Gold Coast Health Plan Total Care Advantage HMO D-SNP

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Integrity

Accountability

Collaboration

Trust

Respect

Total Care Advantage HMO D-SNP Overview

1. Introduction to Total Care Advantage HMO D-SNP
2. Eligibility
3. Total Care Advantage Benefits
4. Understanding Total Care Advantage Model of Care
   - MOC 1: Understanding Total Care Advantage D-SNP Members
   - MOC 2: Understanding Total Care Advantage Care Coordination

Introduction: Total Care Advantage (HMO D-SNP)

Total Care Advantage is Gold Coast Health's Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal.

Total Care Advantage is an Exclusively Aligned Enrollment D-SNP (EAE D-ANP), also called a Medi-Medi Plan.

This allows Total Care Advantage (TCA) to serve our members by integrating their Medicare and Medi-Cal benefits and support them with a Model of Care that coordinates their care.

Eligibility for Total Care Advantage

Eligibility requirements

Members can join if they:
- Have both Medicare Part A and B
- Have full-scope Medi-Cal
- Are 21 years or older
- Live in Ventura County

Enrollment is **voluntary**.

To enroll, people can call Total Care Advantage at **1-888-808-7879** or 1-800-MEDICARE.

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Total Care Advantage Benefits

Total Care Advantage provides Medicare services, such as:

- Hospitals
- Providers
- Prescription drugs
- Supplemental Benefits

Total Care Advantage also provides wrap-around services, such as:

- Medicare cost-sharing
- Long-Term Services and Supports (LTSS)
- Transportation

Total Care Advantage also provides Care Coordination where every member is assigned a Care Navigator or Care Manager who:

- Conducts Health Risk Assessment (HRA) to identify member needs and recommended services/supports/benefits.
- Works w/ the member on an Individualized Care Plan (ICP),
- Facilitates Interdisciplinary Care Team (ICT) and
- Provides Transitional Care Services (TCS)

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Total Care Advantage Supplemental Benefits

Supplement Benefits:
- Acupuncture - ASH
- Fitness - Optum One Pass
- Hearing - VSP
- Vision - TruHearing
- Worldwide Emergency

Total Care Advantage members also have supplemental benefits available if they meet criteria such as:
- Readmission Prevention Meals (24 meals/year)
- Readmission prevention Personal Care/Homemaker (64 hours/year)
- SSBCI Social Transportation to Church, Gym, Grocery Store and Senior Center (24 one-way rides/year, 30 miles each ride maximum)
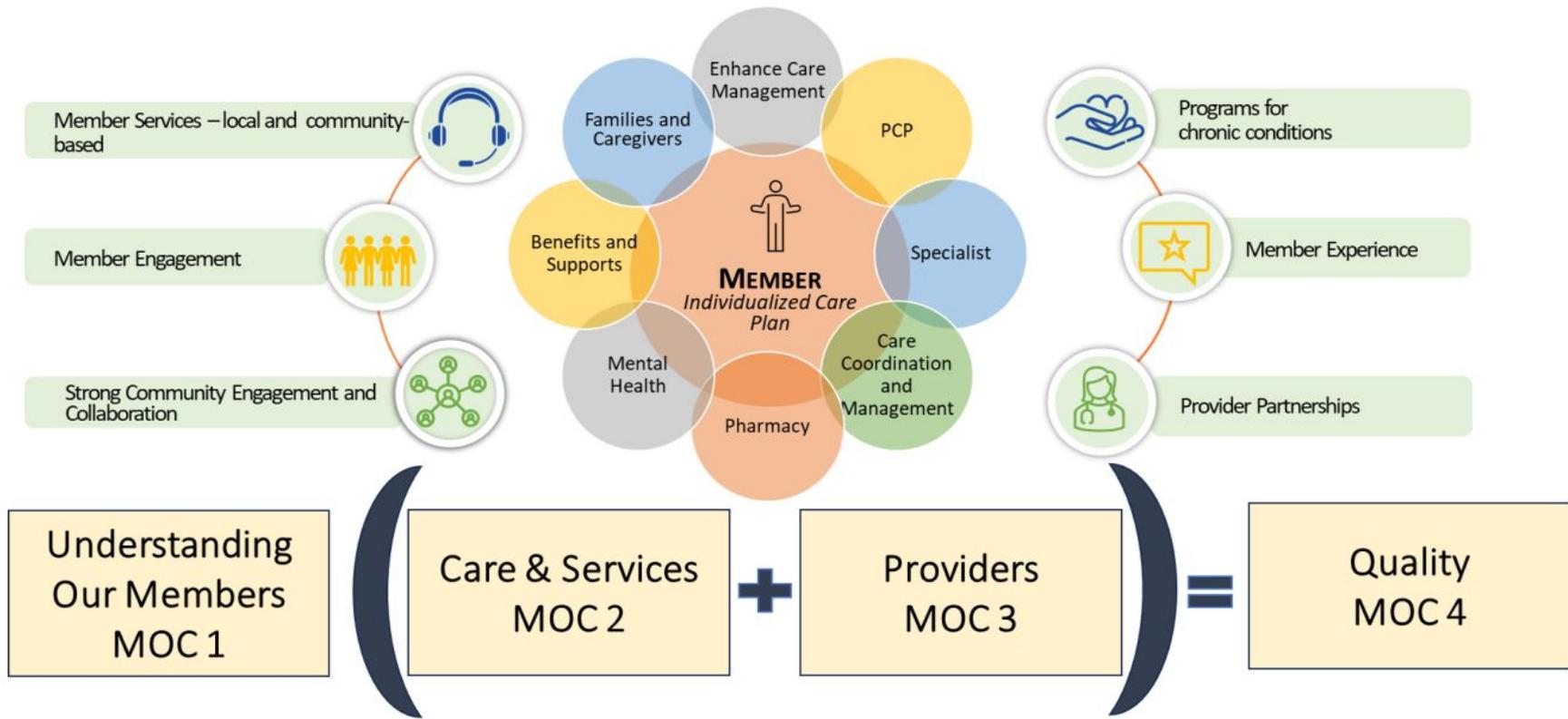
* Community Supports benefits continue to be available to eligible **Total Care Advantage** members
- CBAS and PERS are also available benefits

Total Care Advantage D-SNP Model of Care

MOC 1: Understanding Total Care Advantage D-SNP Members

Objective:

- Become familiar with characteristics of Total Care Advantage D-SNP membership

- Understand most vulnerable target population within Total Care Advantage D-SNP and possible supports

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MOC 1: Understanding Total Care Advantage D-SNP Members

Gold Coast Health Plan — A Public Entity

Members by Age Group

Age Group	Members	% Members
00-64	72	15.8%
65-69	172	37.7%
70-74	92	20.2%
75-79	64	14.0%
80-84	33	7.2%
85-89	13	2.9%
90-94	6	1.3%
95-99	3	0.7%
100+	1	0.2%
Total	456	100.0%

Members by Sex

Sex	Members	% Members
F	259	56.8%
M	197	43.2%
Total	456	100.0%

View Roster (Restricted) ▸

Members by Language

Language	Members	% Members
Spanish	247	54.2%
English	197	43.2%
Tagalog	4	0.9%
	2	0.4%
No Valid Data Reported	2	0.4%
American Sign Language	1	0.2%
Mandarin (China)	1	0.2%
Other	1	0.2%
Russian	1	0.2%
Total	456	100.0%

Members by Ethnicity

Ethnicity	Members	% Members
Hispanic or Latino	274	60.1%
Not Hispanic or Latino	84	18.4%
Decline to Answer	71	15.6%
Asian	18	3.9%
Unknown	6	1.3%
	3	0.7%
Total	456	100.0%

Members by City

City	Members	% Members
OXNARD	179	39.3%
VENTURA	53	11.6%
SIMI VALLEY	42	9.2%
SANTA PAULA	37	8.1%
CAMARILLO	29	6.4%
OJAI	24	5.3%
FILLMORE	23	5.0%
THOUSAND OAKS	23	5.0%
PORT HUENEME	14	3.1%
MOORPARK	10	2.2%
NEWBURY PARK	9	2.0%
OAK VIEW	7	1.5%
OAK PARK	2	0.4%
PIRU	2	0.4%
SAN BUENAVENTURA	1	0.2%
SOMIS	1	0.2%
Total	456	100.0%

Members by Category of Aid

Category of Aid	Members	% Members
SPD	409	89.7%
Adult Expansion	38	8.3%
Adult/Family/OTL IC	6	1.3%
	3	0.7%
Total	456	100.0%

Members by PCP System

PCP System	Members	% Members
CLINICAS	282	61.8%
VCMC	174	38.2%
Total	456	100.0%

Members by Case Type

Case Type	Members	% Members
General	340	74.6%
No Case	80	17.5%
CICM	36	7.9%
Total	456	100.0%

MOC 1: Understanding Total Care Advantage D-SNP Members

Chart 1.3: Number of Chronic Conditions by GCHP D-SNP Cohort
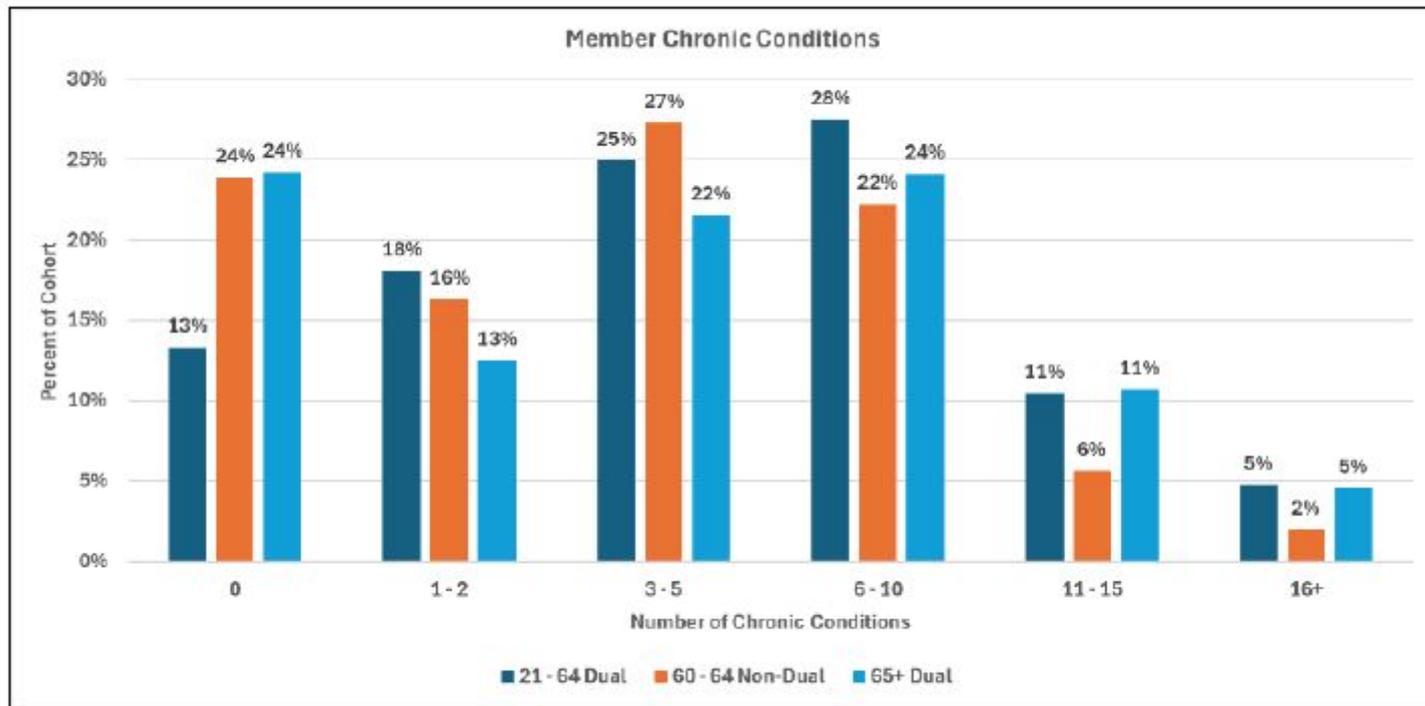
Data Source: Johns Hopkins ACG Patient Data
Data Reference Date: November 2024

MOC 1: Understanding Total Care Advantage D-SNP Members

Most Vulnerable Population Sub-Type	Possible Support Provided
Medical Complexity including CICM* populations: • Individuals At Risk for Avoidable Hospital or ED Utilization • Birth Equity	• Nurse Care Manager • Pharmacist engagement • Chronic Condition Management Program • Referral to palliative care • Referral to high-risk obstetrics care management
Frailty including CICM* populations: • Adults Living in the Community and At Risk for LTC Institutionalization • Adult Nursing Facility Residents Transitioning to the Community	• Social worker engagement • Long Term Services and Support • Referral to palliative Care • Hospice Care
Psychiatric/Behavioral Health Complexity including CICM* population: • Individuals with Serious Mental Health and/or SUD Needs	• Intensive Behavioral Health Care Management • Collaboration with County Behavioral Health Services
Access to Care including CICM* populations: • Adults Living in the Community and At Risk for LTC Institutionalization • Adult Nursing Facility Residents Transitioning to the Community • Individuals in need of specialty care, community or dental care	• Targeted outreach to support connection to primary care and to access preventive services • Dental Care Navigation • Closed loop referral to Medi-Cal services
High Social Need including CICM* populations: • Individuals Experiencing Homelessness • Individuals Transitioning from Incarceration	• Social worker engagement • Long Term Services and Support • Community Supports and Referrals

*In the California D-SNP, the program of ECM-like services is called California Integrated Care Management (CICM).

MOC 1: Understanding Total Care Advantage D-SNP Members

Key Takeaways:

- Majority of likely D-SNP members are 65+

- More than half have 3+ Chronic conditions

- Most common health conditions shared in all 3 cohorts were:
  - Hypertension
  - Disorders of lipid metabolism
  - Type Two Diabetes

- Total Care Advantage D-SNP defines its Most Vulnerable enrollees as those members with complex health and social needs including members who meet California Integrated Care Management (CICM) populations criteria. Vulnerable members will be assigned a nurse care manager or social work care manager.

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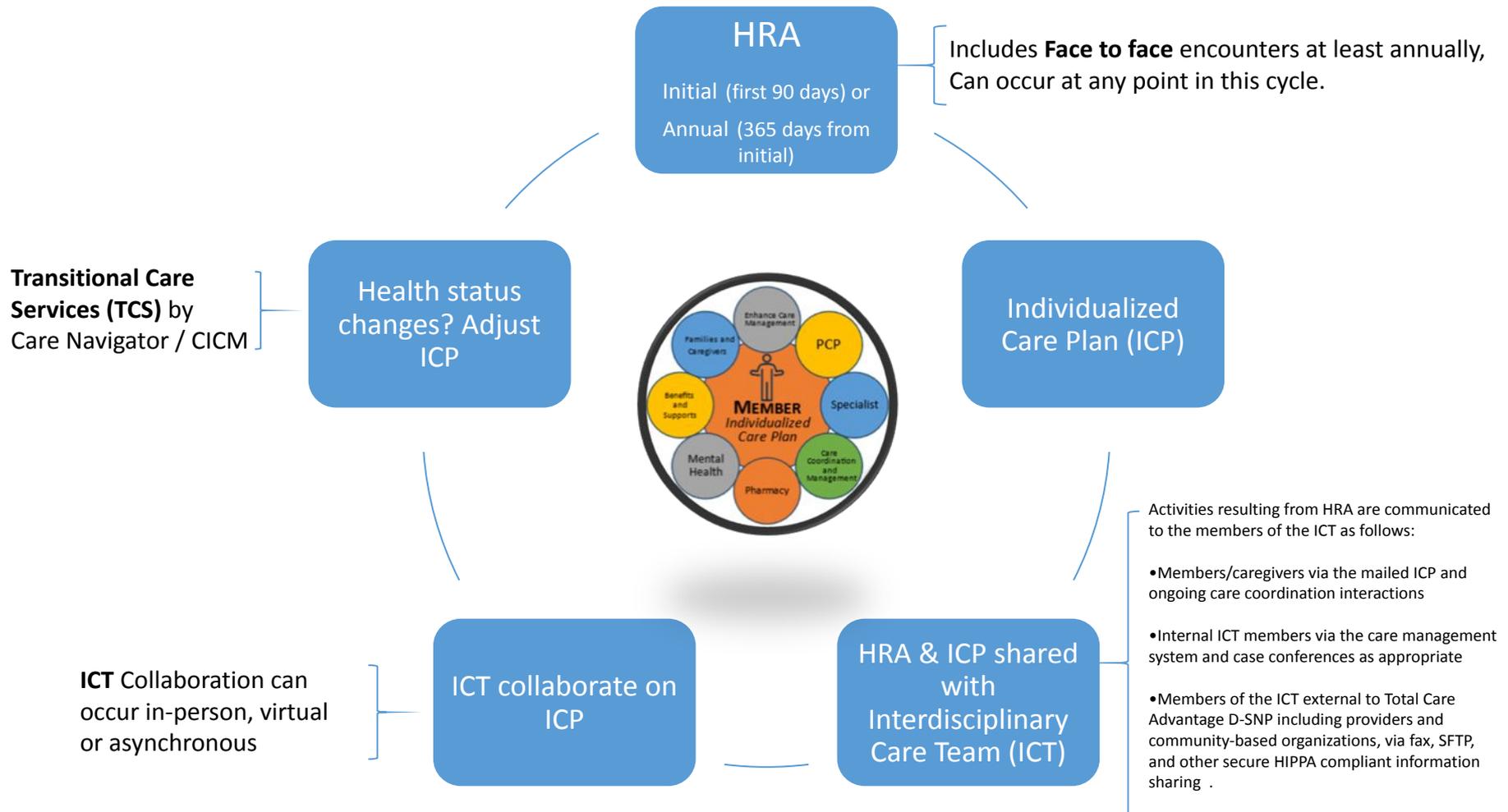TOTAL Care
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MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Objectives:

- Understand Total Care Advantage D-SNP Care Coordination including Health Risk Assessment (HRA) , Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT), Face-to-Face Encounters, and Care Transitions

- Understanding of each Total Care Advantage D-SNP department's role in the Model of Care (MOC).

- Understanding of D-SNP Enhance Care Management (ECM) / California Integrated Care Management (CICM) processes

- Continuity of Care (COC) process

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MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

SNP HRA, Care Plan and Interdisciplinary Care Team Cycle

HRA

Initial (first 90 days) or Annual (365 days from initial)

Includes **Face to face** encounters at least annually, Can occur at any point in this cycle.

Individualized Care Plan (ICP)

HRA & ICP shared with Interdisciplinary Care Team (ICT)

Activities resulting from HRA are communicated to the members of the ICT as follows:

• Members/caregivers via the mailed ICP and ongoing care coordination interactions

• Internal ICT members via the care management system and case conferences as appropriate

• Members of the ICT external to Total Care Advantage D-SNP including providers and community-based organizations, via fax, SFTP, and other secure HIPPA compliant information sharing .

ICT collaborate on ICP

ICT Collaboration can occur in-person, virtual or asynchronous

Health status changes? Adjust ICP

Transitional Care Services (TCS) by Care Navigator / CICM

Health Risk Assessment (HRA)

What: The Health Risk Assessment Tool (HRAT) is an assessment of the medical, functional, cognitive, social, mental and behavioral health needs of D-SNP member.

When: Within 90 days of enrollment and at least annually thereafter. Also conducted with any changes in health status including immediately following hospitalizations.

How & Where:

- All new members are mailed a HRA within 15 days of enrollment to complete and mail back if they are able.

- Care Coordination staff also conduct a phone outreach to members to perform the HRA via telephone or make appointments for an in-person HRA

Who: Total Care Advantage Care Coordination staff, but may engage the support of other plan staff, a provider, community-based organization or third-party vendor to support in the process for members who are hard to reach
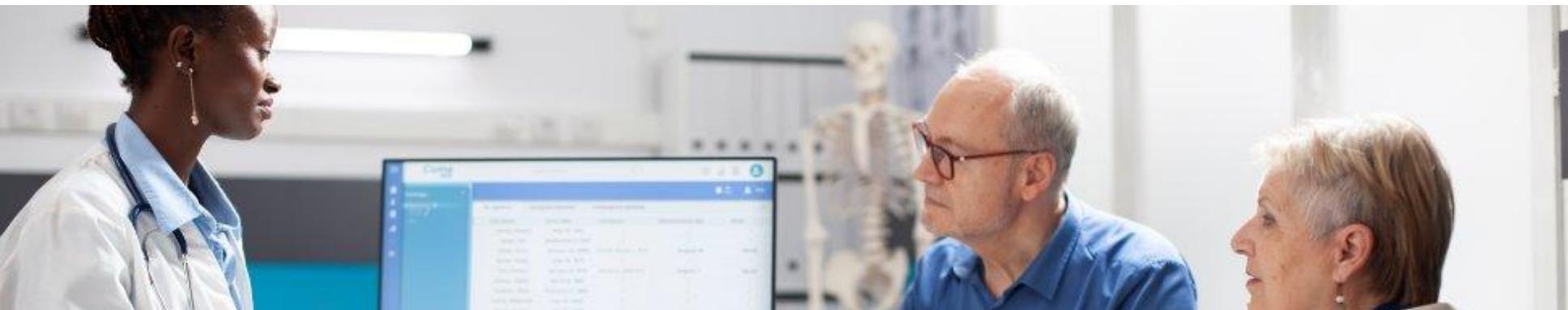
Individualized Care Plan (ICP)

What: The HRA response data is used to develop an individualized care plan (ICP) specific to the member's identified needs.

Who: Care Coordination staff reviews the results of the HRA with the member and/or caregiver and works together to develop an ICP based on needs identified.

When: Within 90 days of enrollment and at least annually thereafter. An ICP is also updated with any changes in health status including immediately following hospitalizations.

Where and How: The members ICP is created and managed in Total Care Advantage D-SNP's care management system. The ICP is sent to the member/caregiver by mail and to the PCP team, with other members of the interdisciplinary care team (ICT) as needed through mail, fax, SFTP or other mechanisms.

MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Additional Individualized Care Plan points:
- The member's ICP includes the member's personalized goals and objectives, specific services and benefits and measurable outcomes
- Goals and objectives are prioritized by the member's preference
- Records including the ICP must be maintained per HIPAA and professional standards
- The ICP is shared with the PCP with the expectation to review, provide additional feedback if appropriate.

Interdisciplinary Care Team (ICT)

What & Who: The ICT includes D-SNP Care Coordination staff, the member/caregiver, PCP team and other providers and community resources, as necessary to prioritize and coordinate care, prompt additional assessments, identify and resolve care gaps, modify the ICP and connect members with resources and treatments.

When: Following every HRA

Where & How: ICT can occur via Live/Realtime (Phone calls, in-person meetings) or Electronic/Paper (Faxes, letters, EHR, other secure electronic formats).

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Interdisciplinary Care Team (cont.)

- The ICP is provided in members preferred language and font size.
- All D-SNP members have an ICT
- Members enrolled in Palliative Care must use the Palliative Care ICT that includes their assigned CICM Care Manager from Total Care Advantage D-SNP.
- The member, caregiver, primary care provider (PCP) and assigned Care Navigator and or CICM Care Manager are core members of the ICT. The following are additional Possible Participants of ICT:

Possible Participant	Member Clinical or Social Need Addressed
Specialist	Complex medical need that cannot be managed by PCP team
Behavioral Health Provider	Complex mental/behavioral or substance use need
Pharmacist	Complex polypharmacy
Medical Director	Complex health system needs
Palliative Care Provider	Member on palliative care
Dementia Care Specialist	Dementia care needs and two or more co-existing conditions, or moderate to severe behavioral issues, or high utilization or live alone or lack adequate caregiver support or moderate to severe functional impairment
Doula	High risk pregnancy
Justice Involved ECM provider	Recent or current incarceration
Independent Living Center care manager	Disability related needs
Disease specific association staff	Complex disease, rare disease focused needs
MSSP Care Manager	Complex home and community-based service needs or transitioning from or to LTC setting
IHSS Social Worker	Member with complex ADL need or transitioning from or to LTC setting
CBAS Provider	Member having difficulty adjusting to adult day services
Housing organization care manager	Member experiencing homelessness
Specific cultural support organization	Members who speak indigenous languages or have cultural needs and preferences that are best supported by organizations that bridge cultural gaps

Face to Face Encounters

What: D-SNP conducts face-to-face encounters with members to promote improved understanding of the member, their needs, and to develop trust with the ICT.

Who: The purpose of the encounter may vary depending on the member of the ICT conducting the encounter.

Where & How: Face-to-face encounters are conducted in-person in the member's home or in their place of preference (e.g., shelter or drop-in center for people experiencing homelessness). Member's may also opt for a virtual encounter with prior written consent.

When: These face-to-face encounters are required within the first 12 months of enrollment and at least annually thereafter.

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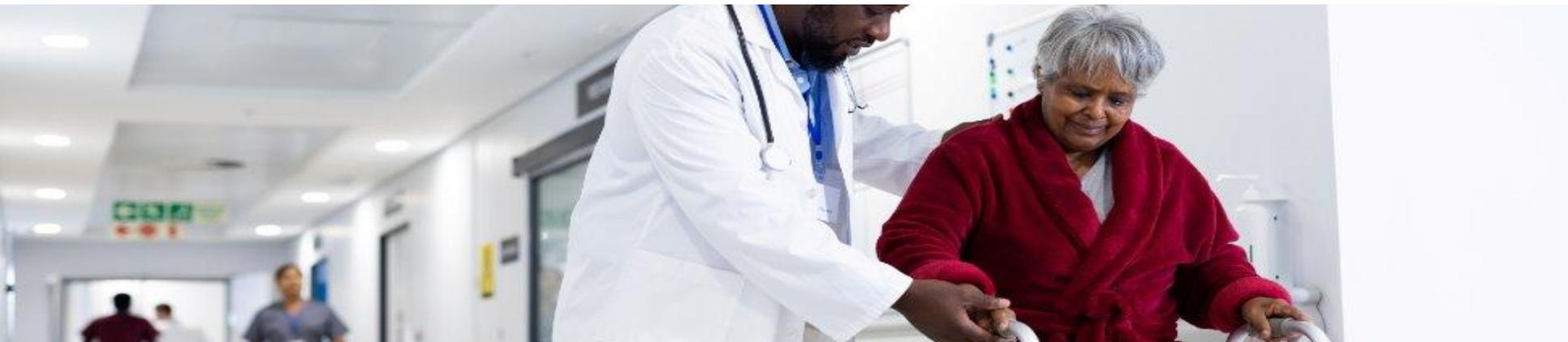**TOTAL Care ADVANTAGE**

Care Transitions

What: D-SNP uses Transitional care service (TCS) protocols in partnership with our provider partners (physician organizations and hospitals) and community-based organization partners to support D-SNP members when moving from one care setting to another.

Who: Transitions of care are managed and coordinated through an assigned care navigator, nurse care manager or social work care manager depending on the needs of the member. Partner with providers including hospitals, nursing homes, physicians, discharge planners and home health providers to support seamless transition from one care setting to another.

Where: Transition of care settings may include hospitals, skilled nursing facilities, the home, home health care, rehabilitation facility, outpatient surgery centers, etc.

When: Care Transitions support is offered by their assigned Care navigator or Care manager with every inpatient admission and related transition in that episode of care. Members will be followed for at least 30 days post discharge.

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California Integrated Care Management (CICM)

What: In the California D-SNP, the program of Enhanced Care Management ECM-like services is called California Integrated Care Management (CICM). The Total Care Advantage D-SNP Model of Care is designed to incorporate all elements of CICM and ensures that the core CICM services are performed by staff with the appropriate training and expertise.

Who: Care coordination to support members with more complex needs is provided by a Total Care Advantage D-SNP Clinical Care manager that is a Registered Nurse, Social worker, LCSW or other licensed behavioral health professional.

Where: A combination of field/member home visits and telephonic visits

When: Home visits are conducted at a minimum annually for more frequently depending on the members needs and consent.

Community Support (CS) benefits and select Supplemental benefits

What: Community Support benefits including but not limited to Housing Transition, Medically Tailored Meals/Medically Supportive meals, Personal Care and Homemaker Services and others CS benefits continue to be available to eligible members and authorized by the GCHP CalAIM team. Medicare Supplemental benefits like Readmission prevention meals and Personal Care are authorized by the members assigned Care Navigator.

Who: Total Care Advantage assigned Care Navigator coordinates with CalAIM team

When: Authorized based on member need and established benefit criteria.
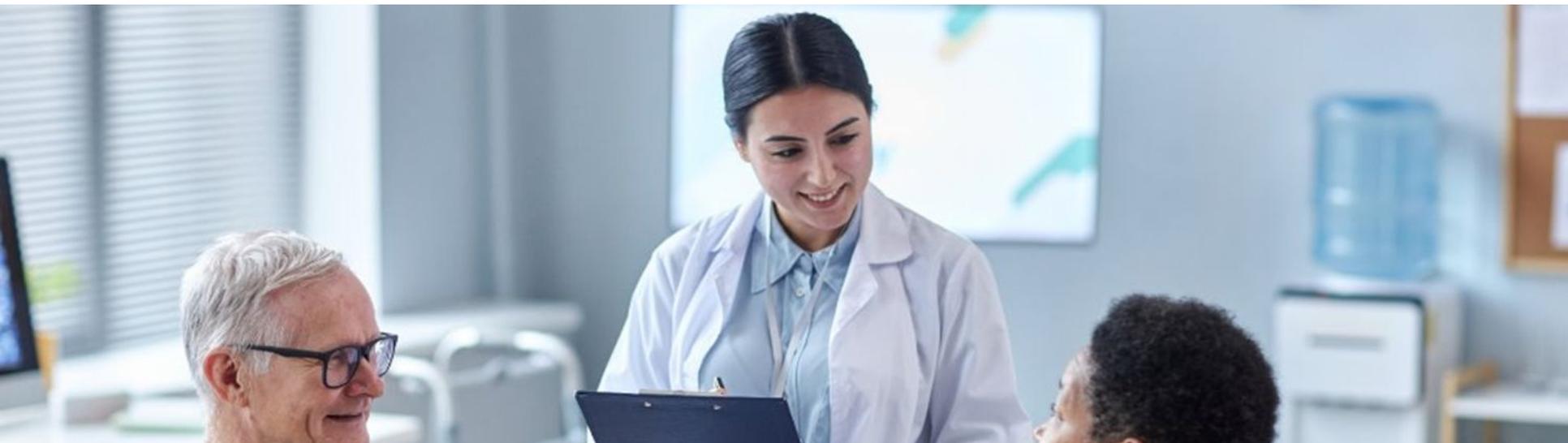
Continuity of Care Process

Continuity of Care (COC)

What: New enrollees with ongoing care or services used in the past 12 months including but not limited to specialty care/treatment (ex. oncology), physician administered medications, ECM, can continue these treatments or services up to 12 months with approval to avoid disruption.

Who: Total Care Advantage sales representatives, call center staff and assigned Care Navigators submit a Continuity of Care form to the Utilization Management team for review and approval. The member's assigned care navigator or CICM care manager coordinates the COC with member and or caregiver once the approval is received.

When: The COC form is completed at the time of enrollment or immediately there after. The COC form asks the member and or their caregiver to list any ongoing care and services which have been used in the past 12 months, these services are reviewed at the member's effective date for necessity and approval.

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MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Key Takeaways:

- Every D-SNP member is assigned a Care Navigator or CICM Care Manager depending on the member's needs.

- Health Risk Assessment (HRA) must be completed in the first 90 days of enrollment, annually and with any change in health status including a hospital

- Individualized Care Plan (ICP) is developed w/ member, patient centered and reviewed/managed w/ Interdisciplinary Care Team (ICT).

- ICT collaboration can occur through same time meetings as well as informal exchanges of information (voice mail, fax, secure email, other).

- Face to Face encounters occur at least annually w/ members care navigator/ Care Manager ideally in member's home or setting of choice. It can also occur in the form of provider visits.

Questions