Minnesota Provider Model of Care Training

Medica AccessAbility Solution Enhanced®

Medica DUAL Solution®

Objectives

- Special Needs Plan Description
- Model of Care Overview and Requirements
- Complete training attestation

Why do I need Model of Care Training?

- Centers for Medicare & Medicaid Services (CMS) Requirement
  - All Medicare Advantage Special Needs Plans (SNPs) must have a Model of Care (MOC) that describes the care and services to be provided to SNP members
  - The MOC is a detailed document (>100 pages) that provides the framework for how Medica identifies and addresses the unique needs of its SNP populations
  - CMS carefully reviews the MOC during an audit to make sure we are implementing all processes as described, including MOC training
- The Centers for Medicare and Medicaid Services (CMS) requires Medica providers who serve Medicare Advantage Special Needs Plan (SNP) members to complete annual training on the SNP Model of Care
- MOC training helps you:
  - Understand the unique characteristics and needs of SNP members
  - Understand the importance of your role as a member of the Interdisciplinary Care Team
  - Learn more about the role of the Care Coordinator (CC), including how you may interface with them and how they can help with the management of your SNP patients

What is a Special Needs Plan (SNP)?

- A type of Medicare Advantage Plan that focuses on certain vulnerable groups of Medicare beneficiaries
- Three types of SNPs:

I-SNP

- Institutional Special Needs Plan
- Enrolls beneficiaries who are institutionalized or require an institutional level of care (LOC)

D-SNP

- Dual Eligible Special Needs Plan
- Enrolls beneficiaries who are eligible for both Medicare and Medicaid

C-SNP

- Chronic Condition Special Needs Plan
- Enrolls beneficiaries with certain chronic and disabling conditions

Medica's Special Needs Plans: D-SNPs

- Medica currently offers two SNPs: Both are D-SNPs with a Minnesota service area

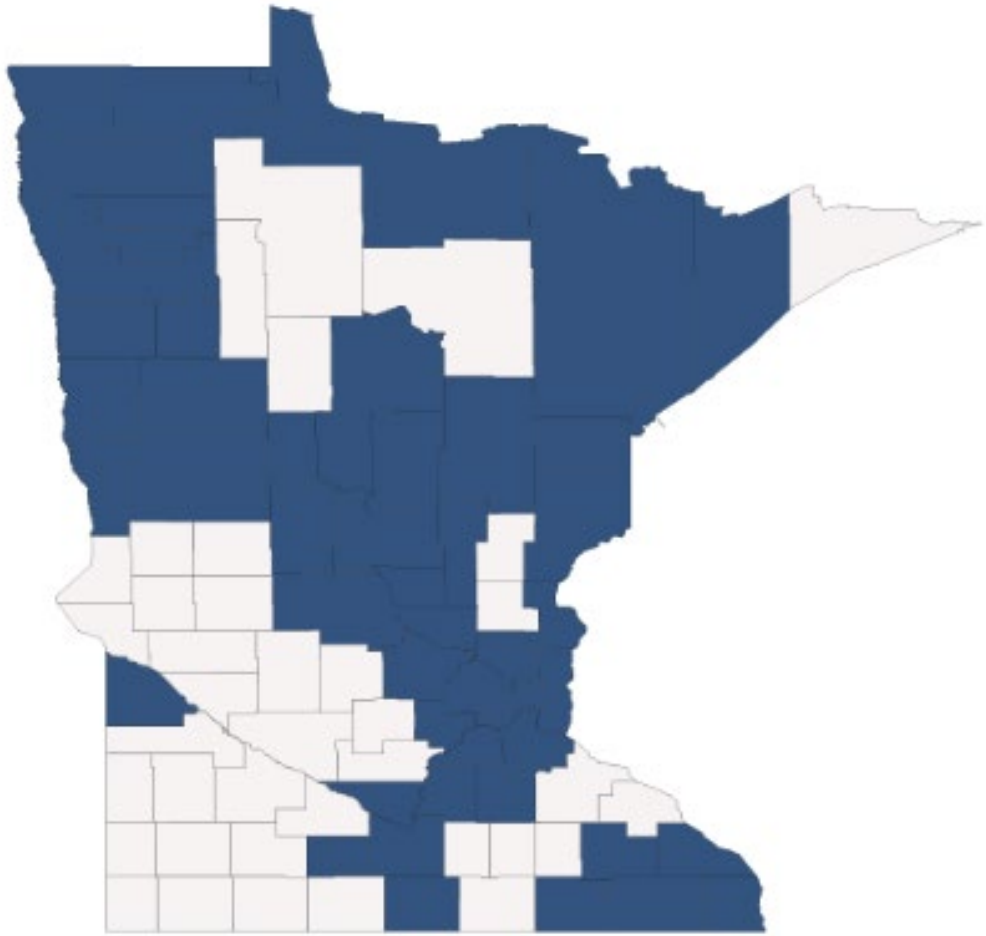
Plan Name	SNP Type	Product Type	State	CMS Contract & Plan #
Medica DUAL Solution® (Minnesota Senior Health Options or MSHO)	D-SNP	HMO	MN	H2458-002
Medica AccessAbility Solution Enhanced® (Special Needs BasicCare (SNBC) Special Needs Plan or SNBC D-SNP)	D-SNP	HMO	MN	H9952-001

Product and Benefit Info

MSHO Eligibility Criteria

***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at www.medica.com**

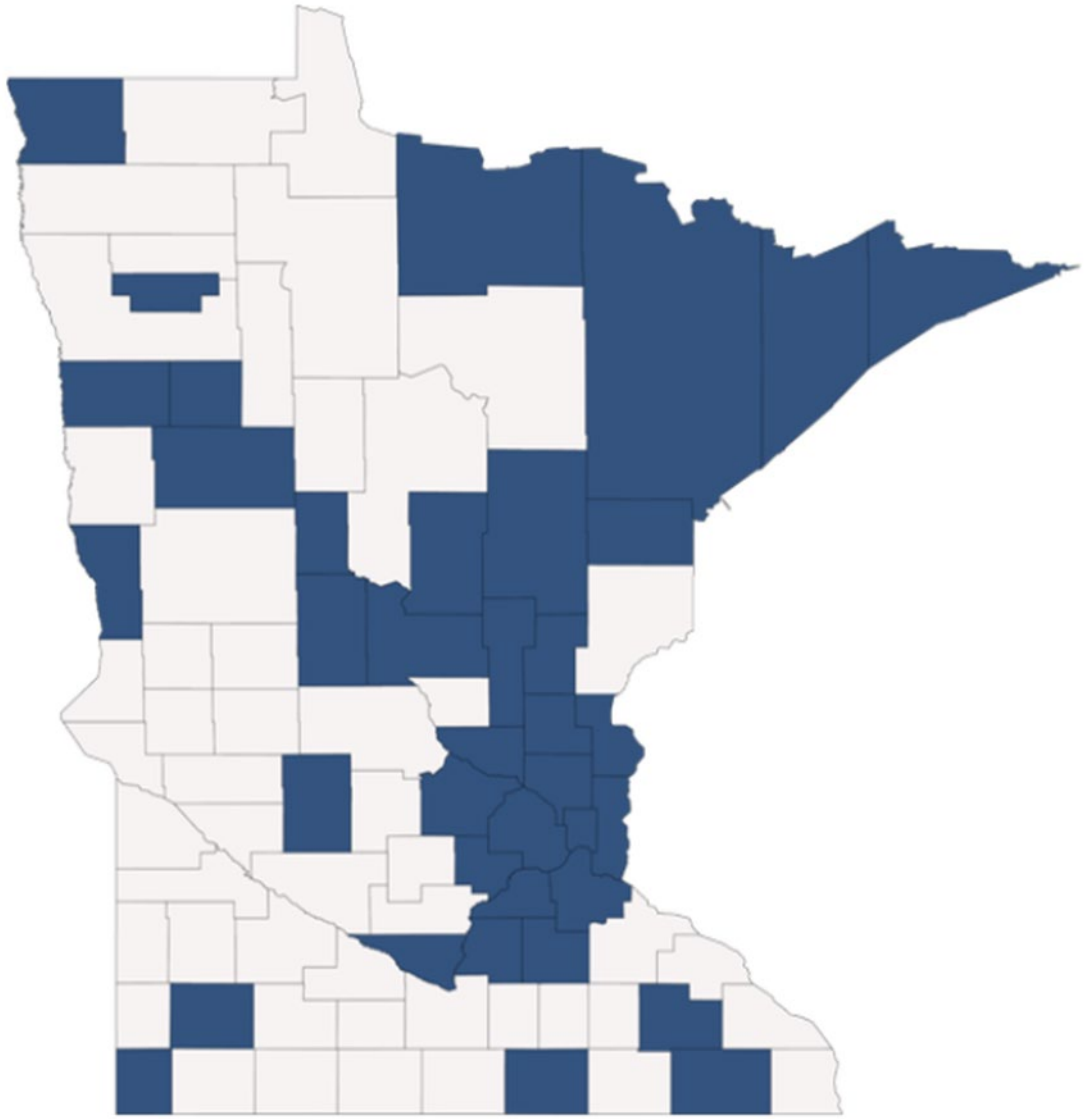
- 65 years or older
- Enrolled in Medicare Parts A & B
- Eligible for Medical Assistance
- Live in the plan's service area



SNBC D-SNP Eligibility Criteria

***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at www.medica.com**

- Age 18-64 with a certified disability
- Enrolled in Medicare Parts A & B
- Be eligible for Medical Assistance
- Live in the plan's service area



Sales and Enrollment Process

SNBC D-SNP	Members or Authorized Reps can complete an application through Medica's sales dept. (Paper, Telephonic, Online)	Enrollment Telephone Numbers: 1 (800) 266-2157 (TTY for the hearing impaired at 711) 8 a.m. to 8 p.m., seven days a week.	Members or Authorized Reps can reach out to their county financial worker	Disability Hub MN
MSHO	Members or Authorized Reps can complete an application through Medica's sales dept. (Paper, Telephonic, Online)	Enrollment Telephone Numbers: 1 (800) 266-2157 (TTY for the hearing impaired at 711) 8 a.m.-8 p.m. CT, 7 days a week.	Members or Authorized Reps can reach out to their county financial worker	Senior Linkage Line

- ***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at*** www.medica.com

Some Benefits and Services (SNBC D-SNP and MSHO)

Medical, Dental, Vision Care, Hearing

Pharmacy: Part D, OTC, Medication Therapy Management

Care Coordination, Disease Management, Health Coaching, 24/7 Nurse Line Telephonic Support through Health Advocate

Transportation to Medical Appointments and the Gym, access to over 20,000 fitness locations, Save on Healthy Food through the Healthy Savings® Program

❖ ***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at*** www.medica.com

Model of Care

What is the Purpose of the Model of Care (MOC)?

To ensure the unique needs of each member are identified and addressed through the plan's care management practices, and provide the foundation for promoting plan quality, access to services, care management, and care coordination processes.

- MOC must meet all CMS requirements
- CMS awards approval of MOC for 1 to 3 years
- CMS requires MOC Training be completed annually

Model of Care: CMS Required Elements

Element 1: Description of SNP Population

Element 2: Care Coordination

Element 3: Provider Network

Element 4: Quality Measurement & Performance Improvement

MOC 1: Description of Population

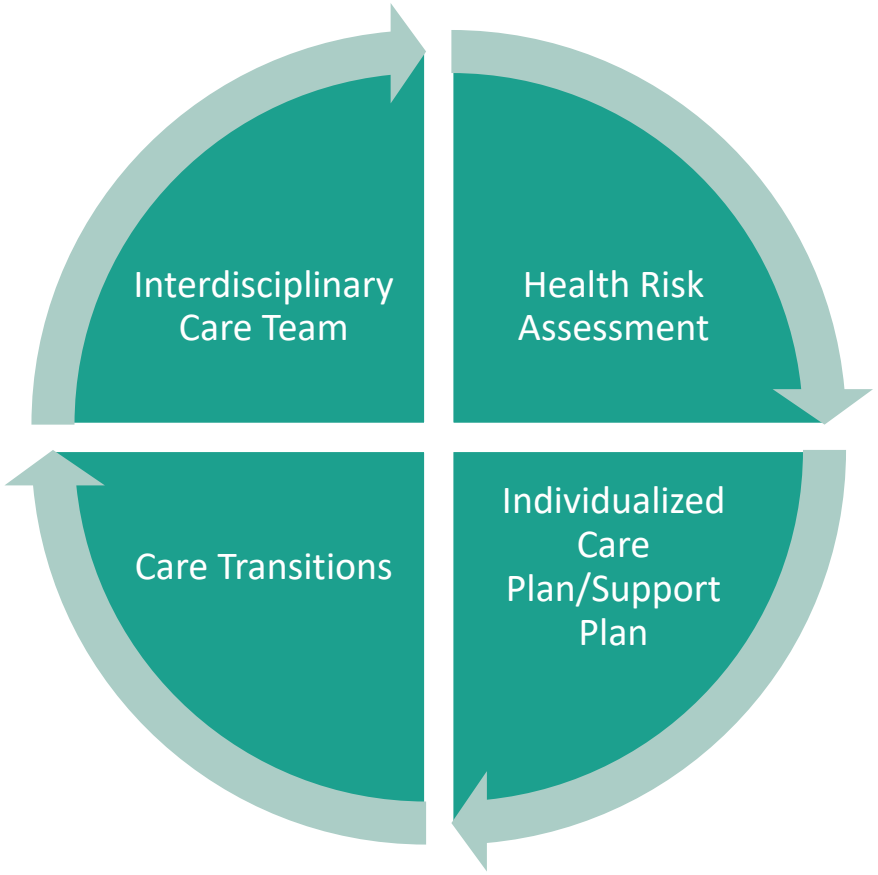
Medica AccessAbility Solution® Enhanced (SNBC D-SNP)	Medica DUAL Solution® (MSHO)
Gender: 57% female and 43% male	Gender: 66% female and 34% male
Average age: 50	Average age:77
Race breakdown: 69.3% White; 24.5% Black; 3.6% Asian; 2% American Indian or Alaska Native; 0.0% Native Hawaiian or Other Pacific Islander; 0.6% Unknown/Other	Race breakdown: 73.0% White; 14.5% Black; 10.0% Asian; 2.0% American Indian or Alaska Native; 0.2% Native Hawaiian or Other Pacific Islander; 0.5% Unknown/Other
% with Chronic Conditions: 96%	% with Chronic Conditions: 95.9%
Top Chronic Conditions: Depression, Hypertension, Hyperlipidemia, Low Back Pain, Diabetes, Persistent Asthma	Top Chronic Conditions: Hypertension, Hyperlipidemia, Depression, Diabetes, Low Back Pain, Chronic Renal Failure
88% live in the community; 12% live in an institutional setting	87% live in the community; 13% live in an institutional setting

MOC 2: Care Coordination

All SNP members have an assigned care coordinator

The Care Coordinator's role:

- Main point of contact ensuring there is collaboration and communication among the member and the member's care team
- Complete Health Risk Assessment and Individualized Care Plan with member
- Assist member and providers with navigating benefits
- Coordinating medical, mental health and dental appointments for the member



Care Coordination Roles and Qualifications

Care Coordinator Qualifications
Registered nurses, social workers (either licensed social worker or social worker who meets the social work standards under the Minnesota State Merit System), public health nurse, physician assistants, nurse practitioners, or physicians

Care Coordinator Roles	
Conduct Health Risk Assessment and develop an Individualized Care Plan with the member based on their identified needs and preferences	Ensure the member's healthcare needs and preferences are shared with the Interdisciplinary Care Team
Provide ongoing monitoring and updating of care plan	Connect the member to resources, health care, and services
Collaborate with different health and social services professionals and across settings of care	Work with the member to live in the least restrictive setting possible and that is the member's choice.

Identifying a Care Coordinator

- All SNP members are assigned a Care Coordinator who is familiar with the area where the member lives
- The Care Coordinator could be employed by Medica, or by one of our County, Care System, or Agency partners
- To identify your patient's Care Coordinator, contact the Provider Service Center at 1-800-458-5512

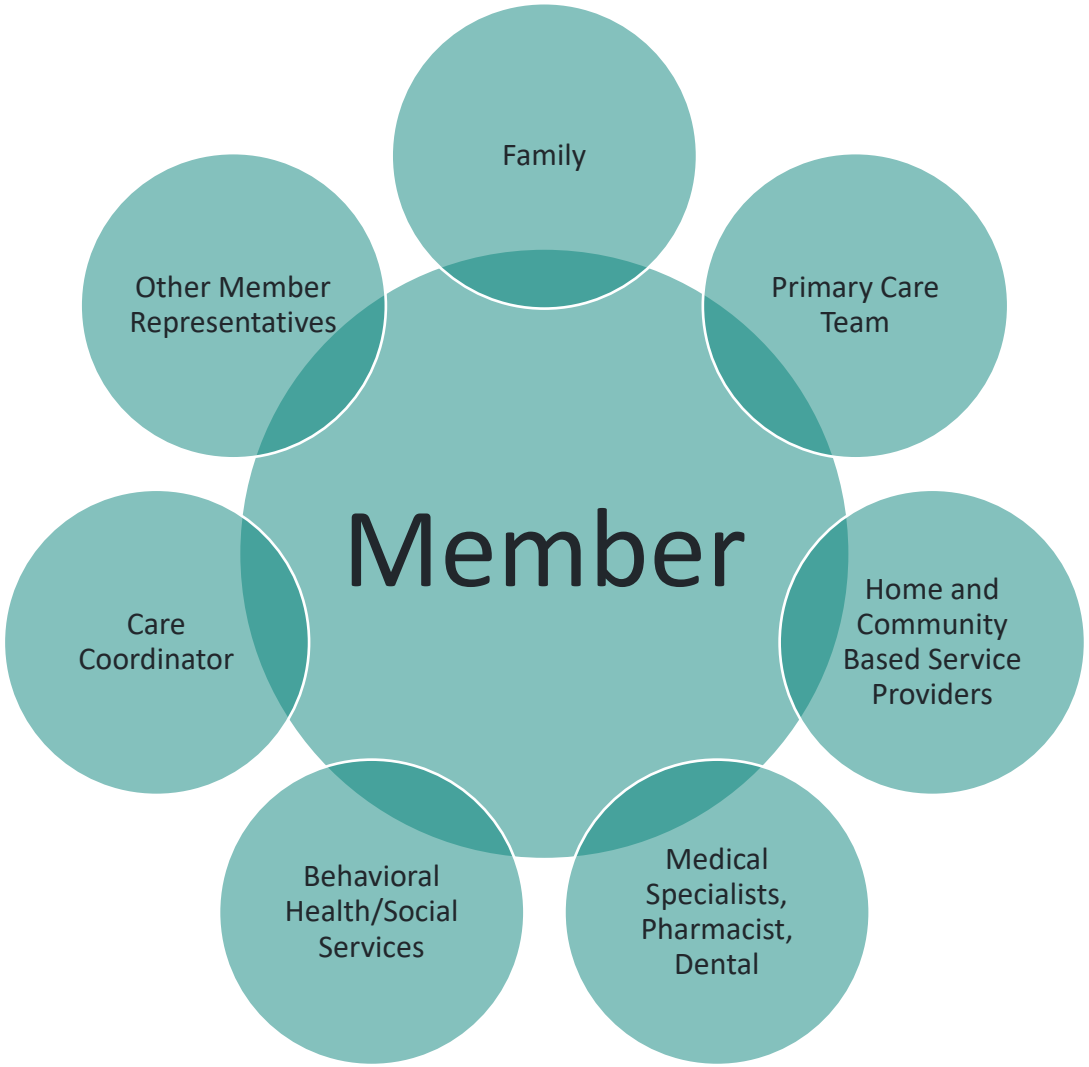
Health Risk Assessment (HRA)

- Completed by Care Coordinator
  - Within 30 days of enrollment (MSHO); within 60 days of enrollment (SNBC D-SNP)
  - With change of condition
  - Within 365 days of the last HRA completed
- An HRA provides the Care Coordinator with pertinent information about a member's medical, functional, cognitive, psychosocial, mental health, and Social Determinants of Health (SDoH) needs.
- The HRA drives the Individualized Care/Support Plan by identifying a member's needs, wants, and concerns

Care/Support Plan

- Required for every member
- Person centered, addresses needs and concerns identified during HRA
- Includes person centered SMART goals
- Completed by Care Coordinator and sent to member within 30 days of HRA
- Summary shared with Primary Care Provider (PCP) and other members of care team per member discretion
- Ongoing monitoring throughout the year with documentation of goal progress based on member-specific follow-up schedule

Interdisciplinary Care Team



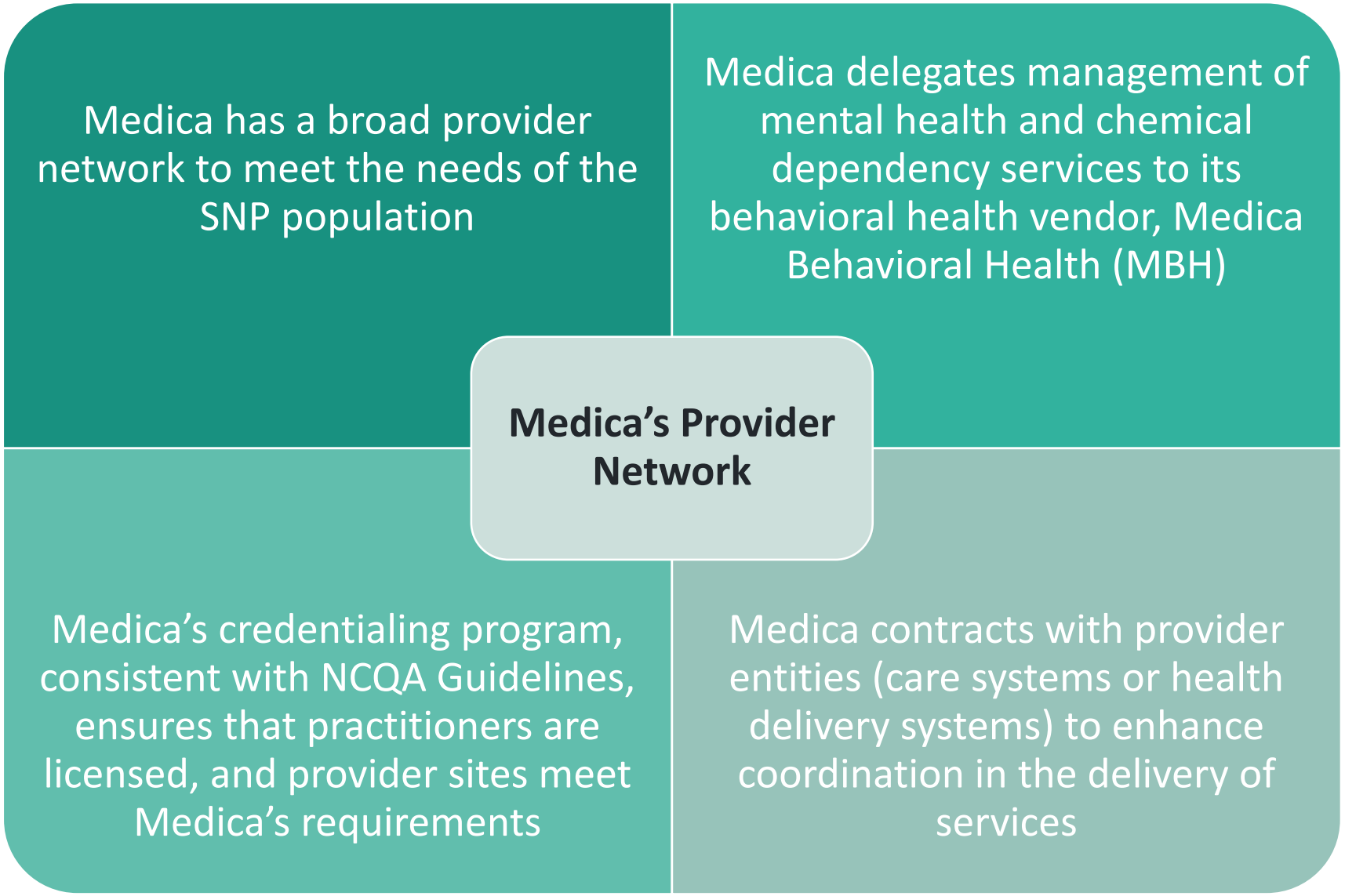
- Collaborative communication between the Care team members and the Medica Care Coordinator is essential to best serving the member and their needs
- Primary Care providers (PCPs) are integral members of the ICT who can provide valuable input on the member's care plan
- Care Coordinators communicate with the PCP at least annually with information about the member's care plan and CC contact information.
- Each member of the ICT has a role in providing the most effective and efficient care for the member

Transitions of Care

**The movement of a patient from one setting of care to another (e.g., hospital to home or nursing facility)*

- When members move from one care setting to another, they are at risk of adverse outcomes due to fragmented care
- Care Coordinators follow up with the member throughout the transition:
  - Discuss their health status changes and discharge instructions
  - Ensure that follow up appointments have been scheduled
  - Ensure member understands any changes in their medication regimen
  - Address social determinants of health issues the member may be facing
  - Determine if member needs any new services or supports upon discharge
- The communication between the Care Coordinator, providers and the member is critical to ensuring an effective transition from one care setting to another or back to home.
- As a provider, your role providing follow-up care and communicating information back to the Care Coordinator regarding transition needs of the member is important to a successful transition plan.
- Care Coordinator updates the member's care plan as necessary and shares with the member and their Interdisciplinary Care Team, as applicable

MOC 3: Provider Network



MOC 4: Quality Measurement and Performance Improvement

- CMS requires SNPs to have a comprehensive Quality Improvement Program that evaluates the effectiveness of the MOC
- For each of the SNPs, Medica establishes process and outcome measures tied to MOC goals, such as:
  - Improving access and affordability
  - Ensuring coordination of care across the care continuum
  - Appropriate utilization of services for preventive health and chronic conditions
  - Implementation of the MOC
  - Improving member satisfaction

Examples of measures include:

Member satisfaction with the Care Coordination Program	Health Risk Assessment Timeliness Rates	Implementation of the Individualized Care Plan
Medication Adherence	Follow-up after ER or Inpatient Admissions	Preventive Care Utilization

Next Steps

Thank you for completing the Medica Provider Model of Care Training

If you're completing the attestation on behalf of your organization, to receive credit for this training, please go to the link below to complete the MOC Training Attestation

https://www.surveymonkey.com/r/MedicaProviderMOCTraining

**Although we ask for a representative to complete one attestation on behalf of their provider organization, all organizations must maintain evidence of each individual provider's completion of annual MOC training and provide such evidence to Medica upon request.*

Model of Care Questions?

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THANK YOU