CareMore Health

Special Needs Plan

Model of Care Training

Purpose

Chapter 42 of the Code of Federal Regulations, Part422 (42CFR422.101(f)(2)(ii) mandates that Special Needs Plans (SNPs) conduct SNP Model of Care (MOC) training for all contracted providers as well as out-of-network providers seen by SNP members on a routine basis.

Model of Care is the evidence-based process by which we integrate benefits and coordinate care for beneficiaries enrolled in a Special Needs Plan.

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Objectives

- Understand characteristics and needs of the chronic, dual eligible, and institutional Special Needs Plans (SNP)
- Be able to identify the components of care planning and the role of the Interdisciplinary Care Team (ICT) in care coordination for SNP members
- Be familiar with key principles for improving transitional care management and the case management referral process
- Recognize measurement outcomes used to evaluate CareMore Health's compliance with the Model of Care

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Model of Care Framework

The Model of Care establishes the foundation for managing and coordinating care for SNP enrollees

Key Components of the MOC:

- **Description of the SNP Population**:
  - Detailed examination of the specific characteristics and needs of the SNP enrollees.
- **Care Coordination:**
  - Strategies and processes for seamless care integration and management.
- **SNP Provider Network:**
  - The network of healthcare providers specializing in accommodating the SNP population's demands.
- **MOC Quality Assessment & Performance Enhancement:**
  - Centers for Medicare and Medicaid (CMS) conducts audits to ensure compliance of MOC performance.

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What is a Special Needs Plan (SNP)?

A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care. SNPs were first established by the Medicare Modernization Act (MMA) of 2003.

SNP enrollment is limited to people with specific diseases, certain healthcare needs, or who also have Medicaid.

SNPs are only available to those beneficiaries who have an additional qualifying condition.

SNPs combine the benefits of Original Medicare (Parts A and B) with prescription drug coverage (Part D).

SNPs tailor their benefits, provider choices, and list of covered drugs (formularies) to best meet the specific needs of the groups they serve.

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Minimum Eligibility Requirements

All members must:

- Have both Medicare Part A & Medicare Part B
- Live in the approved service area

Institutional Special Needs Plan (I-SNP)

- Members must currently reside in a nursing home, or at a home in the community that requires an institutional level of care

Dual Special Needs Plan (D-SNP)

- Members must be eligible for both Medicare and Medicaid benefits

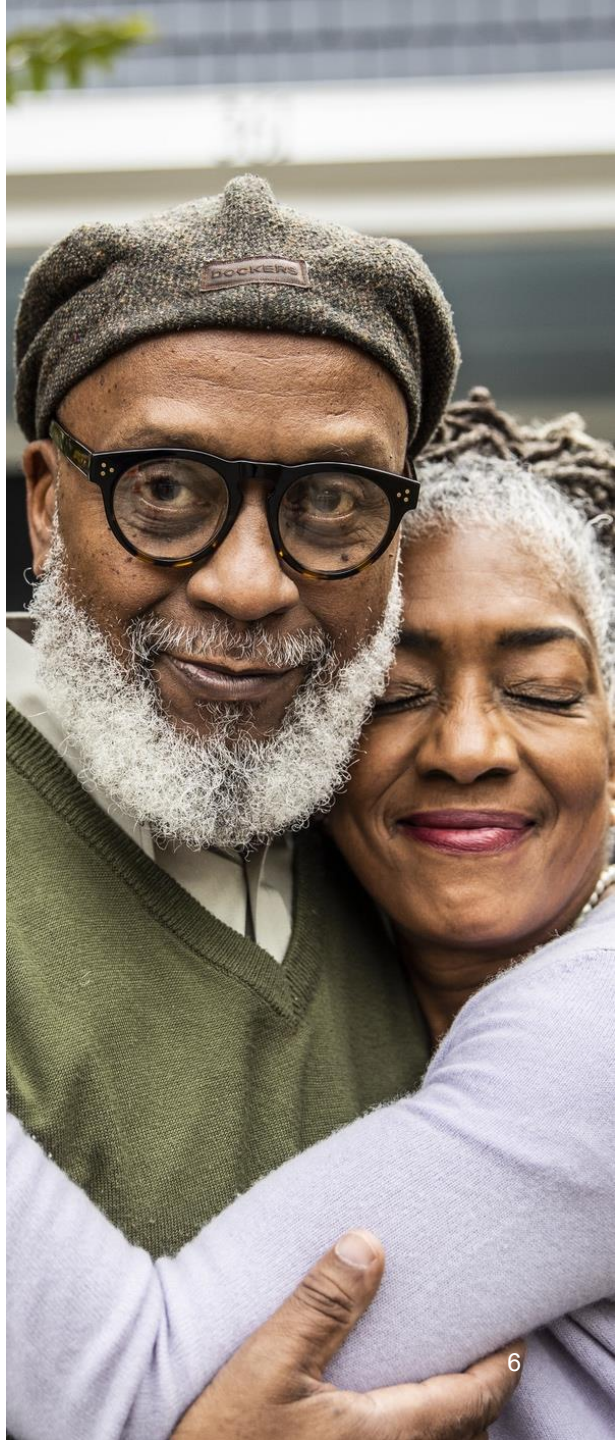
Chronic Special Needs Plan (C-SNP)

Members must be clinically diagnosed with the specific chronic medical disorder(s) covered under the C-SNP, such as:

- Diabetes
- Cardiovascular Disorders
- Lung Disorders
- Neurological Disorders

and/or

- End Stage Renal Disease



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Types of Special Needs Plans (SNPs)

C-SNP – people living with severe or disabling chronic conditions specified by CMS

D-SNP – people who have both Medicare and Medicaid

I-SNP – individuals who live in a skilled nursing facility or require long-term or resident care in a healthcare institution for at least 90 days

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I-SNP Plans

CMS recognizes three main subtypes of I-SNPS. For all I-SNP subtypes, the core eligibility requirement is that a beneficiary, who is enrolled in both Medicare Part A and Part B, must have a need for a long-term, institutional level of care for 90 days or longer.

Institutional-Equivalent SNP (IE-SNP) - individuals who require an institutional level of care, however, reside in the community setting

Facility- Based Institutional SNP (FI- SNP) - individuals who have an actual or expected stay of 90 days or longer in a nursing facility or skilled nursing facility (NF/SNF)

Hybrid Institutional SNP (HI-SNP) - individuals who require long-term facility-level care. This type of plan covers both fully institutional members (I-SNP) and institutional –equivalent (IE-SNP) members

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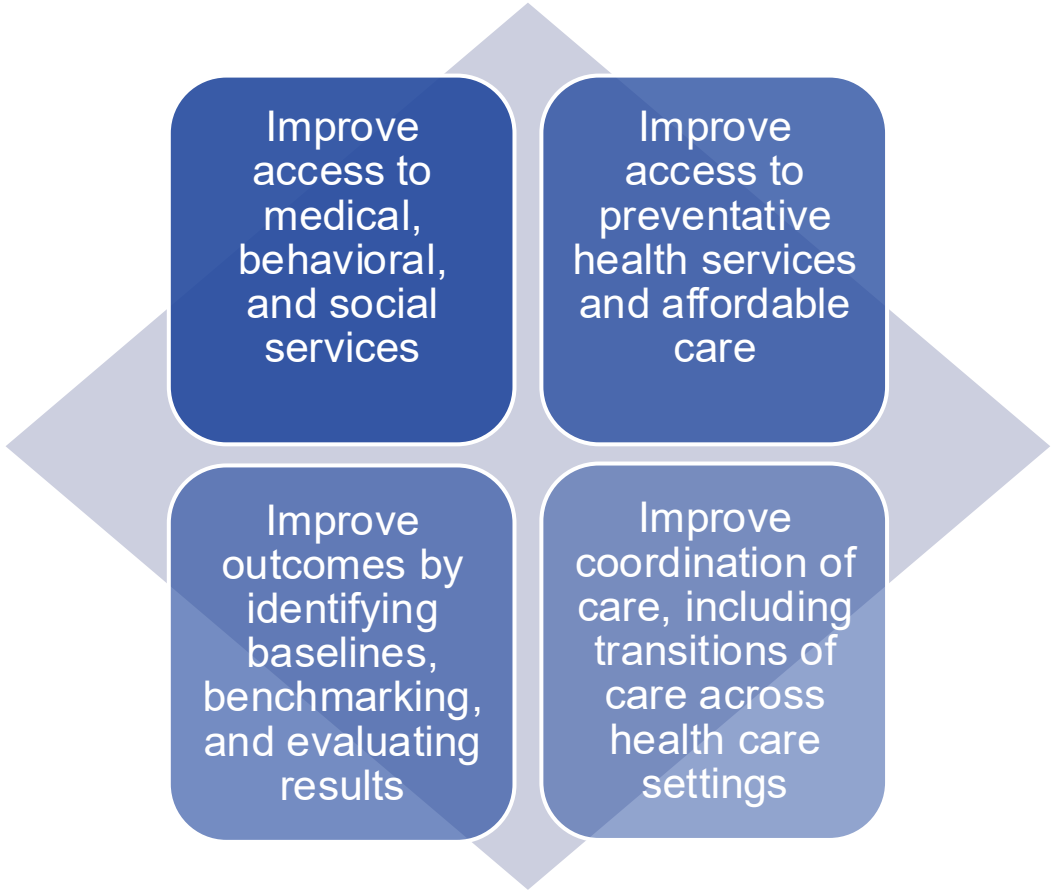
SNP Goals

All SNPs have the following overarching goals:



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SNP Models of Care that CareMore Health Participates With:

Health Plan Partner	Market(s)
Alignment	Arizona, Nevada
Clever Care	California
Elevance	Arizona, California, Nevada
HealthNet	California
LA Care	California
Scan	Arizona, California, Nevada
United Health Care	California
Verda	Arizona

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SNP Population

General and Vulnerable Populations

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Vulnerable Populations

- Intensive management of frail and chronically ill members, identified through our risk stratification model, predictive analytics, data scans, pharmacy utilization reports, PCP referrals, and/or member self-identification. These members are then managed using evidence-based best practices and clinical practice guidelines to ensure optimal care.

- SNP population encounters multiple co-morbidities, such as:
  - High blood pressure
  - High cholesterol
  - Heart disease
  - Depression
  - Poor nutritional status
  - Alzheimer's or other dementia- related disorders

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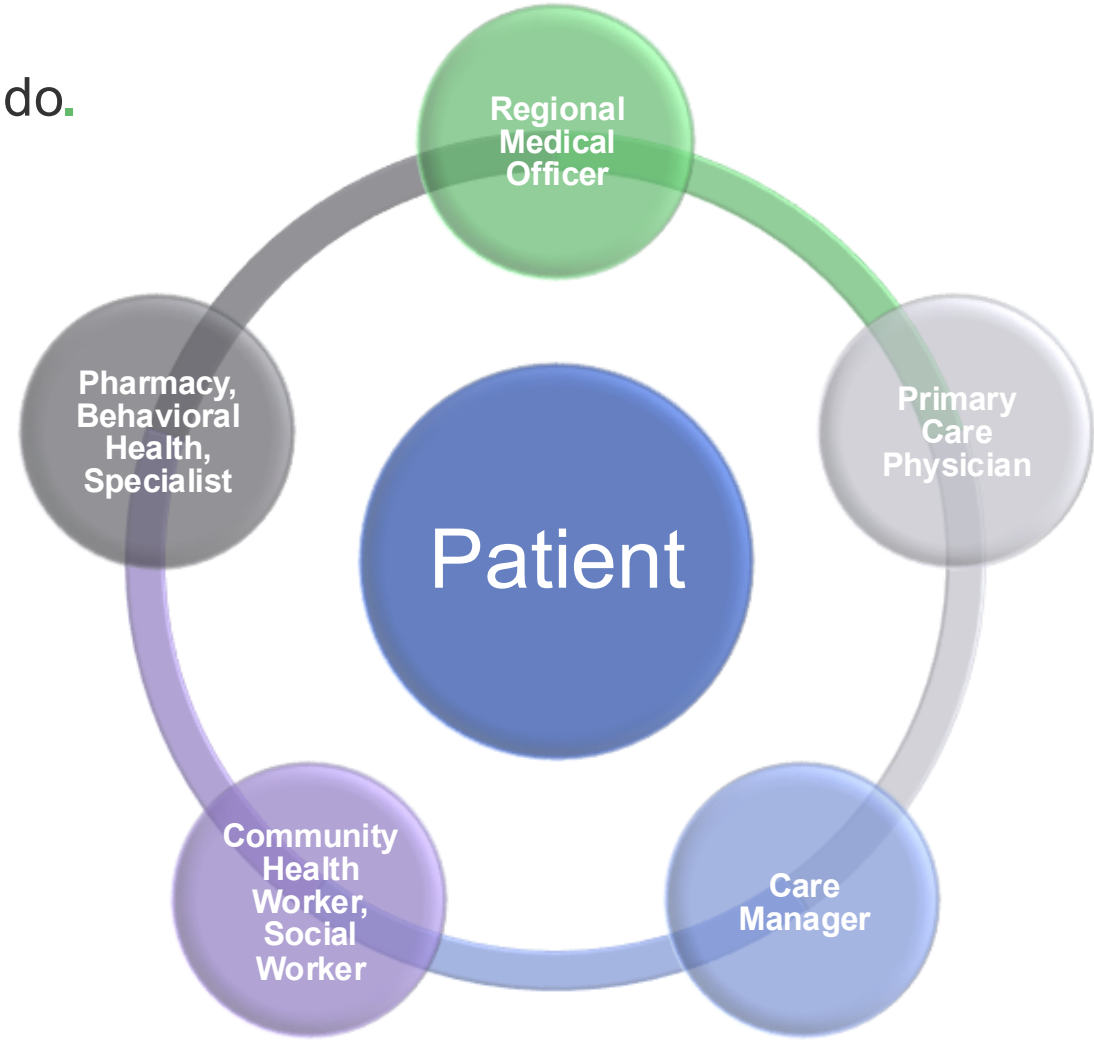
The CareMore Health Approach to the Model of Care

The patient is at the center of all that we do.



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CareMore Health Coordination

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Health Risk Assessment

HRAs allow CareMore to assess the medical, cognitive, functional, psychosocial and behavioral health needs of each beneficiary

The initial HRA is to be completed within 90 days for all newly enrolled SNP members

Annual HRAs are to be completed within 365 days of the last HRA, or as the member's health care status changes

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Individualized Care Plan

The Individualized Care Plan (ICP) is…

Developed by the care manager with input from the member/caregiver and Interdisciplinary Care Team (ICT), based on information obtained from the member's assessment and issues identified on the HRA.

Reviewed and updated by the care manager during the annual reassessment process upon significant change in the member's health status, upon member request, or when deemed necessary by the care manager.

Shared with members of the ICT, as well as the member or caregiver, and other network providers/stakeholders, as needed, to ensure comprehensive coordination of care.

A general ICP will be created for members who are unreachable or unwilling to participate. All members will have an ICP, regardless of their participation status.

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Individualized Care Plan

The ICP…

- Includes the member's self-management and goals
- Identifies measurable outcomes and progress
- Recognizes potential barriers and progress towards goals

Goals

- The member is involved in the development of the ICP and agrees with the care plan and goals
- Goals are prioritized considering the member's healthcare needs and personal preferences

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Care Management Referrals

The Care Management Team helps ensure that members receive personalized care coordination across the entire delivery of care.

The Care Managers focus on clinical, behavioral, and social needs of the CareMore Health member.

Care Management Referrals | Common Referrals

Palliative Services

- Specialized care for people living with a serious or terminal illness
- Provide relief from the symptoms, stress, and discomfort of the illness

Hospice Services

- Focus is on supportive comfort and quality of life, rather than cure
- Goal is to enable members to be comfortable and free of pain, so that they live each day as fully as possible

Social Determinants of Health (SDoH)

- Economic stability, education access, health care access, community/social

Complex Case Management

- Ensures timely access to and coordination of medical and psychosocial services
- Includes: assessment of needs, care plan creation/implementation, care coordination, monitoring, reassessment, follow-up and case conferences

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Interdisciplinary Care Team

Interdisciplinary Care Team (ICT) involves:

A multidisciplinary team evaluates the needs of beneficiaries based on their risk levels and severity of their chronic conditions, as provided for in the ICP.

Coordination of special needs of the beneficiaries, may include but are not limited to the beneficiary and/or caregiver/authorized representative, Advanced Practice Clinician (APC), Care Manager (CM), Social Worker (SW), Behavioral Health Provider (BH), Pharmacist, Specialist, and Primary Care Physician (PCP), or Managed Long Term Services and Supports (MLTSS) Provider – as long as they are part of the plan's care coordination staff, or a contracted health plan provider.

The ICT must include providers with expertise and training (in a defined role appropriate to their licensure).

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ICT Communication

Methods of Communication:

- Telephonic
- Texting
- Virtual
- Face-to-face
- Electronic data transfer record keeping

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Face-To-Face Encounters

Regulations at 42 CFR § 422.101 (f) (1) (iv) require that all SNPs provide face-to-face encounters for the delivery of health care, care management, or care coordination services:

- Within the first 12 months of enrollment
- Annually
- As feasible, with the enrollee's consent

The "as feasible" standard created by the regulation allows for compliance even if an enrollee cannot be engaged so long as the SNP has made reasonable, documented efforts which might include:

- The enrollee does not consent
- The enrollee does not respond to outreach attempts
- The enrollee's current health condition prevents them from participating, such as being hospitalized in an out-of-network facility

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Face-To- Face Encounters

Methods for which these encounters can be conducted:

- In-person
- Remote Technology. This may include a visual real-time, interactive telehealth encounter
- Alternative methods when in-person communication is unavailable or does not meet the need of the enrollee, to provide culturally appropriate and accessible communication in accordance with the beneficiary's choice
- **Note**: Telephonic or other audio-only encounters does not meet the requirement

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Face-To- Face Encounters

The face-to-face encounter may be conducted with the enrollee and a member of the ICT which may include the:

- Primary care provider
- Contracted health plan provider
- Specialty provider
- Advanced practice clinician
- Behavioral health provider
- Pharmacist
- Care manager
- Social worker
- Managed long term services and supports provider
- Community Health Worker

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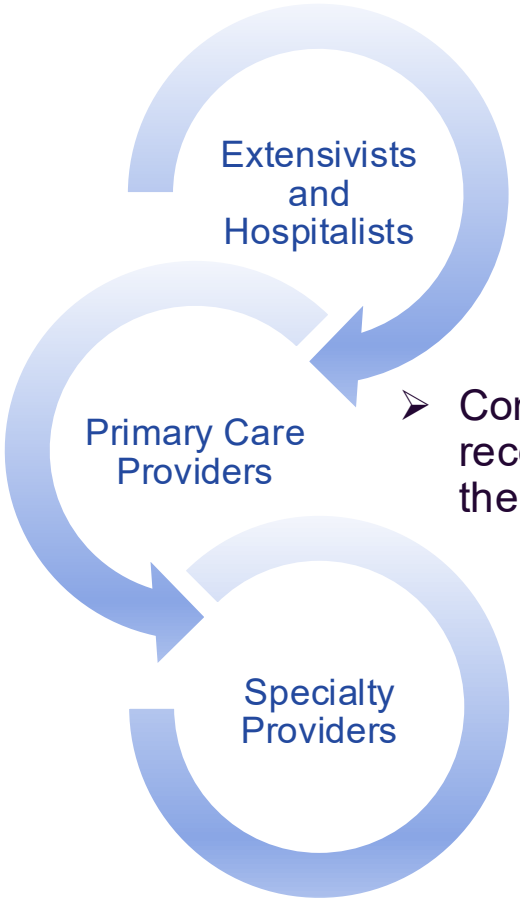
Care Transitions & Health Status Changes

When the health status of a SNP member changes, the ICT is mobilized to provide unique care that is needed.



- Visit the patient while admitted to the hospital/skilled nursing facility
- Consulted on recommended changes to the plan of care
- Consulted based on the patient's needs

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Care Transitions

Care transitions can be a challenging time for members. One objective of the model of care is to ease the transition process by:

- Helping members plan and prepare for care transitions
- Ensure their care continues after transitions complete
- Communicate and coordinate with treating providers

This objective is accomplished by:

- Utilizing interdisciplinary care transition protocols
- Updating, communicating (to patient, PCP, authorized representative, ICT) and implementing ICPs
- Providing clear communication and education to members and caregivers
- Periodic monitoring of health status (progression or decline)

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Care Transitions & Health Status Changes

Care Managers provide outreach and discharge planning support

Care Managers schedule post-hospital follow-up with PCPs

Care Managers continue communication with the member, based on post-discharge risks

Care Managers complete a comprehensive assessment upon discharge to ensure the member has all of their discharge needs met

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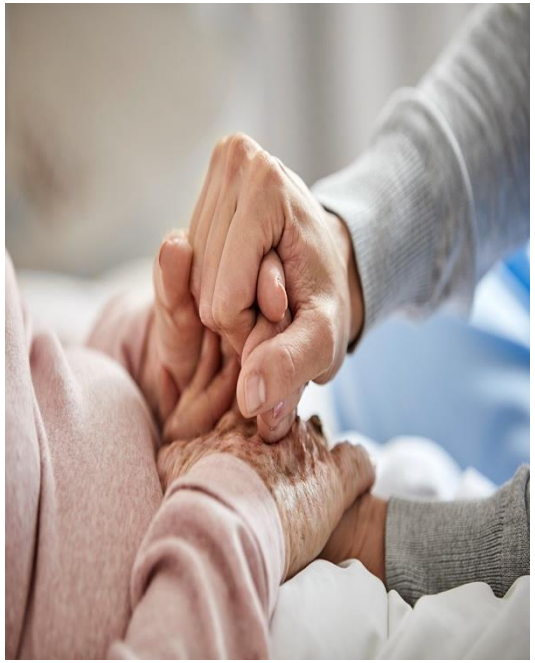
Hospice Services

The philosophy of hospice is to provide support for the member's physical, emotional, and spiritual needs. The focus is on providing quality of life as well as addressing the medical symptoms as part of treating the whole person.



Hospice may be provided at home, in a skilled nursing facility, or at an acute facility.

Hospice members are empowered to make decisions about how they want to live in their final weeks or months. Support is provided to the member, family, and caregivers to support the individual care needs and wishes of the member.

Services are provided by external vendors as the member's primary provider.

CareMore Health's Care Management continues to provide non-hospice care and support through coordination of care with the member's hospice agency telephonically or by conducting face-to-face visits.

Social Services

The need for a social service referral is determined by the requesting clinician.

Common scenarios include:

- Social Determinants of Health (SDoH)
- Member experiencing social isolation
- Declining ability to care for self
- Discussing alternative living arrangements
- Elder abuse (financial, physical, and/or emotional)
- Self neglect
- Substantial need for community resources support
- End-of-life and advance care planning discussion and assistance
- Behavioral health needs, including conservatorship discussions
- Member's health and safety are in jeopardy due to inability to manage personal care or activities of daily living (i.e. getting dressed, going to bed, personal hygiene, continence management, eating and daily routines)

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Provider Network

Specialized Network

Provider Network

CareMore Health contracts with providers in all geographic service areas to ensure the healthcare needs of the SNP members are met.

This includes, but is not limited to:

- Internal medicine
- Endocrinology
- Cardiology
- Oncology
- Pulmonology
- Behavioral health
- Orthopedics
- Ophthalmology

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Provider Network Requirements

CareMore Health tracks all treating providers to ensure they:

- Have an active licensure/certifications that are necessary to participate in the patient's care
- Have access to Clinical Practice Guidelines/Provider Portal
- Actively participate in the interdisciplinary care team (ICT) based on patient's needs
- Participate in the annual SNP model of care training

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Quality Measures

SNP Goals and Performance

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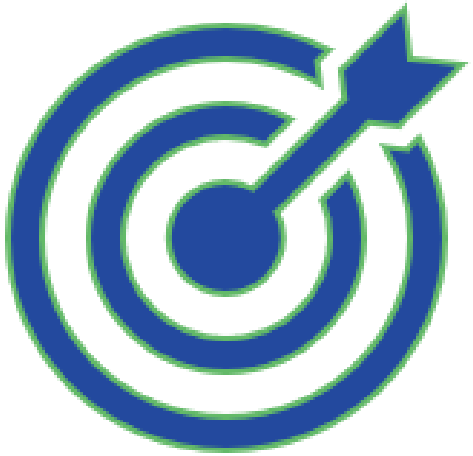
SNP Goals

All SNPs have the following goals:



Improve Access

- To affordable care and preventative health services
- To medical, behavioral, and social services

Improve Coordination

- Coordination of care and transitions of care across healthcare settings

Improve Outcomes

- Use baselines, benchmarks and metrics to assess patient health outcomes or improvements

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SNP Performance

CareMore Health monitors and evaluates each SNP regarding performance and outcomes, including:

- Model of Care goals and progress towards the goals
- SNP- specific HEDIS measures
- Patient satisfaction surveys
- Improvement projects for SNP, chronic care, or disease management

SNP performance evaluation is communicated with executive leadership and submitted annually to the QM Committee

A summary is shared with key stakeholders, such as members and providers, and is available on CareMore Health's public website.

D-SNP California

Dementia/Alzheimer's Care

For patients with dementia care needs, the Interdisciplinary Care Team (ICT) must include the patient's caregiver and a trained dementia care specialist to the extent possible and as consistent with the patient's preferences.

D-SNPs must have trained dementia care specialists on ICTs, as needed.

D-SNPs must have trained dementia care specialists on ICTs for enrollees living with dementia who also have: two or more co-existing conditions, or moderate to severe behavioral issues or high utilization or live alone or lack adequate caregiver support or moderate to severe functional impairment. Dementia care specialists must be trained in: understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and community resources for Members and caregivers.

Dementia care specialists must be included in the development of the Member's ICP to the extent possible and as consistent with the enrollee's preference.

D-SNP California

Dementia/Alzheimer's Care

Resources

Providers are encouraged to leverage "Dementia Care Aware" resources to detect cognitive impairment.

Website: https://www.dementiacareaware.org/

The Dementia Care Aware Warmline is available to health care providers at 1-800-933-1789, from Monday to Friday between 9 a.m. and 5 p.m.

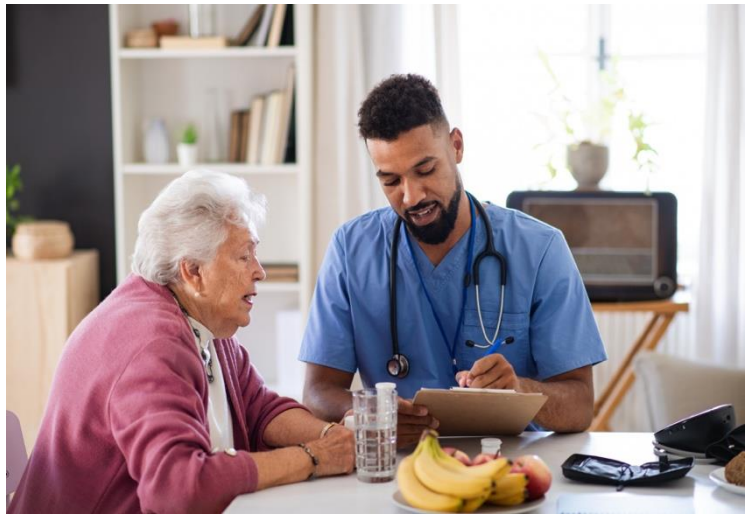
The warmline offers education and decision-making consultation for clinicians and primary care teams in California, covering topics related to dementia screening, assessment, diagnosis, management, and care planning.

D-SNP California

Caregiver Assessment

In 2025, The California Department of Health Care Services (DHCS) revised caregiver provisions to include that D-SNPs must assure that the Health Risk Assessments (HRA) include an assessment question to identify any engaged caregiver.

DHCS defines a Caregiver as “an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation” and “a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition.”



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Resources and References

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2. Special Needs Plans, Medicare Managed Care Manual
   URL: https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/model-care

3. CareMore Health Model of Care Policy CHS-MOC 06 & CHS-CLC-04

4. Palliative Care Definition
   URL: https://www.capc.org/about/palliative-care/

5. Medicare Special Needs Plans (SNP)
   URL: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options/SNP

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7. What are Medicare Special Needs Plans (SNPs)
   URL: What are Medicare Special Needs plans (SNPs)? | UnitedHealthcare

8. What you Need to Know
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9. DHCS CalAIM D-SNP Policy Guide 2025
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