DOCTORS HEALTHCARE PLANS, INC.

2026 Provider Training

SNP – Model of Care (MOC)

Special Needs Plans (SNPs)

TRAINING OBJECTIVE

- Comprehension of our Special Needs Plans (SNPs) components and benefits.
- Understanding how Members qualify for SNPs.
- Review components of SNP Model of Care (MOC).
- Provider expectations with SNP members.
- 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:

- ❑Living in an institution or care facility.
- ❑Qualifies for Medicare and Medicaid.
- ❑Diagnosed 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: 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)

2026 SOUTH FLORIDA PLANS

Miami-Dade & Broward County

DrSelect (HMO)

A Plan with Extra Benefits and Prescription Drug Coverage

REFERRALS REQUIRED

DrElite-SFL (HMO)

A Part B Give-Back Plan with Prescription Drug Coverage

NO REFERRALS

New for 2026!

DrFlex (HMO D-SNP)

A Special Needs Plan with Richer Benefits for Dual Eligible Individuals who have Medicare and Medicaid with Prescription Drug Coverage

REFERRALS REQUIRED

Miami-Dade County

DrMax (HMO)

A Plan with Richer Benefits and Prescription Drug Coverage

NO REFERRALS

DrPlus (HMO D-SNP)

A Special Needs Plan for Dual Eligible Individuals who have Medicare and Medicaid with Prescription Drug Coverage

NO REFERRALS

DrExtraCare (HMO C-SNP)

A Special Needs Plan for people living with Diabetes Mellitus, Chronic Heart Failure, and/or Cardiovascular Disease with Prescription Drug Coverage

REFERRALS REQUIRED

2026 CENTRAL FLORIDA PLANS

New for 2026!

Orlando & Tampa

DrSelect-CFL (HMO)

A Plan with Extra Benefits and Prescription Drug Coverage

REFERRALS REQUIRED

DrPlatinum-CFL (HMO D-SNP)

A Special Needs Plan for Dual Eligible Individuals who have Medicare and Medicaid with Prescription Drug Coverage

REFERRALS REQUIRED

DrTotalCare-CFL (HMO C-SNP)

A Special Needs Plan for people living with Diabetes Mellitus, Chronic Heart Failure, and/or Cardiovascular Disease with Prescription Drug Coverage

REFERRALS REQUIRED

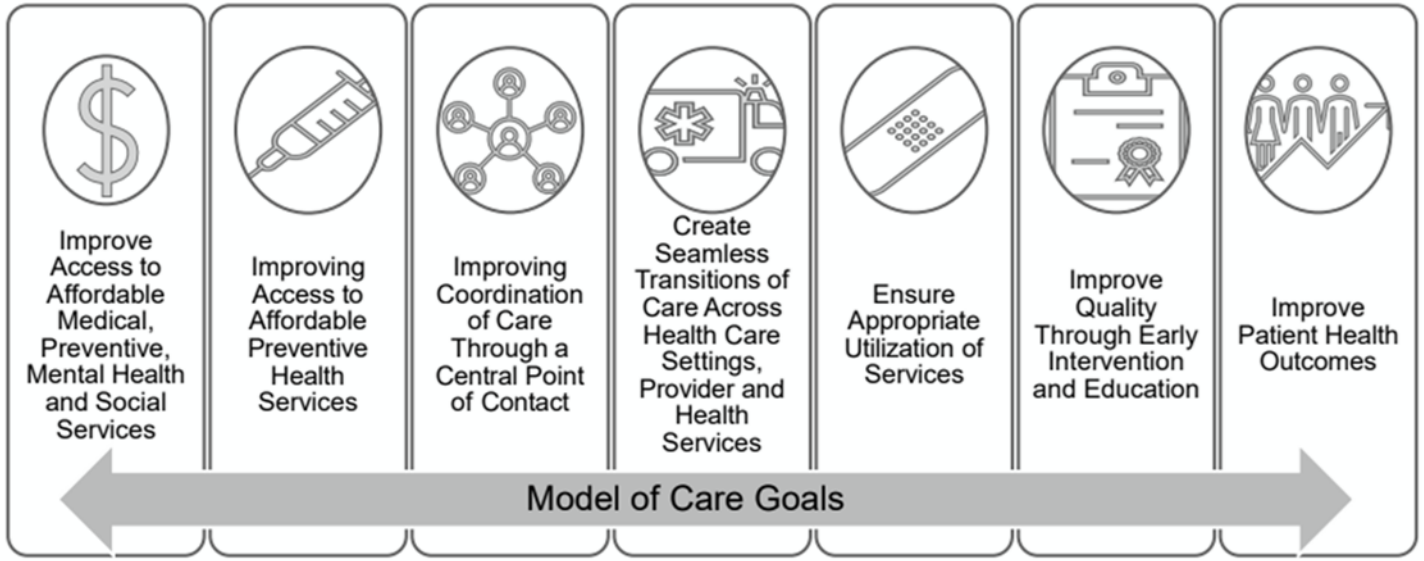
Counties: Orange, Osceola, Seminole, Polk, Hillsborough & Pasco

PROGRAM MISSION & 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 population it serves.

Our Overall MOC Goals Include:



COMPONENTS OF SNP PLANS

The DHCP MOC provides members with:

- Interdisciplinary Care Team (ICT) to coordinate care.
- Individualized Care Plan (ICP) for each member.
- Care Transition Management.
- Case Management.
- Coordination of Care & Benefits.
- Access to Specialized Provider Network.

BENEFITS OF SNP PLANS

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

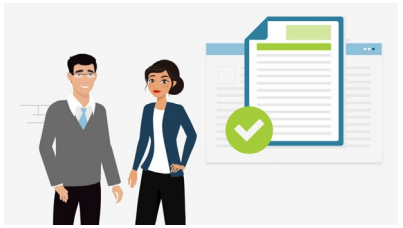
- Matching interactions with member needs in their current state of health.
- Identifying care needs through a comprehensive initial assessment and annual reassessments.
- Creating Individualized Care Plans (ICP) with goals and measurable outcomes.
- Building an Interdisciplinary Care Team (ICT) to meet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

SNP MOC Elements

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

There are 4 MOC Elements:

- Target Population
- Care Coordination
- Provider Network
- Quality Measurement



ELEMENT 1: TARGET POPULATION

Element 1: SNP MOCs must identify and describe the target population, including health and social factors, and unique characteristics of each SNP type.

DHCP 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.

Identifying the Most Vulnerable Beneficiaries: (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.

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ELEMENT 1: TARGET POPULATION

DHCP has 2 types of SNP Plans:

❑ Dual Eligible (D-SNP):

- ➢ Medicaid Eligible
  - This population has a high prevalence of physical and mental health conditions.

❑ Chronic Conditions (C-SNP):

- ➢ Diabetes Mellitus, Chronic Heart Failure, and/or Cardiovascular Disease
  - This population commonly has co-morbidities; a study of data reported that only 25% of Medicare 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.

DSNP & CSNP members are the most vulnerable population to serve.

These populations consist of members who are/have; Frailty/advanced illness, disabled, multiple chronic conditions, multiple hospitalizations, living in skilled nursing (SNF) admissions and/or at the end of their life.

ELEMENT 2: STAFF STRUCTURE

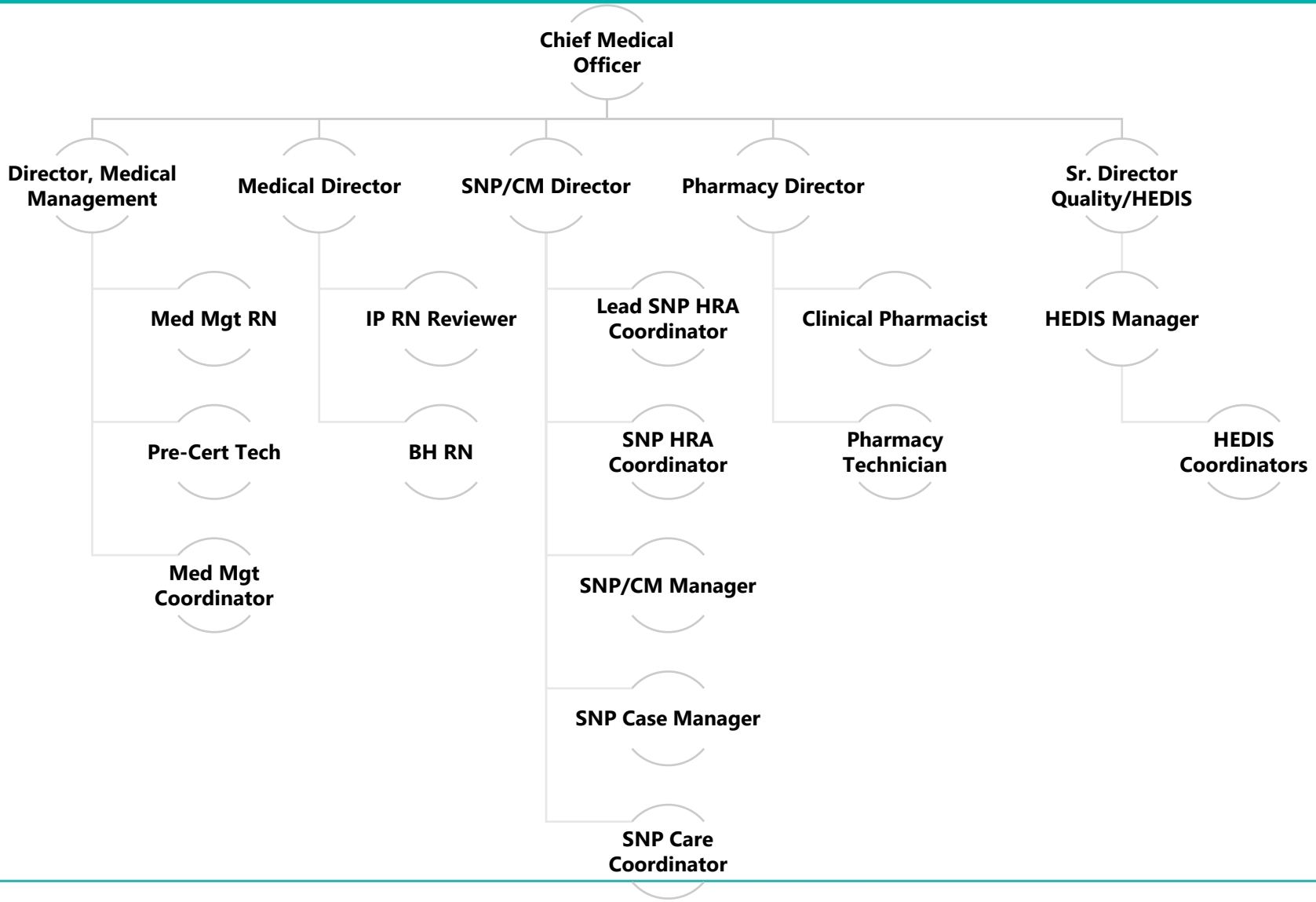
Element 2: SNP MOCs must identify the staff structure and describe the administrative and clinical staff roles and responsibilities.

- **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

- **Describes how the organization conducts initial and annual MOC training for its employed and contracted staff:**
  - Describes how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training.
  - Describes actions the organization takes if staff do not complete the required MOC training.

- **Organizational chart:** Next Slide

ELEMENT 2: STAFF STRUCTURE



ELEMENT 2: SNP MOC TRAINING

Element 2: DHCP conducts initial and annual training regarding the DHCP SNP MOC for employed and contracted staff.

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 KnowBe4 platform.
  - ➢ Attestation is required at the completion of the training module with confirmation of name, title, and date of training.
  - ➢ Evaluation of the training course must be completed.

ELEMENT 2: PROGRAM GOALS

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.

ELEMENT 2: PROGRAM GOALS

C-SNP Coordination goals include:

- ❑ Members are informed of benefits offered by the program.
- ❑ Members or member's caregiver are provided with the goal of promoting member self-confidence in managing their condition(s).
- ❑ Members have access to staff that have knowledge of programs and community resources.
- ❑ Members are informed of rights to pursue appeals and grievances.
- ❑ Members are provided information on how to access providers that focus on their current chronic disease.
- ❑ Members are provided with preferred language education on their conditions.

ELEMENT 2: INTEGRATED SERVICES

DHCP has contracted the below vendors to provide Health Care Services:

DENTAL PROVIDER

FloridaDental Benefits

NETWORK PROVIDER

HEALTH NETWORK ONE

VISION PROVIDER

iCare HEALTH SOLUTIONS

FITNESS BENEFIT

Silver&Fit

PHARMACY BENEFIT MANAGER

PREPAID CARD

nations benefits

MEAL DELIVERIES

nations market

ELEMENT 2: CASE MANAGEMENT PROGRAM

DHCP Case Management Program includes:

- **Case/Care Management:** assesses, plans, facilitates, and advocates to meet an individual's comprehensive health needs, using available resources to promote quality cost-effective outcomes.
- **Disease Management:** A program which coordinates healthcare interventions and communications designed for populations with conditions in which patient self-care efforts are significant. It aims to prevent exacerbations and complications, and reduce the need for expensive medical resources.
- **Coordination of Services:** Case Managers coordinate with the different disciplines involved in a patient's care to ensure smooth transitions and continuity of care.
- **Transitions of Care Services:** Case Managers focus on managing and coordinating patient care as they move between different healthcare settings (e.g., from hospital to home, or to a skilled nursing facility), to prevent readmissions and ensure seamless follow-up.
- Special Needs Program Case Planning: Developing individualized plans for individuals who require specific assistance due to medical, mental, or psychological disabilities, ensuring they receive the specialized support and services needed to meet their unique goals.

The Case Management Staff includes:

- Pharmacists
- Registered Nurses
- Social Services
- Targeted Case Management

ELEMENT 2: CASE MANAGEMENT

DHCP Case Management Program includes:

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

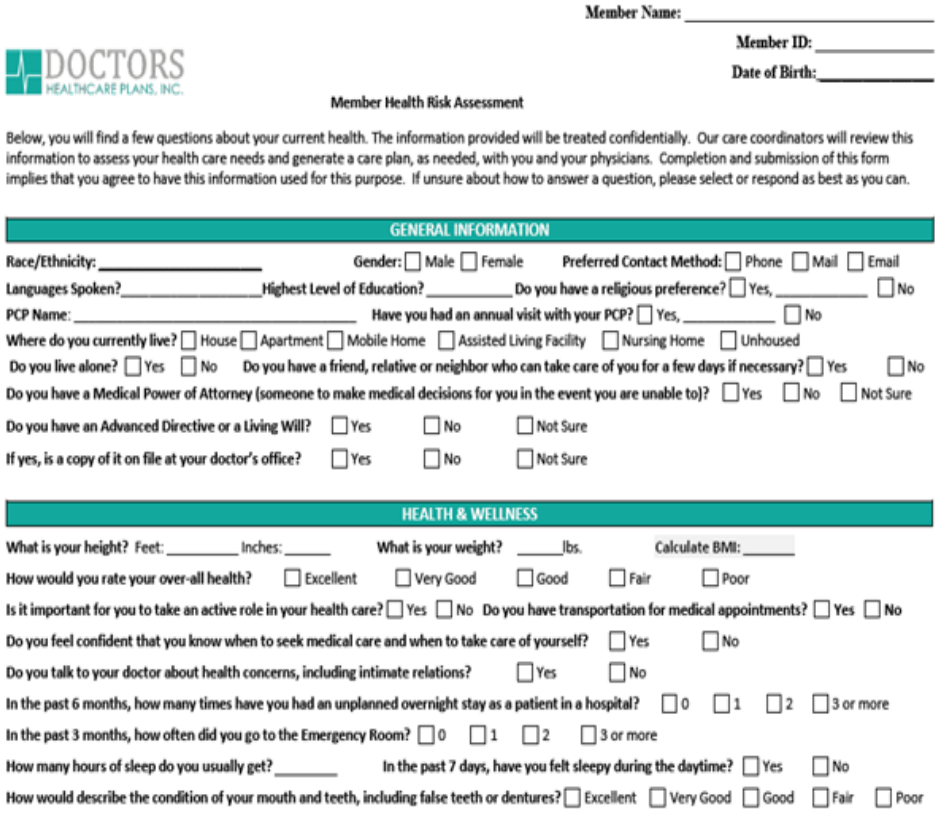
ELEMENT 2: HEALTH RISK ASSESSMENTS (HRA)

All SNP members receive a Health Risk Assessment (HRA) that is:

- A comprehensive initial assessment is completed within 90 days of enrollment.
- An annual reassessment of the individuals' medical, physical, cognitive, psychosocial, functional and mental health needs.
- Members will be educated of their rights to have an Advanced Directive and Durable Power of Attorney.
- Completed via mail, phone call, online or member portal.

HRA's 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



Member Name: _____

Member ID: _____

Date of Birth: _____

DOCTORS HEALTHCARE PLANS, INC.

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 have a religious preference? ☐ Yes, _____ ☐ No

PCP Name: _____ Have you had an annual visit with your PCP? ☐ Yes, _____ ☐ No

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

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

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

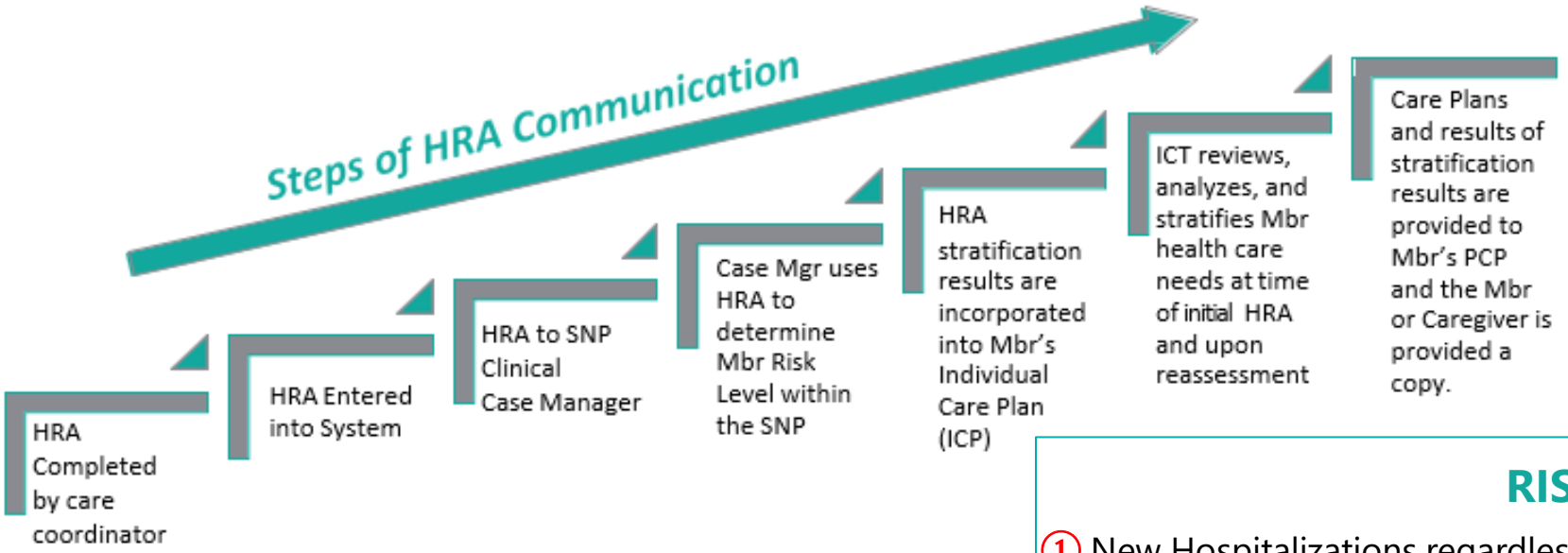
In the past 6 months, how many times have you had an unplanned overnight stay as a patient in a hospital? ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

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

ELEMENT 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.

ELEMENT 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 for improvement.
- 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 occur to include 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.

ELEMENT 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 the health status of members and ensure that 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 Service Specialist
- Pharmacist
- Behavioral Health Specialist
- Social Worker
- Nurse Practitioners
- Pastoral Care
- Palliative Care HC
- Home Care
- Dietician/Nutritionist
- Targeted Case Manager

ELEMENT 2: MANAGEMENT OF CARE TRANSITIONS

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.

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.

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.

ELEMENT 3: PROVIDER NETWORK

Element 3: 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:

- Comprised of specialized expertise which corresponds to our target population.
- Oversees its provider network and facilities and maintains and updates accurate provider information.
- Ensures that its providers are competent and have active licenses.

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 by:

- Requiring SNP MOC training during the initial contracting period and then subsequent annual trainings.
- Documenting evidence that DHCP 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 by Providers.

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.

ELEMENT 4: QUALITY IMPROVEMENT PROGRAM

Element 4: 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 the health outcomes and implementation of SNP MOCs by:

- 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 (QIC) is comprised of our Medical Director, Quality Director, SNP/Case Management Director and all other Department Directors, as well as, external Physician consultants, to create 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, 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.

ADDITIONAL RESOURCES

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

PROVIDER EXPECTATIONS

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

The Primary care providers, DHCP case managers and members are the primary members of the SNP member care team.

PCP's are expected to contribute in the following areas:

- ❑Participate in ensuring safe care transitions.
- ❑Participate as a member of the SNP member's ICT (when needed).
- ❑Collaborate with the DHCP assigned members care manager to facilitate member coordinated care.
- ❑Review, approve and update members ICP (when indicated).
- ❑Review annually updated clinical care guidelines and care transition protocols (available online).
- ❑Review care gap reports provided on a monthly basis.
- ❑Schedule member for annual wellness visits to address preventive care.
- ❑Manage members with chronic conditions by addressing needs.

FINALLY….

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 for participating in our 2026 SNP MOC Training Program.

Please click the link below to complete the attestation form that confirms you have completed the 2026 MOC Training.

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

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