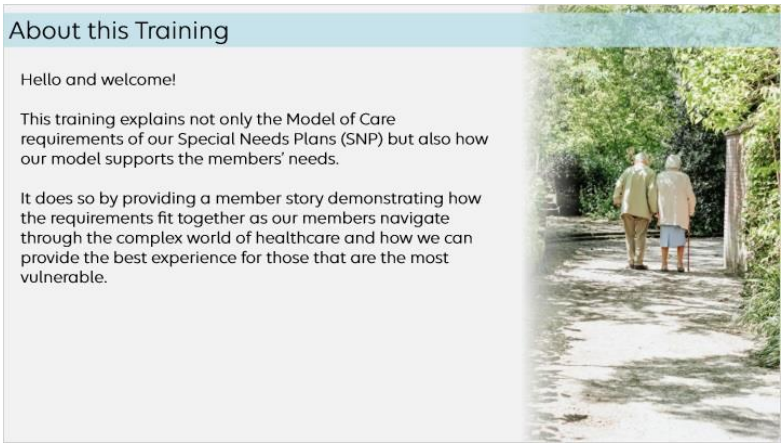
2025 SNP Model of Care

1. SNP Model of Care

1.1 Course Introduction

1.2 About this Training



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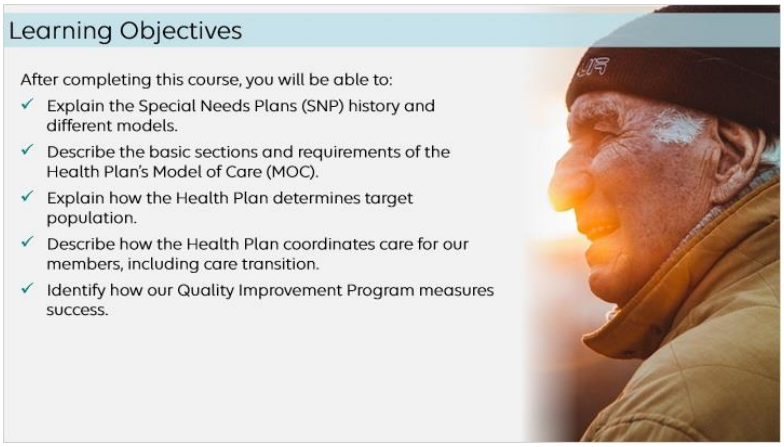
Hello and welcome!

This training explains not only the Model of Care requirements of our Special Needs Plans

(SNP) but also how our model supports the members' needs.

It does so by providing a member story demonstrating how the requirements fit together as our members navigate through the complex world of healthcare and how we can provide the best experience for those that are the most vulnerable.

1.3 Learning Objectives



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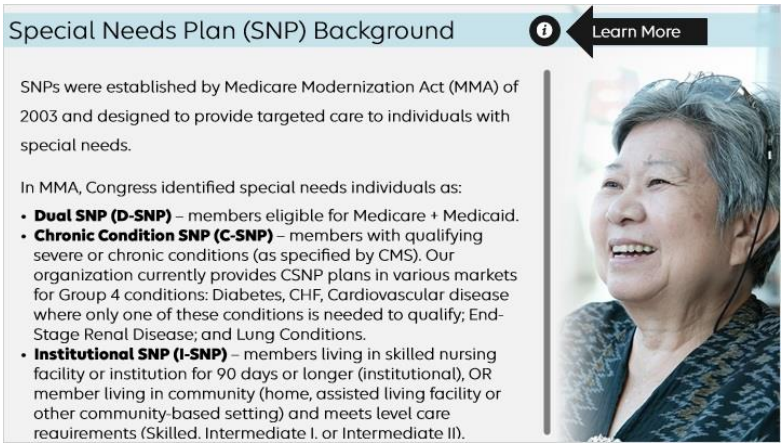
After completing this course, you will be able to:
- Explain the Special Needs Plans (SNP) history and different models.
- Describe the basic sections and requirements of the Health Plan's Model of Care (MOC).
- Explain how the Health Plan determines target population.
- Describe how the Health Plan coordinates care for our members, including care transition.
- Identify how our Quality Improvement Program measures success.

1.4 Model of Care Background



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Established by Medicare Modernization Act (MMA) of 2003 and designed to provide targeted care to individuals with special needs

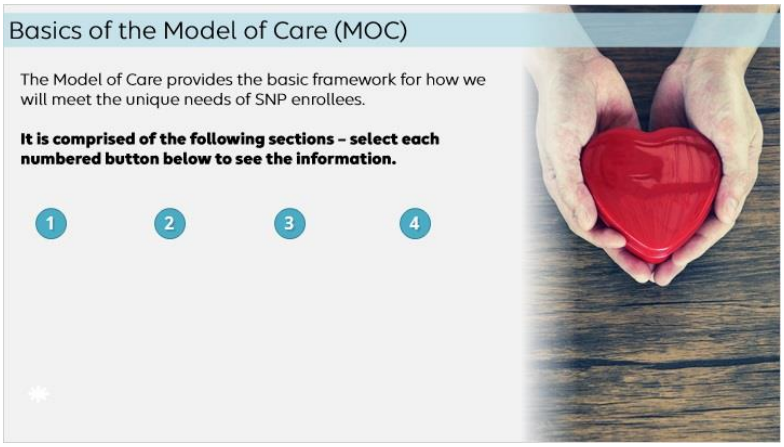
In MMA, Congress identified special needs individuals as:

- Dual SNP (D-SNP) – members eligible for Medicare + Medicaid.
- Chronic Condition SNP (C-SNP) – members with qualifying severe or chronic conditions (as specified by CMS) - Our organization currently provides CSNP plans in various markets for Group 4 conditions: Diabetes, CHF, Cardiovascular disease where only one of these conditions is needed to qualify; End-Stage Renal Disease; and Lung Conditions.
- Institutional SNP (I-SNP) – members living in skilled nursing facility or institution for 90 days or longer (institutional), OR member living in community (home, assisted living facility or other community-based setting) and meets level care requirements (Skilled, Intermediate I, or Intermediate II).

(Rollover Text / "Learn More")

SNPS
Special Needs Plans (SNPs) are different from most Medicare Advantage Plans as focus is on beneficiaries who have special needs & would benefit from enhanced care coordination as described in the Model of Care (MOC).

1.5 Basics of the Model of Care (MOC)



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Section 1856(f)(7) of the Patient Protection and Affordable Care Act stipulates that all Medicare Advantage Organizations (MAO)s offering **Special Needs Plans (SNPs)** must submit an evidence-based Model of Care (MOC) to CMS for the National Committee for Quality Assurance (NCQA) evaluation and approval in accordance with CMS guidance. As provided at 42 CFR §422.101(f) and §422.152(g), SNPs must develop and implement a MOC that provides the structure for care management processes and systems that will enable the health plan to provide coordinated care for special needs individuals. A MAO must develop separate MOCs to meet the needs of the targeted population for each SNP type it offers.

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The Model of Care provides the basic framework for how we will meet the unique needs of SNP enrollees.

It is comprised of the following sections:

1.MOC 1: Description of SNP Population
- Target Population
- Most Vulnerable Population

2.MOC 2: Care Coordination
- Mandated Health Risk Assessment and Annual Re-assessment
- Face-to-Face Encounter
- Individualized Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- Transitions of Care

3.MOC 3: Provider Network for D-SNP
- Specialized Expertise
- Use of Clinical Practice Guidelines and Transitions of Care Protocol

- Provider Network Training Initially and Annually

4.MOC 4: Quality Measurement & Performance Improvement

1.6 MOC 1: Determining Target Population

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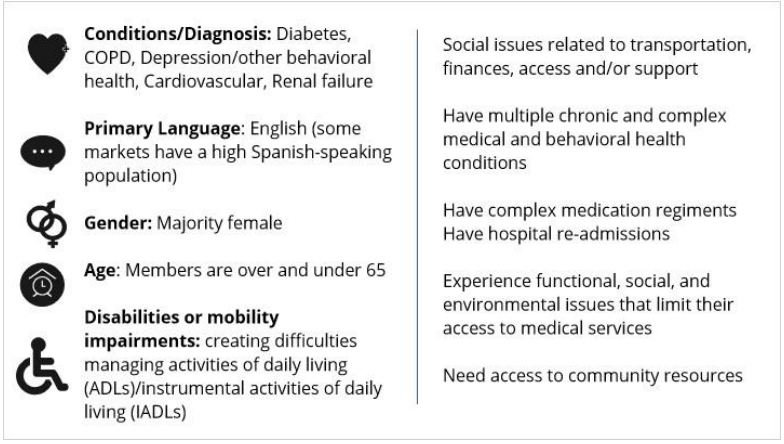
Determining our target population and those members that are considered the most vulnerable is part of the MOC requirements.
We perform a population assessment that includes both internal and external information about the population in each market.
We evaluate social, environmental, medical, and demographic factors to determine the needs of the population we serve in our SNP plan.
This assessment helps us to determine if we have the correct network and programs in place to assist us in managing those most in need.
Below is an example of the results of a population assessment and some of the needs that have been identified that may impact the care our members require.



1.7 MOC 2: Care Coordination

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Care Coordination ensures health needs of beneficiaries of a SNP are coordinated & health needs information is shared among inter-disciplinary staff of health plan and PCP.

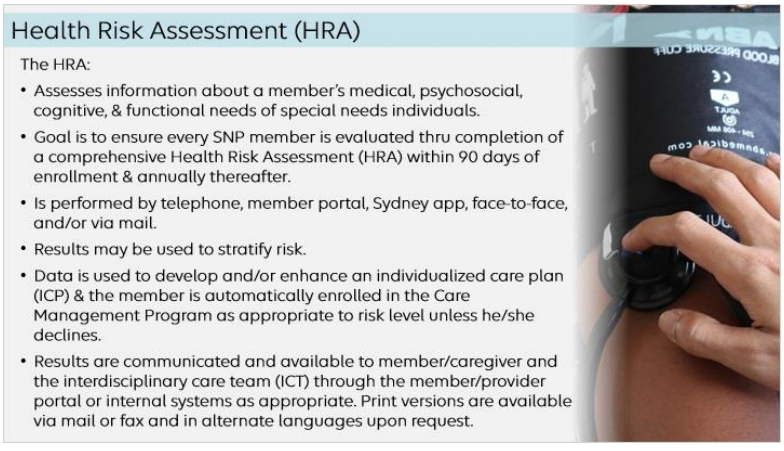
It coordinates delivery of services & specialized benefits that meet needs of most vulnerable population in a SNP.

Health Plan associates perform health risk assessments (HRAs) and develop an Individualized Care Plan (ICP) for all members.

All members have an established Inter-Disciplinary Care Team (ICT).

Health Plan associates manage Care Transitions when members experience a significant change in health status.

1.8 Health Risk Assessment (HRA)



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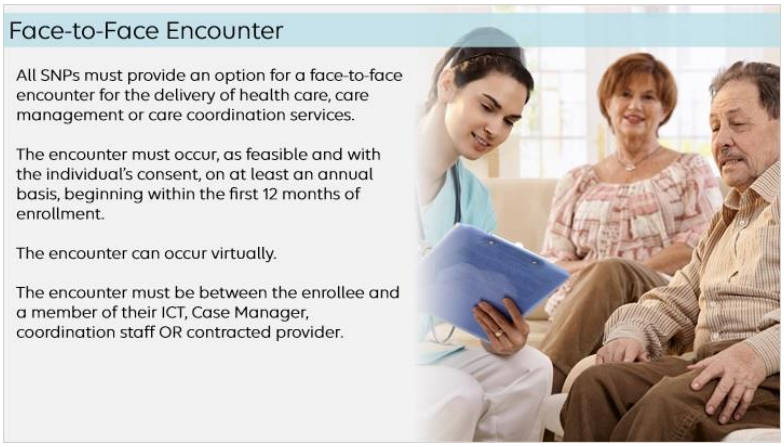
The HRA:

- Assesses information about a member's medical, psychosocial, cognitive, & functional needs of special needs individuals.
- Goal is to ensure every SNP member is evaluated thru completion of a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment & annually thereafter.
- Is performed by telephone, member portal, Sydney app, face-to-face, and/or via mail.
- Results may be used to stratify risk.
- Data is used to develop and/or enhance an individualized care plan (ICP) & the member is automatically enrolled in the Care Management Program as appropriate to risk level unless he/she declines.
- Results are communicated and available to member/caregiver and the interdisciplinary care team (ICT) through the member/provider portal or internal systems as appropriate. Print versions are available via mail or fax and in alternate languages upon request.

1.9 Face-to-Face Encounter



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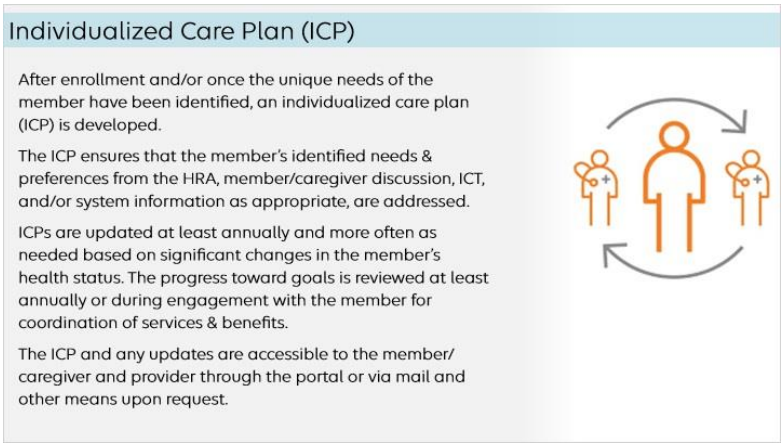
All SNPs must provide an option for a face-to-face encounter for the delivery of health care, care management or care coordination services.

The encounter must occur, as feasible and with the individual's consent, on at least an annual basis, beginning within the first 12 months of enrollment.

The encounter can occur virtually.

The encounter must be between the enrollee and a member of their ICT, Case Manager, coordination staff OR contracted provider.

1.10 Individualized Care Plan (ICP)



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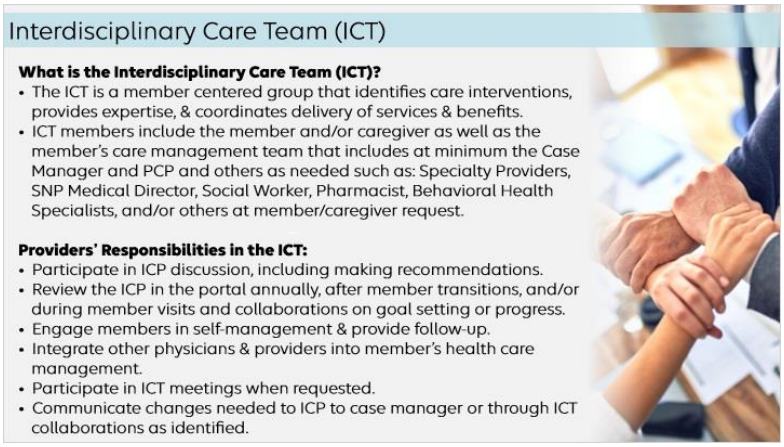
After enrollment and/or once the unique needs of the member have been identified, an individualized care plan (ICP) is developed.
The ICP ensures that the member's identified needs & preferences from the HRA, member/caregiver discussion, ICT, and/or system information as appropriate, are addressed.
ICPs are updated at least annually and more often as needed based on significant changes in the member's health status. The progress toward goals is reviewed at least annually or during engagement with the member for coordination of services & benefits.
The ICP and any updates are accessible to the member/caregiver and provider through the portal or via mail and other means upon request.

1.11 Interdisciplinary Care Team (ICT)



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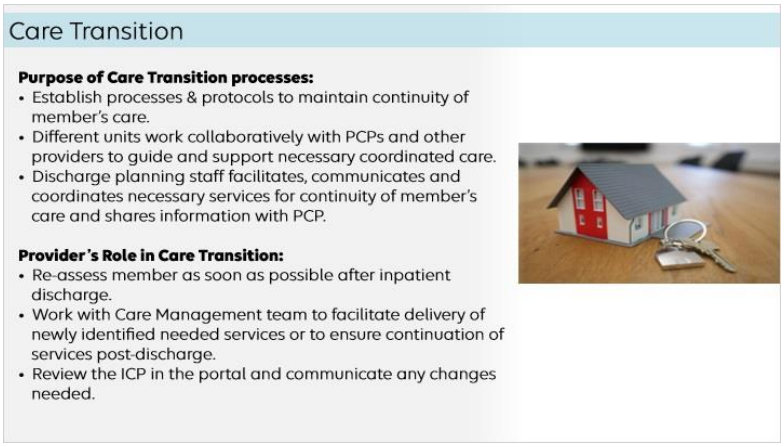
What is the Interdisciplinary Care Team (ICT)?

- The ICT is a member centered group that identifies care interventions, provides expertise, & coordinates delivery of services & benefits.
- ICT members include the member and/or caregiver as well as the member's care management team that includes at minimum the Case Manager and PCP and others as needed such as: Specialty Providers, SNP Medical Director, Social Worker, Pharmacist, Behavioral Health Specialists, and/or others at member/caregiver request.

Providers' Responsibilities in the ICT:

- Participate in ICP discussion, including making recommendations.
- Review the ICP in the portal annually, after member transitions, and/or during member visits and collaborations on goal setting or progress.
- Engage members in self-management & provide follow-up.
- Integrate other physicians & providers into member's health care management.
- Participate in ICT meetings when requested.
- Communicate changes needed to ICP to case manager or through ICT collaborations as identified.

1.12 Care Transition



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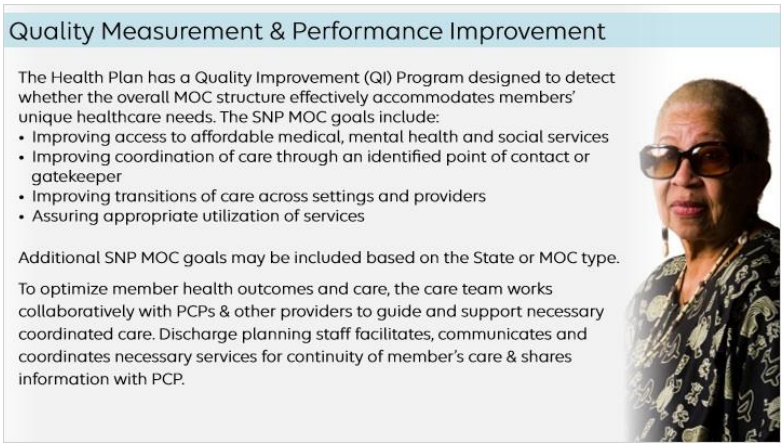
Purpose of Care Transition processes:

- Establish processes & protocols to maintain continuity of member's care.
- Different units work collaboratively with PCPs and other providers to guide and support necessary coordinated care.
- Discharge planning staff facilitates, communicates and coordinates necessary services for continuity of member's care and shares information with PCP.
-

Provider's Role in Care Transition:

- Re-assess member as soon as possible after inpatient discharge.
- Work with Care Management team to facilitate delivery of newly identified needed services or to ensure continuation of services post-discharge.
- Review the ICP in the portal and communicate any changes needed.

1.13 Quality Measurement & Performance Improvement



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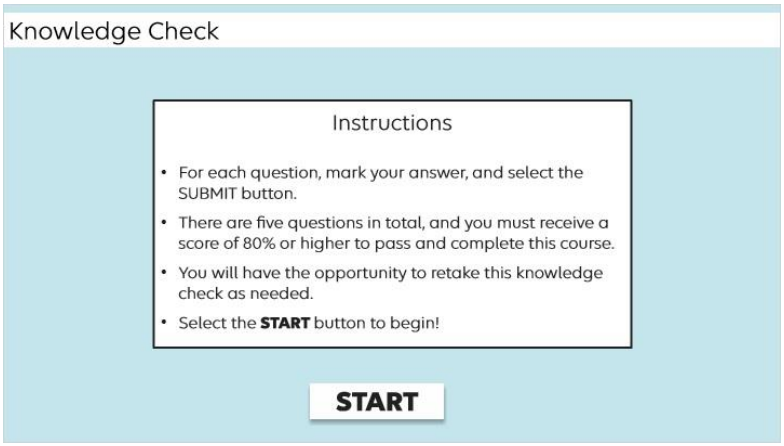
The Health Plan has a Quality Improvement (QI) Program designed to detect whether the overall MOC structure effectively accommodates members' unique healthcare needs. The SNP MOC goals include:

- Improving access to affordable medical, mental health and social services
- Improving coordination of care through an identified point of contact or gatekeeper
- Improving transitions of care across settings and providers
- Assuring appropriate utilization of services

Additional SNP MOC goals may be included based on the State or MOC type.
To optimize member health outcomes and care, the care team works collaboratively with PCPs & other providers to guide and support necessary coordinated care. Discharge planning staff facilitates, communicates and coordinates necessary services for continuity of member's care & shares information with PCP.

1.14 Knowledge Check

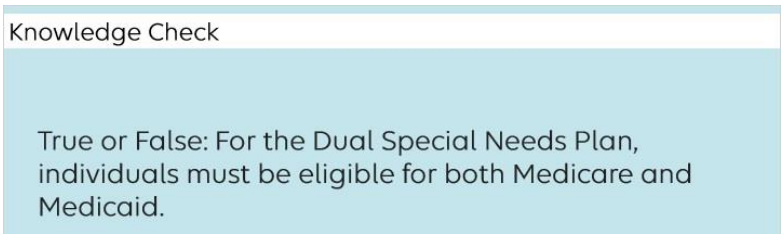


Notes:

It's time for a Knowledge Check! Review the question, mark your answer, and select the SUBMIT button to see if you are correct. There are ten questions in total, and you must receive a score of 80% or higher to pass and complete this course. You will have the opportunity to retake the knowledge check as needed. Select the START button to begin!

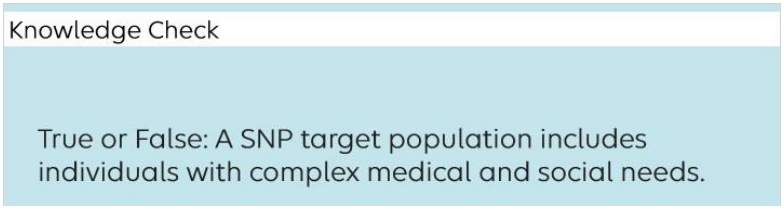
1.15 Knowledge Check: Dual Special Needs Plan

True or False: For the Dual Special Needs Plan, individuals must be eligible for both Medicare and Medicaid.



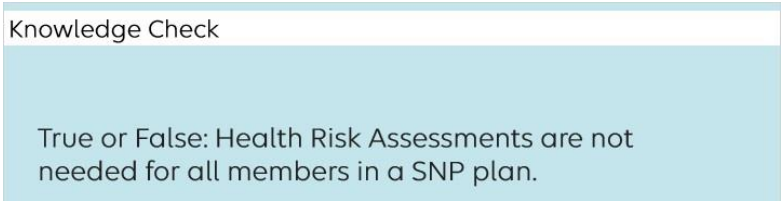
1.16 Knowledge Check: SNP Target Population

True or False: A SNP target population includes individuals with complex medical and social needs.



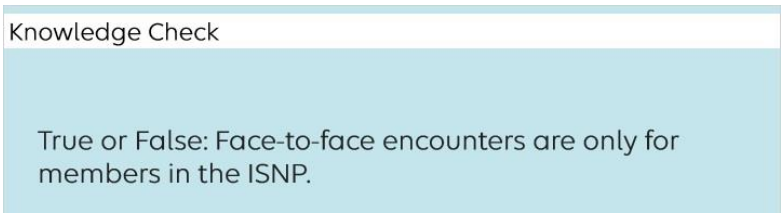
1.17 Knowledge Check: Health Risk Assessments

True or False: Health Risk Assessments are not needed for all members in a SNP plan.



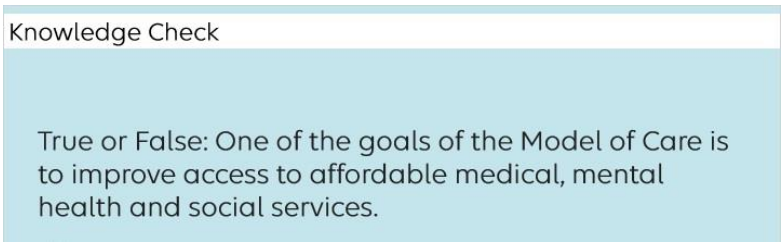
1.18 Knowledge Check: Face-to-face Encounters

True or False: Face-to-face encounters are only for members in the ISNP.

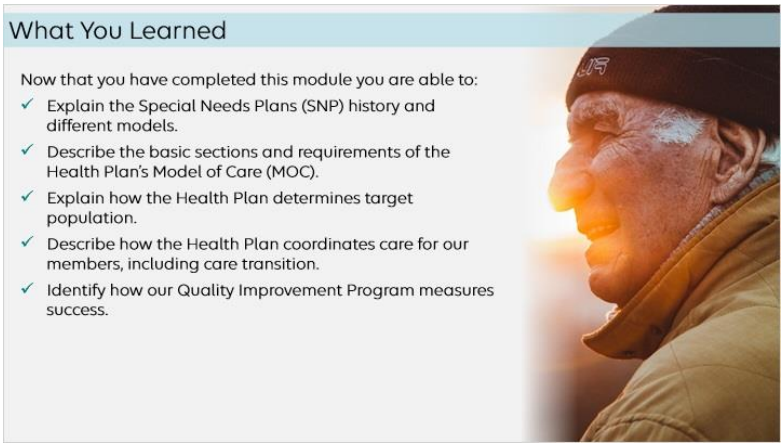


1.19 Knowledge Check: Model of Care Goals

True or False: One of the goals of the Model of Care is to improve access to affordable medical, mental health and social services.



1.21 What You Learned



Notes:

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Now that you have completed this module you are able to:
- Explain the Special Needs Plans (SNP) history and different models.
- Describe the basic sections and requirements of the Health Plan's Model of Care (MOC)
- Explain how the Health Plan determines target population

- Describe how the Health Plan coordinates care for our members, including care transition
- Identify how our Quality Improvement Program measures success

1.22 Close