2025 Model of Care Provider Training

L.A. Care HEALTH PLAN®

For All of L.A.

L.A. Care *Medicare Plus*™

(HMO D-SNP)

PL1697 1023

Training Topics

- Overview of L.A. Care’s Dual Special Needs Plan (D-SNP)
- What is the L.A. Care’s Model of Care (MOC)?
- What are the MOC Roles and Responsibilities for Providers

Training Objectives

- Understanding of L.A. Care Medicare Plus D-SNP and Coverage
- How to deliver coordinated care and care management in accordance with L.A. Care's Model of Care
- Be compliant with Completing L.A. Care Model of Care Training Requirements

CMS Requirements Overview

The Centers for Medicare & Medicaid Services (CMS) requires healthcare providers and their staff who provide care to L.A. Care Medicare Plus (HMO D-SNP)’s members regularly, must complete Model of Care (MOC) training initially and annually thereafter

What is a Dual Special Needs Plan (D-SNP)?

- Type of Medicare Advantage (MA) plan that's available to individuals who are entitled to both Medicare and Medi-Cal

- D-SNPs must do the following:
  - Administer Medicare benefits
  - Assist and coordinate access to both Medicare and Medi-Cal services on behalf of the member

Exclusively Aligned Enrollment (EAE)

State policy requirement under the California Advancing and Innovating Medi-Cal (CalAIM) Initiative

Exclusively Aligned Enrollment (EAE) Mandate

- Enrollment of Duals into a single Managed Care Organization (MAO) for Medicare and Medi-Cal
- Medicare will be the “Lead Plan” aligning with Medi-Cal Plan Enrollment

L.A. Care Medicare Plus™ (HMO D-SNP) + L.A. Care® Medi-Cal

L.A. Care Medicare Plan Information

One Health Plan for Medicare and Medi-Cal Coverage

- **Plan Name:** L.A. Care Medicare Plus (D-SNP)
- **Contract-PBP:** H1224-001
- **Eligible Members:** Full Duals Medi-Medi
- **Plan Type:** Exclusively Aligned Enrollment D-SNP

L.A. Care Medicare Plus (HMO D-SNP)

L.A. Care Medicare Plus *combines Medicare and Medi-Cal benefits into one plan, and it coordinates all benefits and services under both programs.*

	Medicare		Medi-Cal (COB Rules)
Premium	$0		
Part B Cost-Shares	20%		Picks Up Medicare Cost-Share
Part A/B Deductibles	Original Medicare	COB	Picks Up Medicare Deductibles
Part D Cost-Share	$0	COB	$0

For a full list of benefits visit: https://medicare.lacare.org/

L.A. Care Model of Care (MOC)

CY2025 Change Highlights

Caregivers in the ICP and ICT

- Member's caregiver must be actively engaged in the Individualized Care Plan (ICP) development and the Interdisciplinary Care Team (ICT) meetings

Advance Care Planning

- Providers must perform ACP discussions during the Annual Wellness Exam (AWE) or other visits

What is the L.A. Care Model of Care (MOC)?

L.A. Care's blueprint for the care of our members

- Coordinate comprehensive care for vulnerable and at-risk members, focusing on their health conditions and social factors
- Improving quality, access, affordability, and care integration
- And helps members by ensuring smooth care transitions, promotes preventive health services, appropriate utilization of benefits and ultimately by improving member health outcomes

Model of Care (MOC) Components

Description of the D-SNP Population

Care Coordination

Specialized Provider Network

Quality Measurements and Performance Improvement

L.A. Care Medicare Population

General Characteristics

- Older adults (65+ years old)
- Members with disabilities and those who are blind or disabled (ABD)
- Have multiple health conditions, complex care needs, and cognitive/behavioral conditions

Most Vulnerable

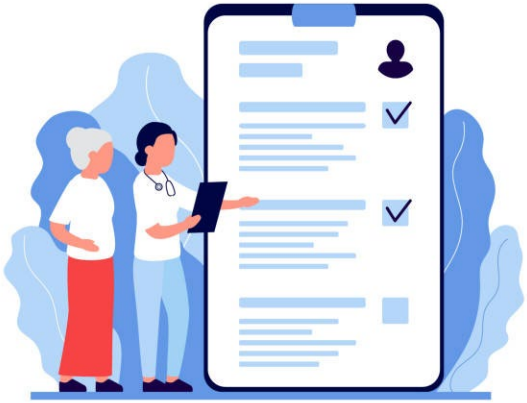
- Complex or multiple chronic conditions
- Disabled or frail
- Facing socioeconomic challenges
- Dementia-related disorders
- Near the end of life
- Multiple medications (polypharmacy)

Care Coordination

Health Risk Assessment (HRA)

- L.A. Care administered member self reported questionnaire tool asses member's risk level and needs
- Identification of the member's medical, mental, and other health needs, identification of member's caregiver, Medi-Cal services the member is currently accessing
- If a caregiver is identified, the Care Manager will complete a Benjamin Rose Caregiver Strain assessment on the caregiver
- Must be completed for all members initially and annually thereafter. Providers are encouraged to remind members the importance of completing an HRA and are encouraged to review completed HRAs

Individualized Care Plan (ICP)



- Developed by Care Manager for all members initially and annually
- Includes Health Risk Assessment (HRA) results or if absent, historical claims or utilization data
- Includes member self-manage (SMART) goals **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**ime-Dimensioned
- Involves member and/or caregiver, Care Manager, Primary Care Provider or specialist, Interdisciplinary Care Team including other appropriate participants and consistent with members preference
- Share ICPs physical copy with members in their preferred language/format and provide a copy to ICT participants upon request

Interdisciplinary Care Team (ICT)

- The ICT is a cross-functional team of supports to assist members with their individualized care needs and help address any identified complexities, barriers, and unmet needs
- At a minimum must include the Core Team and any clinical and/or non clinical individuals actively involved in the member's care and consistent with member's preference
- All required ICT participants must attend the annual ICT meeting

Core Team

Member/Caregiver
Care Manager
PCP or Specialist acting as PCP

Clinical

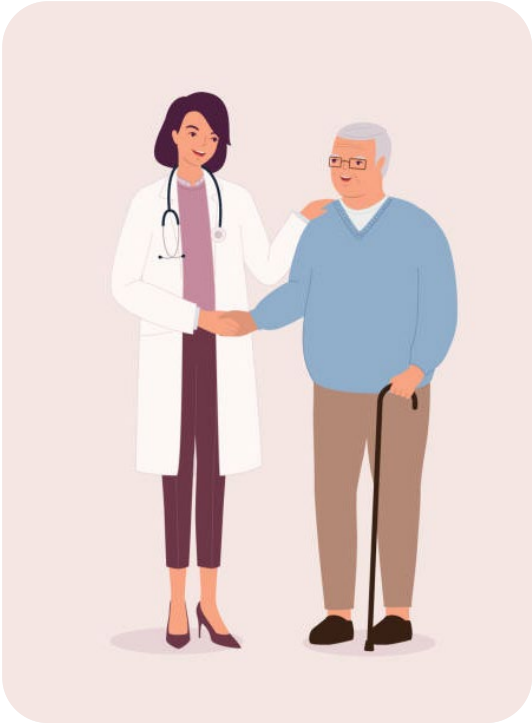
Specialist
Pharmacist
Social Worker
Certified Health Educators
Registered Dietitians
Medicare Directors
In-Home Support Services Provider
Community Based Adult Service Provider
Multi-Service Senior Services Program Care Manager
Palliative Care Team
Dementia Care Specialist
Nursing Facility care team

Non-Clinical

Family Members
Appointed Designee
Community Health Worker
Care Management Coordinator
Community-Based Organizations
Community Supports providers
Waiver Agencies (California Community Transition Lead and Home and Community Based Services)

Face-to-Face Encounters

- Every member will have a face-to-face encounter within the first twelve (12) months of initial enrollment and then annually thereafter
- Must be with member's Primary Care Provider, Specialist, Care Manager or member of their Individualized Care Team (ICT)
- Visits must be in-person or through a real-time video call if member accepts
- Visits must be tracked through claims, encounters or documentation of member declining face-to-face visit



Transitions of Care (TOC)

The coordination of member's care when moving from one setting (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another

Care Managers are responsible for the following:

- Contacts the member within 72 hours after being discharged
- Coordinate care and services, review medications, and schedule follow-up appointments including face-to-face visit with their PCP within 30 days
- Update member's care plan as needed and notify Interdisciplinary Care Team of transition

PCPs are responsible for the following:

- Conducting a visit with the member within 30 days of discharge, including completing a Medication Reconciliation
- Documenting receipt of notification of Inpatient Admission and receipt of discharge information in the medical record

State Policy Requirement: Palliative Care

Multidisciplinary approach to specialized social and medical care for people with serious and advanced illnesses with the goal to improve the quality of life for both the Member and their family

Delivery of the following Palliative Care services managed by L.A. Care:

- Advance Care Planning
- Palliative Care Assessment and Consultation
- Plan of Care
- Palliative Care Team of doctors, nurses, social workers, chaplain, and other specialists.
- Care Coordination
- Pain and Symptom Management
- Mental Health and Medical Social Services

Referral to L.A. Care's Care Management

- Members eligible for palliative care services per Senate Bill 1004

Source: https://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

State Policy Requirement: Enhanced Care Coordination

Delivery of enhanced care coordination of Medicare and Medi-Cal services for the most vulnerable

Identification and referral to L.A. Care's Care Management for following at risk populations of focus:

- Adults at risk for avoidable hospitalization or emergency room utilization
- Adults living in the community and at risk for institutionalization
- Adult nursing facility residents transitioning to the community
- Pregnancy, postpartum and birth equity

State Policy Requirement: Dementia Care and Training

Detection of Cognitive Impairment

- Providers must complete Cognitive Health Assessment (CHA) training through Dementia Care Aware
- PCPs and other providers are encouraged to conduct CHAs during office visits for early detection of cognitive impairment

Quality Performance

- Participating Provider Group (PPG) are subject to the Mild Cognitive Impairment (MCI) annual performance monitoring and data collection in the format provided by L.A. Care

Dementia Care Aware Training: https://www.dementiacareaware.org/
Mini-Cog: https://www.alz.org/media/Documents/mini-cog.pdf

Care Coordination for Members with Cognitive Impairment

- Suspected or confirmed diagnosis of Alzheimer's or dementia should include the Member's caregiver and a trained dementia care specialist in the interdisciplinary care team (ICT) to the extent possible and consistent with the Member's preferences

Quality Measurement and Performance Improvement

Model of Care Key Quality Performance Improvement Areas

Access and Affordable Care	Coordination of Care	Transition of Care	Preventive Services and Chronic Conditions
• Getting Needed Care • Getting Appointments and Care Quickly • Ease of Getting Needed Prescription Drugs	• Health Risk Assessment (HRA) • Individualized Care Plan (ICP) • Interdisciplinary Care Team (ICT)	• Notification of Inpatient Admission • Receipt of Discharge Information • Patient Engagement after Inpatient Discharge and Medication Reconciliation • Plan All Cause Readmissions (30 Day Unplanned)	• Annual Wellness Exam (AWE) • Flu Shots • Breast and Colon Cancer Screenings • Blood Pressure, Cholesterol and Diabetes Control • Monitoring Physical Activity • Fall Risk Prevention • Managing Urinary Incontinence • Depression Screening and Management

Regulatory References

CMS Medicare Managed Care Manual for Special Needs Plans (SNPs):
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf

CMS SNP Model of Care (MOC) information:
https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

Electronic Code of Federal Regulation:
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422

DHCS D-SNP Policy:
https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-(D-SNP)-Contract-and-Program-Guide.aspx

Dementia Care Aware Training:
https://www.dementiacareaware.org/