JQ Josh Qualls

SCAN HEALTH PLAN 2025 SPECIAL NEEDS PLAN MODEL OF CARE TRAINING

When it comes to delivering exceptional care and support to seniors, SCAN Health Plan (SCAN) stands out as a trailblazer in the Medicare Advantage (MA) space. As one of the nation's largest not-for-profit MA plans, SCAN proudly serves over 280,000 members with a singular mission: **to keep seniors healthy and independent.**

Founded with a commitment to understanding and meeting the unique needs of older adults, SCAN goes beyond traditional medical coverage. Its comprehensive approach includes robust medical benefits, prescription drug coverage, and specialized support services tailored to the challenges seniors face every day. Whether it's managing chronic conditions, navigating healthcare complexities, or accessing resources to maintain independence, SCAN ensures seniors have the tools and care they need to live their best lives.

With decades of experience and a heart for service, SCAN Health Plan continues to redefine senior healthcare— staying healthy and independent isn't just a goal; it's a promise.

- CMS SNP MOC Training Requirements
- REMINDERS: California FIDE-SNP
- Overview of Special Needs Plans
- SCAN C-SNPs
- SCAN FIDE-SNP - California Only
- SCAN I-SNP
- MOC 1: Description of SNP Population (General Population)
- MOC 2: Care Coordination
- MOC 3: Provider Network
- MOC 4: MOC Quality Measurement and Performance Improvement
- Training Attestation
- Resources

Lesson 1 of 12

CMS SNP MOC TRAINING REQUIREMENTS

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Special Needs Plan Model of Care Annual Training Requirements:

If you are a healthcare professional who provides care to SCAN Special Needs Plans Members, the **Centers for Medicare & Medicaid Services (CMS) requires you to complete SNP Model of Care (MOC) training every year.**

This annual SNP MOC training is a 10 to 15-minute self-guided course that ensures all medical staff are educated, aware, and confident they are providing the highest level of care and services to SNP members.

CONTINUE

Lesson 2 of 12

REMINDERS: CALIFORNIA FIDE-SNP

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REMINDERS FOR ALL CALIFORNIA FIDE-SNP PROVIDERS:

1. Dementia Training Requirements
2. Enhanced Care Management

1. DEMENTIA TRAINING REQUIREMENTS:

ALZHEIMER'S DISEASE AND RELATED DEMENTIAS TRAINING (ADRD)

THE DHCS POLICY GUIDE STATES **ALL PROVIDERS AND STAFF WHO INTERACT WITH FIDE-SNP MEMBERS ARE REQUIRED TO COMPLETE DEMENTIA TRAINING.** WHILE SCAN DOES NOT MANDATE A SPECIFIC TRAINING

PROGRAM, WE RECOMMEND AND SUPPORT DEMENTIA CARE AWARE AS AN EXCELLENT OPTION.

The California Department of Health Care Services (DHCS) has established **dementia care training requirements** for providers participating in FIDE-SNP plans to improve care for members with dementia and Alzheimer's disease.

SCAN has adopted and supports the Alzheimer's Association Dementia Care Aware training to meet these requirements. Dementia Care Aware provides a statewide standard of care for dementia screening in California, through equity-focused, culturally appropriate training for primary care providers across all payers, including Medicare, Medi-Cal, and other coverage. These trainings include:

- Overview of dementia
- Review of screening tools
- Team-based implementation strategies
- Conducting initial & comprehensive cognitive health assessments

INITIAL SCREENING

COMPREHENSIVE ASSESSMENT

The initial screening tool for Alzheimer's disease and related dementias is called the Cognitive Health Assessment (CHA). The CHA is designed for use in primary care settings to identify early signs of cognitive impairment in patients, particularly those over 65. It includes cognitive and functional screening tools like the Mini-Cog and ADLs/IADLs, assessing both patient and care partner perspectives.

A positive result from the CHA suggests possible cognitive decline but is not a diagnostic tool, instead prompting further steps toward a formal assessment and management plan if needed

INITIAL SCREENING

COMPREHENSIVE ASSESSMENT

When the Cognitive Health Assessment (CHA) indicates potential impairment, a comprehensive assessment becomes essential. This more detailed evaluation may involve additional tools to assess cognitive symptoms, screen for conditions that mimic dementia (e.g., depression, substance use), and order tests such as lab work or imaging if symptoms have been present for less than a year.

The aim is to differentiate between mild cognitive impairment, dementia, and other conditions, enabling a tailored care plan and support for the patient and their caregivers.

TO GET TRAINED, OR FOR MORE INFORMATION PLEASE VISIT:

DEMENTIA CARE AWARE WEBSITE

DEMENTIA CARE AWA...

DHCS POLICY GUIDE

DHCS POLICY GUIDE

2. ENHANCED CARE MANAGEMENT (ECM)

SCAN maintains a FIDE-SNP Model of Care (MOC) which includes programs to ensure that Dually Enrolled (Medicare and Medi-Cal) members have access to ECM services in compliance with Cal-AIM Dual Eligible Special Needs Plans Policy Guide and Cal-AIM Enhanced Care Management Policy Guide.

Keeping Seniors Healthy and Independent

SCAN provides ECM services to members identified as meeting the criteria for the following 4 ECM populations:

1. Adults Living in the Community and at Risk for Long-Term Care Institutionalization
2. Adult Nursing Facility Residents Transitioning to the Community
3. Adults without Dependent Children/Youth Living with Them Experiencing Homelessness
4. Adults At Risk of Avoidable Hospital or ED Utilization

Enhanced Care Management services include but are not limited to: outreach and engagement, enhanced coordination of care, health promotion, comprehensive transitional care, member and family supports; coordination of and referral to community and social support services, and comprehensive assessment and care management plan: through primarily in-person contact or if in-person contact is unavailable or does not meet the needs of the Member, alternative methods (i.e., telehealth) will be used in accordance with Member choice.

If you have any questions regarding Enhanced Care Management, please visit:

DHCS CAL-AIM ECM REQUIREMENTS

DHCS ECM

CONTINUE

Lesson 3 of 12

OVERVIEW OF SPECIAL NEEDS PLANS

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SPECIAL NEEDS PLAN

Special Needs Plans (SNPs) are Medicare Advantage coordinated care plans specifically designed to provide targeted care and limit enrollment to special needs individuals.

WHAT IS A SPECIAL NEEDS PLAN (SNP) MODEL OF CARE? (MOC)?

The SNP Model of Care (MOC) is a plan for delivering coordinated care and care management to members with special needs. It describes the structure, processes, and care management systems of Special Needs Plans (SNPs) that provide care to the members enrolled in these plans. It is considered a vital quality improvement tool to address the unique needs of each member.

Click the buttons below to learn more about SNP Models of Care:

CMS.GOV / SPECIAL NEEDS PLANS (SNPS)

CMS / SNP

NCQA / SNPS

NCQA / SNPS

NCQA SNP SCORING GUIDELINES

NCQA GUIDELINES

SCAN SPECIAL NEEDS PLANS

SCAN offers the following SNP plans:

The MOC provides the framework for how the SNP will identify and address the unique needs of its members.

CHRONIC CONDITIONS C-SNP	FIDE-SNP	INSTITUTIONAL I-SNP

Chronic Condition Special Needs Plans (C-SNP) serving Members with specific severe or disabling chronic conditions including cardiovascular disorders, chronic heart failure, diabetes mellitus, and end-stage renal disease (requiring any mode of dialysis)

SCAN offers the following C-SNP:

1) SCAN Balance-Heart First: is a multi-condition SNP for members with the following chronic conditions - Chronic Heart Failure, Cardiovascular Disease, or Diabetes.

2) VillageHealth: SCAN partners with DaVita Integrated Kidney Care to serve members with End Stage Renal Disease (ESRD).

CHRONIC CONDITIONS C-SNP | FIDE-SNP | INSTITUTIONAL I-SNP

California Only

Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) serving Members in designated counties, who are at least 65 years of age, dually eligible and dually enrolled with SCAN

SCAN is the only Fully Integrated Dual Eligible (FIDE) SNP in California. That means members enroll both their Medicare and Medi-Cal benefits with SCAN.
SCAN offers the following FIDE-SNP:

1) Connections: These members are eligible to receive all Medicare and Medi-Cal benefits.

2) Connections at Home: Members are eligible to receive all Medicare and Medi-Cal benefits and meet Nursing Facility Level of Care (NFLOC) which qualifies them for home and community-based services.

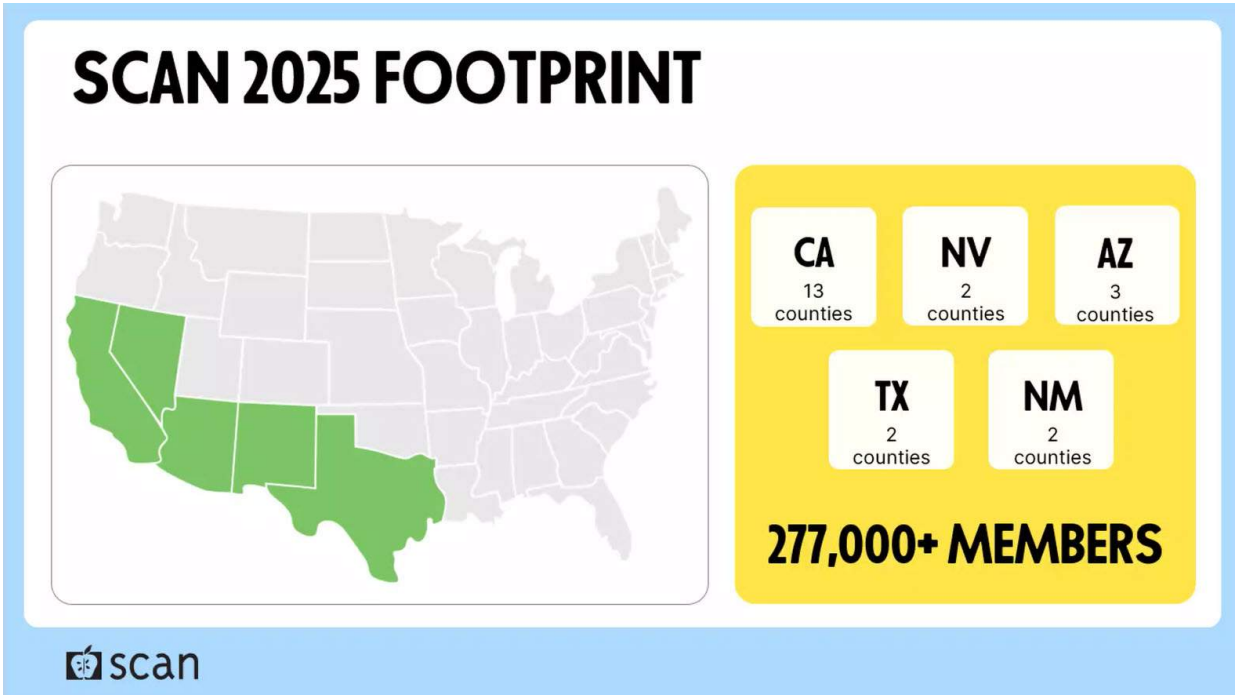
CHRONIC CONDITIONS C-SNP | FIDE-SNP | INSTITUTIONAL I-SNP

Institutional Special Needs Plan (I-SNP) serving Members who live in institutions or are institutional equivalent (living in the community, i.e., in Assisted Living) and require an institutional level of care. Members must meet nursing facility level of care criteria and reside in designated counties

SCAN offers the following I-SNP:

1) Embrace is a plan that serves beneficiaries who are eligible for Medicare who choose to reside in a qualifying institution or the community.

SCAN BY STATE - MOVED TO FRONT



SCAN C-SNPS

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SCAN BALANCE-HEART FIRST - C-SNP

Over the years, SCAN has built comprehensive systems of care that provide our members living with chronic conditions, such as CHF, CVD, and diabetes the full range of services and support they need to remain healthy and independent. As described in this Model of Care (MOC), SCAN Balance-Heart First offers SNP members a coordinated and integrated care management model.

This model rests on an interdisciplinary approach to their care. Components of this approach include, primary care physician (PCP), specialists, benefits tailored to meet their unique needs, annual health risk assessment (HRA), care managers, care navigators, individualized care plan (ICP) that reflects their personal goals and objectives and the most current approaches to caring for persons with CHF, CVD, and diabetes, disease management, care transitions and attention to and coordination with social and/or community-based services members need to remain healthy, safe and independent.

VILLAGEHEALTH - C-SNP

VillageHealth is built on SCAN and DaVita IKC's longstanding experience and knowledge in meeting the needs of medically complex populations. Enrollees diagnosed with ESRD are among the most complex and vulnerable of the Medicare population. Most require dialysis

multiple times per week, take a range of medications and are at high risk for hospitalization, institutionalization, and adverse health outcomes. The majority are considered disabled, are generally dually eligible for Medicare and Medicaid and have multiple co-occurring morbidities which add to the complexity of their care and the need for careful and ongoing care coordination, along with care management.

The VillageHealth model of care is tailored specifically to the needs of these members. The plan offers comprehensive, integrated services and the full range of services and support. VillageHealth uses a patient-centered approach that includes close and collaborative coordination with dialysis centers, nephrologists and care management strategies that have demonstrated effectiveness in managing member needs. Each VillageHealth member is considered vulnerable, so a care manager is assigned to every member. Nephrologists serve as the members' physician of choice (POC) with significant coordination with other providers necessary to manage co-morbidities and co-occurring conditions.

SCAN FIDE-SNP - CALIFORNIA ONLY

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FULLY INTERGRATED DUEL ELIGIBLE (FIDE)-SNP

The FIDE-SNP operates under a contract with CMS as well as a CMS-approved Medicare Improvements for Patients and Providers Act (MIPAA)-compliant contract with the DHCS (Department of Health Care Services), the California Medicaid agency.

Under these plans, members enroll with SCAN to coordinate the delivery of both Medicare and Medi-Cal benefits.

SCAN FIDE-SNP PLANS

SCAN has two FIDE-SNP Plans in California. Click below for more information.

CONNECTIONS / FIDE-SNP	DESIGNED FOR PEOPLE WHO HAVE BOTH MEDICARE AND MEDI-CAL. INCLUDING MEDICARE BENEFITS, ALL MEDI-CAL BENEFITS, PLUS DRUG COVERAGE AND EXTRA BENEFITS LIKE TRANSPORTATION, DENTAL, VISION COVERAGE, ACUPUNCTURE, HEARING AND MORE.
CONNECTIONS AT HOME / FIDE-SNP	DESIGNED FOR PEOPLE WHO HAVE BOTH MEDICARE AND MEDI-CAL, AND MEET THE STATE OF CALIFORNIA CRITERIA FOR NURSING FACILITY LEVEL OF CARE AND LIVE IN THEIR OWN HOME OR NURSING FACILITY. AS THE ONLY FIDE SNP IN CALIFORNIA, SCAN PROVIDES AND ADMINISTERS ALL THE MEDICARE

FOR MORE INFORMATION:

—

LTSS benefits are managed by SCAN. If you have a member who may qualify for LTSS, please contact us via Member Services: 800-559-3500, or our LTSS Call Center: 800-887-8695.

SCAN I-SNP

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I/IE-SNP - EMBRACE

This institutional and institutional equivalent special needs plan (I/IE SNP) supports members in the home and/or community, by bringing our bio-psycho-social model to frail Medicare enrollees, regardless of their place of residence. More than 400,000 Californians are cared for annually in long-term care facilities and many hundreds of thousands more, live in the community with frailty.

SCAN Embrace (HMO I-SNP / HMO-POS I-SNP) brings a mobile care team to senior living communities, where our clinicians care for patients in the comfort of their own homes. We partner with communities to coordinate all aspects of care, minimize unnecessary hospitalizations, and ensure patients remain healthy and independent for as long as possible. Our clinical team is available 24/7 to provide medical support for patients whenever they need it. We believe that nothing should stand in the way of our patients being their healthiest and happiest.

Our unique model is available to members enrolled in the SCAN Embrace (HMO I-SNP / HMO-POS I-SNP) plan. SCAN Embrace covers everything Original Medicare does, and much more. This means patients pay $0 for most doctor's visits and also get extra benefits such as dental care, vision and hearing exams, and transportation, to name a few.

MOC 1: DESCRIPTION OF SNP POPULATION (GENERAL POPULATION)

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DESCRIPTION OF SNP POPULATION

SENTENCE DESCRIBING MOC 1

HOW WELL DO YOU KNOW SNP PATIENT POPULATION?

HOW WELL DO YOU KNOW YOUR OVERALL SNP POPULATIONS?

DIAGNOSIS VERIFICATION (C-SNP MEMBERS)

SCAN has until the end of the first month of enrollment (30th day following enrollment) to confirm the diagnosis.

SCAN Care Coordination staff conduct outreach to the delegated provider group or the individual provider's office to obtain confirmation of the qualifying condition.

UNDERSTAND HEALTH DISPARITIES OF SNP MEMBERS

Medical Factors

- Self-rated health status (excellent, very good, good, fair, poor)
- Utilization (visits to the emergency room in the past year)

Social Factors

- Living situation
- Help and support

Cognitive Factors

- Cognitive Health (Changes in thinking, Remembering, or Making Decisions)
- Mental Health (PHQ-2 (Score >= 3))

Enviornmental Factors (housing stability)
Living Condition (financial stability)
Co-Morbidities

DEMOGRAPHICS AND UNIQUE CHARACTERISTICS OF SNP MEMBERS

Demographics

- Age
- Gender
- Race
- Ethnicity

Unique Characteristics (Activities of Daily Living and Functional Status)

- Bathing
- Eating
- Using the Toilet
- Falls

HOW WELL DO YOU KNOW YOUR MOST VULNERABLE SNP POPULATIONS?

C-SNP SCAN BALANCE-HEART FIRST - MOST VULNERABLE

SCAN identifies the most vulnerable enrollees within the C-SNP SCAN Balance-Heart First population as those who have four (4) or more co-morbid chronic conditions

C-SNP VILLAGEHEALTH END STAGE RENAL DISEASE

VillageHealth has a significant proportion of members who are of Hispanic or Latino, which makes members more vulnerable than the overall VillageHealth population as it could lead to miscommunication or misunderstanding of instructions during care plan development, post discharge planning or issues with education/information provided. Additionally, the majority of VillageHealth members are dual eligible; about 95% of the VillageHealth members have Low-Income Subsidy (LIS). This suggests additional vulnerability, that most plan members have a poor socioeconomic status which may result in problems accessing necessary transportation, food security, caregiving services and other services that may not be covered by either Medicare or Medi-Cal.

FIDE-SNP - MOST VULNERABLE

SCAN defines the most vulnerable enrollees within the D-SNP population as those who meet Nursing Facility Level of Care (NFLOC) criteria. D-SNP members who meet NFLOC are identified as needing Long Term Services and Supports (LTSS) due to physical, functional, or cognitive limitations.

I/IE-SNP - MOST VULNERABLE

While nursing home eligibility is a marker of complexity, in addition to nursing home status, SCAN defines vulnerable I/IE-SNP members as those at highest risk for poor health outcomes, unplanned transitions of care, hospitalization, readmissions following hospitalization and greater utilization of health care resources in general. These members are generally defined as enrollees with:

- Multiple chronic conditions and co-morbidities impacting multiple organ systems, new catastrophic diagnoses and/or terminal conditions or near end of life
- Limitations in their functional abilities including vision and hearing
- Mentally frail with moderate to severe forms of dementia or memory loss, and/or have experienced acute mental health events
- Language, literacy and/or cultural issues that make navigating the health care delivery system difficult or challenging
- Socially isolated and/or unstable living environment, including lack family or other caregiver support in the home or community, problems with transportation, housing or other services important for their health and well-being
- Limited financial resources, such as income that can contribute to challenges assuring food security, transportation, access to goods and services necessary to their well-being

MOC 2: CARE COORDINATION

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Care coordination helps ensure that the health care needs, preferences for health services, and information sharing across health care staff and facilities are met over time for each SNP enrollee. Care coordination maximizes the use of effective, efficient, safe, high-quality patient services (including services furnished outside the SNP's provider network) that ultimately lead to improved health care outcomes.

SNP STAFF STRUCTURE

- Roles and responsibilities of employed or contracted staff who perform administrative plan functions, including oversight functions, that directly or indirectly affect care of enrollees in the SNP.
- Clinical staff's roles and responsibilities, including oversight functions, that directly or indirectly affect care of enrollees in the SNP.
- Staff responsibilities coordinate with the job title (provide organization chart).
- Contingency plans used to address ongoing continuity of critical staff functions.
- Organization conducts MOC training for its employed and contracted staff.
- Organization documents and maintains training records as evidence that employees and contracted staff completed MOC training.
- Actions the organization takes if staff do not complete the required MOC training.

HEALTH RISK ASSESSMENT (HRA)

- How the organization conducts the initial HRA and annual reassessment for each enrollee.
- Process (policies and procedures) for completing the HRA and how the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each enrollee (Element 2D).
- How the organization then disseminates the HRA information to the Interdisciplinary Care Team (ICT) and subsequently how the ICT uses that information (Element 2E).
- Detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable) the HRA results, including how the results are communicated back to the ICT, PCP, and other applicable providers.

FACE-TO-FACE ENCOUNTER

- Process, including policies, procedures, purpose, and intended outcomes of the face-to-face encounter.
- For instances in which the SNP is providing the encounter, identify staff (employed and/or contracted) who may conduct the face-to-face encounter.
- How the SNP will verify through data collection that the enrollee has participated in a qualifying face-to-face encounter.
- What types of clinical functions, assessments, and/or services may be conducted during the face-to-face encounter.
- Description of how health concerns and/or active or potential health issues will be addressed during the face-to-face encounter.
- How the SNP will conduct care coordination activities through appropriate follow-up, referrals, and scheduling, as necessary. This includes how the SNP determines and conducts these care coordination activities when the plan reviews data associated with a face-to-face encounter between an enrollee and a provider.

INDIVIDUALIZED CARE PLAN (ICP)

- Essential components of the ICP.
- Process to develop the ICP, including the applicable staff involved and how often the ICP is modified as enrollee health care needs change.
- Personnel responsible for development of the ICP, including how enrollees and/or caregivers are involved.
- How the ICP is documented and updated, and where it is maintained.
- How updates and modifications to the ICP are communicated to the enrollee and other stakeholders.

INTERDISCIPLINARY CARE TEAM (ICT)

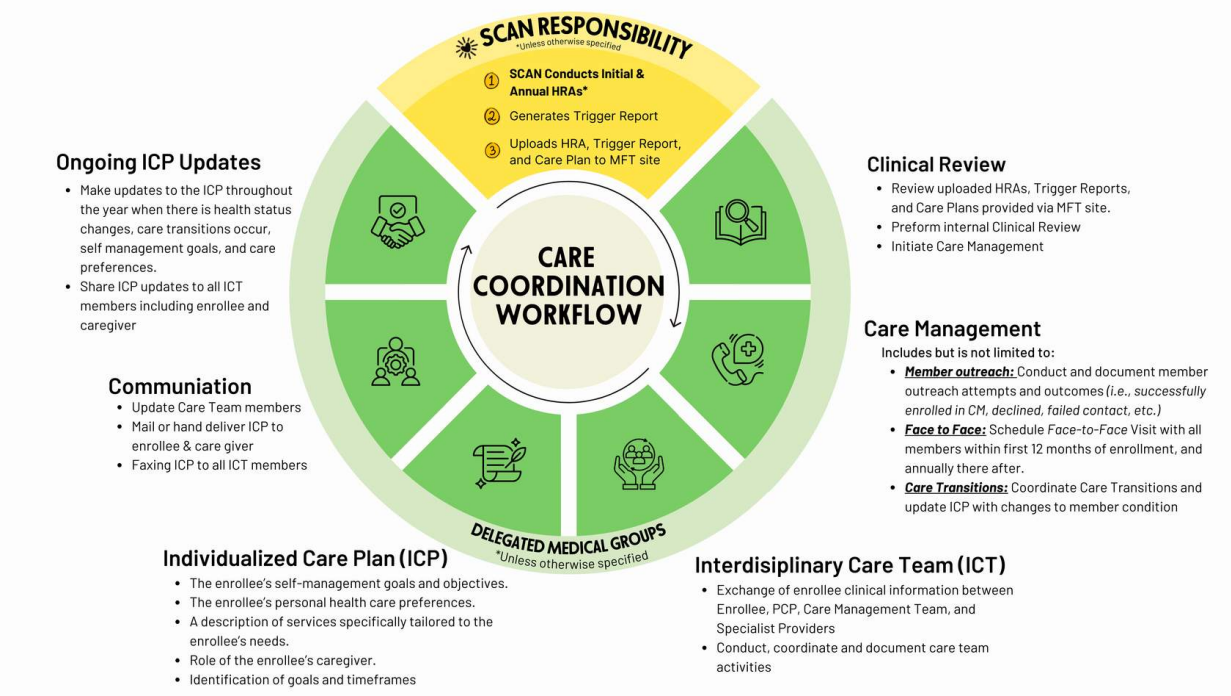
- Comprehensive description of how the organization determines the composition of ICT membership, including addition of team members to address the unique needs of enrollees.
- Roles and responsibilities of the ICT members (including enrollees and/or caregivers) and how each contributes to the development and implementation of an effective interdisciplinary care process.
- How ICT members use the outcomes to evaluate, contribute, and continually manage and improve the health status of SNP enrollees.
- How the SNP's communication plan to exchange enrollee information occurs regularly within the ICT, including evidence of ongoing information exchange,

CARE TRANSITION PROTOCOLS

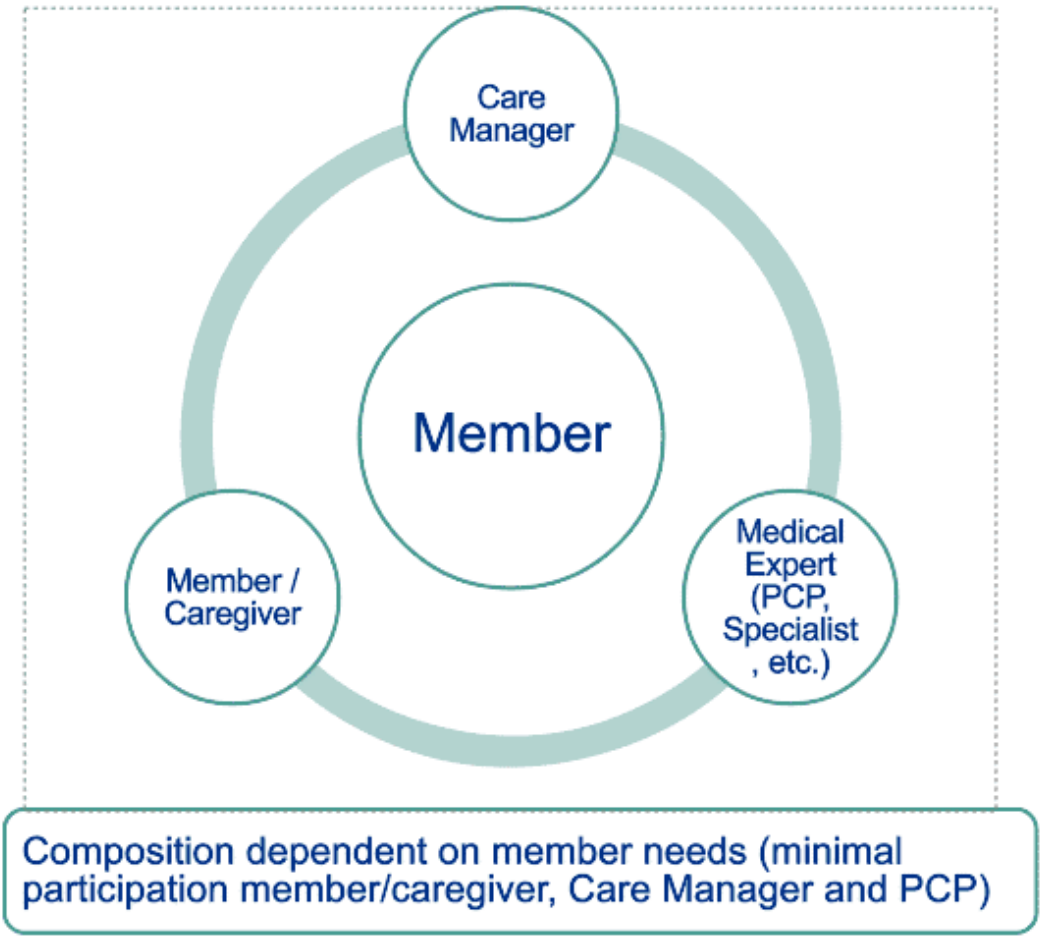
- How the organization uses care transition protocols to maintain continuity of care for SNP enrollees.
- Personnel responsible for coordinating the care transition process.
- How the organization transfers elements of the enrollee's ICP between health care settings when the enrollee experiences a transition in care.
- Process for enrollees to access their personal health information to facilitate communication with providers in other healthcare settings or specialists.
- How enrollees and/or caregivers will be educated about the enrollee's health status to foster appropriate self-management activities and the expectation for demonstrating understanding of appropriate self-management.
- How and when the enrollees and/or caregivers are informed about the point of contact throughout the transition process.

CARE COORDINATION PROCESS

Click the see the graphic larger



INTERDISCIPLINARY CARE TEAM (ICT)



- All ICT participants are required to complete annual MOC training
- The ICT addresses the unique needs of the member, coordinates care and develops ICP
- Format: In- person, Telephonically, Electronically
- Outcomes of the ICT contribute to the continual management and improvement of member health status

SNP ICT OPERATIONS AND DOCUMENTATION

Complete ICT within 30 calendar days of receipt of Trigger report and ICP

Document:

1. Date member trigger report/referral received
2. Member's acuity level
3. Date of ICT
4. ICT Participants
5. Clinical Review
6. Summary of case discussion and recommendations

Document failed contact and member declined

INDIVIDUALIZED CARE PLAN (ICP)

CREATING THE SNP CARE PLAN

Click through the process of creating a SNP Care Plan

STEP 1

REVIEW HRA / ICP

Upon receipt of SCAN documents: Review HRA/ICP for triggered members

STEP 2

COMPLETE A CLINICAL REVIEW

Complete a clinical review of all available member medical records to identify any new concerns and document

STEP 3

OUTREACH TO MEMBER

Outreach to member, documenting attempts and outcome within 30 days of receipt of trigger report

STEP 4

REVIEW TRIGGERS

Review all triggers with the member on your outreach and assess for any other concerns, determine acuity level and need for case management.

STEP 5

REVIEW FINDINGS

Review all findings in your Interdisciplinary Rounds

SEND REVISED CARE PLAN

Send the revised care plan to PCP and member

WHEN TO UPDATE THE CARE PLAN

- [ ] Clinical review identifies a change of health status not reflected on the SCAN care plan
- [ ] During member outreach/assessment, a new concern is identified
- [ ] As a result of Interdisciplinary Team review
- [ ] A change of health status that occurs at any point during the member journey (e.g. admit/discharge from a facility)

CARE TRANSITIONS

Member is discharged

Post hospital follow-up call

Schedule PCP / Specialist follow-up appointment

Care Manager calls the member and completes the post discharge assessment

Assess acuity level

Conduct Interdisciplinary Care Team (ICT)

Update the Care Plan & share it with members of the ICT

Schedule follow-up with Care Manager

CARE TRANSITIONS (CT) DOCUMENTATION

Care Transitions documentation MUST include:

1. "Patient outreach was completed/attempted within 5 business days of discharge from one setting to another".
2. Notification to PCP within five business days of discharge
3. Ensure follow-up services and appointments are scheduled within 5 business days of transition
4. The team ensures there is an identified provider directing the member's care and any other providers who need to be aware of the

transition are notified.

5 Care plan transferred between settings before, during, after transition of care

6 Member coaching occurred

7 Members of the ICT and members/caregivers have access to the plan of care

ADVANCE CARE PLANNING

ADVANCE DIRECTIVE IS AN ONGOING CONVERSATION THAT:

- [ ] Involves shared decision making to clarify and document an individual's wishes, preferences, and goals regarding future medical care.
- [ ] This comprehensive process is critically important to ensuring patients receive the medical care they want in the event they lose the capacity to make their own decisions.
- [ ] PCPs are required to educate and should encourage each Member to complete an advance directive and document in the Member's medical record
- [ ] Completed advance directives must be placed in a prominent place in the Member's medical record (See 42 CFR 422.128(b)(1)(ii)(E)).

MOC 3: PROVIDER NETWORK

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PROVIDER NETWORK

The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP enrollees. The SNP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized health care needs of the target population identified in MOC 1 and provide oversight information for all its network types. SNPs must ensure that their MOC identifies, fully describes, and implements the following elements for their SNP provider networks.

SPECIALIZED EXPERTISE

- Provide a complete and detailed description of the specialized expertise that corresponds to the target population identified in MOC 1.
- Explain how the SNP oversees its provider network facilities and oversees that its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to SNP enrollees.
- Describe how the SNP documents, updates, and maintains accurate provider information.
- Describe how providers collaborate with the ICT and contribute to an enrollee's ICP to provide necessary specialized services.

USE OF CLINICAL PRACTICE GUIDELINES (CPGS) AND CARE TRANSITION PROTOCOLS (CTPS)

- Explain the process for monitoring how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to each SNP's target population.
- Identify challenges where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP enrollees.
- Provide details regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made for clinically complex members, incorporated into the ICP, communicated to the ICT, and acted upon by the ICT.
- Describe how SNP providers ensure continuity of care using the care transition protocols outlined in MOC Element 2F in and outside of the network.

MOC TRAINING FOR THE PROVIDER NETWORK

- Detail training for network providers and out-of-network providers seen by enrollees on a routine basis.
- Describe how the organization documents evidence of training (maintains records) on the MOC training.
- Explain challenges associated with the completion of MOC training for network providers and out-of-network providers seen by enrollees on a routine basis.
- Describe the specific actions taken when the required MOC training is deficient or has not been completed.

SNP MODEL OF CARE TRAINING

- SCAN requires initial and annual SNP Model of Care training for network providers who see SNP members on a routine basis.
- CMS requires proof of completion of SNP Model of Care Training
- SNP Training must meet CMS Requirements
- As a courtesy, SCAN provides this SNP Training that meets CMS Requirements
- Complete and submit the attestation form at the end of this training to fulfil this requirement

IT IS THE RESPONSIBILITY OF THE MEDICAL GROUPS OR PROVIDER TO MAINTAIN PROOF OF COMPLIANCE.

MOC 4: MOC QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

JQ Josh Qualls

QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

The goal of performance improvement and quality measurement is to improve the SNP's ability to deliver health care services and benefits to its SNP enrollees in a high-quality manner. Achievement of this goal may be the result of increased organizational effectiveness and efficiency through incorporation of quality measurement and performance improvement concepts that drive organizational change.

MOC QUALITY PERFORMANCE IMPROVEMENT PLAN

- Describe the overall quality improvement plan and how the organization delivers or provides appropriate services to SNP enrollees based on their unique needs.
- Describe the process for how the plan collects information, including specific data sources as well as performance and enrollee health outcome measures it uses to continuously analyze, evaluate, and report MOC quality performance.
- Describe how its leadership, management groups, other SNP personnel, and stakeholders are involved with the internal quality performance process.
- Describe how SNP-specific measurable goals and health outcome objectives are integrated in the overall performance improvement plan, as described in MOC Element 4B. The process includes how it determines if goals are met (including specific benchmarks and time frames).

MEASURABLE GOALS AND HEALTH OUTCOMES FOR THE MOC

- Identify and define the specific measurable goals and health care needs used to improve access and affordability of the SNP population included in MOC 1.
- Identify specific enrollee health outcome measures used to measure overall SNP population health outcomes at the plan level.
- Describe how the SNP establishes methods to assess and track the MOC's impact on SNP enrollees' health outcomes.
- Describe the processes and procedures the SNP will use to determine if health outcome goals are met.
- Describe the steps the SNP will take if goals are not met in the expected time frame.

MEASURING PATIENT EXPERIENCE OF CARE (SNP ENROLLEE SATISFACTION)

- Describe the specific SNP survey(s) used.
- Explain the rationale for the selection of a specific tool or tools.
- Explain how the results of patient experience surveys are integrated into the overall MOC performance improvement plan.
- Detail the steps taken by the SNP to address issues identified in enrollee survey responses.

ONGOING PERFORMANCE IMPROVEMENT EVALUATION OF THE MOC

- Describe how the organization will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC.

- Detail how the organization will use the results of the quality performance indicators and measures to continually assess and evaluate quality.
- Detail the organization's ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation.
- Describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.

DISSEMINATION OF SNP QUALITY PERFORMANCE RELATED TO THE MOC

- Describe how performance results and other pertinent information is shared with multiple stakeholders.
- State the scheduled frequency of communications with stakeholders.
- Describe the methods for ad hoc communication with stakeholders.
- Identify the individuals responsible for communicating performance updates in a timely manner.

SNP MOC MONITORING AND OVERSIGHT

SNP MOC OVERSIGHT (ANNUAL AUDIT)

Scheduled Annually

- Request for audit document

Timely Submission of audit documents

- This includes MOC training for ICT participants of selected files.

- **Audit Performed**

  - Ensure appropriate participants available for case review

- **Notification of Audit Outcome**

  - Pass
  - CAP

- **Once CAP is issued we cannot change audit results for untimely submission of documents**

CORRECTIVE ACTION PLAN – CREATING A SUCCESSFUL RESPONSE

- **Corrective Action Plans**

  - Perform Root Cause Analysis - the “why” deficiency occurred.
  - Corrective Action Plan - Group plan for correcting deficiency including
  - Implementation Date(s)
  - Responsible Individual- Must be a person not a department

- **Repeat Deficiencies**

  - Each repeat deficiency requires new Root Cause Analysis and Corrective Action Plan.

- **File Review Deficiencies**

- File Review Deficiencies require Root Cause Analysis and Corrective Action Plan including implementation of any process change (including staff training, etc.)

TRAINING ATTESTATION

JQ Josh Qualls

I have completed this training in its entirety, I will use the link below to attest, AND I will save a copy of that attestation for my own personal records

- ○ YES
- ○ NO

SUBMIT

2025 SNP MODEL OF CARE TRAINING ATTESTATION

CLICK THE LINK TO THE RIGHT TO COMPLETE THE ONLINE ATTESTATION FORM

!! SAVE A COPY FOR YOUR RECORDS

LINK TO ATTEST

Lesson 12 of 12

RESOURCES

JQ Josh Qualls

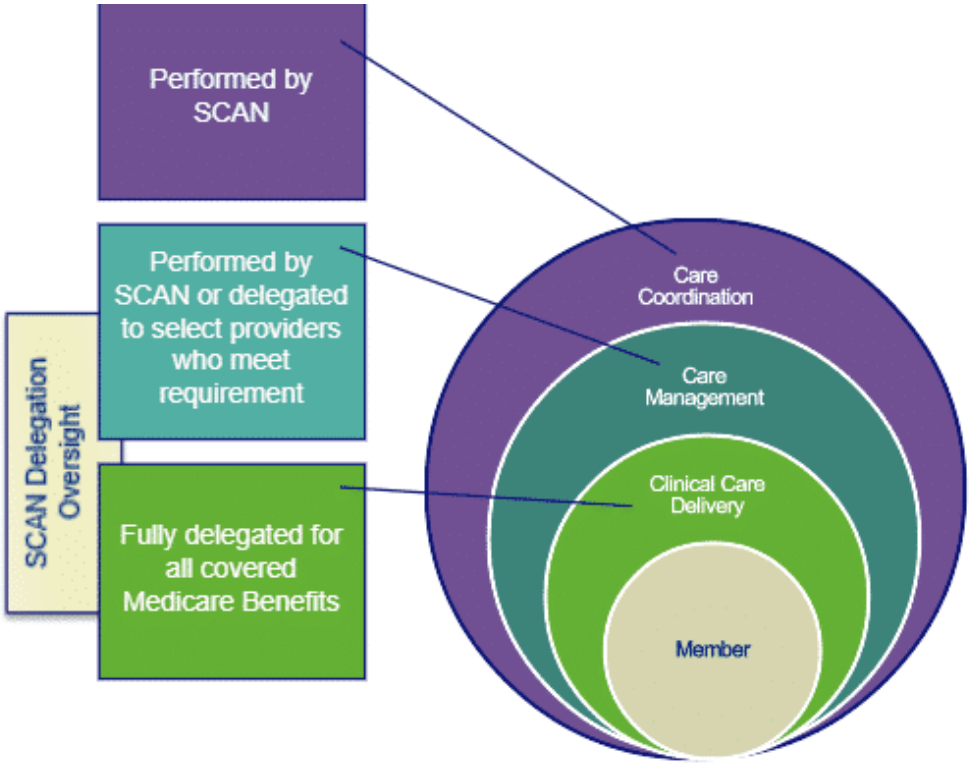
D-SNP FOCUS - ALZHEIMER'S DISEASE AND RELATED DEMENTIAS (ADRD)

- Alzheimer's Dementia Care Specialist Training
- Available tools to assess patient cognition: Dementia Care Aware website and associated resources
- DHCS CalAIM D-SNP Policy Guide 2023
- National Institute on Aging (NIH) Assessment of Cognitive Complaints Toolkit
- California Alzheimer's Disease Centers' "Assessment of Cognitive Complaints Toolkit for Alzheimer's Disease"
- 2023 Alzheimer's Disease Facts and Figures

CMS SNP RESOURCES

- CMS Website
    - Medicare Managed Care Manual - Chapter 5
    - Medicare Managed Care Manual - Chapter 1

DELEGATED MODEL



SCAN DELEGATES CARE AND SERVICES TO CONTRACTED PROVIDER ORGANIZATIONS TO PROVIDE MEDICAL AND MENTAL HEALTH CARE AND SERVICES.

SCAN SUPPORTS MEMBERS IN A COMPREHENSIVE MANNER, WHILE PROVIDING THE INFORMATION, SUPPORT AND ASSISTANCE NECESSARY TO MORE ACTIVELY MANAGE THEIR OWN CARE, INCLUDING ASSESSING THE MEMBER'S NEEDS (HRA) AND COORDINATING CARE AND BENEFITS

SCAN SUPPORTS PROVIDER ORGANIZATIONS BY PROVIDING:

- TRAINING
- TECHNICAL ASSISTANCE AND TOOLS
- EVIDENCED BASED PRACTICE GUIDELINES
- COLLABORATION ON QUALITY MEASURES (I.E., CMS 5 STAR, CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) AND HEALTH OUTCOMES SURVEY (HOS))

SCAN PERFORMS OVERSIGHT THROUGH INITIAL AND ANNUAL AUDITS TO EVALUATE THE DELEGATE'S ABILITY TO PERFORM DELEGATED ACTIVITIES AND REPORTING.

SCAN MONITORS MEMBER EXPERIENCE (GRIEVANCE TRENDS AND QUALITY INVESTIGATIONS)

QUESTIONS AND COMMENTS

SUBMIT YOUR QUESTIONS AND COMMENTS

HCOMPLIANCE@SCANHEALTHPLAN.COM

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