Kern Family Health Care®

Medicare (D-SNP)

Model of Care Training for Providers CY 2026

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Introduction

The KHS Provider Model of Care (MOC) Training equips you with essential knowledge to deliver high-quality, coordinated care for Kern Health System's (KHS) Dual Special Needs Plan (DSNP) members under the new Kern Family Health Care Medicare HMO D-SNP (KFHCM). Covering critical topics such as the importance of the MOC, care coordination, quality improvement strategies, and practical applications through case studies, this training emphasizes your role in fostering comprehensive, individualized care. You will learn about key tools, including Health Risk Assessments (HRAs), Individualized Care Plans (ICPs), and Interdisciplinary Care Teams (ICTs), and their application in addressing the unique needs of DSNP members. Completion and attestation of this training is an annual requirement, ensuring alignment with CMS and state-specific quality standards while enhancing health outcomes and patient satisfaction.

KHS Quick Facts and DNSP

- **Kern Health Systems (KHS)** serves approximately 404.000 **Medi-Cal Members.**
- KHS has been in operation since **1993**, providing high-quality healthcare services to our members.

- **New DSNP in 2026**: KHS offers a new Dual Special Needs Plan (DSNP) starting in 2026, aimed at expanding access to coordinated care for individuals eligible for both Medicare and Medicaid called Kern Family Health Care Medicare (KFHCM).

MOC Training Requirement

- **Annual Requirement:** Completing Model of Care (MOC) training is an annual requirement for providers who care for KFHCM D-SNP members.

- **Training Completion:** Providers need to review the training content and attest that they will apply the principles in the MOC when caring for KFHCM D-SNP members and have completed the annual training requirement.

Overview of DSNP

- **Definition:** Dual Special Needs Plan (DSNP) is a type of Medicare Advantage plan for individuals eligible for both Medicare and Medicaid.

- **Exclusively Aligned Enrollment Integrated Dual Eligible Special Needs Plan (EAE SNP):** All members have the same Medi-Cal and Medicare provider under one plan: Kern Family Health Care Medicare HMO (D-SNP).

- **Purpose**: To provide coordinated care that improves health outcomes and reduces costs.

Importance of MOC

- **Definition:** The Model of Care (MOC) is a comprehensive plan designed to meet the unique needs of DSNP members.
- **Approval**: The MOC is approved by the National Committee for Quality Assurance (NCQA) and the California Department of Health Care Services (DHCS).
- **Framework**: The MOC provides the framework in which KFCAHP will manage DSNP members, ensuring comprehensive and individualized care.
- **Comprehensive Care:** Ensures comprehensive and individualized care for DSNP members across all Medi-Cal and Medicare benefits.
- **CMS and DHCS Alignment:** Aligns with CMS and California-specific requirements for quality and performance improvement.

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TRAINING OBJECTIVES

Provider Role and Responsibilities

- Encourage DSNP members to complete their Health Risk Assessments (HRAs) and engage with their KFCAHP care team.
- Review the Individualized Care Plans (ICPs) developed by the KFCAHP Care Team.
- Conduct face-to-face encounters with members, as appropriate.
- Collaborate with KFHCM to deliver integrated care across the Medi-Cal and Medicare benefit continuum.
- Communicate effectively with the KFCAHP care team and participate in interdisciplinary care team (ICT) meetings.

Role of the KFHCM Care Team

- Conducts initial and annual Health Risk Assessments (HRAs) to identify member health risks and needs.
- Develops Individualized Care Plans (ICPs) tailored to each member.
- Sends ICPs to the member/caregiver and the member's Primary Care Provider (PCP) for their review.
- Invites the PCP to participate in the interdisciplinary care team (ICT) meetings.

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SPECIAL NEEDS PLAN MODEL OF CARE (SNP MOC)

Components of the MOC

MOC 1

Description of SNP Population

Target Population: This component provides a detailed description of the target population the SNP serves. It includes demographic information, health conditions, and specific needs if the members.

MOC 2

Care Coordination

Comprehensive Care: Outlines how the SNP will coordinate care for its members. IT includes processes for coordinating medical, behavioral and social services to ensure comprehensive and continuous care.

MOC 3

Provider Network:

Network Details: Describes the provider network that will deliver care to SNP members. IT details the selection criteria for providers, network adequacy and strategies to ensure access to high-quality care.

MOC 4

Quality Measurement & Performance Improvement:

Evaluation Measures: Outlines the measures that will be used to evaluate the effectiveness of the MOC. It includes quality improvement activities, performance metrics and strategies for continuous improvement in care delivery.

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KEY COMPONENTS OF CARE COORDINATION

Health Risk Assessment (HRA)

Purpose
The purpose of Health Risk Assessments (HRAs) is to identify member health risks and needs.

- Initial and annual HRAs conducted by the KFHCM Care Team.
- HRAs include physical, behavioral, and social determinants of health.
- HRAs identify current or potential Long-Term Services and Supports (LTSS) needs.

- KFHCM is required to try and obtain an HRA on every member within 90 days of enrollment and annually thereafter.

Provider Role: The role of the provider is to encourage members to complete their HRAs.

Individualized Care Plan (ICP)

Purpose

The purpose of an Individualized Care Plan (ICP) is to develop a personalized care plan tailored to each member's unique needs.

- ICPs are created by the KFHCM Care Team based on HRA results and member preferences.
- ICPs are shared with the member/caregiver and the member's PCP.
- ICPs cover all Medi-Cal and Medicare benefits.
- ICPs are reviewed and updated regularly by KFHCM Care Team to reflect changes in member health status.
- CMS requires an ICP be created for each member and be shared with the member and PCP.

Provider Role: The role of the provider is to review the ICPs and provide feedback, as needed, and collaborate with the KFHCM Care Team to ensure the ICP meets the member's needs.

Interdisciplinary Care Team (ICT)

Purpose

The purpose of the Interdisciplinary Care Team (ICT) is to provide comprehensive and coordinated care through collaboration among healthcare providers.

- ICT meetings include the KFHCM Care Team, PCPs, specialists, and other relevant providers, including dementia care specialists and palliative care specialists, when appropriate.
- Meetings focus on discussing member care plans and addressing any issues.
- Every member must have an ICT at least annually.

Provider Role: The role of the provider is to participate in ICT meetings as needed and communicate effectively with the care team to ensure coordinated care.

Transitions of Care (ToC)

Purpose

The purpose of Transitions of Care (TOC) is to ensure a smooth transition for members moving between care settings.

- The TOC team identifies members who have been hospitalized or have had a significant change in their health status.
- The team assists with the transition to the member's home or another care setting, ensuring continuity of care.
- The team coordinates follow-up visits with the member's PCP and arranges for necessary support services, including transportation, DME, and/or LTSS.

Provider Role: The role of the provider is to collaborate with the ToC Team to ensure a seamless transition, follow up with the member to monitor their progress, and participate in ICT meetings, as needed.

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KHS QUALITY IMPROVEMENT PROGRAM

Key Components

Quality Improvement Framework

- **Definition:** The structured approach KHS uses to continuously improve the quality of care provided to members.
- **Goals:** To enhance patient safety, improve health outcomes, and increase member satisfaction.

Performance Metrics

- **Measurement:** The specific metrics used to evaluate the effectiveness of care and identify areas for improvement.
- **Examples**: Member health outcomes, patient satisfaction scores, and care coordination effectiveness.

Quality Improvement Activities

- **Strategies:** The initiatives and activates implemented to drive quality improvements.
- **Examples:** Training programs, process improvements, and member feedback initiatives.

Continuous Improvement

- **Approach:** The commitment to ongoing assessment and refinement of care processes to ensure continuous improvement.
- **Examples:** Regular performance reviews, data analysis, stakeholder engagement.

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Improvement Strategies

Data Driven Decision Making

- **Use of Data:** Leveraging data to identify trends, monitor performance, and inform improvement strategies.
- **Tools:** Analytics platforms, dashboards, and reporting systems.

Staff Training and Development

- **Education:** Ongoing training programs for staff to enhance their skills and knowledge in quality improvement practices.
- **Professional Development:** Opportunities for staff to engage in professional development and continuous learning.

Member Engagement

- **Involvement:** Actively involving members in quality improvement initiatives to gather feedback and enhance care experiences.
- **Feedback Mechanisms:** Surveys, focus groups, and member advisory panels.

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CASE STUDIES AND PRACTICAL APPLICATIONS

Example 1: Hospitalization and Transition of Care

Scenario: An elderly member is hospitalized.

Action: The Transition of Care (TOC) team identifies a member who had a recent hospitalization. The team assists the member with the transition to their home, ensuring they have necessary medications and support. They arrange for the member to make follow-up visits to their Primary Care Provider (PCP) and also arrange for transportation. A new Health Risk Assessment (HRA) is conducted to identify any changes in the member's health status. The member's care manager follows up with the member, updating the Individualized Care Plan (ICP) to reflect the new assessment. The care manager coordinates with the Interdisciplinary Care Team (ICT) to address any identified needs and ensure a seamless transition of care.

Example 2: Comprehensive Support for Dementia

Scenario: A member with dementia who requires comprehensive support.

Action: The KFHCM Care Team includes dementia care specialists in the ICT. They develop an ICP that addresses medical, behavioral, and social needs. Face-to-face encounters are conducted regularly in the member's home to monitor the member's status and provide caregiver support.

Example 3: Addressing Social Determinants of Health

Scenario: A member with social determinants of health impacting their well-being.

Action: The KFHCM Care Team identifies these factors through the HRA and incorporates LTSS services into the ICP. The team collaborates with community resources to address housing, nutrition, and transportation needs, ensuring comprehensive care.

Resources

Member Services	D-SNP Care Team	KFHCM (HMO D-SNP)	Claims Questions	Fraud, Waste, & Abuse
• Toll Free: • 1-866-661-3767 • TTY Users: 711 • Local: • 661-716-5342	• Care Manager: • 661-716-5342	• https://www.Kernfamilyhealthcare.com/	Send claims to Kern Family Health Care Medicare (D-SNP) PO Box 9187 Bakersfield, CA 93389-0187 1-866-661-3767 or 661-716-5342, TTY 711	Contact the Fraud Team by emailing: fraudteam@khs-net.com

You have completed Annual MOC provider Training for CY 2026

Thank you for the care you provide to KFHCM D-SNP members!

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