CareSource

CareSource PROVIDER

D-SNP & MyCare Model of Care Training

Let's Get to Know Each Other Better

WHO IS CARESOURCE

SERVING DUAL-ELIGIBLES

MODEL OF CARE

Please Note: Throughout this training, we will refer to the model of care for CareSource Dual Advantage as the "**D-SNP Model of Care**."

Who is CareSource?

PART 1

CareSource

Our MISSION

To make a lasting difference in our members' lives by improving their health and well-being.

OUR PLEDGE

- ✓ Make it easier for you to work with us
- ✓ Partner with providers to help members make healthy choices
- ✓ Direct communication
- ✓ Timely and low-hassle medical reviews
- ✓ Accurate and efficient claims payment

Health Care with HEART

MISSION FOCUSED

Comprehensive, **member-centric** health and life services

EXPERIENCED

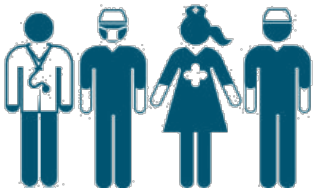
With over **29 years of service**, CareSource is a leading non-profit health insurance company

DEDICATED

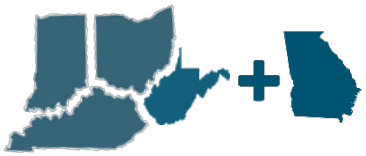
We serve over **1.8 million members** through our: Medicaid, Marketplace, MyCare, Medicare Advantage and Dual Special Needs Plans, in addition to our TriWest Healthcare Alliance.

29
YEARS
MISSION-DRIVEN CARE

1.8 MILLION
MEMBERS



93%
MEDICAL COST RATIO



COVERAGE
OH, KY, IN, WV, GA

A-Z
CONSUMER
ADVOCACY

$14.5M
FOUNDATION GRANTS AWARDED IN OHIO*

CareSource

* The CareSource Foundation currently is only in Ohio

Our PLANS

CHILDREN, PREGNANT WOMEN & WORKING FAMILIES

LOW-INCOME

MEDICAID

Plan Components:
- Risk-based managed care
- People who are aged, blind or have disabilities
- Healthy Start
- Healthy Families

MEDICAID & MEDICARE Eligible

18+

CARESOURCE MYCARE® OHIO

Details:
- Managed care
- Coordination of physical, behavioral & long-term care services

COMMERCIAL HEALTH PLAN

MARKETPLACE

Details:
- Established 2014
- Qualified health plan
- Reduced premiums or cost-sharing based on member income
- Pediatric Dental & Vision included
- Optional Adult Dental, Vision and Fitness

MEDICARE Eligible

65+

CARESOURCE ADVANTAGE

Details:
- Offers more coverage that original Medicare
- Medicare Part A, Part B, and prescription drug Part D benefits
- No limits due to pre-existing conditions

DUAL Eligible

MEDICAID & MEDICARE

CARESOURCE DUAL ADVANTAGE

Details:
- Combines benefits of Medicare and Medicaid into single plan
- Adds additional benefits outside of Medicare and Medicaid plans

CareSource

Serving Special Needs Populations

PART 2

CareSource

Our Duals

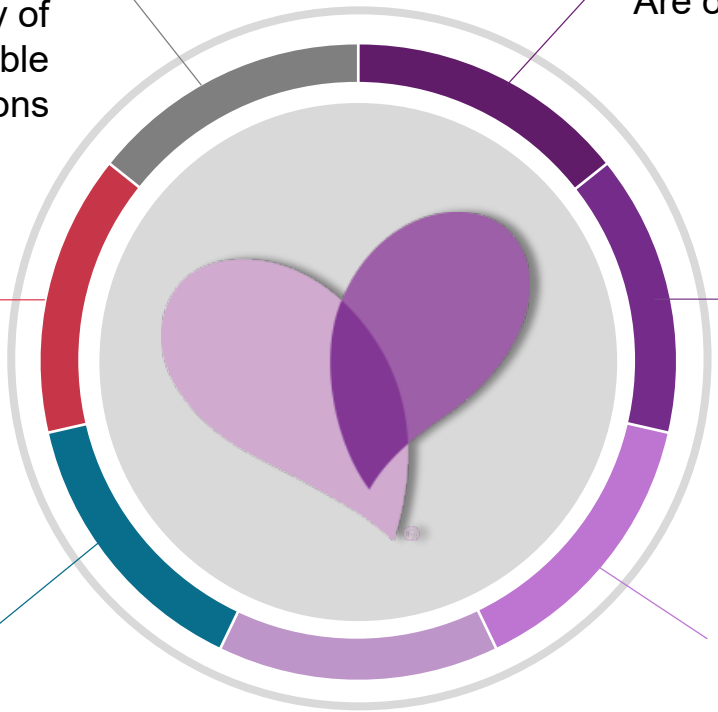
CareSource Dual Advantage serves people who are dually eligible for Medicare and Medicaid. We also serve dual-eligibles through the Ohio MyCare program.

Our person-centered, integrated care model provides care coordination to a population with complicated health care needs.

Redefining independence.

CareSource

Ohio Dual-Eligible *Member Snapshot*



25%
Have 4 or more of any of the common dual-eligible medical conditions

55%
Are over the age of 50

28,200
Members

48%
Are under the age of 65

62% Caucasian

31% Black/African Americans

46% Male

67% Female

Serving
OHIOANS

*CareSource membership that is dual-eligible for MyCare and D-SNP programs .

Training Objectives

- ✓ Provide understanding of D-SNP and MyCare
- ✓ Describe the annual model of care training requirement
- ✓ Describe the model of care
  - ✓ Elements: Health Risk Assessment Tool (HRAT), Interdisciplinary Care Team (ICT), Care Management, Individualized Care Plan (ICP), Care Coordination, Measurement & Evaluation
- ✓ Web-Based Access
- ✓ Contacts

CMS Requirements

The **Centers for Medicare & Medicaid Services (CMS)** requires all contracted medical providers and staff receive basic training about the D-SNP and MyCare Model of Care and to annually complete a refresher training.

The Model of Care for D-SNP and MyCare is the framework for delivering coordinated care and care management to dual-eligible, special needs members.

This training guide will outline the D-SNP and MyCare model of care and how that is delivered through our care management staff in partnership with our network of contracted providers.

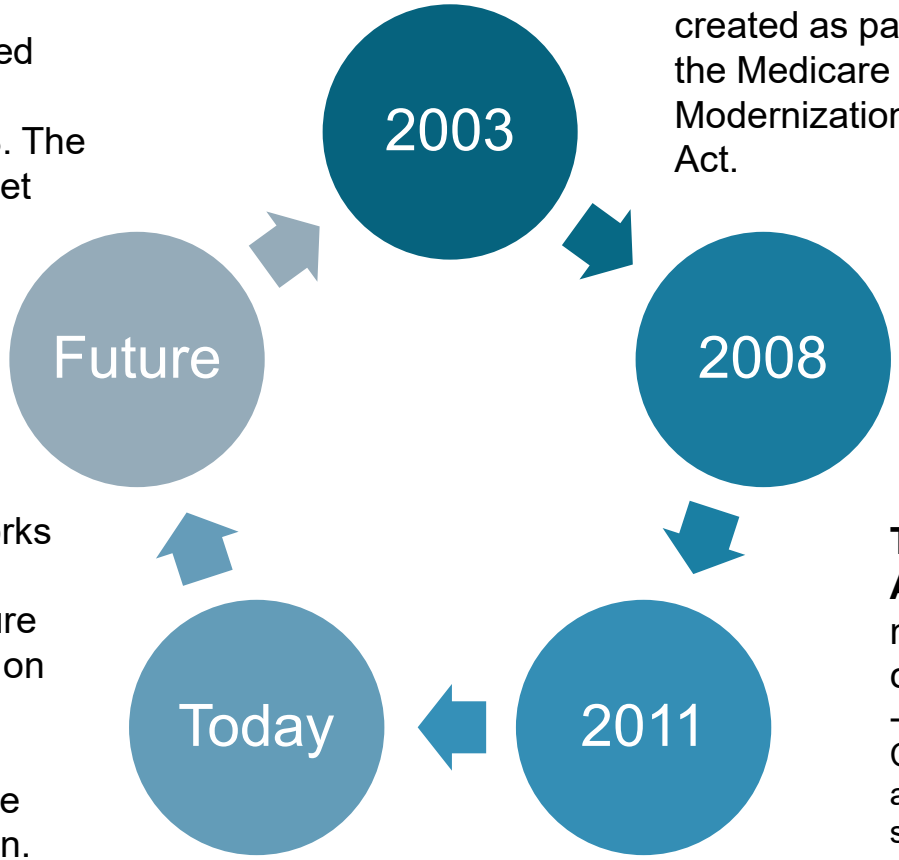
Overview

PART 3

CareSource

History of SNP Model of Care

Section 206 of MACRA extended the SNP until December 2018. The Bipartisan Budget Act of 2018 permanently extended these programs.



SNPs were created as part of the Medicare Modernization Act.

CMS contracted with the National Committee for Quality Assurance (NCQA) to develop a strategy to evaluate the quality of care provided by SNPs.

CareSource works with our health partners to ensure they are trained on our customized model of care processes for the DSNP population.

The Patient Protection and Affordable Care Act (ACA) mandated further SNP program changes:

-Required all SNPs to submit Models of Care (MOCs) that comply with an approval process based on CMS standards

-NCQA must **review and approve** these MOCs

CareSource

What are Special Needs Plans?

According to CMS' definition, 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.

A special needs individual could be any one of the following:

- An **institutionalized** individual
- A **dual-eligible**
- An individual with a **severe or disabling chronic condition**, as specified by CMS.

What is a Dual Special Needs Plan?

CMS categorizes and defines three different types of SNPs:

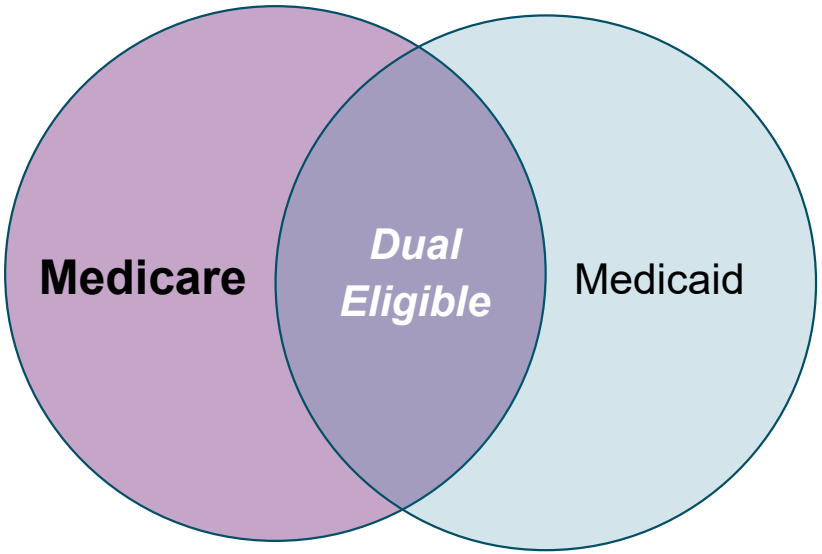
- Chronic Condition SNP (C-SNP)
- **Dual Eligible SNP (D-SNP)**
- Institutional SNP (I-SNP)

D-SNPs enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and individual's eligibility.

D-SNPs are *custom designed* to serve eligible members who reside in the program's service area and meet dual-eligibility status requirements.

Dual eligibility qualification is determined by the member's enrollment in a federally administered Medicare program and state-administered Medicaid program.

Who are Dual-Eligibles?



Coverage

- Medicare is always primary
- Medicaid is the payer of last resort and supplements Medicare coverage

Qualifications

- Member reenrolled in Medicare Part A and/or Part B
- Based on assets and income through the Medicare Savings Program (MSP)
- Eligibility for SSI
- Other optional means, such as medically needy or through Section 1115 waiver (state specific)

Dual Status – Full & Partial

- Full duals are eligible for Medicaid benefits
- Partial duals are only eligible for premium and for some levels of assistance with Medicare cost sharing

Who are Dual-Eligibles?

The dual-eligible population has some of the nation's sickest and most vulnerable individuals.

- Multiple chronic conditions and co-morbidities
  - Cardiovascular, dialysis, respiratory, neurological
- Exacerbating behavioral health conditions
  - Dementia, depression, substance abuse
- Compounding social determinant needs
  - Homelessness, food insecurity, loneliness, caregiver support

D-SNP Model of Care

PART 4

Please Note: Throughout this training, we will refer to the model of care for CareSource Dual Advantage as the "**D-SNP Model of Care**."

CareSource

Model of Care Goals

This Model of Care (MOC) was developed in accordance to CMS standards and NCQA guidelines. It serves as a strategy and plan for delivering care coordination, collaborating on care goals, and evaluating the effectiveness of the program.

Program goals include:

- Improving individual health and well-being
- Improving quality of care
- Increasing access to care
- Creating affordable care for members and demonstrating value of care
- Integrating and coordinating care across specialties and settings
- Providing seamless transitions of care
- Improving preventive health service utilization
- Encouraging appropriate utilization and cost effectiveness

Model of Care Elements

The Model of Care relies on a collaborative relationship between the **provider role** and **staff role** to deliver on each element. Providers will ensure active implementation of each of these elements with the support of care management.

Element 1
Health Risk Assessment Tool

Element 2
Interdisciplinary Care Team

Element 3
Individualized Care Plan

Element 4
Care Management & Coordination

Element 5
Measurement & Evaluation

*HRAT completion is a STARS measure.

CareSource

Element 1: Assessment

HEALTH RISK ASSESSMENT TOOL (HRAT):

- **Identifies members** with the most urgent needs
- Drives **the level of care coordination** the member requires
- Engages the member by including active **needs review** and **goal setting**
- Creates the member's **Individualized Care Plan**
- **Comprehensively assesses** the medical, functional, cognitive, psychosocial, and mental health needs of the member
- Must be completed telephonically or in person by the care manager (per the member's choice) **within 90 days of enrollment**
  - The assessment is then repeated on annual basis (365 days), or if a significant change event occurs in the member's health, such as sudden illness.

Element 2: Care Team

INTERDISCIPLINARY CARE TEAM (ICT):

- Ensures each member is managed by a **cross-disciplinary team of professionals** with competency and training to meet the member's diverse and complex needs
- Formed based on the **member's needs and preference**
- Team is **coordinated by the care manager** who will facilitate meetings and keep the team updated with information involving the member's care plan
- Team meets **formally on a regular basis** to discuss the status and progress of the member, including a review of the member's utilization, needs, and goals.
- Team will meet **as often as needed** based on the member's needs and in the event of a change in the care plan.

Element 2: Care Team

ICT ROLES & RESPONSIBILITIES

- Determining each member's needs and goals
- Coordinating member's care
- Identifying programs and anticipate crises
- Educating the member about conditions and medications
- Coaching the member to use the individualized care plan as a tool to maintain and improve his or her health
- Referring the member to community resources based on their needs
- Managing transitions of care, including proactively identifying problems causing the need for a transition and preventing unplanned transitions
- Coordinating Medicare and Medicaid benefits for the member
- Identifying and assisting the member with changes in his or her Medicaid eligibility

Element 3: Care Plan

INDIVIDUALIZED CARE PLAN (ICP):

- Serves as the **primary tool for continuous monitoring** of the member's current health status. It is the ongoing action plan to address the member's care needs in conjunction with the ICT and member.
- Utilized as a **common data source across the ICT** members to understand the member's services, needs and goals.
- Contains **member-specific issues, goals, and interventions** that address issues found during the HRAT and any team interactions
- **Leverages data** such as: health risk assessment results, laboratory results, pharmacy data, emergency department and hospital claims data, care manager observations, ICT input, member preferences and goals
- Exists as an **evolutionary document** that changes as the member's needs and goals change

Element 3: Care Plan

CARE PLAN TOOLS

The Member Profile is the centralized and comprehensive file containing the member's information and health records. The profile is the mechanism used to communicate the member's ICP contents, health records, and other important member information to members of the ICT, including the member and caregiver.

The profile is made available electronically to promote visibility of the care plan to those involved in the member's care.

Element 3: Care Plan Tools

PROVIDER PORTAL

The Provider Portal is the tool used to communicate the member's profile with the provider and chosen ICT. The tool comprises the HRAT, ICP and member health records and is made available to the PCP at all times. The portal:

- Summarizes the ICP
- Captures HEDIS gaps in care
- Contains medication review notes
- Includes diagnoses from claims data, lab results, and a list of current medications filled by the member

Element 3: Care Plan Tools

MEMBER PORTAL

The Member Portal is the communication tool used with the member and caregiver to communicate the member's profile. In addition to providing information about the plan, the member portal:

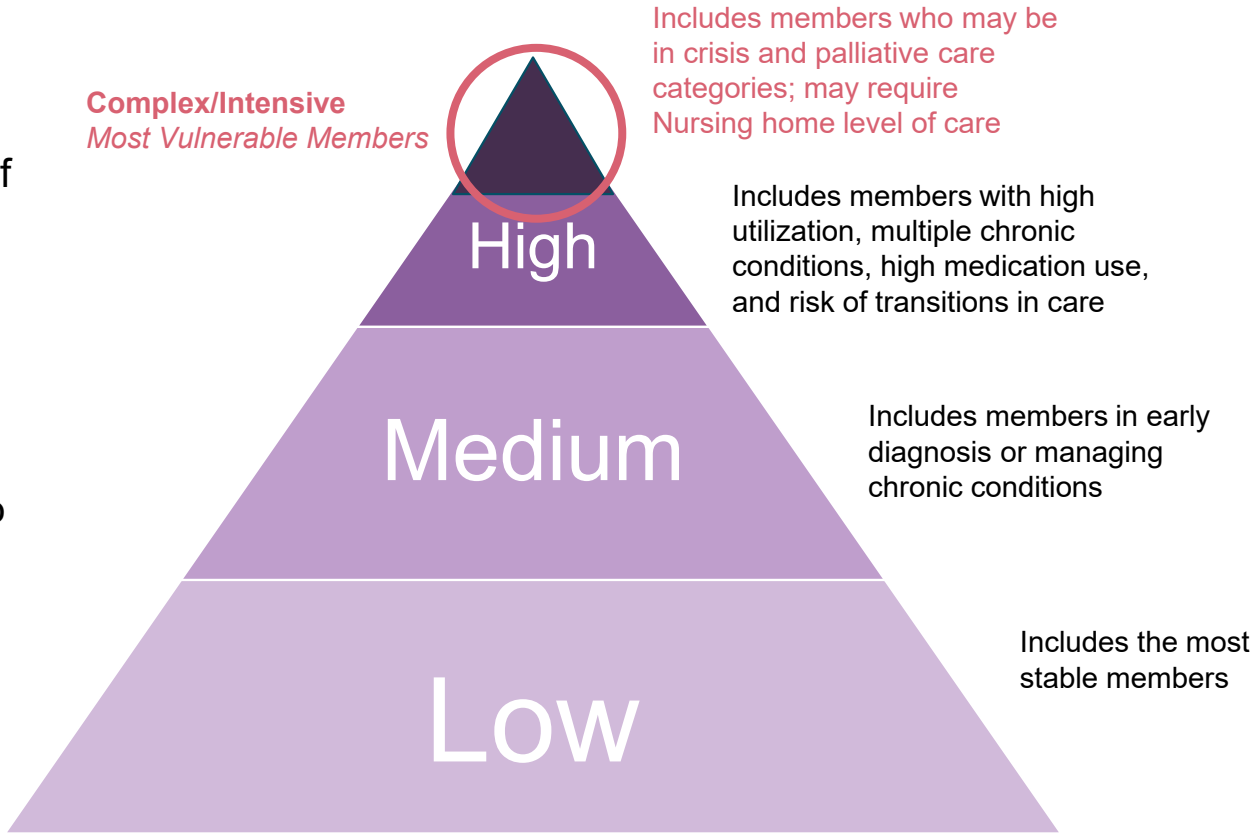
- Summarizes the ICP for the member
- Documents service and treatment utilization
- Provides necessary contact information

Element 4: Care Management

RISK STRATIFICATION

Member data undergoes: risk stratification, acuity assignment and evaluation for assessment of proper care programs and clinical treatment.

- **Risk stratification** occurs through a system-based, automated approach that applies predictive analytics to the member's demographic data
- **Acuity assignment** follows once the member's HRA, care manager, and ICT data are incorporated into the system



Members are **stratified based on their medical, behavioral and social needs** and placed into appropriate clinical programs to improve their health and well-being.

CareSource

Element 4: Care Management

BENEFITS & PROGRAMS

Members will be connected to a variety of **care management programs and interventions,** such as:

- Disease management and education
- Diet and nutritional education
- Medication therapy management
- Behavioral health services
- Life and social services
- Transportation

Element 4: Care Coordination

PROVIDER/STAFF COLLABORATION

CareSource's care manager is the central point of contact for ICT members, including the member and providers. The **care manager** coordinates the member's care by:

Improving coordination of care

- **The provider** is responsible for identifying the needs of the beneficiary.
- **The care manager** will coordinate with the member, PCP, and members of the ICT to promote the appropriate delivery of care in an integrated format.
- **All members** will have a PCP and care manager and the benefit of coordinated efforts between both.

Coordinating seamless transitions across specialties and settings through specific interventions

- The care manager will **notify the PCP** about the transition.
- The care manager will **share the member's ICP** with the PCP, hospitalist, facility, and/or the member/caregiver.
- The care manager will **contact the member** prior to a planned transition to provide education and support.

Element 5: Care Coordination

SIGNIFICANT CHANGE EVENTS

CareSource care managers will coordinate the **significant change event transition process** with specific discharge protocols to help members back into their homes and communities.

Through **regularly scheduled follow-up calls** post-discharge, case managers will work closely with the member to:

- **Help the member understand** discharge diagnoses and instructions
- Facilitate and schedule **follow-up appointments**
- Assist with **home health needs** or ordering equipment
- **Help remove barriers** to prescriptions
- **Coordinate resources** for social determinant needs
- **Provide education** on new or continuing medical conditions

Element 5: Quality

MEASUREMENT

Performance, quality and health outcome measurements are collected, analyzed and reported to **evaluate the effectiveness** of the model of care.

Our Quality department reviews the following measures:

- Healthcare Effectiveness Data and Information Set (HEDIS): used to measure performance on dimensions of care and service
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
- Other health outcomes surveys
- CMS reporting elements
- Clinical service quality improvement projects

Element 5: Quality

PERFORMANCE EVALUATION

Once performance data is collected, the Model of Care must be held to **program standards and outcome goals**, including evaluation of the following areas:

- Improving access and affordability of healthcare needs
- Improving coordination of care and delivery of services
- Improving transitions of care across health care settings
- Ensuring appropriate utilization of services for preventive health and chronic conditions

Roles & Responsibility

PROVIDERS ARE RESPONSIBLE FOR:

- **Communicating** with care managers, ICT members, members/caregivers about the ICP, course of treatment, and medical education
- **Collaborating** with CareSource to create the member's ICP
- **Reviewing and responding** to member-specific information and notifications
- **Maintaining the ICP** in the member's medical record
- **Participating in the ICT**, providing input and insight
- **Reminding the member** the importance of the HRAT in to form an appropriate plan of care
- **Encouraging the member** to work with the care management team
- **Completing this model of care training** upon onboarding and annually

Roles & Responsibility

OUR STAFF IS RESPONSIBLE FOR:

- **Reminding the member** the importance of the HRAT in informing an appropriate plan of care
- **Encouraging the member** to work with their care management team
- **Encouraging PCPs** and specialty providers to participate with the member's ICT
- **Supporting PCPs to** regularly access the members' ICPs
- **Reminding providers** and staff to perform their MOC training annually

MyCare Model of Care

PART 5

CareSource

Model of Care Elements

The MyCare Model of Care follows the same guidelines of the D-SNP program with slight variation. The elements include:

Element 1
Health Risk Assessment Tool

Element 2
Interdisciplinary Care Team

Element 3
Individualized Care Plan and Tools

Element 4
Care Management & Coordination

Element 5
Quality Measurement & Evaluation

*HRAT completion is a STARS measure.

CareSource

MyCare Overview & Advantages

MyCare Ohio is a demonstration project that integrates Medicare and Medicaid services into one program, operated by a Managed Care Plan.

The plan is a coordinated approach to providing health care and long-term services and supports. Requirements are based on a 3-way agreement between CMS, ODM and CareSource as well as the provider agreement defined by ODM.

Advantages of this program are:

- Single point of contact for care
- Care management support 24/7
- Team of professionals to coordinate care
- One ID card (for opt-in members)
- Focus on prevention and wellness
- Nurse Advice Line
- Better coordination = better health outcomes
- Health partners submit claims to one place (for opt-in members)
- Enhanced benefit package for opt-in members

MyCare Model of Care Goals

The MyCare Model of Care (MOC) was developed in accordance to CMS standards and NCQA guidelines. It serves as a strategy and plan for delivering care coordination, collaborating on care goals, and evaluating the effectiveness of the MyCare program.

Program goals include:

- Improving access to physical and behavioral health care
- Access to preventative care
- Provider network access
- Care Coordination through identified point of contact including Health risk assessment, care plan and TDCT- Trans-disciplinary care team
- Improving transitions across the health care continuum
- Appropriate utilization of services
- Improving the member outcomes

Target Population

- Eligible for Medicare (Parts A, B and D) and FULLY eligible for Medicaid;
- Over the age of 18
- Living in one of the demonstration counties.
- Home & Community Based Services, (HCBS) Waiver members, Long term Care (LTC) Residents, and Community Well Members
- Under 65 and disabled
- Low income elderly

Waiver Service Coordination/HCBS

CareSource works with **Area Agencies on Aging** to provide care management to our waiver members. This includes members receiving Home and Community Based Services (HCBS).

Services & supports provided in the home and community include:

- Personal Care Services
- Home Delivered Meals
- Home Making Services
- Adult Day Care
- Emergency Response System (ERS)
- Non-emergency transportation
- Home modifications

Care Management Visit Schedule

- All members **must have a face to face visits.**

- Assessment and visit requirements
  - ❖ Intensive 30 days / monthly visit for life of demo
  - ❖ High 30 days / monthly visit for 6 months
  - ❖ Medium 60 days / visit 1st 2 months, then quarterly
  - ❖ Low 75 days / visit 1st 4 months, then biannually
  - ❖ Monitor 75 days / visit 1st 6 months, then annually

- Initial and ongoing (event based) assessments, as well as annual reassessment.
- Reassessment must occur within 365 days of last assessment.

Care Management Visit Schedule

Our tailored approach to care coordination enables our staff to build an **individualized, comprehensive plan of care** that can adapt based on a Member's developing needs and personal goals.

- Stratify enrollee
- Assess needs & personal goals
- Confirm stratification & acuity
- Develop member-centered care plan & service plan
- Implement new plan with member
- Monitor & reassess care plan

Transitions & Post Discharge

Goals

- ↓ ER visits
- ↓ Hospital admits/ readmits
- ↑ Compliance w/ MD d/c plan
- ↑ Use of appropriate med choices/combos
- ↑ Use of appropriate Community Referrals
- ↑ Member Satisfaction & Health Outcomes

Transition Coordinator Role

- LOC requests for NF & Waiver will be sent to the local AAA by the TC
- CareSource TC will determine LOC for LTC members

CareSource

Care Treatment Plan

OUR CARE TREATMENT PLAN IS FOCUSED ON:

- Creating **individualized & personalized** member treatment plans
- **Actions and goals** with timeframes for completion
- Developed on **assessment findings**, member preferences & input from the TDCT
- **PCP outreach and engagement**

Other Care Management Interventions

SPECIALIZED INTERVENTION PROGRAMS INCLUDE:

- Medication Reviews
- Treatment Plan Support
- Care Transitions
- Post Discharge Support
- Self-Care Management
- Independence at Home
- Intrapersonal & Social Relationships
- Care Coordination
- Decision Coaching
- Connections to Community Resources
- Preventative & Screening Services
- Health Education
- Knowledge of when to call physician

Member & TDCT Resources

RESOURCES INCLUDE:

- **Provider Portal** is the tool used to communicate the member's profile with the provider and chosen ICT.
- **Member Portal** is the tool used to communicate all member activities within a central location.
- CareSource Website for general plan information
- CareSource **Call Center**
- **24 hour** Nurse Advise Line
- **24 hour** Behavioral Health Line

Health Partner Network

NETWORK OVERVIEW:

- **Comprehensive network of primary care providers and specialists**, such as cardiologists, neurologists, and behavioral health specialists to meet the complex health needs of the MyCare and Medicare Advantage population

- MyCare has specialized **Long Term Services and Support providers** that specialize in services for complex Nursing Facility and Waiver members

Quality Improvement

CareSource has a Quality Improvement program that monitors the health outcomes and implementation of the MyCare Model of Care (MOC) by:

- Identifying and defining measurable MOC goals
- Collecting HEDIS, STARS and quality withhold measures
- Conducting a Quality Improvement Project (QIP) annually that is relevant to improving Long term care rebalancing to the My Care.
- Chronic Care Improvement Program (CCIP) that identifies eligible members and intervenes to improve disease management and evaluates program effectiveness (Cardiac Medications)
- Communicating goal outcomes to stake holders

Roles & Responsibility

OUR STAFF IS RESPONSIBLE FOR:

- **Reminding the member** the importance of the HRAT in informing an appropriate plan of care
- **Encouraging the member** to work with their care management team
- **Encouraging PCPs** and specialty providers to participate with the member's ICT
- **Supporting PCPs to** regularly access the members' ICPs
- **Reminding providers** and staff to perform their MOC training annually

Provider Portal

Providers can use the Provider Portal as the **central communication tool** to engage in the activities described as part of the Model of Care. With this tool, providers can:

- Check member eligibility and benefit limits
- Submit claims and verify claim status
- Find prior authorization requirements
- Verify or update Coordination of Benefits information (COB)
- Submit and check the status of a Prior Authorization request
- Access member HRATs, ICPs, member record, etc.

Providers can access the Provider Portal 24 hours a day, 7 days a week at **CareSource.com** > Providers > Log-In

CareSource

Thank you!

CareSource offers benefits that cover the full spectrum of our members' journeys. Regardless of their age, we offer a lifetime of care and an unwavering promise of *health care with heart*.

MISSION-DRIVEN CULTURE

INNOVATIVE CONSUMER-DRIVEN BENEFITS

COMMUNITY-BASED PARTNERSHIPS

CareSource®