PASSPORT ADVANTAGE (HMO SNP)

Passport Advantage (HMO SNP) Model of Care Training (Providers)

2021 Sign In Date: _____

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Passport Advantage (HMO SNP) is an HMO Special Needs plan with a Medicare contract and an agreement with the Kentucky Department for Medicaid Services. Enrollment in Passport Advantage depends on contract renewal.

Training Objectives

At the conclusion of this training, the following learning objectives will be addressed:

- Dual Special Needs Plan (SNP) requirements
- Describe Model of Care (MOC) components:
- Description of the SNP population
- Care coordination – explain how Passport Advantage and providers coordinate care for duals
- Provider network
- Quality measurement and performance improvement
- Describe provider role and support within MOC context

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Dual Special Needs Plan (DSNP)

A dual special needs plan compared to Original Medicare:

- Is a Medicare Advantage Prescription Drug Plan (MA-PD) with additional requirements, primarily around Model of Care (MOC). The MOC is a framework of how a plan addresses the unique needs of its membership.

- Covers all Original Medicare (FFS) benefits, including A/B and D (prescription drugs)

- Must have a contract with the State Medicaid agency to either provide or coordinate Medicaid benefits; Passport Advantage must coordinate Medicaid benefits

Per CMS requirements, a Special Needs Plan (SNP) must provide Model of Care training to their contracted providers

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Passport's Special Needs Population

- Eligible for **full** Medicaid benefits; must involuntarily dis-enroll a member that loses full Medicaid status
  - be enrolled in Medicare Part A and B
- Resides within service area counties: Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington
- Can enroll members living in the community and those in an institutional setting

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Prevalent Diagnoses

Medical Diagnoses	Behavioral Health Diagnoses
Diabetes	Mood Disorders (e.g. Bipolar, Depressive Disorder)
High Blood Pressure/Hypertension	Anxiety
Chronic Obstructive Pulmonary Disease	Schizophrenia
Heart Disease and Failure	Mental & Behavioral Disorders (due to psychoactive substance use)
Hypercholesterolemia	

Full benefit duals are more likely to be chronically ill compared to the regular Medicare population.

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Most Vulnerable Subpopulations

Population Identification	Definition
Multiple hospitalizations	2 or more within 6 months, including medical or behavioral health
Readmission	Within 30 days of prior inpatient discharge
Poly and/or high-risk pharmacy utilization	10 or more chronic prescriptions
Social Determinants of Health	Conditions in which people are born, grow, live, work, and age.
Use of DME	Individuals using Durable Medical Equipment
Chronic Conditions	1 or more of the following and compounding severity: Diabetes, Asthma, COPD, Hypertension, Coronary Artery Disease, CHF, and Metabolic Syndrome

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Benefits Chart – DSNP Members

Benefit	Original Medicare	Passport Advantage	PHP/MCO	DMS	Member Pays
Medicare A/B		X			$0
Skilled Nursing Facility		X		X	$0
Hospice	X				$0
Clinical Trials	X				$0
Medicare Cost Sharing			X	X	$0
Supplemental Benefits		X			$0
Prescriptions (based on Subsidy- LIS level 1)		X			Generic- $3.70; All others - $9.20
Prescriptions (based on Subsidy- LIS level 2)		X			Generic- $1.30; All others - $4.00
Prescriptions (LIS level 3- Institutionalized)		X			$0
OTC medications		X	X	X	$0
Routine Eye Care			X	X	$0
Routine Dental		X	X	X	$0
NON-emergent Transportation			X	X	$0

Passport Advantage is financially responsible for all MAPD benefits; not for Medicaid benefits or cost sharing

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CY2021 Supplemental Benefits

- Supplemental benefits are in addition to the standard Medicare covered services and cannot replicate a Medicaid benefit and no deductible or coinsurance is applied.
- Fitness Benefit
  - Free gym membership to one gym of member's choice, healthy aging program or home fitness program
  - Silver & Fit Program
  - No Authorization or Referral required
- Meal Benefit
  - Plan outreach occurs after a member is discharged from inpatient admission for 3 days or longer to opt-in for the service
  - No cost to member
  - Up to 2 meals every day for 7 days, for a maximum of 14 meals after each inpatient stay
  - No Authorization or Referral required

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Supplemental Benefits Cont'd

Dental Services

- Preventative services
  - Cleaning and Fluoride Treatment – one (1) every six (6) months
- Comprehensive services - $2,000 maximum coverage amount per year
  - Dentures – One set every 60 months
  - Diagnostic clinical oral evaluation – One (1) every six (6) months
  - Diagnostic imaging – For clinical reasons as determined by the dentist and can adhere to different timeframes
  - Resin-based composite restorations - One (1) every thirty-six (36) months
  - Inlay/Onlay restorations and crown restorations - One (1) per 60 months, per tooth
  - Endodontics – One (1) per lifetime per tooth.
  - Periodontics – One (1) procedure every 24 months, per quadrant.

Vision Services

- Eyeglasses (lenses and frames) or Contact Lenses
- $300 annually - the member can spend the $300 any way that they choose (example: 2 pairs of glasses, 1 pair of glasses and contacts, etc.)
- Routine vision screening covered under Medicaid benefit

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Supplemental Benefits Cont'd

Hearing Services

- Up to two TruHearing hearing aids every year (one per ear)
  - TruHearing Advanced and Premium hearing aids
    - Various styles and colors
    - Member must see a TruHearing provider to use benefit
  - Up to $500 per ear
  - Purchase includes
    - 3 provider visits within first year of purchase
    - 45 day trial period
    - 3 year extended warranty
    - 48 batteries per aid

OTC

- $40 allowance per month
- No rollover from month to month

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Preventive Services

- No coinsurance, copayments or deductibles for all Original Medicare Preventive Services that are offered at zero dollar cost sharing

Referral Requirements

- Referrals are not required for mental health and psychiatric specialty services

- **NEW - Referrals are no longer required**
  - Physician/Practitioner Specialist Services, including doctor's office visits
  - Podiatry Services
  - Other Health Care Professional Services

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Cultural & Linguistics Standards

- Provide language assistance services at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
- Provide to patients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- Assure the competence of language assistance provided. Family and friends should not be used to provide interpretation services (except on request by the patient).
- Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups represented in the service area.

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Continuity of Care Standards

Passport Advantage is required to monitor our provider's medical records for continuity of care.

Examples of the monitoring criteria are:

- At each office visit, the history and the physical performed are documented and reflect appropriate subjective and objective information for presenting complaints, including any relevant psychological and social conditions affecting the patient's medical/behavioral health.
- The working diagnosis is consistent with the clinical findings.
- The plan of action and treatment is consistent with the diagnosis and includes medication history, medications prescribed; including the strength, amount, and directions for use, as well as any therapies or other prescribed regimen.
- Lab and other studies are ordered as appropriate.
- Additional details and requirements are found in your Provider Manual.

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Access and Availability

- Passport Advantage is required to monitor our provider's access and availability.
- The provider network is designed to meet the unique needs of the dual population for access, availability and specialty.
- Passport Advantage members select a primary care physician who has contractual accountability for making appropriate and timely referrals to specialists.
- All practitioners are required to be accessible 24/7, which may include approved coverage standards.
- Access to care standards is assessed as part of Quality Improvement activities.

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Medicare Record Documentation Standard

- Medical records should be complete and legible and include the legible identity of the provider and the date of service.
- Medical records must include the NCQA's guidelines for 21 core elements for medical record documentation.
- Medical records, in any media type (paper, electronic health record) must be compliant with all HHS, CMS and DMS requirements, including signature standards.
- Additional details and requirements are found in your Provider Manual.

Care Coordination Requirements

ICP – action oriented with goals and interventions specifically tailored to the member's needs.

- Created for every member, whether reached and assessed or not
- Interventions may include:
  - education about their diagnoses;
  - identification of additional services;
  - education and support on self-management;
  - assistance with coordinating provider visits;
  - identifying and coordinating "gaps in care";
  - relevant community resources.
- Reviewed and updated by the ICT
  - At initial creation, with change in health status or transitions in care, and annually thereafter
  - ICP shared with member (with consent), the PCP, or other practitioners

ICP Components with Description

ICP Components	Description
Medical History	Assessment of medical, psychosocial and cognitive needs; frailty
Member Personal Health Preferences	Language and cultural preferences for health care and communication (mail, phone); Caregiver status; Articulated stressors
Member's personal high level self-management goals and objectives	Articulated goals provided by member and/or caregiver
Identified problem list and potential barriers	Articulated by member and/or caregiver and augmented by care management staff
Short and long-term goals, interventions and timeframes for reevaluation	Identification of member and care management system generated goals based on health status, medical/behavioral health history, care gaps and social needs as determined by systemic triggers, care manager and ICT. Unmet goals are triggered as interventions and/or alerts to the care management team
Notes	Open text notes gathered by the care management team through engagement with the member and/or ICT
Alerts and Action Items	System triggered care management team outreach or interventions based on unmet goals, gaps in care, and/or revised member health status

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Care Coordination Requirements

ICT – to coordinate care

- Knowledge, skill and expertise necessary to accurately identify the member's needs and appropriate services and design specialized interventions

- Internal and external resources coordinated by the care manager
  - Resources may also include: medical, behavioral, pharmacist and psychosocial
- Care Advisor (Care Manager) or Health Educator – Primary Point of Contact, members have access via a toll-free phone number
  - Coordinates the external ICT participants, including conversations with their PCP, specialists and community resources
  - Assists the member in articulating questions to ask providers
  - Internal ICT participants document their activities within the care management system
- Transitions of Care management - moving between care settings

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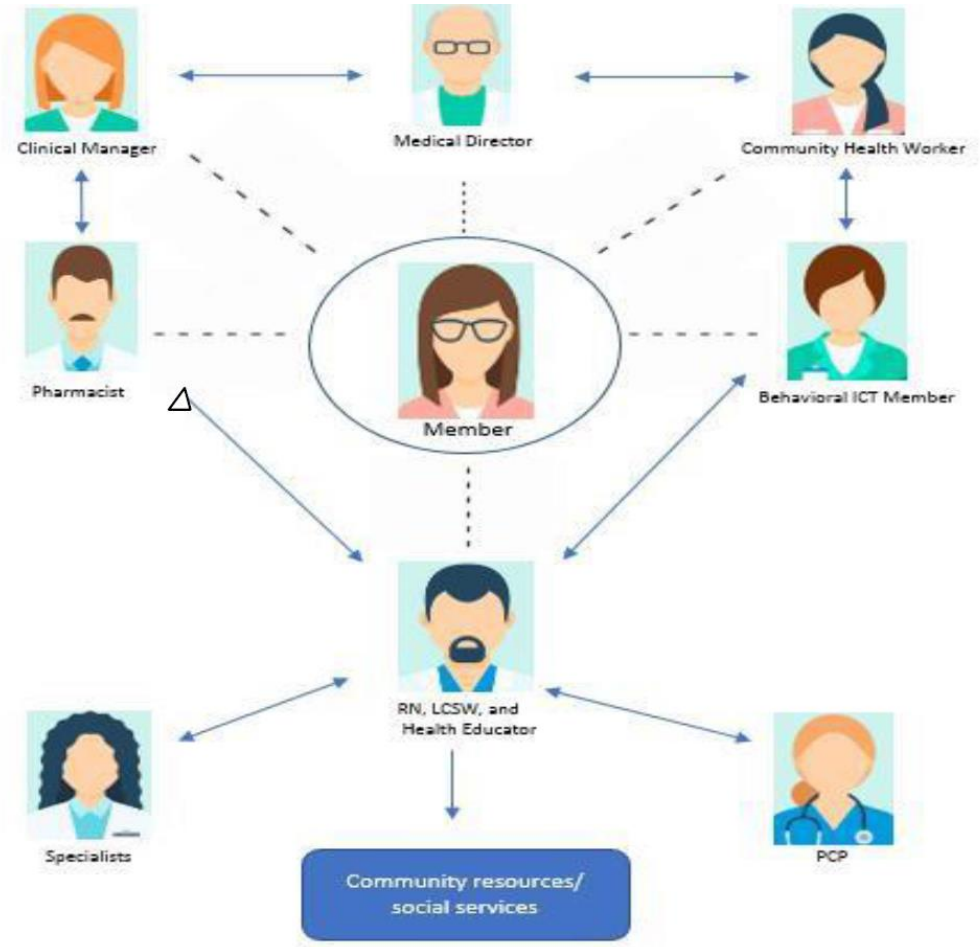
Potential ICT Participants



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Specialized Network

- Network contracting focused on existing comprehensive Passport Health Plan Medicaid provider network – awareness of population needs and preferences, benefits and contractual obligations associated with Medicaid recipients.
- PCP and other provider collaboration with the Interdisciplinary Care Team (ICT) and Individualized Care Plan (ICP).
- Evidence based clinical practice guidelines – utilization of services; address gaps in care; document any exceptions to guidelines in the medical record.
- Support care transition protocols and coordinating continuity of care.
- The PCP office is a member of the care team and serves as the coordination hub for the individualized care plan.
- Annual Model of Care training and Product and Benefits required.

Quality Improvement Program

- SNPs have the same performance improvement requirements as other coordinated care plans, such as:
  - HEDIS
  - CAHPS
  - HOS (Health Outcome Survey)
  - Chronic Care Improvement Program
  - Quality Improvement (QI) Program Description, Work Plan and annual Evaluation
- QI Plan is tailored to meet the unique needs of our membership

Clinical Practice Guidelines

- Evidence based clinical practice guidelines promote the use of nationally recognized and accepted practices for providing the right care at the right time.

- The Plan updates its clinical practice guidelines minimally every two years.

- Clinical Practice Guidelines address the most prevalent diagnoses anticipated within the DSNP population
  - Standards of Medical Care in Diabetes
  - Prevention, Detection, Evaluation and Treatment of High Blood Pressure
  - Chronic Obstructive Pulmonary Disease
  - AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary & Other Atherosclerotic Vascular Disease
  - Practice Guidelines for the treatment of Patients with Major Depressive Disorder
  - Adult Preventive Health

MOC Measurable Goals & Health Outcomes

- Goals have been identified relevant to the dual population that address:
  - Access and Affordability
  - Improvements in care management and appropriate delivery of services
  - Enhanced transitions across health care settings and providers
  - Ensuring appropriate utilization of services for preventive health and chronic conditions; and
  - Improving health outcomes

Goals and health outcomes draw upon nationally developed guidelines, such as HEDIS, CAHPS, HOS, star ratings, structure and process measures, and evidenced based clinical practice guidelines

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Ongoing Performance Improvement Evaluation of the MOC

- Progress on goals is monitored and reviewed by the Quality Medical Management Committee, as specified in the QI work plan
- Annually, a formal evaluation is conducted of the quality improvement plan, including MOC performance data
- Results are analyzed for root cause and to identify barriers to achieving desired results; the Plan-Do-Study-Act (PDSA) methodology is utilized for improvement activities
- Results are disseminated through various communication methods to:
  - internal staff
  - committees
  - board of directors (BOD)
  - members
  - providers

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Provider Role & Support for Model of Care

- Encourage members to complete Health Risk Assessment and to call care coordination
- Review a member's individualized care plan and make modifications, as relevant
- Participate on a member's interdisciplinary care team, when possible
- Assist with discharge needs when notified of a transition of care
- Integrate MOC documents within the member's medical record

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Initial, Annual Training & HIPAA

- Annually, providers are required to attest or provide copies of staff and provider certificates of completion of:
  - Fraud, Waste & Abuse Training
  - General Compliance
  - Code of Conduct
  - Passport Advantage's Model of Care

- Annually, providers are required to provide a HIPAA training class for themselves and their staff.

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Next Steps

1. Ensure all providers and employees are trained on Passport Advantage's Model of Care as well as additional Compliance Training & Requirements as listed in the Provider Attestation

2. Ensure completed Attestation has been submitted to Passport Advantage by Authorized Representative

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Resources

- Medicare Managed Care Manual
- Medicare.gov
- Passport Advantage Model of Care
- Passport Advantage 2021 Evidence of Coverage
- Passport Advantage 2021 Summary of Benefits

Questions?

- Provider Services @ 1-844-859-6152
- Magan Wagner: Magan.Wagner@MolinaHealthCare.Com

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