2023

Model of Care Training

Clear Spring Health

Clear Spring Health

OVERVIEW

What is the Model of Care Training?

The Model of Care is the plan used by Clear Spring Health for delivering and managing care to special needs members. The plan provides the basic framework under which Clear Spring Health meets the regulatory requirements as defined by CMS. This training will assist you, our providers, in how to manage our special needs members while understanding CMS requirements.

Define and Describe

- Training requirement
- D-SNPs and C-SNPs
- Special Needs Plan's offerings
- Member qualification requirements
- Describe Clear Spring Health's MOC
- Identify plans most vulnerable members
- Detail Benefit Offerings

Training Requirements

The Centers for Medicare & Medicaid Services (CMS) requires all contracted Medicare providers and staff to receive basic training about the Special Needs Plans (SNP) Model of Care. Clear Spring Health is responsible for conducting our own MOC training, which means you may be asked to complete multiple trainings by different health plans. CMS requires that Clear Spring Health provide MOC training annually and show evidence our providers completed the training.
In order to ensure Clear Spring remains compliant with CMS regulatory requirements for Model of Care training, your must complete the Attestation Form upon completion of the training. The Attestation Form is found on Clear Spring Health website.

Training Objectives

The following objectives will be covered during this training:

1) Description of the different types of Special Needs Plans (SNP)
2) Description of the Model of Care (MOC) Elements:
    a. MOC 1: Program Description- SNP Population
    b. MOC 2: Care Coordination
    c. MOC 3: Provider Network
    d. MOC 4: Quality Measurement and Performance
3) Provider Responsibilities
4) Attestation process to document compliance with annual MOC Training

MOC 1: SNP Population

MOC 1: Program Description - SNP Population

The description of the SNP population includes the characteristics related to Clear Spring Health's membership including demographics, social factors, environmental factors, living conditions, cognitive factors and co-morbidities.

- The description also includes:
  - A description of Clear Spring Health's most vulnerable members
  - How the Plan determines and tracks member eligibility
  - Specially tailored services offered to members* How Clear Spring Health works with community partners

What are Special Needs Plans?

Special Needs Plans (SNPs) are a type of Medicare Advantage plan that focus on Medicare Beneficiaries with special needs who would benefit from increased, focused coordination of care.

- There are three types of SNPs designed for specific groups of members with special health care needs:
  - Beneficiaries with **Dual Eligibility** who qualify for both Medicare and Medicaid (**D-SNP**)
  - Beneficiaries with **Chronic Conditions** (**C-SNP**)
  - Beneficiaries who are **Institutionalized** or eligible for Nursing Home Care (**I-SNP**)
- All Clear Spring Health's SNP Plans consist of D-SNP and C-SNPs; Clear Spring Health does not have I-SNP plans, currently.

D-SNP Eligibility Requirements

1. Must reside in the plan service area and provide proof of permanent residence
2. Must be entitled to Medicare Part A and be enrolled in Medicare Part B
3. Have Medicaid: one of the following:
   - Full Medicaid (only)
   - Qualified Medicare Beneficiary without other Medicaid (QMB Only)
   - QMB Plus
   - Specific Low-Income Medicare Beneficiary without other Medicaid (SLMB Only)
   - SLMB Plus
   - Qualifying Individual (QI)
   - Qualified Disabled and Working Individual (QDWI)

MOC 1: SNP Population

C-SNP Eligibility Requirements

1. Must be eligible for Medicare
2. Must reside in the Plan service area and provide proof of residence
3. Must be entitled to Medicare Part A and be enrolled in Medicare Part B
4. Must have one of the following chronic conditions:
    - Diabetes Mellitus
    - Chronic Heart Failure
    - Cardiovascular Disorders

Clear Spring Health offers two Special Needs Plans for 2023

Medicare-Medicaid Dual Eligible Program (D-SNP):

Available for Plans

- H6672 001 - Georgia
- H9403 001 – South Carolina

Each D-SNP plan must have a State Medicaid Agency Contract (SMAC) which may define additional state required benefits or requirements.

Medicare-Medicaid Chronic Condition Program (C-SNP):

Available for Plans

- H6672 003 – Georgia
- H9403 003 – South Carolina

Accreditation for C-SNP and D-SNP Programs is granted by the National Committee for Quality Assurance (NCQA). NCQA assesses the Model of Care (MOC) from each SNP according to detailed CMS scoring guidelines. Accreditation for C-SNP is provided annually. Accreditation for D-SNP can be from 1 to 3 years and is based on how well the MOC Program meets the scoring guidelines.

MOC 2: Care Coordination

Care Coordination element includes:

- **Health Risk Assessment (HRA)**- CMS requires that every SNP member receive a comprehensive assessment to determine member's health status.
- **Interdisciplinary Care Team (ICT)** – CMS requires a team of individuals both professional and personal (caregivers/family) to be involved in the member's care.
- **Individualized Care Plan (ICP)** – CMS requires a plan of care be developed by nursing personnel based on HRA results to help members achieve their individual health care goals and objections. The ICP must also include identified barriers and interventions.
- **Transition of Care (TOC)** - Coordinating transition of care and its impacts to the member's health status.

Health Risk Assessment Tool

- The **Health Risk Assessment Tool (HRAT)** helps identify a member's most urgent needs by identifying:
  - Medical conditions
  - Functional status (i.e., activities of daily living)
  - Cognitive health
  - Psychosocial health
  - Mental health conditions
  - Social determinants of health
- Clear Spring Health makes best efforts to complete the HRAT:
  - Within 90 days of member's enrollment and annually thereafter
  - When there is a change in the member's condition
  - When the member has had a transition of care (i.e. hospitalization)
- The results of the HRAT are used to create the **Individualized Care Plan (ICP)**, identify member's individualized care needs. Results are communicated with the members of the care team. Physicians are urged to encourage their members to complete the HRA in order to better coordinate care.

Categorizing Members At Risk

HRAT results are reviewed and analyzed to categorize the members into Risk Groups based on established criteria.

Members may fall into **3 Risk Groups:**

High Risk: The most vulnerable members with multiple chronic conditions and high utilization (ER visits, hospitalizations)

Moderate Risk: Members with two or more chronic conditions and frequent utilization

Low Risk: Members with no chronic conditions or just one, and who are stable and able to self-manage

MOC 2: continued

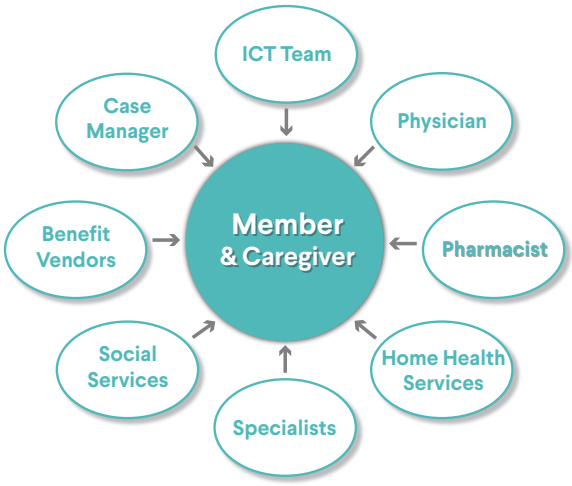
Individualized Care Plan (ICP)

An Individualized Care Plan (ICP) is developed by the care team in collaboration with the member and includes:

- Problems
- Goals
- Interventions

The Interdisciplinary Care Team

All members are managed by the ICT to help achieve the plan goals.



ICT Responsibilities:

- Determine member's needs
- Identifying problems
- Provide member education
- Determine if goals have been "met" or "not met"
- Refer/inform member of community resources
- Manage care transitions
- Assist with coordination of benefits
- Encourage self-management of their condition

ICT Communication

ICT communication with members of the team can be done through a variety of methods:* Telephone

- Fax
- General mail
- Secure e-mail
- In person
- Text messages
- Member/Provider portals
- Virtual / teleconference meetings
- Other methods preferred by member

Care Coordination: The Care Manager

Coordination of care for SNP members is completed across various services through a central point of contact, the Case Manager. Every member is assigned to a Case Manager, and he/she is responsible for all the member's care.

MOC 2: continued

How to improve care:

- The Case Manager coordinates the care provided by the PCP, specialists and other members of the ICT.
- The PCP is responsible for member care and identifying member needs.

Providing Transition of Care

- Transition of care occurs when members move from one care setting to another during an episode of illness. For example:
  - Hospital to home
  - Hospital to a Skilled Nursing facility or Rehab
  - Nursing home to hospital

- The Case Manager is responsible for ensuring a seamless transition of care between settings by:
  - Sharing the Individualized Care Plan (ICP) with the PCP, hospitalist, facility and/or caregiver as applicable
  - Notifying the PCP of any member transition
  - Contacting the member of any planned transition and answering any questions and to provide educational materials

Transition of Care: Post-Hospitalization

- Contact with member after hospitalization:
  - Members are called 72 hours (3 days) after hospital discharge and 14 days after in a follow-up call
  - A post-discharge or transitional assessment is conducted
  - Medication reconciliation is conducted
  - ICP is updated with new information
  - A Meals Form (SNP) is completed, and post-discharge meals are delivered to member's home

- Case Manager assists member with:
  - Understanding the discharge diagnosis and hospital instructions
  - Scheduling follow-up appointments
  - Any additional needed services: Home Health, DME etc.
  - Understanding and learning about relevant medical conditions

MOC 3: Provider Network

Provider Network

MOC 3 describes the expertise in Clear Spring Health's provider network that is made available to SNP members.

- Clear Spring Health must maintain a specialized provider network that have the can attend to SNP member's needs.

- This element describes the following:
  - How the network corresponds to the target population
  - Oversight provided by Clear Spring Health to all our network facilities and providers
  - Provider collaboration with ICT and contribution to the implementation and maintenance of member's ICP
  - Collaboration between providers and the plan to coordinate member's care

- Clear Spring Health must comply with CMS expectation with regards to Provider Network

  1) Contract with Board Certified providers

  2) Monitor network providers to ensure they use nationally recognized clinical practice guidelines

  3) Process providers through the credentialing process to ensure that providers are licensed and competent.

  4) Document the process to linking SNP members to the correct provider

  5) Coordinate the sharing of member's health information among providers and members of the ICT.

Provider Role:

- Communicate with SNP care managers, ICT members, members and caregivers
- Collaborate with care managers and in maintaining the member's medical records
- Reviews and responds to patient-specific communications
- Maintain ICP information within member's medical records
- Participate in the interdisciplinary care team meetings
- Educate member on the importance of the HRA which is essential in the development of the ICP
- Encourage the member to work with the CM team
- Complete the MOC training upon onboarding with Clear Spring Health and annually thereafter:

Clear Spring Staff Roles:

- Explain to the member the importance of the HRA
- Encourage members to work with their Care Management Team
- Encourage our PCPs and other providers to participate in the ICT
- Remind PCP to access the SNP members Individualized Care Plan (ICP) ICP direct link:
- Conduct annual MOC training as required:
- Complete attestation after completing MOC training

MOC 4: Quality Measurement & Performance Improvement

Quality Measurement & Performance Improvement

CMS requires that all Plans have performance improvement and quality measure in place to evaluate the success of the MOC program.

To evaluate, Clear Spring Health conducts the following projects:

- Measures member outcomes annually utilizing Health Effectiveness and Information Set (HEDIS) as the measurement tool
- Monitors quality of care
- Evaluate the Model of Care (MOC) by reviewing goals

Model of Care Goals

Clear Spring Health determines goals for the MOC based on the following:

1. Medicare Star Measures
2. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
3. Healthcare Effectiveness Data and Information Set (HEDIS)
4. Health Outcomes Survey (HOS)
5. Quality of Care
6. Evaluation of complaints and grievances

MOC Training Attestation Form:
https://clearspringhealthcare.com/for-providers/provider-overview/

If you have any questions about the Model of Care, please don't hesitate to call

Provider Services at 1-866-788 3640

Health Services Department at 1-866-689-8761

You can access a copy of the MOC training at in our website:
https://clearspringhealthcare.com/for-providers/provider-overview/