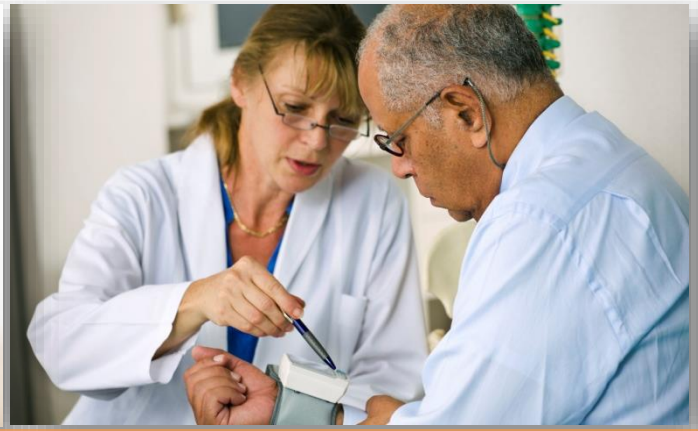
CENTERS PLAN FOR HEALTHY LIVING


SPECIAL NEEDS PLAN

Model of Care Training

WHAT IS A SNP?

The Medicare Modernization Act of 2003 established Special Needs Plans (SNP).

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

- A Dual Special Needs Plan (D-SNP) services members with both Medicare and Medicaid eligibility.
- A Medicaid Advantage Plus Plan (MAP) services members with both Medicare and Medicaid, and requires at least 120 days of community based long term care services.
- An Institution Special Needs Plan (I-SNP) services members who reside in a contracted skilled nursing facility for 90 days or longer.

Model of Care (MOC)

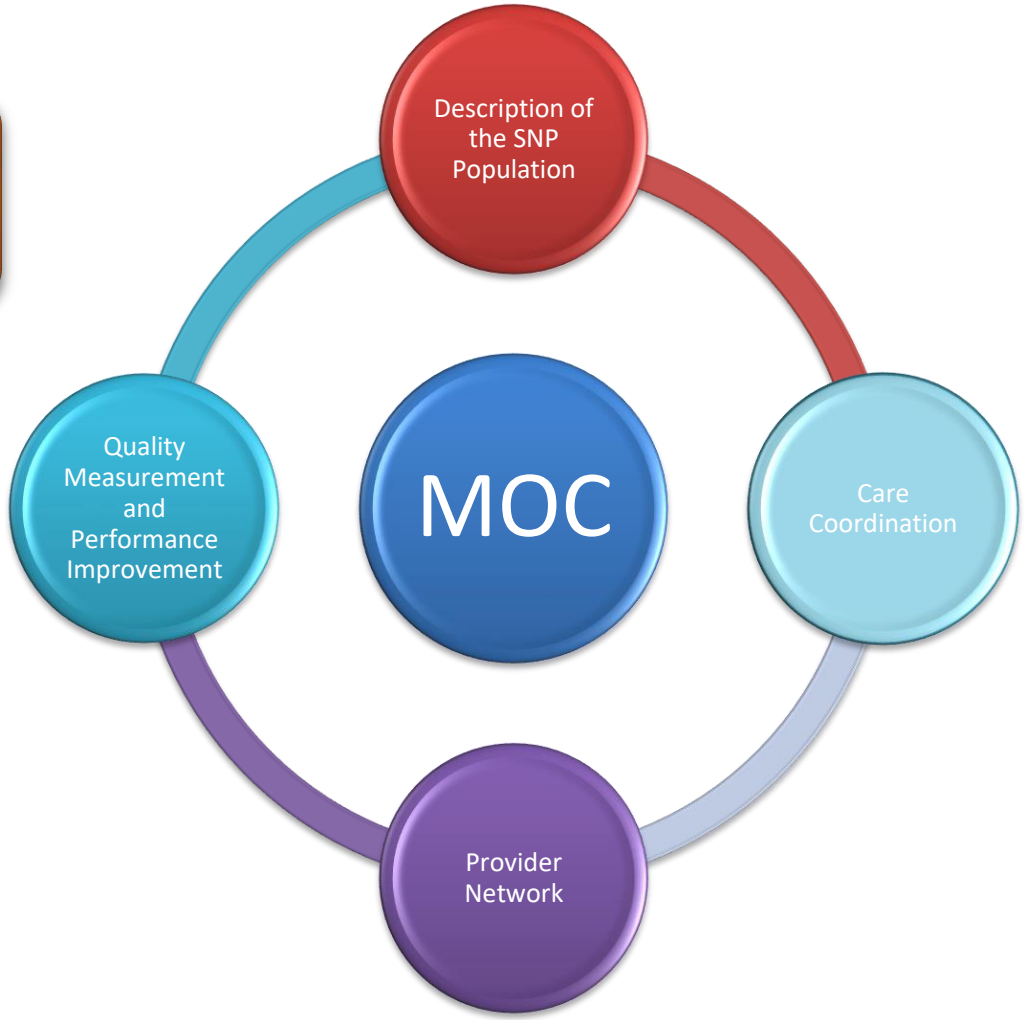
Centers Plan for Healthy Living has created a Model of Care (MOC) as required by the Centers for Medicare and Medicaid (CMS).

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

Centers Plan for Healthy Living employees and providers are required to complete an initial MOC training and annually thereafter.

Categories of the MOC

Every MOC must provide information in these four categories:



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Description of the SNP Population

Members enrolled in the D-SNP and MAP qualify for both Medicare and Medicaid. Members enrolled in the I-SNP reside in a nursing home contracted by the Health Plan.

CPHL SNP members are vulnerable, with complex health needs. They are a low-income population and are elderly and/or disabled. Many members have functional or cognitive impairments, as well as multiple chronic conditions

Centers Plan for Healthy Living monitors and tracks population demographics to enable us to rapidly add specialists to accommodate our members' needs. CPHL also addresses ethnic, language, and cultural considerations by hiring bilingual staff and keeping cultural needs in mind when assigning staff to members.

Care Coordination

Staff Structure and Roles

Centers Plan for Healthy Living has a variety of staff roles to ensure that all aspects of our members' needs are coordinated and addressed effectively.

Clinical Management Department

- Chief Medical Officer, AVP of Clinical Operations, Director of Care Management, Clinical Team Manager, Clinical Educator, Care Manager, Assessment Nurse, Social Worker, Clinical Pharmacist, Director of Utilization Management, Utilization Management Nurse, Director of Quality

Administrative Staff

- Human Resources, Network/Provider Operations, Operations Department, Member Services, Claims, Enrollment, Grievances and Appeals, Sales, Corporate Compliance

Care Coordination

Health Risk Assessment (HRA)

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

Areas Assessed by the HRA

- ❑ Physical needs, including medical conditions
- ❑ Functional needs, including activities of daily living
- ❑ Behavioral and Cognitive needs, including mental health conditions
- ❑ Psychosocial needs, including living arrangements, preferences, and goals

Care Coordination

Individualized Care Plan (ICP)

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

An ICP is developed after the member's initial HRA. A new ICP is created annually and if the member experiences a significant change in his or her status based on the HRA conducted. The member may also request a review of his or her ICP.

The ICP is a personalized plan that is created to help members 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 members achieve their goals.

Care Coordination

Interdisciplinary Care Team (ICT)

The Individualized Care Plan is created, reviewed, and approved by the Interdisciplinary Care Team (ICT). The ICT is a member-centric group. The member is a necessary member of the ICT. The Care Manager coordinates and organizes ICT meetings and the development of the ICP for DSNP and MAP members. The Nurse Practitioner (NP) works with the Skilled Nursing Facility (SNF) to organize and develop the ICP for ISNP members. Other members of the ICT may include the Primary Care Physician (PCP), the member's designee or family member, and home health aide/PCA/CDPAS. Additional parties can include behavioral health professionals, a social worker, a nutritionist, rehabilitation professionals, palliative care, a pharmacist, and others as needed.

The PCP is invited to participate in ICT meetings telephonically or face to face. The PCP reviews and authorizes the ICP, which should be evidence based to address medical needs. The PCP may also review the HRA and make recommendations based on review of the assessment and the PCP's own findings.

Care Coordination

Care Management

DSNP and MAP members are eligible to work with a Care Manager (CM) and ISNP members with the NP to develop a plan of care that is individualized for them. The CM/NP will assess the member'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 member with receiving benefits and other resources available to the member; and will coordinate health services as needed.

Members 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. Members will be educated on advance directives. When applicable and desired, members 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 member relevant to the member's specific health needs and goals.

Care Coordination

Transition of Care Protocols

The Care Manager identifies members at high risk for transitions. He or she coordinates services and provides education to try to reduce transitions.

When a member experiences a transition to another care setting, such as a hospital, skilled nursing facility, rehabilitation facility, outpatient center, or another setting, the Care Manager will share the information with the ICT. Pre-authorizations must be in place for planned transitions. The Care Manager and Utilization Management Nurse will communicate with the alternate care setting regarding the member's medications, demographics, and advance directives. The Care Manager, Utilization Management, and the hospital or other care setting develop a safe discharge plan and notify the ICT, including the member and the PCP.

After discharge, the Care Manager follows up with the member to ensure services are appropriate and timely. The Care Manager helps the member schedule follow-up appointments. The member will receive a new HRA and a new ICP. The new ICP will address the reason for the transition and will provide interventions to reduce re-admissions.

Provider Network

Evidence-based practice guidelines used by Centers Plan for Healthy Living include nationally recognized guidelines that are made accessible to providers on the Centers Plan for Healthy Living website. Centers Plan for Healthy Living monitors providers' practice to ensure guidelines are followed.

All participating providers receive mandatory MOC training. The training takes place upon joining the Centers Plan for Healthy Living Network and annually thereafter. Participating providers also receive a copy of our Provider Newsletter which may contain updates on the MOC.

Our members have a robust network of providers and facilities available to provide necessary care. We continuously monitor our members' 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 Centers Plan for Healthy Living evaluate the effectiveness of the MOC and identify opportunities for improvement.

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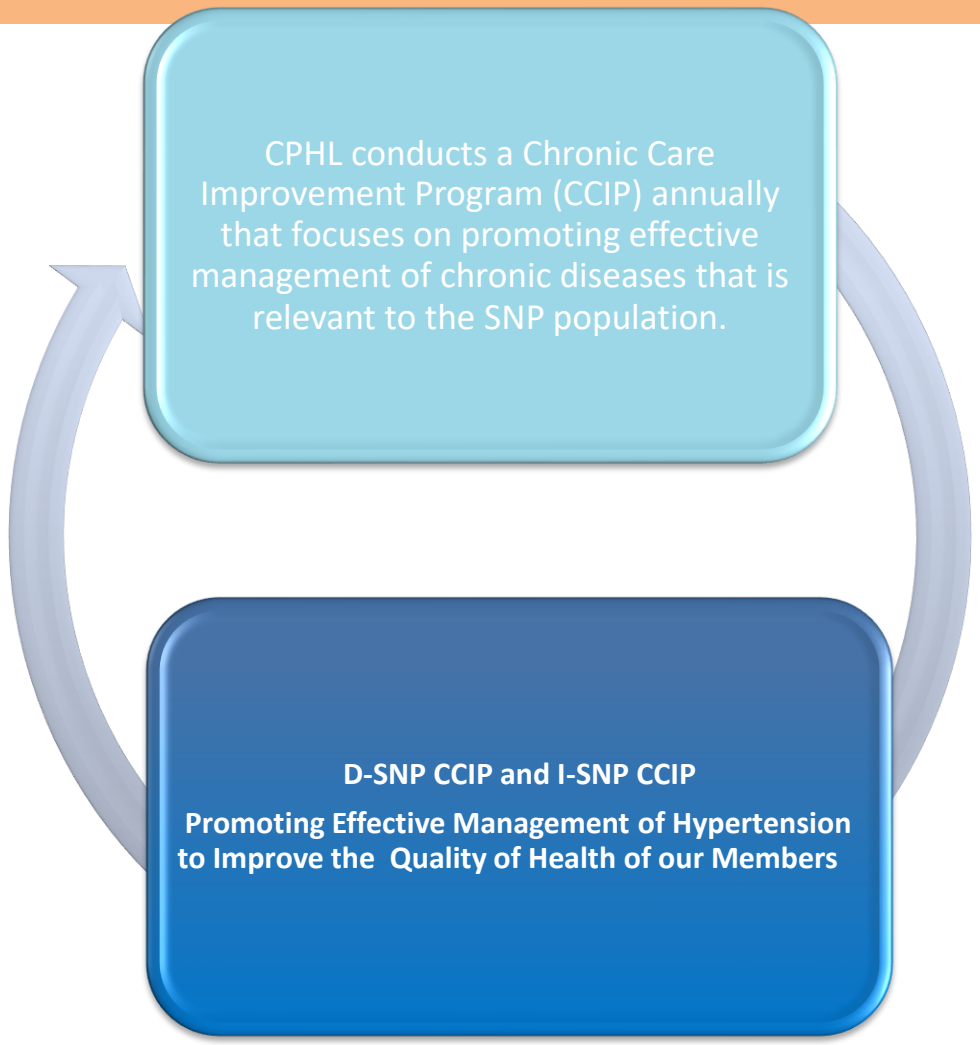
Quality Measurement/Performance Improvement



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

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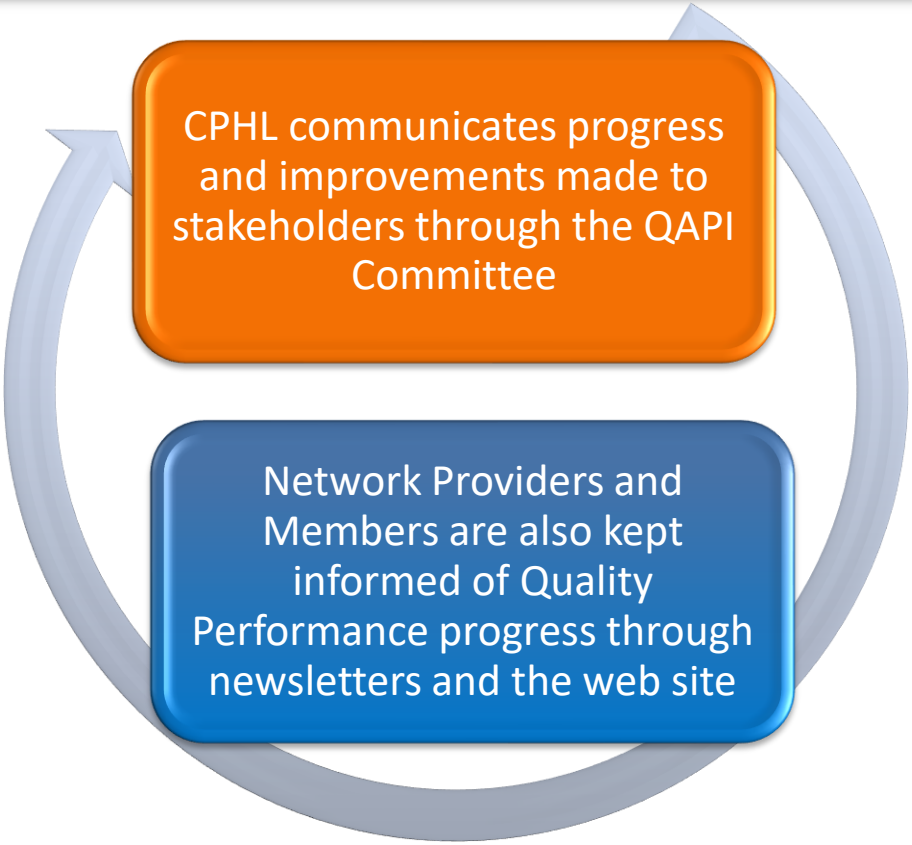
Quality Measurement/Performance Improvement

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 Center's Plan for Healthy Living D-SNP, MAP and I-SNP Plans.

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