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Special needs Plan Model of care Network Provider Training

2026

Special Needs Plans and the Model of Care

Special Needs Plans (SNP) are Medicare Advantage plans designed for individuals with defined needs:

- Chronic conditions (C-SNPs),
- Institutional or nursing-level care needs (I-SNP), or
- Dual eligible Medicare-Medicaid (D-SNP).

These types of plans provide coordinated, targeted care to meet each member's unique needs.

CMS requires each Special Needs Plan to submit and operate under an approved **Model of Care (MOC)** document**.** The MOC is the plan's framework that outlines how the plan:

1. Identifies member needs,
2. How care is coordinated,
3. How the network is structured and,
4. How quality and performance is measured

YOUR ROLE: All medical office staff and providers serving SNP members are expected to understand and apply the Model of Care elements in daily practice

References: Social Security Act Section 1859(f)(7); Medicare Managed Care Manual (MMCM), Chapter 16B

2026 SCAN SPECIAL NEEDS Plans

SCAN OFFERS 3 TYPES OF SNPs:

1 Chronic Condition (C-SNP)

For members with qualifying chronic conditions

Balance, Strive
- Chronic Heart Failure
- Cardiovascular Disease
- Diabetes

Village health:
SCAN partners with DaVita Integrated Kidney Care to serve members with
- End Stage Renal Disease (ESRD)
- Chronic Kidney Disease (CKD)
- Post-Renal Transplant.

2 Institutional SNP (HI-SNP & FI-SNP)

For members in facilities needing institutional level of care

Embrace & Embrace together:
A plan that serves beneficiaries who are eligible for Medicare who choose to reside in a qualifying institution or the community.

3 Dual-Eligible SNP (FIDE-SNP)

For members eligible for both Medicare & Medi-Cal – California Only

Connections:
These members are eligible to receive both Medicare and Medi-Cal benefits

Connections at Home:
Members are eligible to receive all Medicare and Medi-Cal benefits and meet Nursing Facility Level of Care (NFLOC) which qualifies them for home and community-based services.

ELEMENTS OF A cms model of care

The Model of Care is organized into four segments:

MOC 1

SNP Population

Defines the SNP population, its most vulnerable members', and diagnosis verification requirements.

MOC 2

Coordination of Care

Explains how the plan connects the right services to the right member at the right time (e.g. HRA, ICP, ICT).

MOC 3

Network

Outlines the network provider expertise that supports consistent, high-quality care for complex populations

MOC 4

Content Gap Analysis

Describes how the plan measures outcomes to continuously improve SNP care

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MOC 1: The SNP population

Know your whole patient – not just the diagnosis

UNDERSTAND YOUR PATIENTS

Demographics: Age, disability, geography

Clinical Profile: Conditions, comorbidities, risk level

Social Risk Factors: Housing, food, transportation, language preferences/translation needs

High-Risk Patients: Identify the most vulnerable

Care Needs and Challenges

High Needs: Multiple chronic conditions

Functional limitations: cognitive, behavioral health needs

Social Drivers: Impacting outcomes

DIAGNOSIS VERIFICATION REQUIREMENTS

Confirm: qualifying conditions within first two months of enrollment

Timely: Submit to avoid involuntary disenrollment

Accurate: provider documentation for compliance and coordinated care

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Moc 1: Diagnosis Verification

Diagnosis Verification

Diagnosis (Dx) Verification is the process of confirming that a member has the chronic condition required to qualify for enrollment in a Chronic Special Needs Plan (C-SNP).

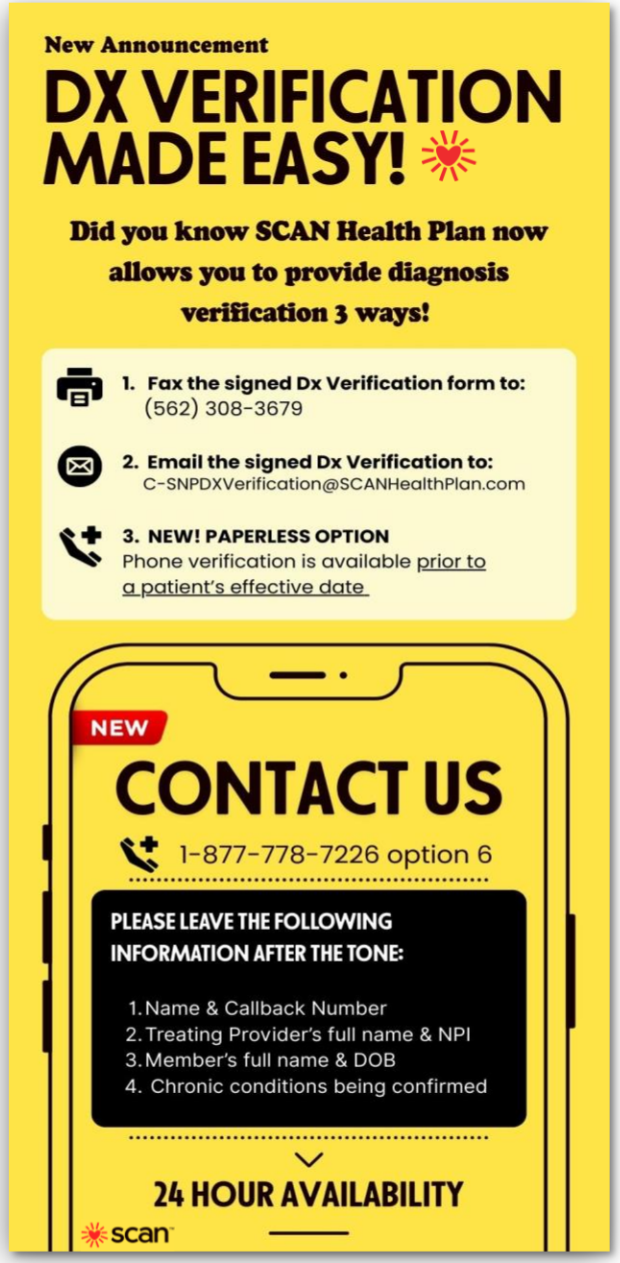
CMS requires this verification to make sure members are only enrolled in plans that match their health needs, which helps ensure they receive the right benefits, care, and coordination.

Member Enrolls → Provider Confirms Diagnosis → Verification Submitted

- ✓ **Verify** diagnosis within the first 2 months of enrollment. CMS requires Special Needs Plans (SNPs) to verify that each enrollee meets the chronic condition eligibility criteria through the member's treating provider to stay enrolled in a CSNP.
- ✓ **Documentation** of verification is required and maintained by SCAN for compliance and audit purposes
- ✗ **If not verified or confirmed not to have a qualifying condition** member must make a plan change or will be involuntarily disenrolled
- ✗ **Claims** submission is no longer allowed by CMS for C-SNP chronic condition verification.

Treating Provider Definition: The verifying provider must have an ongoing relationship with the members to ensure they are familiar with the member's health status. This ensures that the provider can accurately confirm the presence of the qualifying condition(s) as required by CFR 422.52(f)(1)(i).

Eligible provider credentials: MD, DO, PA, NP
Not eligible: Pharmacists, RNs, and office staff are not included as eligible providers for this purpose



MOC 2: Coordination of care

HEALTH RISK ASSESSMENTS (HRA) & INDIVIDUALIZED CARE PLANS (ICP)

- HRA's assess clinical, functional, psychosocial, and social risk factors.
- Results are used to develop and update an individualized care plan (ICP) aligned to the member's goals and needs
- PCPs are expected to review and support the ICP during routine and episodic care

CARE TRANSITIONS & CARE COORDINATION

- Support safe transitions across care settings
- PCPs are expected to collaborate to ensure timely follow-up, medication reconciliation, and timely continuity of care
- Members and caregivers must be informed of a clear point of contact throughout the transition process

FACE-TO-FACE VISITS

- At least one face-to-face encounter annually, conducted in person or via real-time interactive telehealth
- PCPs are expected to document identified needs, care plan updates, and follow-up actions resulting from the encounter

MOC 2: Individualized Care Plan

The individualized Care Plan (ICP) is developed for each SNP member using input from but not limited to the member, caregivers, providers, and care team. It reflects the member's health needs, preferences, and goals.

When to Update the Care Plan:

At least annually or:

- New concern is identified during outreach
- Change in Health Status
- After ICT review
- Transition event (admit or discharge from the hospital)

STEP 1	STEP 2	STEP 3	STEP 4	STEP 5
Review HRA, Triggers & ICP	**Clinical Review**	**Patient Outreach**	**Review and Assess Triggers**	**Review findings with care team**
Upon receipt of SCAN documents via MFT: Review HRA/ICP for triggered members	Complete a clinical review of all available member medical records to identify any new concerns and document	Outreach to member, documenting attempts and outcome within 30 days of receipt of trigger report	Review all triggers with the member on your outreach and assess for any other concerns, determine acuity level and need for case management	Review all findings in your Interdisciplinary Rounds, update care plan, and return to SCAN

Document if you failed to contact the patient or if the member declined

MOC 2: Care transitions

Goal to reduce readmissions and ensure safe recovery

PCP Responsibilities

1. Notification of discharge

Receive & Review Discharge

- Review the discharge summary
- Identify any new risks

2. Patient Follow-Up

Complete Post Discharge Visit

- Ensure follow-up services and appts are scheduled timely
- Assess acuity

3. Medication Reconciliation

Ensure Medication Accuracy

- Perform a comprehensive medication reconciliation
- Educate patient on potential issues that could lead to readmission

4. Update care plan

Update Individualized Care Plan (ICP)

- Changes in condition
- New Diagnosis
- Functional/Social Needs

Communicate relevant updates to ICT as needed

5. Coordinate Care

Engage with Care Team

- Specialists
- Hospital discharge planners
- SNFs and/or home health
- SCAN CM Team- when appropriate

MOC 2: Face to face visits

Why this matters:

- Face to face visits strengthen care planning and coordination
- Improve alignment of care goals with member needs
- Supports better outcomes for high needs SNP members

Visit Frequency

SNP members should be offered at least one face-to-face visit within the first 12 months of enrollment and annually thereafter, when feasible

Visit Format

Visits may be conducted in person or via real-time interactive technology, when appropriate

Purpose of the Visit

Face-to-face visits help identify clinical, functional, cognitive, and social needs that may not be fully captured through other interactions

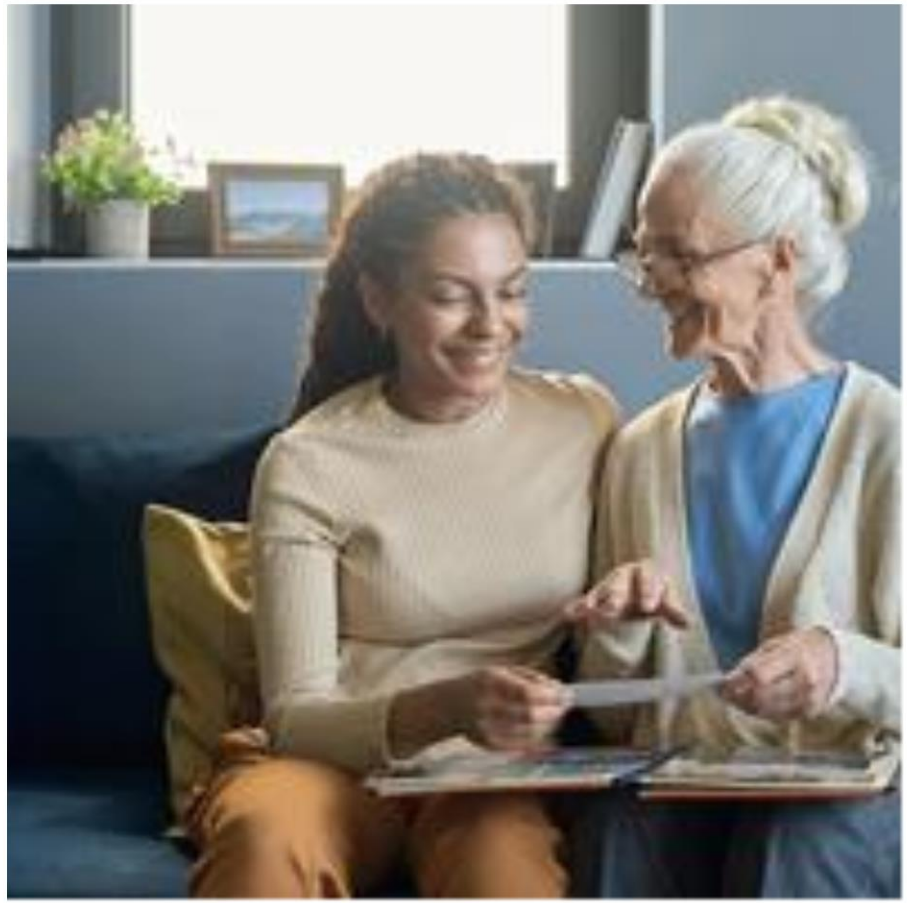
Supporting Care Planning

Information from the visit supports the Health Risk Assessment (HRA), Individualized Care Plan (ICP), and Interdisciplinary Care Team (ICT) collaboration

If Not Completed

If a visit is declined or not feasible, the reason should be documented

MOC 2: Advance Care Planning



Advance Directives are an ongoing, documented conversation that supports shared decision-making of a patient's end of life wishes, preferences, and goals for future medical care.

Primary care providers should educate Members on Advance Directives and encourage completion.

Advance Directive discussions and completion status must be documented in the Member's medical record.

MOC 3: Network

Your role in the SNP provider network

As a network provider, you deliver care tailored to members with complex and specialized needs, supported by a coordinated care team.

Specialized Expertise

- Providers must have specialized expertise aligned to the SNP target population.
- The SNP ensures licensed, credentialed providers and maintains accurate network records.
- Providers must collaborate with the ICT and contribute to each enrollee's ICP.

Use of Clinical Practice Guidelines (CPGs)

- Use appropriate clinical guidelines and protocols
- Identify when guidelines require modification for vulnerable or clinically complex Members.
- Document, communicate, and implement approved modifications through the ICP and ICT, including continuity of care during transitions.

Annual MOC Training

- MOC training required for all providers who provide care to SNP members (in and out of network)

⚠ It is the responsibility of the provider and/or Medical Groups to maintain proof of training completion

MOC 4: how we measure success

Your role in the SNP provider network

SCAN does not delegate quality improvement however, SCAN requires contracted provider organizations to have a quality improvement program and support the SCAN QIP activities including but not limited to providing access to information systems and/or information sharing, access and availability reporting, provision of requested medical records and/or documentation and HEDIS reporting

QUALITY METRICS

- Quality metrics are used to measure care quality, outcomes, and member experience.
- Performance is monitored and reviewed regularly to identify gaps and improvement opportunities.
- Results drive targeted actions and improvements aligned with SNP MOC and CMS requirements.

QUALITY IMPROVEMENT PROGRAM

- SCAN's Quality Improvement (QI) Program oversees and evaluates the quality, appropriateness, and outcomes of clinical and non-clinical care delivered to SNP enrollees.
- The QI Program drives continuous improvement, addresses enrollee needs (including SNP subpopulations), and supports safe, equitable, and coordinated care.

MEMBER EXPERIENCE

- Collaboration with medical groups and providers on quality measures (i.e., CMS5Star, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS))
- SCAN monitors member experience (grievance trends and quality investigations)