial, cognitive, functional and mental health needs as well as risks for members.

- An **initial HRA** will be attempted to be completed with the member within 90 days of enrollment.
- An **annual HRA** is completed at a minimum 365 days from the last completed HRA.
- A **reassessment HRA** is completed if there is a care transition or change in a member's health status that warrants a reassessment.
- Clinical review of the HRA is completed by an appropriately credentialed staff member on the care team, either by the Provider or at L.A. Care depending on assignment.
- HRA responses are used to identify needs that are incorporated into the member's individualized care plan (ICP) and communicated to the interdisciplinary care team (ICT).
- HRAs identify a member's risk level and helps determine member outreach frequency.
- Members have the right to refuse to complete the HRA.

# Provider Responsibilities for HRAs

- Encourage completion of HRA mailed back to L.A. Care when received through mail, printed from L.A. Care's website or calling L.A. Care customer services to complete an HRA telephonically

- Educating members on the importance of HRA
    - May qualify for additional benefits
    - Identification of physical, behavioral, functional, cognitive, and/or social conditions requiring provider or care management interventions (such as referrals to specialists, community resources, or MLTSS)
    - Higher accuracy and relevance of the member's Individualized Care Plan (ICP) that may lead to better health outcomes

# Individualized Care Plan (ICP) Regulations

Regulations at 42 CFR §422.101(f)(ii); 42 CFR §422.152(g)(2)(iv) stipulate that all SNPs **must develop and implement an ICP for each individual enrolled in the SNP**.

The member's HRA outcomes and/or other available health data are used to develop the member's ICP *regardless* of whether the member was reached or unwilling to participate. Claims and pharmacy data can also be used.

Care Managers (PPG and L.A. Care) work with the member and their PCP as well as other participants of the ICT to prepare, implement, evaluate, and update the ICP.

# Individualized Care Plan (ICP) Process

The HRA, conversations with the member, health records, and recommendations from the ICT are all used in the creation of the ICP for all SNP members.

Care Plan implementation is performed in coordination with ICT participants to ensure all aspects of the member's care are aligned.

Throughout the ICP development and with any updated HRAs, such as when there are changes in health status or care transitions, the member's evolving needs are continually reassessed against care plan goals and interventions.

ICP required essential components:

- Member-centric problems and preferences
- Interventions and goals, including self-management activities
- Tailored services appropriate for the member's conditions and preferences such as health education, online classes, long term services and supports, palliative care, and medication therapy management.

# Interdisciplinary Care Team (ICT)

**Regulations at 42 CFR §422.101(f)(iii); 42 CFR §422.152(g)(2)(iv) require all D-SNP plans to use an ICT in the care management for each member.**

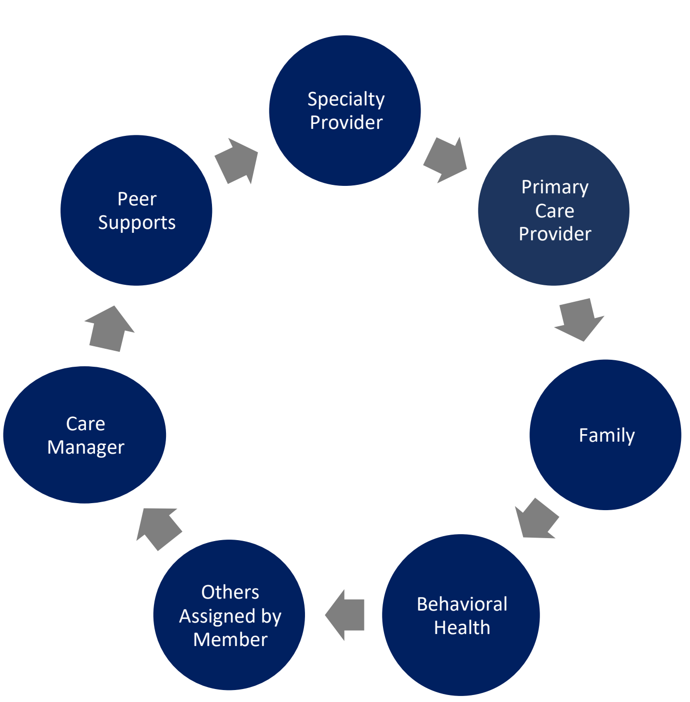
- L.A. Care and PPGs will hold ICT meetings in consideration of the member's stratified risk level
- Providers are expected to:
  - Accept invitations to attend member ICT meetings whenever possible.
  - Collaborate in the development, implementation, and monitoring of the members ICP.
  - Maintain copies of the HRA, ICP, ICT worksheets, and transition of care notifications in the member's medical record when received.
  - Collaborate and actively communicate between the participants of the ICT to support member coordination of care as well as document any exchanges within the member medical file.
- All D-SNP members must have *at least one* ICT meeting annually, or more often as warranted by changes in condition or needs, and the recommendations documented accordingly.

# ICT Participants

The PCP is a primary ICT point of contact for the member's Care Manager.

L.A. Care staff work with all participants of the ICT in coordinating the plan of care for the high risk and complex members.

The assigned Care Managers are responsible for developing the ICP for low-risk members, communicating updates with all the ICT participants, and documenting all communications, recommendations, and action items.



# ICT Coordination Participants and Process

The Care Manager (PPG or L.A. Care) is responsible for identifying the participants of the ICT based on the member’s preferences and care needs.

ICT participants always include the member, primary care physician, and assigned care manager. ICT participants may also include but are not limited to:

- Member’s friends or family members
- Member’s IHSS worker
- Social workers
- Specialists
- Behavioral health professionals
- Pharmacists
- Community Health Workers
- Other participants as needed or requested by the member

# Face-to-Face Encounters

Regulations at 42 CFR § 422.101(f)(1)(iv) require that all **D-SNPs must offer face-to-face encounters to each member** for the delivery of health care or for care coordination services. Face-to-face encounters must occur, as feasible and with the member's consent, on at least an annual basis beginning **within the first 12 months of enrollment**.

The face-to-face encounter must be between the member and individuals such as:

- Contracted plan healthcare **Providers including the PCP or Specialist**.
- A member of the member's ICT.
- The plan's care management staff.

A face-to-face encounter can be either in-person or through a visual, real-time, interactive telehealth encounter.

# Face-to-Face Encounters: Provider Responsibilities

For Face-to-Face encounters, **Providers should code the visit and make this data available to L.A. Care** (claim, encounter, adult wellness exam form).

L.A. Care will develop claims/encounter monthly reporting that includes data collection of qualifying Face-to-Face encounters providers performed using billing codes such as:

- **PCP or Specialist telehealth, office, or other outpatient services**
  - CPT codes: 99201-99205, 99211-99215, 99241-99245
  - UB Revenue: 051x, 0520-0523, 0526-0529, 0982, 0983
- **Preventive medicine**
  - CPT codes: 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429
  - HCPCS codes: G0344, G0402, G0438, G0439
- **General medical examination**
  - ICD codes: V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

# Transitions of Care (TOC) Element and CMS requirements

Regulations at 42 CFR §422.101(f)(2)(iii-v); 42 CFR §422.152(g)(2)(vii-x) require all D-SNPs to coordinate the delivery of care.

Care Management teams at the PPGs and L.A. Care, in coordination with Providers, are responsible for:

- Following L.A. Care’s Transition of Care Protocol
- Following members across care settings during transitions
- Identifying at-risk members as a result of transitions of care
- **Notifying ICT participants of changes to the member’s health status and ICP as a result of transition of care**
- Performing transitional care management services and communications

# Transitions of Care (TOC): Provider Responsibility

The assigned care management team (PPG or L.A. Care) will manage and facilitate care transitions for members following hospitalizations or through other level/setting of care changes.

L.A. Care has developed a TOC protocol and works with Providers to ensure:

- **Timely notification of an Inpatient Admission and Discharge Information**: Communication with ICT participants upon notification of a member's inpatient admission or discharge.
- **Member Post-Discharge Outreach**: In-home visits or phone calls by the Care Management team within 72 hours post discharge to ensure:
  - Coordination of care and services
  - Medication reconciliation
  - Scheduling of follow up appointments
- **Member Face-to-Face encounter before and/or after Inpatient Discharge**: Evidence of member encounter either prior to or within 30 days after their discharge (e.g., office visits, visits to the home, telehealth).

# MOC 3: Provider Network

# Provider Network Responsibilities

**Network Providers are responsible for performing the following**:

- Proper application and use of evidence-based clinical practice guidelines and protocols ensuring the "Right Care at the Right Time" for the member when authorizing care and services, while appropriately applying exceptions or modifications to use of guidelines.
- Communication to participants of the member's ICT when medical and care decisions are made outside of the recognized guidelines/protocols.
- Communication with and participation in the ICT, including with the Care Manager and the member and/or caregivers.
- Review of the HRA results and communication of findings to the ICT in the development of the member's ICP.
- Collaboration on the implementation of the member ICP with ICT participants.
- Collaboration with participants of the members ICT related to specialized treatment/service.
- Proper use of care transition protocols.
- Completion of Model of Care training - Initial/annual and with evidence of training completion.

# MOC 4: Quality Measurement and Performance Improvement

# MOC Performance Goals

**Goals:**

- Ensure member access to medical, behavioral health, and social services.
- Provide access to affordable care.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across healthcare settings and providers.
- Improve access and utilization of preventive health services.
- Improve appropriate utilization of services for chronic conditions.
- Improve experiences of care.
- Improve member satisfaction.

# MOC Quality Measurement and Performance Improvement

## L.A. Care will be responsible for:

- Development and implementation of Quality Performance Improvement Plan
- Creation of measurable **goals and health outcomes** that support the MOC
- Application and Monitoring of all regulatory requirements (i.e., NCQA, CMS, Electronic Code of Federal Regulation, etc.) related to the MOC through detailed reporting
- Establishing mechanisms for the measurement of the **Patient Care Experience**
- Creation and implementation of process for Ongoing **performance improvement evaluations**
- Communication plan to disseminate SNP Quality Performance related to the MOC

# MOC Quality Measurement and Performance Improvement (continued)

**Providers will have the responsibility to:**

- Encouraging members to complete an initial and annual HRA.
- Assist in the creation, implementation, and ongoing communication of interventions/goals related to the ICP.
- Identification and closer of gaps in care- This can occur during routine Face-to-Face visits or wellness exams.
- Participation in ICT meetings to help identify and address member care needs/services and/or barriers to care.
- Support and assist in the coordination of member access to care and services during care transitions to ensure continuity of care and/or when there is a health status change.
- Application of member benefits according to D-SNP regulatory requirements.

# Training Recap and References

# Training Recap

You should be able to understand both the importance and key requirements of the MOC including:

- ❑ Members completion of Health Risk Assessment (HRA) by L.A. Care
- ❑ Implementation of Individualized Care Plans (ICPs) that are aligned with the member's needs and preferences
- ❑ Coordinated clinical care and services between Medicare and Medi-Cal for the member
- ❑ Participation in the Interdisciplinary Care Team (ICT)
- ❑ Responsiveness and cooperation with plan's clinical representatives and other participants of the member's ICT
- ❑ Referring member to medically necessary services in accordance with plan benefits.
- ❑ Coordinated support of members during Transitions of Care (TOC)
- ❑ Annual Face-to-Face or telehealth visits with members
- ❑ Timely communication and submission of documentation
- ❑ Initial and Annual MOC training for applicable parties

# Regulatory References

CMS Medicare Managed Care Manual for Special Needs Plans (SNPs): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf

CMS Requirements for Quality Assessment: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf

CMS SNP Model of Care (MOC) information: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

NCQA MOC Approval Process: https://snpmoc.ncqa.org/

Electronic Code of Federal Regulation: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422