# CCA Medicare Maximum
## (HMO D-SNP)

Model of Care Annual Provider Training
2024

Improving care for people with disabilities and chronic health needs

*Updated: January 2024*

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# TRAINING OBJECTIVES

**Purpose**: The Centers for Medicare & Medicaid Services (CMS) **requires** providers to complete an annual CCA Health RI D-SNP Model of Care (MOC) training if you are either contracted to see CCA Health RI D-SNP members or an out-of-network licensed independent practitioner (LIP) who routinely treats and/or provides services to CCA Health RI D-SNP members.

The intent of the CMS requirement is to ensure providers and D-SNP plans can seamlessly coordinate the care for this population with complex needs.

At the conclusion of this training, you will be able to:

- Define a Dual Eligible Special Needs Plan (D-SNP)
- Understand a D-SNP Model of Care
- Recognize common characteristics of Rhode Island dually eligible members
- Identify CCA Health Rhode Island
- Understand CCA Medicare Maximum (HMO D-SNP) plan basics
- Understand CCA D-SNP Clinical Care Coordination Model including:
  - Interdisciplinary Care Team (ICT)
  - Assessments
  - Individualized Care Planning
  - Transitions of Care
- Understand CCA's Quality Oversight
- Contact CCA Health – Rhode Island

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# Special Needs Plans

The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care to individuals with special needs. In the MMA, Congress identified "special needs individuals" as:

1. Institutionalized individuals;
2. Dual-eligibles; and/or
3. Individuals with severe or disabling chronic conditions, as specified by CMS.

MA CCPs established to provide services to these special needs individuals are called "Specialized MA plans for Special Needs Individuals," or SNPs.

## What is a Dual Eligible Special Needs Plan (D-SNP)?

A Dual Eligible Special Needs Plan (D-SNP) is a type of SNP that enrolls dual eligibles, which are individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). This plan is designed to coordinate care among Medicare and Medicaid to improve care while also lowering costs. In addition to care coordination, D-SNPs can also offer supplemental benefits specially designed to meet the needs of dual eligibles within the plans service area.

# What is a D-SNP Model of Care?

As provided under section 1859(f)(7) of the Social Security Act, every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA).

The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.

**The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.**

# Duals Population Characteristics

The state of Rhode Island currently serves approximately 40,000 full dual eligibles (individuals eligible for full state Medicaid benefits as well as Medicare).

- Approximately 50% are elders (age 65+) and 50% are adults with disabilities
- One-third of RI full dual eligibles are waiver eligible for long-term services and supports or receiving nursing home or hospice care

Common Characteristics of Dual Eligibles in RI:

- Advanced Age/Frailty
- Impoverished
- Minority Status
- Cultural/Language Barriers
- Multiple, Severe Impairments to Activities of Daily Living (ADLs)
- Multiple Chronic Conditions
- High prevalence of severe and persistent mental illness, Alzheimer's disease, or related dementia
- Frequent challenges related to:
  - Housing Security
  - Access to Healthy Foods
  - Access to Health Care Services
  - Transportation
  - Education Levels

# Intro to CCA Health Rhode Island

CCA focuses on complex care for high-need individuals, building on a comprehensive model of *uncommon care*.

This care includes:

- Integrated multi-disciplinary care;
- Inclusion of behavioral, medical and social factors influencing health;
- A commitment to engage and support all our members.

## OUR VISION

To lead the way in transforming the nation's healthcare for individuals with the most significant needs.

## OUR MISSION

To improve the health and well-being of people with significant needs by innovating, coordinating, and providing the highest-quality, individualized care.

# Intro to CCA Health RI Medicare Maximum (HMO D-SNP)

CCA's care model is based on our data-driven understanding of what puts people at risk, leveraging our unmatched ability to identify and engage hard-to-reach individuals.

**Community focus to ensure the most appropriate site of care**

**Seamless integration of care coordination, care delivery and care partnership**

**Innovation to address members' unmet needs**

## Trusting partnerships, appropriate utilization, better outcomes

- Reduction in gaps in care
- Decrease in ED visits, admissions and readmissions
- Reduced poly-pharmacy, improved medication adherence, routine review of safety and effectiveness
- Greater provider satisfaction through clinical support and reduced administrative burden
- Affordability and responsible stewardship of funds

# Care Coordination – Interdisciplinary Care Team

*We partner with our members' doctors, family and caregivers to develop a specific care plan based on their needs that also integrates community resources. Our Member Onboarding team is a clinical function:  specialist from our onboarding team will reach out to members to welcome them to the plan, walk through their benefits and ensure that members are connected with all the supports and services needed to support their health.*

## Community Provider Network

- Primary Care Providers
- Specialty Providers
- Hospital and Outpatient facilities
- Post-acute care and SNFs
- Pharmacies
- Dentists
- Transportation partners
- Long Term Support Services

## CCA Integrated Care Team


## CCA Clinical Supports

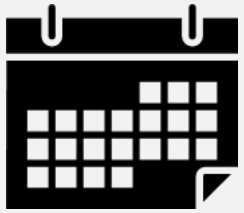
- 24/7 Clinical Response Unit
- instED Mobile Integrated Health
- Pharmacy Support/Medication Management
- Psychiatry & SUD Support
- Advanced Practice Clinicians (APC)

# Care Coordination - Assessments

CCA conducts a Comprehensive Needs Assessment (CNA) for all D-SNP beneficiaries, which helps our care team identify relevant medical, functional, cognitive, psychosocial, and mental health needs to inform and begin the care planning process.

## WHO?

CCA Care Partner (RN)



## WHEN?

**Initial Assessment:** D-SNP beneficiaries are outreached upon enrollment, and CCA's goal is to complete the CNA within 90 days of their coverage effective date

**Reassessment:** D-SNP beneficiaries are outreached for reassessment any time they have a change in health status or, minimally, once every 365 days.

Results inform opportunities, goals, and interventions that can be discussed with the beneficiary as part of the care planning process. Reassessments enable CCA Care Partners to identify changes to the beneficiaries needs and facilitate proactive intervention – the goal is to prevent extended periods of unmet needs for the beneficiary.

# Care Coordination – Individualized Care Plan (ICP)

Individualized Care Plans are developed as a guide to care delivery based upon findings from the Comprehensive Needs Assessment. The ICP is created in conjunction with the member/caregiver, primary care provider, appropriate specialists, and other key community or institutional professionals. Care Plans include:

- Specific services and benefits to be utilized, including the appropriate level of care
- Member preferences
- Identification of measurable outcomes
- Prioritized goals (short and long term)
- Provision of educational materials and one-on-one education opportunities
- Support needs related to coordination of Medicare and Medicaid benefits
- Identification of and strategies to overcome potential barriers to achieving identified goals
- Planning for continuity of care, including transitions of care

# Care Coordination – Transitions of Care (TOC) Team

- Coordinates with facility discharge planners to support safe and member-centered transitions between hospital, SNF/Rehab/LTC and/or home
- Supports direct admission to appropriate facilities as needed
- Consults and collaborates with care team members to ensure services meet new or changing needs
- Monitors utilization to ensure cost-effective and timely interventions

# Care Coordination – Transitions of Care (TOC) Team

## BEFORE ADMISSION (PLANNED ADMISSIONS):

The Care Partner begins coordination with the ICT once made aware of the planned admission. The PCP and/or other relevant provider(s) are contacted by phone, secure email, fax, or other established communication channel. The Care Partner contacts the member and/or caregiver within 2 business days of being notified of the planned admission to ensure the beneficiary and/or their caregiver understands the reason for the admission and/or planned treatments, is aware of the process from admission to post-discharge care, and understands how to contact the Care Partner.

## WHILE INPATIENT:

The TOC Team communicates directly with the hospital staff when the member is inpatient. They are responsible for coordinating the authorizations for continued stays and for obtaining hospital documents, including the discharge summary. The TOC Team does not necessarily perform discharge planning activities, but they coordinate communication about discharge between the hospital, the receiving facility (if applicable), and the member's care team.

## UPON DISCHARGE:

The Care Partner coordinates with the member to ensure they understand their discharge plan and have the appropriate supports in place. The Care Partner will also assist the member with medication reconciliation, scheduling a follow up appointment with their provider, and will reassess the member to identify any changes to their health needs. The Care Partner will utilize the ICT to assist in identifying/meeting the member's emerging needs. For members that are at high risk of readmission, this may include sending a clinician to the member's home for evaluation and support.

# Key Features of the CCA Health RI D-SNP

**instED**

**Clinical Response Unit (CRU)**

**APC and Behavioral Health Resources**

# instED® Mobile Integrated Health Program

- CCA's mobile integrated health program, instED, provides in-home, high-intensity care in the member's setting of choice.
- instED is a reliable resource that fills the gap between primary care and emergency care—even for those with significant health needs.
- instED's website provides direct access to request a visit. instED visits are covered at no cost share for CCA Health RI members.


**85%**

of visits **avoided an emergency department or inpatient admission** within 3 days

**96**

**Net Promoter (patient satisfaction) Score** based on respondent's likelihood to recommend instead to family or friends

**Service Area: instED is available to CCA members in all 5 Rhode Island Counties**

# instED - Mobile Integrated Health Program

*We bring diagnostic testing and treatment capabilities to the patient's home.*

**Illnesses and symptoms:**
- Urinary Tract Infections
- Cellulitis
- Shortness of breath
- COVID and flu-like symptoms
- Migraine/Headaches
- Back and joint pain
- Abdominal pain
- Weakness/lethargy
- Dehydration
- Nausea/Vomiting
- Altered Mental Status
- Edema
- Fever/chills
- Anxiety/depression


**Chronic Conditions:**
- Congestive Heart Failure
- Asthma/COPD
- Chronic kidney disease
- Diabetes
- Autonomic dysfunction
- Behavioral Health

**Injury Treatment:**
- Fall Assessment
- Muscle strain and spasm
- Basic Wound Care
- Sprains and Strains
- Burns

*Including point-of-care testing, blood draws, cultures, ECGs, IV therapies, and first dose medication.*

# CCA's Clinical Response Unit (CRU)

**24/7 clinical first response by CCA can take the burden off PCPs, Emergency Departments, and Outpatient Urgent Care**

- The CRU triages clinical concerns from members experiencing acute medical or behavioral health symptoms 24 hours per day/365 days per year.
- Members speak with a CRU Nurse or Behavioral Health Clinician for assistance, and many issues can be resolved over the phone with the support of the CRU clinicians.
- As needed, the CRU can deploy CCA's clinical resources for a member home visit for urgent care: the community clinical team during business hours, or the instED paramedic team after hours.
- The CRU may determine a member needs 911, ER, or Urgent Care as part of the triage process. The CRU clinician will assist members with accessing the most appropriate site of care.

*A member with an immediate medical or behavioral health need can call CCA to speak with a nurse or licensed behavioral health clinician at 866-610-2273*

***"I need to speak with a nurse/BH clinician"***

# Community APC and Behavioral Health Supports

**Community Advanced Practice Clinician (APC)**

The Community APC is a mobile resource that is available to support the member with:

- Post-Discharge Visit
- Chronic Disease Management
- Acute Medical Needs, including Bridge Prescribing
- Annual Wellness Visits (AWV)

**Psychiatry & SUD Support**

CCA has BH resources that are available to support the member with:

- Post-Psych Hospital Visit
- BH Assessment/Consult
- BH Crisis Consult and Follow up

# Evaluating Quality Across the Care Continuum

## Who Is Evaluating:

- **CMS:** Centers for Medicare and Medicaid Services
- **NCQA:** National Committee on Quality Assurance
- **CCA Health RI**

## What Is Being Evaluated:

- Evidence-based care
- Member reported experience and care
- Operational performance experience
- Provider Performance

## How Are Evaluations Conducted:

- **Medicare Star Rating**
- **HEDIS**: Healthcare Effectiveness Data and Information Set
- **CAHPS**: Consumer Assessment of Healthcare Providers and Systems
- **HOS**: Health Outcomes Survey
- **Member Touchpoint Surveys and Advisor Panels**

# CCA Health RI Contacts

**Contracting (Rhode Island)**
For organizations interested in contracting with CCA Health RI:

*RIContracting@commonwealthcare.org*

**instED**
To refer a patient, call or visit the instED website:

*https://www.insted.us/request-a-visit/*
*833-946-7833*

**Provider Enrollment**
For provider network status, enrollment, disenrollment, or a change to a provider's information:

*pnmdepartment@commonwealthcare.org*

**Provider Services**
Call or email with inquiries about covered services, authorization status, service denials, claims, and benefits:

*providerservices@commonwealthcare.org*
*866-420-9332*
*For clinical concerns or to contact the Care Partner team, select option 4.*

**Member Services**
Members can call or email for information about their health care coverage:

*memberservices@commonwealthcare.org*
*833-346-9222*

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# Please Complete the Following Attestation

https://www.commonwealthcareallia nce.org/ri/providers/training-and-programs/dsnp/complete/


Improving care for people with disabilities and chronic health needs

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