Dual Special Needs Plan (DSNP) Model Of Care Training

December 4, 2025

Welcome!

There is **no sound** until the webinar begins.

Webinar **will be recorded.** Participation in the webinar is agreement to recording.

All participants phones have been **muted** except for the presenter.

Any unanswered questions today, will be addresses **following the presentation.**

Please use the chat for any technical issues.

Agenda: Dual Special Needs Plan (DSNP) Model Of Care Training

In this presentation we will cover:

1. DSNP Model Of Care (MOC) Overview
2. MOC 1:Description of the SNP Population
3. MOC 2: Care Coordination
4. MOC 3: Provider Network
5. MOC 4: Quality Measurement & Performance Improvement

DSNP Model Of Care (MOC) Overview

Purpose

The Model of Care (MOC) training is conducted annually to ensure all contracted and non-contracted medical providers and staff receive training on the DSNPs MOC as required by the Centers for Medicare & Medicaid Services (CMS). Completion of the annual MOC training is mandatory for all providers who serve our DSNP members.

At least one member of a care team location is required to take the annual online training course or attend a live webinar, complete the attestation and distribute the training material to all DSNP care team members.

This course is not fully completed until the attestation is submitted. Please ensure you attest at the end of training.

The goal of the training is to explain how we can work cohesively together to deliver care.

Special Needs Plans (SNPs)

Special Needs Plans (SNPs) were created by Congress through the Medicare Modernization Act of 2003. SNPs are a type of Medicare Advantage Plan. SNP's members are individuals who are entitled to both Medicare (Title XVII) and Medical Assistance from the State plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

There are three types of SNPs that limit membership to specific types of enrollees:

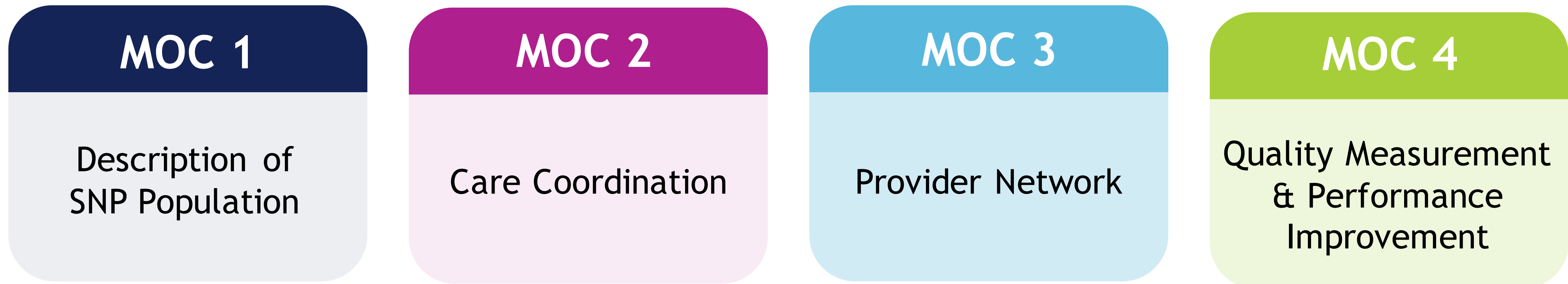
1. **Chronic Care**
   With specific types of chronic conditions
2. **Dual Eligible***
   Who receive both Medicare and Medicaid
3. **Institutional**
   Live in an institution or require nursing care at home

***Jefferson Health Plans Medicare Advantage offers three Dual Eligible Special Needs Plans.**

What is the Model of Care (MOC)?

- The MOC provides the basic framework under which the SNP will meet the needs of each of its members.
- The MOC provides the foundation for promoting quality SNP care management and care coordination processes.
- All Medicare Advantage Organizations that offer SNPs are required to submit a MOC approved by the National Committee for Quality Assurance (NCQA).

The MOC is comprised of 4 Elements outlined below:



MOC Eligibility

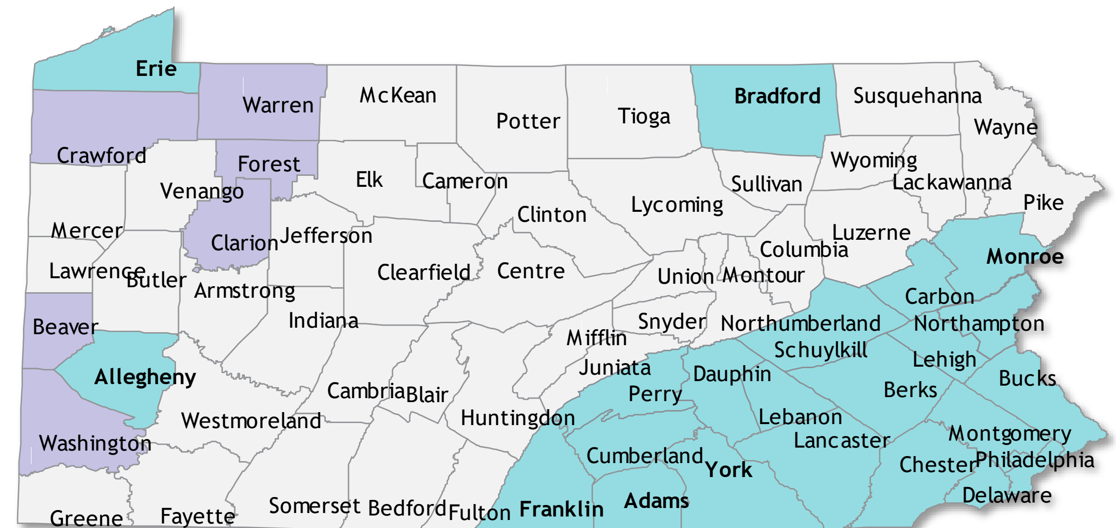
Eligible members

- Must reside within the plan service area
- Must meet dual eligibility status requirements

Primary coverage for DSNP members:

- Medicare is always the primary payer
- Medicaid is the payer of last resort and supplements Medicare coverage
- Members are eligible for special election period to change health plans quarterly throughout the year

In 2026, Jefferson Health Plans Medicare Advantage will offer three DSNP plans, Special, Dual Pearl, and Select, in 28 counties:



Service Area 2025

Expansion Counties for 2026

(Note: Current MA DSNP service may include additional areas in PA

MOC 1:Description of the SNP Population

MOC 1: Description of the SNP Population

Jefferson Health Plans Medicare Advantage performs an annual population assessment to determine the needs of our membership as well as the community we serve. Age, gender, disease prevalence in the region, food sources and other social determinants of health are reviewed.

Using this information, we determine if all resources including community, practitioner, and provider partners are in place to meet the beneficiaries' health and social needs.

MOC 1: Description of the SNP Population

Service Area

Philadelphia County: **92%**
Delaware County: **3%**
Bucks County: **2%**
Montgomery County: **1%**
Others: **2%**

92%
of members live in Philadelphia

Age (Years)

<64: **32.83%**
65-69: **21.94%**
70-74: **21.70%**
75-79: **12.19%**
80-84: **6.47%**
85-89: **3.28%**
+90: **1.59%**

>66%
of members are 65 years of age or older

Gender

Male: **37%**
Female: **63%**

63%
of members are female

Race/Ethnicity

Black: **31%**
White: **21%**
Hispanic: **11%**
Asian/Pacific Islander: **3%**
American Indian: **.04%**
Other: **34%**

31%
are Black

34%
Report other race/ethnicity

Language Spoken

English: **71%**
Spanish: **28%**
Other: **1%**

71%
speak English

MOC 1: Description of SNP Population-Most Vulnerable

Jefferson Health Plans Medicare Advantage has identified the following Most Vulnerable Population (MVP) as hypertensive members who have a high-risk score on their Health Risk Assessment and comorbidities of depression and/or obesity residing in Philadelphia County.

Co-Morbid Condition DSNP vs. MVP	DSNP		MVP	
	Depression	Obesity	Depression	Obesity
Percent	43%	56%	61%	70%

Brain Teaser

1

Description of the DSNP Population

Who are the most vulnerable DSNP Population?

A. All DSNP members are vulnerable.
B. DSNP members who live outside of Philadelphia County.
C. Only those 65 years or older.
D. Hypertensive members who have a high-risk score on their Health Risk Assessment and comorbidities of depression and/or obesity residing in Philadelphia County.

MOC 2: Care Coordination

MOC 2: Care Coordination-Resources to Meet Member's Needs

All DSNP members are assigned to a Care Coordinator upon enrollment to foster and maintain a strong relationship.

The Care Coordinator, along with all clinical areas, educate DSNP members on self-management techniques and provide pharmacy consultation, behavioral health counseling, and clinical oversight.

The Care Coordinators core functions are to promote the highest level of physical, psychological and social functioning possible for the member and their caregivers.

MOC 2: Health Risk Assessment Tool (HRAT)

The HRAT is a CMS approved tool that asks a series of questions designed to assess the medical, functional, cognitive, psychosocial and mental health needs of the member.

This self-reported health risk assessment tool identifies member risk level of care for care coordination:

All DSNP beneficiaries are assessed initially within 90 days of effective date, within 365 days of the last HRAT and with any transition of care or change in condition.

The HRAT is conducted telephonically by Health Assessment Outreach Coordinators and is reviewed by the team leads to evaluate the member's needs and assign to the appropriate Care Coordination team. The assessment can also be mailed to the member or completed in the member portal.

MOC 2: Individualized Care Plan (ICP)

ICPs for members are created utilizing a combination of information available including:

- Heath Assessments results
- Utilization and claims data
- Preventive health information, according to the member's age and gender

The ICP is revised at least annually, or when the member has a significant change in health status, such as an inpatient admission.

The goal is to **educate and empower** the member and/or caregiver to take an active role in managing their healthcare needs.

MOC 2: Individualized Care Plan (ICP)

CMS requires that an Individualized Care Plan (ICP)* be completed for each DSNP member within 30 days of Health Assessment completion. A revised ICP will be completed within 30 days of a revised Health Risk Assessment.

*If a member could not be reached or chose not to create a Health Assessment, the ICP will be based on historical claims data.

The ICP includes:

Member-specific identified goals

Medical, pharmacy, preventive, and behavioral health interventions

Information/access to community resources

MOC 2: Individualized Care Plan (ICP)

All members and their PCPs receive a copy of the ICP with clear action steps for the year.

ICPs are based on issues, interventions and goals:

- Issues are identified using the member's answers on the Health Assessment and other communication with member.
- Interventions are tailored to each member's needs. The ICP will address member-specific barriers to complying with the plan.
- Goals are reassessed at least annually and adjusted accordingly.

Transition of Care

Transition of Care protocols maintain continuity of care for members, reducing complications and readmissions.

- The Care Coordinator may work with a hospital discharge planner and transitional care managers to identify member's health care needs and address barriers/environmental concerns.
- The member and/or caregivers are educated about member's health status to assist with self-management.

Other events that would trigger an ICP include a practitioner referral, member self-referral, and inappropriate use of resources.

- Both the PCP and/or the member can request a meeting to further discuss the ICP.
- The results are communicated to members and their PCP during the Interdisciplinary Team (ICT) Meeting and via mail after the ICT.

MOC 2: Care Coordination Interdisciplinary Care Team (ICT)

Purpose: The ICT is a group of individuals from diverse fields who work together toward a common goal for the member, which is to improve care.

Composition is specific to the member but may include:

1. **Core Team:** Member and/or representative, primary care provider and care coordinator.
2. **Ad hoc:** Medical director, specialist, clinical supervisor, pharmacy, utilization review nurse, behavioral health care coordinator, etc.

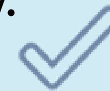
MOC 2: Care Coordination ICT

Member and/or caregiver, in collaboration with the care coordinator, identifies issues and barriers and then prioritizes the goals and set timelines to close these goals.

PCPs are invited to participate in the ICT along with the ICP developed by the Care Coordinator and the member.

Special accommodations will be made for members with hearing, visual impairments, language and literacy barriers, and/or cognitive deficits.

Each member's ICP will be reviewed at least annually.



Formal ICT meetings scheduled 3 days per week include members who have had a recent discharge from an acute inpatient stay or SNF, readmissions or any changes in condition that the care coordinator would like to discuss with the ICT.

Brain Teaser

2

Individualized Care Plan (ICP)

Which of the following events will trigger an ICP?

A. An inpatient event.
B. Practitioner referral.
C. Beneficiary self-referral.
D. Inappropriate use of resources without a PCP visit.
E. All the above.

MOC 3: Provider Network

MOC 3: Provider Network

The plan establishes a provider network necessary to service the needs of a diverse member population to ensure all members receive quality care.

- The plan ensures, through the credentialing and network adequacy processes, that providers are well trained and accessible in treating the needs of our member population.
- The plan documents, updates, and maintains accurate provider information.
- Providers collaborate with the ICT and contribute to the ICP to provide specialized services.

The plan oversees how network providers use evidence-based medicine by:

- Monitoring how network providers use appropriate clinical practice guidelines and nationally recognized protocols for target population, and if they need to be modified for vulnerable members.
- Monitoring provider's adherence to clinical and preventive guidelines through the Quality and Clinical Review (QCR) program.

MOC 3: Provider Network Training

The plan must provide initial and annual training for both in-network and out-of-network providers **who provide more than three (3) in person visits to a DSNP member**.

- Training is available through live webinars and web-based self-led training modules.

All provider training is documented and tracked. **Reports are run monthly to monitor completed trainings.**

The training plan describes actions to be taken when training is not completed timely.

Brain Teaser

3

Provider Network

How does the MOC establish a provider network with specialized expertise?

A. The plan ensures, through the credentialing and network adequacy processes, that providers are well trained and accessible in treating the needs of our member population.

B. The plan documents, updates and maintains accurate provider information.

C. Providers collaborate with the ICT and contribute to the ICP to provide specialized services.

D. All the above.

MOC 4: Quality Measurement & Performance Improvement

MOC 4: Quality Measurement & Performance Improvement

Jefferson Health Plans Medicare Advantage has a quality improvement program (QIP) that encompasses an annual Program Description, Program Evaluation, and Work Plan.

The program scope includes reviewing and analyzing goals related to the four MOC elements:

- **MOC1:** Description of the SNP Population
- **MOC2:** Care Coordination
- **MOC3:** Provider Network
- **MOC4:** Quality Measurement & Performance Improvement

MOC 4: Quality Measurement & Performance Improvement

The overarching goals for the MOC are:

- Improving and maintaining access to essential services (medical, behavioral health, social services, preventive health)
- Improving and maintaining affordable care
- Improving and maintaining care coordination
- Improving or maintaining seamless transitions of care
- Ensuring appropriate utilization of medical and preventive health services
- Improving and maintaining beneficiary health outcomes and member satisfaction

MOC performance is monitored on a continuous basis, using various data sources, and re-assessing if goals are not met.

MOC 4: Quality Measurement & Performance Improvement

Goal	Measure	Objective
Ensure appropriate utilization of medical and preventive health standards for beneficiaries	Annual Wellness Visit (AWV)	Increase AWV to improve health outcomes
	Controlling High Blood Pressure (CBP)	Improve blood pressure control in members with hypertension
	Care of Older Adults (COA): Medication Review	Assess medication review annually
Improve or maintain seamless transitions of care	Plan All Cause Readmissions (PCR)	Decrease readmission rates through care coordination with providers/facilities
Improve and maintain beneficiary health outcomes and member satisfaction	Case Management Survey	Improve members' experience with JHP case management
	Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey	Improve members' experience with health care interactions and measure outcomes

Brain Teaser

4

Quality Measurement & Performance Improvement

Which of the following MOC evaluation goals and metrics are included?

A. Improving and maintaining access to essential services (behavioral, medical, social, & preventive health) and affordable care.

B. Improving and maintaining care coordination and seamless transitions of care.

C. Appropriate utilization of medical and preventive health services.

D. Improving and maintaining health outcomes and member satisfaction.

E. All the above.

How can you help?

1. Reach out to the care coordinators if you identify an issue and want to update the member's ICP.
2. Participate in ICT, your input is valuable to the health of the member/patient.

Thank you for joining the DSNP MOC Medicare training!

Please complete your DSNP Attestation using the link below.
https://www.healthpartnersplans.com/home/providers/training-and-education/dsnp/

Get in touch with us!

Contact us via the Provider Services Helpline: **1-888-991-9023**
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