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Network*Cares* (PPO D-SNP)
2023 Model of Care Training

Introduction

- This course is offered to meet the CMS regulatory requirements for Model of Care Training for the Network Health Dual-Eligible Special Needs Plan (D-SNP)
- It also ensures all providers who work with our D-SNP members have the specialized training this unique population requires

Network*Cares* contacts

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What is a Medicare Advantage Special Needs Plan?

- Special Needs Plans (SNPs) were created by Congress as part of the Medicare Modernization Act (MMA) of 2003, as a new type of Medicare-managed care plan focused on certain vulnerable groups of Medicare beneficiaries

- Network Health offers a dual-eligible SNP (D-SNP), called Network*Cares,* which includes individuals who are enrolled in Medicare and Medicaid

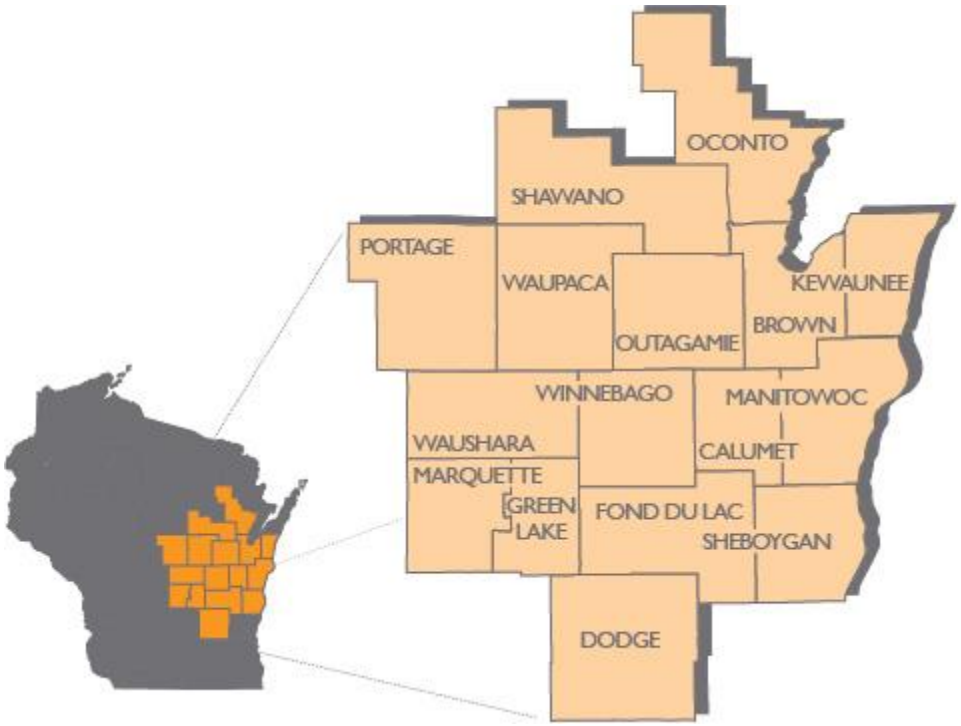
- Network*Cares* provides reimbursement for all medically necessary Medicare-covered benefits

Network*Cares* (PPO D-SNP) Eligibility and Membership

- Members must live in Network Health's 16-county northeast Wisconsin service area
- Members must have Medicare Parts A and B
- Members must have Medicaid from the state of Wisconsin
- Members are still in the Medicare program, have Medicare rights and protections and receive all regular Medicare covered services

Service Area

In 2023, Network*Cares* is available in the following counties



Network*Cares* Service Area

- Brown
- Calumet
- Dodge
- Fond du Lac
- Green Lake
- Kewaunee
- Manitowoc
- Marquette
- Oconto
- Outagamie
- Portage
- Shawano
- Sheboygan
- Waupaca
- Waushara
- Winnebago

Preferred Provider Organization (PPO)

- Network Health contracts with a network of providers within our service area to provide Medicare-covered services
- Members can use any provider who accepts Medicare and Medicaid
- Referrals are not required for members to see in- or out-of-network providers

What is covered?

- Network*Cares* follows Medicare's coverage rules to decide which services are medically necessary

- Network*Cares* provides reimbursement for all medically necessary covered benefits whether they are received in- or out-of-network

Supplemental Benefits

Vision benefit through EyeMed

- Annual routine vision exam (not covered by Medicare)
  - $0 copayment in-network
  - $40 reimbursement out-of-network
- Allowance offered towards eyewear and/or contacts, including enhancements
  - $400 allowance offered in-network
  - $400 reimbursement offered out-of-network

Comprehensive dental benefits with Delta Dental Medicare Advantage

- Up to $3,000 annually
- Preventive cleanings and exams – one per six months
- Bitewing X-rays – one per year
- Full mouth X-rays – one per five years
- Basic – fillings, extractions and repairs at 100 percent
- Major – periodontics and oral surgery at 50 percent
- No deductible

Supplemental Benefits

Over-the-Counter (OTC) allowance of $60 per quarter

- Benefit allows the member to order OTC products – some examples include the following
  - Denture cleaning tablets/denture cream
  - Diabetic socks
  - Face masks/gloves
  - Pain relievers
  - Hand sanitizer
- These items must be ordered from the *OTC Catalog*
  - D-SNP members receive a printed copy in the mail with their 2023 member guide

SilverSneakers® fitness

- Provides access to more than 16,000 gyms nationwide

Supplemental Benefits

Hearing

- Annual routine hearing exam (not covered by Medicare)
  - $0 copayment in-network
  - $40 reimbursement out-of-network
- Select hearing aids available for $495-$1,695 per device
  - Includes fitting and follow up visit
- Members should check their Medicaid coverage first

Health Risk Assessment (HRA) Reward

- Earn a $50 reward for completion of a health risk assessment

Supplemental Benefits

Meal delivery

- 28 meals delivered to your home after qualifying hospital, hospital observation or skilled nursing facility stay
- Available through Mom's Meals
- D-SNP members can contact their Network Health care manager to take advantage of this benefit

Non-emergency transportation

- Up to 24 one-way rides within the Network Health service area
- Provided through Aryv
- Member must connect with their care manager within seven days of the qualifying stay to arrange the meal delivery

2023 Chronic Condition (SSBCI) Benefits

Acupuncture

- Maximum 12 visits per year for members who are undergoing chemotherapy and experiencing severe nausea

Transportation

- An additional 24 one-way rides for members with end-stage renal disease to get to and from dialysis

In-home palliative care

- One home-based palliative care consultation and evaluation and up to two follow up home-based palliative care visits for members with the following
  - Cancer
  - Congestive heart failure
  - Chronic obstructive pulmonary disease (COPD)
  - Chronic kidney disease
  - End stage renal disease
  - Rheumatoid arthritis
  - Alzheimer's
  - Parkinson's
  - Multiple sclerosis
  - Liver cirrhosis

Coordination of Benefits

- Medicare (Network*Cares*) is the primary insurance
- Medicare (Network*Cares*) pays first, then Medicaid pays up to the Medicaid-approved amount
- Providers should not bill the member any unpaid balance

Personal Service

Network*Cares* care management team includes the following.

- Social workers (SWs) and registered nurses (RNs) provide care management services to members, which includes assisting members with accessing community services and coordinating medical care
- Pharmacists and medical directors are available for case consultation and to provide clinical guidance when appropriate
- A member of the Network*Cares* team contacts members to complete the health risk assessment

D-SNP Model of Care Goals

- Improve access and affordability of health care needs
- Improve coordination of care through the direct alignment of the health risk assessment, individualized care plan and interdisciplinary care team
- Improve care transitions across the health care settings and providers
- Improve utilization of services for preventive health and chronic conditions

D-SNP Care Coordination

The Centers for Medicare & Medicaid Services requires D-SNP members to be managed by using the following.

- **Health Risk Assessment (HRA)**
  - Initial HRA must be completed within 90 days of member's effective date
  - Annual HRA must be completed within 365 days of the previous HRA
- **Individualized Care Plan (ICP)**
- **Interdisciplinary Care Team (ICT)**

Health Risk Assessment

Topics assessed in both Initial HRA and annual HRAs

- Medical history (chronic conditions, emergency room visits, hospitalizations, medications, etc.)
- Psychosocial (living situation, behavioral health, socio-economic needs, etc.)
- Functional status (activities of daily living, safety, etc.)
- Cognitive functioning
- Advance directives

Health Risk Assessment

ICP Development

- All Network*Cares* members are assigned a social worker (SW) or registered nurse (RN) who is responsible for the care management plan and for supporting the member through transitions

Personnel

- A member of the Network*Cares* team contacts members to complete their HRA via phone
- The member's assigned SW or RN is responsible for reviewing, analyzing and stratifying health care needs

Communication Mechanisms

- The member's assigned SW or RN discusses with the member/member representative, by phone or in person, the HRA results as a basis for developing or modifying an individualized care plan

Individualized Care Plan

ICP Components

Individualized care plans

- Self-management goals and objectives
- Personal health care preferences
- Description of services tailored to the member's needs
- Identification of goals
- Member representative or caregiver role(s) related to interventions, as applicable
- Other components as identified by member or care manager

Setting and assessing prioritized goals

- Follow up on identified barriers to meeting goals
- Monitor condition(s) for red flags
- Facilitate activation of advance directive, if needed
- Offer resources to be used by member
- Collaborative approaches for member and family participation
- Follow up communication plan and schedule with members, providers and community partners

Individualized Care Plan

ICP Review

- The member's assigned SW or RN reviews, updates and/or implements an ICP with the member/responsible party at least annually or as needed, if the member's condition(s) change

ICP Communication

- The ICP and revisions are communicated by the member's assigned SW or RN to the member/member representative by phone, electronically, fax or mail.
- The RN or SW may also contact the community care partner and/or network providers by phone, fax or mail as a result of the communications plan developed during the care planning session with the member or member representative

D-SNP Interdisciplinary Care Team

Every Network*Cares* member has an Interdisciplinary Care Team (ICT) that can vary depending on the needs of the member.

Composition of the ICT

- The member
- The member's assigned care manager (RN or SW)
- The member's personal doctor
- Any "as needed" participants

Examples of "as needed" participants

- Community care partner
- Restorative health specialist (physical, occupational, speech)
- Home care nurse, home health aide, community resources
- Pharmacist, dietitian, nutritionist
- Specialist physicians

D-SNP Interdisciplinary Care Team

Facilitating Member Participation

- Upon enrollment in care management, a member/member representative receives written communication including a welcome letter and care coordination brochure
- While involved in active care management, members or member representative are involved in ICP development

How the ICT Operates and Communicates

- All members are assigned an RN or SW who is responsible for the care management plan and supporting the member through transitions
- The RN or SW works with the member and other ICT participants to develop an individualized care plan

D-SNP Interdisciplinary Care Team

Primary Care Model of Health Care

- Network*Cares* operates under a primary care model of health care
- The personal doctor–also known as the primary care practitioner (PCP)–is responsible for directing and coordinating specialty care
- Members have access to all plan providers
- Network Health's care managers facilitate and encourage communication between the member and member's PCP

Care Management

- The member's RN or SW is responsible for coordinating health care management activities
- The plan requires prior authorization or prior notification for certain services

Care Transitions

Care Transitions Process

- The assigned RN or SW will attempt to contact all D-SNP members within three business days of notification from an in-network inpatient hospital stay
- The assigned RN or SW and member/member representative will work together to update the member's ICP
- ICP will be communicated to applicable members of the member's ICT
- If available, information about other care transitions such as a skilled nursing facility stay, observation stay or emergency department visit will be reviewed with the member.
    - ICP will be updated, as needed

Care Management for the Most Vulnerable Populations

There are several ways to identify the most vulnerable individuals between regular reassessments.

- A member, member representative or provider may contact any member of the care management team with a concern
- HRA, claims and authorization data is used to identify members who have experienced a readmission and are considered high risk

Summary

- Network*Cares* is a dual-eligible special needs plan (D-SNP)
- To be eligible, members must live in Network Health's 16-county northeast Wisconsin service area and be enrolled in Medicare and eligible for Medicaid from the state of Wisconsin
- Network*Cares* members have an interdisciplinary care team which consists of the assigned RN or SW, the member's PCP, the member/member representative and any other identified participants, as appropriate
- The D-SNP Model of Care goals include the below
  - Improve accessibility and affordability of health care needs
  - Improve coordination of care through the direct alignment of the HRA, ICP and ICT
  - Improve utilization of services for preventive health and chronic conditions

What is the Care of Older Adults (COA) Measure?

The intent of this measure is to ensure that older adults receive the care they need to optimize their quality of life.

As the population ages, physical and cognitive function can decline, and pain becomes more prevalent. Older adults may also have more complex medication regimens. Screening of elderly patients is effective in identifying functional decline.

Eligible Population

- Medicare-special needs population
- 66 years of age and older as of December 31 of the measurement year

Exclusion

- Members who received hospice care anytime during the measurement year

Three Reported Indicators

Three indicators are reported for COA

- Medication review – by prescribing practitioner or clinical pharmacist
- Functional status assessment
- Pain assessment

Requirements for Indicators

Medication review

At least once during the calendar year, a medication review must be administered.

- Medication list in the medical record, and evidence of a medication review signed by a prescribing practitioner or clinical pharmacist and the date it was performed
- Notation that the member is not taking any medication and the date when it was noted

Requirements for Indicators

Functional status assessment

At least once during the calendar year one of the below should be assessed.

- Instrumental activities of daily living or activities of daily living
- Result of standardized functional assessment tool

Requirements for Indicators

Pain assessment

At least once during the calendar year, one of the below pain assessments must occur.

- Documentation that the patient was assessed for pain (which may include positive or negative findings for pain)
- Assessment result using a standardized pain assessment tool

Qualifying Codes

Medication Review & Medication List

- CPT: **90863, 99483, 99605, 99606**
- CPT II: **1160F, 1159F**
- HCPCS: **G8427**

Transition of Care Management Services

- CPT: **99495, 99496**

Functional Status

- CPT: 99483
- CPT II: 1170F
- HCPCS: G0438, G0439

Pain Assessment

- CPT II: 1125F, 1126F

CMS Star Measures

Dual-Eligible Special Needs Plan (D-SNP)

2023 Star Rating*

(Rated on a scale of 1 through 5, with 5 being the best)

SNP Care Management – 4 Star

COA-Pain – 5 Star

COA-Med review – 5 Star

**The Network Health Medicare Advantage 2023 PPO plans earned a 5 Star Rating overall.*

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Thank You

Every year, Medicare evaluates plans based on a 5 Star rating system.

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