OneCare Model of Care

CalOptima Health

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Learning Objectives

○ After completing the module, you will be able to:

- ■ Define CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, and Model of Care (MOC)

- ■ Identify the four core elements of the OneCare MOC

- ■ Describe eligibility for OneCare participation and identify specialized services for the most vulnerable OneCare members

- ■ Define care coordination, Health Risk Assessment (HRA), Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT)

- ■ Understand the essential role of the contracted network of providers, adherence to care standards and oversight

This is Aptos 12 pt. You can place footnotes in this section here. If you do not have footnotes, just leave the field as is and it will not show up in your presentation.

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Learning Objectives (cont.)

○ After completing the module, you will be able to:

- Describe the quality measurement and performance improvement outcomes of the MOC

- Define how MOC effectiveness is measured

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Course Content

○ OneCare MOC Overview

○ OneCare Population

○ Care Coordination

○ Care Staff Roles and Responsibilities

○ Key Components

■ HRA

■ ICP

■ ICT

○ Specialty Programs

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Course Content (cont.)

○ Evaluating the MOC

○ Communication Processes and Methods

○ Updates to Dual Eligible Special Needs Plan (D-SNP)

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Overview

- The Centers for Medicare & Medicaid Services (CMS) require:

  - All Medicare Advantage Special Needs Plans (MA-SNPs) to have an MOC

  - All employed and contracted personnel and providers of the MA D-SNP are to be trained on the MOC

- The OneCare MOC is CalOptima Health's road map for care management policies, procedures and operational systems

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Overview (cont.)

○ This course describes the OneCare MOC and how CalOptima Health and its network of contracted providers work together to ensure the success of the MOC and enhance the coordination of care for the members

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What Is OneCare?

- OneCare is:
  - CalOptima Health's MA-SNP
  - Also known as:
    - HMO-SNP
    - SNP
    - D-SNP

- Serves people:
  - Eligible and enrolled in CalOptima Health for both Medicare and Medi-Cal (Medicaid) benefits
  - Residing in Orange County
  - Age 21 and older

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Model of Care

- A document required by CMS for a D-SNP
  - Defines the care management policies, procedures and operational systems for OneCare
  - Is member-centric, with the ongoing focus on the member and the member's family/caregiver
- Four core elements are:
  - Population description of SNP
  - Care coordination
  - Provider network
  - Quality measurement and performance improvement

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OneCare Population

○ OneCare population description includes:

- Eligibility to participate

- Social, cognitive and environmental factors; living conditions; and comorbid conditions of members

- Medical and health conditions impacting members

- Unique characteristics of the population

- Identification of the most vulnerable members of OneCare with specialized services listed for these members

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OneCare Population (cont.)

○ OneCare's most vulnerable members are the following special populations:

- Frail and/or disabled

- Experiencing or at risk for homelessness

- At risk for avoidable hospital or emergency department (ED) admission

- Serious mental illness and/or substance use disorder (SUD)

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OneCare Population (cont.)

- At risk for institutionalization or long-term care

- Eligible for palliative care (Medi-Cal disease-specific criteria)

- Homebound

- Cognitive impairment (Alzheimer's, related dementias or documented dementia care needs)

Knowledge Check

○ 1. What does the abbreviation OC MOC mean?

- a. Orange Coast Care Model of Orange County

- b. Open Care Coordinator Model of Orange County

- c. OneCare Model of Care

- d. OneCare Medicare Order for Care

○ 2. Care coordination is one of the four core elements of the MOC

- a. True

- b. False

Knowledge Check (cont.)

○ 3. OneCare-eligible vulnerable members include those who:

- a. Are frail and/or disabled
- b. Have a serious mental illness and/or SUD
- c. Are homebound
- d. All of the above

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Knowledge Check — Answers

○ 1. c. OneCare Model of Care

○ 2. a. True

○ 3. d. All of the above

Care Coordination

- Care coordination includes:
  - Organization of member care activities
  - Sharing information among all the health care participants involved with a member's care
  - Achieving safer and more effective care
  - Closed-loop coordination of all benefits, including Medicare, Medi-Cal, long-term services and supports (LTSS)
- Main goal of care coordination is:
  - To meet members' needs and preferences in the delivery of high-quality, high-value health care

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Care Coordination (cont.)

○ Care coordination components include:

- Staff structure
  - Administrative, clinical and oversight roles specific to OneCare, including a personal care coordinator (PCC)
- HRA
  - Assessment of the OneCare members' health and social needs
- ICP
  - A plan of care for the OneCare member based on information from the HRA
- Care transition protocols
  - Guidelines on how to manage the OneCare member across the care continuum

Care Coordination (cont.)

○ Care coordination components include:

- ICT
    - Includes the member's primary care provider (PCP), case manager and others, as appropriate. Each OneCare member has a care team to ensure care coordination occurs in a structured collaborative process. The team is involved in creating and updating the ICP. They have formal meetings as needed to discuss the member's care, review the ICP and ensure care coordination occurs as appropriate

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Staff Structure and Roles

○ Organized to align with essential care management roles:

- Administrative

- PCC
    - At CalOptima Health
    - At contracted health networks

- Clinical

- Oversight

Administrative

- Manages:
  - Enrollment
  - Eligibility
  - Claims
  - Grievances and provider complaints
  - Information communication
  - Collection, analysis, and reporting of performance and health outcomes data

PCC

○ At CalOptima Health

- Administers the HRA for each member
  - Initial and annually thereafter
  - May be face-to-face, virtual, telephonic or paper-based
  - Enters HRA responses into a data platform for a registered nurse (RN) to review
  - Note — HRA collection not delegated to the health networks

- Communicates key event triggers to the health network
  - For example, significant changes in a member's medical condition

- Conducts warm transfer calls of the member to the health network

PCC (cont.)

- Maintains knowledge of all benefits, including Medicare, Medi-Cal and LTSS

○ At a health network

- Member's point of contact and liaison between the member, provider, health network and CalOptima Health

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PCC (cont.)

- At a health network
  - Role:
    - Guides member in understanding and accessing their benefits with awareness of all Medicare, Medi-Cal and LTSS benefits
    - Schedules, facilitates and participates in ICT meetings, as appropriate
    - Assists member with scheduling appointments, facilitates referrals
    - Assists with the coordination of members' health care needs
    - Notifies the member's care team of key events
    - Facilitates communication of ICP to PCP and other care team members, including the member

Clinical Staff

○ Examples of clinical staff may include:

- PCP

- RN case manager

- Licensed clinical social worker (LCSW)

Clinical Staff (cont.)

○ Role:
- Advocate for, inform and educate members
- Coordinate care
- Identify and facilitate access to community resources
- Educate members on health risks and management of illnesses
- Empower members to be advocates of their health care
- Maintain and share records and reports
- Assure Health Insurance Portability and Accountability Act (HIPAA) compliance

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Oversight

○ CalOptima Health and the health networks collaborate to support the MOC

Oversight (cont.)

○ Role:
  - Monitor MOC implementation
  - Evaluate effectiveness of the MOC
  - Assure licensure and competency
  - Assure statutory and regulatory compliance
  - Monitor contractual and delegated services
  - Monitor ICTs
  - Assure timely and appropriate delivery of services
  - Assure providers use evidence-based clinical practice guidelines
  - Assure seamless transitions and timely follow-up

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Health Risk Assessment

- Process:
  - CalOptima Health PCC:
    - Administers initial HRA and annual HRA for each member
    - Uses a standardized HRA tool (Note: HRA completion is not delegated to health network)
  - May be face-to-face, virtual, telephonic or paper-based
  - Identified care needs are categorized into care domains:
    - Physical Health, Behavioral Health, LTSS, Access to Care, Care Coordination, and Promotion of Self-Management/Health and Wellness Monitoring

Health Risk Assessment (cont.)

○ Process:
- Used by clinical staff to evaluate the medical, psychosocial, cognitive and functional needs, caregiver status, and current services received with medical and behavioral health history
- Used to develop a member's ICP

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Interdisciplinary Care Team

○ Role and process:

- All OneCare members have an ICT

- Includes the member's medical, behavioral and ancillary providers

- Convenes as appropriate to manage the member's care and assure care coordination

- Analyzes and incorporates the results of the initial or annual HRA into the ICP, utilizing evidence-based guidelines

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Interdisciplinary Care Team (cont.)

- Role and process:
    - Collaborates to develop the member's ICP annually, or to update the member's ICP with changes in health care status
    - Manages the medical, cognitive, psychosocial and functional needs of each member
    - Communicates the ICP to all caregivers for care coordination
    - Provides a copy of the ICP to the member in the member's preferred language, font and print size

Interdisciplinary Care Team (cont.)

○ Formal versus informal ICT

- All OneCare members have an ICT
- All OneCare members should have evidence of Informal ICT collaboration. Examples include:
  - Collaboration with the PCP and other specialists
  - Input from members of the ICT into the ICP

Interdisciplinary Care Team (cont.)

○ Formal versus informal ICT

  ▪ Formal ICT meetings will be held for:

    • High-risk members

    • Any members enrolled in care coordination or complex case management (CCM)

    • Member identified in a vulnerable population (must use a palliative care ICT for members enrolled in palliative care)

    • If member or PCP requests

Composition of ICT Meeting

○ ICT composition is determined by member's needs and preferences

Core Participants	Additional Participants	
• Member and/or designated representative • PCP assigned to member	• Behavioral health specialist • Pharmacist • Case manager • Health network PCC • Therapist (speech and/or physical) • Nutritionist • Appropriate specialist	• Health educator • Disease management specialist • Social worker • LTSS liaison • Dementia care specialist

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Individualized Care Plan

○ Process:

- Developed by ICT for each OneCare member

- Includes the member's personalized goals and objectives, specific services and benefits, and measurable outcomes

- Goals and objectives prioritized by the member's preference

- Written ICP communicated to member, caregivers and providers

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Individualized Care Plan (cont.)

○ Process:

- Members and/or caregivers (at member's request) given a copy of the ICP and asked to sign off

- Written ICP reviewed and revised by PCP or ICT annually or when health status changes

- Accessible to all care providers

- Records maintained per HIPAA and professional standards

ICP Communication

○ The ICP is shared with the PCP to review, provide additional feedback (if appropriate) and sign

○ The ICP is also shared with appropriate specialty providers and ICT participants

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Self-Directed Care

○ Self-direction enables members to live independently in their own home and community

○ When members self-direct their care, they hire caregivers and become their employer

○ Members decide what services they need, when they need them and how they would like to receive them

○ Self-directed care empowers members to have choice over their own care and lives

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Knowledge Check

○ 1. Who administers the initial HRA?

- ▪ a. Member's doctor
- ▪ b. Member's caregiver
- ▪ c. CalOptima Health PCC
- ▪ d. Member's care coordinator

○ 2. Who develops the member's ICP?

- ▪ a. Member's care coordinator
- ▪ b. ICT
- ▪ c. Health network PCC
- ▪ d. Member's caregiver

Knowledge Check (cont.)

- 3. The purpose of care coordination is to organize and coordinate the member's care activities
    - a. True
    - b. False

Knowledge Check — Answers

○ 1. c. CalOptima Health PCC

○ 2. b. ICT

○ 3. a. True

OneCare Provider Network

○ CalOptima Health

- Contracts with board-certified providers

- Monitors network providers to ensure they use nationally recognized clinical practice guidelines

- Ensures that network providers are licensed and competent through a formal credentialing review

OneCare Provider Network (cont.)

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- Maintains a broad network of specialists that includes palliative care, pain management, chiropractors and psychiatrists

- Monitors network adequacy to ensure access to care

- Provides training on OneCare MOC for providers and those who routinely interact with OneCare members:

  - Ensures provision and attestation of initial and annual MOC training

OneCare Provider Network (cont.)

○ OneCare provider network includes:

- PCPs
- Specialized expertise:
  - Specialists, hospitalists, pharmacists, crisis teams
  - Skilled nursing facilities (SNFs)
  - Behavioral health providers
  - Palliative care providers
  - Allied health providers, ancillary services
  - Substance abuse detoxification and rehabilitation services

OneCare Provider Network (cont.)

○ OneCare provider network includes:

- Use of evidence-based clinical guidelines and care transition protocols.

  - Formalized oversight of provider network adherence to nationally recognized care standards

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OneCare Programs and Services

○ OneCare specialty programs and services include:

- Behavioral health
- Specialty services:
  - Dialysis
  - Transportation
  - Durable Medical Equipment (DME)
  - Home health
- Psychosocial programs such as drug and alcohol treatment

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OneCare Programs and Services (cont.)

○ OneCare specialty programs and services include:

- Referrals to:
  - Community-Based Adult Services (CBAS)
  - In-Home Supportive Services (IHSS)
  - Community Supports
  - Housing assistance
  - Meals on Wheels
  - Personal finance counseling

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OneCare Programs and Services (cont.)

○ OneCare specialty programs and services include:

- Disease management and health education programs
- Community-based resources, such as:
  - Aging & Disability Resource Connection of Orange County (ADRCOC)
  - Alzheimer's OC
  - Multi-Purpose Senior Services Program (MSSP)
  - Office on Aging (OOA)
  - Dayle McIntosh Center (independent living center)

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Evaluating the Model of Care

○ CMS defines processes and tools to measure health care outcomes

  ▪ Purpose is to ascertain whether health plans provide high-quality health care for their members

○ Processes include:

  ▪ Quality measurement (QM)

  ▪ Performance improvement (PI)

Evaluating the Model of Care (cont.)

○ Methods include:

- MOC Quality PI Plan

- Measurable goals and health outcomes measurements

- Measuring patient experience of care

- Ongoing performance improvement evaluation

- Dissemination of SNP quality performance related to the MOC

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Performance Measurement

○ Uses standardized quality improvement measures to gauge performance and health outcomes, such as:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Disease management measures
- Utilization management measures
- Member satisfaction (surveys)
- Provider satisfaction (surveys)
- Ongoing monitoring of complaints and grievance summaries
- Tracking and assessing completion of MOC training

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Measurable Goals

○ Evaluates measurable goals that:

- Improve coordination of care

- Appropriate utilization of services for preventative health and chronic conditions

- Improve member experience

- Enhanced care transitions across all health care settings and providers

Measurement of Effectiveness

○ Evaluates measures of effectiveness by collecting and reporting data on:

- ▪ Improvement in access to care
- ▪ Improvement in member health status
- ▪ Staff implementation of MOC
- ▪ Comprehensive HRA
- ▪ Implementation of ICP
- ▪ Provider network of specialized expertise
- ▪ Application of evidence-based practice
- ▪ Improvement of member satisfaction and retention

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OneCare Clinical Guidelines

○ Supports the physician management of chronic conditions

- Disseminates best practices, evidence-based guidelines

- Shares provider tool kits to promote education and adherence

Communication Processes and Methods

○ Utilizes an integrated system of communication for members and providers on both a scheduled and as-needed basis

- Methods include:
  - Member newsletters
  - CalOptima Health website
  - Networking and focus group sessions
  - Conferences: face-to-face, telephonic, electronic
  - Committees: Utilization Management Committee (UMC), Quality Assurance Committee (QAC), Member Advisory Committee (MAC) and Provider Advisory Committee (PAC)

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Knowledge Check

- 1. CalOptima Health monitors network adequacy to ensure members have access to care
  - a. True
  - b. False
- 2. Specialty programs or services for OneCare members include:
  - a. Behavioral Health
  - b. Health education
  - c. DME
  - d. All of the above

Knowledge Check cont.

○ 3. OneCare develops its own quality improvement measures to measure performance and health outcomes

  ▪ a. True

  ▪ b. False

Knowledge Check — Answers

○ 1. a. True

○ 2. d. All of the above

○ 3. b. False

LTSS Liaison

○ OneCare must have staff to serve as liaisons for the LTSS provider community to help facilitate member care transitions

○ These staff must be trained to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules

○ Staff serving as liaisons for the LTSS provider community must participate in the ICT, as appropriate

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Dementia Care Specialists

○ OneCare has dementia care specialists who have received intensive training through Alzheimer's OC

○ The training includes understanding Alzheimer's Disease and Related Dementias (ADRD), symptoms and progression, understanding and managing behaviors and communication problems caused by ADRD, caregiver stress and its management, and community resources for enrollees and caregivers

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Dementia Care Specialists (cont.)

○ The dementia care specialist must participate in formal ICT meetings for members with dementia

○ The care team for members with documented dementia care needs must include the member's caregiver and a trained dementia care specialist to the extent possible and as consistent with the member's preferences

Dementia Care Specialists (cont.)

○ These ICT members must be included in the development of the member's ICP to the extent possible and consistent with the member's preference

○ The ICP should also include any referrals to community-based organizations (CBOs), such as those serving members with dementia

Updates to OneCare

○ Enhanced Care Management (ECM) updates

○ Face-to-face requirements

○ Palliative care

○ Dementia Care Aware

○ Continuity of care

Enhanced Care Management

○ OneCare members may meet the criteria for an ECM population of focus

○ There is overlap in the D-SNP MOC and ECM requirements, which can result in confusion for members if they receive services from both programs

○ OneCare is responsible for providing ECM-like services to members who are eligible and agree to enroll

○ ECM-like services are provided primarily through in-person contact

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Face-to-Face Requirement

○ OneCare is required to provide a face-to-face encounter for the delivery of health care, care management or care coordination services between the member and a member of their care or case management teams

○ The main purpose of the face-to-face encounter is to promote and ensure OneCare members are seen and clinically assessed at least annually by their PCP or specialist serving as the PCP

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Face-to-Face Requirement (cont.)

○ CalOptima Health will track and monitor OneCare members to ensure they have or are offered a face-to-face encounter at least annually

Palliative Care

○ Palliative care is available to OneCare members

- Eligibility criteria are outlined in the D-SNP Policy Guide
  - The D-SNP Policy Guide can be found at DHCS.ca.gov

- Providers must be educated on the program and process to make referrals

- For OneCare members enrolled in a palliative care program:
  - The palliative care coordinator serves as lead care manager
  - Must use a palliative care ICT meeting
  - Palliative care provider is part of the member's care team.
  - The ICP is developed and updated by and/or shared with the palliative care team as appropriate

Dementia Care Aware

○ Face-to-face encounters and/or responses to the HRA may indicate potential cognitive impairment

  ▪ Members should be referred to their providers for further diagnostic evaluation when appropriate.

  ▪ Provider should conduct a full diagnostic workup when memory concerns are identified

○ The Dementia Care Aware training and resources are available to support providers when detecting cognitive impairment

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Continuity of Care

○ May be telephonic requests from member, their authorized representative or treating providers

- ▪ Includes DME and medical supply providers

○ Requests will be completed within:

- ▪ 30 calendar days from request
- ▪ 15 calendar days, if the member's medical condition requires immediate attention
- ▪ Three calendar days if there is a risk of harm to the member

○ Member notification within seven calendar days of completion

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Continuity of Care (cont.)

- Must notify member 30 calendar days before the end of the continuity of care period

- Must allow the member to continue treatment for up to the 12-month continuity of care period

Model of Care Summary

○ OneCare's MOC:

- Defines and creates a comprehensive strategy and infrastructure for the care of our members

- Meets the unique needs of the dual-eligible population by:

  - Setting agencywide strategic goals

  - Contracting with expert practitioners

  - Striving to meet each member's unique medical, psychosocial, functional and cognitive needs

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Acronyms List

Acronym	Definition
ADRD	Alzheimer's Disease and Related Dementias
CBAS	Community-Based Adult Services (formerly Adult Day Care)
CMS	Centers for Medicare & Medicaid Services
DME	Durable Medical Equipment
ECM	Enhanced Care Management
QAC	Quality Assurance Committee
HEDIS	Health Care Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act

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Acronyms List (cont.)

Acronym	Definition
HRA	Health Risk Assessment
ICP	Individualized Care Plan
ICT	Interdisciplinary Care Team
IHSS	In-Home Supportive Services
LCSW	licensed clinical social worker
LTSS	Long-Term Services and Supports
MAC	Member Advisory Committee
MOC	Model of Care
MSSP	Multi-Purpose Senior Services Program
PAC	Provider Advisory Committee

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Acronyms List (cont.)

Acronym	Definition
PCC	personal care coordinator
PCP	primary care provider
PI	performance improvement
QM	quality measurement
RN	registered nurse
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SUD	substance use disorder
UMC	Utilization Management Committee

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References

○ CalOptima Health Policy GG.1204: Clinical Practice Guideline

○ CalOptima Health Policy EE.1103: Provider Network Training

○ CalOptima Health Policy MA.6032: Model of Care

○ CalAIM Dual Eligible Special Needs Plans: Policy Guide: Contract Year 2024

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