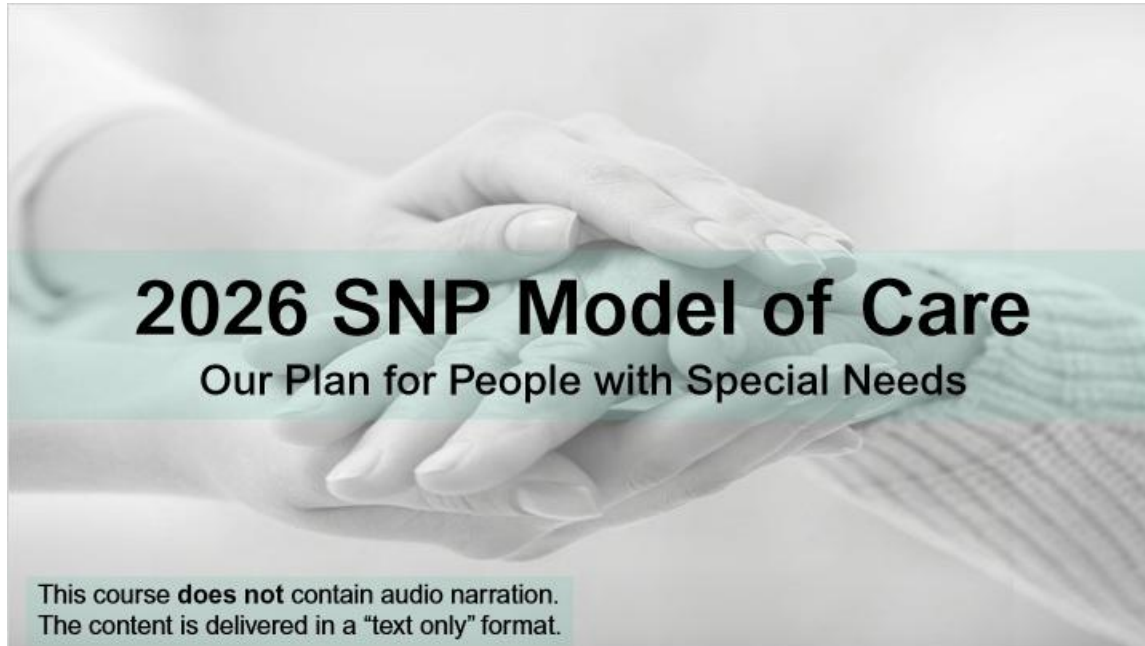


2026 SNP Model of Care

1. SNP Model of Care

1.1 Title



2026 SNP Model of Care

Our Plan for People with Special Needs

This course **does not** contain audio narration.
The content is delivered in a "text only" format.

Notes:

1.2 About This Training

About This Training

Hello and welcome!

In this training, you will delve into the Model of Care requirements for Elevance Health's Special Needs Plans (SNP), highlighting how the organization's approach is designed to support the unique needs of members. You'll discover how these requirements seamlessly integrate to guide members through the intricate healthcare landscape, ensuring the best possible experience for our members and providing enhanced care for the most vulnerable.



Notes:

(Slide Text)

In this training, you will delve into the Model of Care requirements for Elevance Health's Special Needs Plans (SNPs), highlighting how the organization's approach is designed to support the unique needs of members. You'll discover how these requirements seamlessly integrate to guide members through the intricate healthcare landscape, ensuring the best possible experience for our members and providing enhanced care for the most vulnerable.

1.3 Learning Objectives

Learning Objectives

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 the target population.
- ✓ Describe how the Health Plan coordinates care for members, including care transition.
- ✓ Identify how Elevance Health's Quality Improvement Program measures success.



Notes:

(Slide Text)

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 the target population.
- Describe how the Health Plan coordinates care for members, including care transition.
- Identify how Elevance Health's Quality Improvement Program measures success.

1.4 SNP Background

Special Needs Plan (SNP) Background

[Learn More](#)

SNPs were established by the Medicare Modernization Act (MMA) of 2003 and are designed to provide targeted care for individuals with special needs.


In the MMA, Congress identified special needs individuals as Dual SNP (D-SNP), Chronic Condition SNP (C-SNP), and Institutional SNP (I-SNP).

Select each button below to learn more about each designation.

[D-SNP](#)

[C-SNP](#)

[I-SNP](#)



D-SNP (Slide Layer)

Special Needs Plan (SNP) Background

[Learn More](#)

SNPs were established by the Medicare Modernization Act (MMA) of 2003 and are designed to provide targeted care for individuals with special needs.

In the MMA, Congress identified special needs individuals as Dual SNP (D-SNP), Chronic Condition SNP (C-SNP), and Institutional SNP (I-SNP).

Select each button below to learn more about each designation.

[D-SNP](#)

[C-SNP](#)

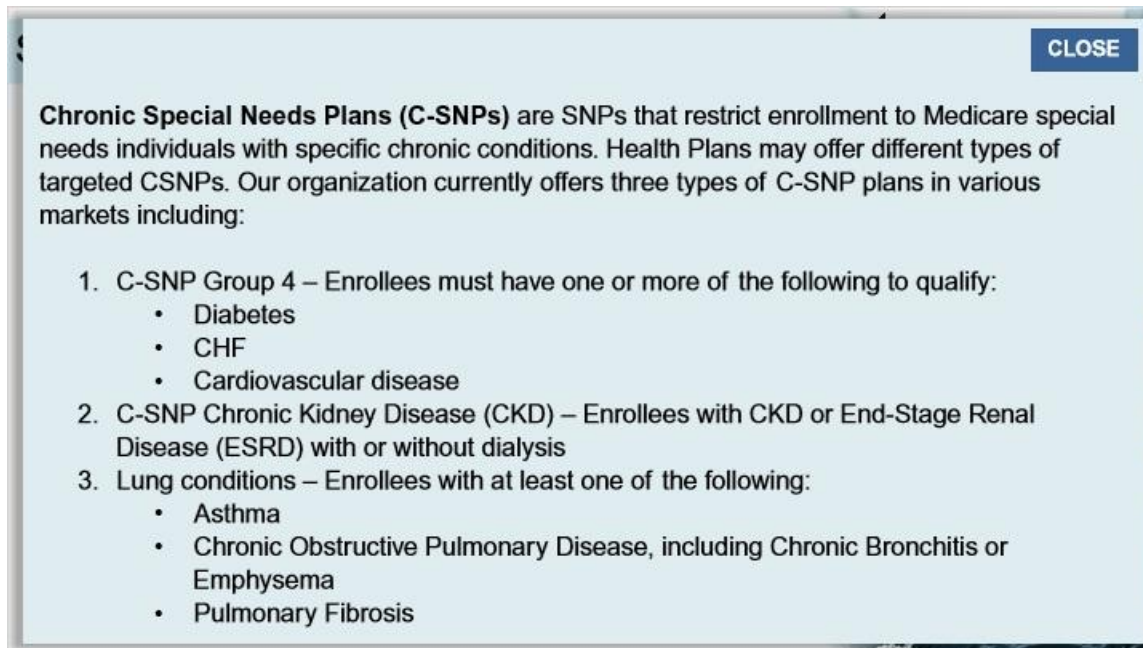
[I-SNP](#)

[CLOSE](#)

Dual Special Needs Plans (D-SNPs) are for enrollees with both Medicare and Medicaid eligibility.



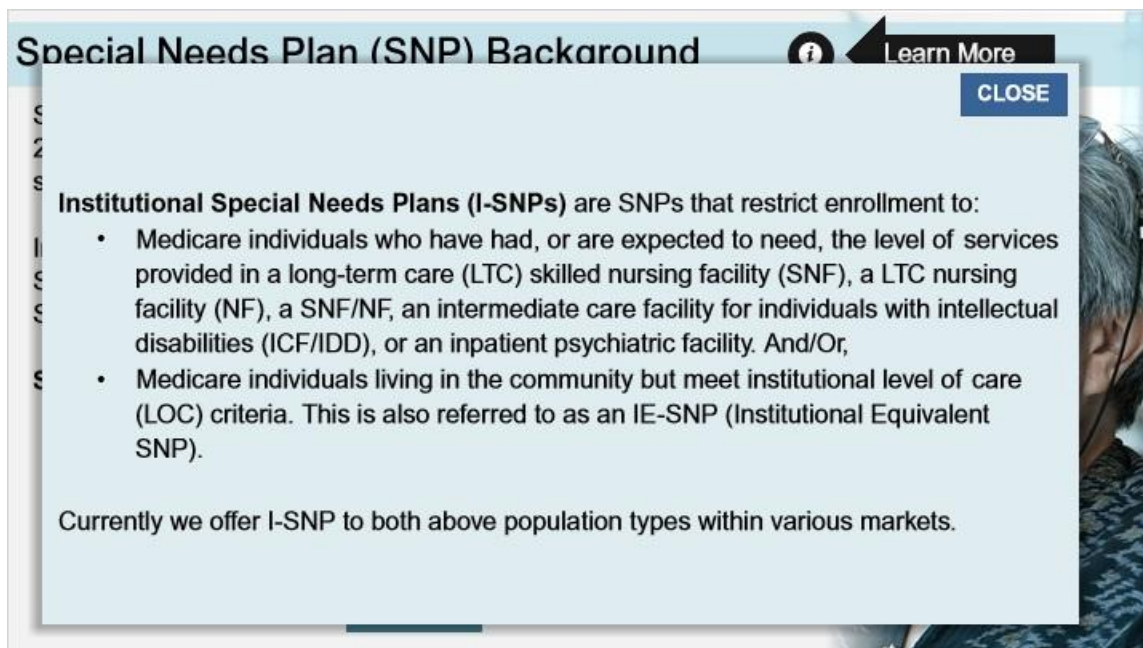
C-SNP (Slide Layer)

A slide layer with a light blue background and a dark blue 'CLOSE' button in the top right corner. The text describes Chronic Special Needs Plans (C-SNPs) and lists three types of plans with their respective qualification criteria.

Chronic Special Needs Plans (C-SNPs) are SNPs that restrict enrollment to Medicare special needs individuals with specific chronic conditions. Health Plans may offer different types of targeted CSNPs. Our organization currently offers three types of C-SNP plans in various markets including:

1. C-SNP Group 4 – Enrollees must have one or more of the following to qualify:
 - Diabetes
 - CHF
 - Cardiovascular disease
2. C-SNP Chronic Kidney Disease (CKD) – Enrollees with CKD or End-Stage Renal Disease (ESRD) with or without dialysis
3. Lung conditions – Enrollees with at least one of the following:
 - Asthma
 - Chronic Obstructive Pulmonary Disease, including Chronic Bronchitis or Emphysema
 - Pulmonary Fibrosis

I-SNP (Slide Layer)

A slide layer with a light blue background and a dark blue 'CLOSE' button in the top right corner. The text describes Institutional Special Needs Plans (I-SNPs) and lists two types of individuals eligible for enrollment. A 'Learn More' button is visible in the background.

Special Needs Plan (SNP) Background [Learn More](#)

Institutional Special Needs Plans (I-SNPs) are SNPs that restrict enrollment to:

- Medicare individuals who have had, or are expected to need, the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility. And/Or,
- Medicare individuals living in the community but meet institutional level of care (LOC) criteria. This is also referred to as an IE-SNP (Institutional Equivalent SNP).

Currently we offer I-SNP to both above population types within various markets.

Notes:

(Rollover Text / "Learn More")

SNPS

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

(Main Slide Text)

SNPs were established by the Medicare Modernization Act (MMA) of 2003 and are designed to provide targeted care for individuals with special needs.

In the MMA, Congress identified special needs individuals as Dual SNP (D-SNP), Chronic Condition SNP (C-SNP), and Institutional SNP (I-SNP).

Select each button below to learn more about each designation.

(D-SNP Button Text)

Dual Special Needs Plans (D-SNPs) are for enrollees with both Medicare and Medicaid eligibility.

(C-SNP Button Text)

Chronic Special Needs Plans (C-SNPs) are SNPs that restrict enrollment to Medicare special needs individuals with specific chronic conditions. Health Plans may offer different types of targeted CSNPs. Our organization currently offers three types of C-SNP plans in various markets including:

1. C-SNP Group 4 – Enrollees must have one or more of the following to qualify:
 - Diabetes
 - CHF
 - Cardiovascular disease
2. C-SNP Chronic Kidney Disease (CKD) – Enrollees with CKD or End-Stage Renal Disease (ESRD) with or without dialysis
3. Lung conditions – Enrollees with at least one of the following:
 - Asthma
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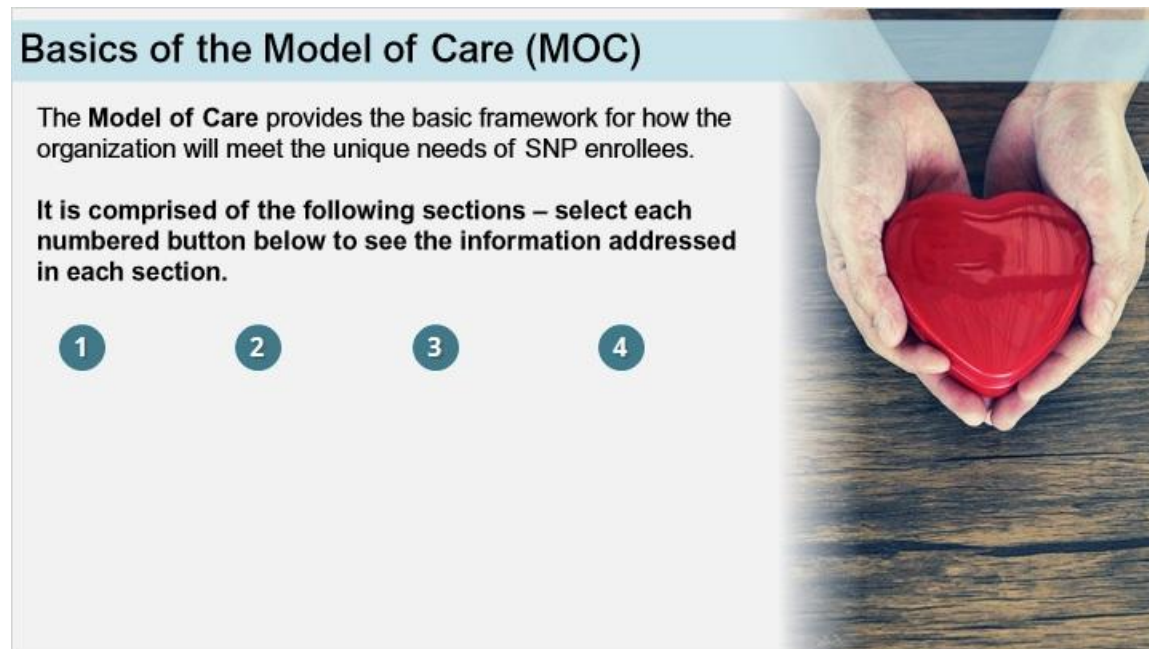
(I-SNP Button Text)

Institutional Special Needs Plans (I-SNPs) are SNPs that restrict enrollment to:

- Medicare individuals who have had, or are expected to need, the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility. And/Or,
- Medicare individuals living in the community but meet institutional level of care (LOC) criteria. This is also referred to as an IE-SNP (Institutional Equivalent SNP).

Currently we offer I-SNP to both above population types within various markets.

1.5 Basics of the Model of Care (MOC)



Basics of the Model of Care (MOC)

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

It is comprised of the following sections – select each numbered button below to see the information addressed in each section.

1 2 3 4

The slide features a light blue header with the title. Below the title, there is a paragraph of text, followed by another paragraph of text. At the bottom of the text area, there are four circular buttons numbered 1 through 4. To the right of the text area is a photograph of two hands holding a red heart over a wooden surface.

Notes:

(Slide Text)

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

It is comprised of the following sections – select each numbered button below to see the information addressed in each section.

1. Description of SNP Population

- Target Population – Overall population to be served
- Most Vulnerable Population – High-risk subset of the overall population

2. Care Coordination

- Initial Health Risk Assessment and Annual Re-assessment
- Face-to-Face Encounter
- Individualized Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- Transitions of Care

3. Provider Network

- Specialized Expertise
- Use of Clinical Practice Guidelines and Transitions of Care Protocol
- Provider Network Training Initially and Annually

4. Quality Measurement & Performance Improvement

- MOC Quality Improvement Plan
- Measurable Goals and Health Outcomes for MOC
- Measuring Patient Experience of Care (SNP Enrollee Satisfaction)
- Ongoing Performance Improvement Evaluation of the MOC
- Dissemination of SNP Quality Performance Related to the MOC

1.6 Basics of the Model of Care (MOC) (cont'd)

Basics of the Model of Care (MOC)

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

Note: Section 1856(f)(7) of the Patient Protection and Affordable Care Act requires all Medicare Advantage Organizations (MAOs) offering **Special Needs Plans (SNPs)** to submit an evidence-based Model of Care (MOC) for evaluation and approval by the National Committee for Quality Assurance (NCQA), following CMS guidelines. According to 42 CFR §422.101(f) and §422.152(g), SNPs must develop and implement an MOC that outlines the care management processes and systems needed to deliver coordinated care to special needs individuals. Each MAO must create separate MOCs tailored to the targeted population for each type of SNP it offers.



Notes:

(Slide Text)

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.

1.7 Determining Target Population

Determining Target Population

Determining the target population and identifying members who are considered the most vulnerable is part of the MOC requirements.

A population assessment is conducted that includes both internal and external information about the population in each market.






Social, environmental, medical, and demographic factors are evaluated to determine the needs of the population served in the SNP plan.

This assessment helps determine whether the correct network, benefits, and programs are in place to manage those who are most in need.

Select the button below to view an example of the results of a population assessment and some of the needs that have been identified, which may impact the care required.

[Example](#)



Population assessment results:	Identified needs:
 Conditions/Diagnosis: Diabetes, COPD, Depression/other behavioral health, Cardiovascular, Renal failure	Social issues related to transportation, finances, access and/or support
 Primary Language: English (some markets have a high Spanish-speaking population)	Have multiple chronic and complex medical and behavioral health conditions
 Gender: Majority female	Have complex medication regimens Have hospital re-admissions
 Age: Members are over and under 65	Experience functional, social, and environmental issues that limit their access to medical services
 Disabilities or mobility impairments: creating difficulties managing activities of daily living (ADLs)/instrumental activities of daily living (IADLs)	Need access to community resources

Notes:

(Slide Text)

Determining the target population and identifying members who are considered the most vulnerable is part of the MOC requirements.

A population assessment is conducted that includes both internal and external information about the population in each market.

Social, environmental, medical, and demographic factors are evaluated to determine the needs of the population served in the SNP plan.

This assessment helps determine whether the correct network, benefits, and programs are in place to manage those who are most in need.

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• **(Example Button Text)**

Population assessment results:

Conditions/Diagnosis: Diabetes, COPD, Depression/other behavioral health, Cardiovascular, Renal failure

Primary Language: English (some markets have a high Spanish-speaking population)

Gender: Majority female

Age: Members are over and under 65

Disabilities or mobility impairments: creating difficulties managing activities of daily living (ADLs)/instrumental activities of daily living (IADLs)

- Identified needs:
 - Social issues related to transportation, finances, access and/or support
 - Have multiple chronic and complex medical and behavioral health conditions
 - Have complex medication regimens
 - Have hospital re-admissions
 - Experience functional, social, and environmental issues that limit their access to medical services
 - Need access to community resources

1.8 Care Coordination

Care Coordination


Care Coordination ensures the health needs of SNP members are organized and that pertinent information is shared appropriately with their interdisciplinary care team (ICT).

It organizes the delivery of services and specialized benefits to meet the needs of the target and most vulnerable population in an SNP.

Health plan associates and delegates, where applicable, conduct or review health risk assessments (HRAs) and use this as a basis to develop an individualized care plan (ICP) for each member.

All members have an established interdisciplinary care team (ICT).

Care coordination is provided for care transitions when members move between healthcare settings or experience a significant change in health status.



Notes:

(Slide Text)

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All members have an established interdisciplinary care team (ICT).

Care coordination is provided for care transitions when members move between healthcare settings or experience a significant change in health status.

1.9 Health Risk Assessment (HRA)

Health Risk Assessment (HRA)

The HRA:

- Assesses information about a member's health conditions, psychosocial, cognitive, functional, and health-related social needs.
- The goal is to ensure every SNP member is evaluated through the completion of a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment and annually thereafter, or sooner if there is a significant change in health.
- It is performed by telephone, electronically (e.g., online, email, SMS), face-to-face, and/or via mail.
- Results are used as one method of stratifying risk.
- Data is used to develop and/or enhance an Individualized Care Plan (ICP), and the member is automatically enrolled in the Care Management Program as appropriate to the risk level unless they decline.
- Results are communicated and made available to the member/caregiver and the interdisciplinary care team (ICT) through various means as appropriate, including the member/provider portal, internal systems, email, and print versions (via mail or fax), and in alternate languages upon request.



Notes:

(Slide Text)

The HRA:

- Assesses information about a member's health conditions, psychosocial, cognitive, functional, and health-related social needs.
- The goal is to ensure every SNP member is evaluated through the completion of a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment and annually thereafter, or sooner if there is a significant change in health.
- It is performed by telephone, electronically (e.g., online, email, SMS), face-to-face, and/or via mail.
- Results are used as one method of stratifying risk.
- Data is used to develop and/or enhance an Individualized Care Plan (ICP), and the member is automatically enrolled in the Care Management Program as appropriate to the risk level unless they decline.
- Results are communicated and made available to the member/caregiver and the interdisciplinary care team (ICT) through various means as appropriate, including the member/provider portal, internal systems, email, and print versions (via mail or fax), and in alternate languages upon request.

1.10 Face-to-Face Encounter

Face-to-Face Encounter

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, at least once annually, beginning within the first 12 months of enrollment.

The encounter can occur either in person or through a visual, real-time, interactive telehealth encounter.

The encounter must be between the enrollee and a member of their ICT, a case manager, coordination staff, or a contracted health care provider.



Notes:

(Slide Text)

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The encounter must be between the enrollee and a member of their ICT, a case manager, coordination staff, or a contracted health care provider.

1.11 Individualized Care Plan (ICP)

Individualized Care Plan (ICP)

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 electronically (e.g., secure online or via email) or via mail and other means upon request.



Notes:

(Slide Text)

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.

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1.12 Interdisciplinary Care Team (ICT)

Interdisciplinary Care Team (ICT)

What is the Interdisciplinary Care Team (ICT)?

The ICT is a team of professionals from various disciplines that work together with the member/caregiver to manage their individualized care. At minimum, each member's ICT is composed of the member/caregiver, care manager and primary care provider. Additional participants, such as specialty providers, the SNP medical director, social workers, pharmacists, and behavioral health specialists, may be involved as needed or upon request.

Providers' Responsibilities in the ICT:

- Participate in ICP discussions, 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 and provide follow-up.
- Integrate other physicians and providers into the member's health care management.
- Participate in ICT meetings when requested.
- Communicate any changes needed to the ICP to the case manager or through ICT collaborations as **identified**.



Notes:

(Slide Text)

What is the Interdisciplinary Care Team (ICT)?

The ICT is a team of professionals from various disciplines that work together with the member/caregiver to manage their individualized care. At minimum, each member's ICT is composed of the member/caregiver, care manager and primary care provider. Additional participants, such as specialty providers, the SNP medical director, social workers, pharmacists, and behavioral health specialists, may be involved as needed or upon request.

Providers' Responsibilities in the ICT:

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- 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 and provide follow-up.
- Integrate other physicians and providers into the member's health care management.
- Participate in ICT meetings when requested.
- Communicate any changes needed to the ICP to the case manager or through ICT collaborations as **identified**.

1.13 Care Transition

Care Transition

Purpose of Care Transition Processes:

- Establish processes and protocols to ensure members move smoothly between care settings -such as from a hospital, skilled nursing facility, or behavioral health facility back to the home or community—**without disruption in care or service.**
- Care teams work collaboratively with members, PCPs and other providers to guide and support transitional care.

Provider's Role in Care Transition:

- Reassess the member as soon as possible after inpatient discharge.
- Collaborate with the care management team to facilitate the delivery of newly identified services or ensure continuation of services post-discharge.
- Review the ICP in the portal and communicate any changes needed.



Notes:

(Slide Text)

Purpose of Care Transition Processes:

- Establish processes and protocols to ensure members move smoothly between care settings -such as from a hospital, skilled nursing facility, or behavioral health facility back to the home or community—**without disruption in care or service.**
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Provider's Role in Care Transition:

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Collaborate with the care management team to facilitate the delivery of newly identified services or ensure continuation of services post-discharge.

Review the ICP in the portal and communicate any changes needed.

1.14 Quality Measurement & Performance Improvement

Quality Measurement & Performance Improvement

The Health Plan has a Quality Improvement (QI) Program designed to assess whether the overall MOC structure effectively accommodates members' unique healthcare needs. The SNP MOC goals include, but are not limited to:

- Improving access to affordable medical, mental health, and social services
- Improving health outcomes and the use of preventive health services
- Improving coordination of care

Additional SNP MOC goals may be included based on the state or MOC type. MOC goals are measured using a combination of clinical outcome metrics, care coordination performance, member experience and satisfaction, and quality improvement metrics. These may include HEDIS and Star ratings; completion of HRAs, ICTs, ICPs; CAHPs survey results; and utilization goals such as reducing ER and admission rates.



Notes:

(Slide Text)

The Health Plan has a Quality Improvement (QI) Program designed to assess whether the overall MOC structure effectively accommodates members' unique healthcare needs. The SNP MOC goals include, but are not limited to:

- Improving access to affordable medical, mental health, and social services
- Improving health outcomes and the use of preventive health services

Improving coordination of care

Additional SNP MOC goals may be included based on the state or MOC type. MOC goals are measured using a combination of clinical outcome metrics, care coordination performance, member experience and satisfaction, and quality improvement metrics. These may include HEDIS and Star ratings; completion of HRAs, ICTs, ICPs; CAHPs survey results; and utilization goals such as reducing ER and admission rates.

1.15 Knowledge Check

Knowledge Check

Instructions

For each question, mark your answer, and select the SUBMIT button.

There are five 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 this knowledge check as needed.

Select the **START** button to begin!

START

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!

1.16 Knowledge Check: Dual Special Needs Plan

(Multiple Choice, 0 points, 1 attempt permitted)

Knowledge Check

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

- True
 False

Correct	Choice
X	True
	False

1.17 Knowledge Check: SNP Target Population

(Multiple Choice, 0 points, 1 attempt permitted)

Knowledge Check

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

- True
 False

Correct	Choice
X	True
	False

1.18 Knowledge Check: Health Risk Assessments

(Multiple Choice, 0 points, 1 attempt permitted)

Knowledge Check

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

- True
- False

Correct	Choice
	True
X	False

1.19 Knowledge Check: Face-to-face Encounters

(Multiple Choice, 0 points, 1 attempt permitted)

Knowledge Check

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

- True
- False

Correct	Choice
	True
X	False

1.20 Knowledge Check: Model of Care Goals

(Multiple Choice, 0 points, 1 attempt permitted)

Knowledge Check

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

- True
 False

Correct	Choice
X	True
	False

1.21 RESULTS

(Results Slide, 0 points, 1 attempt permitted)

RESULTS

YOUR SCORE: 0%
PASSING SCORE: 0%

Results for

1.16 Knowledge Check: Dual Special Needs Plan

1.17 Knowledge Check: SNP Target Population

1.18 Knowledge Check: Health Risk Assessments

1.19 Knowledge Check: Face-to-face Encounters

1.20 Knowledge Check: Model of Care Goals

Result slide properties

Passing Score

80%

Notes:

Success (Slide Layer)



A slide layer with a light blue background. At the top center is a white circle containing a blue checkmark. Below it is the word "RESULTS" in large, bold, black capital letters. Underneath is the text "GOOD JOB! YOU PASSED THE COURSE!". Below that is a paragraph: "Select the **REVIEW QUESTIONS** button to review your answers, or select the **NEXT** button to continue." In the center is a white rectangular box containing two lines of text: "YOUR SCORE: 0%" and "PASSING SCORE: 0%", where the percentages are displayed in a yellow progress bar style. At the bottom center is a blue button with the text "REVIEW QUESTIONS" in white capital letters.

RESULTS

GOOD JOB! YOU PASSED THE COURSE!

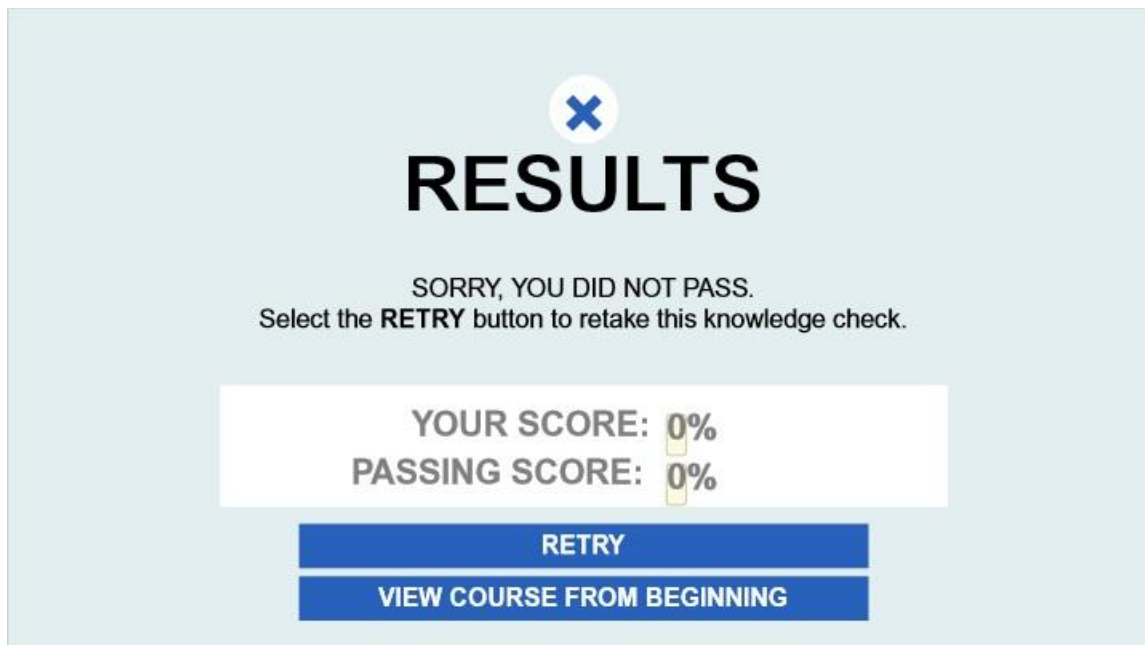
Select the **REVIEW QUESTIONS** button to review your answers, or select the **NEXT** button to continue.

YOUR SCORE: 0%

PASSING SCORE: 0%

REVIEW QUESTIONS

Failure (Slide Layer)



A slide layer with a light blue background. At the top center is a white circle containing a blue 'X'. Below it is the word "RESULTS" in large, bold, black capital letters. Underneath is the text "SORRY, YOU DID NOT PASS.". Below that is a paragraph: "Select the **RETRY** button to retake this knowledge check." In the center is a white rectangular box containing two lines of text: "YOUR SCORE: 0%" and "PASSING SCORE: 0%", where the percentages are displayed in a yellow progress bar style. At the bottom center are two blue buttons stacked vertically. The top button has the text "RETRY" in white capital letters, and the bottom button has the text "VIEW COURSE FROM BEGINNING" in white capital letters.

RESULTS

SORRY, YOU DID NOT PASS.

Select the **RETRY** button to retake this knowledge check.

YOUR SCORE: 0%

PASSING SCORE: 0%

RETRY

VIEW COURSE FROM BEGINNING

1.22 What You Learned

What You Learned

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 the target population.
- ✓ Describe how the Health Plan coordinates care for members, including care transition.
- ✓ Identify how Elevance Health's Quality Improvement Program measures success.



Notes:

(Slide Text)

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

1.23 Close



2026 SNP Model of Care
Our Plan for People with Special Needs

Thank you for learning!
Select the **Exit** button to be marked complete and close the course.

Exit

Notes: