2026 SPECIAL NEEDS PLAN (SNP) MODEL OF CARE (MOC) STAFF TRAINING

H5496

IMPERIAL HEALTH PLAN
OF CALIFORNIA

SNP Overview

The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage Coordinated Choice Plans specifically designed to provide targeted care to individuals with special needs.

"Special needs individuals" are

1) dual eligible; Members who qualify for both Medicaid and Medicare
2) institutionalized individuals; and/or
3) individuals with severe or disabling chronic conditions, as specified by CMS

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SNP POPULATION

- **Imperial Health Plan services SNP members in the following counties.**

California		
• Alameda • Contra Costa • Fresno • Kern • Kings • Los Angeles • Madera • Merced • Orange • Placer • Riverside • Sacramento • San Bernardino • San Diego • San Francisco • San Joaquin • San Mateo	• Santa Barbara • Santa Clara • Stanislaus • Tulare • Ventura • Yolo • Amador • Butte • Del Norte • El Dorado • Glenn • Humboldt • Imperial • Inyo • Marin • Mariposa • Mendocino	• Modoc • Monterey • Mono • Napa • Nevada • Plumas • San Benito • San Luis Obispo • Santa Cruz • Shasta • Siskiyou • Solano • Sonoma • Tehama • Tuolumne • Yuba

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SNP Overview

- We perform a population assessment to build a Model of Care that will best serve the needs of the members.
- Some of the factors identified include but are not limited to the following:

Age
Gender
Ethnicity
Incidence of major diseases and chronic conditions
Language barriers and health literacy
Identification based on multiple hospital admissions, high pharmacy utilization, high cost
Combination of medical, psychosocial, cognitive and functional challenges

Special Needs Plan (SNP)

Chronic Condition SNP (C-SNP)

→

Members with chronic and disabling disorders. One or more of the following chronic diseases depending on the specific plan

→

- **Diabetes**
- **Chronic Heart Failure**
- **Cardiovascular Disorders**
  - **Cardiac Arrhythmias**
  - **Coronary Artery Disease**
  - **Peripheral Vascular Disease**
  - **Chronic Venous Thromboembolic Disorder**

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MOC Goals

Improve Transitions of Care

- Communication between providers
- Assistance in Transition to care settings (home, hospital, etc.)

Improve Access to Services

- Preventive Health both general & patient specific
- Community Resource needs both Clinical and Non-Clinical Health Department, Rural Clinics, Home Care Senior Centers, Food, Transportation, Housing

Improve Outcomes

- Improve perceived Health Status
- Medication adherence and safety

Performance of goals measured through reporting, monitoring, and surveys of membership.

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Staff Structure

All staff work as an integrated team for care management of the enrollee.

Staff Roles include but are not limited to:

Administrative Staff

- Member/Enrollee Services
- Customer Service Staff
- Appeals and Grievances Staff
- Member/Enrollee Accounting Team
- Claims Team

Clinical Staff

- Behavioral Health Clinicians
- Licensed Clinical Social Workers
- Psychologists
- Mental Health Counselors

Medical Clinicians

Community Connectors

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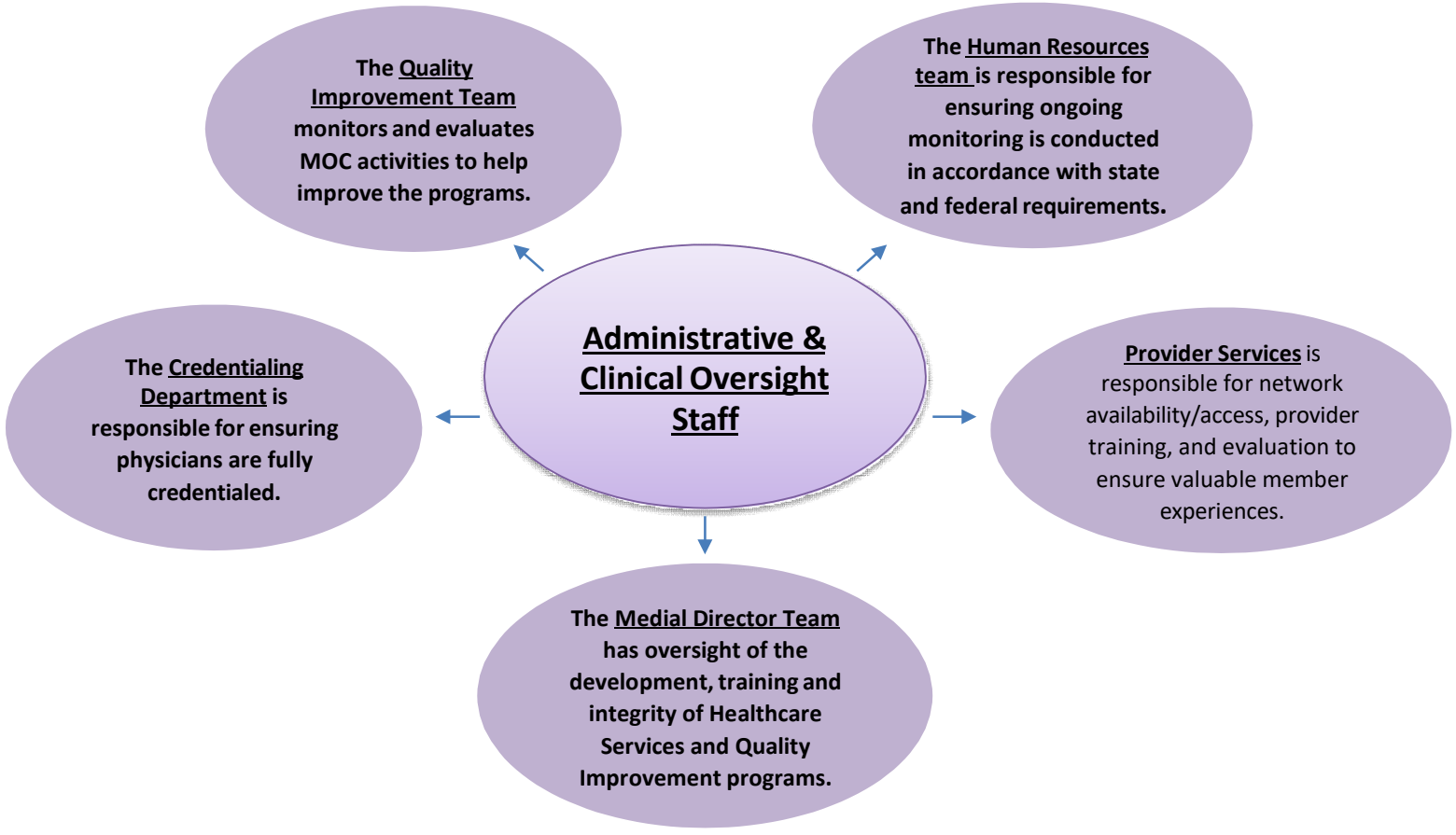
Staff Structure and Description



The team serves as a resource for Integrated Case Management Teams and providers regarding member/enrollee's health care needs and care plans
Selects and monitors usage of nationally recognized medical necessity criteria, preventive health guidelines and clinical practice guidelines.

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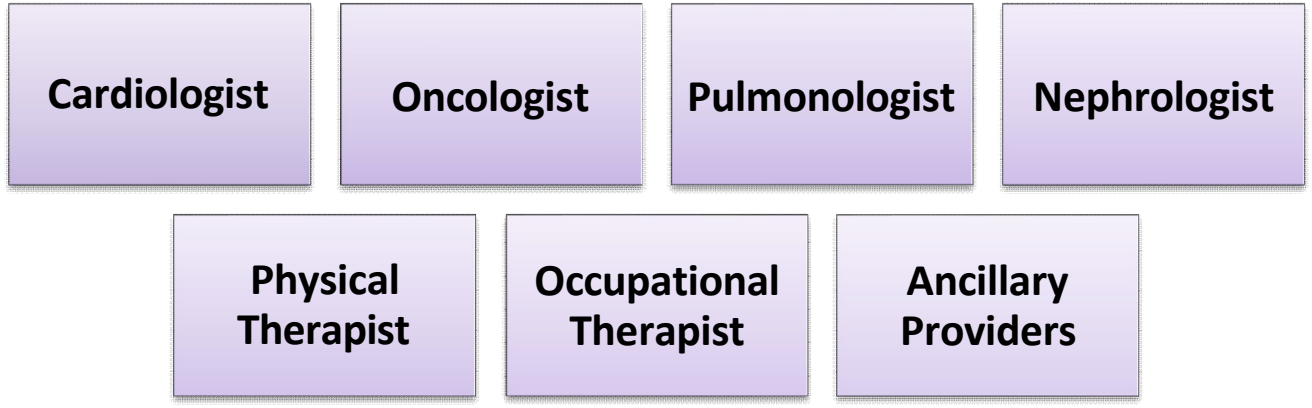
Specialized Provider Network

Imperial has an adequate and specialized provider network that maintains the appropriate licensure and competency to address the needs of the target population.



Imperial provides the full SNP Model of Care with team based internal case management when it is not provided by the member's primary care provider and medical group.

The provider network includes providers with specialized expertise who follow evidence-based clinical practice guidelines and protocols.

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Model of Care Training

Initial/Annual Training

- -Network Providers
- -Health Plan Staff

Training Methods

- -Webinars
- -On Site at Provider Office
- -Provider Manual with written training materials for reference/attestations

Components of Training

- - Model of Care Elements
- - Plan Processes and Procedures
- - Health Plan Tools and Resources

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Health Risk Assessment (HRA)

An HRA is conducted to identify medical, psychosocial, cognitive, functional, and mental health needs and risks.

Imperial attempts to complete initial HRA within 90 days of enrollment and annually via telephone.

Multiple attempts are made to contact the patient including mailed surveys.

The patient's HRA responses are used to identify needs, incorporated into the member's care plan and communicated to care team via electronic medical management system, the provider portal or by mail.

If patient is unreachable, medical history from member's provider will be used to complete HRA.

Patient is reassessed if there is a change in health condition and these and annual updates are used to update the care plan.

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Individual Care Plan (ICP)

1) Individual Care Plan (ICP) is created for each patient by the Case Manager with input from the care team.

2) The member and caregivers are involved in development of and agrees with the care plan and goals.

3) ICP is based on the patient's assessment and identified problems.

4) Goals are prioritized considering patient's personal preferences and desired level of involvement in the process.

5) ICP is revised when change such as new diagnosis/hospitalization or at least annually and communicated to Interdisciplinary care team (ICT) and member.

6) Patient's self-management plans and goals are described.

7) Barriers and progress towards goals are listed.

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Care Management

Case Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) which includes designated IHP's staff, the member and their family/caregiver, doctors, specialists and vendors, anyone involved in the member's care based on the member's preference of who they wish to attend.

Case Managers strive to do the right thing for members by encouraging self-management of their condition as well as communicating the member's progress toward these goals to the other members of the ICT.

Imperial is responsible to maintain a single, integrated care plan that requires reaching out to external ICT members to coordinate many separate plans of care into one that is made available to all providers based on member's preference.

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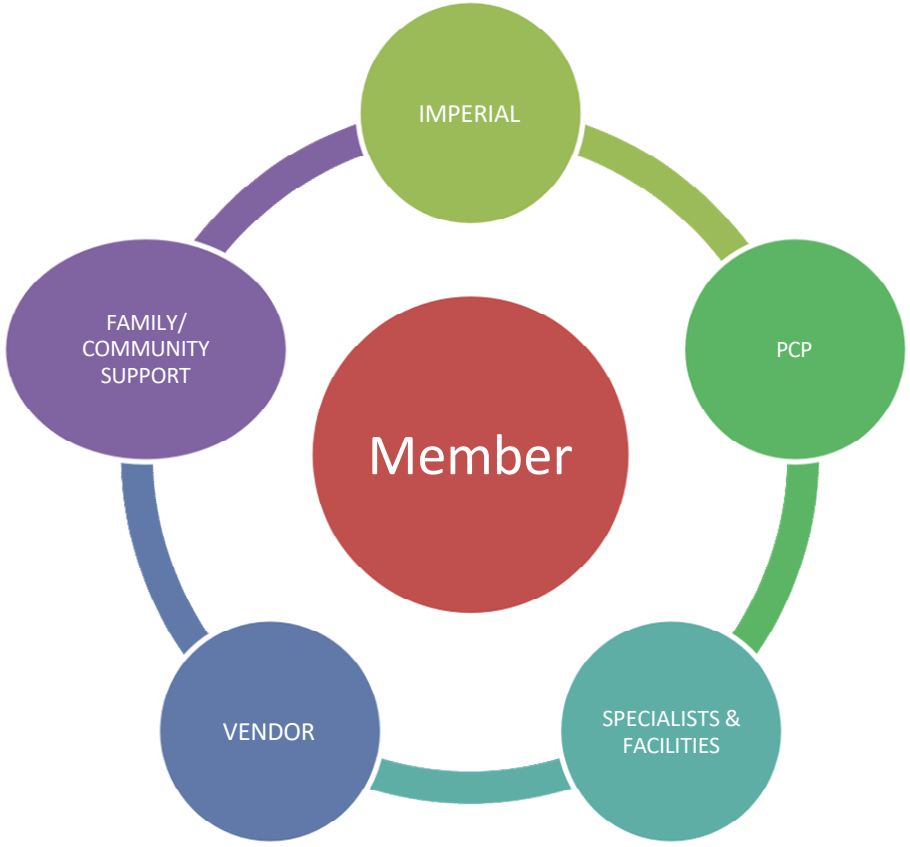
Interdisciplinary Care Team (ICT)/Integrated Communication Network

Imperial's staff works with all members of the ICT in coordinating the plan of care for the enrollee.



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Face-to-Face Encounters

What are Face-to-Face encounters?

In-person doctor's visit
Telehealth

Appropriate Personnel for Face-to-Face

Physicians
Specialists
Contracted Providers/Physicians
Pharmacists
Behavioral Health

Clinical Functions of Face-to-Face

- **Completing HRA**
- **Care Plan Review**
- **Health Education Referrals**
- **Coordinating Appointments**
- **Home Health Enrollment**
- **Annual Wellness Visits & Preventative Exams**
- **Medication Management**
- **Behavioral Health Assessment**

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Performance and Health Outcomes Measurement

Process Measures

Timeliness of Assessment processes

Physician Relationship (% populations with PCP or Medical Home Relationship)

Care Meetings

Case/Care Management performance

Care Measures

Utilization Patterns

Prescribing Patterns

Drug interactions

Readmissions

Quality Measures

HEDIS

Quality of Care Concerns

Satisfaction Surveys

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QUESTIONS/COMMENTS

Providers:

- Please contact our Provider Relations Department at (626) 838-5100 Prompt 5

Staff:

- Please contact us via email at populationhealth@imperialhealthplan.com

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