Model of Care (MOC) Training 2027
Dual Special Needs Plan (DSNP)

Peak Health Proprietary & Confidential

TRAINING OBJECTIVES & ATTESTATION

Training Objectives:

- Provide understanding of DSNP
- Describe the annual model of care training requirement
- Describe the model of care
  - **Elements:** Health Risk Assessment (HRA), Face-to-Face Encounter, Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT), Transitions of Care
- Attest Training Completion via Workday or Web-Based Access

Attestation:

To ensure you receive credit, **make sure you attest to completing this training**. You can attest by:

Following the link at the end of this presentation



Visiting our website:
Peak Health - Helping You Reach New Heights
Providers Scroll to bottom of page, under Tools & Resources, and select Forms

CMS REQUIREMENTS

The **Centers for Medicare & Medicaid Services (CMS)** requires all contracted medical providers and staff receive basic training about the **Dual Special Needs Plan (DSNP) Model of Care (MOC)** and to annually complete a refresher training.

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

This training guide will outline the **DSNP Model of Care** and how that is delivered through our care management staff in partnership with our network of contracted providers.



MODEL OF CARE OVERVIEW

A **Model of Care** is a comprehensive plan that outlines how Peak Advantage Medicare Plans will provide care to specific populations with unique health needs known as a **Special Needs Plan (SNP)**.

It is a framework that details how Peak Health will identify, address the needs of its members, ensuring they receive specialized care and support.

The **Model of Care** is based on NCQA's evaluation of scoring guidelines of criteria established by CMS and is organized into **four standards**.

- MOC 1: **Description** of the **SNP Population**
- MOC 2: **Care Coordination**
- MOC 3: **Provider Network**
- MOC 4: **Quality Measurement** & **Performance Improvement**

MODEL OF CARE GOALS

Each plan must develop a **Model of Care and a Quality Improvement program** and **evaluate the effectiveness**.

The MOC is a plan for delivering care management and care coordination to:

1. Improve quality
2. Increase access to care
3. Create affordability
4. Coordinate care and Improve transitions across specialties
5. Provide seamless transitions of care
6. Improve use of preventative health services
7. Improve member health
8. Drive member satisfaction

MOC 1: DESCRIPTION OF THE SNP POPULATION



Peak Rise will serve people who are dually- eligible for Medicare and Medicaid.
DSNP

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

MOC 1: DSNP Population: Who Can Join a Dual-Eligible Special Needs Plan (DSNP)?

Medicare Eligible

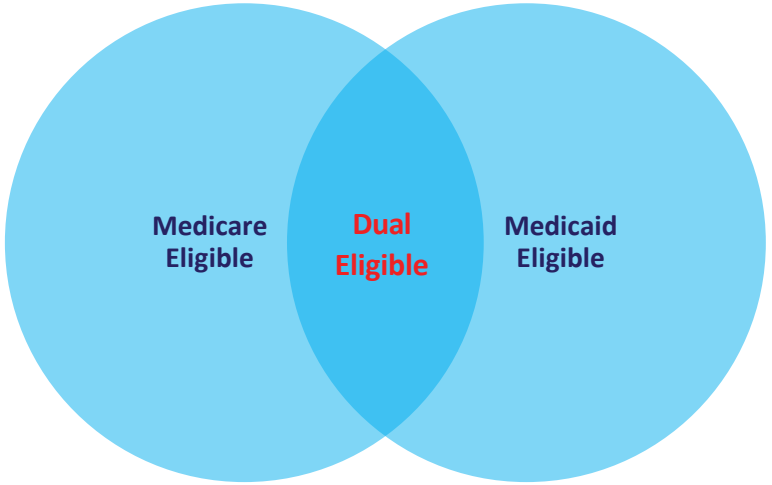
- People 65 and Older
- People of any age who have kidney failure or long-term kidney disease
- People who are currently disabled and unable to work

Dual Eligible

- Low-income people who are disabled and cannot work
- Low-income people 65+

Medicaid Eligible

- Pregnant woman
- Children under 19
- People who are 65+
- People who are blind
- People who are disabled
- People who need nursing home care



MOC 2: Care Coordination

Health Risk Assessment:

- **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**
- **Individualized Care Plan (ICP)** is developed based on the results of the assessment
- **Comprehensively assesses** the medical, functional, cognitive, psychosocial, and mental health needs of the member
- Must be completed **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

MOC 2: Care Coordination

Health Risk Assessment Analysis

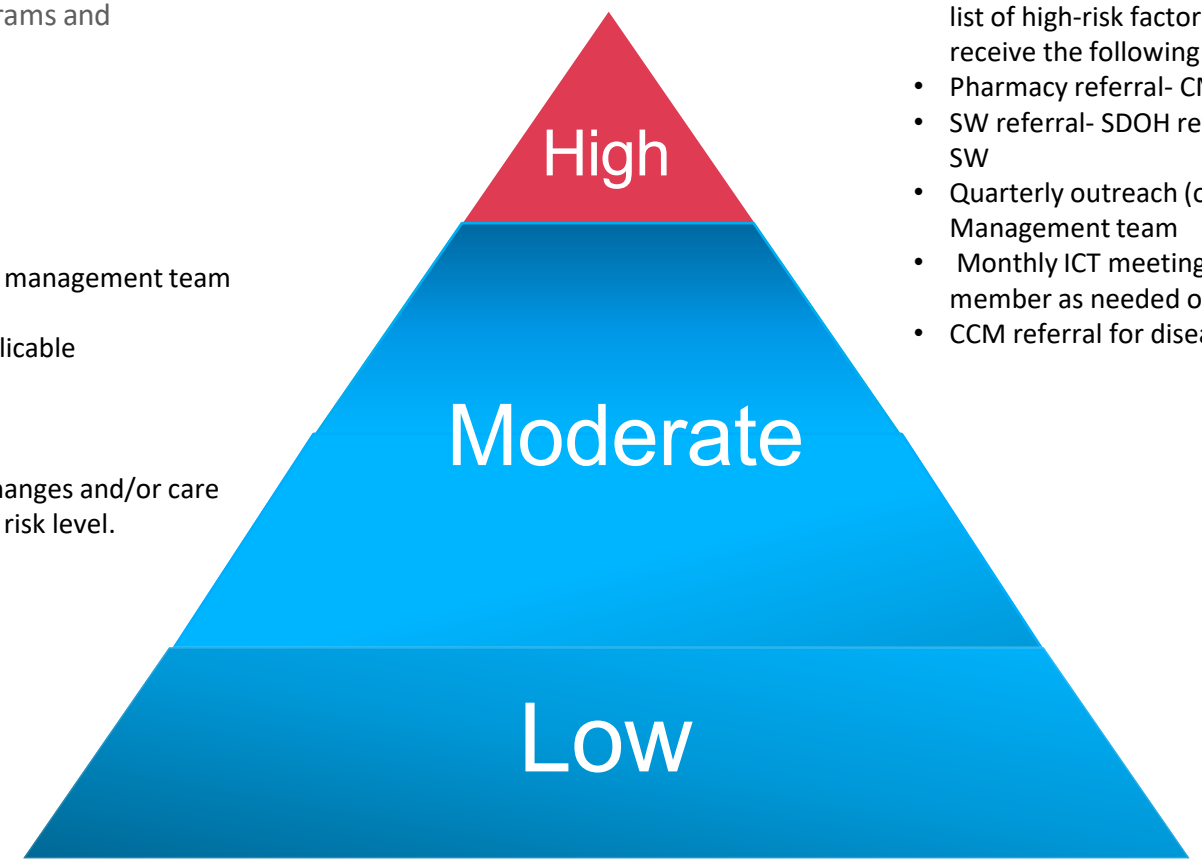
Each member undergoes risk stratification, acuity assignment and evaluation for assessment of proper care programs and clinical treatment.

Moderate Risk

- Annual outreach (or more often as needed) by care management team with ICP review and/or update
- Referral into a disease management program if applicable
- Pharmacy referral based on member need
- Social work referral based on member need
- ICT meetings as applicable, or at least annually
- Members will be monitored for any health status changes and/or care transitions that may support an adjustment of their risk level.

Low Risk

- A member of the Care Management team is responsible for the care plan and task assignment and routine outreach.
- The members' care plan and HRAT are reviewed at least annually and assessed by the care team for any changes in member condition.
- Members will be monitored for any health status changes and/or care transitions that may support an adjustment of their risk level.

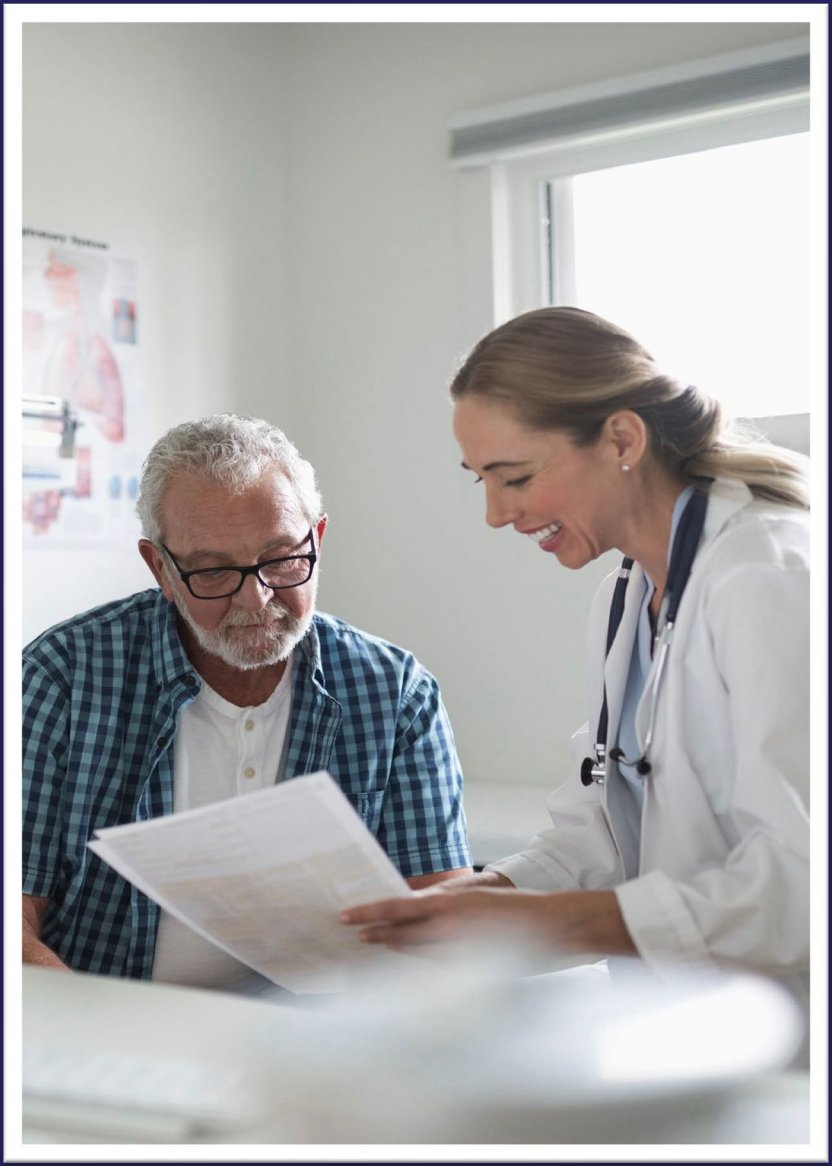


Members are **stratified based on their medical, behavioral and social needs** and placed into appropriate clinical programs to improve their health and well-being.

High Risk

- High Risk members are those members identified as having high or complex clinical needs that may require a higher level of care coordination and services with the likelihood of inpatient admission. An HRAT score and having at least 2 factors from the list of high-risk factors listed in MOC 1. These members will receive the following additional services:
- Pharmacy referral- CMR
- SW referral- SDOH review- some may even be followed by Peak SW
- Quarterly outreach (or more often as needed) by Care Management team
- Monthly ICT meeting to review any high risk/high need member as needed or at least annually
- CCM referral for disease management if agreeable

MOC 2: Care Coordination



Face-to-Face Encounter:

- All members are offered the opportunity for a face-to-face encounter for the delivery of health care, care management, or care coordination.
- Face-to-face encounters must occur with the member's consent ***annually*** beginning within the ***first 12 months of enrollment.***
- Must be between the member and a participant of the member's ICT.
- Must be in-person, or through a visual, real-time or interactive virtual encounter.

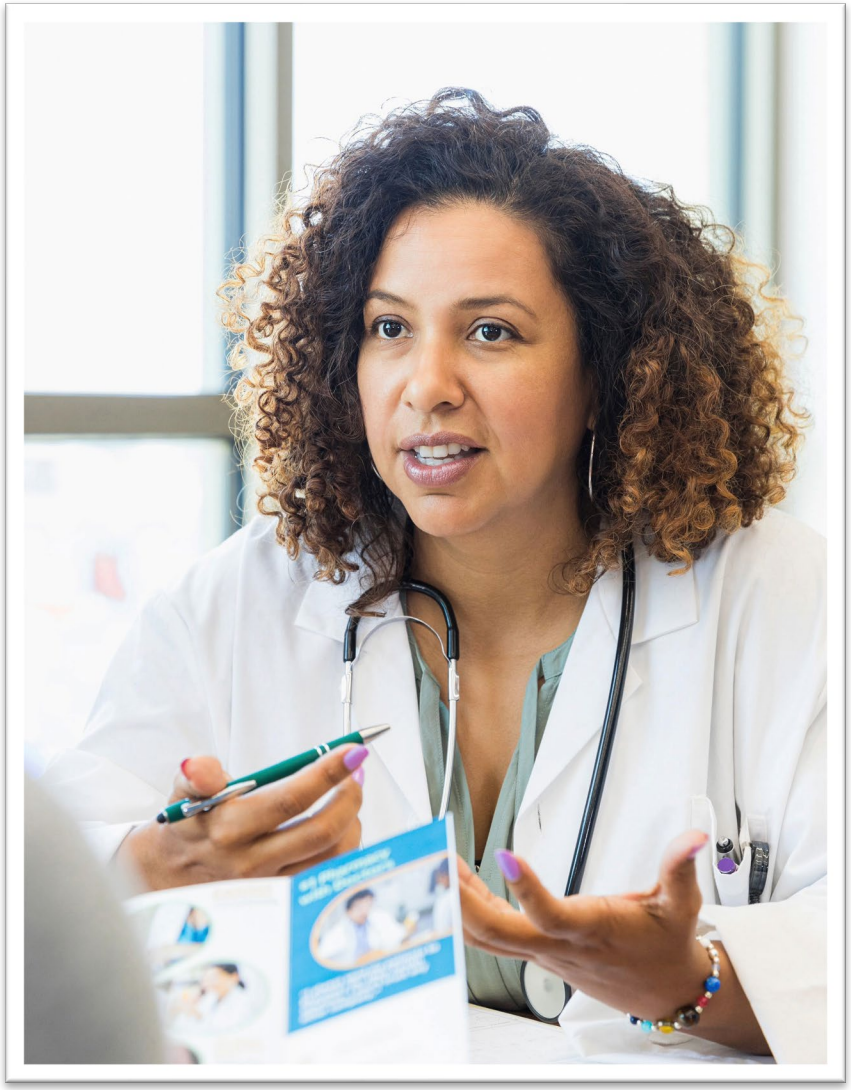
MOC 2: Care Coordination

Care Management Engagement 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.



MOC 2: Care Coordination



CARE PLANS FOCUSED ON:

- Creating **individualized & person-centered member** treatment plans
- **Actions and goals** with time frames for completion
- Developed on **assessment findings**, member preferences and input from the Intradisciplinary Care Team (ICT)
- **PCP outreach and engagement**

MOC 2: Care Coordination

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.

MOC 2: Care Coordination

INTERDISCIPLINARY 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



MOC 2: Care Transitions



ICT ROLES & RESPONSIBILITIES

- Providers (both in-network and out-of-network) are required to notify Peak Health when a care transition is planned or when a provider becomes aware that a member has experienced an unplanned transition. These requirements must be followed in accordance with Peak Health's prior authorization policies. Notification expectations are communicated to providers through the Peak Health Provider Manual, and the Peak Health website per clinical provider updates.
- Provider notification of planned or unplanned transitions to Peak Health must be submitted via provider portal submission, designated UM telephone lines, secure email, or fax
- Care Transition protocols utilized to support coordination of care across health care settings. The following factors are described.
  - Process and rationale for coordinating services
  - The staff involved in the management of care transitions
  - Support and education
  - Communication of the ICP and availability of health information

MOC 2: Care Coordination

Provider Roles & Responsibilities

- **Communicating** with case managers, ICT participants, members/caregivers about the ICP, course of treatment, and medical education.
- **Collaborating** with Peak Health to create the member's ICP.
- **Reviewing -**to member-specific information and notifications via the provider portal or member's EMR.
- **Providing** input to the ICP or ICT meeting by contacting the Peak Health CM team via phone, email, secure messaging or fax. (see contact list on last slide)
- **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 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.

MOC 2: Care Coordination

Peak Health Staff Roles & Responsibilities

- **Educating the member** on the importance of completing the HRA tool 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.

MOC 2: Care Coordination

ICT RESOURCES INCLUDE:

- Members have assigned **Care Managers** who are the point of contact for member needs.
- **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.
- **Contact information** for Peak CM team: Phone, email, fax- used to submit input to the ICP or ICT meeting. (see contact slide)
- Peak Health **website** for general plan information

MOC 2: Care Coordination

Support Tools

Provider Portal

The provider portal is the tool used to share the member's profile with the provider and chosen ICT. The portal comprises the HRA tool, ICP and member health records and is always available to the PCP. 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

Member Portal

The member portal is the communication tool used with the member and caregiver to share 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

MOC 2: Care Coordination

TRANSITIONS OF CARE

- Peak Health case managers will coordinate the **Transition of Care Process** with specific clinical practice guidelines and 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:

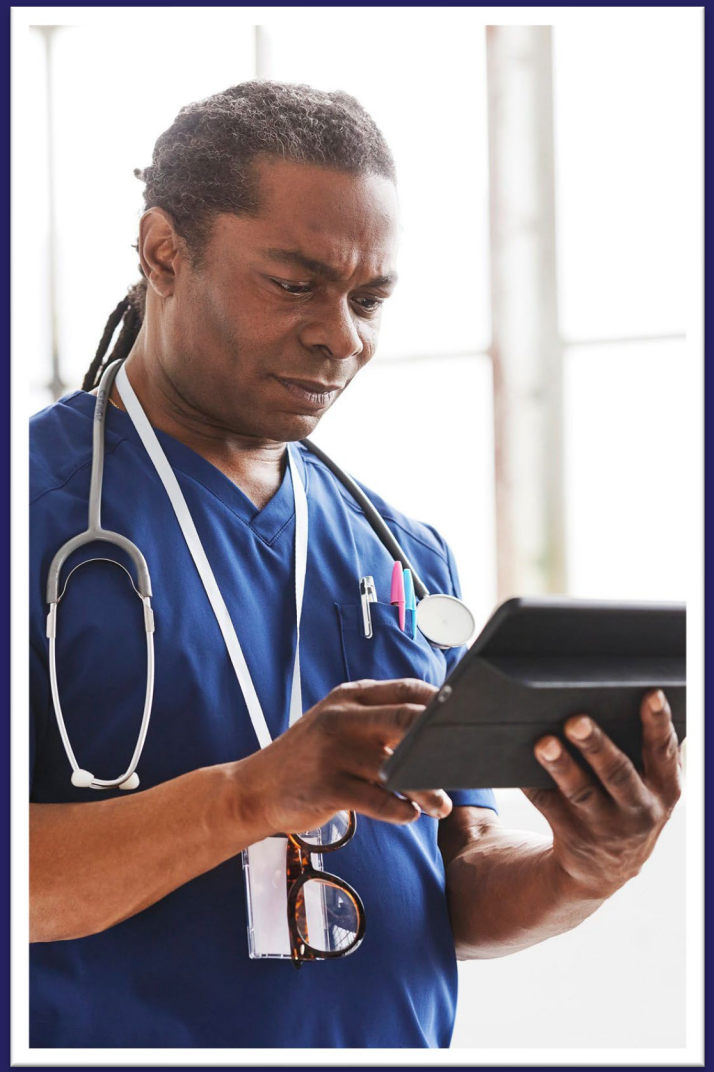
  - Help the member understand discharge diagnoses and instructions
  - Facilitate and schedule follow-up appointments
  - Assist with home health needs or ordering equipment
  - Help remove barriers to prescriptions
  - Coordinate resources for social determinant needs
  - Provide education on new or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

MOC 3: PROVIDER NETWORK

CMS Expectations of Network Management

- Prioritize contracting with Board Certified Providers
- Monitor network providers to assure they use nationally clinical evidence-based guidelines.
- Assure that providers are licensed and competent through a formal credentialing process
- Coordinate the maintenance and sharing of member's health care information among providers and the ICT

MOC 3: PROVIDER NETWORK



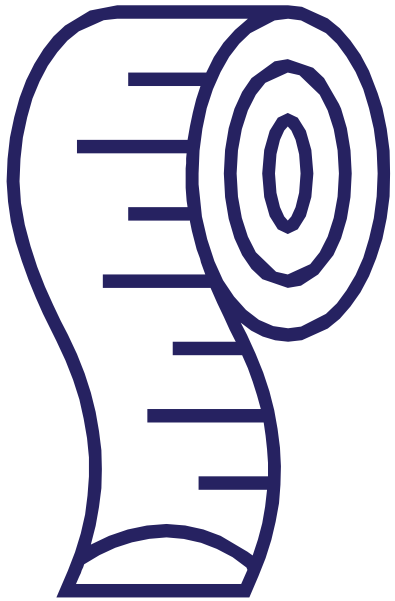
CLINICAL PRACTICE GUIDELINES

- Peak Health uses evidence-based, nationally recognized CPGs.
- CPGs are posted on the Peak Website for easy access.
- CPGs are intended to serve as a resource for providers and may be used as a guide for managing or treating a clinical condition.
- Information contained in the CPGs is not a substitute for a provider's clinical judgment.
- Certain CPGs may not always be appropriate for some members with complex health care needs.
- In the event a service requested, or member need arises, that does not clearly meet CPG requirements, the Case Manager will work with the ICT and the Utilization Management team to review the member's needs and services may be approved.

MOC 4: QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

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
- Health Outcomes Surveys **(HOS)**
- **CMS** reporting elements
- Clinical service **Quality Improvement** projects

MOC 4: QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

PERFORMANCE IMPROVMENT

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 health care 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



MOC 4: QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

Peak Health has a Quality Improvement program monitors the health outcomes and implementation of the Peak Health (plan name) by:

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



Contact Page

- DSNP Peak Care Management Phone number: 800-440-5417
- DSNP Peak Care Management Email: **PEAKDSNPCAREMANAGEMENT@peakhealth.org**
- DSNP Peak Care Management Fax: 304-974-3064
- 24/7 nurse triage line: 1-844-484-0307
- Peak Health Member services phone number: 1-855-962-7325
- Peak Health Provider services phone number: 1-833-969-7325
- Utilization Management Fax Number (Prior Auth): 304-974-3191
- Pre-cert line- 1-844-484-0302

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