Hamaspik

MANAGED CARE

Provider Training

MODEL OF CARE TRAINING

2023

Hamaspik
MANAGED CARE

Table of Contents

Hamaspik Acronyms

- ICT = Interdisciplinary Care Team
- ICP = Interdisciplinary Individualized Care Plan
- HRA = Health Risk Assessment
- ADT = Admission, Transfer, Discharge
- MOC = Model of Care

*For all MOC terminology, please refer to the full Hamaspik Model of Care, available upon request.

Purpose

- Illustrate the purpose of the Model of Care
- Explain Dual Eligible Special Needs Plan (D-SNP) Benefits and Eligibility
- Review Hamaspik's D-SNP and MAP SNP Plan Benefit Package
- Clarify D-SNP and MAP Care Coordination and Navigation of Services

Introduction

As provided under section 1859(f)(7) of the Social Security Act (the Act), every Medicare Special Needs Plan (SNP) must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA).

The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.

Our Mission

Hamaspik Managed Care is committed to excellence in providing access to quality driven health care coverage in a culturally sensitive, timely and responsive manner.

Approval Process

- The NCQA MOC approval process scores each of the clinical and non-clinical elements of the MOC.

- SNPs are approved for one, two, or three-year periods.

- Hamaspik, Inc. has been approved for a three year period, expiring 12-31-2026.

Model of Care Overview

MOC Training for the Provider Network

Ongoing Performance Improvement Evaluation of the MOC

Dissemination of SNP Quality Performance related to the MOC

MOC Quality Measurement & Performance Improvement

Measurable Goals & Health Outcomes for the MOC

Measuring Patient Experience of Care (SNP Member Satisfaction)

Description of SNP Population & Plan

CMS contract includes two Special Needs Plans (SNPS):

- **Medicare Advantage Plan**
- **Medicaid Advantage Plus Plan**

Enrollment Criteria:

- **Dual eligible, entitled to Medicare Part A & enrolled in Medicare Part B.**
- **Have New York State Medicaid.**
- **Reside in the plan's service area and be US citizens or legal residents.**
- **To enroll in the MAP plan, members must also have a need for home and community based long-term care services.**

Covered Benefits

HAMASPIK MEDICARE SELECT DSNP

- √ Primary Care Physicians
- √ Specialists
- √ Inpatient & Outpatient Hospital Care
- √ Emergency & Urgent Care
- √ Ambulance Services
- √ Home Health Services
- √ Durable Medical Equipment (Medicare)
- √ Mental Health Services
- √ 24-Hour Nurse Hotline
- √ Diagnostic Testing
- √ Therapeutic Services
- √ Physical Therapy, Occupational Therapy, and Speech/language Pathology
- √ Over-the-Counter Health Items
- √ Healthy Foods Benefit
- √ Part D Prescription Drugs
- √ Skilled Nursing Facility care
- √ Vision & Eyeglass Providers
- √ Fitness Benefits
- √ Acupuncture
- √ Worldwide Emergency Coverage
- √ Assistance with Household Utilities

HAMASPIK MEDICARE CHOICE MAP

- √ Primary Care Physicians
- √ Specialists
- √ Inpatient & Outpatient Hospital Care
- √ Emergency & Urgent Care
- √ Ambulance Services
- √ Home Health Services
- √ Durable Medical Equipment (Medicare)
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- √ Physical Therapy, Occupational Therapy, and Speech/language Pathology
- √ Over-the-Counter Health Items
- √ Healthy Foods Benefit
- √ Part D Prescription Drugs
- √ Skilled Nursing Facility care
- √ Vision Benefits and Eyeglasses
- √ Acupuncture
- √ Worldwide Emergency Coverage
- √ Medical Transportation
- √ Dental Care
- √ Hearing Exams and Hearing Aids
- √ Personal Care Services (including CDPAS)
- √ Social and Adult day Care Services
- √ Home Delivered Meals
- √ Assistance with Household Utilities

Most Vulnerable Population

Most vulnerable enrollees

Those that require special health care services because of age-related physiological changes, multiple chronic physical and mental conditions, and limited social resources.

To aid most vulnerable SNP members

Hamaspik's Care Management (CM) team completes the Social Determinants of Health Assessment along with the HRA Tool, to determine each member's unique barriers and challenges.

Interdisciplinary Care Team(ICT)

Interventions are added into each member's ICP and reviewed during Interdisciplinary Care Rounds (ICR) with the full Interdisciplinary Care Team (ICT). ICT reviews each member's ICP in Interdisciplinary Care Rounds sessions.

Performance Improvement Project - SDOH

Hamaspik deployed a Performance Improvement Project to begin collecting SDOH data and creating immediate linkages to community and government resources for our membership, with domains like food and housing stability.

MOC 2 Element B: Health Risk Assessment Tool (HRAT)

The HRAT is comprised of questions from the CMS framework as well as from the Uniform Assessment System (UAS) prescribed by NYS Department Of Health (UAS-NY).

Initial and annual HRAT assessments

Hamaspik completes HRAT within 90-days of enrollment for its membership.

The period of initial HRAT completion begins post completion of the enrollment application and within 90 days of active enrollment into the DSNP or MAP plan.

Hamaspik then conducts the annual HRAT within one year of the initial HRAT.

Valuable data source

Information gathered by the HRAT, and other data sources are stratified into three levels of risk that drive the intensity of care coordination and frequency of member outreach required.

The risk level is based on the member's overall health status and stability, complexity of illness, treatment and medication regimen and ability to self -manage disease.

Use of HRAT information

The content of the HRAT has a direct effect on the development of the Interdisciplinary Care Plan (ICP) and ongoing coordination of Interdisciplinary Care Team (ICT) activities.

All HRAT are disseminated to the ICT during the Interdisciplinary Care Rounds (ICR), as well as provided to the MAP assessors prior to a member's UAS assessment.

Care Transition & Continuity of Care

Upon notification of admission, the Transition of Care (TOC) team documents the plan's EHR, notifies NYS DOH, and outreaches to the facility, member, and ICT, to inform them of the member's admission as applicable. Service Interruptions are put in place.

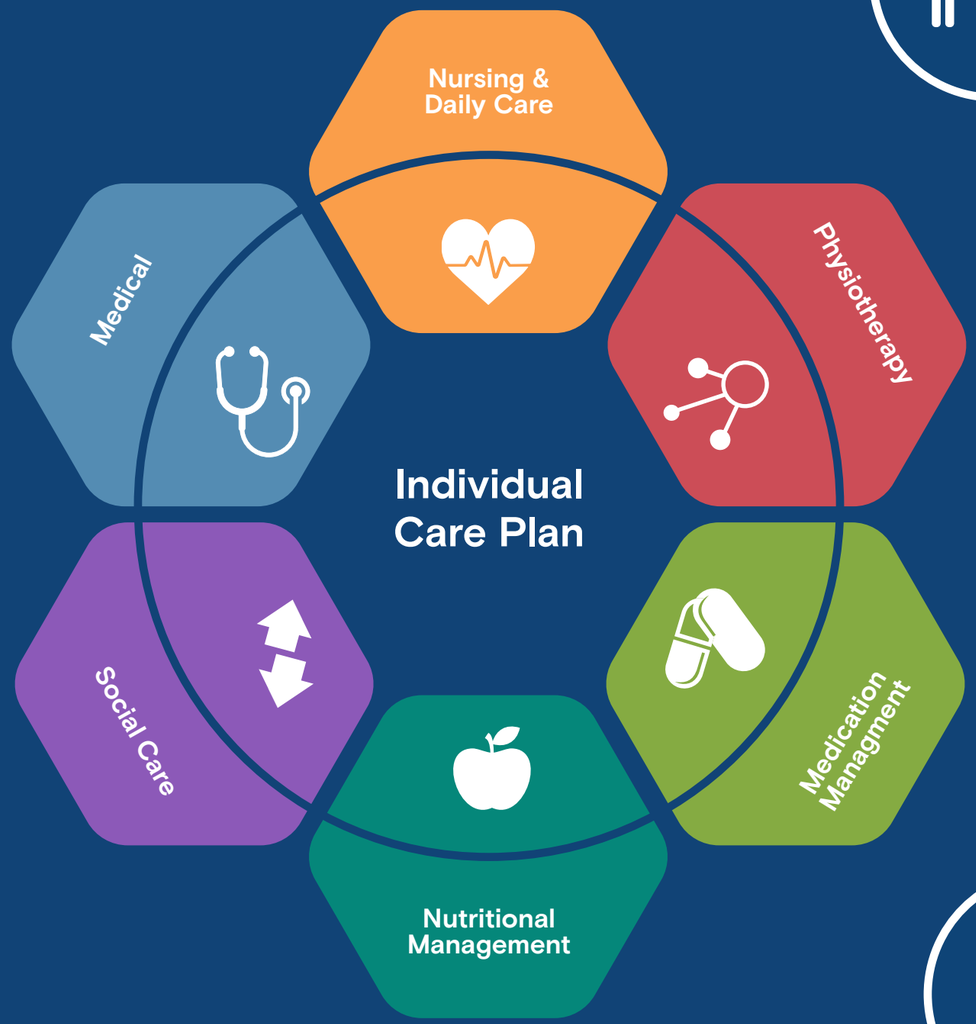
For transitions to and from inpatient and other healthcare facilities, the TOC Coordinator ensures that communication of pertinent information to the receiving location occurs within 1 business day of notification of the transition.

The TOC CM in collaboration with the primary Care Manager (CM) assesses and identifies a member's needs and communicates with the member, family, physician, and other health care providers, to meet the specific transitional care needs of the member within 2 days of notification of the inpatient/SNF admission or transition, and throughout the transition as needed.

The TOC CM notifies the Department of Health or associated MLTC of all member inpatient and SNF admissions within 48 hours of notification, through the Health Commerce portal. For members enrolled in a MLTC program, the TOC CM communicates with other interdisciplinary team members to facilitate transitional care coordination.

Individualized Care Plan (ICP)

The member is involved in the process of the care plan development.*



Hamaspik develops an Individualized ICP for each member, which serves as the basis for care managing the member throughout their enrollment.

Upon completion of the HRAT the Care Planner or supporting ICT member initiates the ICP with input from the Interdisciplinary Care Team.

The Care Planner, reviews the populated opportunities, goals, and interventions from the HRAT, and determines self-management goals and objectives to support the member in receiving healthcare services in alignment with their preferences.

The ICP is fully updated post HRAT and therefore if a member's goals are not met upon review of the Initial, Annual, or reassessment HRAT, the Care Planner addresses barriers and other hindrances with the ICT.

The ICP is adjusted and updated over time, based on the HRAT, Social Determinants of Health and UAS Assessments, quality gaps in care statuses, and claims data, as well as by the assigned Care Management staff who add the updates to said statuses for each opportunity, goal, and interventions.

Provider collaboration with the interdisciplinary care team and the development of the beneficiary's individualized care plan (ICP) will occur in multiple ways:

The care manager may reach out to engage the PCP in care planning for a new beneficiary.

The focus of these discussions would include the results of the member's health risk assessment, diagnoses and their treatment plan(s), medical history, medications, and other service needs or barriers to care.

The provider's input is requested to assist the Interdisciplinary Care Team in the development of a comprehensive care plan.

The PCP is provided with a copy of the member's Interdisciplinary Care Plan (ICP). Additionally, any provider may request review of the ICP.

When the member experiences a change in setting, the care manager will reach out to providers by phone, in order to ensure a smooth discharge plan, and to ensure that the member's follow up care is scheduled and completed.

The Provider Manual includes information about the model of care and interdisciplinary care teams.

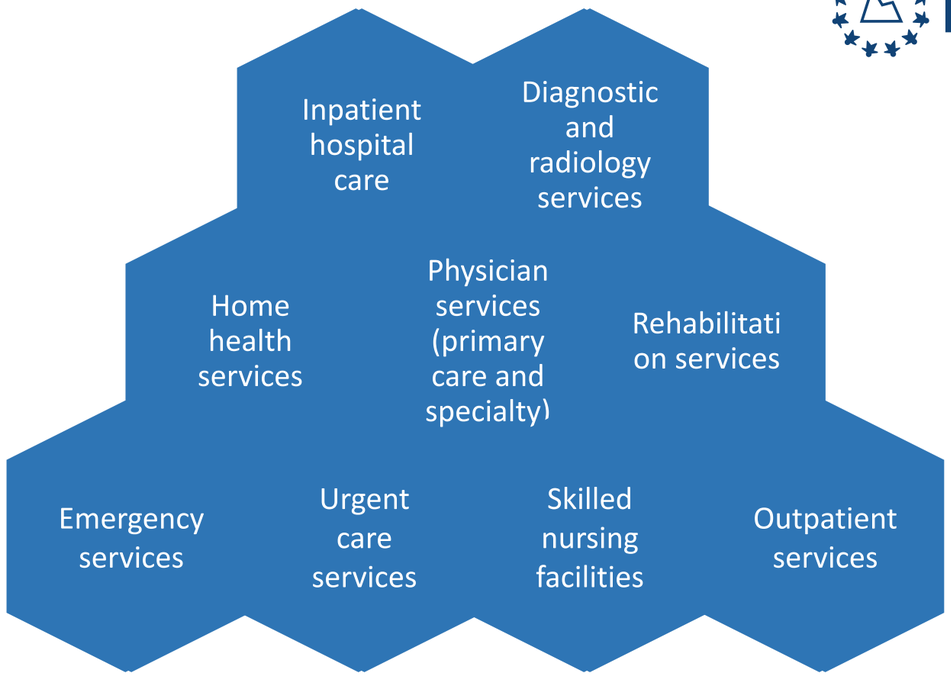
This information is also posted on the plan's website in the Providers section.

Provider Network

Hamaspik's provider network is inclusive of primary care and other specialty providers, hospitals, rehabilitation facilities, licensed home care agencies, and other provider types.

Providers collaborate with the ICT to ensure that member needs are met, appropriate services are authorized or coordinated, and to support care transition protocols.

Hamaspik will not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional acting within the scope of his or her license or certification under state law, solely based on the license or certification. **This prohibition does not preclude any of the following actions by the plan:**



- Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the enrolled Medicare Advantage beneficiaries;
- Use of different reimbursement amounts for different specialties or for different providers in the same specialty; or,
- Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

MOC 3 Element C: MOC Training for the Provider Network

The primary responsibilities of the Provider Relations department will be to partner, educate, support, and maintain relationships between Hamaspik and its network of providers.

Trainings will be provided to all new providers, as a component of the onboarding process that is completed after executing the agreement, and annual refresher training will also be provided.

Due to provider time constraints, the model of care training may most frequently occur when a care manager reaches out to the provider to discuss the condition of an actual member with complex needs.

In the context of a member assessment, development of a care plan, review of medications, or coordination of a hospital discharge, the Hamaspik care manager will reach out to the provider to obtain his input.

Provider Roles & Responsibilities

- Communicate with care Managers, ICT Members, Members and caregivers.
- Collaborate with our Organization on the ICP
- Participate in the ICT including Care Rounds
- Review and Respond to patient –specific communication
- Maintain ICP in member's medical record
- Remind member of the importance of the HRA and Annual Wellness Visit
- Encourage member to work with their ICT
- Send Medical Records
- Code claims appropriately
- Notify Care Manager of any ADTs
- Complete Medication Reconciliation post Discharge
- Complete Follow-up Appointments within 14 days of Discharges
- Complete MOC training upon onboarding and again annually

MOC Quality Measurement and Performance Improvement

- Hamaspik develops the Model of Care Quality Improvement Plan (QIP) by focusing on overall member health status and opportunities for improvement, leveraging the QIP workplan.

- The information is derived from surveys such as CAHPS and HOS, as well as regulatory reporting for and by CMS such as HEDIS, Call Center monitoring, Health Risk Assessment and other internal reporting data.

- The plan has an established Quality Improvement Committee (QIC) that meets quarterly to ensure that this data is reviewed, interventions are created and deployed to support continuous improvement.

- As of 2021, the plan collected data used for Quality Improvement Committee analysis to drive performance outcomes. As Hamaspik SNPs are new plans, the organization continues to include additional performance metrics as the plan becomes eligible for reporting to CMS and other governing bodies.

Org Chart - MLTC- October 2023

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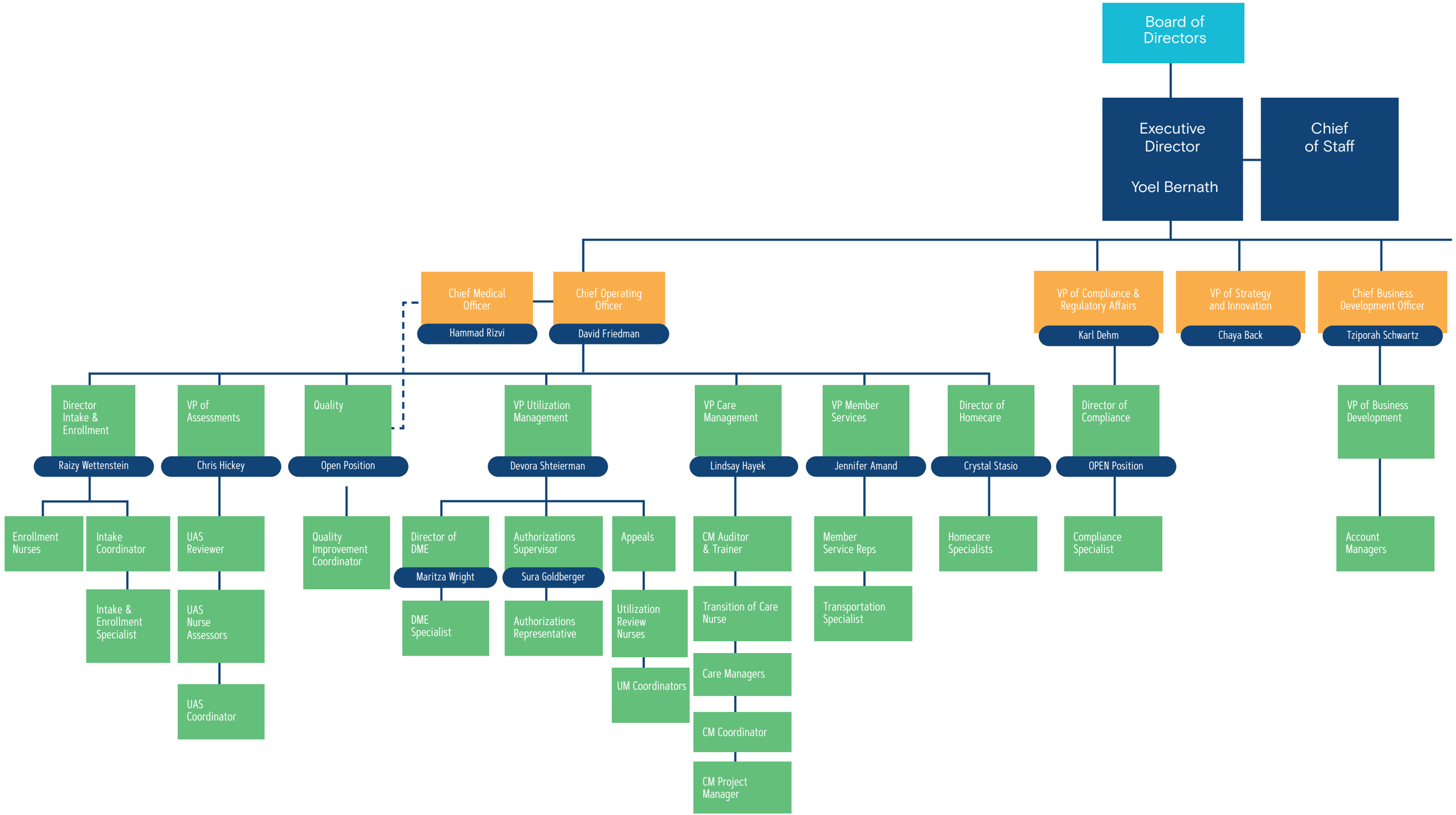

Org Chart - MLTC- October 2023

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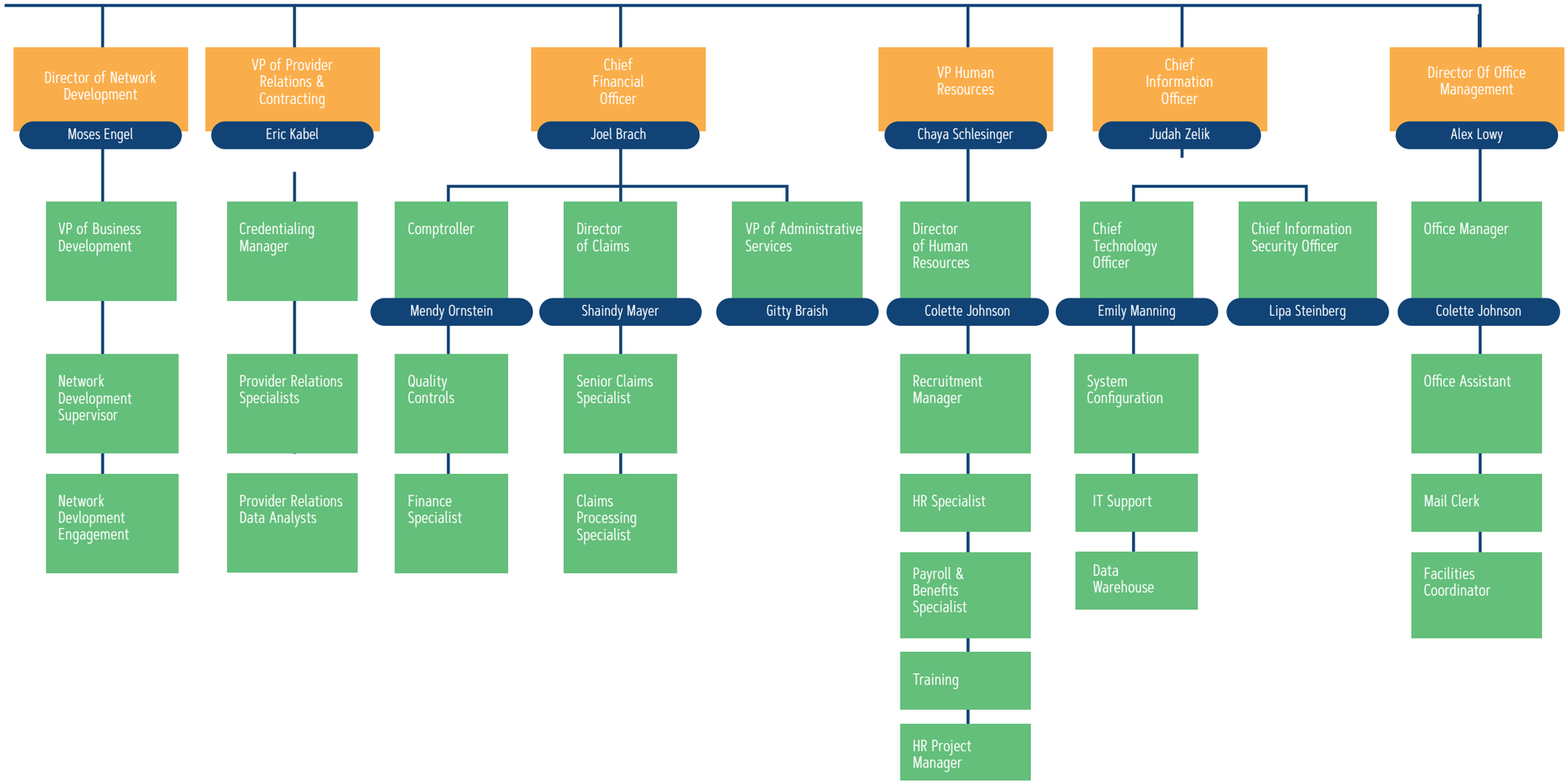

Any Questions?

Hamaspik

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