MODEL OF CARE PROVIDER GUIDE — 2023

OptimaHealth®

OHP_PROV_012023

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Purpose of the Guide

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This document is designed to orient providers to the Optima Health SNP Model of Care Program. The Optima Health Provider Manual, a more extensive resource, is your source of truth for the health plan's policies and procedures.

Provider Training Requirements

Providers are required to review the Model of Care Provider Guide (MCPG) within 30 days of their initial orientation date as a newly contracted provider and by January 31 each subsequent year. **Attestation is required and will be recorded by provider (practice/facility) name, tax identification number (TIN) and email address.** Out-of-network providers must review the MCPG when they sign the requisite Single Case Agreement (SCA). The MCPG and Attestation can be located here and the attestation must be executed by the provider and verified by Sentara Health Plans (SHP), prior to SHP signing and returning the agreement.

Special Needs Plan (SNP) and Model of Care (MOC) Overview

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The Model of Care is an approach to identifying targeted populations for outreach, care management, and disease management, and which specifies expectations for member engagement, assessment, care planning, interdisciplinary team meetings, and other interventions to improve member outcomes and experience.

A Special Needs Plan (SNP), a Medicare Advantage (MA) coordinated care plan (CCP), is specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be:

- an institutionalized individual
- dual eligible
- an individual with a severe or disabling chronic condition, as specified by CMS

An SNP may be any type of MA CCP, including either a local or regional preferred provider organization (i.e., LPPO or RPPO) plan, a health maintenance organization (HMO) plan, or an HMO Point-of-Service (HMO-POS) plan. There are three different types of SNPs:

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

Importance of the MOC

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SNP MOCs are designed to optimize the health and well-being of members, particularly our aging, vulnerable, and chronically ill individuals by:

- matching interactions with member needs in their current state of health
- identifying care needs through a comprehensive initial assessment and annual reassessments
- creating Individualized Care Plans (ICP) with goals and measurable outcomes
- building an Interdisciplinary Care Team (ICT) with goals and measurable outcomes
- ensuring providers are involved in care decisions
- managing utilization effectively
- improving access to affordable medical, mental health, and social services

1) Mandatory High Priority Populations: members must receive high-intensity care management	2) Mandatory Priority Populations: members must receive care management; MCO determines intensity (high, moderate, low)	3) MCO-Determined Priority Populations: MCO determines care management and appropriate intensity (high, moderate, low)
• **CCC Plus Waiver members receiving PDN** • **Children receiving PDN through EPSDT** • **Ventilator-dependent members** • **Members transitioning from an NF to the community** (for a minimum of three months prior to the transition and six months after that transition, or longer if determined necessary by the MCO) **Foster Care/Former Foster Youth:** • members in foster care—or former foster youth—for three months after enrollment into the medicaid program, the child welfare system, or a new foster care home • **members in foster care three months prior to aging out of the child welfare system** • former foster youth for the first three months after aging out of the welfare system **Very Vulnerable Infants:** • substance-exposed infants for first three months of Medicaid enrollment • neonatal abstinence syndrome infants (following diagnosis or identification as part of this population, whichever is later) for first three months of medicaid enrollment • infants admitted to the NICU Level 3 for first three months of Medicaid enrollment	**Members Enrolled in Waivers or With I/DD** • CCC Plus Waiver members (not receiving PDN) • members enrolled in the DD Waivers—Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers • members with intellectual/developmental disabilities (I/DD) **Members in Hospice, Nursing Facilities, or With Dementia** • members receiving hospice benefits • nursing facility members (except for members in the "Mandatory High Priority Population") • members with cognitive or memory problems (e.g., dementia) **Members With SMI or SED** • members with serious mental illnesses and serious emotional disturbances (institutional and community dwelling) • members who receive Mental Health Services, as reflected in the Cardinal Care Summary of Covered Benefits Chart • **individuals in foster care and former foster youth who are not in the "Mandatory High Priority Population"**	**Pregnant Women and Children With High needs/Risk** • members with a high-risk pregnancy, as defined by the contractor • children and youth with special healthcare needs (CYSHCN) • children identified as at risk for developing developmental disabilities or delays (early intervention program) **Members With Other Complex/Chronic Conditions** • members with other complex or multiple chronic conditions (e.g., respiratory conditions, heart disease/heart failure, diabetes, cancer, etc.) • members with end-stage renal disease • members with brain injuries • members with physical or sensory disabilities **Members Meeting Utilization-Based Criteria** • Patient Utilization Management & Safety (PUMS) program members • members with three or more ED visits or hospitalizations related to their chronic medical, physical condition in the past 90 calendar days • members with one or more ED visits or hospitalizations related to their behavioral health or substance use condition in the past three months • members 19 years of age or older who have had two or more falls resulting in an ED visit, hospitalization, or physician office visit within the past 90 calendar days **Members With Behavioral Health (BH/SUD)** • members with behavioral health and substance use disorders **Members With High Social Needs** • members who are experiencing homelessness • justice-involved populations (includes individuals who have a history of incarcerations, probation, and parole supervision) • members who have other high social needs that pose a significant risk to their health, safety, and welfare **Other Populations Based on MCO Determination**

Optima Health MOC Plans

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Optima Health MOC plans are designed to ensure the provision and coordination of specialized services that meet the needs of the SNP eligible beneficiaries. Our SNP plans for 2023 include:

Dual-Eligible SNP: Optima Community Care (HMO D-SNP)

Members enrolled in D-SNP are both Medicare and Medicaid eligible, also called "dual eligible". D-SNP, a Medicare Advantage plan, combines Medicare Part A and Part B benefits, and Medicare Part D prescription drug coverage. Members are the most vulnerable population who are:

- frail
- disabled
- have multiple chronic illnesses
- have had multiple hospitalizations or skilled nursing facility admissions
- at the end of their lives

Chronic SNP: Optima Engage (C-SNP)

The C-SNP (Chronic Condition Special Needs Plan) is a specialized care coordination plan (program) that is an extension of our Medicare Advantage Plan. CMS requires that you have a Medicare Advantage plan to qualify for a C-SNP. C-SNP is solely Medicare related. Optima Health disease management programs include diabetes mellitus, chronic heart failure (CHF), and cardiac conditions.

1. Diabetes Mellitus

- This population commonly has comorbidities; a study of data reported that only 25% of Medicare Part B beneficiaries have diabetes without comorbidity.
- Patients in this population have complex needs and are more likely to see multiple providers, which can result in fragmented, suboptimal care coordination that can increase acute or emergency utilization.

2. Chronic Heart Failure

- This population commonly has comorbidities; a study from the American Heart Association reported that nearly 40% of CHF patients also have five or more noncardiac health conditions, which account for 81% of the total CHF inpatients.
- Patients in this population have complex needs and are more likely to see multiple providers, which can result in fragmented, suboptimal care coordination that can increase acute or emergency utilization.

3. Cardiovascular Conditions

- This population commonly has comorbidities; a study of data reported that only 22% of Medicare Part B beneficiaries have cardiovascular conditions with comorbidities.
- Patients in this population have complex needs and are more likely to see multiple providers, which can result in fragmented, suboptimal care coordination that can increase acute or emergency utilization.

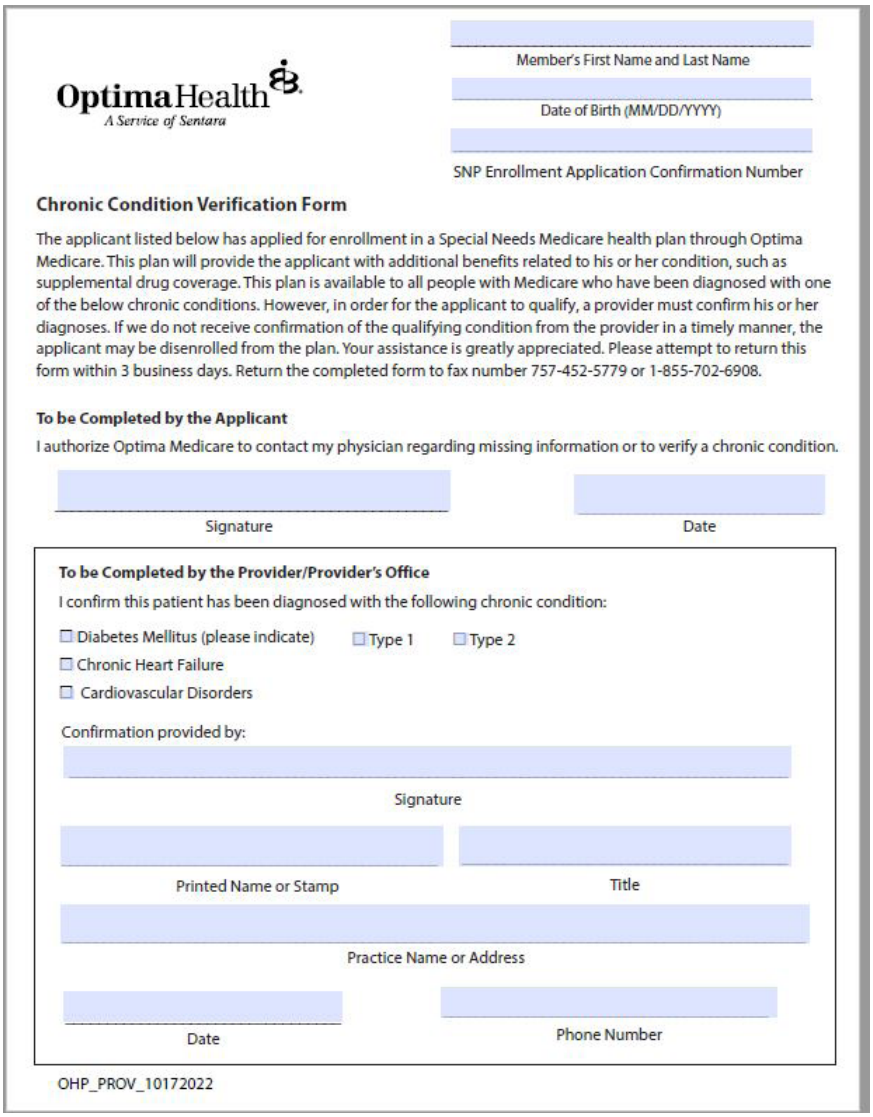
Member Verification and Enrollment – TIME SENSITIVE

Member enrollment into C-SNP is extremely time sensitive. CMS allows seven (7) days to complete the verification process. If enrollment and verification are not completed within this timeframe, the member cannot be enrolled in the C-SNP plan.

It is critical that providers verify the member has been diagnosed with one or more of the qualifying chronic condition (s) on the same day the request is received.

Workflow:

- Day 1: Case Manager contacts the provider office to confirm fax number, explain reason for provider verification and faxes the form to the provider of record.



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Member's First Name and Last Name

Date of Birth (MM/DD/YYYY)

SNP Enrollment Application Confirmation Number

Chronic Condition Verification Form

The applicant listed below has applied for enrollment in a Special Needs Medicare health plan through Optima Medicare. This plan will provide the applicant with additional benefits related to his or her condition, such as supplemental drug coverage. This plan is available to all people with Medicare who have been diagnosed with one of the below chronic conditions. However, in order for the applicant to qualify, a provider must confirm his or her diagnoses. If we do not receive confirmation of the qualifying condition from the provider in a timely manner, the applicant may be disenrolled from the plan. Your assistance is greatly appreciated. Please attempt to return this form within 3 business days. Return the completed form to fax number 757-452-5779 or 1-855-702-6908.

To be Completed by the Applicant

I authorize Optima Medicare to contact my physician regarding missing information or to verify a chronic condition.

Signature

Date

To be Completed by the Provider/Provider's Office

I confirm this patient has been diagnosed with the following chronic condition:

☐ Diabetes Mellitus (please indicate) ☐ Type 1 ☐ Type 2
☐ Chronic Heart Failure
☐ Cardiovascular Disorders

Confirmation provided by:

Signature

Printed Name or Stamp

Title

Practice Name or Address

Date

Phone Number

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- Day 2: If verification form has not been returned by the provider, Optima Health will start the following up process with the office.

Care Management Model

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The Care Management model includes four levels of increasing intensity: care coordination for those with minimal needs and three levels of care management intensity to include low, moderate, and high.

Care Coordination

Population of Focus: Individuals identified as not being in a priority population or otherwise requiring care management.

Key Activities: Initial screening; assessing and coordinating access to needed services (e.g., making referrals); identifying individuals who require care management, as needed; lower staffing requiring; responsive to requests for assistance

If the care coordinator determines that a full HRA and ICP are warranted, the member would transition to care management at the appropriate intensity level.

Care Management:

Populations of Focus: Priority populations according to DMAS and MCOs
Key Activities: Developing comprehensive and centralized care plan, managing physical/behavioral/Rx needs, making timely and necessary referrals, monitoring SDOH needs, implementing and leading interdisciplinary care team, etc.

Low intensity | Moderate intensity | High intensity

Timelines, contact frequency, staffing ratios increase based on level of intensity assigned

- MCOs must assign DMAS mandatory "priority populations" into care management
- MCOs must also identify and assign other individuals who should receive care management even if they do not fit into the priority populations but have increased levels of needs and risk

Members with acute/episodic conditions would transition from care management to care coordination when the MCO determined care management is no longer needed

Supporting levels of care and administrative transitions:

- Supports transitions between clinical settings and the community such as hospital discharges, nursing facility transitions, foster care transitions, etc.
- Minimizes disruptions during transitions between MCOs/FFS/Medicaid eligibility or due to provider contract termination.

Case Management

Clinical case managers assist with member's healthcare needs:

- All SNP members are enrolled in case management. Members have the option of declining participation in case management but will remain assigned to a case manager.
- An individualized care plan (ICP) is developed for each member.
- Members are stratified according to their risk profile to trigger focus on the most vulnerable.

The MOC is designed to ensure the provision and coordination of specialized services that meet the needs of the SNP eligible beneficiaries. Our overall goals are as follows:

1. Addressing the member's healthcare needs as well as the non-medical needs that impact access to healthcare.
2. Improve access to affordable care by making sure our benefits are affordable.
3. Improve coordination of care at both the plan and care levels. Integration of both Medicare and Medicaid ensures the right care for the right member at the right time through the right provider.
4. Support all transitions of care, including facility to facility as well as life transitions.
5. Ensure our members are protected and receive early intervention.
6. Facilitate appropriate utilization of services by ensuring the right care for the right member at the right time through the right provider.
7. Taking the steps necessary to ensure access to benefits and services.
8. Utilize provider network to support specialized needs of our members by having the right providers engaged with our members care and supporting our provider network when needed.

Case Management

SNP Coordination goals include ensuring:

- Members are informed of benefits offered by both programs.
- Members are provided with information on how to maintain Medicaid eligibility.
- Members have access to staff who have knowledge of programs and community resources.
- Members are informed of rights to pursue appeals and grievances through both programs.
- Members are provided information on how to access providers that accept Medicare and Medicaid.
- Plan provides clear communication regarding claims and cost-sharing from both programs.

CMS requires all Special Needs Plans to develop and implement an Individualized Care Plan for each member enrolled in SNP.

- Clinical Case Manager will work with the member or the member's caregiver in developing and implementing the member's ICP.
- ICP is based on the member's HRA and any identified opportunities for intervention.
- ICP is prioritized to consider the member's preferences and their desired level of engagement.
- ICP is updated and revised to reflect any change in the member's medical and psychosocial status, including the evaluation of identified goals and whether they have been met.
- ICP is communicated for coordination of care and when there is a transition to a new care setting, such as a hospital or an SNF.
- ICP is also provided to PCP and member's caregiver.

Interdisciplinary Care Team

CMS requires all SNPs use an Interdisciplinary Care Team (ICT) in the care management of each individual enrolled in the SNP. This team is made up of physicians, clinicians, and any other healthcare practitioners involved in the member's care.

The ICT contributes to improving beneficiary health status. The initial meeting of the ICT occurs after the ICP has been developed. The team continues meeting regularly as needed to manage the medical, cognitive, psychosocial, and functional needs of the member.

ICT Members:

- Member/Caregiver
- SNP Medical Director
- SNP Clinical Director
- Case Managers
- Network Practitioners

Optional ICT Members:

- Specialty Providers
- Pharmacist
- Behavioral Health Specialists
- Social Worker
- Nurse Practitioner
- Palliative Care
- Home Care
- Dietitian/Nutritionist

Members can be faced with significant challenges when moving from one setting to another. The management of transition is focused on supporting our members with their treatment plan as they move from one setting to another to prevent readmissions or delay of care needs.

Personnel Involved in Coordinating Care Transitions

- Utilization Clinical Review Staff
- Case Manager
- Transition Case Manager/Additional Support Staff
- Hospital Case Manager/Discharge Planner

Specialized Intensive Care Management

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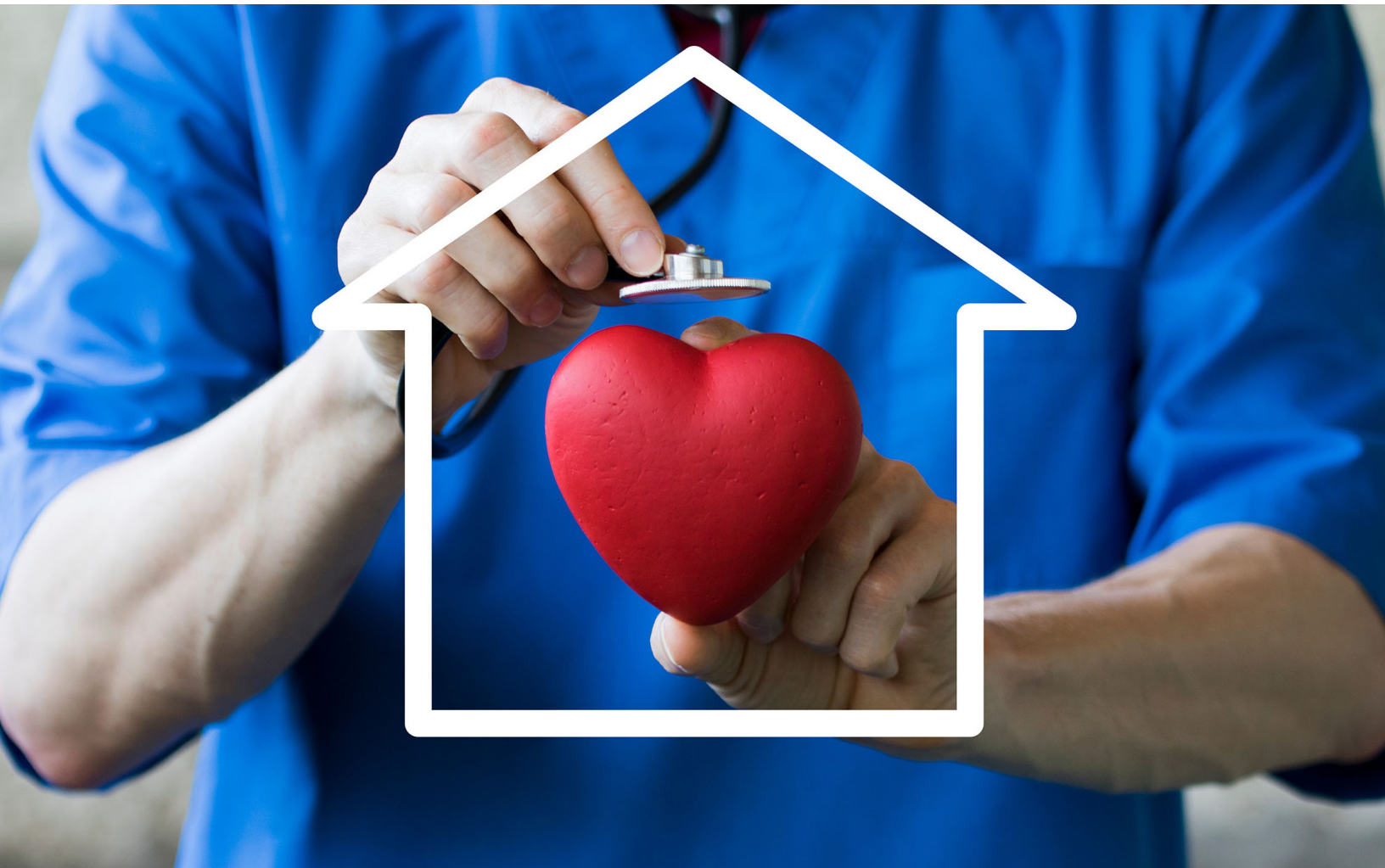
Specialized care managers provide expert and dedicated oversight, continually assessing the member's status and service needs, including:

- Comprehensive, whole-person assessments and care plans developed with input from the member, family, and care team.
- Close monitoring to ensure timely care and services, including nursing, DME, enteral nutrition, and supplies.
- Reporting of quality of care concerns to clinical leadership and provider concerns to network management.
- Proactively ensuring members are not at risk of not getting needed care and services due to:
  - denied service authorizations for any reason, including due to a provider or an MCO error
  - care managers being stretched too thin to provide proactive and effective monitoring
  - lapse in Medicaid coverage, which could result in lapse in care/adverse medical event
  - provider issues, including lack of specialized providers, poor quality service
  - lack of coordination with other insurance



Health Risk Assessment

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- A comprehensive initial assessment is completed within 90 days of enrollment.
- An annual reassessment of the individual's medical, physical, cognitive, psychosocial and functional, and mental health needs is also conducted.
- Members will be advised of their right to an Advanced Directive and Durable Power of Attorney. Additional information will be sent to the member regarding these topics if requested.

Cardinal Care provides the flexibility for MCOs to use telephone or video conference to administer the MMHS and HRA and develop the ICP. The MCO is, however, required to conduct:

- HRA in-person for members in High Intensity CM
- initial HRA and level of care assessments in-person for members in nursing facilities and CCC Plus Waiver members.

Optima Health has contracted vendors to provide healthcare and/or care management services. Here are some examples:

Vendor	Service
Nations Benefits	OTC, Dental, Grocery Allowance
Express Scripts	PBM
SilverSneakers	Fitness Membership
PAPA PALS	In-home Companions
Verida	Transportation Services

Quality Improvement and Performance

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Optima Health evaluates quality performance through the QIC oversight and annual performance evaluation:

- The Quality Improvement Committee comprises our Medical Director and various departmental directors who conduct a comprehensive and effective internal quality performance review. The QIC director works with the departments to collect, analyze, and report on data for evaluation of the MOC. Different reports are generated based on the specific needs and initiatives, as requested by the committee, to meet MOC standards and other improvement initiatives.
- Optima Health evaluates program effectiveness annually at a minimum to identify results from performance indicators, including lessons learned and challenges for the support of ongoing program improvements.
- Optima Health provides evaluation results to key stakeholders annually at a minimum. This evaluation allows the plan to analyze and assess how well the plan manages their SNP population.

Contract Alignment

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The majority of the consolidated contact incorporates the original requirements of the M4 and CCC+ contracts.

Provider Training Attestation

After reviewing this resource in full, please complete the MOC Provider Education Attestation for 2023 using this link. You can also access the form using the QR code.

Helpful Resources

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Optima Health Provider Manual

DMAS Provider Manuals

- EPSDT Supplement B

MES Provider Portal

Commonwealth of Virginia Referral Directory by City/County

Optima Health Quick Reference Resources

- Doing Business With Us
- Avoid Common Claims Errors
- Create Pre-Authorization Submissions Online
- Tips for Using Jiva
- Optima Health LTSS Billing Guidelines
- Optima Health Claims and Billing Quick Reference Guide

E-Booklets

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Doing Business With Us

Slide Presentations

- Transitioning to Cardinal Care