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

2025

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Agenda

- **Special Needs Plan (SNP) Brief Overview**
- **Model of Care Goals and Benefits**
- **Review Model of Care Components (1-4)**
  - Description of the D-SNP Population
  - Care Coordination
  - D-SNP Provider Network Resources & Engagement
  - Quality Measurement & Performance Improvement
- **Providers' Role/Partnership**
- **Q&A Open Discussion**

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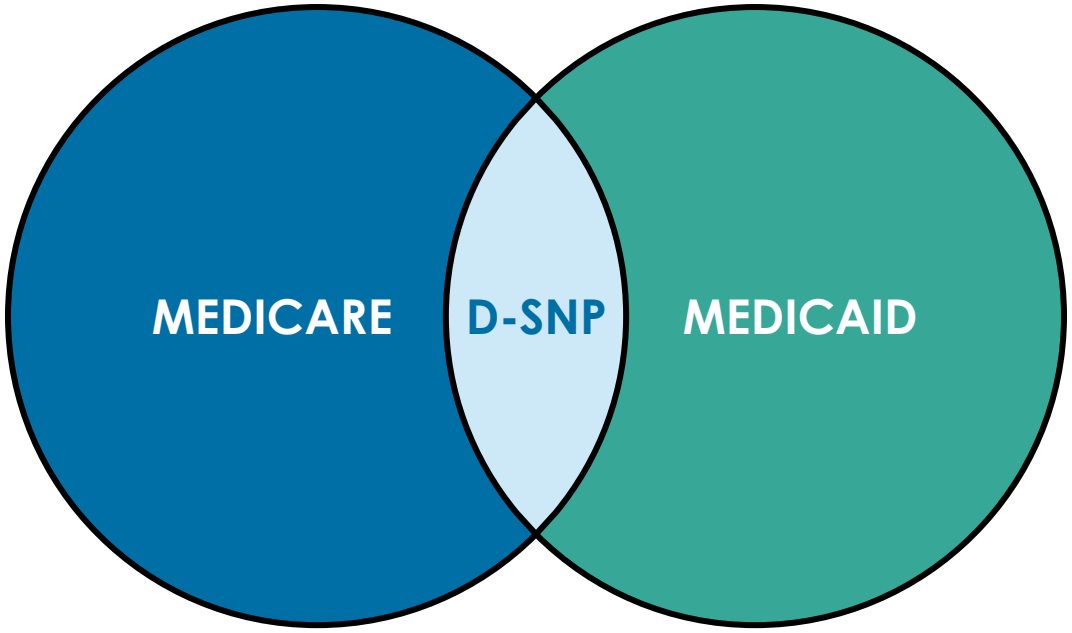
Special Needs Plan (SNP) Brief Overview

What is a SNP?

A Special Needs Plan (SNP) is a type of Medicare Advantage (MA) plan designed to offer tailored care for individuals with special needs.

The aim is **to provide** additional benefits and team-based care **to enhance** health outcomes and **reduce costs** for the special needs population through improved care coordination.



D-SNP: Dual **S**pecial **N**eeds **P**lan

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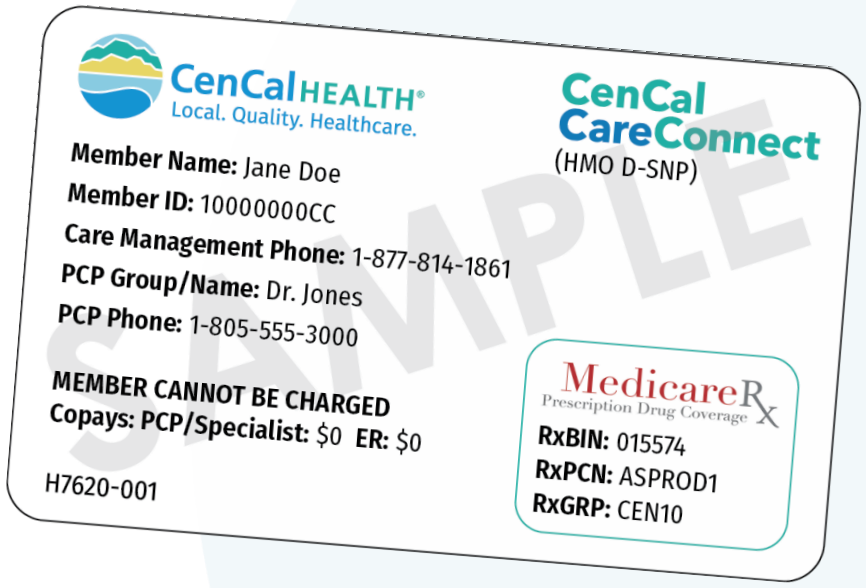
Special Needs Plan (SNP) Brief Overview (cont.)

There are three types of SNPs



1. **I-SNP: *Institutionalized SNP***
   - Members who live in certain institutions, such as nursing homes or long-term facilities
2. **C-SNP: *Chronic Condition SNP***
   - Members with specific chronic conditions, such as diabetes and heart failure
3. **D-SNP: *Dual Eligible SNP***
   - Members who are eligible for both Medicare and Medicaid
     - CenCal Health will manage the D-SNP HMO product
     - CenCal Health's D-SNP product is called CenCal Care Connect

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Introduction to Dually Eligible Beneficiaries

Dually Eligible Definition

- Members with both Medicare and Medi-Cal are often referred as "Dually Eligible Beneficiaries."

CenCal Health currently covers Medi-Cal benefits for dually eligible beneficiaries in both Santa Barbara and San Luis Obispo counties. Members with Medicare and Medi-Cal already receive Medi-Cal covered services through CenCal Health.

Today, CenCal Health **covers nearly 23,000 duals** through Medi-Cal.

Santa Barbara County	**San Luis Obispo County**
Approximately 15,000	Approximately 8,000

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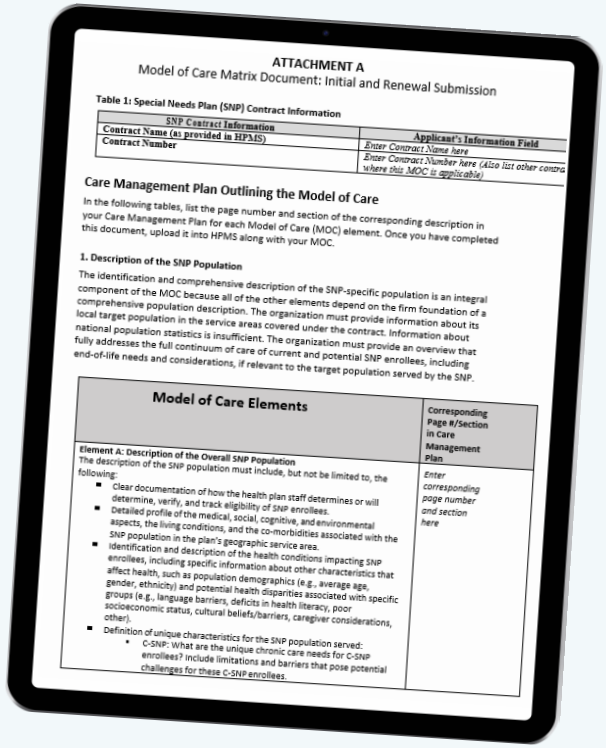
What is a D-SNP Model of Care (MOC)?

What is a Model of Care?

MOC is a **comprehensive document that describes how CenCal Health will provide care** to members enrolled in D-SNP


ATTACHMENT A

Model of Care Matrix Document: Initial and Renewal Submission

Table 1: Special Needs Plan (SNP) Contract Information

SNP Contract Information	Applicant's Information Field
Contract Name (as provided in HPMS)	Enter Contract Name here
Contract Number	Enter Contract Number here (Also list other contra where this MOC is applicable)

Care Management Plan Outlining the Model of Care

In the following tables, list the page number and section of the corresponding description in your Care Management Plan for each Model of Care (MOC) element. Once you have completed this document, upload it into HPMS along with your MOC.

1. Description of the SNP Population

The identification and comprehensive description of the SNP-specific population is an integral component of the MOC because all of the other elements depend on the firm foundation of a comprehensive population description. The organization must provide information about its local target population in the service areas covered under the contract. Information about national population statistics is insufficient. The organization must provide an overview that fully addresses the full continuum of care of current and potential SNP enrollees, including end-of-life needs and considerations, if relevant to the target population served by the SNP.

Model of Care Elements	Corresponding Page #/Section in Care Management Plan
Element A: Description of the Overall SNP Population The description of the SNP population must include, but not be limited to, the following: ▪ Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP enrollees. ▪ Detailed profile of the medical, social, cognitive, and environmental aspects, the living conditions, and the co-morbidities associated with the SNP population in the plan's geographic service area. ▪ Identification and description of the health conditions impacting SNP enrollees, including specific information about other characteristics that affect health, such as population demographics (e.g., average age, gender, ethnicity) and potential health disparities associated with specific groups (e.g., language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other). ▪ Definition of unique characteristics for the SNP population served: ▪ C-SNP: What are the unique chronic care needs for C-SNP enrollees? Include limitations and barriers that pose potential challenges for these C-SNP enrollees.	Enter corresponding page number and section here

What are the Goals of the MOC?

- **To ensure** that the unique needs of each member is identified and can be addressed
- **To promote** enhanced quality, care management and care coordination processes
- **To improve** seamless and timely transitions of care to ensure appropriate level of care
- **To increase** member satisfaction by ensuring seamless navigation through health care services with personalized and tailored support

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D-SNP MOC Components Overview

The requirements for MOC 1-4 consist of the following components:

Description of the SNP Population	• General Population • Most Vulnerable High-Risk Members
SNP Care Coordination	• Staff Structure • Health Risk Assessment (HRA) • Face-to-Face Encounters • Individualized Care Plan (ICP) • Interdisciplinary Care Team (ICT) • Care Transition Protocols
SNP Provider Network	• Specialized Expertise • Use of Clinical Practice Guideline Protocols • Provider MOC Training • Provider Collaboration with ICT
SNP MOC Quality Measurement & Performance Improvement	• Quality Performance Improvement Plan • Measurable Goals and Health Outcomes for the MOC • Measuring Patient Experience of Care • Ongoing Performance Improvement Evaluation of the MOC

MOC Goals

The Model of Care (MOC) has several goals including:

Improving:

- **Access**: Improving access to essential and affordable services, such as medical, behavioral health, and social services
- **Care coordination**: Integrating and coordinating care across specialties, and ensuring appropriate utilization of services
- **Quality of Care:** (medical and behavioral health) delivery through implementing evidence-based practices, fostering a culture of continuous improvement, and ensuring patient-centered approaches that optimize health outcomes and member satisfaction

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MOC Goals (cont.)

- **Health outcomes**: Through reduction of avoidable ED visits and Inpatient admissions, improved self-management, functional status, improved pain management, and improved quality of life
- **Preventive care**: Improving access to preventive care, early interventions for rising risk and patient-centered chronic disease management needs through goal setting
- **Care transitions**: Improving seamless and timely transitions of care to ensure appropriate level of care
- **Interventions:** That address the varied cultural, racial, ethnic, linguistic, and additional unique needs of members
- **Member satisfaction**: Increasing member satisfaction by ensuring seamless navigation through health care services with personalized and tailored support

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Description & Demographics of the D-SNP Population

Santa Barbara (SB) & San Luis Obispo (SLO) Counties *Total Full Duals:* 23,170

Demographic	SB & SLO County
Female	55%
Male	45%
English-speaking	73%
Spanish-speaking	25%
Other/Unknown	2%

Demographic	SB County	SLO County
Full Duals	66%	34%*
Female	54%	57%
Male	46%	43%

Target Population Characteristics: Describes the specific population the SNP serves, including demographic details such as age, gender, ethnicity, and health status.

Health Status and Disparities: Provides an overview of the major diseases, chronic conditions and disparities faced by the target population.

Unique Characteristics: Highlights the unique needs and challenges of the SNP population, including access to care, language barriers, health literacy, socioeconomic status, cultural beliefs, education level, social, cognitive, and environmental factors.

MOC-1

Description of CenCal Health's Duals Population

General D-SNP Population

MOC must describe how it identifies its members and the target population, including the characteristics of the population it intends to serve:

- average age
- gender
- ethnicity
- language
- the incidence and prevalence of diseases
- chronic conditions
- education level
- income/poverty level
- living status
- significant barriers that D-SNP members face

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MOC-1

Description of CenCal Health's Duals Population

Most Vulnerable Population

MOC must **describe how the most vulnerable members differ from the general D-SNP population** and **provide details on the additional benefits** for the most vulnerable members that go above and beyond those available to the general D-SNP population.

Very complex members may have multiple co-morbidities, require help managing their conditions and navigating the healthcare system, and may be cognitively impaired, frail, elderly, or disabled, with limitations in daily functional activities.

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Who are the most vulnerable members?

Significant care needs and instability in clinical and social situations that puts the member at immediate or increase risk for institutionalization or increased morbidity.

Conditions and Disabilities

- Multiple chronic conditions
- Mental health and behavioral health conditions
- Substance use disorder
- Cognitive and/or physical impairment
- Frailty Factors including housing stability
- Advance Illness/End of life support

Health Care Utilization

- At least 1 Inpatient visit within a 12-month period
- At least 3 ER visits within a 12-month period
- 0 or 1 PCP visit in a 12-month period
- 5 or more medications for management of chronic conditions per month

Social Risk Factors

- Housing instability, homelessness, unsafe living situation.
- Food Insecurity
- Severe physical impairment
- Multiple stays in detoxification programs
- Single without reliable family or social support
- Transportation challenges

Other Risk Factors

- Low Income
- Social Isolation
- Low Literacy

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Description of the SNP Population: Populations of Focus

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by the state.

This includes the following Populations of Focus:

- Adults experiencing homelessness
- Adults at Risk for Avoidable Hospital or ED utilization
- Adults with serious Mental Health and/or Substance Use Disorder
- Adults transitioning from Incarceration
- Adults living in the Community and at Risk for Long Term Care
- Adult Nursing Facility residents transition to the community
- Adults who are Pregnant or Post-Partum and subject to Racial and Ethnic disparities
- Adults with documented Dementia needs

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MOC-1 Palliative Care

Patients with a serious illness/diagnosis or life limiting illness.

Palliative Care Team – focuses on the member's physical, medical, psychosocial, emotional, and spiritual needs, and provides input and guidance to the ICT regarding the member's care plan.

Disease Specific Criteria for Palliative Care

- Congestive Heart Failure (CHF)
- Advanced Cancer
- Advanced Liver Disease
- Chronic Obstructive Pulmonary Disease (COPD)

Program Services Offered

- Advanced Care Planning
- Care Assessment and Consultation
- Plan of Care (Individualized per members needs)
- Care Coordination
- Pain and Symptom Management
- Mental Health and Social Services

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Alzheimer's/Dementia

DHCS requires provider education on Alzheimer's disease and related dementias, which affect a significant portion of our D-SNP population.

Key Information and Support for Providers/Caregivers:

- Understanding Alzheimer's disease and related dementias
- Symptoms and progression
- Understanding and managing behaviors and communication problems
- Caregiver stress and its management
- Community resources for members and caregivers such as Alzheimer's Association
- Dementia Care Specialist participation in the Interdisciplinary Care Team (ICT) when clinically appropriate
- Provider Training Resource: California Department of Public Health; Dementia Care Aware Training

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Chronic Conditions for D-SNP Population

- Hypertension
- Glaucoma
- Cataract
- Rheumatoid Arthritis
- Ischemic Heart Disease
- Depression
- Anemia
- Heart Failure
- Osteoporosis
- Hyperlipidemia
- Atrial Fibrillation
- Benign Prostatic Hyperplasia
- Diabetes
- Hypothyroidism
- COPD
- CVA/TIA
- Non-Alzheimer's Dementia
- CKD
- Asthma
- Pneumonia

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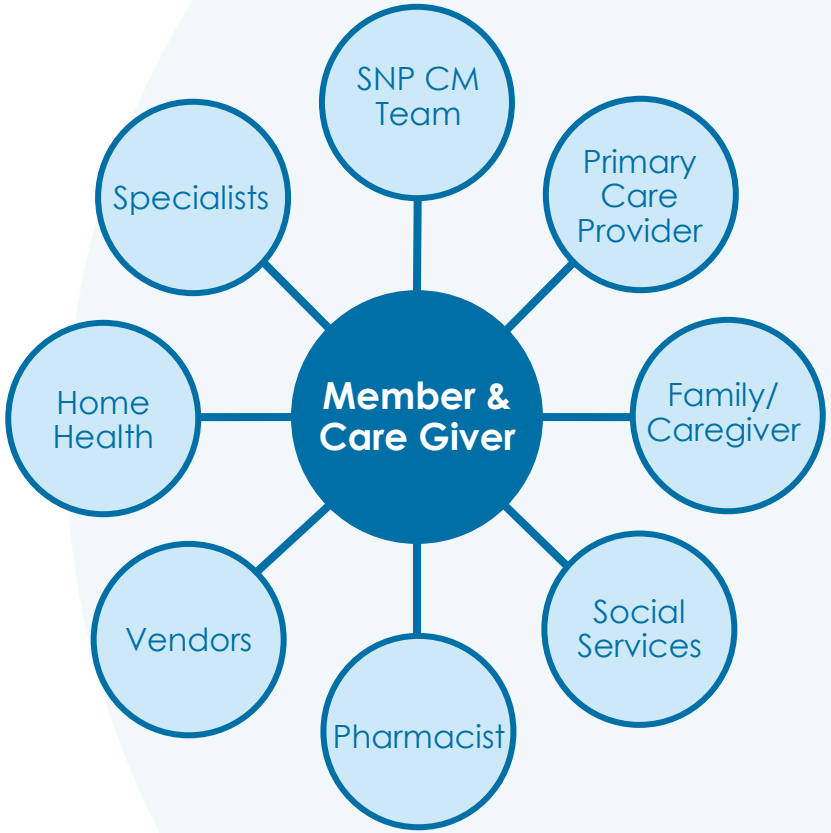
MOC-2 Care Coordination

This section describes how CenCal Health plans to provide comprehensive care coordination for every D-SNP member, including:

All staff positions who may be involved in care coordination, ICT and their role and responsibilities, staff qualifications, and staff training on the MOC.



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MOC-2 Care Coordination

Members of the Interdisciplinary Care Team (ICT) may consist of, but are not limited to:

- Member and/or Caregiver
- Case Manager-RN
- Medical Director
- Primary and Specialty Care Providers
- Dementia Care Specialist
- Palliative Care Specialist
- Home Health Providers
- Community Resource Partner (ex. CBAS, MSSP, IHSS, LTC, etc.)
- Registered Dieticians/ Nutritionists and Health Educators
- Behavioral Health Professionals
- Pharmacy
- Utilization Management Representative
- Provider Relations Representative
- Other Health Plan staff or members as appropriate and requested by the member

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MOC-2 Care Coordination Collaboration

Additionally, MOC-2 describes the essential functions of care coordination for each D-SNP member which includes:

- **Health Risk Assessment (HRA):** to be completed within 90 days of enrollment. Reassessed annually thereafter.
- **Face-to-Face Encounter:** to be performed within 12 months and annually.
- **Individualized Care Plan (ICP):** must be created within 90 days of enrollment. The ICP will be updated at least annually and after a change in health conditions.
- **Interdisciplinary Care Team (ICT):** collaboration within the members of the care team and member to identify any conditions or problems. Performed initially, annually and with any transition in care or change in health conditions.
- **Care Transition Protocols:** to ensure safe transitions throughout the health system, the member will be outreached within 2 business days of discharge and see a provider within 7-14 days.

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MOC-3 Provider Network

Includes:

- CenCal Health's provider network (including facilities) and how they are qualified to meet the D-SNP members' needs
- Specialty expertise and SNP Oversight
- CenCal Health's process to ensure accurate credentialling, update provider information (directory)
- Training and oversight, including in-network and out-of-network providers seen routinely by enrollees
- How network providers collaborate with the ICT
- Describing how providers use Clinical Practice Guidelines (CPGs). Ex: CenCal Health's Website Provider Resources
- Describing how providers ensure continuity of care using CenCal Health's Care Transitions Protocols

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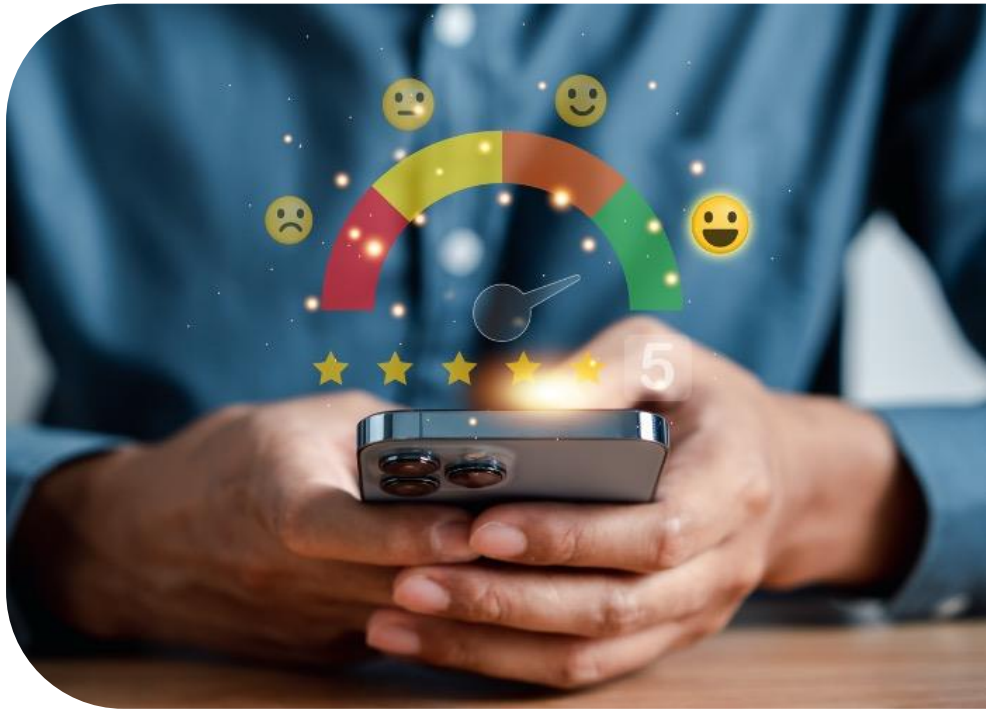
MOC-4

MOC Quality Measurement & Performance Improvement

This section of the MOC describes the following elements:

- **Detailed description** of CenCal's MOC quality performance improvement plan
- **Defines** measurable goals, the process to track, and steps to take if goals aren't met
- **Describes** how member experience is measured and included in performance improvement
- **Describes** the process for continuous monitoring and evaluation of the MOC performance



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MOC-4 MOC Quality Measurement & Performance Improvement

Examples of CenCal Health population health management programs to be implemented for D-SNP include:

- **Coordinated Transitions Between Medical Settings**: Standardized timely follow-up with members with multiple high-risk conditions who visit the ER
- **Cancer Prevention:** Health promotion & management to increase early detection & prevention of breast cancer among eligible members
- **Chronic Disease Management:** Health promotion & management of members with chronic conditions, focusing on comprehensive diabetes management to improve health outcomes

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MOC Provider Partnership

Provider Role:

- **Respond** to patient-specific communication requests in a timely manner
- **Assist** in reminding the member of the importance of completing their Health Risk Assessment survey (HRA) which is essential in the development of the ICP
- **Provide** patient care through Face-to-Face (F2F) in-person/telehealth visit with the member
- **Maintain** ICP in the member's medical record
- **Communicate** with care management, Individual Care Team (ICT) members and caregivers
- **Attend** or provide input for ICT Meetings
- **Encourage** medication adherence
- **Promote** quality Improvement through wellness exams and preventive screenings
- **Complete** Model of Care (MOC) provider training and attestation

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Provider Role: Transitions of Care

Care transition: planned or unplanned inpatient hospitalization, observation, skilled nursing facility stay or emergency department visit.

- Care manager will outreach the D-SNP member to ensure they have a follow-up appointment scheduled with the provider within **7-14 days** of discharge and will assist in obtaining an appointment if one has not been arranged.
- The Individualized Care Plan (ICP) will be updated with information regarding the care received and will be shared with the provider and member.
- An Interdisciplinary Care Team (ICT) will be conducted to ensure communication within the applicable members of the ICT.

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