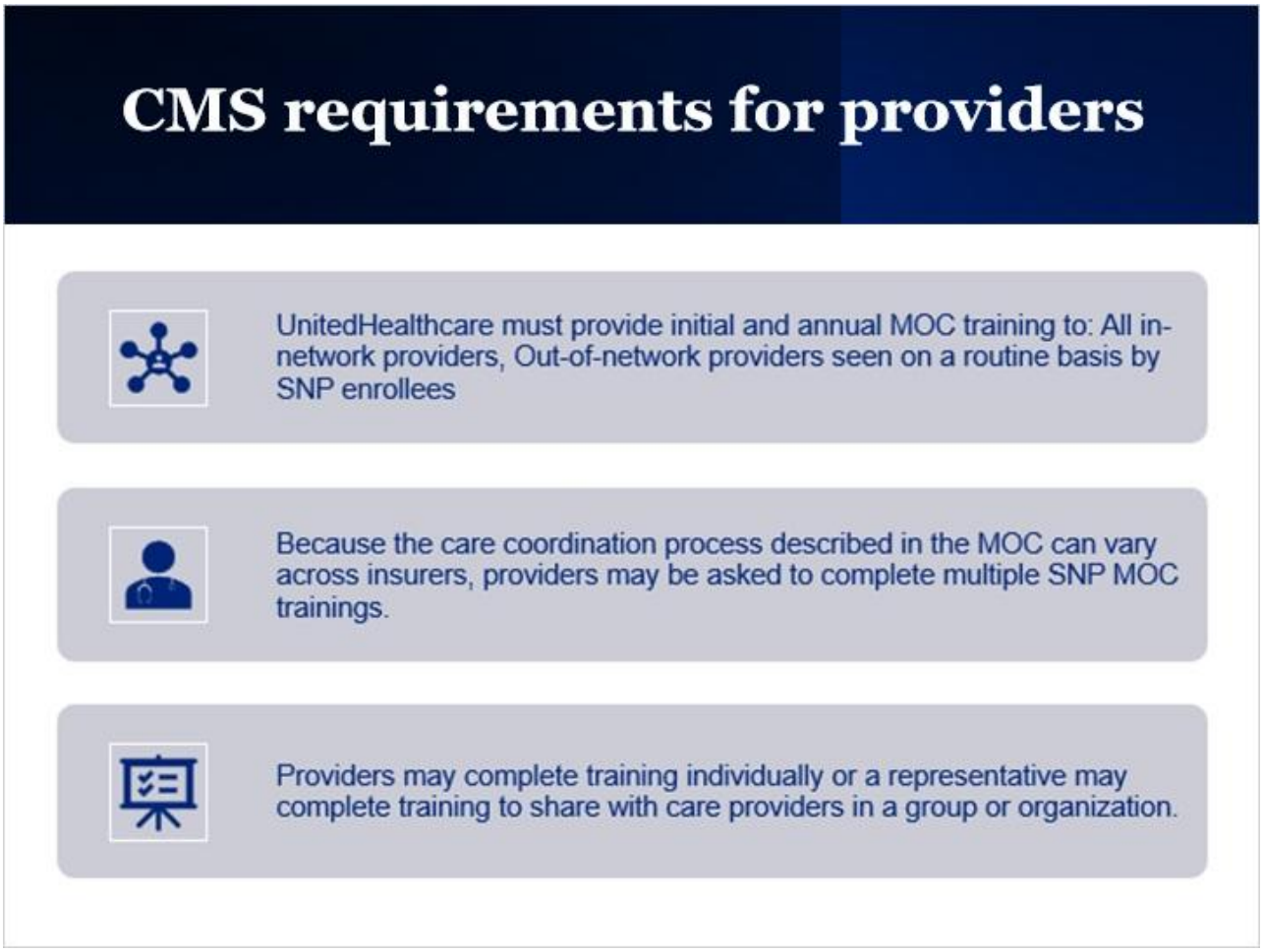
Special Needs Plan Model of Care Training 2026-Provider



Notes:

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1.2 CMS requirements for staff



1.3 CMS requirements for staff

CMS Requirements For Employees

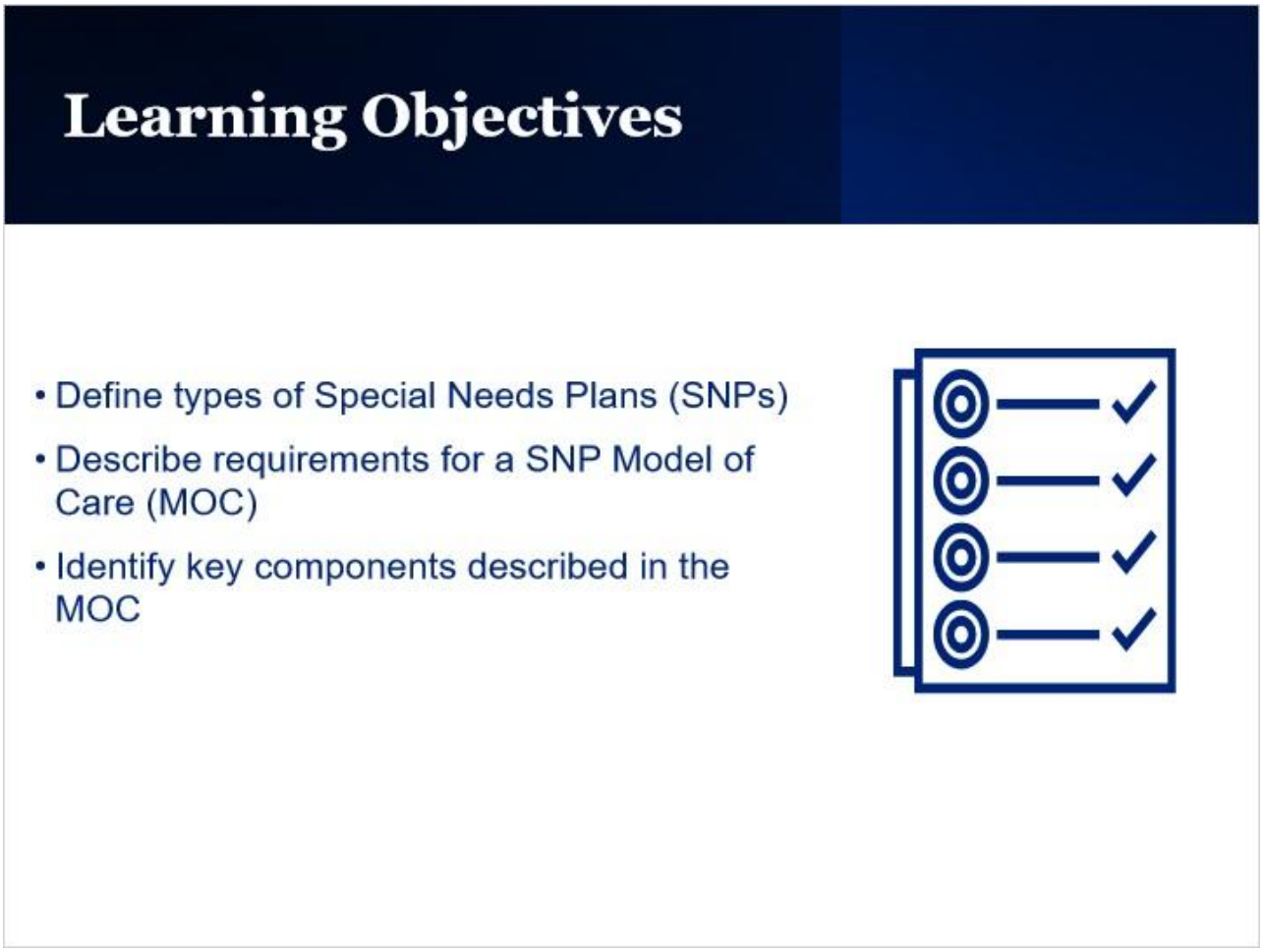
The Centers for Medicare & Medicaid Services (CMS) requires initial and annual Model of Care (MOC) training.

Special Needs Plan (SNP) staff must complete initial and annual MOC training:

- All employed and contracted SNP staff
- Staff across all health plan functions of SNPs
- Staff who directly or indirectly affect care coordination for SNP members

Included roles, but not limited to:		
Appeals & Grievances	Clinical Support	Network Adequacy
Behavioral Health Counseling	Credentialing	Pharmacy Consultation
Case Management	Customer Service	Quality Management
Claims Processing	Data Analytics	Staff Education
Claims Verification	Enrollment & Eligibility	
Clinical Administrative Coordinators	Medical Management	

1.4 What is a special needs plan (SNP)?



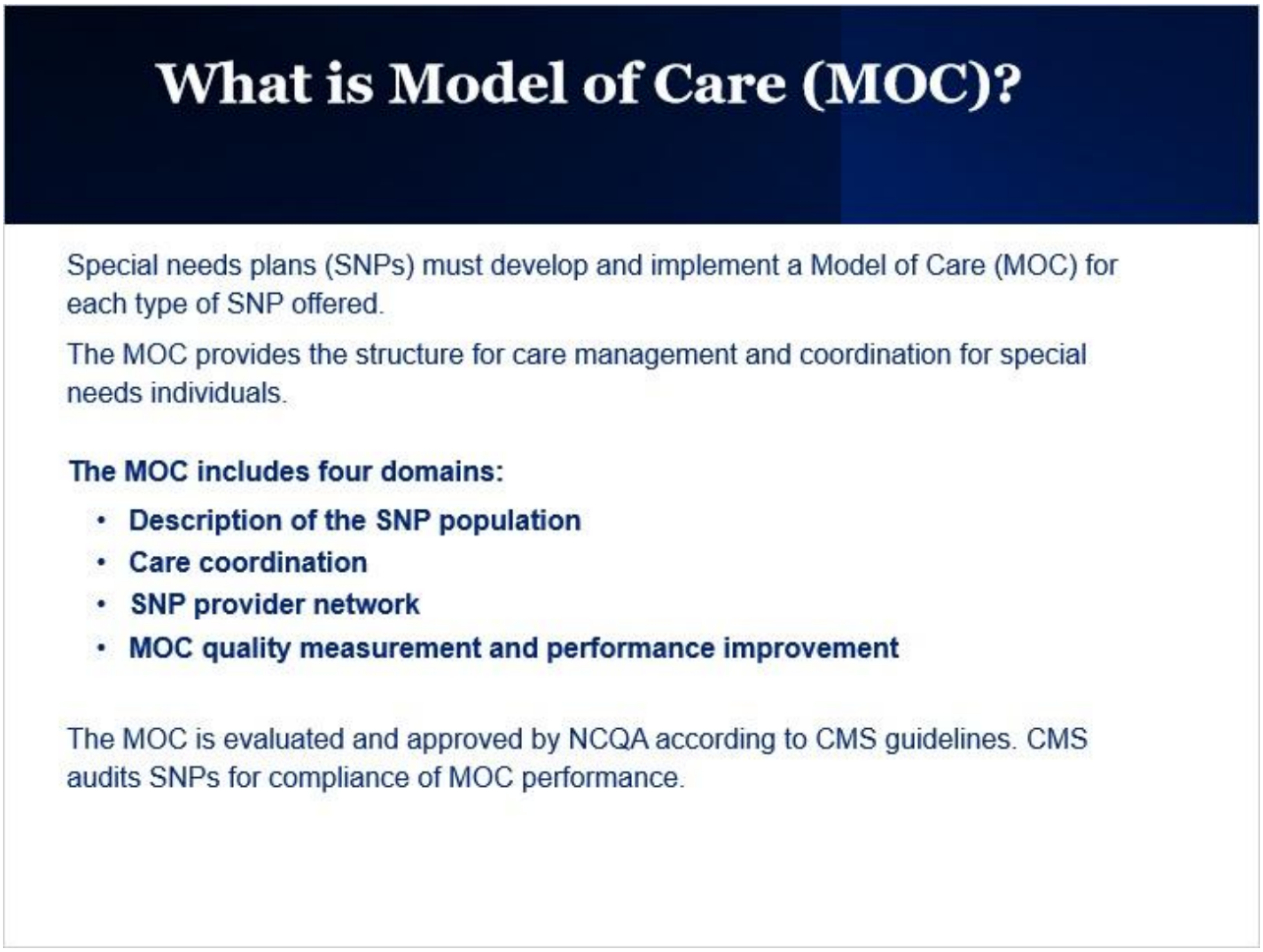
1.5 What is a special needs plan (SNP)?



1.6 What is a special needs plan (SNP)?

Types of Special Needs Plans	
Chronic Condition Special Needs Plan (C-SNP)	Enrolls individuals with specific severe or disabling chronic condition specified by CMS.
Dual Eligible Special Needs Plan (D-SNP)	Enrolls Medicare Advantage-eligible individuals entitled to both Medicare and Medicaid.
Fully Integrated Dual Eligible (FIDE) SNP	A D-SNP that provides access to Medicare and Medicaid benefits managed under one health plan.
Highly Integrated Dual Eligible (HIDE) SNP	A D-SNP that advances Medicare/Medicaid integration to align services with a focus on long-term supports and services (LTSS) and/or behavioral health.
Facility-based Institutional SNP (FI-SNP)	Enrolls Medicare Advantage-eligible individuals who have an actual or expected stay of 90 days or longer in a nursing facility or skilled nursing facility (NF/SNF) (1)Restricts enrollment to MA eligible individuals who meet the definition of institutionalized;(2)Must own or contracts with at least one institution, specified in the definition of institutionalized in this section, for each county in the plan's service area; and(3)Must own or have a contractual arrangement with each institutionalized facility serving enrollees in the plan.
Institutional Equivalent SNP (IE-SNP)	Enrolls individuals who require an institutional level of care, but reside in the community setting.

1.7 What is Model of Care (MOC)?



1.8 Special needs plan (SNP) population



1.9 Special needs plan (SNP) population

Care Coordination

SNPs coordinate the delivery of care for SNP enrollees.

The MOC describes the essential components of care coordination:

- Staffing structure of the SNP
- Administration of the Health Risk Assessment Tool (HRAT)
- Face to Face encounter
- Creation and updates of the Individualized Care Plan (ICP)
- Membership of the Interdisciplinary Care Team (ICT)
- Care transition protocols



1.10 Care coordination (cont.)

Care coordination (cont.)

SNP staff:

- The MOC defines staff roles and responsibilities across health plan functions affecting the care coordination of SNP enrollees and contingency plans for ongoing continuity of critical staff functions. Also, the MOC describes the initial and annual MOC training for SNP staff and providers.

The description includes staff responsible for:

- Administrative functions
- Enrollment and eligibility verification
- Claims processing
- Administrative oversight

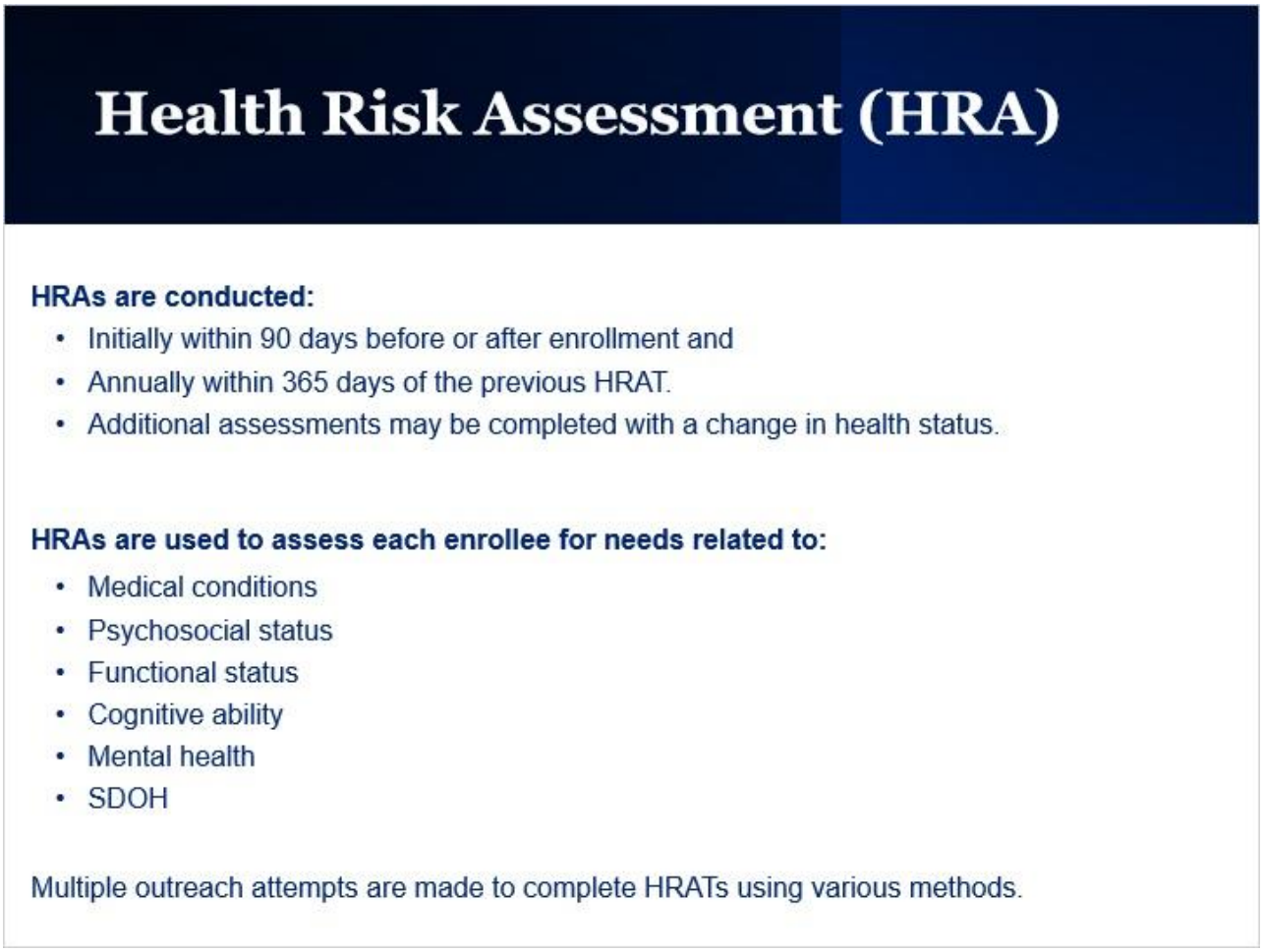
Clinical responsibilities:

- Direct care and education
- Care coordination
- Pharmacy consultation
- Behavioral health counseling
- Clinical oversight



- SNP MOC training is to be completed initially and then annually.
- Management is accountable for compliance with MOC training.

1.11 Care coordination (cont.)



1.12 Care coordination (cont.)

Individualized Care Plan (ICP)

An ICP is developed to address needs identified in the HRA. The MOC describes the process to develop and communicate the ICP. **ICP must be developed within 90 days** of completing the initial HRA **or** within 90 days of the effective date of enrollment—**whichever is later**.

ICP development:

- All members are required to have an ICP.
- May be updated more frequently depending on the individual needs of each enrollee, such as a change in conditions, transition of care, etc.
- For those enrollees who are unable to be reached or do not complete an HRA, an ICP may be completed using age-appropriate preventive recommendations and/or relevant information available to the health plan.

The ICP must include, but is not limited to:

- The enrollee's self-management goals and objectives
- The enrollee's personal health care preferences
- A description of services specifically tailored to the enrollee's needs
- Identification of measurable goals and action taken if goals are not met

1.13 Care coordination (cont.)

Interdisciplinary Care Team (ICT) & Individualized Care Plan (ICP)

ICT Overview

- The Model of Care (MOC) describes ICT composition and communication.
- Every member has access to an ICT, which uses the ICP to manage and coordinate care.
- ICT members may include:
  - Enrollee and/or caregiver/authorized representative
  - PCP, care managers, and specialty providers
  - Clinical pharmacists, behavioral health specialists, and other service providers

ICP Sharing Methods

- Verbal: Face-to-face or telephonic communication
- Written: In person, mail, email, and fax
- Electronic: Access to clinical documentation

Provider Access

- View and comment on ICP via Care Conductor or Community Care Tools
- ➡ Sign in at UHCprovider.com

1.14 Care coordination (cont.)

Care Transitions Protocols

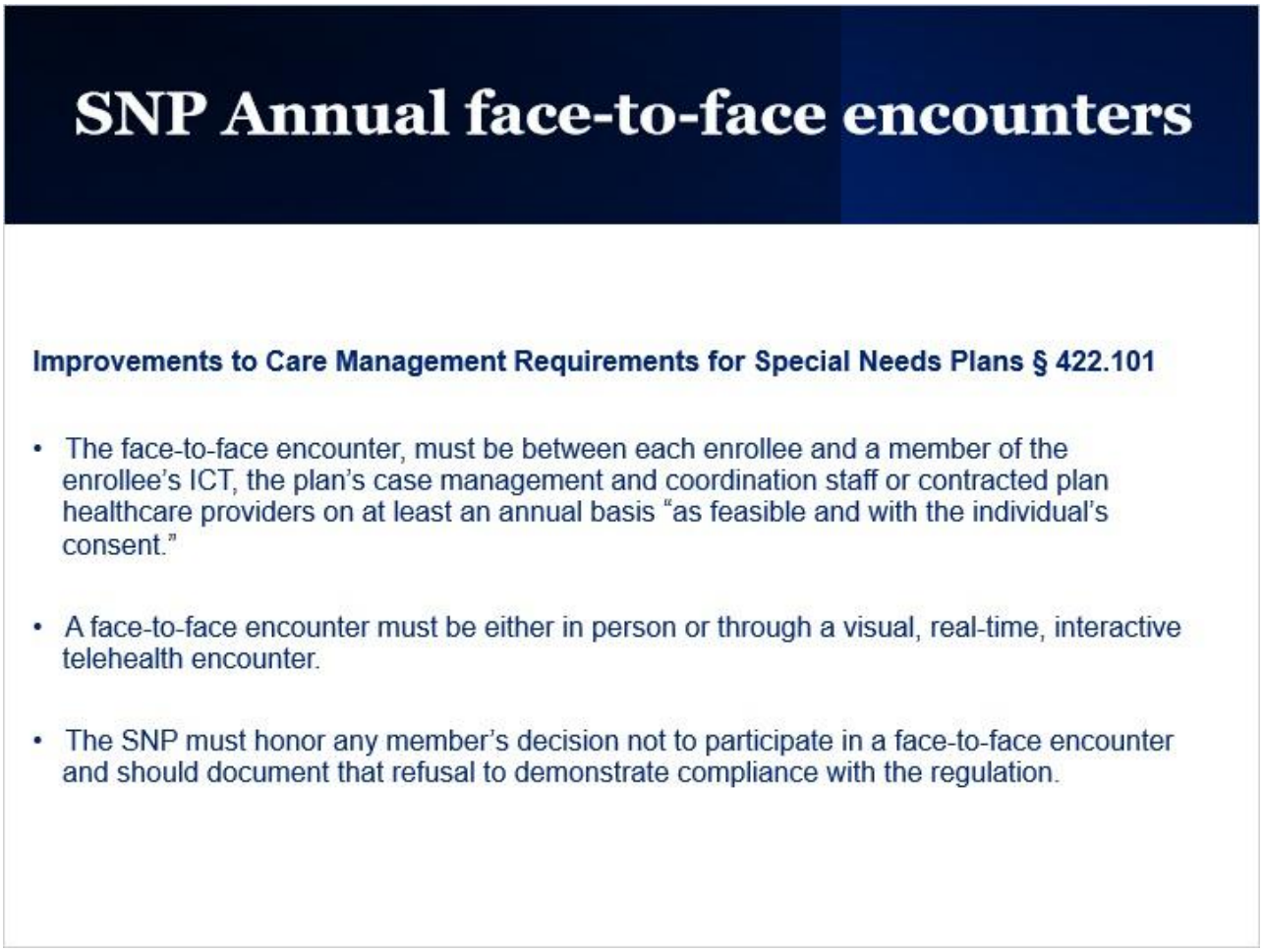
The MOC describes care transition protocols utilized to support coordination of care across health care settings.

The following factors are described:

- The process and rationale for coordinating services
- The personnel involved in the management of care transitions
- Support and education provided during transitions
- Communication of the ICP and availability of health information



1.15 SNP Annual face-to-face encounters



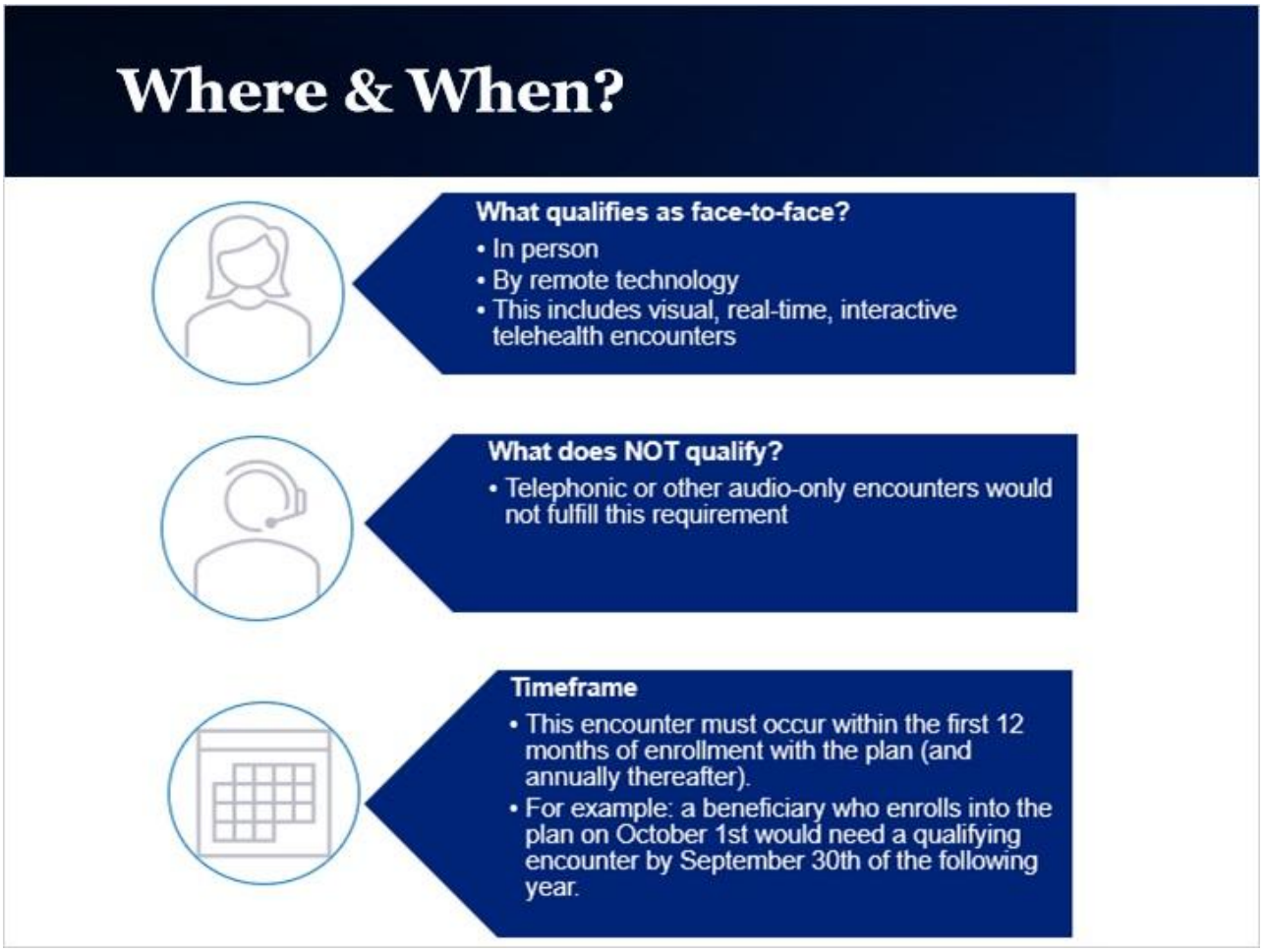
1.16 "As feasible standard"



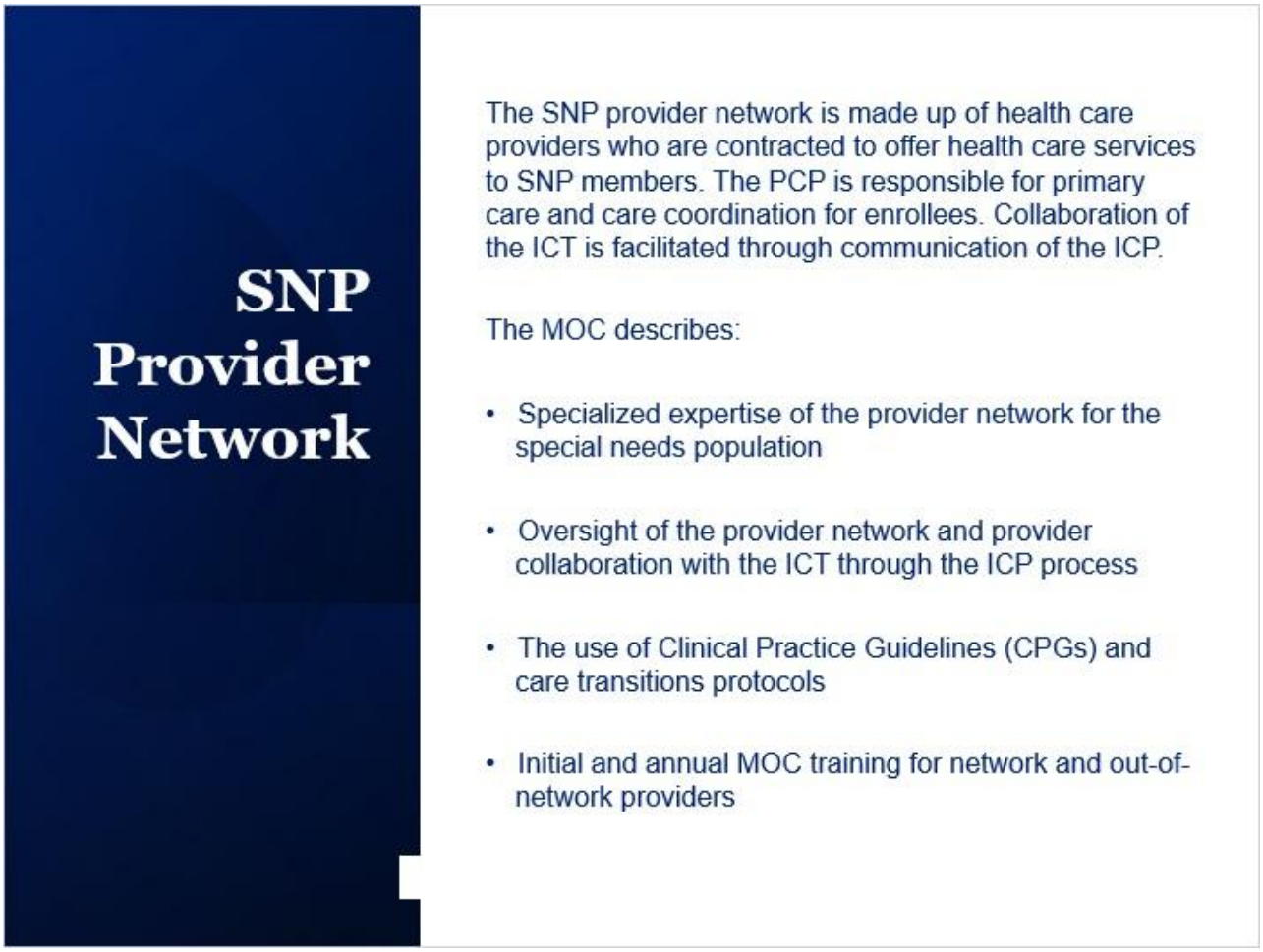
1.17 SNP Annual face-to-face encounters



1.18 SNP Annual face-to-face encounters



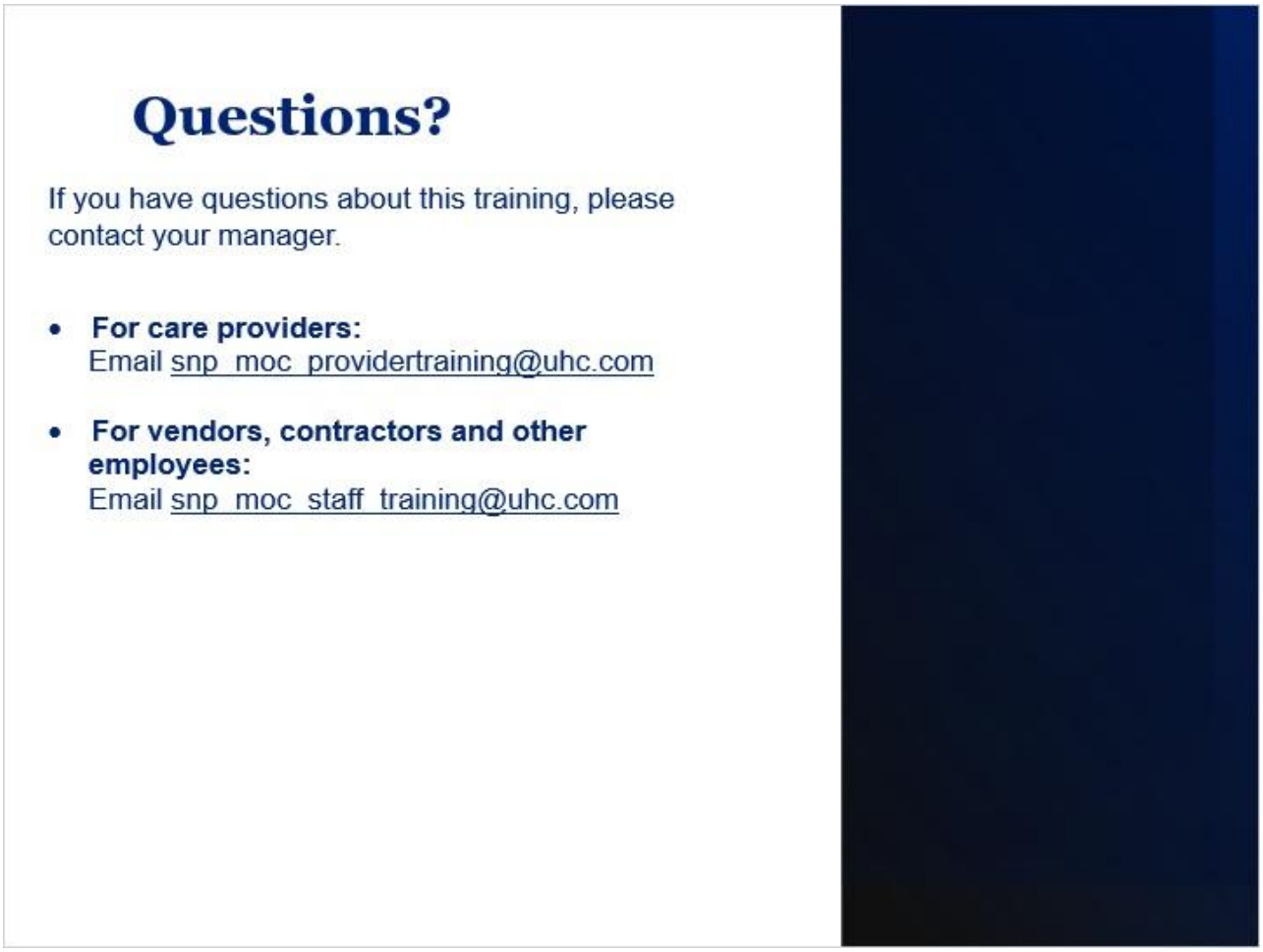
1.19 SNP Provider Network



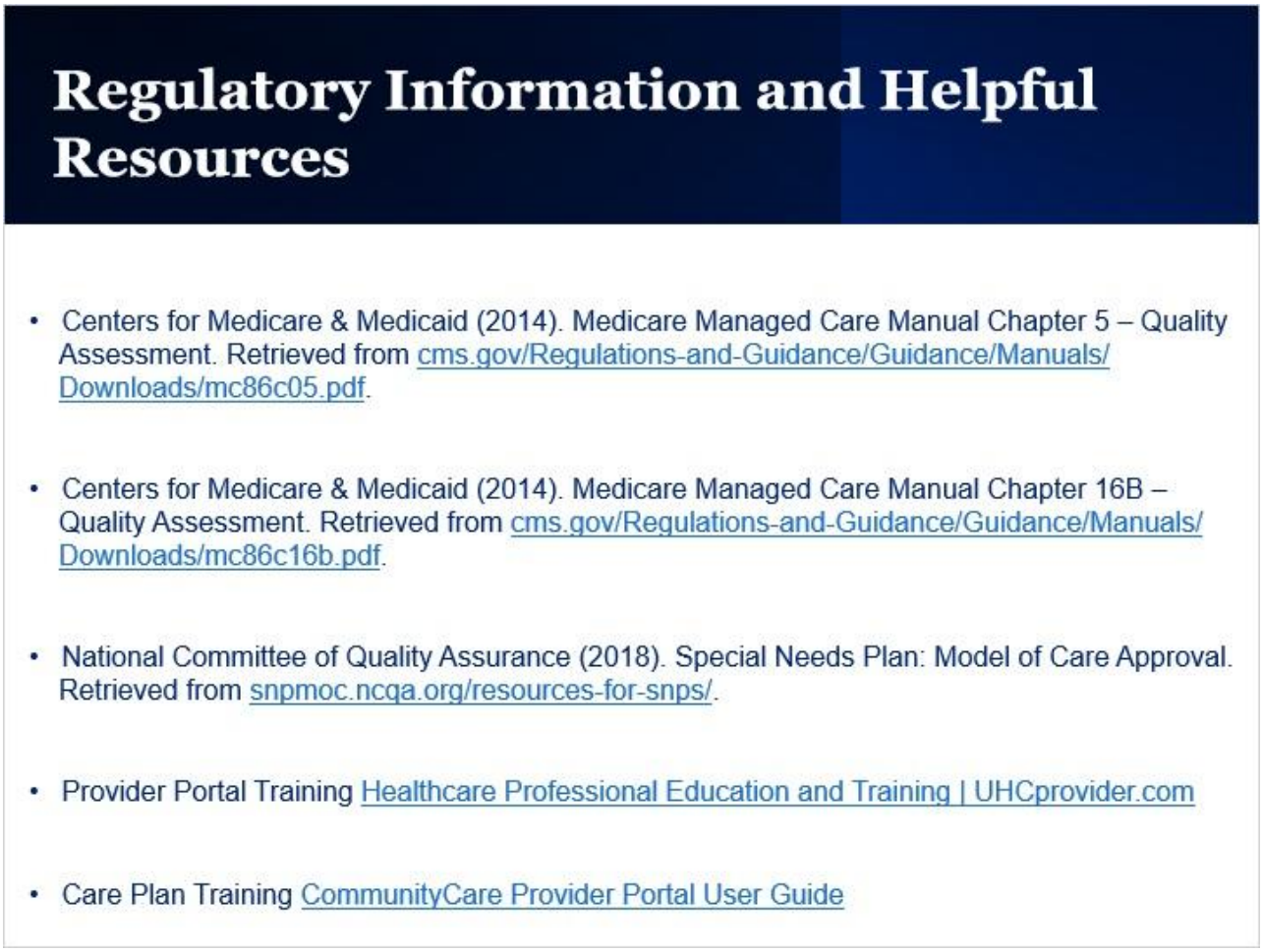
1.20 Quality measurement and performance improvement



1.21 Questions?



1.22 Resources



Notes: