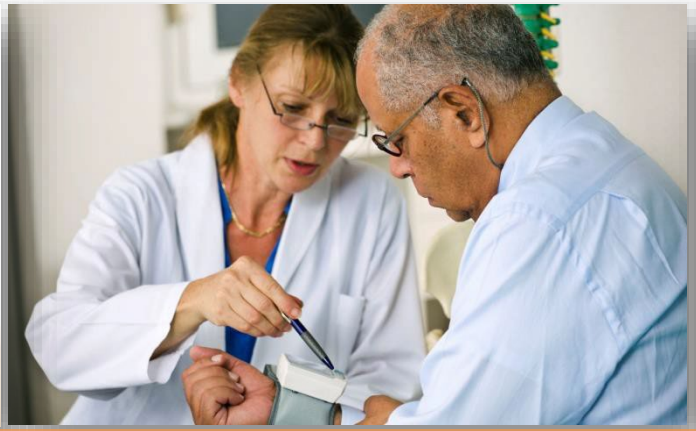
CENTERS PLAN FOR HEALTHY LIVING


SPECIAL NEEDS PLAN (SNP)

Model of Care Training (MOC)

WHAT IS A SNP?

A **SNP (Special Needs Plan)** is a type of HMO that only allows beneficiaries who meet specific eligibility criteria to enroll.

- Individuals with a specific disease(s) or characteristic(s) – C-SNP/Chronic Condition SNP.
- Individuals who live in a nursing home or require nursing level of care at home – I-SNP/Institutional SNP
- Individuals who are Dual Eligible (have both Medicare and Medicaid) – D-SNP/Dual Eligible SNP

WHAT IS A SNP? (cont.)

Centers Plan for Healthy Living (CPHL) participates in two types of SNPs:

D-SNP

- **Coordination Only D-SNPs (e.g., Centers Plan for Dual Coverage Care)**

- **Fully Integrated Dual Eligible/ FIDE D-SNPs (e.g., Centers Plan for Medicaid Advantage Plus)**
  In order to be eligible, enrollees must require care management, and be expected to need at least one of the following Community-Based Long-Term Care services for more than 120 days from the effective date of enrollment:
  o Nursing services in the home;
  o Therapies in the home; Home health aide services;
  o Personal care services in the home;
  o Adult day health care;
  o Private duty nursing; or
  o Consumer Directed Personal Assistance Services (CDPAS)

- **Highly Integrated Dual Eligible/HIDE D-SNPs (Centers Plan does not offer a HIDE D-SNP).**

I-SNP

An **Institution Special Needs Plan (I-SNP)** serves enrollees who reside in a skilled nursing facility specifically contracted with the I-SNP (not just in the plan's network), for 90 days or more.

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Model of Care (MOC)

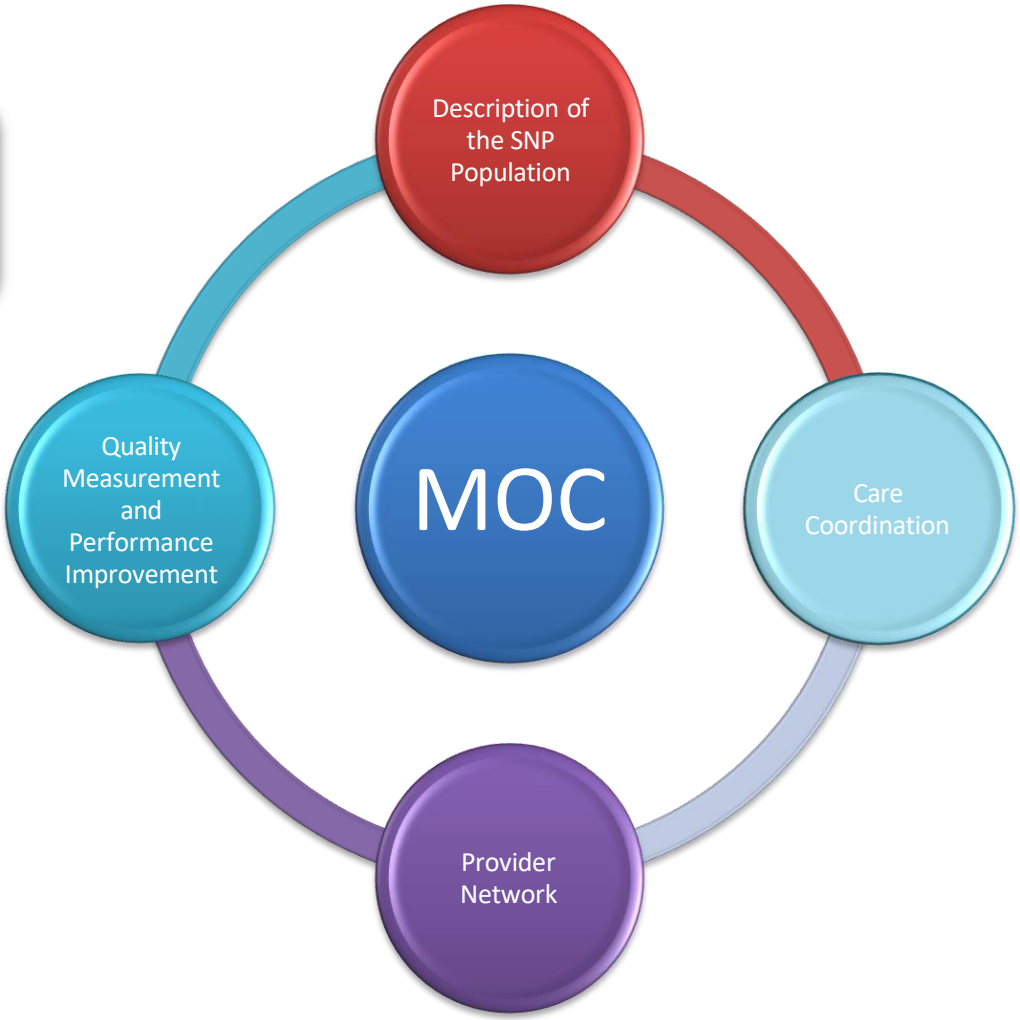
CPHL has created a Model of Care (MOC) as required by the Centers for Medicare and Medicaid (CMS).

A MOC describes how the SNP will identify and address the needs of enrollees. This training will review the MOC for Centers Plan for Healthy Living's D-SNP and I-SNP.

Centers Plan for Healthy Living employees and providers are required to complete an initial MOC training and annual MOC trainings

Categories of the MOC

Every MOC must provide information in these four categories:



Description of the SNP Population

- Enrollees in the coordination only D-SNP must have Medicare Part A & B and must be enrolled in Medicaid and/or MSP
- Enrollees in the I-SNP must have Medicare Part A & B, reside in an I-SNP-contracted nursing home for at least 90 days.
- Enrollee in the FIDE D-SNP (MAP) must: have Medicare Part A & B, require long-term care services for a continuous period of more than 120 days from the date of enrollment, and have full benefit Medicaid.

CPHL's SNP enrollees are elderly and/or disabled, low-income, and have complex health needs. Many I-SNP enrollees also have functional or cognitive impairments, and multiple chronic conditions; SNP enrollees are generally a vulnerable population.

CPHL monitors and tracks population's demographics in order to add providers to accommodate enrollee needs rapidly. CPHL also addresses ethnic, language, and cultural considerations by hiring bilingual staff, and keeping cultural needs in mind when assigning staff to enrollees.

Care Coordination: Staff & Roles

Staff Structure and Roles

Centers Plan for Healthy Living has a variety of staff roles to ensure that all aspects of enrollee care is coordinated and enrollee needs are addressed effectively

D-SNP Clinical Management Department

Chief Medical Officer, VP of Clinical Operations, Director of Medicare, Assistant Director of Delegated Care Management, Assistant Director of Medicare, Clinical Team Manager, Clinical Education, Care Manager, Nurse Assessor, Social Worker, Pharmacy, Utilization Management, Quality Management, Behavioral Health Care Management

I-SNP Clinical Management Department

Chief Medical Officer, Director of I-SNP, I-SNP Manager, Nurse Practitioners, Transitional Care Coordinator, Clinical Pharmacist, Utilization Management, Quality management

Administrative Staff

Human Resources, Network/Provider Operations, Member Services, Claims, Enrollment, Grievances and Appeals, Business Development, Corporate Compliance

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Care Coordination: Assessment Tool

Health Risk Assessment (HRA)

Centers Plan for Healthy Living uses the Health Risk Assessment (HRA) to assess every enrollee. This assessment is initially performed within 90 days of enrollment. Enrollees are routinely reassessed annually (365 days after the last HRA). A new assessment is also conducted if the enrollee experiences a major change in condition. The information obtained during the assessment is applied to our Risk Stratification model to ensure that enrollees' needs are met appropriately.

Areas the HRA assesses:

- ❑ Medical needs, including medical conditions
- ❑ Functional needs, including activities of daily living (ADLs)
- ❑ Behavioral and Cognitive needs, including mental health conditions
- ❑ Psychosocial needs, including living arrangements and advance directives

Face-to-Face Encounters

As part of CMS regulations, SNPs must provide a face-to-face encounter for the delivery of health care, care management or care coordination services.

D-SNP

This face-to-face encounter must occur as feasible, within the first 12 months of enrollment and at least annually thereafter. This face-to-face encounter is part of Care Management's strategy to improve healthcare outcomes through enrollee and Interdisciplinary Care Team (ICT) engagement and participation.

I-SNP

All encounters conducted by I-SNP nurse practitioners are face-to-face on-site at nursing facilities.

Care Coordination: Care Plan

Individualized Care Plan (ICP)

The Care Manager, enrollee and/or caregiver, PCP, and other applicable members of the Interdisciplinary Care Team (ICT) develop an Individualized Care Plan (ICP) based on the clinical needs, personal goals, and preferences identified by the HRA and other assessments. The HRA provides information about the enrollee's medical and functional needs, strengths, weaknesses, and preferences. The Plan's Risk Stratification Tool provides additional information about the enrollee's current clinical condition.

An ICP is developed after the enrollee's initial HRA. A new ICP is created annually and if the enrollee experiences a significant change in status based on the HRA conducted.

The ICP is a personalized plan that is created to help enrollees maintain and improve their health and functioning. Specific medical, functional, and behavioral needs are identified. Barriers to care are recognized and addressed. Individualized goals are created, and services are recommended and authorized to help enrollees achieve their goals.

Care Coordination: The Team

Interdisciplinary Care Team (ICT)

A SNP's Interdisciplinary Care Team (ICT) plays an instrumental role in the enrollee's care and is responsible for coordinating and delivering comprehensive care to meet the unique needs of the plan's enrollees. The composition of CPHL's ICT is carefully designed to ensure that the team members possess the expertise, training and capabilities necessary to address the specific health conditions and social determinants of health affecting its D-SNP enrollees. The ICT for CPHL enrollees is comprised of health care professionals and assigned based on the enrollee's assessment findings to improve the enrollee's health status and quality of life. For each enrollee, the ICT, at a minimum, is comprised of the enrollee and/or caregivers, the Care Management Team, and the enrollee's PCP. Additional ICT members may include specialists, pharmacists, behavioral health specialists, social workers, therapists, nutritionists, and other clinical disciplines as required by the results of the Health Risk Assessment.

Care Coordination: Care Management

Care Management

D-SNP enrollees are eligible to work with a Care Manager (CM) and I-SNP enrollees with the Nurse Practitioner (NP) to develop a plan of care that is individualized for them. The CM/NP will assess the enrollee's clinical history, medications, functional and cognitive needs, cultural and linguistic considerations, and barriers to meeting care plan goals. The CM/NP will assist the enrollee with receiving benefits and other resources available to the enrollee; and will coordinate health services as needed.

Enrollees who accept Care Management will be monitored for hospitalizations, ER visits, high-risk medications, medication compliance, and compliance and progress with Care Plan goals. HEDIS measures are identified and addressed. Enrollees will be educated on advance directives. When applicable and desired, enrollees will be educated on hospice and end of life care. The Care Manager will help coordinate these services and will provide support as indicated.

The CM/NP will also provide self-management plans and education to the enrollee relevant to the enrollee's specific health needs and goals.

Care Coordination: Transitions

Transition of Care Protocols for D-SNP

The Care Manager identifies enrollees at high risk for transitions, coordinates services, and provides education to try to reduce transitions.

When an enrollee experiences a transition to another care setting, such as a hospital, skilled nursing facility, rehabilitation facility, outpatient center, or another setting, CPHL's Care Management team will share the information with the ICT. Prior authorizations must be in place for planned transitions. The Care Manager and Utilization Management Nurse will communicate with the alternate care setting regarding the enrollee's medications, demographics, and advance directives. The Care Manager verbally communicates the contents of the ICP with the staff at the inpatient facility. The Care Manager, Utilization Management, and the hospital or other care setting develop a safe discharge plan and notify the ICT, including the enrollee and the PCP.

After discharge, the Care Manager follows up with the enrollee to ensure services are appropriate and timely, and helps the enrollee schedule follow-up appointments. The enrollee receives a new HRA and will be involved in creating their ICP. The enrollee's new ICP will address the reason for the transition, and will provide interventions to reduce re-admissions.

Care Coordination: Transitions

Transition of Care Protocols for I-SNP

When an enrollee experiences a transition to another care setting, such as a hospital or outpatient center, or another setting, the nurse practitioner and/or SNF will share the enrollee's current ICP with the treating facility regardless of their network affiliation. The Transitional Care Coordinator initiates contact with the receiving facility to begin the discharge planning process and the UM nurse reviews clinical information concurrently to ensure medical appropriateness. The nurse practitioner, transitional care coordinator and UM nurse work in tandem with the SNF to schedule follow up appointments, transportation, obtain addition orders for services that may be needed and securing required authorizations if needed.

Provider Network

The evidence-based clinical practice guidelines CPHL uses are based on nationally recognized protocols for assessment, care, and maintenance of health. These guidelines are available to providers on the plan's website (www.centersplan.com). CPHL monitors providers' practices to ensure guidelines are followed.

All participating providers receive mandatory MOC training. Reminder of the MOC training is shared with Providers quarterly.

Our enrollees have a robust network of providers and facilities available to provide necessary care. We continuously monitor our enrollees' needs to see if the Plan needs to expand the network and extend new provider contracts.

In-network facilities and providers need to participate in a rigorous credentialing process. Providers are re-credentialed every 3 years.

Quality Measurement/Performance Improvement

The Quality Assurance Performance Improvement (QAPI) Committee structure helps CPHL evaluate the MOC's effectiveness and identify opportunities for movement.

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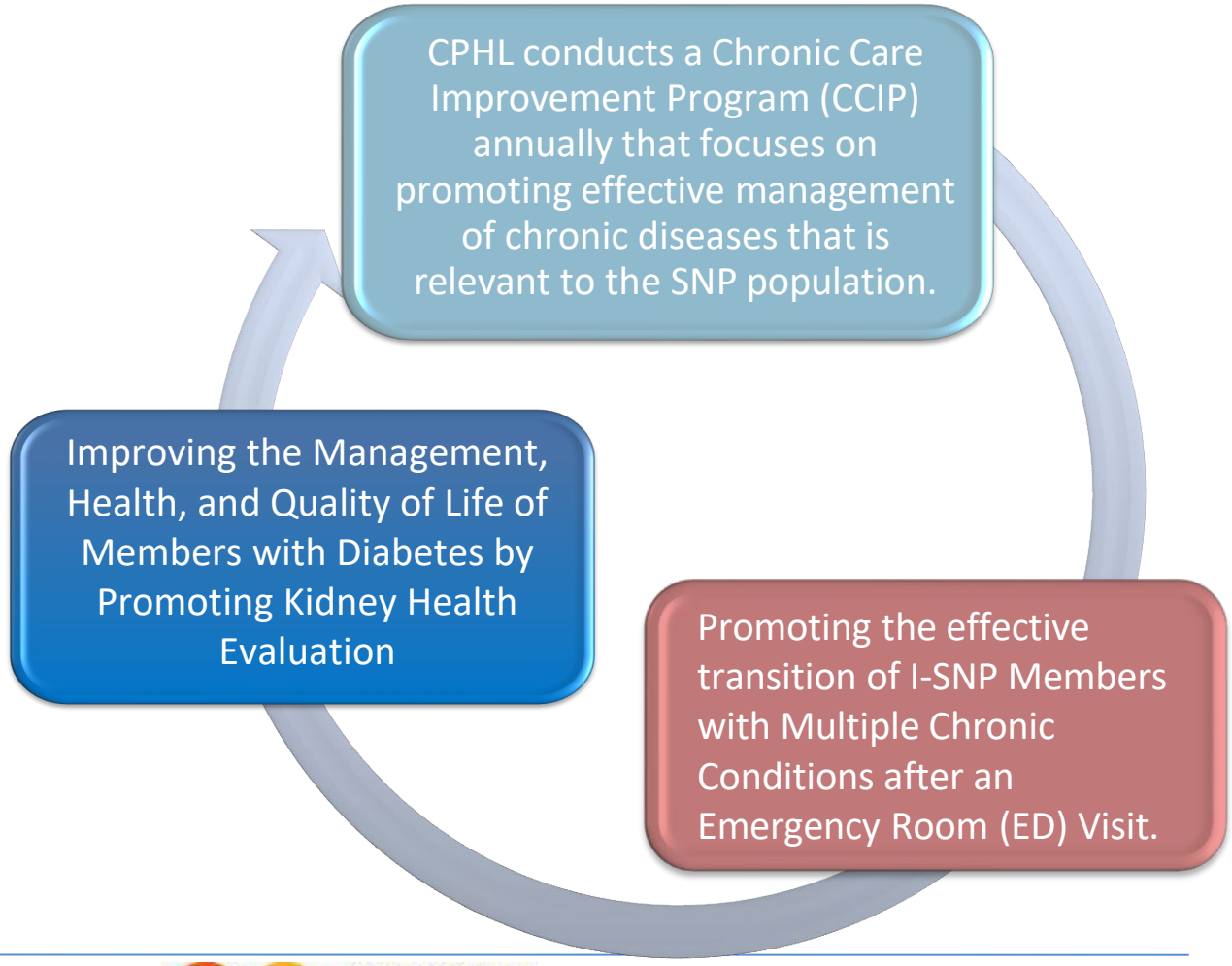
Quality Measurement/Performance Improvement

CPHL monitors and evaluates performance and identifies areas for improvement through the collection, analysis, and evaluation of data including claims encounter data, pharmacy data, lab data, vendor data, supplemental data sources, medical records, survey data, and/or utilization management data.



Quality Measurement/Performance Improvement

Quality Improvement activities that impact the SNP population are monitored through the Quality Assurance Performance Improvement (QAPI) Committee's approved Work Plan.

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MOC Training

Thank you for completing the MOC Training for CPHL's D-SNP and I-SNP