CareSource

CareSource PROVIDER

D-SNP 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

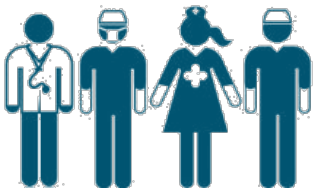
EXPERIENCED

With over **30 years of service**, CareSource is a leading non-profit health insurance company

DEDICATED

We serve over **1.9 million members** through our: Medicaid, Marketplace, MyCare, Medicare Advantage and Dual Special Needs Plans, in addition to our TriWest Healthcare Alliance.

30
YEARS
MISSION-DRIVEN CARE



93%
MEDICAL COST RATIO

A-Z
CONSUMER
ADVOCACY

1.9 MILLION
MEMBERS

COVERAGE
OH, KY, IN, WV, GA

$21.2M
FOUNDATION GRANTS SINCE 2006

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Our PLANS

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

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

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

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

CareSource serves MA/D-SNP members in Ohio, Georgia and Kentucky.

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Serving Special Needs Populations

PART 2

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Our Duals

CareSource Dual Advantage serves people who are dually eligible for Medicare and Medicaid.

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

Redefining independence

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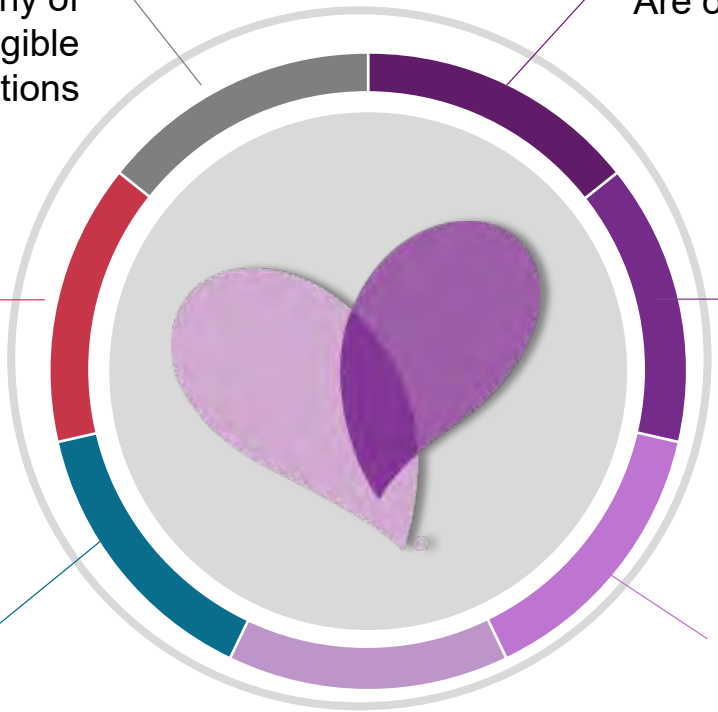
CareSource Dual-Eligible *Member Snapshot*



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

89%
Are over the age of 50

31,488
Total Members

29%
Are under the age of 65

60% Female

40% Male

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

Training Objectives

- ✓ Provide understanding of D-SNP
- ✓ Describe the annual model of care training requirement
- ✓ Describe the model of care
  - ✓ Elements: Health Risk Assessment Tool (HRA tool), 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 Model of Care and to annually complete a refresher training.

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

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

Overview

PART 3

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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:

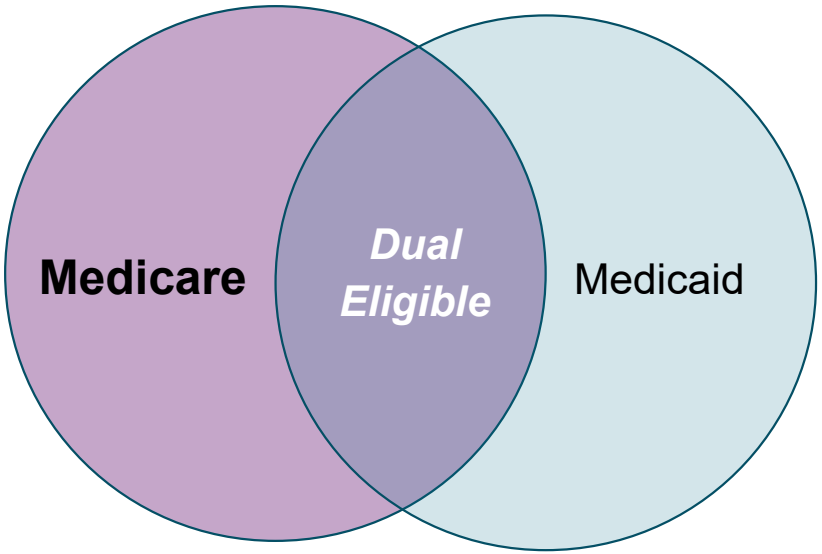
- Chronic Condition SNP (C-SNP)
- **Dual Eligible SNP (D-SNP)**
- Institutional SNP (I-SNP)

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

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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**."

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Model of Care Goals

This Model of Care (MOC) was developed in accordance with 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. Care management staff will ensure active implementation of each of these elements with the support of providers.

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

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Element 1: Assessment

HEALTH RISK ASSESSMENT (HRA) TOOL:

- **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 case 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 has access to 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 case manager** who will facilitate meetings and keep the team updated with information involving the member's care plan
- Team meets **as often as individualized needs and preference warrant** to discuss the status and progress of the member, including a review of the member's utilization, needs, and goals and any changes to the care plan.

Element 2: Care Team

ICT ROLES & RESPONSIBILITIES

- Determining each member's needs and goals
- Coordinating member's care
- Identifying programs and anticipating 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
- Helping members access resources to resolve eligibility issues

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 HRA tool and any team interactions
- **Leverages data** such as: health risk assessment results, laboratory results, pharmacy data, emergency department and hospital claims data, case 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 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 HRA tool, 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

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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:

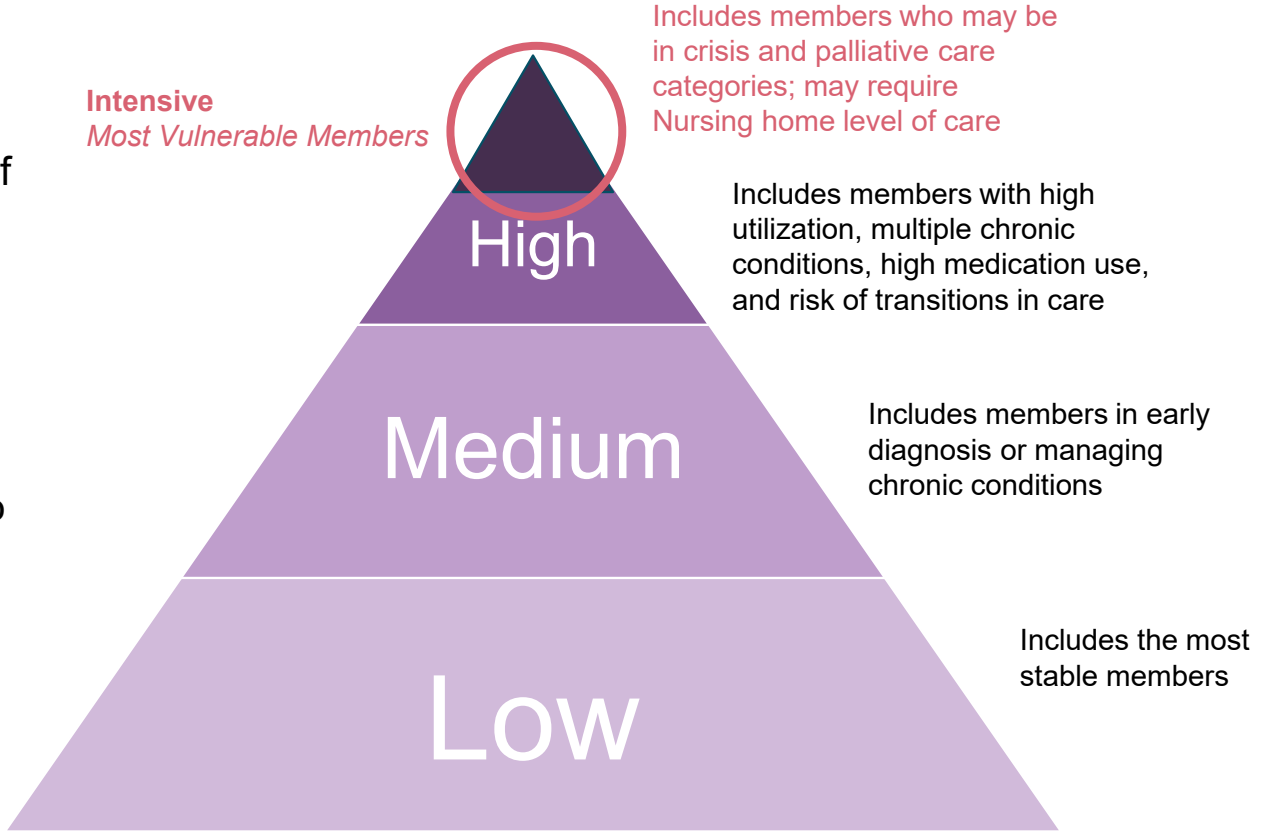
- Summarizes the ICP for the member
- Documents service and treatment utilization
- Displays current medications
- Provides necessary contact information

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, case 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.

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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 case manager is the central point of contact for ICT participants, which includes the member and providers. The **case manager** coordinates the member's care by:

Improving coordination of care

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

Coordinating seamless transitions across specialties and settings through specific interventions

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

CareSource partners with our providers on comprehensive transitions of care between the care settings. This requires successful transfer of information from clinicians to the patient and family to reduce adverse events and prevent readmissions. Engaging patients and families in the discharge planning process helps make this transitions safe and effective.

Element 5: Care Coordination

TRANSITIONS OF CARE

CareSource case managers will coordinate the **transition of care 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 case managers, ICT participants, 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
- **Educating the member** on the importance of completing the HRA tool in order to inform his or her individualized 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:

- **Educating the member** on the importance of completing the HRA tool in order to inform his or her individualized 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
- **Informing PCPs** of changes to the members' ICPs based on needs and preferences
- **Notifying providers** of potential gaps in care
- **Reminding providers** and staff to perform their MOC training annually

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®