L.A. Care Medicare Plus™
(HMO D-SNP)

L.A. Care HEALTH PLAN®
For All of L.A.

2024 D-SNP Provider Model of Care Training

Training Topics

- Training Objectives
- Dual Special Needs Plan (D-SNP) – Member Benefit Overview
- What is the D-SNP Model of Care (MOC)?
- Model of Care Requirements and Provider Roles and Responsibilities
    - Description of L.A. Care's DSNP Population
    - Care Coordination
    - Provider Network
    - Quality Measurements and Performance Improvement

MOC Training Objectives

Objectives:

- Overview
- Outline the basic components of L.A. Care's D-SNP Model of Care (MOC), including Member Benefits
- Describe L.A. Care's MOC
- Describe the essential role of L.A. Care Providers in the implementation of the MOC, including participation in the member's:
    - Health Risk Assessment (HRA)
    - Individualized Care Plan (ICP)
    - Interdisciplinary Care Team (ICT)
    - Face to Face Encounter

CMS Requirements Overview

- The Centers for Medicare & Medicaid Services (CMS) want all healthcare providers who see members regularly to get training on the D-SNP Model of Care (MOC)

- The MOC helps healthcare providers understand and take care of special needs of their members as well as giving guidance on delivering coordinated care and care management

- To comply with the requirement, this training will teach about the MOC and how L.A. Care and their contracted providers can work together to successfully deliver the Model of Care

Who can enroll in L.A. Care's D-SNP?

- An eligible member must meet all the following requirements to be enrolled:
  - Enrolled in Medicare Part A (Hospital)
  - Enrolled in Medicare Part B (Medical)
  - Lives in Los Angeles County
  - Meets the California Medicaid requirements for QMB+, SLMB+ or FBDE
  - Enrolled in a Medi-Cal Managed Care Plan
  - Must be 21 years of age or older

- Enrollment begins during the Annual Election Period (2023 October 15 – December 7)

Ongoing Eligibility Verification

If you're an L.A. Care, Medicare Plus member, you may be disenrolled from the plan for these reasons:

- If member no longer qualifies for Medi-cal, L.A. Care will continue to provide all plan-covered Medicare benefits up to 3 months before being dis-enrolled.
    - the member will go on Medicare Fee-For-Service. If Medi-Cal is regained within 3 months, the member returns to L.A Care’s D-SNP plan.

- If you're away from L.A. Care's service area temporarily for up to 6 months or move permanently, you'll be removed at the beginning of the following month after the 6th month.

D-SNP Member Billing

- If you're a member of L.A. Care Medicare Plus, you get both Medicare and full Medi-Cal benefits.
- You won't be charged extra for Medicare costs like deductibles, coinsurance, or copayments.
- Medicare pays first for services, and Medi-Cal pays second, but for things covered by both, like Skilled Nursing Facility care, Medicare pays first before Medi-Cal helps.

Provider Model of Care (MOC) Training Requirements

- L.A. Care keeps records of training for all providers (both in and out-of-network) who take care of L.A. Care D-SNP members.

- All staff involved in managing L.A Care's D-SNP members care must complete the MOC training when the member enrolls and again every year.

- The training is available on the Provider website and can be used as a resource to meet the initial and yearly MOC training needs.

New for 2024: Training Requirements

Dementia Care Specific Training

- DHCS requires **providers** to complete MOC training as well as Dementia Care Aware training.
- Dementia care **specialist** will also be required to complete dementia care training
- The training covers important topics like Alzheimer's Disease and other dementias, their symptoms, behaviors, communication problems, and community resources for members and caregivers
- Dementia care specialists will also be a required participant of the members interdisciplinary care team (ICT)
- **Mild Cognitive Impairment (MCI): will be a performance measure for 2024, reported annually**
    - Members must receive cognitive screen with approved tools
    - Denominator: All members 65+, Numerator: who received a cognitive screen
    - Providers will only be able to bill and report if completed Dementia Care Aware specific training

What is the L.A. Care Model of Care (MOC)?

The MOC is L.A. Care's blueprint for the care of D-SNP members; it is used to coordinate comprehensive care for vulnerable and at-risk members, focusing on their health conditions and social factors

- It helps providers by improving quality, access, affordability, and care integration

- And helps members by ensuring smooth care transitions, promotes preventive health services, appropriate utilization of benefits and ultimately by improving member health outcomes.

Model of Care Provider Roles and Responsibilities: PCP

The member's Primary Care Provider (PCP) plays a crucial role in their care. The PCP helps by doing the following:

- Reviewing the member's Health Risk Assessment (HRA)
- Having Face-to-Face visits or tele-visits with the member every 12 months
- Assisting with the development and communication of the member's Individualized Care Plan (ICP)
- Attending and taking part in the member's Interdisciplinary Care Team meetings
- Joining in Quality-of-Care initiatives like completing Annual Wellness Visits
    - Where Advanced Care Planning is discussed and completed

Coordination of Medicare/Medi-Cal

It's important to know the following about D-SNP benefits:

- Both Medicare and Medi-Cal benefits must work together and providers must understand both programs
- Support with maintaining Medi-cal coverage is a key component
- Members can file appeals and grievances with both Medicare and Medi-Cal
- Coordination is needed with a member's MCP if Medi-Cal and Medicare plans don't match up

Model of Care Roles and Responsibilities: PPG

L.A. Care's D-SNP Model of Care helps PPG partners support the member by:

- Improving communication with the member, PCP, ICT, and Medi-Cal services
- Providing Care Management for low-risk members through Health Risk Assessment
- Creating and executing Individualized Care Plans to address each member's needs.
- Holding regular Interdisciplinary Care meetings to review member needs and ensure everyone is on the same page.
- Assisting with care transitions and encouraging members to have an annual Face-to-Face visit.

Sections of the Model of Care (MOC)

The MOC is comprised of four sections:

- MOC 1: Description of the D-SNP Population
- MOC 2: Care Coordination (through a dedicated care management team and program)
- MOC 3: Provider Network
- MOC 4: Quality Measurements and Performance Improvement

Each element has corresponding factors L.A. Care must meet when implementing the MOC. Those factors will be outlined within this training.

MOC 1: Description of Member Population

L.A. Care's provider partners are responsible for supporting the D-SNP Population, which includes:

- Members with disabilities and those who are blind or disabled (ABD)
- Have multiple health conditions, complex care needs, and cognitive/behavioral conditions.

Description of Most Vulnerable Members

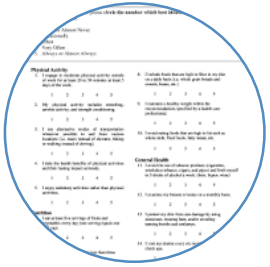
L.A. Care identifies the D-SNP member population at greatest risk and directs care management services and resources toward them

L.A. Care's most vulnerable members have many characteristics, such as:

- Having complex or multiple chronic conditions
- Being disabled or frail
- Facing socioeconomic challenges
- Having dementia-related disorders
- Being near the end of life
- Dealing with multiple medications (polypharmacy)

MOC 2: Care Coordination

D-SNP members are required to have the following elements completed:



Health Risk Assessment

Face to Face Encounter

Individualized Care Plan

Interdisciplinary Care Team

Care Transition Protocols

Care Coordination Overview

Coordination of Care is how L.A. Care organizes and shares the member's health needs and preferences with their Interdisciplinary Care Team (ICT).

It involves:

- Health Risk Assessment (HRA) to understand each member's risk level (Low, High, Complex) within 90 days of enrollment
- Creating an Individualized Care Plan (ICP) within 45 calendar days (30 business days) of HRA Completion
- Meeting face-to-face with each member within 12 months after they join.
- Forming an Interdisciplinary Care Team (ICT) meetings to insure care coordination
    - At least yearly, due to TOC, or change in health condition
- Following protocols for Transitions of Care (TOC) and Continuity of Care (COC)
    - Timely engagement and member encounter (Telehealth/F2F/In-home) within 30 days following discharge

HRA Components

L.A. Care does Health Risk Assessments (HRAs) to find members' medical, mental, and other health needs and risks.

- An HRA will be completed within 90 days of joining and do one every year after that, members can refuse completion if not agreeable
- The HRA will be used to complete the member Individualized Care Plan
- HRAs show the member's risk level and how often they should be contacted
- PPGs will be delivered completed HRAs for Low Risk members who are delegated to them for Care Coordination

HRA components

PPGs:

Are to encourage member completion of HRA and have it mailed back when received through mail or printed from L.A. Care's website

New For 2024:

- If a caregiver is identified during the HRA, the Care Manager will complete a Benjamin Rose Caregiver Strain assessment
- For specific populations social needs related to housing, food security, and transportation will be identified.
- An HRA must be completed to be considered for supplemental benefits; HRAs will also include questions about Advanced Care Planning (ACP).

Individualized Care Plan (ICP) Regulations

According to regulations, all SNPs must create and follow an ICP for each member

- ICPs will be developed using HRA results and health data, even if the member didn't participate within 45 calendar (30 business days) of HRA completion
- Care Managers (from PPG and L.A. Care) work with the member, their PCP, and other ICT participants to prepare, implement, evaluate, and update the ICP
- The ICP will include member specific, measurable and timely goals that account for any member barriers
- When the ICP is updated, the member gets a physical copy in their preferred language/format. External ICT participants can also access it upon request, using secure fax, email, or mail.

Interdisciplinary Care Team (ICT)

According to regulations, all D-SNP plans must use an ICT for each member's care management

L.A. Care and PPGs will have ICT meetings based on the member's risk level and are expected to:

- Attend member ICT meetings when possible, including dementia specialists and palliative care teams
- Keep copies of the HRA, ICP, ICT worksheets, and transition of care notifications
- Communicate and coordinate care among ICT participants
- All members must have at least one ICT meeting every year; more if needed due to changes in condition or ICT recommendation

ICT Coordination Participants and Process

The Care Manager (PPG or L.A. Care) is responsible for identifying the participants of the ICT

ICT participants always include the member, primary care physician, and assigned care manager. ICT participants may also include but are not limited to:

- Member's friends or family members
- Member's IHSS worker
- Social workers
- Specialists
- Pharmacist
- Dementia Care Specialist (Requires additional training)
- Palliative Care Team
- Other participants as needed or requested by the member

Face-to-Face Encounters

According to regulations, all D-SNPs must offer face-to-face meetings with each member for health care or care coordination.

- These meetings should happen at least once a year, starting within the first 12 months of joining
- During the face-to-face meeting, the member can talk with people like their PCP, Specialist, or someone from the ICT or care management team
- The meeting can be in-person or through a real-time video call. It should be done when possible and with the member's agreement
- For Face-to-Face encounters, Providers should code the visit and make this data available to L.A. Care (claim, encounter, adult wellness exam form).
- **Annual Wellness Visits can be leveraged to complete this requirement, while addressing Advanced Care Planning and form completion if member desires**

Transitions of Care (TOC) Element and CMS requirements

According to regulation, all D-SNPs' Care Management teams, PPGs and Providers, are responsible for:

- Following L.A. Care's Transition of Care Protocol
- Informing the ICT of any changes in the member's health or care plan due to transitions
- Providing transitional care management services and communications
- Ensuring an understanding of LTSS, DME and community based services available to members

Transitions of Care (TOC): Provider Responsibility

The care management team (either PPG or L.A. Care) helps members during transitions from the hospital or other care settings.

L.A. Care has a plan for transitions and works with Providers to make sure:

- They are told promptly about a member going into or leaving the hospital.
- The Care Management team visits or calls the member within 72 hours after leaving the hospital
- They coordinate care and services, review medications, and schedule follow-up appointments
- They have a face-to-face visit with the member either before or within 30 days after leaving the hospital.

New for 2024: Palliative Care

Palliative Care:

D-SNPs are required to deliver Palliative Care services modeled after the Medi-cal program and are required to provide at minimum:

- 1. Advance Care Planning
- 2. Palliative Care Assessment and Consultation
- 3. Plan of Care
- 4. Palliative Care Team of doctors, nurses, social workers, chaplain, and other specialists.
- 5. Care Coordination
- 6. Pain and Symptom Management
- 7. Mental Health and Medical Social Services

PPGs will be responsible for knowing about this requirement and referring members back to L.A. Care if need for Palliative Care arises

New for 2024: Enhanced Care Coordination

L.A. Care will be required to deliver Enhanced Care Management-like services to specific D-SNP members

These members will get extra help in coordinating their care and will include the following populations of focus:

- Members at risk for avoidable hospitalization or ER utilization
- Adults living in the community and at risk for institutionalization
- Adult nursing facility residents transitioning to the community
- Pregnancy, Postpartum and Birth Equity

PPGs will be responsible for knowing about this requirement and referring members back to L.A. Care if need for Enhanced Care Coordination arises

MOC 3: Provider Network Responsibilities

Network Providers have important responsibilities, including:

- Evidencing provider expertise and specialization
- Using evidence-based clinical guidelines and protocols to ensure members get the right care at the right time and understanding the process when deviating from them
- Participating in all elements of members care coordination- HRA/ICP/ICT/TOC
- Completing and attesting to Model of Care training initially and yearly thereafter including any additional suggested trainings such as Dementia Care Aware

MOC 4: Quality Measurement and Performance Improvement

L.A. Care's responsibilities include both for L.A Care and PPG delegated functions:

- Making a plan to improve the access, quality, timeliness of care
- Improve coordination, utilization of care and the member experience
- Setting goals and health outcomes that match the MOC (Like HRA/ICP/ICT/TOC)
- Following all the rules set by regulators (like NCQA, CMS, etc.) and reporting the details
- Sharing information about the quality and performance of care in the SNP and the MOC

Regulatory References

CMS Medicare Managed Care Manual for Special Needs Plans (SNPs): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf

CMS Requirements for Quality Assessment: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf

CMS SNP Model of Care (MOC) information: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

NCQA MOC Approval Process: https://snpmoc.ncqa.org/

Electronic Code of Federal Regulation: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422

NCQA MOC Scoring Guidelines: https://snpmoc.ncqa.org/scoring-guidelines-2023

DHCS DSNP Policy Guide CY2024: https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-CalAIM-D-SNP-Policy-Guide-2024-June.pdf

Dementia Care Aware Training: https://www.dementiacareaware.org/

Reporting Tech-Specs: https://www.dhcs.ca.gov/Documents/D-SNP-Reporting-Requirements-Technical-Specifications-6-29-23.pdf

Dementia Care Resource: https://www.dementiacareaware.org/wp-content/uploads/2023/04/dca-faq-care-provider-R6.pdf

Q & A Session