SNP Model of Care Provider Training

Special Needs Plans (SNPs) • 2023

Our Mission

To develop and establish a healthcare organization that is responsive and attentive to the needs of all Medicare beneficiaries by offering high quality, cost effective healthcare services.

DOCTORS HEALTHCARE PLANS, INC.

Training Objectives

- Comprehension of our Special Needs Plans (SNPs) components and benefits
- Understanding how Members qualify for SNP
- Review components of SNP Model of Care (MOC)
- Communicate training and comprehension requirements
- Explain SNP Care/Case Management processes and philosophy
- Describe Health Risk Assessment (HRA) Process
- Review Quality Outcomes & Measures
- Describe Roles & Responsibilities
- Provide information about DHCP SNP Resources

SNP Model of Care (MOC)

A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be any one of the following:

- An institutionalized individual, A
- dual eligible, (Medicare & Medicaid)
- An individual with a severe or disabling chronic condition, as specified by CMS.

A SNP may be any type of Medicare Advantage Coordinated Care Plans (MA CCP), including either a local or regional preferred provider organization (i.e., LPPO or RPPO) plan, a health maintenance organization (HMO) plan, or an HMO Point-of-Service (HMO-POS) plan. There are three different types of SNPs:

- Chronic Condition SNP (C-SNP)
- Dual Eligible SNP (D-SNP)
- Institutional SNP (I-SNP)

Special Needs Plans (SNPs) Programs

DHCP MOC is designed to ensure the provision and coordination of specialized services that meet the needs of the SNP eligible beneficiaries.

Doctors Healthcare Plans (DHCP) offers three Special Needs Plans for 2023:

Medicare-Medicaid Dual Eligible Program (D-SNP)

- Dual Eligible
  - DrPlus (002) Miami-Dade
  - DrPlus-B (010) Broward

Chronic Disease Programs (C-SNP)

- Diabetes and/or Chronic Heart Failure
  - DrExtraCare (004) Miami-Dade
- *Our C-SNP plans focus on providing Members with education about their disease, self-management/care, medication, and nutrition.*

SNP Program Mission & MOC Goals

Our SNP Program Mission:

The DHCP SNP Programs are designed to maximize the quality of care, access to care, and health outcomes for the SNP populations it serves.

Our Overall Model of Care (MOC) Goals include:

- Improve access to essential services
- Improve access to affordable care
- Improve coordination of care
- Improve transitions of care
- Improve access to preventive health services
- Facilitate appropriate utilization of services
- Improve beneficiary health outcomes
- Engage provider network in DHCP support services

SNP Model of Care (MOC)

DHCP Model of Care Provides Members with:

- Health Risk Assessments
- Interdisciplinary Care Team (ICT) to Coordinate Care
- Individualized Care Plan (ICP) for each Member
- Specialized Provider Network
- Integrated Communication Systems
- Additional Benefits
- Coordination of Care
- Care Transition Management
- Case Management for all Members
- Coordination of Benefits for all Members
- Quality Improvement Program

Health Services

Plan benefits and the Models of Care (MOCs) are designed to optimize the health and well being of Members, particularly our aging, vulnerable, and chronically ill individuals by:

- Matching interactions with member needs in their current state of health.
- Identifying care needs through a comprehensive initial assessment and annual reassessments.
- Creating Individualized Care Plans (ICP) with goals and measurable outcomes.
- Building an Interdisciplinary Care Team (ICT) to meet these needs.
- Ensuring Providers are involved in care decisions.
- Effectively managing utilization.
- Improve access to affordable medical, mental health, and social services.

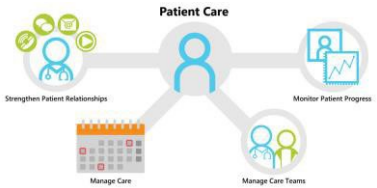
SNP Model of Care (MOC) Elements

SNP Model of Care is the overall plan for SNP structure, processes, resources, and requirements.

There are four (4) Model of Care Elements:

MOC 1 | MOC 2 | MOC 3 | MOC 4

Target Population | **Care Coordination** | **Provider Network** | **Quality Measurement**



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SNP Model of Care (MOC 1)

Overall SNP Population

SNP MOCs must identify and describe the target population, including health and social factors, and unique characteristics of each SNP type.

Our MOCs:

- Provide a foundation upon which the remaining measures build a complete continuum of care (e.g., end-of-life & special considerations) for current and potential members DHCP intends to serve
- Describe how DHCP staff will determine, verify and track eligibility of SNP beneficiaries
- Describe the social, cognitive and environmental factors, living conditions and co-morbidities associated with the SNP population
- Identify and describe the medical and health conditions impacting SNP beneficiaries
- Define the unique characteristics of the SNP population served

Capture Most Vulnerable Beneficiaries:

- Important to note that the focus is on population-level, not individual members:
  - What makes them "different from the general population"?
  - Include specially tailored services for members considered "most vulnerable" (e.g. multiple hospital admissions or excessive spending on medications above set limits)
  - Go above and beyond those service provided to the general population
  - Defines and identifies the most vulnerable beneficiaries within the SNP population and provides a complete description of specially tailored services for such beneficiaries
  - Explains how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable beneficiaries
  - Illustrates a correlation between the demographic characteristics of the most vulnerable beneficiaries and their unique clinical requirements
  - Identifies and describes established relationships with partners in the community to provide needed resources

It's important to note, that while national statistics provide some idea of the chronic diseases and comorbidities certain populations face, the population description must speak specifically to each SNP's target population for the service area.

Doctors HealthCare Plans (MOC 1)

Overall SNP Population(s)

- **Dual Eligible ▪ DrPlus/DrPlus-B**
  - A. Medicaid Eligible
    - This population has a high prevalence of physical and mental health conditions.
  - B. Most Vulnerable Population
    - Members who are frail
    - Members who are disabled
    - Members who have multiple chronic illnesses
    - Members who have had multiple hospitalizations or skilled nursing facility admissions
    - Members who are at the end of their life

All our Members are particularly vulnerable due to barriers they encounter related to ethnicity, health literacy, and socio-economic status.

- **Diabetes Mellitus /Chronic Heart Failure ▪ DrExtraCare**
  - A. Dx-Diabetes and/or Chronic Heart Failure
    - This population commonly has co-morbidities; a study of data reported that only 25% of Mcare Part B beneficiaries have diabetes without co-morbidity.
    - Patients in this population have complex needs and are more likely to see multiple providers, which can result in fragmented sub-optimal care coordination that can increase acute or emergency utilization.
  - B. Most Vulnerable Population
    - Members who are frail
    - Members who are disabled
    - Members who have multiple chronic illnesses
    - Members who have had multiple hospitalizations or skilled nursing facility admissions
    - Members who are at the end of their life
    - Members who are diabetic with complications

SNP Model of Care (MOC 2)

SNP Staff Structure

SNP MOCs must identify the staff structure and describe the administrative and clinical staff roles and responsibilities.

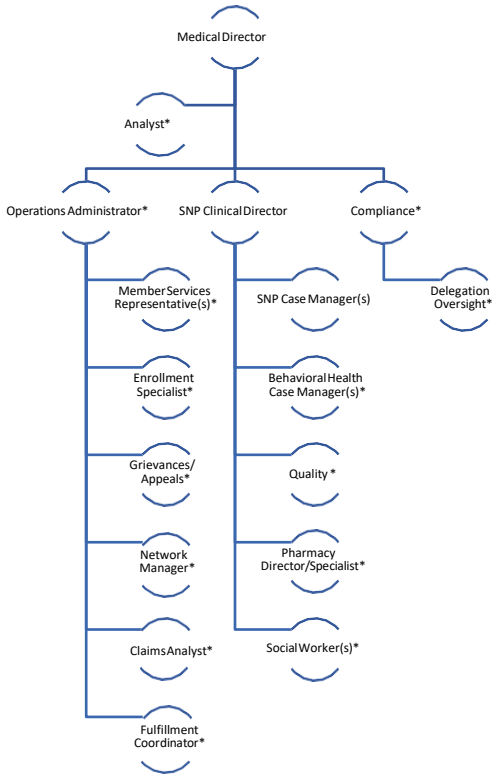
Our MOCs:

- Describe staff structure and functions
  - The administrative staff's roles and responsibilities, including oversight functions
  - Describe the clinical staff's roles and responsibilities, including oversight functions
  - Describe how staff responsibilities coordinate with the job title
  - Describe contingency plans used to address ongoing continuity of critical staff functions
- Describe how the organization conducts initial and annual MOC training for its employed and contracted staff
  - Describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training
  - Describe actions the organization takes if staff do not complete the required MOC training
- Include an organizational chart

SNP Model of Care (MOC 2)

SNP Staff Structure

Our Organizational Chart



**These positions are cross-functional matrix positions in that these positions primarily reside in other departments within the organization and do not work exclusively with the SNP Program. The staff in these positions possess the requisite skills and knowledge specific to the SNP program that is required to perform job responsibilities involving SNP members, SNP data, or the SNP program.*

SNP Model of Care (MOC 2)

SNP MOC Training

DHCP conducts initial and annual training regarding the DHCP SNP MOC for all providers in our network, to include delegates.

Training Standards & Requirements

- Initial training to be completed within 30 days from hire and each calendar year thereafter.
  - Training may be provided in person, through self-study via DHCP website or online via the Knowb4 platform.
- Attestation to training completion is required.
  - Confirming name, title, and date of training
- Training evaluation must be completed.

SNP Model of Care (MOC 2)

Medicare & Medicaid Coordination

D-SNP Coordination goals include:

- Members are informed of benefits offered by both programs.
- Members are provided with information on how to maintain Medicaid eligibility.
- Members have access to staff that have knowledge of programs and community resources.
- Plan provides clear communication regarding claims and cost-sharing from both programs.
- Members are informed of rights to pursue appeals and grievances through both programs.
- Members are provided information on how to access providers that accept Medicare and Medicaid.

SNP Model of Care (MOC 2)

Integrated Services

DHCP has contracted the below vendors to provide Health Care and/or Care Management Services:

Magellan Health - Behavioral Health

MedImpact – Pharmacy Benefits (Part D)

Hear USA - Hearing Services

Florida Dental Benefits- Dental

Argus- Vision

DHCP Transportation Services, LLC - Transportation Services

Deliver Lean- Post Discharge Meal Benefit

Silver&Fit® - Fitness Membership

OTC Health Solutions - Over the Counter (OTC)

SNP Model of Care (MOC 2)

Case Management Program

DHCP Case Management Program includes:

- Case/Care Management
- Disease Management
- Coordination of Services
- Transitions of Care Services
- Special Needs Program Case Planning

The Case Management Staff includes:

- Physicians
- Pharmacists
- Registered Nurses
- Health Coaches
- Social Services
- Targeted Case Management

SNP Model of Care (MOC 2)

Case Management

DHCP assigns a Clinical Case Manager to each SNP Member to assist with the Member's health care needs and:

- All SNP members are enrolled in case management.
- Each member has an individualized care plan developed.
- Members may opt out of case management but remain assigned to a Case Manager.
- Members are stratified according to their risk profile to focus resources on the most vulnerable.

SNP Model of Care (MOC 2)

Health Risk Assessments (HRA)

All SNP Members receive a Health Risk Assessment (HRA).

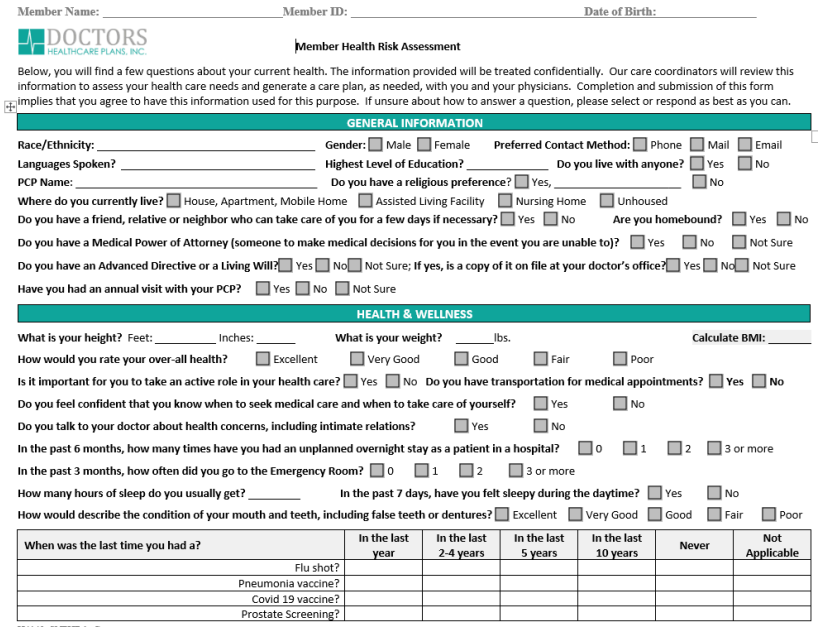
Code of Federal Regulations (42 CFR §422.101(f)(i); 42 CFR §422.152(g)(2)(iv)) require that all SNPs conduct a Health Risk Assessment for each individual enrolled in the SNP.

Our HRAs are used to:

- Identify Individual Health Needs
- Risk Stratify Members for Service
- Nominate Members for Case Management Programs
- Initiate Care Plans
- Communicate with Physicians, Interdisciplinary Care Team (ICT), Members, Care Givers, and Ancillary Providers

Our HRAs are completed by:

- Mail
- Phone Call
- Online (in development)



Member Name: _____ Member ID: _____ Date of Birth: _____

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Member Health Risk Assessment

Below, you will find a few questions about your current health. The information provided will be treated confidentially. Our care coordinators will review this information to assess your health care needs and generate a care plan, as needed, with you and your physicians. Completion and submission of this form implies that you agree to have this information used for this purpose. If unsure about how to answer a question, please select or respond as best as you can.

GENERAL INFORMATION

Race/Ethnicity: _____ Gender: ☐ Male ☐ Female Preferred Contact Method: ☐ Phone ☐ Mail ☐ Email

Languages Spoken? _____ Highest Level of Education? _____ Do you live with anyone? ☐ Yes ☐ No

PCP Name: _____ Do you have a religious preference? ☐ Yes, _____ ☐ No

Where do you currently live? ☐ House, Apartment, Mobile Home ☐ Assisted Living Facility ☐ Nursing Home ☐ Unhoused

Do you have a friend, relative or neighbor who can take care of you for a few days if necessary? ☐ Yes ☐ No Are you homebound? ☐ Yes ☐ No

Do you have a Medical Power of Attorney (someone to make medical decisions for you in the event you are unable to)? ☐ Yes ☐ No ☐ Not Sure

Do you have an Advanced Directive or a Living Will? ☐ Yes ☐ No ☐ Not Sure; If yes, is a copy of it on file at your doctor's office? ☐ Yes ☐ No ☐ Not Sure

Have you had an annual visit with your PCP? ☐ Yes ☐ No ☐ Not Sure

HEALTH & WELLNESS

What is your height? Feet: _____ Inches: _____ What is your weight? _____lbs. Calculate BMI: _____

How would you rate your over-all health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Is it important for you to take an active role in your health care? ☐ Yes ☐ No Do you have transportation for medical appointments? ☐ Yes ☐ No

Do you feel confident that you know when to seek medical care and when to take care of yourself? ☐ Yes ☐ No

Do you talk to your doctor about health concerns, including intimate relations? ☐ Yes ☐ No

In the past 6 months, how many times have you had an unplanned overnight stay as a patient in a hospital? ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

In the past 3 months, how often did you go to the Emergency Room? ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

How many hours of sleep do you usually get? _____ In the past 7 days, have you felt sleepy during the daytime? ☐ Yes ☐ No

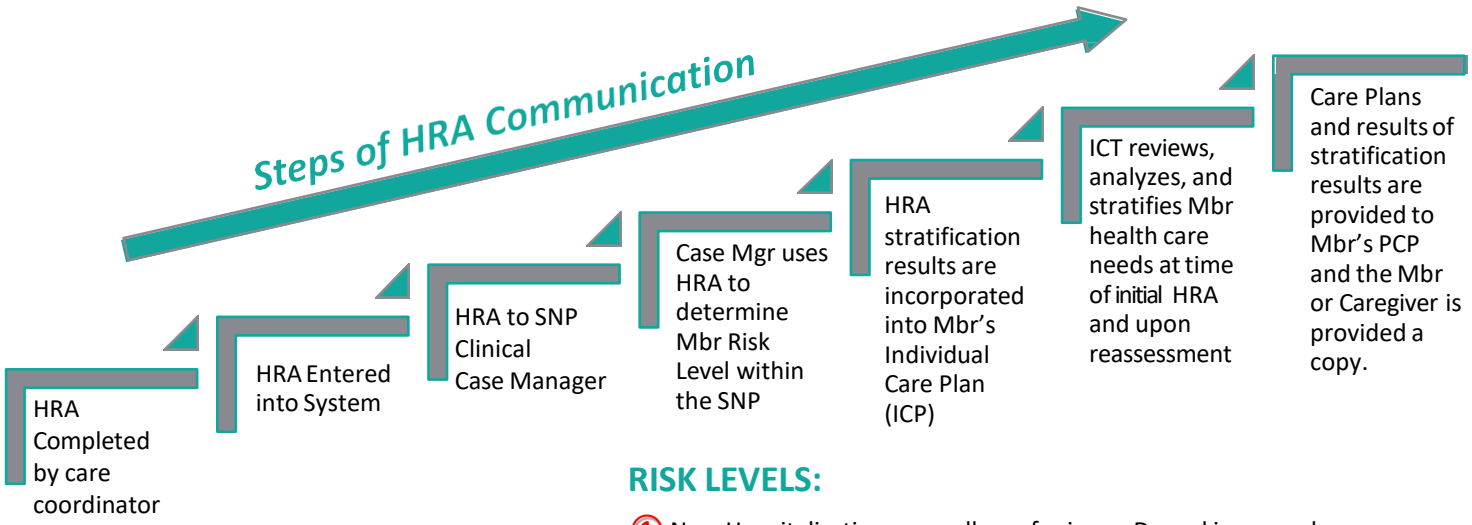
How would describe the condition of your mouth and teeth, including false teeth or dentures? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

When was the last time you had a?	In the last year	In the last 2-4 years	In the last 5 years	In the last 10 years	Never	Not Applicable
Flu shot?						
Pneumonia vaccine?						
Covid 19 vaccine?						
Prostate Screening?						

- *A comprehensive initial assessment is completed within 90 days of enrollment.*
- *An annual reassessment of the individuals' medical, physical, cognitive, psychosocial and functional, and mental health needs is also conducted.*
- *Members will be educated of their right to an Advanced Directive and Durable Power of Attorney, if necessary and additional information will be sent to them regarding these topics if they desire.*

SNP Model of Care (MOC 2)

Health Risk Assessments (HRA)

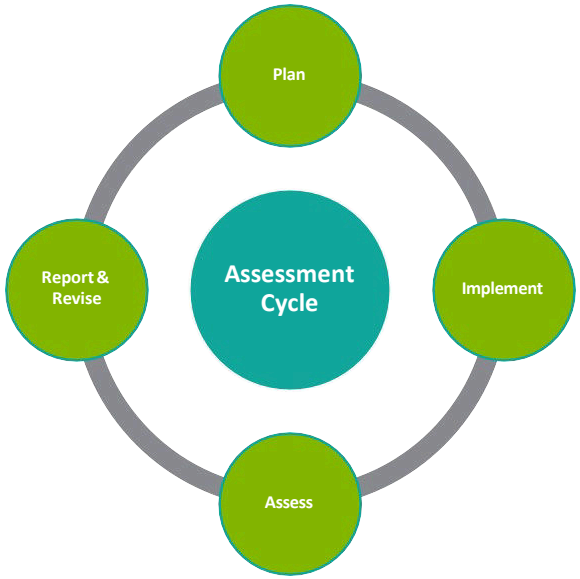


RISK LEVELS:

1. New Hospitalizations regardless of primary Dx and increased symptoms compared to baseline
2. Stable symptoms, at previous level of functioning, no hospitalizations in past 2 months (or 1 if enrolled in Health Coaching Program)
3. Stable symptoms, at previous level of functioning, no hospitalizations in past 3 months (or 2 if enrolled in Health Coaching Program)
4. Stable symptoms, at previous level of functioning, no hospitalizations in past 6 months (or 3 if enrolled in Health Coaching Program)
5. No hospitalizations

SNP Model of Care (MOC 2)

Individualized Care Plan (ICP)



Code of Federal Regulations (42 CFR §422.101(f)(ii); 42 CFR §422.152(g)(2)(iv)) requires all SNPs to develop and implement an ICP for each individual enrolled in SNP.

- The DHCP Clinical Case Manager creates the Member's ICP
- The Member and/or their caregiver is involved in the development of their Care Plan
- The ICP is based on the Member's HRA and any identified opportunities
- The ICP is prioritized to consider the Member's preferences and their desired level of engagement
- The ICP is updated to reflect any change in the Member's medical and psychosocial status
  - Revision includes evaluation of identified goals and whether they are met
- The ICP is communicated for coordination of care and when there is a transition to a new care setting, such as a hospital or Skilled Nursing Facility (SNF)
- The ICP is also provided to PCP and Member/Caregiver

SNP Model of Care (MOC 2)

Interdisciplinary Care Team (ICT)

Code of Federal Regulations (42 CFR §422.101(f)(iii); 42 CFR §422.152(g)(2)(iv)) require that all SNPs use an ICT in the care management of each individual enrolled in the SNP.

The DHCP ICT contributes to improving beneficiary health status and they meet regularly to manage the medical, cognitive, psychosocial and functional needs of the Member.

The Member and/or Caregiver is included on the ICT.

ICT Members:

- SNP Medical Director
- SNP Clinical Director
- Case Managers
- Network Practitioners

Optional Team Members:

- Specialty Providers
- Social Services Specialist
- Pharmacist
- Behavioral Health Specialist
- Social Worker
- Nurse Practitioners
- Pastoral Care
- Palliative Care HC
- Home Care
- Dietician / Nutritionist
- Targeted Case Manager

SNP Model of Care (MOC 2)

Management of Care Transitions

Members can be faced with significant challenges when moving from one setting to another. The management of transitions is focused on supporting our Members with their treatment plan as they move from one setting to another to prevent re-admissions or delay of care needs.

Code of Federal Regulations (42 CFR §422.101(f)(2)(iii-v); 42 CFR §422.152(g)(2)(vii-x)) require all SNPs to coordinate the delivery of care. Code of Federal Regulations (42 CFR §422.101 (f)(2)(iii)-(v);42 CFR§422.152(g)(2)(ix)) require SNPs to demonstrate the use of clinical practice guidelines and care transition protocols.

Personnel Involved in Coordinating Care Transitions

- Utilization Clinical Review Staff
- Case manager
- Transition Case Manager/Additional Support Staff
- Hospital Social Worker

Our in-patient (IP) concurrent review and care coordination processes allow us to identify transition of care needs.

Clinical staff coordinate with providers to assist Members in the hospital, SNF, or other setting to access care as appropriate.

The SNP Case Manager, Social Workers and TCM ensure Members have appropriate follow-up care after transition to any new setting.

SNP Model of Care (MOC 3)

Provider Network

Code of Federal Regulations (42 CFR§422.152(g)(2)(vi)) require SNPs to demonstrate that the provider network has specialized clinical expertise in delivery of care to beneficiaries.

The DHCP provider network is comprised of specialized expertise which corresponds to our target population.

- DHCP oversees its provider network and facilities and oversees that its providers are competent and have active licenses
- How the SNP documents, updates and maintains accurate provider information
- How providers collaborate with the ICT and contribute to a beneficiary's ICP to provide necessary specialized services

Regulations at (42 CFR§422.101(f)(2)(ii)) require that SNPs conduct MOC training for their network of providers.

DHCP complies with the network training requirements:

- Requiring initial and annual trainings for network providers
  - During the new and annual provider orientations, in which providers are given the Model of Care training, provider manual, drug formulary, provider directory, and referral authorization form, providers complete the Provider Orientation sign-in sheet and an attestation of training. Similarly non-network providers, who have seen over 5 DHCP members or who have 5 encounters with members are also sent the MOC training information by mail and asked to submit an attestation confirming their review of the information.
- Documenting evidence that the organization makes available and offers MOC trainings for network providers
- Monitoring challenges associated with completion of MOC trainings for improvement opportunities
- Taking action when the required MOC training is deficient or has not been completed

SNP Model of Care (MOC 4)

Quality Improvement Program (QIP)

Code of Federal Regulations (42 CFR §422.152(g)) require that all SNPs conduct a Quality Improvement Program (QIP) that measures the effectiveness of its MOC.

DHCP Quality Improvement Program (QIP) monitors health outcomes and implementation of SNP MOCs:

- Collecting SNP specific HEDIS® measures.
- Meeting SNP Structure and Process standards.
- Conducting QIP reviews that focus on improving clinical services as they relate to our SNP population (i.e., Fall Prevention).
- Providing a chronic care improvement program for chronic disease that identifies eligible members, intervenes to improve disease management, and evaluates program effectiveness.
- Collecting data to evaluate if SNP and MOC goals are met.
  - Using encounter data, HRAs, CAHPS, HOS and other methodologies as needed for data collection.
  - Actions are taken when goals are not realized.
  - QIC investigates to determine actions required.
    - What was the root cause or factors that resulted in not meeting goals? Time frame, goal too broad or too specific?
- The Quality Improvement Committee is comprised of our Medical Director and various departmental directors and unit supervisors (both internally and externally), as well as external experts for a comprehensive and effective internal quality performance process. The SNP Director works with the departments to collect, analyze, report on data for evaluation of the MOC. Different reports are generated based on the specific needs and initiatives as requested by Committee to meet MOC standards and other improvement initiatives.
  - Support from our PBM, BH, and Vision Vendors is a must to effectively measure performance.
- DHCP evaluates Program effectiveness annually at a minimum to identify results from performance indicators, including lessons learned and challenges for the support of ongoing Program improvements.
- Evaluation results provided to Board and key stakeholders annually at a minimum.

Additional Recourses

Additional Resources Include:

- DHCP Portal
  - Member Portal
  - Provider Portal
- Materials, including:
  - Health Risk Assessment
  - DHCP Quality Goals, Measures, and Activities Guide
- CMS SNP and Related Links
- Office and Individual Training and Materials
  - Health & Wellness Programs
  - Disease Specific Materials
  - Interaction with a certified health educator or other qualified individual

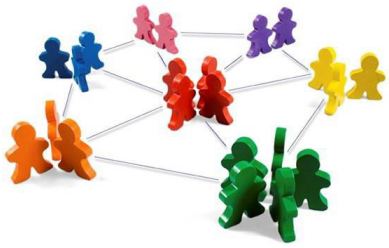
In-Closing

It is important that the entire DHCP Team, including our internal staff, our Members, and our network of providers work together to successfully meet our SNP MOC mission and goals.

Improve Health Outcomes

Improve Access to Affordable Care & Preventive Services

Improve Coordination &Transition of Care



Facilitate Provider Engagement & Appropriate Utilization

Thank You!!!!

Thank you for participating in our 2023 SNP MOC Training Program.

To complete the self training, please click on link below:

https://www.doctorshcp.com/snp-moc-training-attestation-form/

For any SNP related questions or inquiries please contact us at:
SNP@doctorshcp.com