Senior Care Options

Model of Care Training

WellSense
HEALTH PLAN

Objectives of this Presentation

Introduce you to the WellSense Senior Care Options (SCO) Model of Care.

Provide an opportunity for you to consider ways that the WellSense SCO staff can work with you to enhance care and quality of life for our SCO members, your patients.

Allow you to easily meet requirements set forth by the Centers for Medicare and Medicaid Services (CMS) to complete annual SCO Model of Care training.

Attesting to Completion of this SCO Model of Care Training

Please note: At the end of this Model of Care Training presentation you will be required to submit an attestation to having completed this training.

It is important that you submit the attestation as directed in order to meet requirements of the Centers for Medicare & Medicaid Services.

What is Senior Care Options (SCO)?

- A special program for people 65 and older who are eligible for MassHealth Standard Medicaid
- Includes all benefits offered by both Medicare and Medicaid
- Some individuals in the program will be dually eligible, having both Medicare and Medicaid coverage, and others will have coverage under Medicaid only
- WellSense SCO's current service area is Suffolk, Barnstable, Bristol, Hampden and Plymouth Counties, meaning an individual must reside in one of these counties in order to enroll in WellSense SCO

Benefits covered under our Senior Care Options Plan

Medicare Part A services	Medicare Part B services	Medicare Part D services	Standard Medicaid Benefits, including long term services and supports (LTSS)
• Inpatient care in a hospital • Skilled Nursing Facility care • Nursing home (inpatient care in SNF that is not custodial or long-term care) • Hospice care • Home Health care	• Medically necessary services • Preventive services • Durable Medical Equipment (DME) • Mental Health services- inpatient, outpatient, partial hospitalization • Limited outpatient prescription drugs	• Pharmacy services (Prescription drugs)	• Personal Care Attendant • Home delivered meals • Homemaker/personal care services • Companion Services • Personal Emergency Response Services • Adult Day Health • Grocery shopping

There is **no cost sharing** for any covered service

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2022 Supplemental Benefits

Up to $600 a year to make approved healthy food and drug store purchases with our Over-the-Counter (OTC) card.

Up to $325 a year for an enhanced vision benefit to pay for better quality prescription eyeglasses or sunglasses.

Up to $250 a year for gym memberships or fitness tracker purchase as a part of our fitness reimbursement.

World-wide emergency care covering urgent care outside of the US and its territories

SCO members are eligible to receive additional, supplemental benefits outside the standard Medicare and Medicaid benefits

Interdisciplinary Care Team (ICT)

All individuals participating in a SCO plan are assigned a:

- Primary Care Clinician who is a community-based physician or nurse practitioner credentialed with our SCO program
- SCO Care Manager who is a registered nurse coordinating care for our members across the care continuum
- Geriatric Support Services Coordinator (GSSC) who coordinates home and community based services

Additional SCO staff may be incorporated into the ICT as needed:

- Specialty providers
- Behavioral Health Care Manager
- Social Work Care Manger
- Pharmacist
- Geriatrician

Model of Care Goals

To tailor services provided to each individual in order to best meet their specific needs and challenges and provide person-centered care in the least restrictive setting by collaborating with the Interdisciplinary Care Team and other clinicians to facilitate:

- **Patient access** to essential services, including medical, mental health, community-based, and long-term social and support services
- **Care coordination** through an identified point of contact
- **Seamless transitions** of care across health care settings, providers and health services
- **Appropriate utilization** of services

Formal Assessments

Initial Assessments

SCO Care Managers meet face-to-face with members to complete two initial assessments within 30 days of their effective date with the plan:

- **Health Risk Assessment (HRA)**
- **Minimum Data Set-Home Care (MDS-HC**): an instrument that provides a standardized assessment of the member to facilitate care management

These assessments capture pertinent information (e.g., medical, behavioral health, medication history) that are used to develop the Individualized Care Plan (ICP).

Ongoing Assessments

All members will receive an HRA every six months by a member of the ICT. Individuals who require complex care or who are high risk will also receive quarterly assessments to monitor chronic conditions and/or ongoing needs.

Individualized Care Plans (ICP)

ICPs are developed by the Interdisciplinary Care Team (ICT), in collaboration with the member and the member's PCP, SCO Care Manager, and other healthcare and social services staff as needed.

ICPs include person-centric problems, interventions and goals, as well as services the member will receive, as approved by the ICT, including:

- Medical conditions management
- Long-term services and supports
- Skilled nursing, OT, PT, ST
- Behavioral health and substance use
- Transportation
- Other services, as needed

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Primary Care Clinician's Role within the ICT

Primary Care Clinicians are asked to collaborate with SCO staff by:

- Reviewing and providing feedback, if needed, to their patient’s initial and updated Individualized Care Plans (ICP).
- Being available to the SCO Care Manager to discuss changes in patient status, order requests (e.g., DME, pharmacy, etc.), and other services needed to support a patient through transitions of care or to help them remain in the community.
- Reviewing the Centralized Enrollee Record (CER) when necessary to coordinate care for their patient with the ICT .

Clinician and Organizational Provider Requirements

All clinicians and organizational providers in the WellSense SCO network must be credentialed initially, then re-credentialed by the health plan every two years. If you are already credentialed with WellSense, you do not have be credentialed again for SCO.

All clinicians and organizational network providers must comply with the CMS requirement to participate and attest to participation in this plan-specific annual Model of Care (MOC) training.

Advance Directives

WellSense SCO encourages all clinicians to discuss with their patients the importance of advance directives and to assist in their preparation, if requested.

Advance directives and health care proxies are collected by the SCO Care Manager at time of a member's initial assessment. Clinicians and organizational providers can request a copy from the SCO Care Manager by calling 855-833-8125.

Delivering Culturally Competent Care to SCO Members

As healthcare disparities among cultural minority groups persist in our country, culturally and linguistically appropriate services (CLAS) are increasingly recognized as an important strategy for improving quality of care to diverse populations.

WellSense SCO has e-learning programs that will equip you with the knowledge, skills, and awareness to best serve all patients, regardless of cultural or linguistic background.

If you would like to learn more about CLAS, please click here.

Centralized Enrollee Record (CER)

The CER is a single, centralized, comprehensive record containing information relevant to maintaining each member's general health and well-being with clinical information concerning their illnesses, chronic medical conditions, service plans and utilization history.

The CER documents the member's medical, functional and social status and is accessible via WellSense's online provider portal.

You can access the WellSense HealthTrio Provider Portal by visiting:

https://bmchp-wellsense.healthtrioconnect.com

You may also access necessary patient documentation by contacting your patient's SCO Care Manager.

Clinical Vendors

Vendor Category	Vendor	Contact Info
Behavioral Health	Beacon Health Options • Manages inpatient and outpatient behavioral health and substance use services. • Prior authorization may be required for certain services.	https://www.beaconhealthoptions.com/ 866-444-5155
DMEPOS	Northwood • Manages durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) network. • Prior authorization is required for all DMEPOS dispensed and billed by a DMEPOS supplier.	https://northwoodinc.com/ 866-802-6471
NEMT	Coordinated Transportation Solutions • Provides non-emergency medical and social transportation for covered medical appointments • Network consists of livery and taxi operators, wheel chair van providers, public transportation, and ambulance companies	https://www.ctstransit.com/ 855-833-8125 option 9
High End Radiology	eviCore • Manages outpatient non-emergency high end radiology (MRI, CT, PET, Nuclear Cardiology) • Prior authorization may be required for certain services.	https://www.evicore.com/ 866-802-6471
Dental	DentaQuest • Manages the dental network. • Prior authorization may be required for routine dental care.	http://www.dentaquest.com/ 844-234-9829

Pharmacy Services

The SCO formulary differs from the plan's Medicaid product because it must follow Medicare Part D requirements.

Copays and over-the-counter drugs are covered by Medicaid

Prescriptions can be filled at any network pharmacy

- Different pharmacy networks for SCO Duals and Medicaid Only

Specialized pharmacy services are covered if they are provided at no additional cost for in-network pharmacies including:

- Mail order
- Adherence packaging

The formulary, pharmacy finder and associated clinical policies can be found here.

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Quality: Performance & Health Outcome Measurement

WellSense's Quality Improvement Program is based on the Institute for Healthcare Improvement's (IHI) Triple Aim framework to improve:

- An individual's health status and quality of care
- An individual's perception of the healthcare experience
- Cost efficiencies in the delivery of health care services

The Plan regularly reviews, prioritizes and deploys initiatives to encourage and improve network performance in select areas measured by the STAR Ratings program (Part C & D Measures).

Part C:

- Breast Cancer Screening
- Colorectal cancer screening
- Diabetes Care
- Plan All-Cause Readmissions
- Getting Needed Care
- Member Complaints

Part D:

- Appeals Processing
- Getting Needed Prescription Drugs
- High Risk Medication
- Medication Adherence (Diabetes, Hypertension, Cholesterol)
- Medication Therapy Management Completion

These initiatives often include outreach to our members and network clinicians and organizational providers to collaborate on improving quality of care, health outcomes, medical expense and the patient experience.

Member Appeals

A **Member Appeal** is when the Member or the Member's Authorized Representative, including a clinician or organizational provider on a Member's behalf, requests a review of partially or fully denied health care services the member believes he/she is entitled to receive. Clinicians or organizational providers may be asked to work with WellSense to help us process Member Appeals (e.g., by providing timely additional clinical information to support the appeal request).

- ***Standard Appeals*** are processed within 30 calendar days (for medical requests) and within 7 calendar days (for medication requests) of the receipt date of the request.
- ***Expedited Appeals*** are processed within 72 hours of the receipt of the request

Expedited Appeals are reserved for instances where a clinical or organizational provider feels that awaiting the standard resolution of member appeal could seriously jeopardize the member's life or health, or the member's ability to attain, maintain or regain maximum function

A clinician or organizational provider must assert that the standard timeframe could result in serious risk or harm to the member's life/condition

Member Grievances

A **Member Grievance** is any expression of dissatisfaction relayed by a member or their Appointed Representative, including a clinician or organizational provider on behalf of a member to WellSense.

Grievances may be related to quality of care concerns, attitude and service of clinicians, organizational providers or office staff, lack of cleanliness of a provider office, wait times to see a provider, etc.

The clinician's or organizational provider's responsibility in response to a grievance is to:

- Cooperate fully with WellSense's Appeal & Grievance staff, RNs and Medical Directors who may reach out to you as part of the investigation
- Provide all requested information to the Appeal & Grievance Specialist in a timely manner.

- ❑ **Standard Grievances** require a response to the Plan within **5-7 business days**
- ❑ **Expedited Grievances** may require an immediate response, depending upon the specific situation, but generally require a response to the Plan within **24-72 hours**.

Attestation

Thank you for completing the Model of Care training.

We look forward to working with you to help your patients, our members, receive exemplary care and achieve the best possible quality of life.

Please click here to complete the required attestation.