ALL STAFF AND CONTRACTED PROVIDER

Model of Care Training

CY 2023 to 2024

Model of Care Training Objectives

1. Introduction Medicare Advantage Prescription Drug (MAPD) Plan
2. Outline the basic concepts of Special Needs Plans
3. Identify the requirements for success
4. Describe the purpose and key components of the Model of Care

Medicare Health Insurance

Population

1. People 65 or older
2. Disabled
3. End-Stage Renal Disease

Health Plan Parts

1. Medicare Part A (Hospital Coverage)
2. Medicare Part B (Medical Coverage)
3. Medicare Part D (Pharmacy Coverage)

Enrolled Members Receive Services Through the Plan

1. All Part A and Part B Covered Services (A+B=C)
2. Some plans may provide additional benefits

MAPD Part C & D Plans

MA Plans-Private Contracted Companies

1. All Part A and Part B Covered Services (A+B=C)
2. Some plans may provide additional benefits

Includes Prescription Drug Coverage (Part D)

1. This is known as an MA-PD Plan

Members are still in the Medicare Program

1. Medicare will pay Leon Health Plans every month for Member's care
2. Members have Medicare rights and protections

Special Needs Plans

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals. Three categories:

- Chronic Conditions Special Needs Plans (C-SNPs)
- Dual Eligible Special Needs Plans (D-SNPs)
- Institutional or Institutional Equivalent (I-SNP, IE-SNP)

Dual Special Needs Plan

Medicaid Eligibility Categories

The Medicaid eligibility categories encompass all categories of Medicare Savings Programs:

- Full Medicaid (only);
- Qualified Medicare Beneficiary without other Medicaid (QMB Only);
- QMB Plus;
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB Only);
- SLBM Plus;
- Qualifying Individuals (QI); and
- Qualified Disabled and Working Individual (QDWI)

Leon Dual Special Needs Plans

Who can join?

- Be at least 18 and over the age of 65
- Enrolled in Medicare Part A
- Enrollment Medicare Part B
- Lives in the Plan's service area (Miami-Dade)
- and have Medicaid or a Medicare Saving Program mentioned in the previous slide

Successful Performance Elements

- Medical Management

Focus on prevention and improve access to services:

- Routine Visits
- Care Protocols
- Skill in Place (for applicable plans)

Goals

- Limit Avoidable Hospitalizations
- Avoid Emergency Visits
- Avoid Re-admission

As the payer, Leon can pay for benefits that directly contributes to better outcomes clinically or member satisfaction

- Quality
  - Improving access and affordability
  - Improving coordination of care and delivery of services through the direct alignment of the HRAT, ICP and ICT
  - Enhancing care transitions across health care settings and providers
  - Ensuring appropriate utilization of preventive health and chronic conditions

Model of Care (MOC) Defined

A Model of Care must be included in the contract terms between Dual Special Needs Plans and CMS as a mandatory requirement.

The "Model of Care is approved by National Committee for Quality Assurance (NCQ A). The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and an integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

Model of Care Sections and Elements

MOC 1: Population of the SNP Plan

- Description of overall SNP population
- Description of most vulnerable population

MOC 2: Care Coordination

- Staff Structure and MOC Training
- Health Risk Assessment Tool (HRAT)
- Interdisciplinary Care Team (ICT)
- Care Transition Protocol (TOC) for Change in Health Status

MOC 3: Provider Network

- Specialized Network
- Use of Clinical Practice Guidelines
- MOC Training

MOC 4: Quality Measurement and Performance Improvments

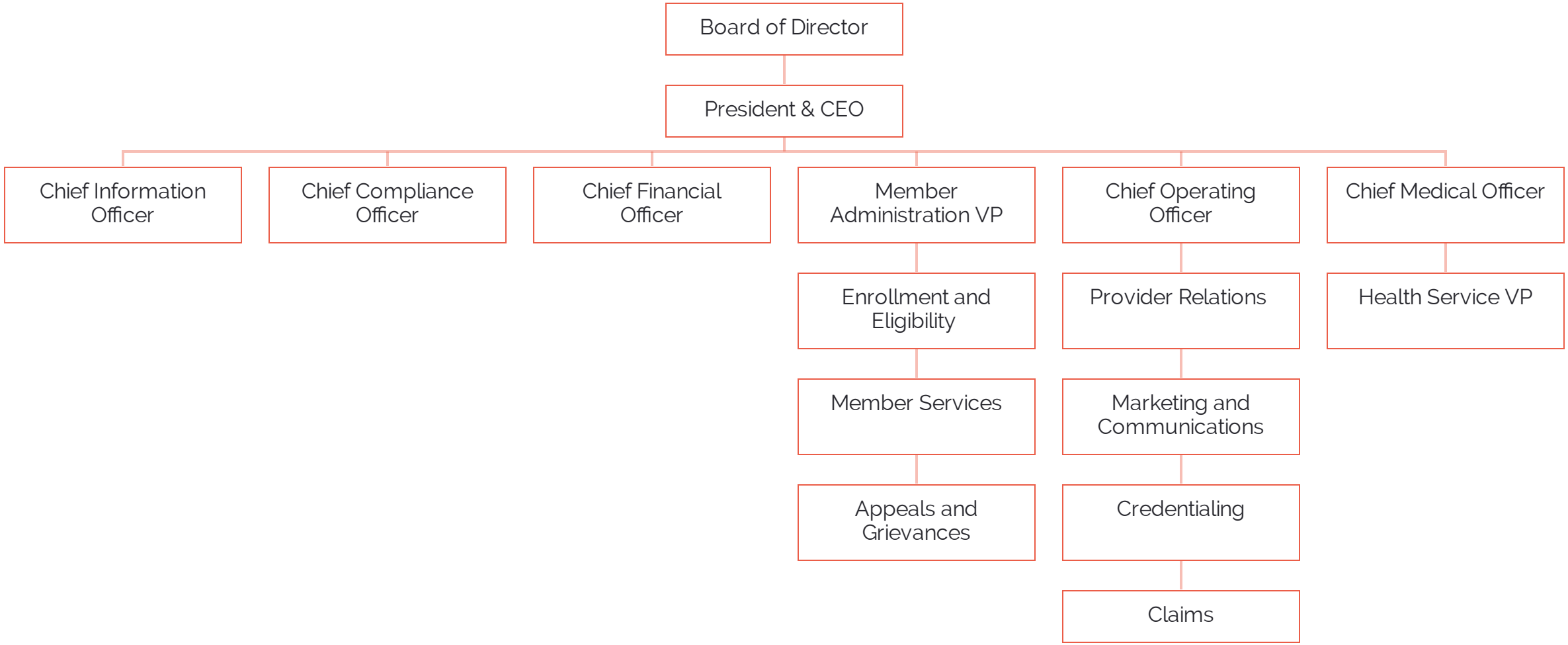
- Quality Performance Improvement Plan
- Measurable goals and Health Outcomes for the MOC
- Measuring Patient Experience of Care
- Ongoing Performance Improvement Evaluation of the MOC
- Dissemination of SNP Quality Performance related to the MOC

MOC 1: Description of the SNP Population (General Population)

LHP will determine and verify all new MA-PD D-SNP applications to confirm Florida Medicaid eligibility prior to submitting the enrollment request to CMS. The Florida Agency for Health Care Administration (AHCA), which oversees Medicaid within the state, enrolls all duals into a Medicaid managed care plan, which is responsible for any Medicare cost sharing amounts. AHCA provides an additional payment to D-SNP plans to provide wrap around services (cost-sharing) on behalf of Medicaid recipients who choose to enroll in a Medicare Advantage D-SNP, as an alternative option.

Eligibility is verified on a monthly basis with AHCA. Members that lose their eligibility will be given a 12-Month grace period to retain their Medicaid or Medicare Saving Program.

Administrative & Clinical Staff Structure



MOC 2: Care Coordination

Potential Member Touch Points

MOC 2: Care Coordination

SNP Staff Structure

Role	Responsibilities
Health Services VP (Licensed)	Oversee clinical and administrative staff, including case coordination/management, behavioral health, and utilization management
Registered Nurse (RN)	Manage Case Management Services: Supervise clinical and administrative aspects of case management for SNP members. Ensure adherence to AAAHC accreditation standards and clinical practice guidelines. Analyze utilization data for effective program implementation and timely care services. Leadership and Coordination: Direct the medical management department, establishing policies and objectives. Coordinate staff activities, participating in committees and management initiatives. Collaborate with operating departments to implement best practices and achieve goals. Strategic Planning and Performance: Develop departmental objectives and budget to support strategic plans. Evaluate and enhance medical service functions in alignment with company mission. Participate in accreditation processes, provider education, and contracting.
Chief Medical Officer (CMO) (Licensed)	Risk Adjustment and Quality Improvement: Manage risk adjustment processes to optimize health plan revenue. Lead quality improvement initiatives to enhance patient outcomes. Review and process clinical appeals and utilization management decisions. Clinical Oversight and Support: Supervise clinical and administrative staff in case management. Collaborate with treating providers, offering clinical expertise. Ensure adherence to evidence-based guidelines and protocols. Interdisciplinary Collaboration: Participate in interdisciplinary care team rounds for case discussions. Infuse research-supported practices into case management model. Serve as a point of contact for provider inquiries and coordination issues.
Behavioral Health Practitioner (Licensed)	Leadership and Supervision: Manage and supervise clinical and administrative staff. Oversee the integration of behavioral health care within case management and service coordination. Interdisciplinary Collaboration: Contribute to interdisciplinary care team rounds to identify behavioral health care needs. Integrate behavioral and physical care for comprehensive patient support. Provider Liaison: Act as the intermediary between LHP and healthcare providers. Ensure effective communication and collaboration between the two entities.

MOC 2: Care Coordination

SNP Staff Structure

Role	Responsibilities
Medical Management Manager (Licensed)	Leadership and Management: Supervise clinical and administrative staff and ensure compliance with CMS requirements. Develop departmental objectives and organize activities to achieve goals. Manage budgets, forecasts, and strategic planning for effective resource allocation. Regulatory Compliance and Process Management: Ensure adherence to Medicare Advantage and CMS regulations. Oversee day-to-day activities, including care transitions and utilization analysis. Monitor and assure compliance with Medicare guidelines, company mission, and policies. Collaboration and Innovation: Develop communication plans with external providers and state agencies. Participate in interdisciplinary activities, meetings, and seminars. Integrate research-based best practices, concepts, and tools into operations.
Utilization Management (UM) Nurse (Licensed) Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN)	Inpatient Admission Management: Coordinate with case management and PCP teams for inpatient admissions and discharge planning. Facilitate smooth discharge arrangements for members. Review and ensure medical necessity and appropriate level of care for members. Chart Review and Clinical Support: Audit member charts on-site and via phone for compliance and medical necessity. Serve as a clinical resource for referral staff and offer appropriate referrals. Provide education to members and healthcare providers. Data Management and Documentation: Enter assessment, authorization, and review data into the system. Maintain accurate and organized records of assessments and authorizations. Ensure timely and thorough documentation for effective care coordination.
Quality Improvement Director (Licensed) Registered Nurse (RN) or Nurse Practitioner (NP)	Quality Oversight and Improvement: Manage quality staff and oversee day-to-day operations of the Quality Improvement (QI) Department. Develop, implement, and evaluate Quality Improvement Projects (QIP) for the D-SNP population. Recommend and initiate performance improvement initiatives across functional areas. Compliance and Documentation: Monitor activities to ensure compliance with AAAHC accreditation standards. Coordinate the development and implementation of QI plans and evaluations. Ensure accurate documentation of quality improvement activities and plans. Corporate Collaboration and Innovation: Support corporate initiatives by participating in committees and projects. Incorporate research-based best practices into quality improvement initiatives. Manage HEDIS®, STARS, CAHPS®, and HOS submissions to enhance quality outcomes.

MOC 2: Care Coordination

SNP Staff Structure

Role	Responsibilities
Pharmacy Director (Licensed) Clinical Pharmacist	Oversee clinical and administrative staff Ensure compliance with pharmacy requirements and guidelines Ensure there is a consolidated pharmaceutical therapy plan, in conjunction with the members' provider and interdisciplinary care team Provide member outreach to improve pharmaceutical outcomes as needed to address and try to resolve drug-related problems (medication adherence, interactions, etc.)
Case Manager (Licensed) Registered Nurse (RN)	Lead and manage clinical, non-clinical, and administrative teams. Oversee D-SNP members, particularly vulnerable populations. Collaborate with interdisciplinary care teams to create personalized care plans, promote member engagement, address individual needs, and ensure effective care transitions.
Case Coordinator; Licensed Practical Nurse (LPN);Registered Nurse (RN)	Reports to the Case Manager, overseeing non-clinical and administrative staff. Manages the HRA process and MOC activities, including care transitions. Collaborates with members and providers to design care plans, support engagement, address individual needs, educate on conditions, and ensure effective post-discharge care.
Behavior Health Case Manager (Licensed) Registered Nurse (RN) with experience in social work	Gather information from members, caregivers, and providers to assess needs and capabilities. Manage chronic conditions and health services, ensuring delivery and follow-up. Coordinate referrals, integrate voluntary services, collaborate on discharge plans, and arrange various care services for members, collaborating with healthcare professionals and conducting reassessments as needed.
Social Worker (Licensed) Clinical Social Worker (LCSW) with a background in social services or other applicable health-related field	Assist RN Case Manager by conducting member outreach and coordinating care. Connect members with community resources, social services, and benefits, acting as an advocate. Arrange transportation, provide educational support, and aid in discharge planning alongside RN Case Managers.
Clinical Support Associates	Proficient non-clinical staff under RN Case Manager or Medical Management Manager's supervision. Offer administrative aid to Case Management and Utilization Management teams. Assist in data collection, Health Risk Assessment, and survey completion for members. Contribute to care planning information, manage SNP membership processes, and handle UM documentation, including authorizations and member communication.

MOC 2: Care Coordination

Initial and annual MOC training for employed and contracted staff

All employees supporting the D-SNP receive required Model of Care training at the time of hire and then at a minimum annually thereafter. Model of Care training is integrated within other CMS-required training requirements, such as fraud, waste and abuse, HIPAA, etc.

MOC 2: Care Coordination

Health Risk Assessment Tool (HRAT)

Responses to the HRAT are stored within the case management system with the results from the initial assessment used to inform the stratification and generation of an individualized care plan (Details for developing and updating the ICP are in Elements C-D-E). The Plan utilizes a comprehensive Health Risk Assessment Tool (HRAT) that collects information that addresses the CMS required domains of medical, psychosocial, cognitive, functional, and mental health needs. The HRAT includes questions that address the following sections:

- General Information/Demographics
- Health and Wellness
- Emotional Health • Medical History
- Daily Activities
- Lifestyle
- Medications

CMS requires that Special Needs Plans conduct health risk assessments on all new members within 90 days of the effective date of enrollment and then reassessment at least within 365 days of the previous health risk assessment.

MOC 2: Care Coordination

Interdisciplinary Care Team (ICT)

The Interdisciplinary Care Team (ICT) is a group of professionals, paraprofessionals, and non-professionals who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of member needs, identify appropriate services, and design specialized interventions responsive to those needs. The plan ensures team members identified as ICT members have completed LHP's annual MOC training and have the expertise in an applicable specialty for the targeted members.

Interdisciplinary Care Team (ICT) Participants	Interdisciplinary Care Team (ICT) Roles & Responsibilities
Member and/or Caregiver	Communicate personal preferences and goals
RN Case Manager (Medical or BH background)	"Team" lead and responsible for ICP development and approval, including oversight of Case Coordinator activities. Responsible for convening ICT and communicating and disseminating ICT decisions. Serve as point of contact for ICT participants
Case Coordinator	Responsible for ICP development and execution under the direction of the RN Case Manager
Chief Medical Officer	Review and offer modifications / interventions related to evidence-based medical healthcare services to improve health status
BH Practitioner	Review and offer modifications / interventions related to evidence based behavioral healthcare services to improve health status
LCSW	Review and offer modifications / interventions related to social services and community resources that could benefit the member
Clinical Support Associate	In support of the RN Case Manager, distribute ICPs to participants prior to the ICT meeting Schedule ICT Meetings and document participant names and credentials within the case management system
Clinical Pharmacist	Review medication regimen and adherence and offers suggestions to enhance, such as for sub-therapeutic treatment, medication safety issues, and high-risk medications to improve health status
Medical Management Manager	Provide recommendations on covered benefits that may be available to support interventions
Primary Care Provider	Support ICT on clinical care recommendations and interventions to improve health status
Community Resources (ad hoc)	Support ICT with social recommendations and interventions
Contracted specialists (ad hoc)	Support ICT on clinical care recommendations and interventions to improve health status
Other (ad hoc)	As needed to provide necessary input and/or as requested by the member

MOC 2: Care Coordination

Individualized Care Plan (ICP)

An ICP is generated for each member using the best available information at the time of completion. Data sources may include, but is not limited to:

- Health Risk Assessment Tool (HRAT) results
- Pharmacy claim data
- Medical claim data
- Member and/or caregiver interactions and personal healthcare preferences

ICP Components	Description
History	Assessment of medical, psychosocial, cognitive, functional, and mental health needs
Stratification Level	Based on HRA data, augmented by additional data, when available
Advance Directives	Member wishes and status of documentation
Member health care preferences; role of caregiver	Language and cultural preferences for health care; communication (mail, phone, etc.); caregiver status; specifically tailored to the beneficiary's needs.
Members personal high-level self-management goals and objectives	Expressed by member and/or caregiver
Short-and longer-term goals and interventions by priority and timeframes for reevaluation	Identification of goals based on health status, medical/behavioral health history, care gaps and social needs as determined by RN Case Manager and/or Case Coordinator and ICT. Unmet goals are triggered as interventions and/or alerts to the case management team.
Identified problem list and potential barriers	Expressed by member and/or caregiver and augmented by case management staff
Clinical "gaps in care" and interventions	Planned or targeted outreach based on clinical gaps in care and interventions to achieve goals
ICT composition	RN Case Manager, Case Coordinator, clinical pharmacist, LCSW (when relevant), Chief Medical Officer, PCP, member and/or their caregiver, other practitioners as necessary to address the unique needs of each member
Roles of member and/or caregiver	Identification of goals met or not met; If not met a re-assessment for alternatives.
Notes	Open text based on case management team and conversations with the member and/or ICT

MOC 2: Care Coordination

Individualized Care Plan (ICP) Essential Components and Processes

Should contain SMART Goals:

S = Specific (Direct, Detailed, and Meaningful)

M = Measurable (Quantifiable to track progress or success)

A = Attainable/Achievable (Realistic, Include member preferences)

R = Relevant (Aligns with the member and/or ICT's Goals)

T = Time-Bound (Time-based, time limited, time/cost limited, timely, time-sensitive)

Measurable and Realistic Outcomes.

Identification if goals are met/not met

Barriers should be documented.

Member self-Management goals & personal healthcare preferences.

Description of services specifically tailored to the beneficiary's medical, psychosocial, functional, and cognitive needs.

Process for how the ICP is documented and updated as well as, where the documentation is maintained to ensure accessibility by the ICT, provider network, member and/or caregiver(s).

How updates to the ICP are communicated to the beneficiary/caregiver(s), the ICT, applicable network providers, other SNP personnel and other ICT members, as necessary.

MOC 2: Care Coordination

Individualized Care Plan (ICP) Essential Components and Processes

Regulations at 42 CFR 422.101(f)(2)(iii-v); 42 CFR 422.152(g)(2)(vii-x) require all SNPs to coordinate the delivery of care.

Following members across care settings during transitions (i.e. admission to a hospital) through the use of Utilization Management Registered Nurse who coordinates discharge planning and post-discharge services with the hospital, Plan Provider and CM to ensure smooth transition.

Indenturing at-risk members through the HRA and Most Vulnerable Member reports and notifying the Plan Provider of status or status changes.

Requiring Plan Providers to provide transitional care management visits and communications.

MOC 3: Provider Network

Specialized Network

The Plan provides a comprehensive contracted network of providers, facilities, ancillary service providers, specialist physicians, and acute care facilities with the specialized clinical expertise pertinent to the care and treatment of long-term senior housing residents.

Providers are responsible for being active members of the interdisciplinary care team supporting continuity of care.

Providers are responsible to follow clinical practice guidelines including transitions of care

Providers are required to administer a Model of Care training initially and annually there after.

MOC 4: MOC Quality Measurements and Performance Improvment

Ongoing Performance Improvement Evaluation of the MOC occurs through the plan committees

Dissemination of SNP Quality Performance related to the MOC

The Plan's QI program is assessed annually and reviewed by the Quality Improvement Committee (QIC) to determine the overall effectiveness of the program, including the MOC, and appropriateness of care and services furnished to member.

Wellness and Health Care Planning

Medicare Advantage Valued-Based Insurance Design (VBID) Model.

Leon Health, Inc. takes part in the Medicare Advantage Value-Based Insurance Design (VBID) Model, which mandates the provision of Wellness and Health Care Planning services. These services are accessible through various channels, including:

Annual Welness Visit

Health Risk Assessment

Care Management Program

A crucial aspect of the Wellness and Health Care Planning involves educating members about Advance Directives. These are legally binding documents enabling individuals to articulate their medical treatment preferences and instructions in the event they're incapable of communicating due to illness or incapacity. Advance directives empower individuals to retain authority over their healthcare choices, ensuring their values and wishes are honored. Various types of advance directives, such as living wills, durable power of attorney for healthcare, and do-not-resuscitate (DNR) orders, serve distinct roles in guiding medical decisions. These documents offer guidance to medical practitioners and family members, guaranteeing alignment between medical care and personal preferences even when direct communication is unfeasible.

Providers within the plan should facilitate communication about these documents during their Annual Wellness Visits.