Model of Care
CA 2022 Health Plan Compliance Training

Model of Care

Training goals:

- This course provides an overview of Optum's Model of Care (MOC) for delivering coordinated care and case management to Special Needs/Dual Eligible patients with both Medicare and Medicaid.
- CMS, through our contracted health care plans, requires that all Optum providers, teammates and affiliated partners receive basic training on Optum MOC. This course describes how all providers, teammates and affiliated partners can work together to successfully deliver Optum MOC.

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Model of Care

In this training:

- ❑ Describe Special Needs Plans
- ❑ Define Optum's Model of Care
- ❑ Identify the Key Elements of Care Coordination
- ❑ Explain the Specialized Provider Network
- ❑ Identify Quality Management & Performance
- ❑ Improvement Requirements
- ❑ Recognize MOC as Patient-Centered
- ❑ Summarize How MOC Parts Work Together

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Special Needs Plan (SNP):

- ❑ Background:
  - ❑ SNPs were created as part of the Medicare Modernization Act of 2003 (MMA)
  - ❑ A Medicare Advantage coordinated care plan was specifically designed to provide targeted care to individuals with special needs
- ❑ Requirements:
  - ❑ Medicare Advantage plans must design special benefit packages for special needs individuals
- ❑ Benefits:
  - ❑ Improve care and decrease healthcare costs
  - ❑ Through improved coordination and continuity of care (COC)

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SNP types:

- Dual Eligible (D-SNP):
  - Eligible for both Medicare and Medicaid
- Chronic Disease (C-SNP):
  - With specific severe of disabling chronic condition
- Institutional (I-SNP):
  - Requiring institutional level of long-term care or equivalent living in community

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SNP goals:

- Improve access:
  - To medical, mental health and social services
  - To affordable care and preventive health services
- Improve coordination:
  - By coordinating care through an identified point of contact
  - Through transitions of care across health care settings, providers and services
- Improve outcomes:
  - Patient health outcomes
  - Identify how various demographic factors combine to adversely affect health status

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Model of Care (MOC)

MOC description:

- MOC is considered a vital quality improvement tool for ensuring that the unique needs of each patient enrolled in a Special Needs Plan are identified and addressed.
- The MOC provides a patient-centered approach that emphasizes coordination of benefits and services to improve quality of care and healthcare outcomes.

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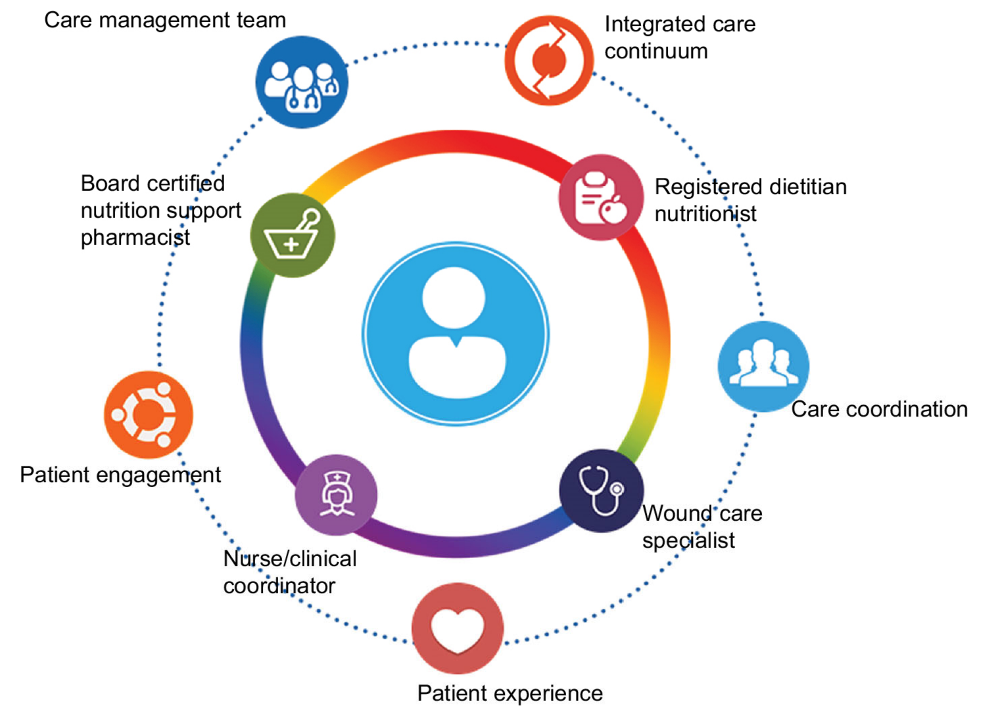
MOC description:

- ❑ Description:
  - ❑ MOC is considered a vital quality improvement tool for ensuring that the unique needs of each patient enrolled in a SNP are identified and addressed
- ❑ Patient-Centered Approach:
  - ❑ The MOC provides a patient-centered approach that emphasizes coordination of benefits and services to improve quality of care and healthcare outcomes
- ❑ Patient-Centered Care:
  - ❑ Focuses medical attention on individual patients' needs and concerns, rather than doctors'



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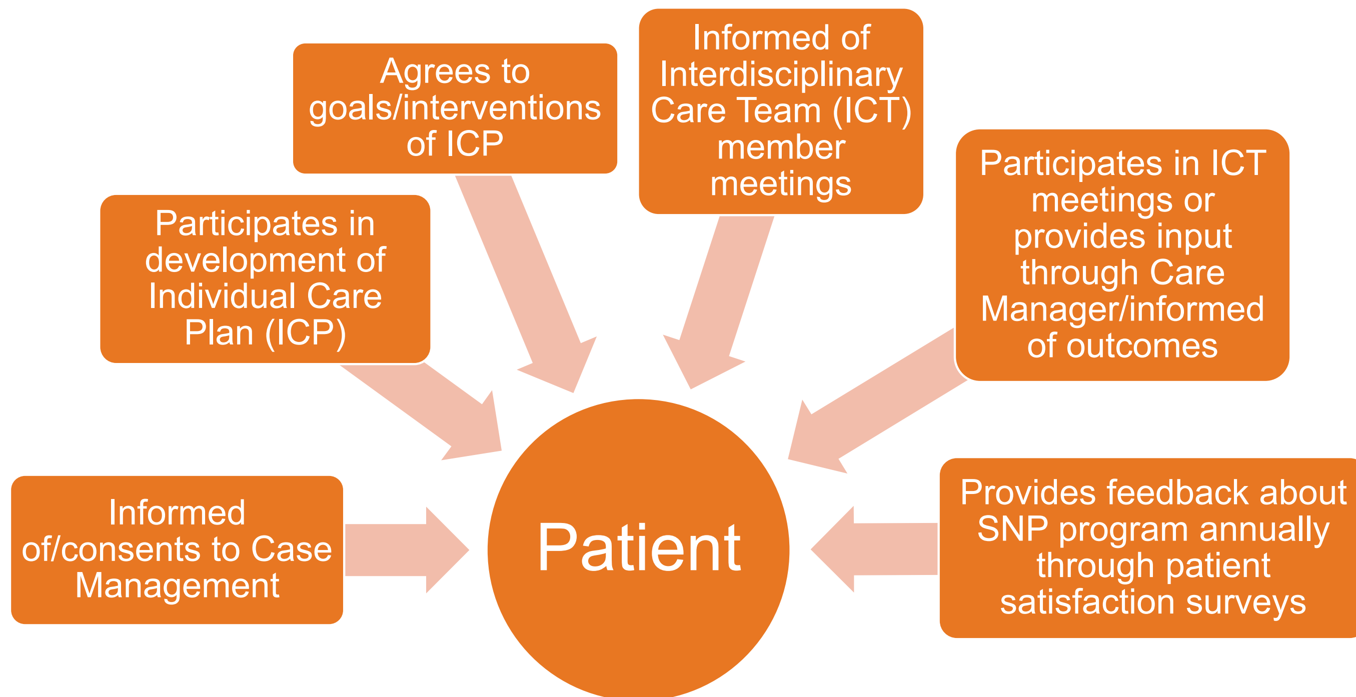
Patient-centered approach:



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Care coordination:

- Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care.

- The main goal of care coordination is to meet patients’ needs and preferences in the delivery of high-quality high-value health care.

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Care coordination involves:

- ❑ Deliberately organizing patient care activities
- ❑ Meeting patients' needs and preferences
- ❑ Sharing information
- ❑ Teamwork

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Care coordination components:

- ❑ Staff roles
- ❑ Health Risk Assessment (HRA)
- ❑ Individualized Care Plan (ICP)
- ❑ Interdisciplinary Care Team (ICT)
- ❑ Care transition protocol

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Staff organized to align with essential care:

- ❑ Administrative
  - ❑ Teammates in Claims, Contracting, Referral Management, etc.
- ❑ Clinical
  - ❑ Providers, Specialists, Behavioral Health, Pharmacists, etc.
- ❑ Patient Care Coordinator
  - ❑ Teammates assigned to manage patient's care—Case manager, social worker, etc.
- ❑ Oversight
  - ❑ Those involved in quality oversight, both internal and external

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What is a Health Risk Assessment (HRA)?:

- A HRA is a questionnaire used to evaluate a patient's health risks and quality of life
- Results are used to develop a patient's Individualized Care Plan (ICP)
- HRA identified care needs are categorized into Care Domains:
  - Access
  - Behavioral Health
  - Coordination of Services
  - Health Monitoring
  - Long-Term Care
  - Long-Term Services and Supports (LTSS)
  - Medical-Acute
  - Medical-Chronic

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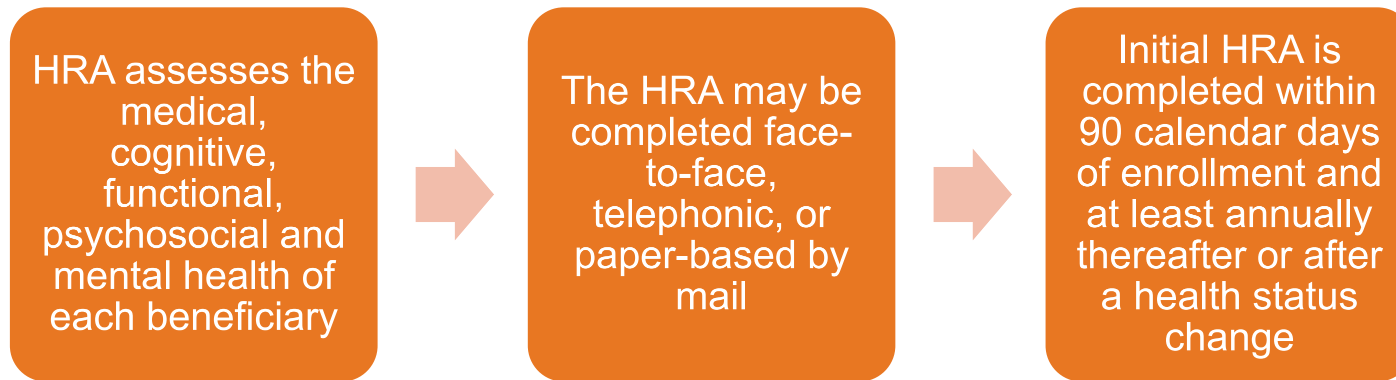
HRA:



- ❑ Results are used to develop patient's ICP
- ❑ Not all health plans delegate accountability to Optum
- ❑ Optum uses health plan's standardized HRA tool, if delegated

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Individualized Care Plan (ICP):

- ❑ Evidence-based
- ❑ Collaborative process
- ❑ Specific services tailored to the patient as needed
- ❑ Facilitate individual's and family's comprehensive needs
- ❑ Promote quality and cost-effective outcomes

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Individualized Care Plan (ICP):

- ICP is developed by an Interdisciplinary Care Team (ICT)
- The care plan is reviewed or revised annually or when health status changes
- Includes personalized goals and objectives, specific services and benefits, and measurable outcomes
- Patient/caregiver is involved and may sign the care plan
- Goals and objectives are prioritized by patient preferences.

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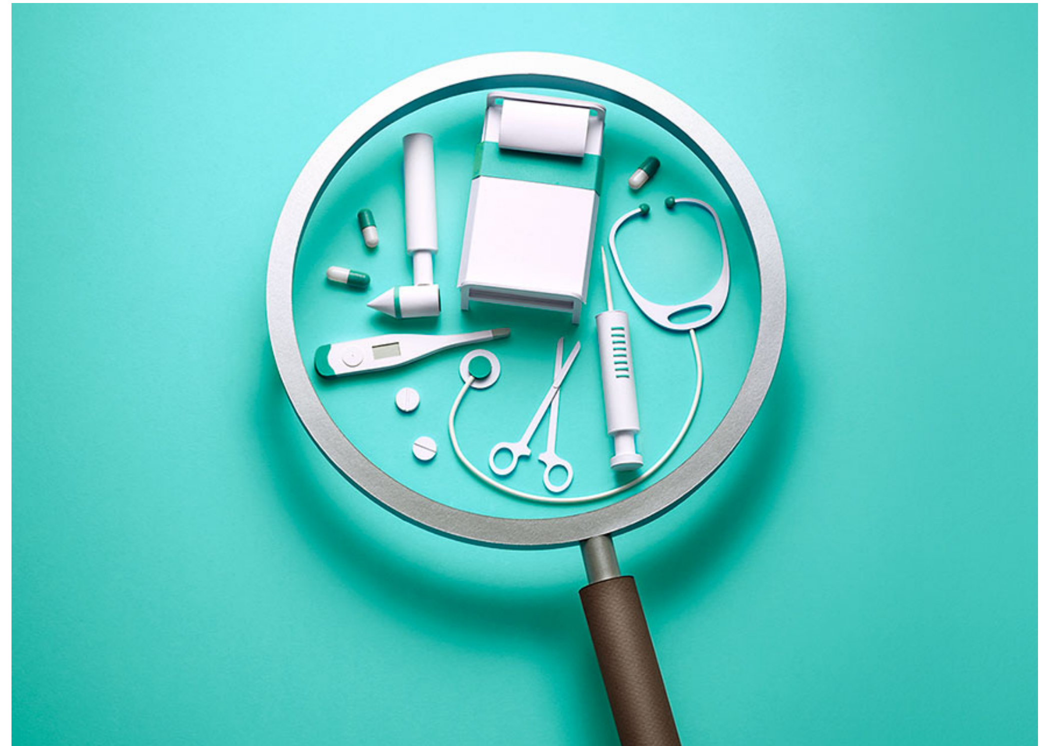
ICP:

- Evidence-Based Care Management (CM)
  - Patient is notified of the CM single point of contact by letter or phone call
  - Patients may opt out of active CM, however CM must continue to attempt contact annually, or whenever there is a change in status
  - Patients are stratified according to risk profile, to focus resources on our most vulnerable patients (that is, those who are frail, disabled, and or those with chronic diseases)
  - Patients with only a behavioral health (that is those with drug/alcohol addiction, schizophrenia, major depression, bipolar or paranoid), must receive CM from their Behavioral Health provider
  - Contingency planning must be in place to avoid disruption of services for events such as disasters



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Interdisciplinary Care Team (ICT):

- ICT facilitates care management, assessment, care planning, authorization of services and care transitions
- Composition of ICT is dependent on the member's medical and psychosocial needs as determined by the HRA and ICP
- Typically includes case managers, social workers, care coordinator, medical director and treating physicians
- Patients and caregivers are encouraged to participate

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ICT:

- ❑ Aligned with the delegated delivery system. PCPs and specialty physicians are active participants
- ❑ Each member of ICT has specific defined roles and responsibilities based on their expertise
- ❑ Review and analyze available data to ensure improvement in the patient's health status

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ICT:

- ❑ Analyzes and incorporates the results of the initial or annual HRA into the ICP, using evidence-based guidelines
- ❑ Collaborates to develop and update the patient's ICP annually
- ❑ Manages the medical, cognitive, psychosocial, and functional needs of each patient
- ❑ Communicates the ICP to all caregivers for care coordination
- ❑ Provides a copy of the ICP to the patient in the patient's preferred language, font and print size

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Care transition protocols:

- Care transition is when a patient's care shifts from one care setting to another, such as from a hospital to a patient's home or to a skilled nursing facility and back to the hospital
- Patients are at risk for adverse outcomes when there is transition between settings, and inadequate management of care transitions

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Care transition protocols:

- ❑ Goals
  - ❑ Improve outcomes
  - ❑ Decrease re-admits
- ❑ Prevention
  - ❑ Stratification
  - ❑ Case Management
  - ❑ Disease Management
- ❑ Identification
  - ❑ Pre-authorization
  - ❑ Notification of admits in 24 hours
  - ❑ Daily admission reports
- ❑ Management
  - ❑ Prepare for admission
  - ❑ Communicate care plan
  - ❑ Plan for discharge and follow-up

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Specialized provider network includes:

- ❑ Hospitalists
- ❑ SNF providers
- ❑ Behavioral health providers
- ❑ Pharmacists
- ❑ Crisis teams
- ❑ Allied health providers
- ❑ Ancillary services
- ❑ Substance abuse detoxification / rehabilitation services

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Quality management & performance improvement:

- Standardized quality improvement measures are used to measure performance and health outcomes:
  - Tracking and assessing completion of MOC training
  - Specific HEDIS measures
  - Disease management
  - Patient experience surveys
  - Provider satisfaction surveys
  - Ongoing monitoring of complaints and grievances
  - Provider satisfaction surveys
  - Goal outcomes are communicated to stakeholders

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Quality management & performance improvement:

- The Institute for Healthcare Improvement (IHI) triple aim impacts Optum’s plan for Quality management and performance improvement
- We must conduct a Quality Improvement program to monitor health outcomes and implementation of the MOC
  - We do this by identifying and defining measurable MOC goals, and collecting data to evaluate annually if measurable goals have been met

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ICP - Individualized Care Plan Steps

Components of the Care Plan

Define Care Opportunities	Goal definitions	Address care gaps in goals or problems	Barriers	Patient centered
Define Care Goals including prioritization of identified goals based on patient preference if engaged, or if not engaged, then based on risk	❖ Specific ❖ Measurable ❖ Achievable ❖ Realistic ❖ Time Bound	❖ Problems should be personalized to patient based on record or patient interview	❖ Identify and document barriers that may hinder goal achievements ❖ Barriers may be: ❖ Medical/Health ❖ Psychosocial ❖ Functional/ADL ❖ Cognitive ❖ Additional concerns	❖ Confirm that the patient agrees with the goals and interventions. ❖ Interventions should be achievable which will lead to goal success and improved patient outcomes

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CalOptima

OneCare (OC)

- One Care is CalOptima's Medicare Advantage plan focusing on the SNP population
- Serves people in Orange County who are eligible for Medicare and Medi-Cal
- CalOptima is responsible for the completion of the HRA
- Essential care management roles include the use of Personal Care Coordinators (PCC)
- In the network setting, the PCC is responsible for helping the member understand their benefits, schedule and participate in ICT meetings, assist member with care coordination, notify the member's care team of key events and facilitate communication of the ICP to the PCP and care team members, including member
- The ICP must be signed by the PCP.

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Cal Optima

OneCare Connect (OCC)

- One Care Connect is part of California's Cal MediConnect program. This program combines Medicare and Medi-Cal benefits. Enrollment in this program is optional
- Criteria for enrollment include:
  - Age 21 or older
  - Lives in Orange County
  - Enrolled in MediCare Parts A, B and D and receives full Medi-Cal benefits without a share of cost.
    - Share of cost exceptions: members living in a nursing home, are enrolled in a Multipurpose Senior Services Program (MSSP) or have In-Home Supportive Services (IHSS)
- CalOptima is OCC utilizes PCC's to assist members with the completion of the HRA
- The network has a staffing requirement to maintain a ration of PCC's to members and this data is shared with the plan on a monthly basis.
- The HRA responses suggest a care management level of risk which is evaluated by a Registered Nurse (RN).

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HealthNet

Delegated for SNP and CMC

- CMC is a Medicare Medicaid Plan (MMP). This is a product that will be sunsetting at the end of 2022.
- The MMP is a "demonstration plan" that combines Medicare and Medicaid. It's a three-way contract between CMS, Medicaid and Health Net as defined in Section 2602 of the Affordable Care Act.
- ICP's are set in a SMART format – Specific, Measurable, Achievable, Relevant and Time Bound.
- Barriers are identified and added to each ICP.
- The ICP is an active dynamic document and interventions must be addressed at least annually
- The ICP is developed within 90 days of enrollment, or within 30 days of receipt of a Health Risk Assessment (HRA) or a Transition in Care. Members can opt in or opt out of the ICP creation.
- If the HRA arrives after the ICP has been developed, it must be reviewed and the ICP updated with new information.
- Inter-disciplinary Care Team (ICT) must be completed annually and when a member requests it.

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LA Care

Delegated for CMC

- Managed Long-Term Services and Support (MLTSS) are not the responsibility of the group except for Skilled level of care
- Continuity of Care (COC) is offered by the plan and must be requested to the plan in order for patients to remain with an out of network provider for a designated time period
- Behavioral health services do not need a referral, LA Care partners with Beacon Health Options. Access is via phone 1-877-344-2858
- ICT training must be documented before a care team member can participate.
- ICP development timeline:
  - Within 30 days of HRA receipt, or Transition of Care
  - Within 90 days of enrollment if no HRA is available
- ICT timeline: within 45-60 days of ICP creation date

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SCAN SNP

Patients are referred via “Trigger” report

- ❑ Triggers may be based on the plan HRA, or on a transition of care event
- ❑ Follow our MOC Process for outreach
- ❑ ICP is developed based on the trigger report and follows SMART format
- ❑ ICT documentation is within 30 days of the trigger report. SCAN will accept the sharing of the ICP with the member and PCP as proof of ICT. Complete IDT Summary note.
- ❑ If a SCAN ICP is sent to the group, the group is expected to review the SCAN ICP and the trigger in the development of the group ICP.

SCAN Model of Care here.

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United Health Care

- ❑ Optum is delegated for the C-SNP product
- ❑ This is a new product for UHC and Optum, beginning in January 2022.
- ❑ ICP development timeline:
  - ❑ Within 30 days of HRA receipt, or Transition of Care
  - ❑ Within 90 days of enrollment if no HRA is available
- ❑ ICT timeline: within 45-60 days of ICP creation date
- ❑ Behavioral Health follows the Optum delegation and contract. BH services are not carved out.

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Thank you.

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