Steward Health Care Network

HEALTH CHOICE

Annual Provider Medicare Model of Care Training 2018-2019

Steward Health Choice Generations	CMS Contract H5587
Steward Health Choice Generations – Utah	CMS Contract H9455

Reviewed and Revised October 2018

Introduction

Thank you for taking the time to learn more about our members. We appreciate your collaboration.

The Steward Health Choice Model of Care (MOC) training includes an overview of our general approach to care coordination, describes the guiding principles we apply to drive improved outcomes for the members that we serve.

An annual review of the Model of Care is conducted by Health Choice's Case Management in conjunction with Quality Management as well as the Quality Management Committee.

The Centers for Medicare and Medicaid (CMS) require all Health Choice staff, contracted and non-contracted medical providers to receive basic training about the D-SNP Model of Care (MOC).

Learning Objectives

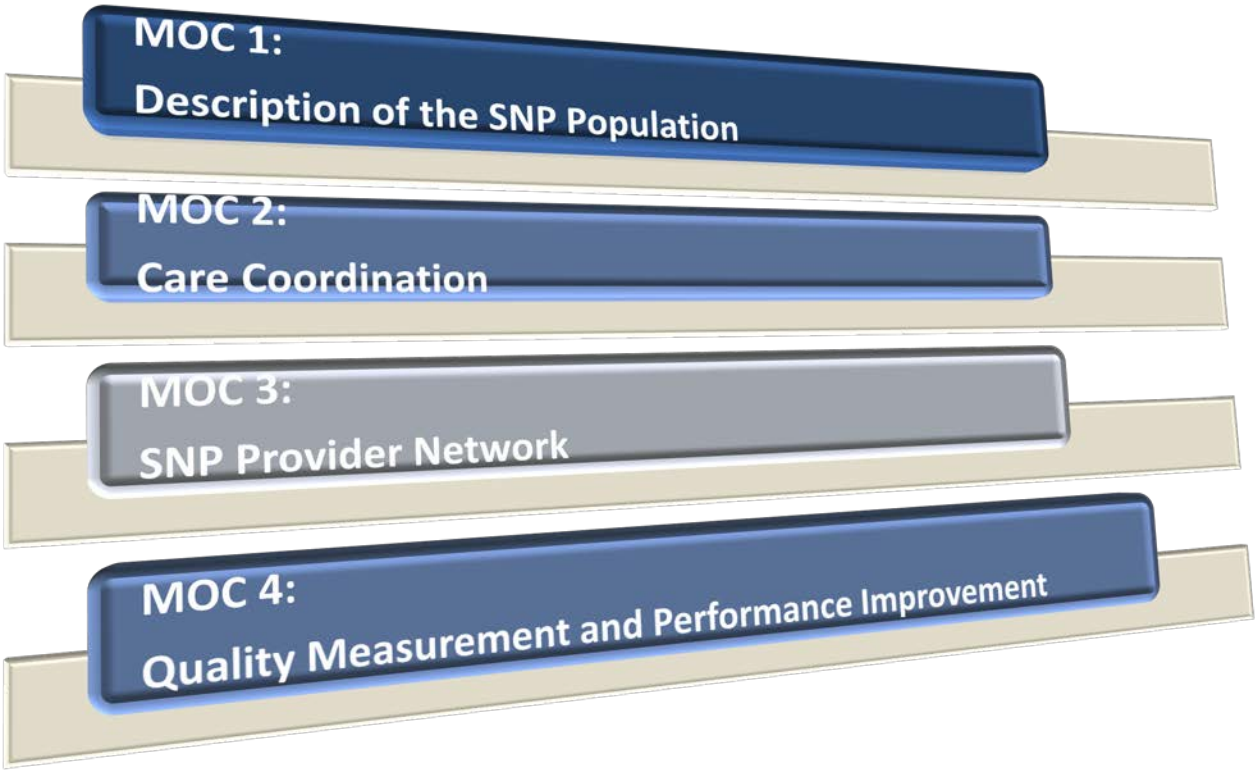
- Understand the goals of the MOC and how you can collaborate
- Understand key elements of the MOC and role of Steward regarding care coordination and CMS requirements

Goals of the Special Needs Plan

- Steward Health Choice Generations HMO Special Needs plan is a Dual Eligible Special Needs Plan (D-SNP). The MOC is designed to ensure the provision and coordination of specialized services that meet the needs of the dual eligible beneficiaries by:
  - Improving member Health Outcomes
  - Improving Seamless Transitions of Care Across Healthcare Settings, Providers, and Health Services
  - Improving Access to Preventive Health Services
  - Assuring Appropriate Utilization of Services

MOC Elements

- There are 4 elements to the MOC of which each contain multiple sub-elements



Element 1 – SNP Population in Arizona

As a dual eligible plan, Steward Health Choice Generations D-SNP serves both physical health and behavioral health needs of beneficiaries in the following counties:

Eligible Beneficiaries	Counties in Which Program Offered
Full benefit Medicaid-Medicare eligible (Duals) beneficiaries enrolled in the Arizona Medicaid Acute Care program	• Apache • Coconino • Gila • Maricopa • Mohave • Navajo • Pinal • Yavapai
Full benefit Medicaid-Medicare eligible (Duals) beneficiaries with Serious Mental Illness enrolled in an Arizona Medicaid integrated behavioral health/acute care plan	• Apache • Coconino • Gila • Mohave • Navajo

HCG Population Analysis – HOS Survey

- The Steward Health Choice Generations Dual population is especially vulnerable because of multiple challenges impacting their ability to manage their health: socioeconomic barriers, low health literacy, multiple chronic physical and behavioral health conditions.
- In reviewing 2018 plan data [e.g. The Healthcare Effectiveness Data and information set (HEDIS), Health Outcome Survey (HOS) Cohort 17 (2014-2016)] the following describes some characteristics of the population as noted in the affixed table:

Table 9: *2014-2016 Cohort 17 Performance Measurement* Demographics for MAO H5587 and HOS Total at Baseline and Follow Up

	MAO H5587		HOS Total	
	Baseline	Follow Up	Baseline	Follow Up
Age	(N=134)	(N=134)	(N=87,779)	(N=87,779)
65-69	39.6%	30.6%	29.6%	17.8%
70-74	22.4%	24.6%	28.1%	29.8%
75-79	23.1%	20.1%	20.1%	22.8%
80-84	10.4%	14.2%	13.2%	16.0%
85+	4.5%	10.4%	9.0%	13.7%
Gender	(N=134)	(N=134)	(N=87,779)	(N=87,779)
Male	33.6%	33.6%	41.2%	41.2%
Female	66.4%	66.4%	58.8%	58.8%
Race	(N=134)	(N=134)	(N=87,779)	(N=87,779)
White	79.1%	79.1%	84.1%	84.1%
Black	3.0%	3.0%	8.8%	8.8%
Other/Unknown	17.9%	17.9%	7.1%	7.1%
Marital Status	(N=126)	(N=126)	(N=86,608)	(N=84,721)
Married	19.0%	18.3%	56.0%	53.5%
Widowed	24.6%	27.8%	23.9%	26.8%
Divorced or Separated	47.6%	44.4%	15.7%	15.4%
Never Married	8.7%	9.5%	4.4%	4.3%
Education	(N=126)	(N=127)	(N=86,095)	(N=84,021)
Did Not Graduate HS	50.0%	44.9%	18.4%	18.1%
High School Graduate	27.0%	29.9%	33.2%	33.5%
Some College	15.9%	19.7%	25.1%	24.8%
4 Year Degree or Beyond	7.1%	5.5%	23.3%	23.6%
Annual Household Income	(N=129)	(N=122)	(N=80,248)	(N=78,030)
Less than $10,000	52.7%	52.5%	10.6%	10.6%
$10,000-$19,999	21.7%	24.6%	18.0%	17.2%
$20,000-$29,999	3.9%	4.1%	16.2%	16.0%
$30,000-$49,999	3.9%	0.8%	21.5%	21.6%
$50,000 or More	2.3%	0.8%	22.8%	23.7%
Don't Know	15.5%	17.2%	10.8%	10.9%
Medicaid Status	(N=134)	(N=134)	(N=87,778)	(N=87,775)
Medicaid	100%	99.3%	15.9%	16.6%
Non-Medicaid	0.0%	0.7%	84.1%	83.4%

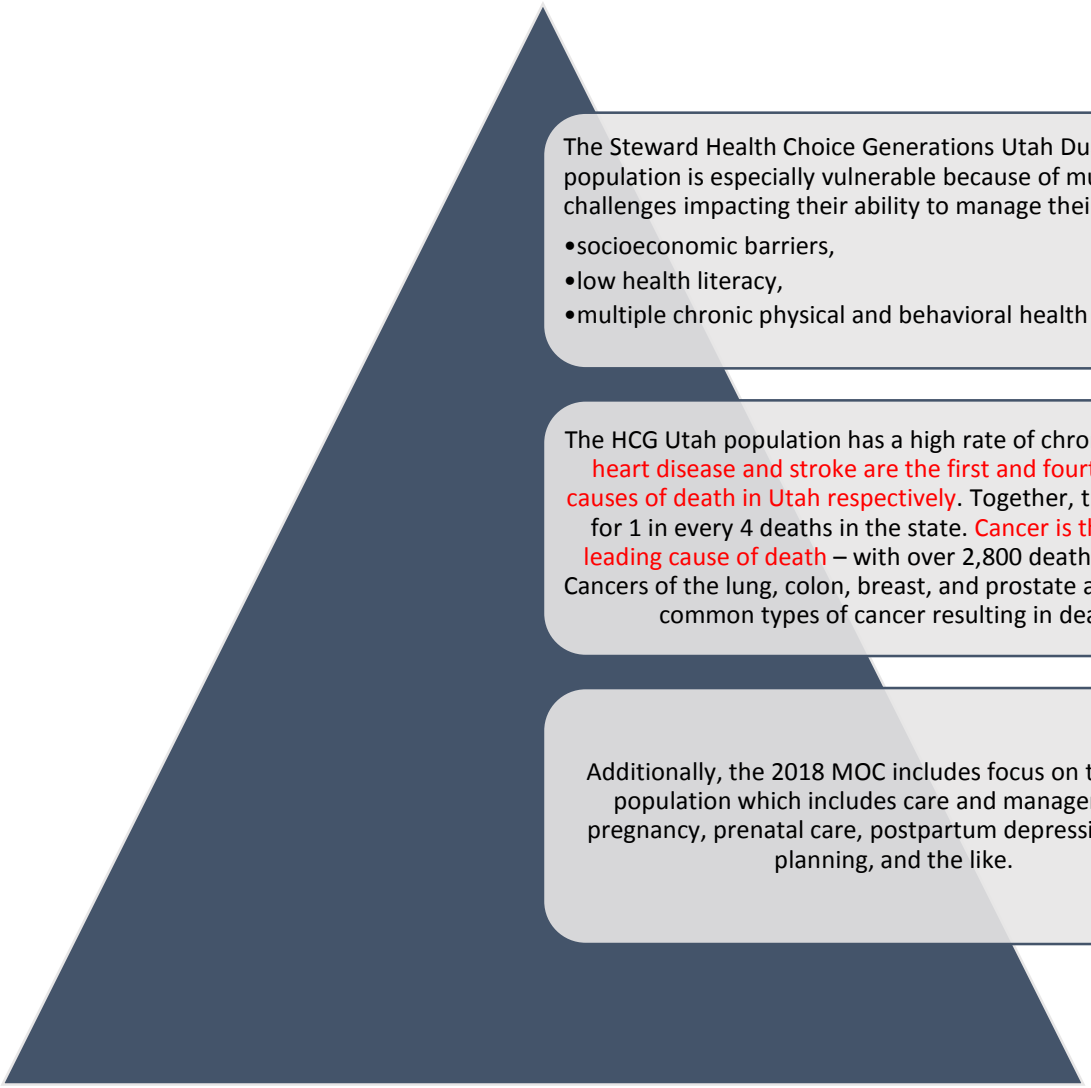
SNP Population in Utah

Steward Health Choice Utah Generations D-SNP is a Dual Eligible Special Needs Plan (D-SNP) serving five counties in Utah. The D-SNP serves the Medicare and Medicaid populations in the following counties. To be eligible for the Medicaid program listed, individuals must meet criteria:

- Be entitled to Medicare Part A, be enrolled in Medicare Part B and UDOH (Medicaid),
- Be a Utah Resident in the counties we serve
- Be a United States citizen or a qualified immigrant
- Have a Social Security number or applies for one
- Applies for potential income that may be available, such as unemployment, pensions, and Social Security
- Income is under 100% of the Federal Poverty Level

Eligible Beneficiaries	Counties in Which Program Will be Offered
Full-benefit Medicaid-Medicare eligible (Duals) beneficiaries enrolled in the Utah Medicaid Acute Care Program	• Utah • Salt Lake • Davis • Tooele • Weber

HCG Utah Population Facts



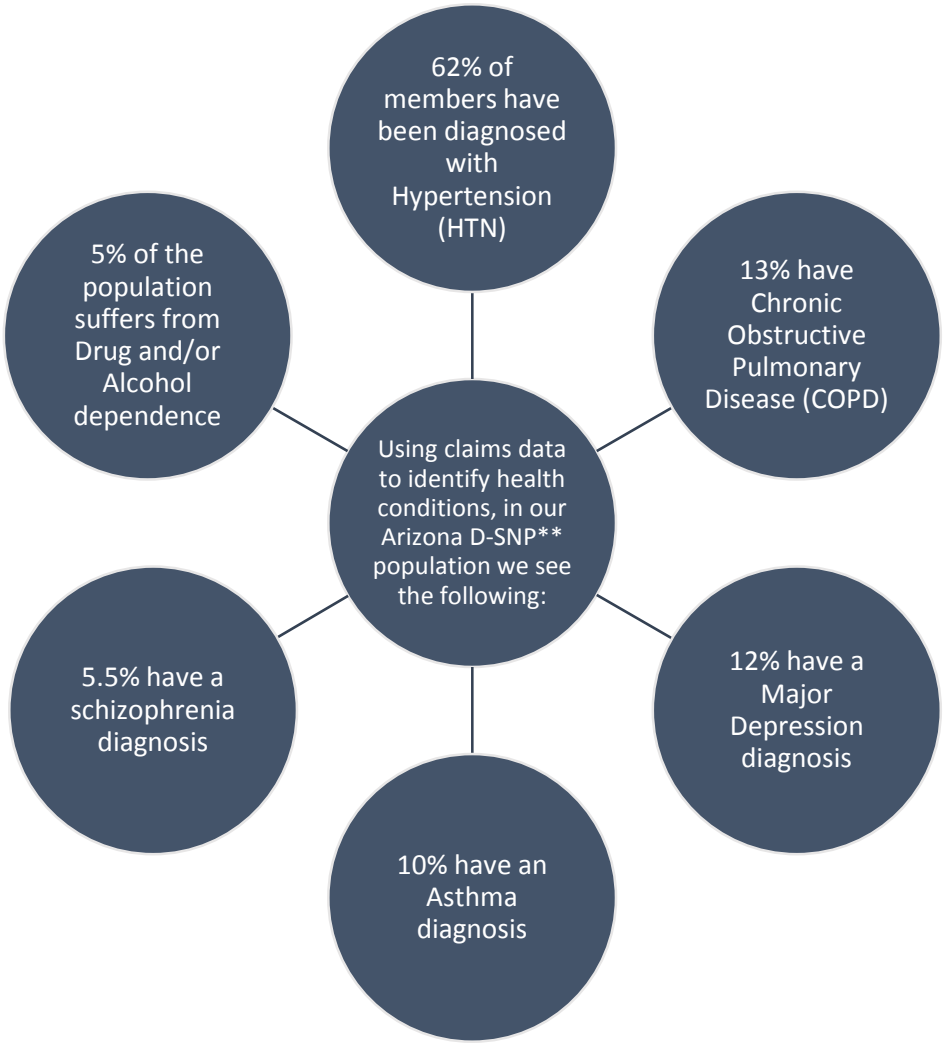
The Steward Health Choice Generations Utah Dual population is especially vulnerable because of multiple challenges impacting their ability to manage their health:

- socioeconomic barriers,
- low health literacy,
- multiple chronic physical and behavioral health conditions.

The HCG Utah population has a high rate of chronic illnesses; heart disease and stroke are the first and fourth leading causes of death in Utah respectively. Together, they account for 1 in every 4 deaths in the state. Cancer is the second leading cause of death – with over 2,800 deaths per year. Cancers of the lung, colon, breast, and prostate are the more common types of cancer resulting in death.

Additionally, the 2018 MOC includes focus on the female population which includes care and management of pregnancy, prenatal care, postpartum depression, family planning, and the like.

Vulnerable Sub-Populations

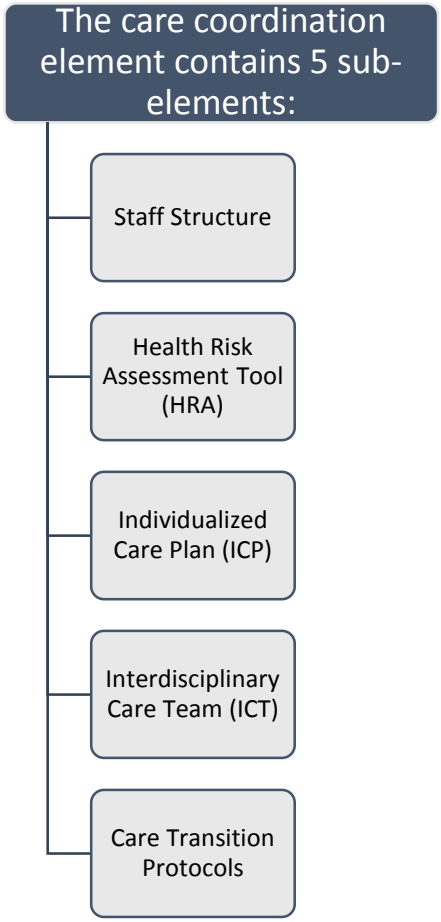


Health Choice Generations has programs specifically tailored for vulnerable beneficiaries. Currently in place are care management programs such as diabetes, heart disease, asthma, hepatitis C, and HIV programs. Still, the overall characteristics of these beneficiaries make them particularly vulnerable, requiring both specialty care management programs and collaboration with behavioral health and community resources.

** Utah statistics are not available as the plan is pre-operational in 2018.

Element 2 – Care Coordination

The care coordination team supports our SNP members and providers by helping to ensure that our members healthcare needs are met over time using high quality services that ultimately lead to improved health outcomes



Health Risk Assessment (HRA)

ENGAGEMENT

- The MOC describes the process for conducting the HRA which may be completed by phone or by written survey. As part of the member's interdisciplinary care team, providers can encourage members to engage.

FREQUENCY

- The plan is required to conduct a HRA on each new member within 90 days of their enrollment and conduct a reassessment at minimum, annually, or more frequently with any significant change in condition or transition of care.

DATA

- The HRA collects information about the members' medical, psychosocial, cognitive, and functional needs, and medical and behavioral health history.

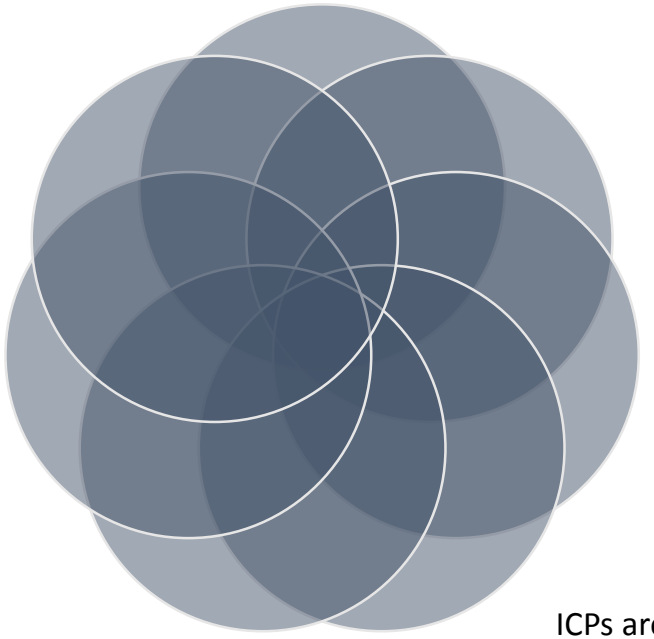
ACTION

- Members are then evaluated for their health risk level and referred to a case management program when appropriate. The HRA is used to develop an individual care plan.

Individualized Care Plan (ICP)

Another a sub-element of the MOC describes the process for developing an Individualized Care Plan based on information received from the HRA

ICPs are revised annually, or when the member has a health status change



The ICP is a summary of the needs and service options identified in the assessment process

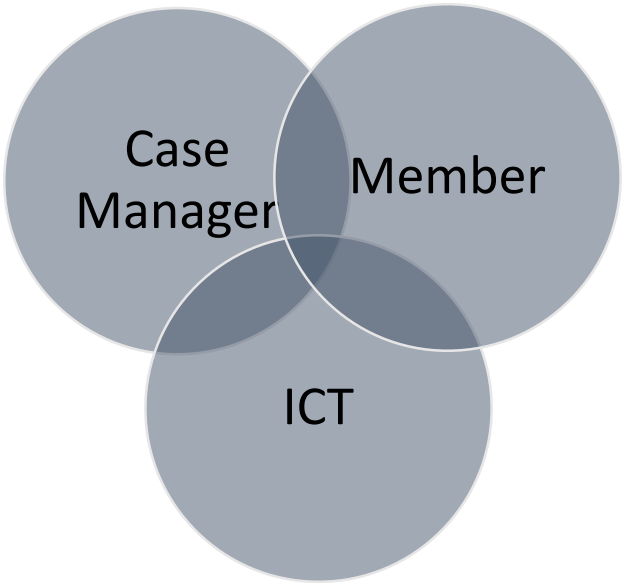
The ICP is developed to identify the member's health care goals and objectives, as well as the activities and services the member agrees to pursue in order to attain optimal health outcomes

The ICP is communicated with all members of the care team including primary care providers

The ICP is tailored to meet the member's needs and preferences

ICPs are developed by the member, their assigned case manager and the member's preference on who will participate in the development of the ICP

Interdisciplinary Care Team (ICT)



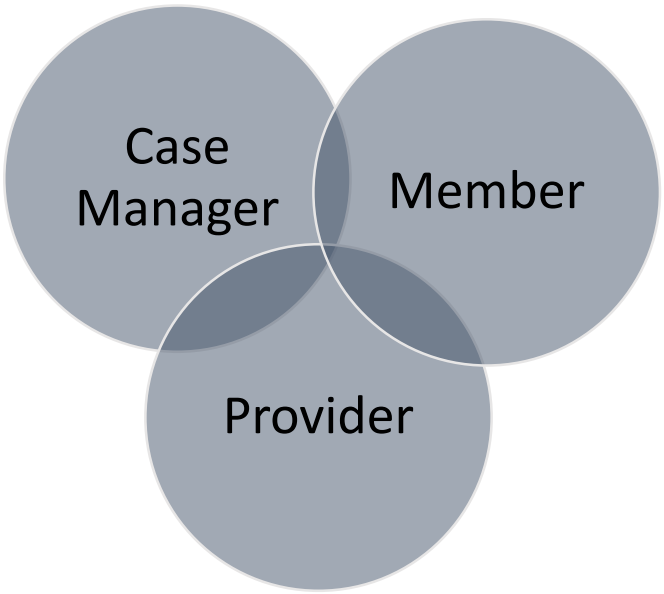
Coordination of Care

- The Provider Role in managing and improving health outcomes by:
  - Re-assess the member to identify health status changes with routine visits
  - Support Quality Initiatives
  - Document in the members record to support accuracy of data used in the care plans
  - Respond to requests for information for Steward Health Choice Case Managers
- The Interdisciplinary Care Team (ICT) offers member-centric delivery of care that focuses on the needs of the member by encouraging and incorporating the member's active participation which includes personal preferences and feedback into the creation of an individualized care plan
- All members of the ICT, which includes the member, receive a copy of the ICP to ensure everyone is following the same plan for continuity of care purposes

Use of Clinical Practice Guidelines

- Steward Health Choice Generations' (HCG and HCGU) Medical Management Committee evaluates and adopts clinical practice guidelines and nationally recognized protocols applicable to the needs of the Plans' membership.
- These guidelines are intended to drive quality improvement and consistency of care our members receive from network providers for both preventive services and chronic conditions.
- These guidelines are available to the plan provider network via the plans' websites.

Transitions of Care

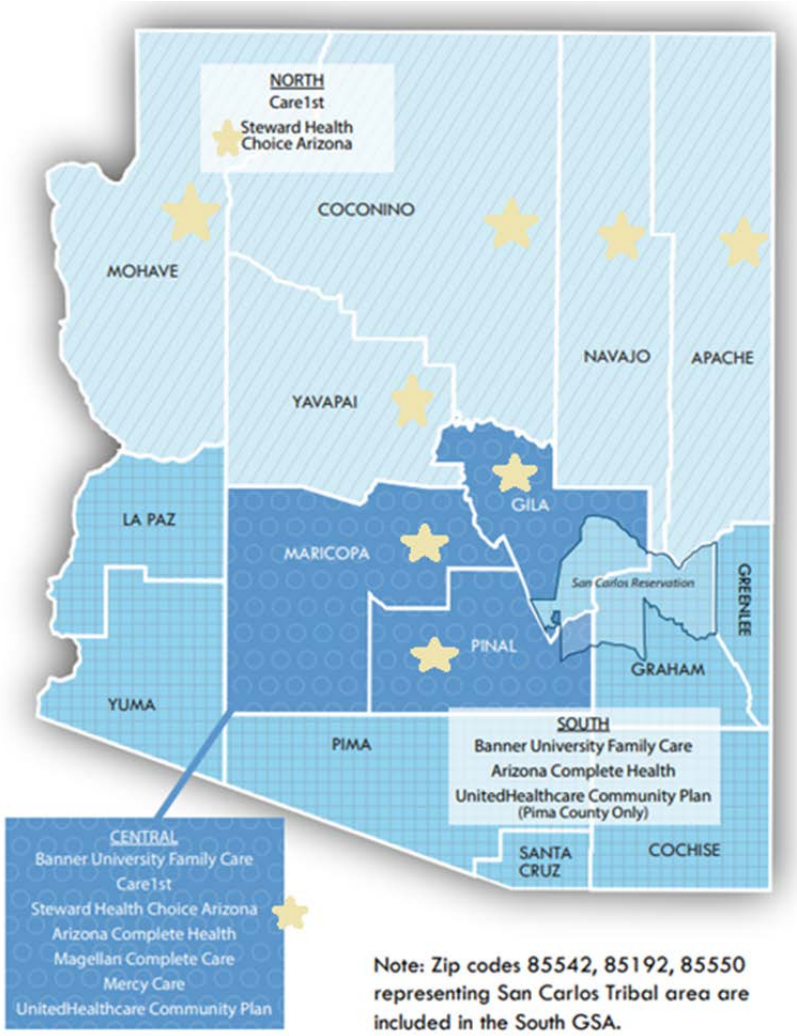


Coordination of Care

- Improving care transitions between care settings is critical to improving individuals' quality of care and quality of life and their outcomes. Effective care transitions:
  - Prevent medical errors
  - Identify issues for early intervention
  - Prevent unnecessary hospitalizations and readmissions
  - Support enrollee preferences and choices
  - Avoid duplication of processes and efforts to more effectively utilize resources
- Care transitions include the coordination of medical and behavioral services when an individual is:
  - Admitted to a hospital for acute medical care
  - Discharged from a hospital to an institutional long-term care (LTC) setting, such as a skilled nursing facility/nursing facility (SNF/NF), inpatient rehabilitation facility (IRF), or intermediate care facility (ICF)
  - Discharged to home
  - Discharged from an institutional LTC care setting to community LTC or vice versa

Element 3 – Arizona Provider Network

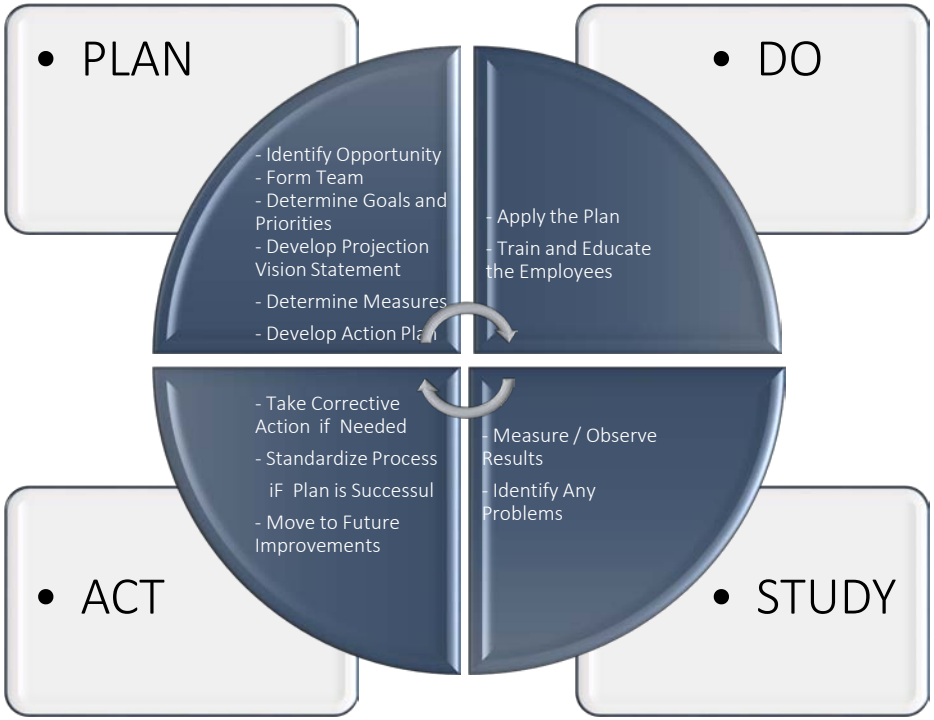
- As a SNP plan, Health Choice is responsible for ensuring the MOC identifies, describes, and implements an extensive network of qualified healthcare providers with demonstrated clinical expertise to meet the needs of our target populations' specialized needs and who do not discriminate against our most vulnerable beneficiaries
- Health Choice's network is comprised of over 2,000 primary care providers and more than 10,000 specialists
- Health Choice providers are trained and capable of meeting the special needs of patients with AIDS, Hepatitis C, Diabetes and a variety of other chronic/complex diseases difficult to effectively treat in rural and/or underserved Arizona



Element 3 – HCG Utah Provider Network

Health Choice Generations Utah offers an extensive network of qualified providers with demonstrated clinical expertise to meet the needs of our target populations' specialized needs and who do not discriminate against our most vulnerable beneficiaries. These include primary care doctors, specialists, and behavioral health providers. The Utah network is comprised of over 961 Primary Care Providers and more than 2400 Specialists. Health Choice providers are trained and capable of meeting the special needs of patients with AIDS, Hepatitis C, Diabetes and a variety of other chronic/complex diseases difficult to effectively treat in rural and/or underserved Utah.

Element 4 –
Providers can participate in Quality Initiatives.
Performance and Health Outcome Measurement



- The goal of performance improvement and outcome measurement as it relates to the MOC is to improve the plan's ability to deliver healthcare services and benefits to its members in a high quality manner
- Through routine analysis, goals are developed and targeted strategies are deployed. Providers support these efforts through surveys, initiatives such as avoiding readmissions or following evidenced based guidelines
- Health Choice utilizes the Plan, Do, Study, Act (PDSA) for all quality improvement initiatives

Element 4 Continued

- Through analysis, Health Choice has established priorities for clinical and case management through a series of sources including the Quality Improvement Plan (QIP), Star Metrics, Chronic Care Improvement Program (CCIP), and internal Quality Improvement Programs:

  - Care for Older Adult Focus: Pain Screening, Functional Status Assessment, and Medication Review
  - Member Satisfaction
  - Use of High Risk Medications
  - Early detection of chronic diagnoses
  - Reducing hospital readmissions
  - Medication Adherence
  - Appropriate timely and proactive medical services

Member Satisfaction

- Providers can encourage their members to participate with surveys
- Health Choice acknowledges that our members face complexities in navigating the Medicare and Medicaid systems, so our teams strive to provide the best service to enhance the member experience
- Health Choice focuses on member satisfaction from an internal and external perspective. Specifically, Health Choice analyzes our annual CAHPS survey results and identifies areas of improvement

Thank you for participating in the MOC training.