Senior Care Options

Model of Care Training

WellSense HEALTH PLAN

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

What is a Model of Care (MOC)?

The Model of Care (MOC) is considered a vital quality improvement tool and integral component for ensuring that the unique needs of each member enrolled in a SNP are identified and addressed. CMS and NCQA requires all SCO plans to submit a MOC detailing four areas:

- Description of the SCO population
- SCO Care Coordination Processes
- SCO Provider Network
- SCO Quality Measurement & Performance Improvement

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

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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2025 Supplemental Benefits

Up to $1,860 per year on a debit card to use toward over-the-counter drugstore items, healthy foods and utilities (electricity, water, sewer, gas, internet and cell phone).

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

Silver Sneakers Fitness Program at no cost

Rides to appointments: Free rides to medical appointments and 10 extra rides per month for social visits

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

Clinical Vendors

Vendor Category	Vendor	Contact Info
Behavioral Health	Carelon Behavioral Health • Manages inpatient and outpatient behavioral health and substance use services. • Prior authorization may be required for certain services.	www.carelonbehavioralhealth.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 Inc. (CTS) • Provides non-emergency medical rides for covered medical appointments and social transportation • Network consists of taxi livery, wheelchair van providers, stretcher and ambulance companies	https://www.ctstransit.com/ 855-833-8125 option 9
High end radiology, Musculoskeletal, and Pain Management, Genetic Testing	eviCore Healthcare Manages pre-service review of: • Radiology services: CT/MRI/MRA/PET • Genetic testing • Musculoskeletal and pain management procedures	https://www.evicore.com/ 888-693-3211
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.

Interdisciplinary Care Team (ICT)

The ICT shares responsibility for coordinating care that meets the member's needs. The care team is informed about, and ready to address, the member's needs holistically.

- The composition of the ICT varies in response to the member's unique needs and priorities. 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:**
  - Nurse Practitioner
  - Specialty providers
  - Behavioral Health Care Manager
  - Social Work Care Manager
  - Pharmacist
  - Geriatrician

SCO Care Manager's Role Within the ICT

- Meets with the member in their home and conducts clinical assessments. The initial assessments occur within the first thirty days of enrollment and are followed by ongoing assessments throughout the member's enrollment.
- Uses the results of assessments in collaboration with the other members of the ICT to identify member needs and create individualized care plans (ICPs) to address those needs.
- Schedules meetings with the member's ICT to update the team on progress towards goals and/or new member issues that need to be addressed.
- Works with the transition of care (TOC) team to ensure seamless member transitions between care settings (for example, from inpatient hospitalization to home).

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 are person centered and include the member's self-management goals and preferences.

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

Primary Care Clinician's Role within the ICT

Primary Care Clinicians 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 and order 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.

The ICT is responsible for maintaining the health and wellness of the member, engaging the personnel necessary to support person-centered care, and collaborating to create and execute the member's ICP leading to informed decision-making and quality outcomes.

Provider Responsibilities – Fall Awareness and Training

Falls are the leading cause of injury to the Elder Population. Every 17 seconds an elder will be treated in the ED for a fall.

•Support members by providing awareness &training to your SCO members.

•Screen all members for fall risk by completing:

A full medication and functional assessment review

A screening for previous falls to determine member risk

•Implement interventions based on falls risk

•Educate office staff on assessing & documenting previous member falls, the cause and interventions put in place to prevent future falls

•Evaluate the effectiveness of the fall prevention activities through a 30 day follow up

For Adult Preventive Guidelines & a Fall prevention checklist visit this link at the Massachusetts Health Quality Partners website: http://www.mhqp.org/products_and_tools/?content_item_id=169#C9

Provider Responsibilities –Cultural Competency

WellSense encourages and expects providers to:

•Be aware of cultural differences and the potential impact of cultural differences

•Acquire cultural knowledge and skills to understand the needs of the populations they serve. Visit wellsense.org/providers/ma/training-and-support

•Ask questions relevant to how the family and culture values might influence the patient's health care perceptions and needs

•Listen to the patient's opinion in considering treatment options

•Assist members (such as those with disabilities) in maximizing both their involvement in their care as well as their independence and functioning

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 and member portal and includes:

- **Member assessments**
- **Individualized care plans**
- **Medication information**

Members and providers can access the WellSense HealthTrio Provider Portal by visiting:

https://bmchp-wellsense.healthtrioconnect.com

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.

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.

SCO Member Rights

Members have the right to:

- **Be free from abuse, neglect, and exploitation**.
- **Approve their individualized care plan.**
- **Appeal any denial, termination, suspension, or reduction in services, or any other change in providers, services, or medications**.
- **Establish an advance directive** giving a designated appointee the right to make health care decisions on their behalf. WellSense encourages members to give providers a copy of the completed directive. A copy is also stored in the Jiva care management system.
- **To contact My Ombudsman**. My Ombudsman helps people enrolled in Medicaid with service or billing problems. They can help the member file a grievance or appeal with Well Sense.
  - Contact Information 855-781-9898 Available 9:00 a.m. -4:00 p.m. Monday through Friday TTY 711
  - E-mail at info@myombudsman.org
  - Write to: Executive Office of Elder Affairs One Ashburton Place, 5th Floor Boston, MA 02108
  - Website: www.mass.gov/MassHealth

Member Inquiries, Appeals and Grievances… *and how to tell the difference*

Inquiry:

- Inquiry examples:
  - Member asks for benefit materials without expressing dissatisfaction
  - Member asks about coverage for a medication, service or supply without expressing dissatisfaction or mentioning receipt of a denial notice
  - Member asks for help with an issue they are having
  - Member needs help coordinating transportation
  - Member wants a call back from their Care Manager

Appeal:

- Types of requests include asking for a prescription, service or supply before they obtain it, such as, but not limited to,
  - Prescription drug from pharmacy
  - Medical drug in doctor's office
  - Durable medical equipment
  - Surgical procedures or therapies
  - Radiology services
  - Home health care
- It's also possible for a member to request a post-service payment appeal. This happens when a member pays out of pocket and submits a receipt for payment. If that payment request is denied, the member or their authorized representative may file an appeal
- Members may appeal any denial, termination, suspension, or reduction in services, or any other change in providers, services, or medications, included in an Individualized Care Plan

Grievance:

- Grievance examples:
  - Members may complain about their Individualized Care Plan
  - Member states they are upset because they didn't receive a call back
  - Member had a poor experience with healthcare provider's office or staff
  - Member feels their provider prescribed the wrong treatment, lab, or medication

Note: these are not all-inclusive examples

Member vs. Provider Appeals *how to tell the difference*

Member Appeals:

- Filed by a member or a member's authorized representative (including a member's healthcare provider or prescriber) asking for a prescription, service or supply before they obtain it, such as, but not limited to,
  - Prescription drug from pharmacy
  - Medical drug in doctor's office
  - Durable medical equipment
  - Surgical procedures or therapies
  - Radiology services
  - Home health care
- Member pays out of pocket and after submitting a receipt for payment and getting a denial, the member or their authorized representative may file an appeal
- A member's healthcare provider will file an appeal on the member's behalf *before* a service is rendered
- Members may also challenge benefit cost shares or exclusions
- It is possible for a non-participating provider to render a service and then file an appeal, too,
  - Pre-service = Member Appeals
  - Post-Service Claim Appeals = Provider Appeals, *more on this below*

Provider Appeals:

- Filed by participating providers *after* a service has been rendered (post-service claim appeals)
  - If UM denies an inpatient acute level of care stay because the services could have been rendered at a lower level of care (like observation)
  - Claim edits (correct coding, CMS MUE, etc)
  - Readmissions
  - Lack of Prior Authorization / Inpatient notification appeals
  - Timely Filing Denials
- Filed by non-participating providers regarding post-service claim appeals, must execute a Waiver of Liability for DSNP members

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). In accordance with regulatory requirements, we may require a completed Appointment of Representative form before we can process the appeal request.

- ***Standard Appeals*** are processed within 30 calendar days (for medical requests or SCO MassHealth Only Medical Drugs) and within 7 calendar days (for Part B medical drug or Part D 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 provides justification 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

Misdirected Appeals and Grievances:

- If you receive a misdirected written or email containing a member appeal / grievance, please redirect to WellSense Member Appeals and Grievances and attach the request you received as quickly as possible
    - Member Appeals and Grievance e-fax: 617-897-0805

Member Grievances

A **Member Grievance** is any expression of dissatisfaction relayed by a member or their Appointed Representative 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.
- Please be sure to respond to all elements of the inquiry from the WellSense Appeals and Grievances Specialist, including any member experience-related perceptions of rudeness, discrimination, or perceived barriers to care

Standard Grievances require a provider to respond to WellSense within **5-7 business days**

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). Examples include:

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.

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.