Medicare Model of Care

PriorityMedicare[SM] D-SNP (HMO)

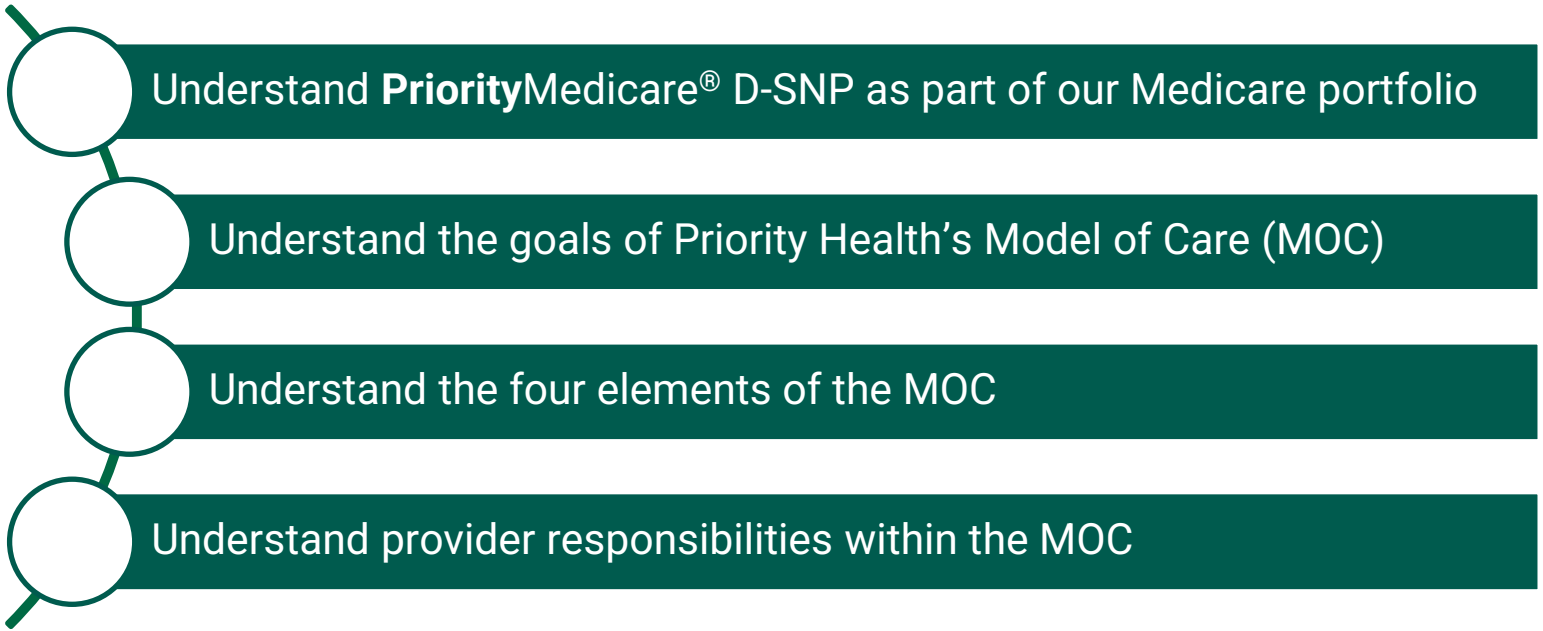
Provider training

PriorityHealth®

THINK SMART. LIVE SMART.™

Model of Care training objectives

Upon completion of this training, providers will be able to:



PriorityHealth

Provider training in Model of Care (MOC)

CMS requirement

The Centers for Medicare and Medicaid Services (CMS) requires all providers who see **Priority**Medicare® D-SNP members to complete Model of Care training upon onboarding and on an annual basis.

PriorityHealth

Provider training in Model of Care (MOC)

Provider responsibilities

Our training is designed to educate providers who serve members who are enrolled in **Priority**Medicare® D-SNP (HMO).

The training focuses on the responsibilities of the provider under the Model of Care.

PriorityHealth

PriorityMedicare D-SNP (HMO)

PriorityMedicare D-SNP (HMO):

- Is available in all 68 counties in Michigan's Lower Peninsula to serve persons who have Medicare and Medicaid benefits (also known as dually eligible).
- Is a type of Medicare Advantage (MA) plan. D-SNP stands for dual eligible special needs plan (SNP).
- Shares the same provider network, formulary and authorization requirements as our other Medicare Advantage plans.

PriorityHealth

What is the Model of Care?

- Our Model of Care (MOC) is our plan for addressing the diverse and complex needs of our members who are covered under Medicare and Medicaid.
- The MOC includes **four elements**, which are required by the Centers for Medicare and Medicaid Services (CMS).
- Persons who are eligible for both Medicare and Medicaid are also known as dually eligible persons.

MOC Element 1
Description of the D-SNP population

MOC Element 2
Care coordination

MOC Element 3
Provider network

MOC Element 4
Quality measurement and improvement

PriorityHealth

Our Model of Care goals

We've established several goals for this program.

PriorityHealth

What do providers need to know?

	The provider's role
MOC Element 1 Description of the D-SNP population	Providers need to understand the characteristics, conditions, and range of medical, behavioral health, long-term services and support and social needs of the population.
MOC Element 2 Care coordination	Providers need to understand the range of tools that are used to address the goals of our MOC including the Health Risk Assessment (HRA), the Individualized Care Plan (ICP) and their role as part of the Interdisciplinary Care Team (ICT).
MOC Element 3 Provider network	Providers need to understand training requirements and guidelines.
MOC Element 4 Quality measurement and improvement	Providers need to understand the goals and desired outcomes for members and how they can help to improve quality.

PriorityHealth

D-SNP population: dually eligible individuals

Persons covered under Medicare and Medicaid are known as dually eligible persons.

To be eligible for a D-SNP, individuals must:

- Live permanently within the approved 68 Medicare counties;
- Be eligible for and enrolled in Medicare Parts A and B;
- Be eligible for full Medicaid benefits; and
- Be 21 years of age or older

MOC element 1
Description of the D-SNP population

MOC element 2
Care coordination

MOC element 3
Provider network

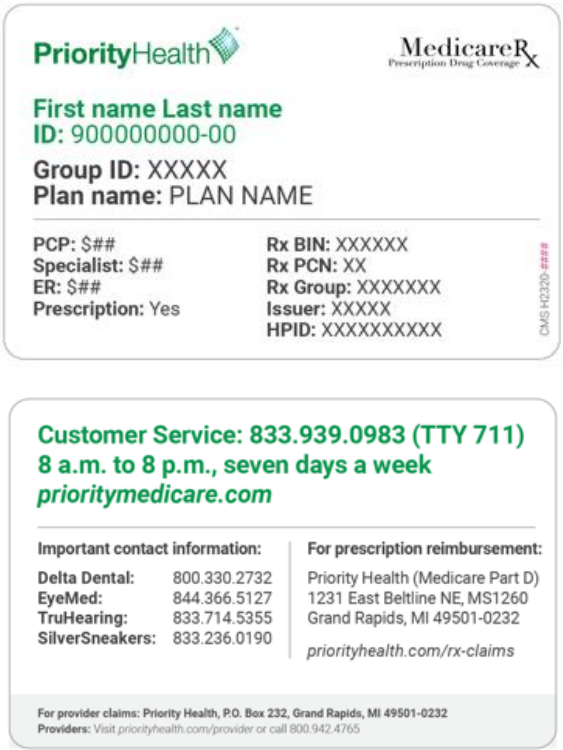
MOC element 4
Quality measurement and improvement

PriorityHealth

D-SNP verification of coverage

Prior to serving the member, it's important to verify coverage. D-SNP members may have both Medicare and Medicaid coverage from Priority Health, but not always. Providers can verify coverage using our Member Inquiry tool at *priorityhealth.com/provider*.

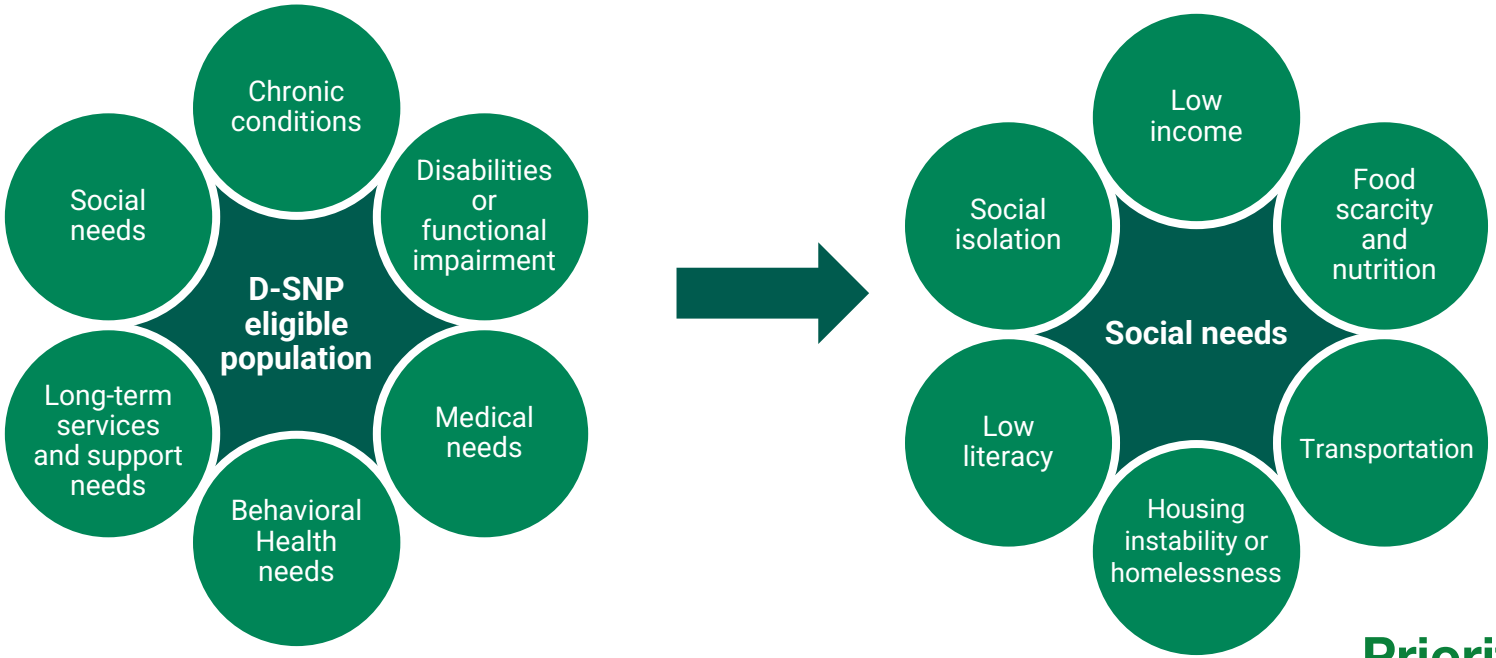
Providers can see members with **Priority**Medicare D-SNP who have Medicaid under another health plan or have traditional Fee-For-Service (FFS) Medicaid



PriorityHealth

Overview of the dually eligible population

The dually eligible population includes some of the most vulnerable populations in Michigan, with high rates of a range of chronic conditions and disabilities and **high social needs.**



PriorityHealth

Diversity of the D-SNP eligible population

The provider's role

- The D-SNP population is diverse in race, ethnicity and language.
- Providers will need to develop a cultural competency in disability that is intersectional across race, ethnicity and language.

PriorityHealth

Population challenges and needs

Key challenges

- Difficulty **accessing services** to maintain or improve health status
- Inconsistent **ability to find physicians** or specialists
- Access to **care in more appropriate settings**
- Lack of **consistent coordination** between medical and behavioral health systems
- Challenges **navigating the complexities** of Medicare and Medicaid

Key needs to address challenges

- **Identify, coordinate, and ensure access** to needed services
- Person-centered care focused **Individualized Care Plan** (ICP)
- Ongoing **support in home and community-based** settings
- Supplemental benefits tailored to the population
- Educate and **support members and their caregivers** in culturally-appropriate ways on resources
    - **200+ languages** for interpretation services

Care coordination for the population

Care coordination
Tools to support coordination of care, continuity of care, seamless transition to care and access to least restrictive setting

Health Risk Assessment (HRA)	Individualized Care Plan (ICP)
Interdisciplinary Care Team (ICT)	Care coordination: Care Management and Care Transitions

MOC element 1
Description of the D-SNP population

MOC element 2
Care coordination

MOC element 3
Provider network

MOC element 4
Quality measurement and improvement

PriorityHealth

What is a Health Risk Assessment?

- The Health Risk Assessment (HRA) is an important part of the member's care coordination, helping us identify members with the most urgent needs.
- **Within 90 days of enrollment,** our care management team will conduct a telephonic HRA. HRAs **are repeated within 365 days.**
- The HRA helps us collect information about the member's medical, behavioral health, cognitive and functional needs. It also helps identify medical and behavioral health history. We use this information to create the member's individualized care plan (ICP).

PriorityHealth

The Health Risk Assessment (HRA)

Every D-SNP member is asked questions that address the following domains:

- Medical
- Behavioral health and substance use
- Functional status
- Cognitive needs
- Long-term services and support (LTSS) needs *
- Social needs

**LTSS is not a covered under D-SNP; LTSS is covered under Medicaid*

PriorityHealth

The Health Risk Assessment (HRA)

What happens after the HRA is completed?

- Upon completion of the HRA, the member is assigned a member of the care management team
- The care management team member will lead the development of the Individualized Care Plan (ICP) in collaboration with the member and the Interdisciplinary Care Team (ICT).

The provider’s role in the HRA

The provider’s role

Providers should remind members of the importance of the annual HRA, which is **essential** in the development of the ICP. However, providers are not responsible for completing an HRA for their D-SNP members.

PriorityHealth

What is an Individualized Care Plan (ICP)?

The ICP is a living document that changes as the member changes. ICPs are reviewed:

- At least annually or more frequently based on the needs identified and interventions deemed urgent, routine and maintenance
- With significant change in member's condition
- With a hospitalization
- At the member's request

How is the ICP developed?

An ICP is developed and maintained for each D-SNP member

- **Member centric** document and **tailored to member needs**
- **Identifies** problems, needs, strengths, goals, interventions (type and frequency), measurable outcomes and responsible personnel
- Accounts for **member and caregiver's** goals, preferences and desired level of involvement in the ICP
- Captures important data and information including:
  - Results from the Health Risk Assessment (HRA)
  - Lab results
  - Pharmacy, emergency department and hospital claims data
  - Input from the interdisciplinary care team (ICT)
  - Care manager interaction

PriorityHealth

The provider’s role in the ICP

The provider’s role

Providers are responsible for collaborating with Priority Health in the development of the ICP. They are also responsible for maintaining the member’s ICP in their medical record.

Providers are not responsible for completing an HRA for their D-SNP members but should remind them of the importance of the annual HRA, which is **essential** in the development of the ICP.

Providers are critical partners in achieving the goals of the ICP.

PriorityHealth

What is an Interdisciplinary Care Team (ICT)?

Each **Priority**Medicare® D-SNP member is managed by a care team.

- The ICT is a member-centric process, where the member sits in the center
- The PCP is the lead of the ICT
- Care managers keep the team updated with information involving the member's care plan
- ICT participants are based on the member's care needs

PriorityHealth

ICT roles and responsibilities

Roles

- Partner with the member to support their goals and needs
- Coordinate member care
- Identify problems and anticipate crises
- Educate members about their conditions and medications
- Coach members to use their individualized care plan (ICP)
- Refer members to community resources

Responsibilities

- Managing transitions by:
  - Identifying problems that could cause transitions
  - Working to prevent unplanned transitions
- Coordinating Medicare and Medicaid benefits for members
- Identifying and assisting members with changes in their Medicaid eligibility

Who are the core members of the ICT?

Care Manager

Primary point of contact

The CM could be an RN, a social worker or a medical care coordinator (MCC)

Primary Care Provider (PCP)

Clinical leader of ICT

Caregiver & member

Participates in the initial development of and updating of the ICP

ICT: the provider's role

The provider's role

- Engage members in their care, and provide access to urgent and routine care for the management of acute and chronic conditions
- Focus on each individual member's special needs
- Enhance communication between care managers, ICT members, members and caregivers
- Accept invitations to attend member's ICT meetings
- Support the member's plan of care
- Maintain copies of the ICP, ICT worksheets and/or transition of care notifications in the member's medical record when received

PriorityHealth

Our provider network

- We have a robust provider network to support our D-SNP members.
- Providers are an invaluable part of the ICT.
- Together, we can collaborate with our provider partners for the benefit of D-SNP members.

MOC element 1
Description of the D-SNP population

MOC element 2
Care coordination

MOC element 3
Provider network

MOC element 4
Quality measurement and improvement

PriorityHealth

Provider training and requirements

The provider's role

New providers

- Training done by assigned performance specialist
- Customized to meet needs of provider/group

Annual and ongoing training

- Bimonthly webinars
- Recorded webinar videos
- Quarterly email newsletters
- Daily updates on website
- In person meetings
- Email campaigns
- Letters

Provider organizations in risk-based contracts

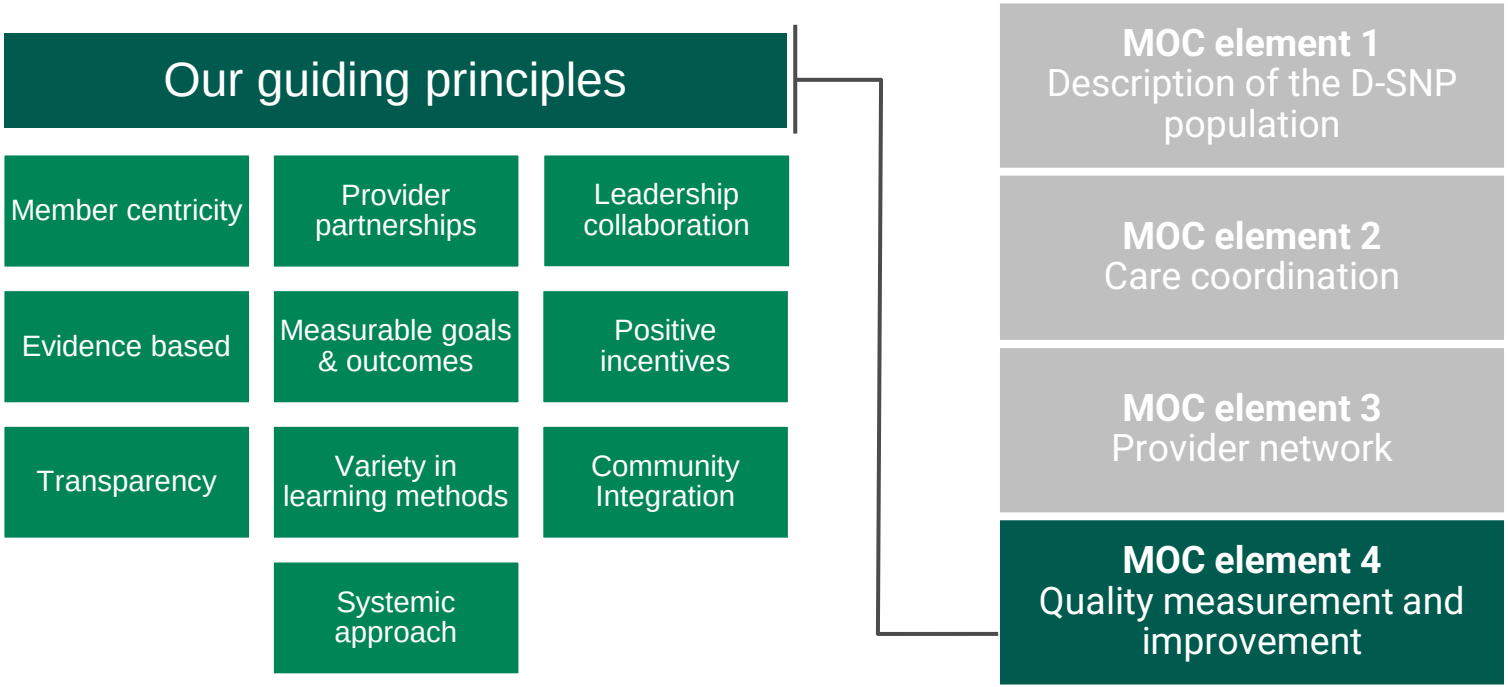
- Regularly scheduled meetings of the Joint Operating Committee (JOC)
- Joint governance structure
- Review progress
- Provide updates and training to maximize performance

Participation metrics tracked

- Provider attestations of training
- Webinar registrations and attendance
- Email views
- Attendance at in person training events

PriorityHealth

Quality measurement and improvement



PriorityHealth

Our measurable goals

For our D-SNP plan, we have established measurable goals across several domains including:

- Improving **access** including preventative care for adults
- Improving **care coordination** including members with HRAs done and care plans completed
- Improving **care transitions** including follow up care after hospitalizations
- Ensuring **appropriate utilization** including preventative care
- Improving **member experience**

The provider's role

Expectations

We partner with providers in many ways to achieve these goals to improve member health.

PriorityHealth

Resources for providers

- Provider Manual
  - *priorityhealth.com/provider/manual*
- Priority Health Provider Services department
  - 800.942.4765
- Care Management department
  - Providers who have members enrolled in our D-SNP plan will receive a letter from a designated care manager with direct contact information.

PriorityHealth


PriorityHealth
THINK SMART. LIVE SMART.