COMMUNITY FIRST
HEALTH PLANS

Medicare Advantage Dual Special Needs Plan (HMO D-SNP)

Model of Care Training

Training for Providers and Medical Office Staff

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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 its enrollees. It is a vital quality improvement tool and an 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.

COMMUNITY FIRST HEALTH PLANS

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 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 offers D-SNP HMO coverage.

Dual Eligible Special Needs Plans (D-SNPs)

- D-SNP individuals are a more vulnerable subgroup of Medicare beneficiaries with complex health care needs. They receive all benefits under the Medicare Advantage Plan, plus additional care coordination benefits.

- D-SNPS must coordinate all services, including enrollment, mandatory benefits, enhanced care coordination, long-term care services, grievances, 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 Medicare Advantage D-SNP Members must reside within the plan's service area.

Our service area includes Bexar County and its surrounding seven counties.

COMAL
GUADALUPE
KENDALL
BANDERA
BEXAR
MEDINA
WILSON
ATASCOSA

D-SNP Population Characteristics

- Many Members may be socially isolated with family or friend caregivers who are overwhelmed 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.
- The D-SNP population may be 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 age 65 and over suffer from Alzheimer's disease or a related dementia.

Vulnerable Sub-Populations

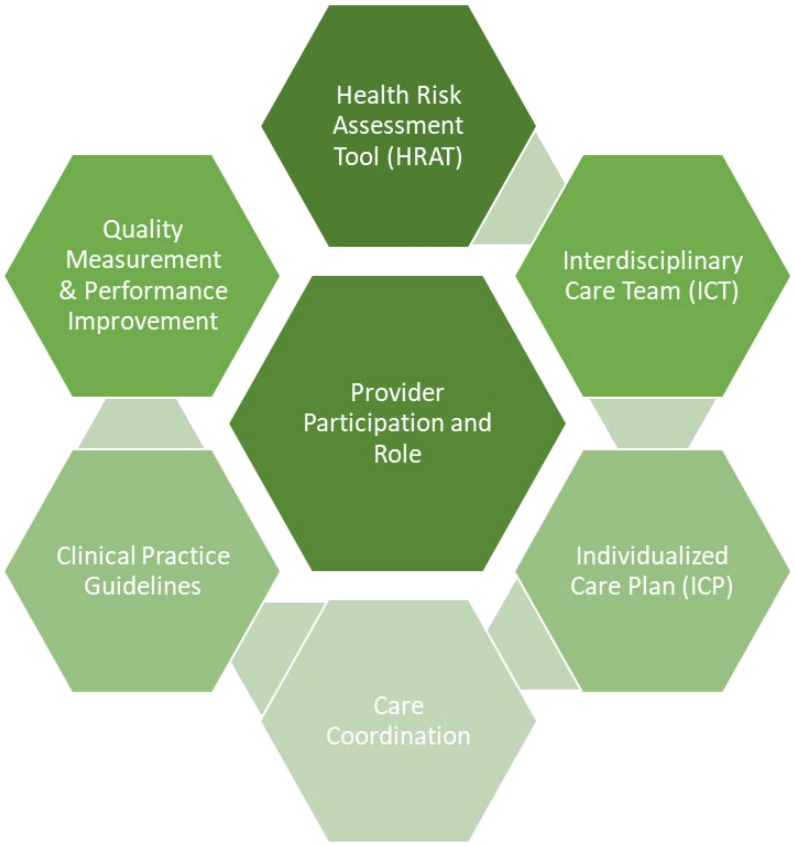
The D-SNP population in its entirety has significant health challenges, but there is a specific segment of the population that is the most vulnerable.

Community First identifies vulnerable Members using the following criteria:
• Three or more complex, 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 SNP need to create a Model of Care (MOC) and a Quality Improvement plan to assess how well they work.
- The Community First MOC is designed to improve quality, access, and affordability of care while coordinating services across different specialties. It focuses on smooth transitions between care, promoting preventive health services, and making sure care is used appropriately and cost-effectively to improve Member health.
- Our MOC also highlights partnerships with community organizations that provide long-term support services, such as shelters, social services, mental health support, transportation, meals, job training, and housing assistance.

The Model of Care design includes the following:



Health Risk Assessments (HRAs)

A standardized Health Risk Assessment Tool is administered to each D-SNP Member.

Health Risk Assessments (HRA) are important because they:

- 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 a Member's individualized care plan

The HRA process is as follows:

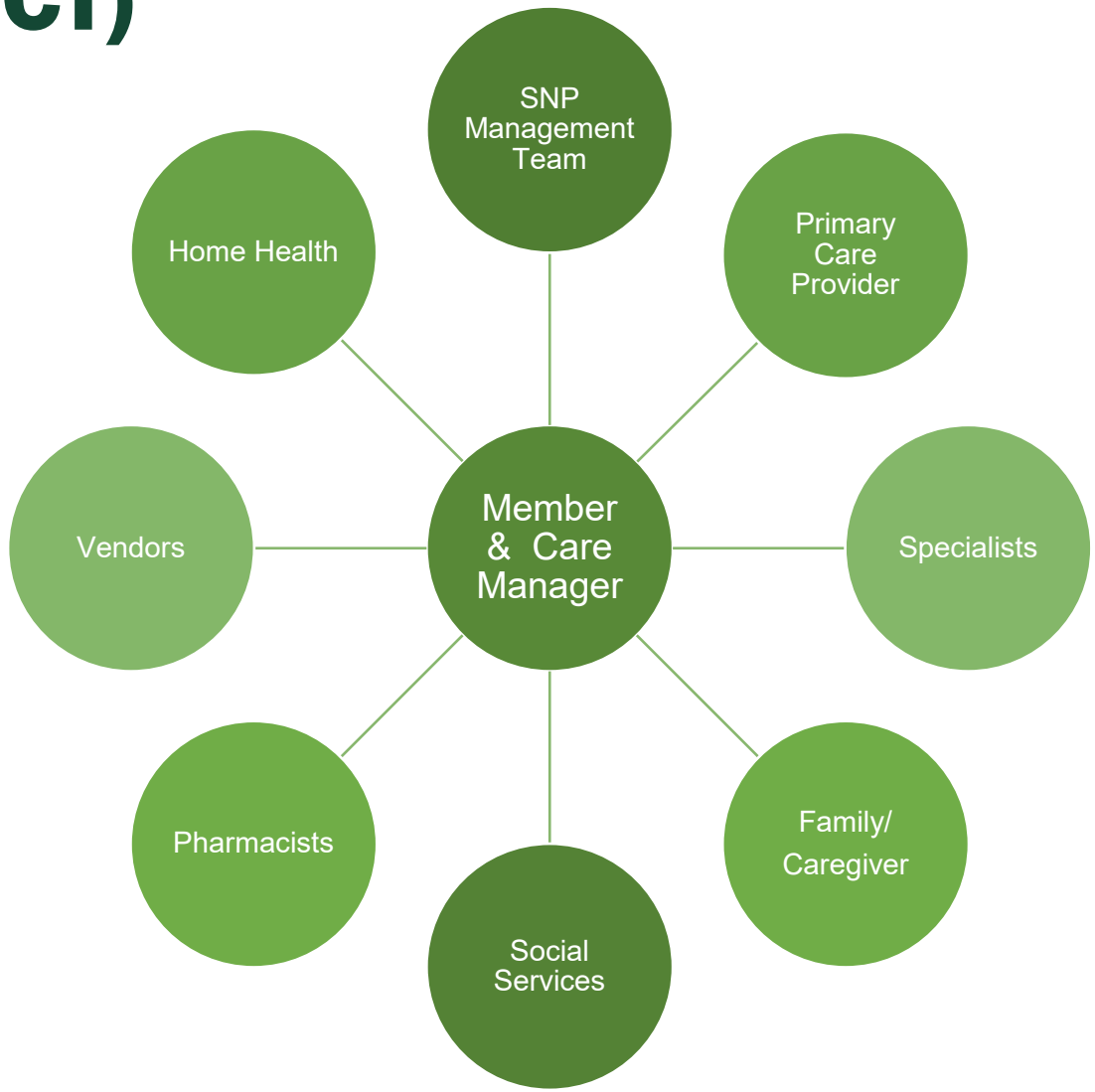
- Administered by a nurse (RN, LVN)
- Completed within 90 days of Member enrollment into D-SNP and then annually
- Assess the following needs of each Member:
  - Medical
  - Functional
  - Cognitive
  - Psychosocial
  - Mental Health

Interdisciplinary Care Team (ICT)

Every D-SNP Member has an ICT team to collaborate on the development and implementation of the Member's care and 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 and the ICP and ICT meeting minutes are stored in the Member's record in the CCA system.

ICT Participants

The primary Care Coordinator assigns the remainder of the ICT, which may include other Community First staff members, including:

- Pharmacist
- Behavioral Health Clinician

The ICT may also include relevant non-Community First staff with Member approval:

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

ICT Roles & Responsibilities

The ICT meets periodically or at the Member's 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 changes in their Medicaid eligibility

Individual Care Plan (ICP)

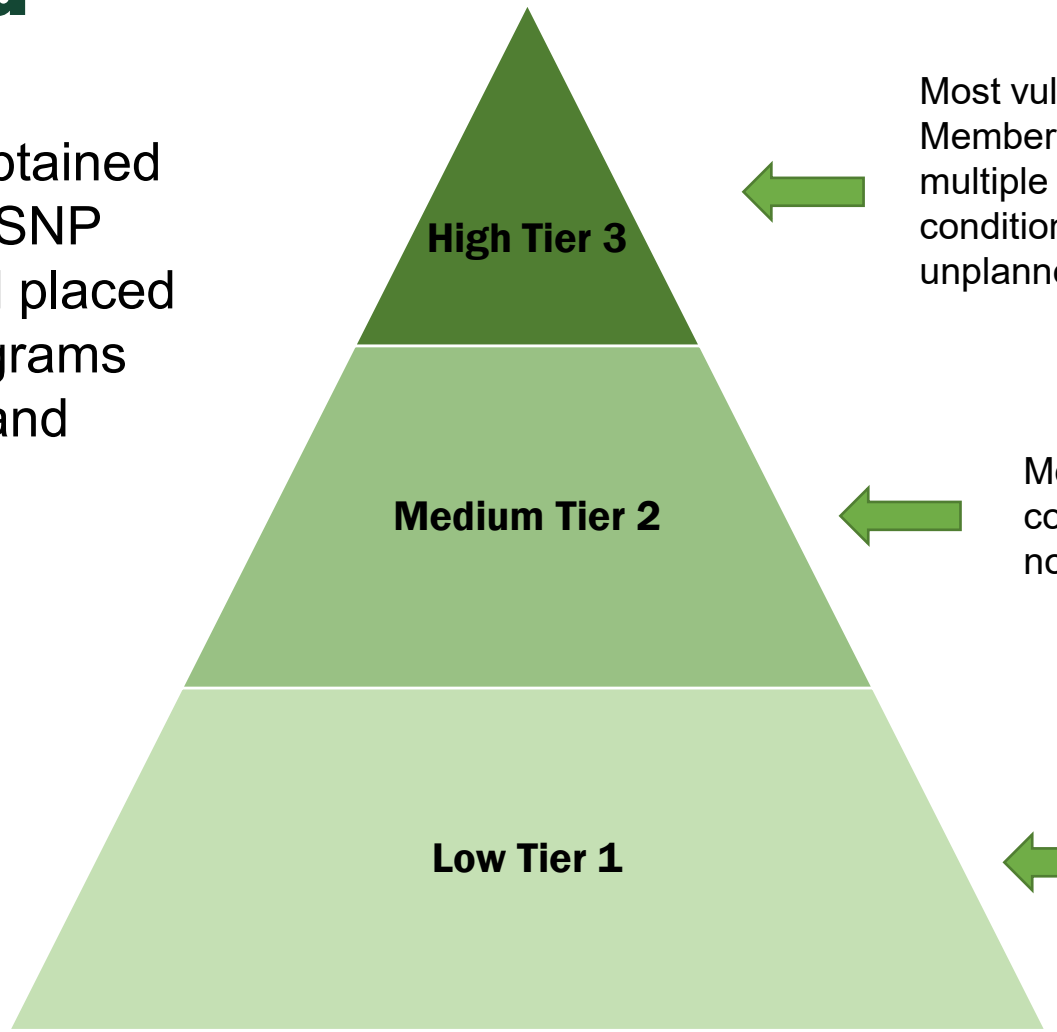
- An **ICP** is the mechanism for evaluating the Member's current health status. It is an ongoing action plan to address the Member's health care needs in conjunction with the ICT and the Member themselves.

- ICPs 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; Members with high utilization and multiple unmanaged chronic conditions that put them at risk for unplanned transitions of care.

Members with multiple chronic conditions, some of which may not be managed.

Most stable D-SNP Members

ICP Communications

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 communication via phone calls establishing or following up on goals in the ICP.
- Electronic access for Community First staff to the Member's ICP within the CCA system.
- Electronic access for Providers via the Community First online Provider Portal.
- Written documentation by mail, secure email, or facsimile to Members.
- Care conferences or other ICT meetings in person, via telephonic conferences, or by individual phone calls.

Care Coordination

The Care Coordination process evaluates Members and guides care, services, and behaviors to meet their individual needs and preferences.

Community First administrative personnel is responsible for plan operations, provider networks, compliance, and business development. Personnel includes:

- Administrative Staff
- Clinical Staff
- Oversight Staff Enrollment and Eligibility

Post-hospitalization transition of care helps Members understand their discharge diagnosis and instructions, facilitate follow-up appointments, schedule transportation, assist with home health care and medical equipment, resolve barriers to obtaining medications, and provide education on medical conditions.

- 3-day post-hospital call
- 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, mobility, and other barriers. These may be more easily identified by a Care Coordinator visiting the Member's 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.

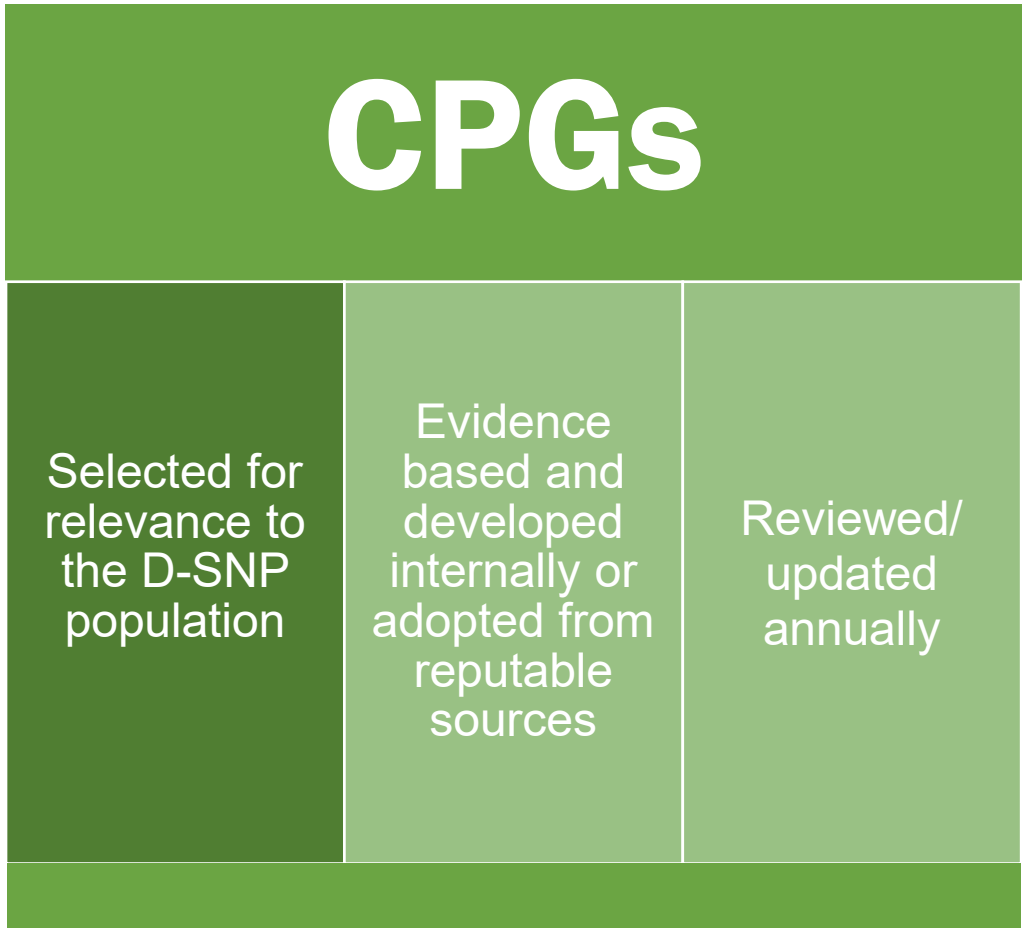
- The PCP or other treating network provider will render medical care, which may take the form of:
    - An annual wellness visit
    - A physical exam
    - Diagnostic lab or radiology services
    - Counseling or education on relevant health topics

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 about access to health care
- Assess the current status of social factors impacting health and well-being, including living situation and family/roommate dynamics, risk of isolation
- Solicit Member concerns about social issues such as housing insecurity, food insecurity, isolation, social interaction, ability to pay 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 the status of Advance Directives and validate the last annual wellness exam

Clinical Practice Guidelines (CPGs)

- 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 biannual Provider Newsletter), in group trainings, and in individual meetings.
- Medical Directors monitor provider adherence to CPGs.



Clinical Practice Guideline Variance

The use of nationally recognized protocols and CPGs may need to be tailored to suit certain 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 preventive 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 of our D-SNP plan in the following areas:

- Improve access and affordability of health care needs.
- Improve coordination of care and appropriate delivery of services.
- Enhance care transitions across all health care 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 patients) by enhancing communication, focusing on each individual Member's 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 Roles & Responsibilities

- Communicate with D-SNP Care Managers, ICT, 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

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

To acknowledge completion and receive credit for this training, please attest using the online form located at:
Medicare.CommunityFirstHealthPlans.com/Providers/Model-of-Care/

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