Dual Special Needs Plan (HMO D-SNP) Model of Care Training

Training for Providers and Medical Office Staff

COMMUNITY FIRST HEALTH PLANS

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Community First Health Plans, Inc.

Community First is proud to offer high-quality health care coverage for individuals and families. We believe that everyone deserves access to the services and support needed to live a healthier life. We are proud to have touched the lives of over 3 million individuals since 1995.

In October 2020, Community First Health Plans, Inc. (Community First) launched two new lines of business: Medicare Advantage Alamo Plan (HMO) and Medicare Dual Eligible Special Needs Plan (D-SNP HMO). There is an annual enrollment period from October 15 to December 7.

Background and Training Requirements:

- As provided under section 1859(f)(7) of the Social Security Act, every SNP must have a Model of Care (MOC) approved by the National Committee of Quality Assurance (NCQA).
- The MOC provides the basic framework under which the SNP will meet the needs of each of it's enrollees. It is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified and addressed through the plan's care management practices.
- The Center for Medicare and Medicaid Services (CMS) requires all medical providers and staff receive basic training about the Special Needs Plans (SNPs) Model of Care.
- Audits are conducted to ensure Providers complete their training. Providers may be subject to suspension if they do not come into compliance within 30 days.

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Training Objectives

- Explain Dual Eligible Special Needs Plans (D-SNP).
- Identify the characteristics of our D-SNP population.
- Describe our Model of Care and recognize the care coordination model of components.
- Learn about the MOC Quality Measurement & Performance Improvement goals.
- Recognize provider roles and responsibilities in serving the D-SNP members.

Special Needs Plans (SNPs)

A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals.

Special needs individuals could be one of the following:

- An institutionalized individual (I-SNP)
- Individuals dually eligible for Medicare and Medicaid (D-SNP)
- Individuals with chronic conditions (C-SNP)

Community First Health Plans, Inc offers D-SNP HMO coverage.

Dual Eligible Special Needs Plans (D-SNPs)

- These individuals are a more vulnerable subgroup of Medicare beneficiaries with complex health care needs and will receive all benefits under the Medicare Advantage Plan plus additional care coordination benefits.

- D-SNPS must coordinate all services, including: enrollment, mandatory benefits, Enhance Care Coordination, long-term care services, grievance and appeals.

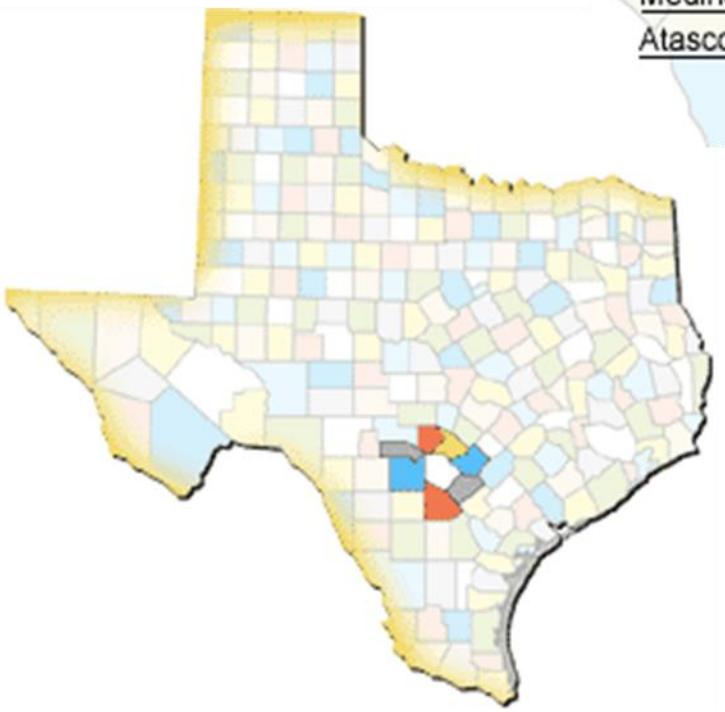
D-SNP plans enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). Medicaid eligibility categories include:

Qualified Medicare Beneficiary (QMB)	Specified Low-Income Medicare Beneficiary (SLMB)
Qualifying Individual (QI)	Qualified Disabled Working Individual (QDWI)

D-SNP Service Area

Community First members must reside within the plan's service area.

Our service area is 8 counties.



D-SNP Population Characteristics

- Many members may be socially isolated with family or friend caregivers who are over-whelmed by member needs and the complexity of the health care system.
- Between 20-25% of the D-SNP population 65 years and older has an independent living disability.
- Unsettled living conditions may result in anxiety, poor nutrition, or other effects, which can negatively affect member health.
- This population is impacted by cognitive decline due to medication side effects, problems with hormones, delirium, brain damage, substance abuse/withdrawals, and a significantly higher rate of mental illnesses such as anxiety disorders, depression, and psychosis.
- Approximately 23% of D-SNP eligible who are aged 65 and over suffer from Alzheimer's disease or a related dementia.

Vulnerable Sub-Populations

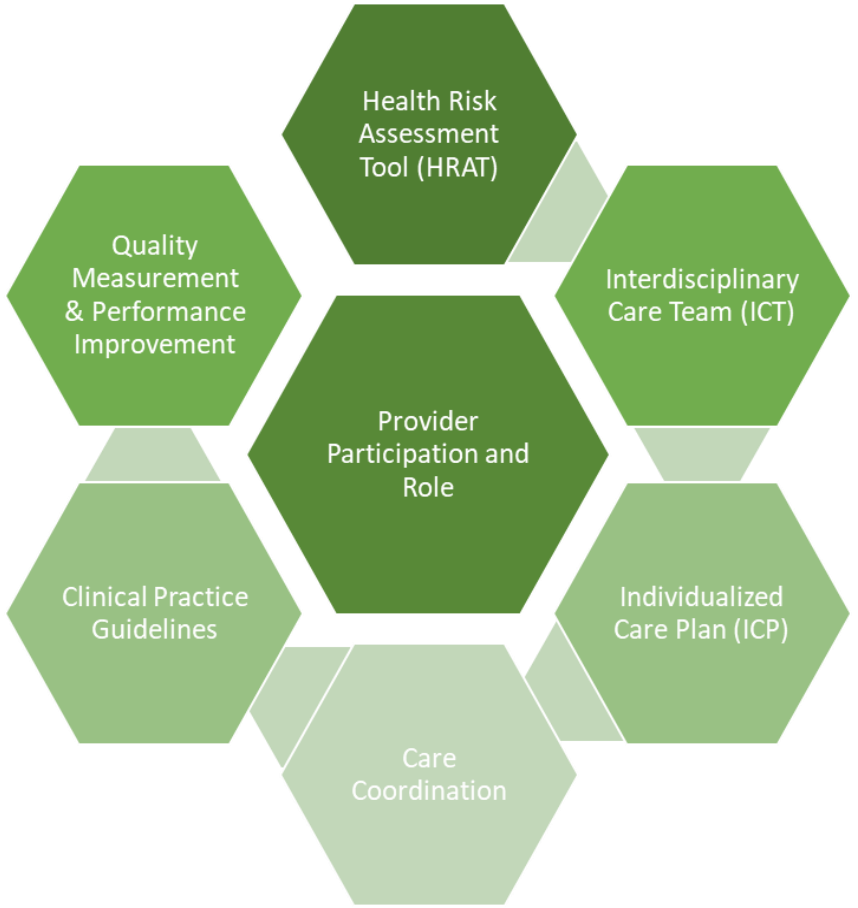
Th entire D-SNP population has significant health challenges, but there is a segment of the population that is the most vulnerable.

Community First identifies vulnerable members using the below criteria:
Complex 3 or more chronic conditions with multiple hospitalizations or skilled nursing facility admissions
Serious mental illness
Living in a rural area with a known lack of transportation
Dementia with limited social support
Advanced age (80+ years of age)

Model of Care (MOC)

- Organizations that offer Special Needs Plans must develop a Model of Care (MOC) and a Quality Improvement plan to evaluate its effectiveness.
- Community First Health Plan's Model of Care is designed to improve quality, increase access, create affordability, integrate and coordinate care across specialties, provide seamless transitions of care, improve use of preventive health services, encourage appropriate utilization and cost effectiveness and improve member health.
- Community First Health Plan's MOC describes relationships with Community Partners who provide Long-Term Services and Supports (LTSS) such as shelters, social service agencies, mental health agencies, transportation, meal services, job skills, and rent/utilize agencies.

The Model of Care design includes the following:



Health Risk Assessments (HRAs)

A standardized Health Risk Assessment Tool (called HRA) is administered for each D-SNP member.

HRA's are important for the following reasons:

- Help identify members with the most urgent needs
- Are an important part of the member's care coordination
- Contain member self-reported information
- Help create member's individualed care plan

HRA Process:

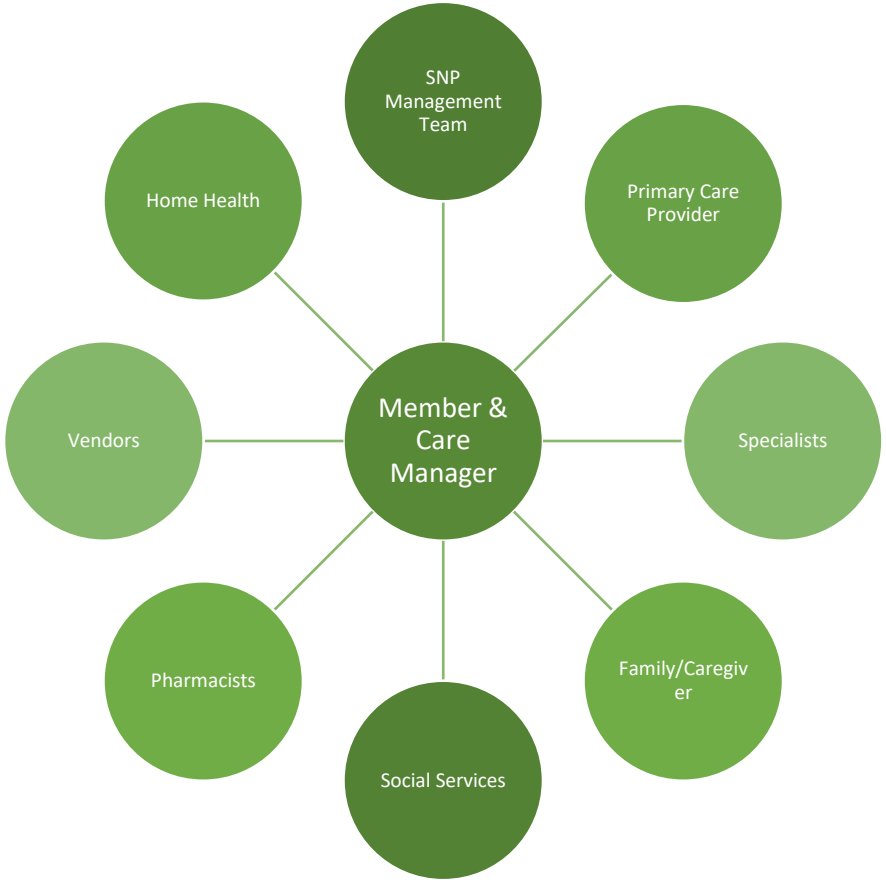
- Administered by Nurses (RN,LVN)
- Completed within 90 days of member enrollment into D-SNP and then annually\
- Assesses the following needs of each member
  - Medical
  - Functional
  - Cognitive
  - Psychosocial
  - Mental Health

Interdisciplinary Care Team (ICT)

Every D-SNP member has an ICT team to collaborate on the development and implementation of the care plan and the member's treatment plan.

- The ICT team consists of a Nurse (RN, LVN), a Social Worker, and a non-clinical support coordinator.
- The primary Care Coordinator is chosen from the team based on the member's primary needs (medical, behavioral, or social).

The ICT team includes:



ICT Meetings

ICT Meeting Preparation:

Each member will have an ICT meeting at least annually, and when there is a change in condition, as required.

- The Care Coordinator ensures that the member receives any necessary assistance and accommodations to prepare for and fully participate in the meeting and care planning process.
- The Care Coordinator may also contact external ICT members for their input if unable to attend the meeting.

The HRA results, the ICP and ICT meeting minutes are stored in the members record in the CCA system.

ICT Participants:

The primary Care Coordinator assigns the remainder of the ICT which may include other health plan staff:

- Pharmacist
- Behavioral Health Clinician

And relevant non-CFHP staff with member approval:

- Key Specialists
- Family Member
- Community-Based Social Worker
- Clergy

ICT Role

The ICT meets periodically or on member request to:

- Determine the member's goals and needs
- Coordinate member care
- Identify problems and anticipate member crisis
- Educate members about their conditions and medications
- Coach members to use their individualized care plan
- Refer members to community resources
- Manage transitions
- Coordinate Medicare and Medicaid benefits for members
- Identify and assist members with change in their Medicaid eligibility

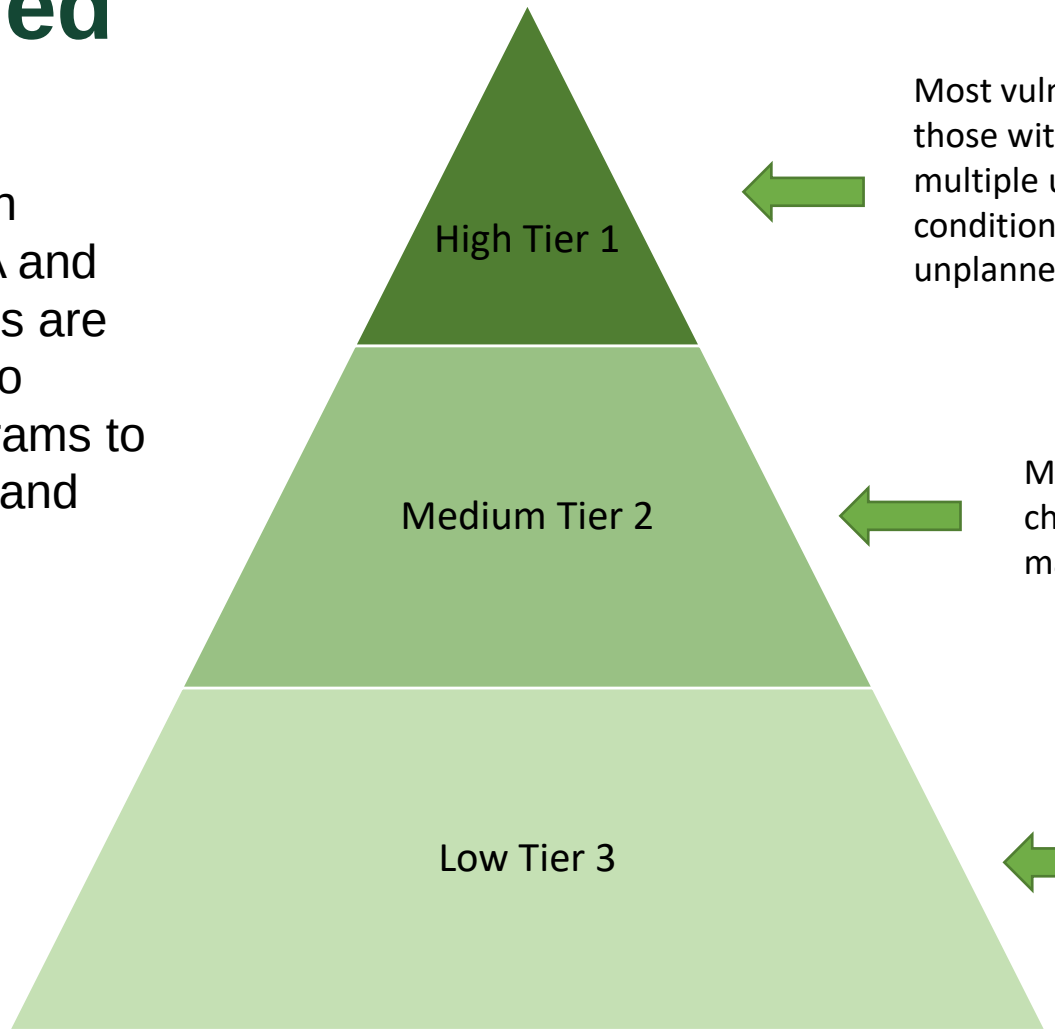
Individual Care Plan (ICP)

- An ICP is the mechanism for evaluating the member's current health status. It's the ongoing action plan to address the member's care needs in conjunction with the ICT and member.
- These plans contain member-specific problems, goals, and interventions, addressing issues found during the HRA and any team interactions.

An ICP is developed and maintained for each D-SNP member using:
HRA Results
Laboratory results, pharmacy, emergency department and hospital claims data
Care Manager interaction
ICT Input
Member preferences and goals
Annual health exam with PCP

ICP Continued

Using the information obtained by the HRA and ICT, D-SNP members are tiered and placed into various clinical programs to improve their health and well-being.



Most vulnerable members - includes those with high utilization and multiple unmanaged chronic conditions that put them at risk for unplanned transitions of care.

Members generally have multiple chronic conditions, some which may not be managed.

Contains the most stable D-SNP Members

Communicating the Individual Care Plan

The ICP is communicated to the members and/or their caregivers, and other key people involved in the member's care, both initially and as updates and modifications are made, in a variety of ways.

- Direct communications by phone calls establishing or following up on the goals in the ICP.
- Electronic access to the member's ICP within the CCA system to staff, and via Provider Portal to providers.
- Written documentation by mail, secure email, or facsimile to members.
- Care conferences or other ICT meeting in person, via telephonic conferences, or by individual calls.

Care Coordination

- The Care Coordination process assesses members and drives care, services, and behaviors to address their individual needs and preferences.
- Community First Health Plan's administrative personnel is responsible for plan operations, provider networks, compliance, and business development. It includes:
  - Administrative Staff
  - Clinical Staff
  - Oversight Staff Enrollment and Eligibility
- There is a post hospitalization transition of care that helps members understand discharge diagnosis and instructions, facilitates follow up appointments, schedules transpiration, assist with need home health care and medical equipment, resolves barriers to obtaining medications, and educates member on new or containing medical conditions. (3 day post-hospital call and a 14 day follow up call).

Care Coordination: Face to Face Encounters

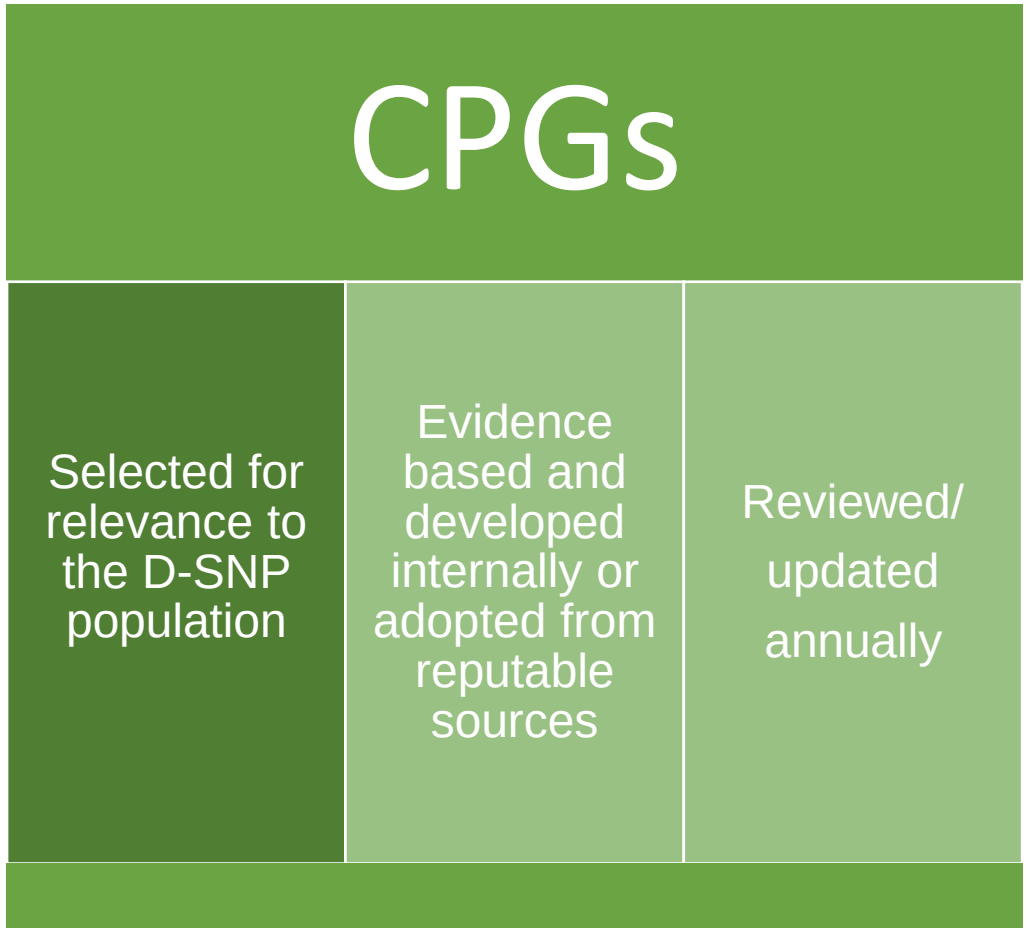
- Face-to-Face visits may identify new health concerns or issues, and non-medical drivers related to housing, family dynamics, nutrition, or mobility, and other barriers may be more easily identified by a Care Coordinator in the member home.
- Through Care Coordination, every D-SNP member must be afforded a face-to-face visit at least on an annual basis, beginning within 12 months of enrollment.
- The PCP or other treating network provider will render medical care which may take the form of an annual wellness visit, a physical exam, diagnostic lab or radiology services, counseling or education on relevant health topics.

Face-to-Face Encounter Requirements

- Assess current health status, current behavioral health status
- Identify any new health symptoms and current substance use status
- Assess current functional status (ADLs and IADLs) and cognitive status
- Solicit member's self-evaluation of health/dental status and concerns to access to health care
- Assess current status of social factors impacting health and wellbeing, including current living situation and family/roommate dynamics, risk of isolation
- Solicit member concerns about social issues such as housing insecurity, food insecurity, isolation and social interaction, ability to pay for regular bills for heating/air conditioning, electricity, or phone
- Solicit member concerns about safety including risks of crime or domestic violence
- Assess sexual activity, needs for family planning, or STD prevention
- Verify status of Advance Directives and validate last annual wellness exam

Clinical Practice Guidelines

- Community First promotes medical, behavioral health, and preventative clinical practice guidelines (CPGs).
- We share CPGs with network providers on the provider portal (including links in the provider newsletter), in group trainings and in individual meetings.
- Medical Directors monitor provider adherence to CPGs.



Clinical Practice Guideline Variance

The use of CPGs and nationally recognized protocols may need to be modified to be appropriate for some vulnerable D-SNP members.

- When a member has several chronic conditions, some of the guidelines are likely to contradict the others.
- A member may be so uncomfortable and distracted by one condition and may not be interested in care plans for other conditions.
- The frail elderly and other vulnerable members may not realize the long-term benefits of preventative care.

Quality Measurements and Improvements

- Community First Health Plans collects performance, quality, and health outcome measurements to analyze and report to evaluate the effectiveness of the model of care.
- Measurement goals are in place to evaluate the performance or our D-SNP plan in the following areas:
  - Improve access and affordability of healthcare needs.
  - Improve coordination of care and appropriate delivery of services.
  - Enhance care transitions across all healthcare settings and providers.
  - Ensure appropriate utilization of services for chronic conditions.

Provider Participation

- Provider partners are an invaluable part of the interdisciplinary care team. Our D-SNP Model of Care offers an opportunity for us to work together for the benefit of our members, your patient, by enhancing communication, focusing on each individual members special needs, delivering care management programs, and supporting the member's plan of care.
- Community First has an established provider network to meet the needs of our members and target population, and our credentialing division is consistent with NCQA.
- Community First contracts with individual providers, provider specialists, hospitals/urgent care facilities, rehabilitation and long-term acute care hospitals, and nursing facilities. This expanded network of provider types and organizations enables Community First to maintain an enhanced program of care coordination and assistance.

Provider Role

- Communicate with D-SNP Care Managers, ICT members, members and caregivers
- Collaborate with our organization on the ICP
- Review and respond to patient specific communication
- Maintain ICP in member’s medical record
- Participate in the ICTs
- Remind members of the importance of the HRA
- Perform Face-to-Face visits
- Encourage members to work with their ICT
- Complete MOC training upon onboarding and again annually

Model of Care Training Due annually by December 31, 2024

- Please go to Medicare.CommunityFirstHealthPlans.com/Providers/Model-of-Care to complete the MOC training online no later than December 31, 2024.

- Attest to training completion using the easy attestation form located on the same page as the training.

Next Steps:

Thank you for completing the Community First Medicare Advantage Dual Eligible Special Needs Plan Provider Training requirement.

To acknowledge completion and receive credit for this training, please attest xxxx.