Dual Eligible Special Needs Plan (DSNP)

Model of Care Training 2021

Overview

- The Model of Care (MOC) is the CCA Health Michigan, Inc. (CCA Health) comprehensive plan for coordinating care and delivering care management services to its special needs plan (SNP) enrollees.
- The Centers for Medicare and Medicaid Services (CMS) requires that all employees and delegated entities receive basic training about the plan's DSNP Model of Care (MOC).
- This training will describe how RMA delivers integrated care management services to its DSNP enrollees.

Training Objectives

- Outline the basic components of the Model of Care (MOC)
- Describe how care management staff coordinates care for SNP members
- Understand the essential role of providers in the implementation of the MOC program
- Describe the metrics used by the Plan to measure performance improvement

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Model of Care Elements

All SNPs must have a MOC approved by the National Committee for Quality Assurance (NCQA). The four main elements of the MOC are:

- Description of the Dual Eligible Population
- Care Coordination
- Provider network
- Quality measurement and improvement

Description of the DSNP Population

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Description of the DSNP population

- Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs.
- CCA Health, offers a Dual Eligible SNP, known as Dual Care Plus, which restricts enrollment to individuals entitled to Medicare and Medicaid
- DSNP enrollees must be entitled to *full* Medicaid benefits

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Special needs of DSNP enrollees

Data available on Michigan's dual eligible population indicates these individuals are typically:

- >64 years of age
- Eligible for Medicare due to a disability
- Have 3 or more chronic conditions
- Lack financial resources to access adequate housing, nutritious food, transportation, medications, etc.

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Most vulnerable sub-populations

The Dual Care Plus MOC identifies enrollees at greatest risk so that resources are directed towards those with increased need for care coordination and care management. The MOC currently identifies the most vulnerable as enrollees that are:

- At high risk for hospital readmission within 30 days of discharge from an inpatient facility
- Have a diagnosis of uncontrolled diabetes
- Diagnosed with significant behavioral health conditions impairing their ability to self-manage their health care needs.

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Care Coordination

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Care Coordination Tools

CCA Health utilizes the following tools to coordinate care for the DSNP enrollee:

- Initial Health Risk Assessments (HRA) and reassessments
- Development and implementation of an Individualized Care Plan (ICP)
- Input from an Interdisciplinary Care Team (ICT)
- Protocols to ensure a seamless transition after discharge from an inpatient facility

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Health Risk Assessments

Every Dual Care Plus enrollee is evaluated with a comprehensive Health Risk Assessment (HRA). Per CMS regulations HRAs must be conducted:

- within 90 days of enrollment
- when the enrollee experiences a significant change of condition, but
- no later than 365 days from the previous HRA

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Health Risk Assessments

Questions on the HRA include:

- Demographic data (e.g., age, gender)
- Self-assessment of health status and activities of daily living (ADLs)
- Functional status and pain assessment
- Medical conditions
- Cognitive status
- Psychosocial risks (e.g., depression, stress, fatigue)
- Behavioral risks (e.g., tobacco use, nutrition, physical activity

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Individualized Care Plans

Care Managers are responsible for creating and implementing an Individualized Care Plan (ICP) for every DSNP member which includes the following:

Problems

Communicated by the member during the HRA and identified by other plan data (e.g., UM, claims, pharmacy)

Goals

What the member hopes to achieve regarding their health

Interventions

Specific actions to support goal achievement and problem resolution

Interdisciplinary Care Team (ICT)

All newly created ICPs, or those with a significant updates, are reviewed and approved by the ICT.

- The core participants of the ICT are the member, their Primary Care Provider (PCP), the Chief Medical Officer, the assigned Care Manager and/or a social worker.
- Additional ICT participants may be requested by the member or identified by the Case Manager (e.g., pharmacist, specialists, clergy)
- The ICT is built around the member's preferences with respect to the member's right to self-direct care. Family members and caregiver participation is encouraged and promoted, with the member's permission.

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Role of the RMA Provider in the ICT

- Accept invitations to attend ICT meetings, whenever possible, to review and discuss the member's care needs
- Provide feedback to the Case Manager on the member's ICP
- Assist the plan with attempts to engage the member in active case management
- Communicate with the member, Care Manager and ICT on established problems, goals and interventions
- Educate members on their conditions, medications and care goals.
- Maintain copies of the ICP and transition of care notifications in the member's medical record

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Care Transitions

The Care Management staff manage transitions of care to ensure that members have appropriate follow-up care after a hospitalization or a change in level of care.

The Transitions of Care (TOC) Program includes:

- Care Manager communication with the member prior to *planned* hospital admissions and upon notification of an *unplanned* admission to coordinate post-discharge needs
- Faxing a copy of the member's ICP to the inpatient facility within one (1) business day of the admission notification

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Care Transitions (continued)

- Facilitating access to all services needed post-discharge (e.g., DME, home health)
- Conducting a post-discharge assessment with the member within three business days of discharge
- Resolving any unmet needs expressed by member during the post-dc assessment

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Provider Network

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MOC Provider Requirements

CMS requires DSNP plans to:

- Maintain a contracted network of provider's with specialized expertise in the needs of DSNP members, including:
  - PCPs
  - Specialists
  - Facilities
  - Ancillary providers
- Monitor network providers to assure the use of nationally recognized clinical practice guidelines, whenever possible.
- Assure providers are licensed and competent through a formal credentialing process

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MOC Provider Requirements (continued)

- Coordinate sharing of the member's ICP amongst providers and the ICT
- Accept invitations to attend ICT meetings, whenever possible, to review and discuss the member's care needs

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Quality Measurement & Performance Improvement

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Quality Components

In compliance with CMS requirements CCA Health, must conduct a Quality Improvement Program to monitor health outcomes and the implementation of the Model of Care by:

- Identifying measurable goals and collecting data to determine if goals have been met
- Reporting on identified trends or issues requiring evaluation and/ore remediation
- Developing targeted strategies and opportunities to enhance care delivery.

Clinical Performance Measures

CCA Health, Quality Improvement plan includes clinical measures to assess:

- Health outcomes (e.g., HEDIS data, CAHPS data)
- Chronic care (e.g., Chronic Care Improvement Program)
- Compliance with clinical practice guidelines (e.g., gaps in care reports)
- Member satisfaction w/ plan performance

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Non-Clinical Performance Measures

CCA Health, Quality Improvement plan also includes non-clinical measures such as:

- Member access to care
- Plan adherence to care transition protocols
- Timely completion of Care Coordination activities (e.g., HRA, ICP, ICT)
- Member satisfaction survey
- Completion rate for advance directives
- Generic dispensing rate for Part D medications

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Performance Assessment

CCA Health, conducts an assessment of its quality improvement plan on an annual basis, at minimum. Results are presented to the CCA Health Michigan, Inc. Quality Improvement Committee. If an identified goal has not been achieved the following processes are preformed to identify opportunities for improvement:

- Root cause analysis
- Discussion with stakeholders
- Implementation of corrective actions
- Re-measurement
- Development of a plan to measure and monitor

Summary

The Model of Care requires us to work together to enhance care and services for DSNP members through:

- Effective communication between members, physicians, providers and CCA Health staff.
- An interdisciplinary approach to managing the member's specific care needs
- Development and implementation of a comprehensive member care plan
- Improving transitions of care across health settings and providers
- Identifying benefits that will best serve the DSNP membership
- Monitoring MOC performance and health outcomes to continually improve care and services.

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Thank You!

- Thank you for your participation in this annual MOC training. We appreciate you taking time to learn about CCA Health, DSNP program.
- Please print and complete the attestation form below:

- Fax the completed form to
- 248 715 5415

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