Minnesota Provider Model of Care Training

Medicare Advantage Special Needs Plans

Why do I need to complete SNP Model of Care Training?

- The Centers for Medicare & 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
- The MOC provides the framework for how Medica identifies and addresses the unique needs of SNP members
- Annual MOC training helps providers:
  - 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 interact with them and how they can help with the management of your SNP patients

Objectives

- Provide an overview of Medicare Advantage Special Needs Plans (SNPs)
- Review SNP eligibility requirements
- Review key SNP benefits
- Review components of the SNP Model of Care (MOC)
- Complete training attestation

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 (Minnesota Integrated Special Needs BasicCare or I-SNBC)	D-SNP	HMO	MN	H9952-001

Product and Benefit Info

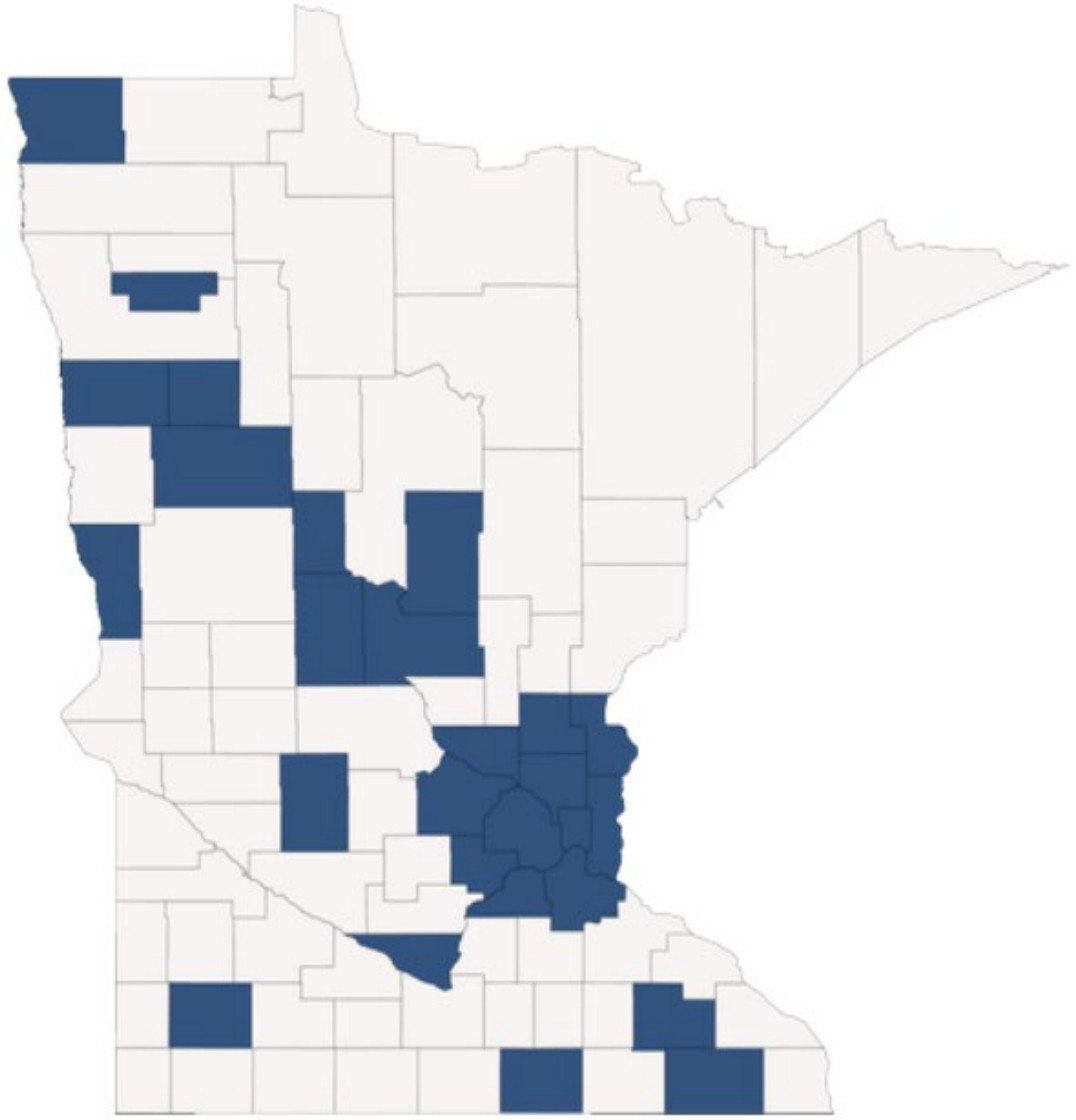
Some Benefits and Services (I-SNBC and MSHO)

- 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

I-SNBC Eligibility

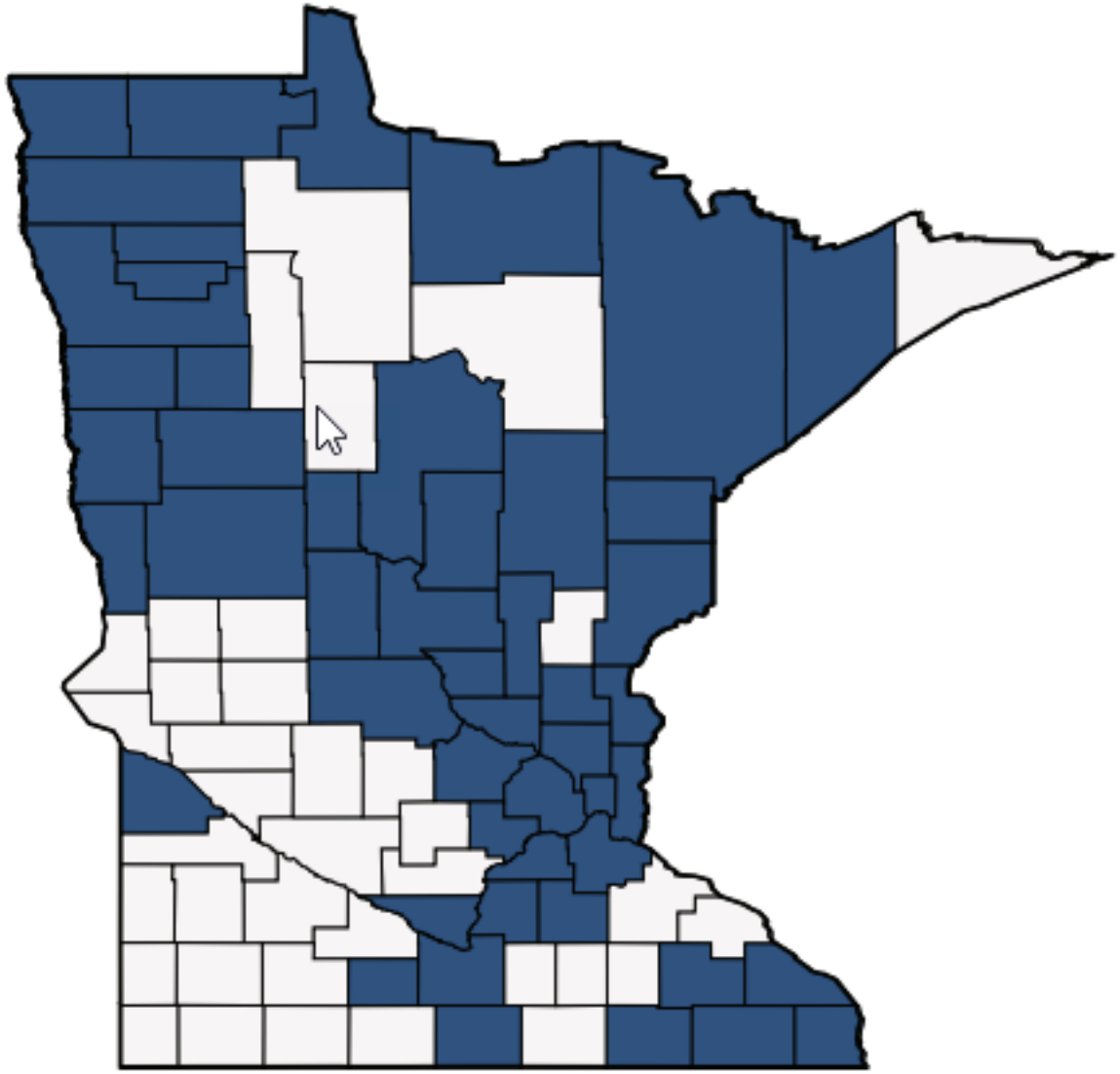
- Be at least 18 and under age 65
- Live in the Medica AccessAbility Solution Enhanced service area
- Enrolled in Medicare Parts A & B
- Medicaid eligible
- Have a certified disability through the Social Security Administration or the State Medical Review team.



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

MSHO Eligibility

- Be 65 years or older
- Live in the Medica Dual Solution service area
- Enrolled in Medicare Parts A & B
- Medicaid eligible



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

Sales and Enrollment Process

I-SNBC	Members or Authorized Reps can complete an application through Medica's sales dept. (Paper, Telephonic, Online)	Enrollment Telephone Numbers: 952-992-2030 or 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: 952-992-2030 or 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	Senior Linkage Line

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

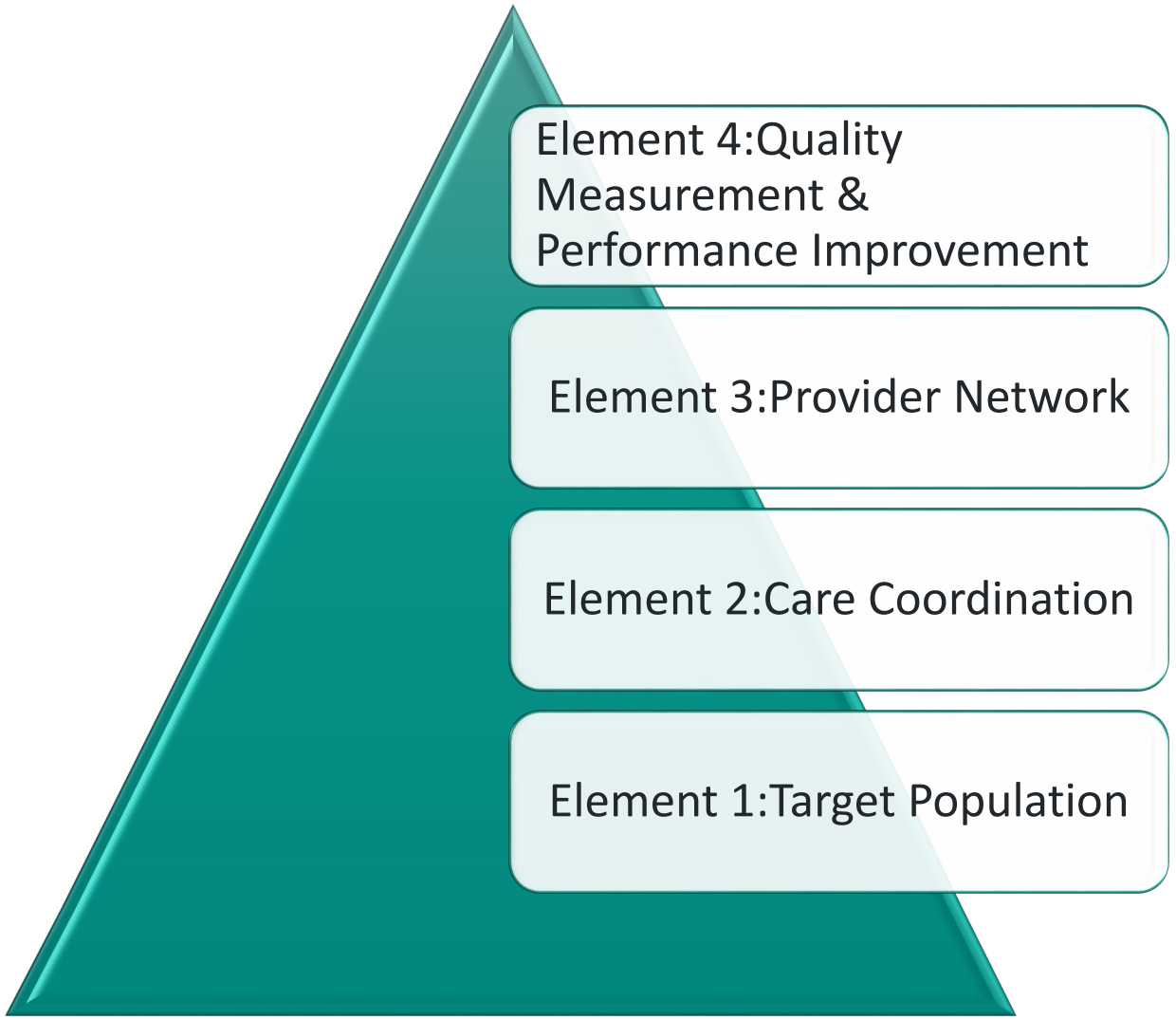
Model of Care

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



MOC 1: Description of Population

Medica AccessAbility Solution® Enhanced (I-SNBC) (D-SNP)	Medica DUAL Solution® (MSHO) (D-SNP)
Gender: 57% female and 43% male	Gender: 69% female and 31% male
Average age: 50	Average age:77
Ethnic breakdown: 66.4% Caucasian; 24.7% Black; .3% Native Hawaiian or Other Pacific Islander; 3.1% Asian; 1% American Indian or Alaska Native; 3.4% Unknown/Other	Race breakdown: 70.3% Caucasian; 13.1% Black; 9.4% Asian; .2 Native Hawaiian or Other Pacific Islander; 2% American Indian or Alaska Native; 5.1% Unknown/Other
Average number of chronic conditions: 7	Average number of chronic conditions: 8
Top Chronic Conditions: Depression, Hypertension, Hyperlipidemia, Low Back Pain, Persistent Asthma, Diabetes	Top Chronic Conditions: Hypertension, Hyperlipidemia, Depression, Diabetes, Low Back Pain, Chronic Renal Failure
98% live in the community; 2% live in an institutional setting	86% live in the community; 14% 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
- Assist member and providers with navigating benefits
- Coordinating medical, mental health and dental appointments for the member

Care Coordination Roles and Qualifications

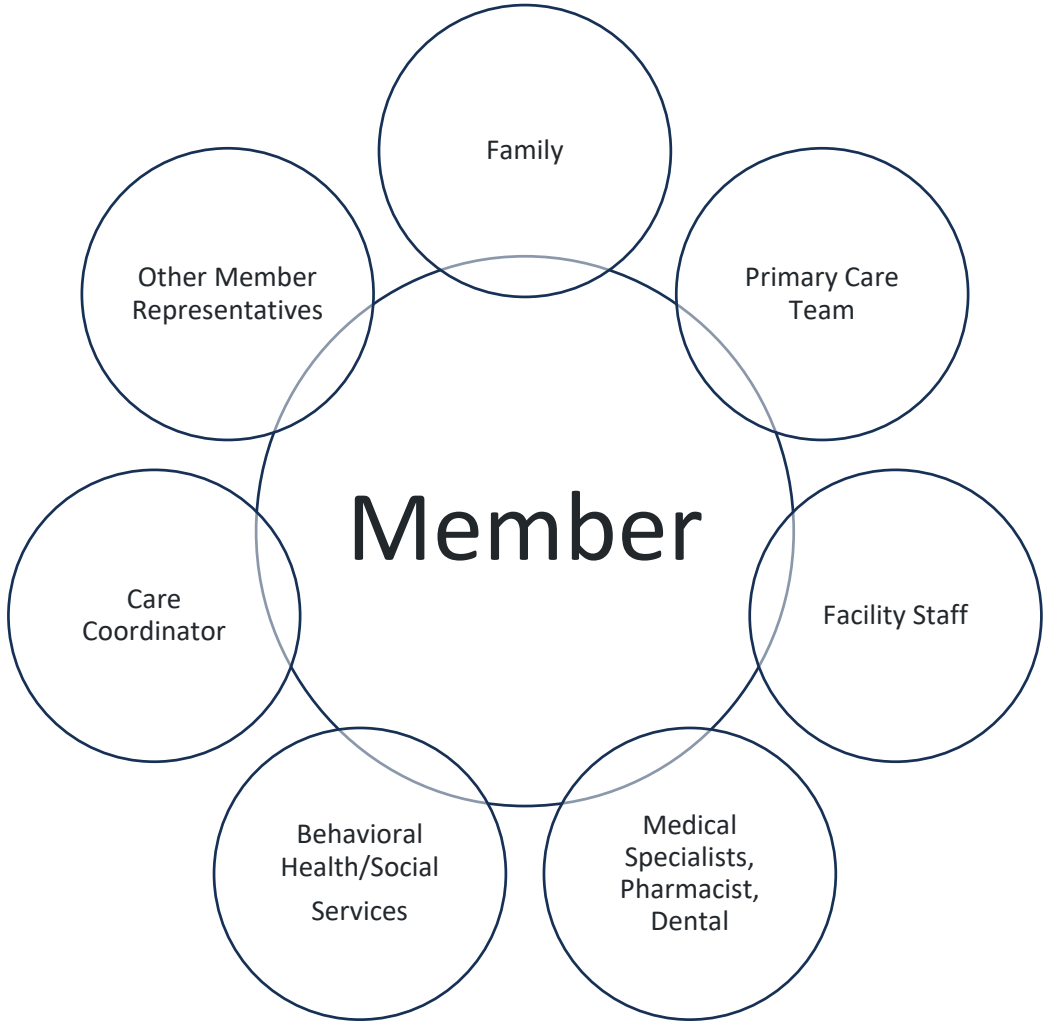
Care Coordinator Qualifications	
MSHO D-SNP I-SNBC D-SNP	Registered nurses, social workers (either licensed social worker or social worker who meets the social work standards under the Minnesota State Merit System), public health nurse, physician assistants, nurse practitioners, or physicians

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 regarding their healthcare is shared across 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 Special Needs Plan members are assigned a Care Coordinator who is familiar with the area where the member lives
- The Care Coordinator could 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

Interdisciplinary Care Team



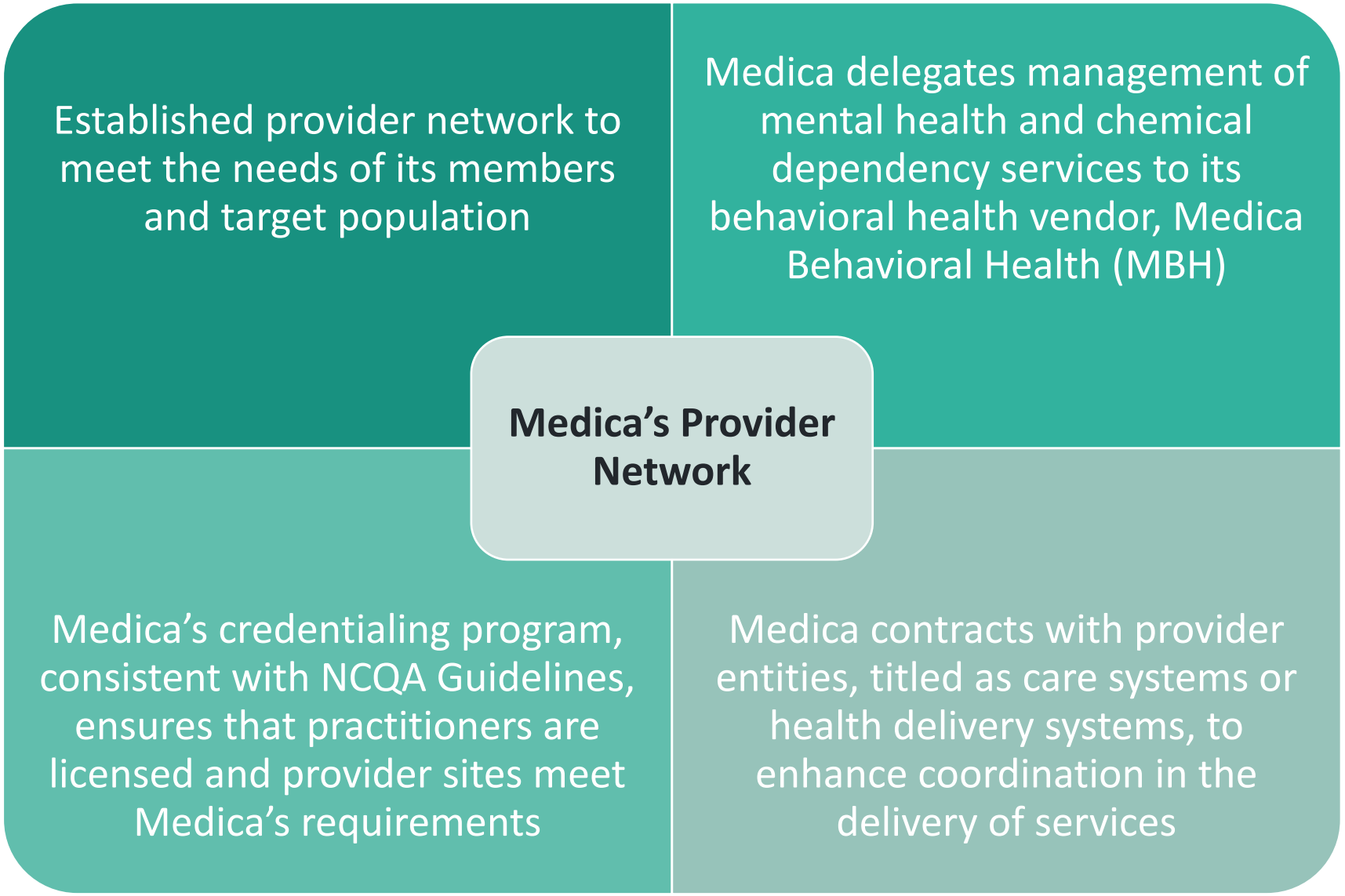
- Collaborative communication between the Care team members and the Medica Care Coordinator is essential to best serving the member and their needs
- Primary Care providers (PCPs) are integral members of the ICT who can provide valuable input on the member's care plan
- Care Coordinators communicate 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
- 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

MOC 3:Provider Network



MOC 4: Quality and Performance Improvement

- CMS requires SNPs to have a comprehensive Quality Improvement Program that evaluates the effectiveness of the MOC

- For each of its SNPs, Medica establishes process and outcome measures tied to MOC goals, including:
  - Improving access and affordability
  - Ensuring coordination of care across the care continuum
  - Appropriate utilization of services for preventive health and chronic conditions

Examples of measures include:

- Health Risk Assessment completion rates
- Care Plan audit performance
- Compliance with transition of care protocols
- Member satisfaction survey results
- Medication adherence rates
- Hospital readmission rates
- Preventive care utilization

Model of Care Questions?

Contact:

Courtney Chupurdy, SNP Program Manager

Courtney.Chupurdy@Medica.com

THANK YOU