Model of Care Overview

Provider Training

As a Special Needs Plan (SNP), Highmark Wholecare is required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care (MOC). In accordance with CMS guidelines, Highmark Wholecare's SNP MOC is the basis of design for our care management policies, procedures, and operational systems that will enable our Medicare Advantage Organization (MAO) to provide coordinated care for special needs individuals.

Our MOC is a vital quality improvement tool and is integral to meeting the unique needs of each member. The MOC is overseen and governed within the Quality department to ensure effectiveness and identify the need to add or change offered services for the most vulnerable members including, but not limited to, those who are frail, disabled, or have multiple chronic conditions. It outlines the goals and objectives for targeted populations, a specialized provider network, the utilization of nationally recognized clinical practice guidelines, and the completion of health risk assessments and other key clinical functions.

The SNP MOC is divided into 4 main sections:

1. Description of the SNP population
2. Care Coordination
3. SNP Provider Network
4. Quality Measurement & Performance

This training will focus on the **SNP Provider Network** section and outlines what Highmark Wholecare expects from our providers in maintaining an effective MOC. The training should be reviewed and attested to on an annual basis.

SNP Provider Network - The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP members. The MOC ensures that the Provider Network is comprehensive and able to care for the unique and specific needs of the population by implementing the following elements throughout the SNP provider network.

1. Specialized Expertise
2. Use of Clinical Practice Guidelines
3. Care Transition Protocols

4. Annual Model of Care Training

Within the above elements, the MOC details the expectations Highmark Wholecare has for contracted and non-contracted providers.

The below is a summary of the expectations and the provider network composition:

- Highmark Wholecare expects all network practicing providers to utilize established clinical practice guidelines when providing member care to ensure the right care is being provided at the right time, as well as to reduce inter-practitioner variation in diagnosis and treatment.
    - We encourage practitioners to follow the adopted clinical practice guidelines but allow practitioners to execute treatment plans based on a member's medical needs and wishes. When appropriate, behavioral health guidelines are followed utilizing national clinical criteria.

- During a care transition, it is expected that the transferring facility will provide a discharge summary and care plan information to the receiving facility ***within one business day***.
    - Members who are transitioning home should receive a copy of their discharge summary and care plan at the time of discharge. A copy should be sent to the primary care physician (PCP) **within one business day.**

- We expect all network providers to receive and attest to MOC training annually. If there is a trend of continued non-attestation, those providers found to be non-compliant with the Model of Care may be targeted for potential clinical review. For those non-compliant providers, individual results such as, but not limited to, utilization patterns, hospital admissions, readmissions and HEDIS performance outcomes may be reviewed. If there are issues identified, a Corrective Action Plan may be requested.

- We conduct medical record reviews at least annually and expect all network providers to respond to record requests timely. Reviews are conducted on PCPs, Specialty Care Practitioners, Behavioral Health Practitioners, and Ancillary providers. Results from the review are communicated to providers and include opportunities for improvement and education as needed.

- We encourage providers to participate in Interdisciplinary Care Team (ICT) meetings. As a provider, you are an important part of the member's ICT. The ICT members conduct a clinical analysis of the member's identified level of risk, needs, and barriers to care to develop an Individualized Care Plan (ICP), which will be reviewed with the member. The ICT analyzes, modifies, updates, and discusses new ICP information with the member and providers as a team, when appropriate.

    - Providers can request an ICT meeting for their members by calling 1-800-685-

5209.

- We expect providers to stay up to date by visiting our website and communicating by utilizing the Provider Portal, as these are the easiest ways for providers to receive information and updates. The following are important communications that can be found on our website:
    - Provider newsletters are updated monthly and highlight information regarding any new clinical programs or updates.
    - Provider manuals are updated annually and reviewed during annual trainings. Current manuals are also available on the provider section of our website.
- The following are functionalities available via the Provider Portal:
    - Automated ICT communications.
        - Care Plans generated or updated by the ICT
        - Discharge reports
        - Quarterly Performance dashboards that show gaps in care and chronic conditions
    - Secure messaging is also available to have open dialog between providers and internal staff who part of the member's ICT.

- We expect all network providers to keep us updated when any of their information changes. This includes information such as changes to the office address, phone numbers, office hours, hospital affiliations, and acceptance of new patients. We use this information to keep our Provider Directory up to date and accurate.

Common MOC Terms and Definitions:

Members may ask you about the following information that is routinely discussed with their case manager.

Health Risk Assessment (HRA): We utilize the HRA to provide each Medicare member a means to assess their health status and needs as well as priorities to improve their health by promoting positive behaviors. The HRA is also used by case managers to provide an assessment of risk that can generate automatic referrals for clinical programs.

CMS has rigid regulations around the frequency in which a HRA should be completed. Newly enrolled members identified by CMS on monthly enrollment file are required to complete an initial HRA within 90 days of their effective date. Existing members are required to complete an HRA within 12 months of the last completed HRA or the member's enrollment date if there is no completed HRA on record.

Individualized Care Plan (ICP): Highmark Wholecare utilizes the information collected from the HRA as well as other available clinical data, such as claims and encounters, to create a care plan that is individualized to each member's needs and priorities. The ICP will be created in conjunction with the member and/or caregiver to ensure it includes consideration of the member's personal care preferences, self-management goals and

objectives. At a minimum, a completed ICP will contain:

- Services and interventions specifically tailored to the member's health and Social Determinants of Health (SDoH) needs
- Documentation of the member's personal healthcare preferences (as appropriate)
- Member self-management goals and objectives (as appropriate)
- Clearly defined goals with measurable outcomes
- Progress and action toward the goals
- Whether the goals have been "met" or "not met"
- Appropriate alternative actions if "not met"

Interdisciplinary Care Team (ICT): Member care routinely demands a combination of efforts from physicians of various disciplines, registered nurses, and licensed social workers, as well as other pertinent skilled health care professionals and paraprofessionals. Comprehensive patient care planning involves coordination, collaboration, and communication between this ICT and the member. Highmark Wholecare's Provider Portal should be utilized frequently for any communication regarding members, their individual ICP, or ICT.

Who to Contact:

All Members have an assigned Care Manager. If you need to reach them about care plans, request additional support for your member, or schedule a formal ICT meeting, Case Management can be reached at the following number: 1-800-685-5209

Specific questions regarding the Model of Care Plan should be addressed with your Highmark Wholecare Provider Representative.

ACTION REQUIRED:

Now that you have reviewed this training, please submit an attestation indicating that you have completed and comprehend the Model of Care training by going to:

https://wholecare.highmarkprc.com/Medicare-Resources/Model-of-Care