VIVA MEDICARE

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

Physician & Provider Training Guide

Purpose of This Training

This document provides physicians and providers with a working understanding of **VIVA HEALTH's Dual Eligible Special Needs Plan (D SNP) Model of Care (MOC).**

The goal is to ensure providers understand:

- The **unique needs of the D-SNP population**
- How **care coordination, Health Risk Assessments, and Individualized Care Plans** work to support positive health outcomes in this population
- The role of the **Interdisciplinary Care Team (ICT)**
- **Provider responsibilities** in quality, transitions of care, and outcomes improvement

Introduction & SNP Population

About VIVA HEALTH

VIVA HEALTH is an Alabama-based, not-for-profit Health Maintenance Organization and part of the UAB Health System. The organization serves Medicare and commercial members statewide, with a robust and growing provider network.

What Is a Dual-Eligible SNP (D-SNP)?

VIVA HEALTH's ***Extra Value*** and ***Extra Care*** plans serve members who are eligible for:

- Medicare Parts A & B
- Full or partial Alabama Medicaid

Members receive coordinated Medicare and Medicaid benefits with minimal or no cost-sharing.

D-SNP Population Overview

Key characteristics of the VIVA HEALTH D-SNP population:

- Predominantly low income ~99.9% qualify for Low Income Subsidy (LIS)

- 72% report annual household income under $20,000
- High chronic disease burden; top 10 diagnoses in this population are hypertension, hyperlipidemia, osteoarthritis, diabetes, pain, CAD, CKD, COPD, cerebrovascular disease, and CHF
- Behavioral health challenges; major depression, bi-polar disorder, and schizophrenia are highly prevalent in the population
- Social vulnerability 28% live alone
- 41% have less than a high school education
- ~50% lack reliable internet access

Why This Matters to Providers

This population experiences:

- Higher hospitalization and readmission risk
- Medication complexity and adherence challenges
- Transportation, food, and housing insecurity
- Lower health literacy and limited support systems

The MOC is designed to support all those who provide care for these members, and manage these complexities.

Care Coordination & Staff Roles

Care Coordination Philosophy

Care coordination ensures member needs are met across time, settings, and providers, emphasizing the right care, in the right setting, and the right time, with appropriate providers.

VIVA HEALTH employs a multidisciplinary team of clinical staff, and also partners with contracted clinical providers. Both employed and contracted clinical personnel perform essential roles in supporting Special Needs Plan (SNP) enrollees. Clinical responsibilities include assessment, care coordination, medication management, behavioral health support, transitions-of-care outreach, and development and monitoring of Individualized Care Plans (ICPs).

Key Clinical Teams Supporting Providers

Care Management (VCare Program):

- Registered Nurses (RNs)
- Licensed Social Workers
- Behavioral Health clinicians

- Pharmacists
- Medical Directors
- Community Health Workers
- Our out-patient, acute, and post-acute provider network

Focus Areas:

- Registered Nurses (RNs)
- Licensed Social Workers
- Behavioral Health clinicians
- Pharmacists

Connect for Quality (C4Q):

- Nurses embedded in or partnered with primary care offices
- Support **HEDIS®, Star measures**, preventive care
- Facilitate **Comprehensive Review Forms (CRFs)**, and communication to the plan regarding member care

Pharmacy Team:

- Medication reconciliation
- Adherence outreach
- Comprehensive Medication Reviews (CMRs)
- Assistance with polypharmacy and safety concerns

Health Services / Utilization Management:

- Prior authorizations
- Concurrent review
- Discharge planning
- Evidence-based clinical guideline application

Provider Role in Care Coordination

Providers are essential partners and:

- Refer members to **Care Management**
- Collaborate on transitions and post-discharge plans
- Participate in **ICT discussions**
- Support medication reconciliation and follow-up care

Health Risk Assessments & Individualized Care Plans

Health Risk Assessment Tool (HRA)

What Is the HRA?

A standardized assessment completed:

- Within 90 days of enrollment and annually thereafter
- After significant health status changes

Five Assessment Domains:

1. Medical
2. Functional
3. Mental Health
4. Cognitive
5. Psychosocial

The HRA identifies:

- Chronic conditions
- Fall risk
- Medication adherence issues
- Understanding of medical instructions
- Social barriers

How Providers Use HRA Information:

- Highlights patient-reported concerns
- Guides care prioritization and informs the member's Individualized Care Plan
- Supports preventive care and behavioral health screening

Individualized Care Plan (ICP)

What Is the ICP?

A **member-specific plan of care** developed using:

- HRA results
- Claims and utilization data
- PCP input
- Member and caregiver goals

Key ICP Components:

- Identified health problems
- Measurable goals and interventions
- Assigned responsibilities
- Timelines and outcome tracking
- Member preferences and caregiver involvement

Provider Engagement:

- PCPs receive copies of ICPs
- Providers are invited and encouraged to offer input into the Care Plan
- Care plans evolve with changes in condition or utilization

Interdisciplinary Care Team & Care Transitions

Interdisciplinary Care Team (ICT)

Every SNP member must have an Interdisciplinary Care Team reflective of their needs and priorities. In it's basic form, each care team includes the member and/or caregiver, their VIVA Care Manager, and the Primary Care Provider. Disciplines may be added as member needs dictate.

Other disciplines available to all members include:

- Specialty Providers
- Geriatricians
- Pharmacists
- Nurses
- Social Workers
- Behavioral Health professionals

ICT Purpose:

- Address complex cases collaboratively
- Reduce fragmentation of care
- Improve outcomes through shared expertise

Provider Participation:

As an essential member of the Care Team, Provider participation is essential and may include:

- Input into the Individualized Care Plan
- Referrals for ICT review for complex cases
- Behavioral health complexity
- Social instability
- Poor disease control

Care Transitions

Transitional care and support are essential to ensure that changes in health status are addressed, and transitions across settings are safe. Our Care Management team provides support to all SNP members who experience a transition.

High-Risk Transition Points Include:

- Hospital ➔ home
- Hospital ➔ SNF/Rehab
- SNF ➔ home
- Home health initiation or discharge

Transition Support Includes:

- Medication reconciliation
- Follow-up appointment scheduling
- Transportation coordination
- Red-flag education
- Care Manager follow-up

Provider Responsibilities:

- Timely discharge summaries
- Medication list accuracy
- PCP follow-up within appropriate timeframes
- Communication with Care Managers on member needs

Effective transitions are critical to reducing readmissions and ED utilization.

Provider Network, Quality & Training Expectations

Provider Network

VIVA HEALTH maintains a rigorous provider network of Primary and Specialty care providers, and also includes:

- Acute Care Hospitals
- Skilled Nursing Facilities (SNFs)
- Long-Term Acute Care (LTAC) hospitals
- Inpatient and outpatient rehabilitation facilities
- Behavioral health hospitals and psychiatric units
- Laboratory and radiology providers
- Dialysis centers
- Home health agencies
- Outpatient surgery centers
- Dental providers

Quality Measurement & Performance Goals

VIVA HEALTH maintains a comprehensive approach to delivering high-quality care, services, and outcomes for SNP enrollees. Oversight of the Quality Improvement (QI) Program is shared by the Performance Improvement Department, Vice President of Clinical Services, Medical Director for Behavioral Health, Executive Director of Health Services Programs, and SNP Administrator. These leaders jointly design, implement, monitor, and refine all QI activities supporting the SNP Model of Care (MOC).

Key D-SNP goals include:

- **Network Adequacy:** 100% CMS compliance
- **PCP Visits:** ≥90% annual visit compliance
- **Care Transitions:** ≥95% outreach after hospitalization
- **Readmissions:** Progressive reduction of 30 day readmissions
- **HRA, ICP, and ICT:** 100% of SNP members are engaged for HRA, ICP, and ICT identification

Performance is monitored through:

- HEDIS®
- Star measures

- Utilization and transition reports
- Member satisfaction surveys

Provider Training Requirements

Model of Care is required by CMS for all Providers at least once per Model of Care approval period. Training is provided through the Provider Portal, or can be done virtually or live by the SNP Administrator or designee.

Key Takeaways for Providers:

- The D-SNP population is **high-risk and highly vulnerable**
- Care coordination succeeds through **strong provider collaboration**
- HRAs and ICPs improve visibility into **patient needs**
- ICT participation enhances **complex case outcomes**
- Timely transitions of care **reduce readmissions**
- Providers play a central role in delivering **patient-centered, outcomes-driven care**

Provider Training Requirements

- Communicate and collaborate with VIVA HEALTH Case Managers, and other ICT members
- Encourage your patient to work with your office, keep appointments and comply with all treatment plans, participate with the care team, and complete the health risk assessment.
- Review and respond to correspondence sent by our Care Managers including the HRA results, the ICP and any request for information.
- Complete the annual MOC provider training and return the attestation.