Health Plan of San Joaquin

Mountain Valley Health Plan

Advantage Dual Special Needs Plan (D-SNP)

CY 2026 Model of Care (MOC) Provider Training

October 2025

Completing Annual Training

Since our Health Plan provides Dual Special Needs Plan (D-SNP) insurance to some of our membership, completion of annual Model of Care training is a requirement of Centers for Medicare and Medicaid Services (CMS).

- Your attendance and completion will be tracked each year.
- You must view every slide of this training to receive a successful completion status
- An attestation of the completion of this training is required.

Objectives

Objectives for this annual training are:

- Provide an overview of the Model of Care (MOC) structure to network and out-of-network providers who see D-SNP members on a routine basis
- Understand the Care Management goals for members of the provider network
- Identify key roles and departments that support the MOC at Health Plan
- Understand he role of an interdisciplinary care team for HPSJ's Special Needs Plan members

Introduction

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- The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care (MOC)
- The health plan is required to submit information to the Centers of Medicare & Medicaid Services (CMS) and to the Department of Health Care Services (DHCS) every year, including Model of Care plan information, and records of initial and annual training for employees and providers.

Definitions of Special Needs Plans (SNP)

Medicare Advantage (MA) coordinated care plans (CCPs) for special needs individuals, referred to as special needs plans (SNPs). There are three types of SNPs, each with restricted enrollment:

- Chronic Condition SNPs: individuals with specific severe or disabling chronic conditions
- Dual Eligible SNPs: individuals who are entitled to both Medicare (title XVIII) Medicaid (title XIX)
- Institutional SNPs: individuals who, for ≥90 days, have had/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.

Definitions of Special Needs Plans (SNP)

Model of Care (MOC):

- Provides the basic framework through which the SNP will meet the needs of each of its enrollees.
- Is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.
- Provides the foundation for promoting SNP quality, care management, and care coordination processes.

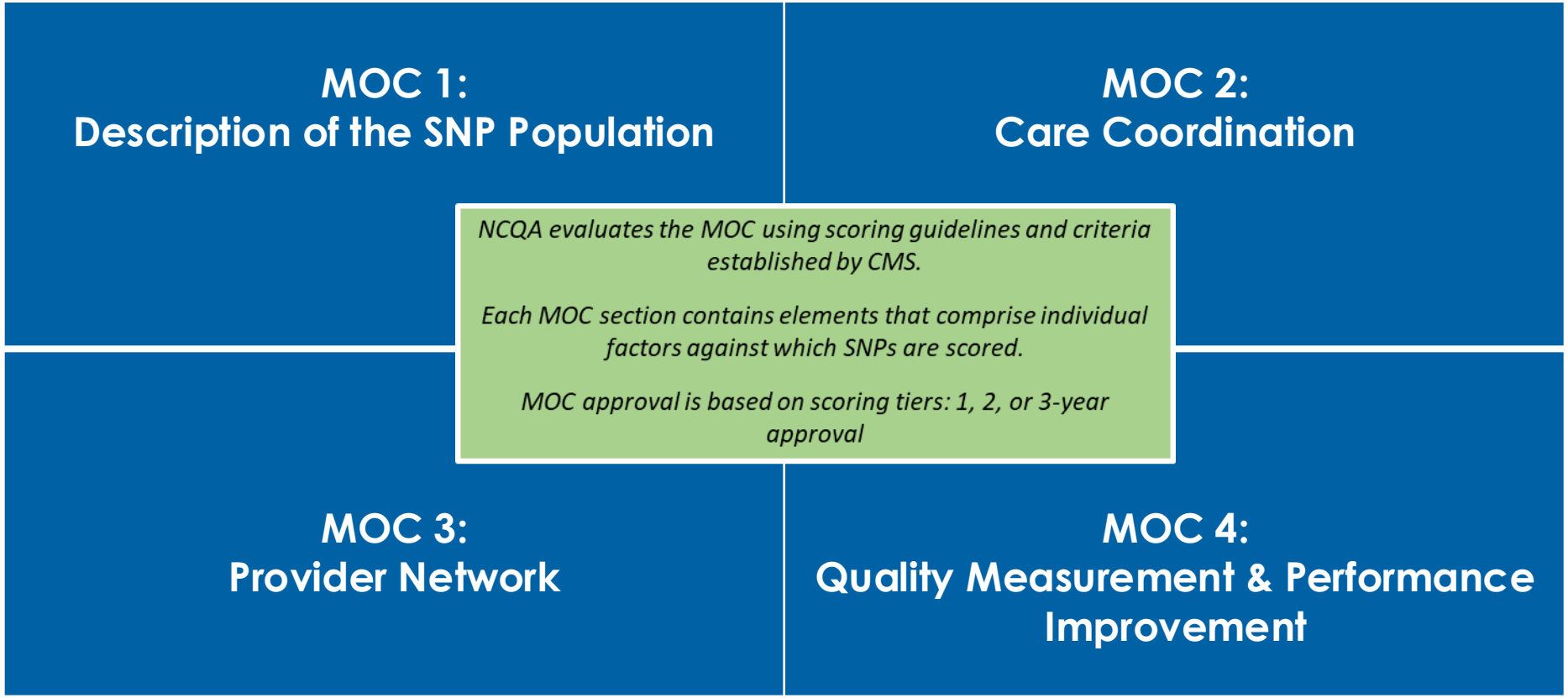
Health Plan's D-SNP Eligibility Requirements

Requirements for Eligibility:

- Live in the Health Plan's approved geographic service area of Alpine, El Dorado, San Joaquin or Stanislaus County
- Enrolled in Medicare Part A
- Enrolled in Medicare Part B
- Qualify for both Medicare and Medi-cal

How the MOC is Organized

The SNP MOC is organized around four sections:



MOC 1: Description of SNP Population

Description of Overall SNP Population

- Determine, verify, and track enrollee eligibility
- Understand health status and disparities of the D-SNP population
- Identify demographics of D-SNP enrollees
- Define the unique characteristics of the Health Plan D-SNP population

Identify Health Plan's Most Vulnerable D-SNP Enrollees

- Define and identify most vulnerable members
- Describe factors contributing to health outcomes of most vulnerable
- Demonstrate the relationship between demographic characteristics and the clinical requirements of most vulnerable members
- Establish partnerships with community-based organizations to facilitate access and deliver specially-tailored services to most vulnerable enrollees

California DHCS Requirements

In the 2026 CalAIM Dual Eligible SNP Policy Guide, DHCS defines additional vulnerable populations and requirements:

- In its 2026 MOC, Health Plan defines its "most vulnerable subpopulations" consistent with the DHCS California Integrated Care Management (CICM) requirements. CICM replaces ECM and "ECM-like care management" requirements for D-SNPs.
- The Health Plan must provide robust care coordination for all SNP enrollees, and identifies the following subpopulations as its most vulnerable, consistent with the DHCS CICM definitions:

Adults Experiencing Homelessness	Adults At Risk for Avoidable Hospital or Emergency Department Utilization
Adults with Serious Mental Health and/or Substance Use Disorder (SUD)	Adults Transitioning from Incarceration
Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization	Adults Nursing Facility Residents Transitioning to the Community
Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities	Adults with Documented Dementia Needs

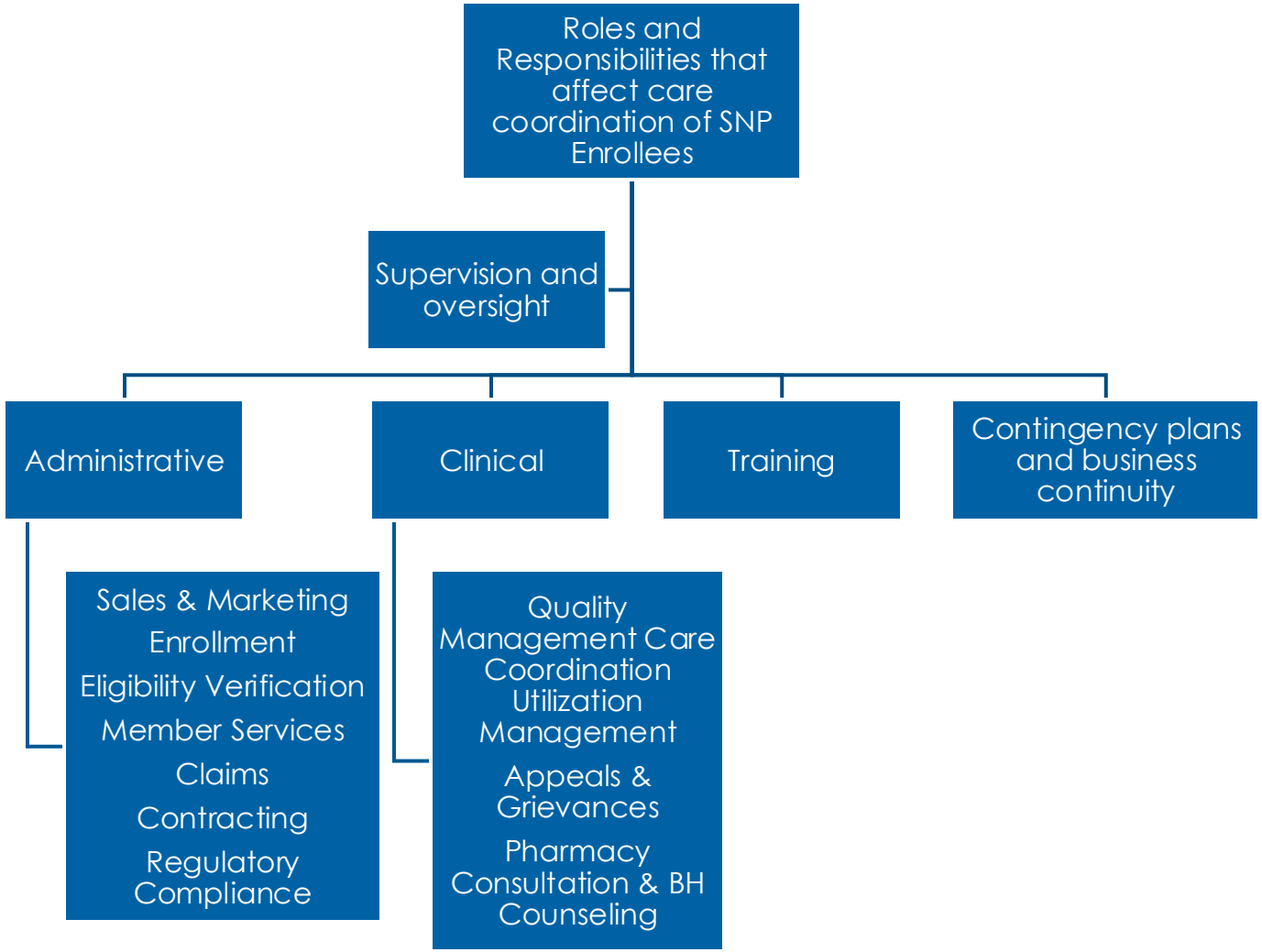
MOC 2: Care Coordination

Specific Care Coordination Goals for D-SNP

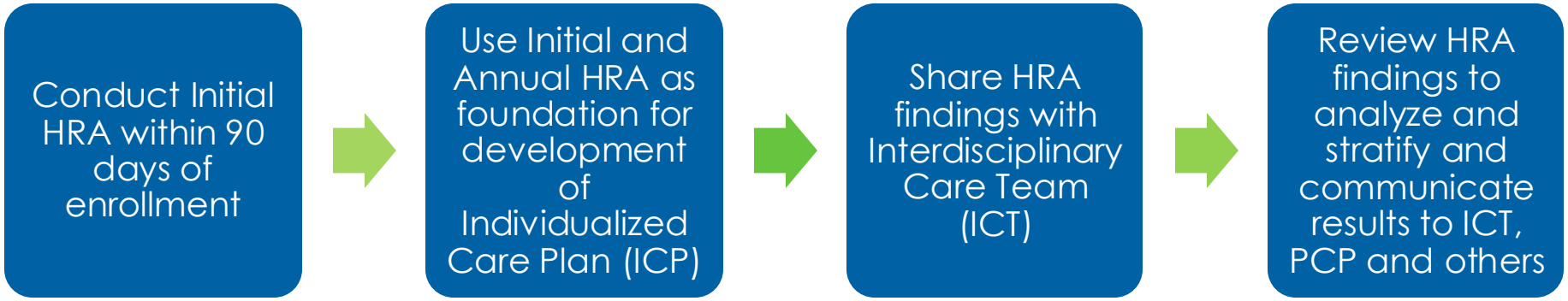
Aspects of Care:

- Use of Health Risk Assessments to determine needs
- Facilitating access to essential services, affordable care and health services
- Provide for face-to-face encounters for the delivery of health care, care management, or care coordination services
- Development of an individualized care plan
- Coordination of care through use of an interdisciplinary care team
- Transitional care across settings, providers, and health services
- Appropriate utilization of services
- Improving health outcomes

SNP Staff Structure



Health Risk Assessment (HRA)



Face-to-Face Encounter

Face-to-face encounters must:

- Occur at least annually beginning in the first 12 months of enrollment
- Be between each enrollee and a member of the enrollee's ICT, the plan's case management and coordination staff or contracted plan health care providers
- In-person, or real-time virtual
- Have a defined intended outcome
- Include clinical functions, assessments or services specified in the MOC
- Be used to identify and address health concerns
- Be used to activate care coordination follow ups (e.g., referrals, etc.)

Individualized Care Plan (ICP)

Includes member goals and preferences, services tailored to meet needs and "SMART" goal statements

Developed by clinical staff for each enrollee, using HRA responses and other available information

Documented and maintained in CM software application

Reviewed and modified at least annually and when change in needs occurs

Is communicated to member and other stakeholders (e.g., ICT)

Interdisciplinary Care Team (ICT)

Composition of ICT is specific to member needs:

- All DSNP members have care coordinated by an ICT
- Composition based on member needs and includes member/caregiver, PCP and other providers
- ICT members have distinct roles and responsibilities
- ICT members use outcomes to evaluate and continually improve health status of members
- ICT members exchange member information regularly
- The member's Primary Care Provider is an important contributing member of the ICT

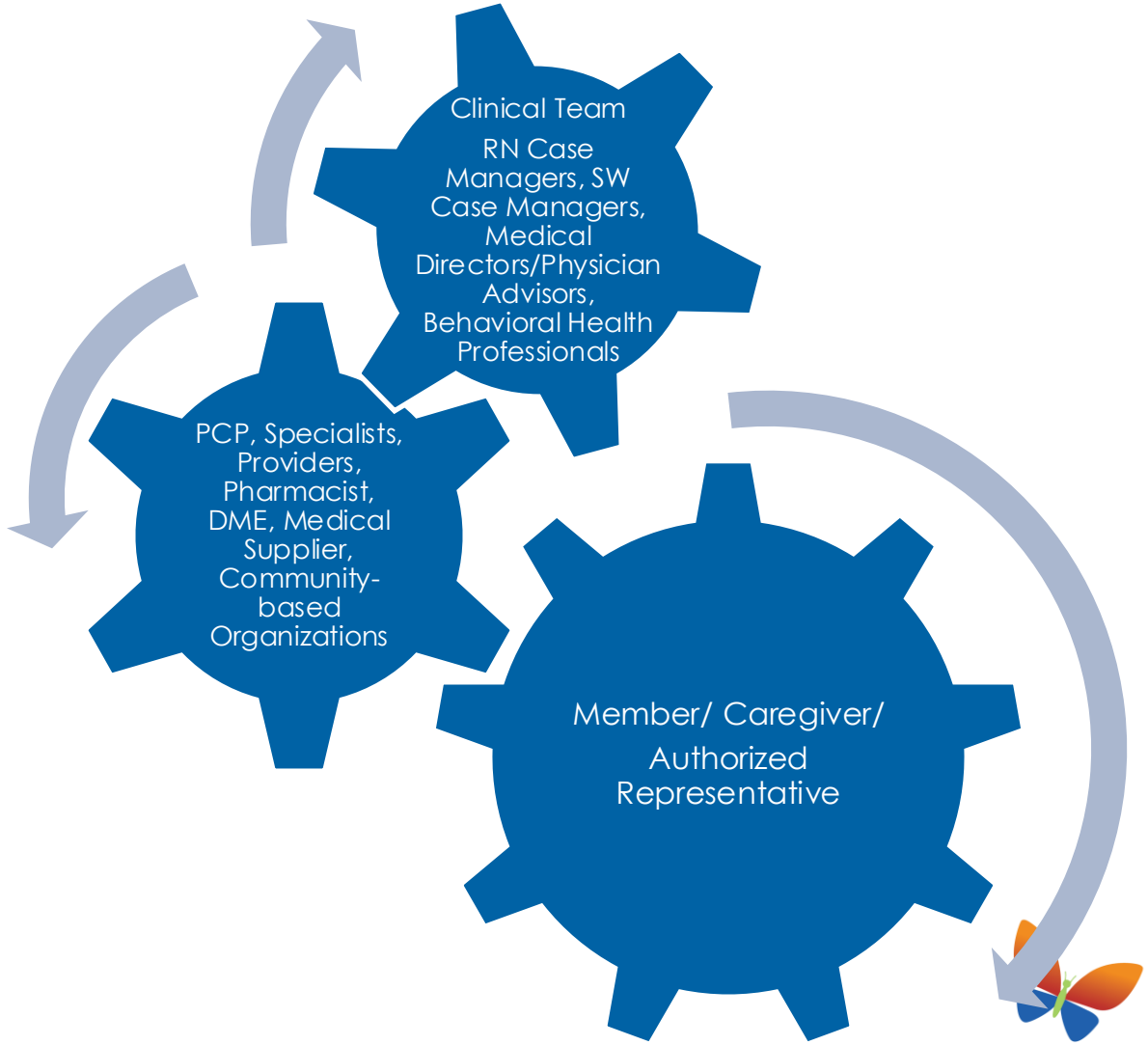
Interdisciplinary Care Team (ICT)

Member Participation

- Member receives a "Welcome Letter"
- Outreach by case management staff to conduct HRA by telephone
- Member/caregiver encouraged to participate in care plan development and ICT
- Case Manager communicates with member/caregiver to discuss care coordination program and individualized care plan
- Member/caregiver encouraged to inform plan for new or changes in condition
- Ongoing communication amongst ICT members is coordinated / ICT meetings as needed

Interdisciplinary Care Team (ICT)

- Member Care Plan must be administered through the ICT
- Invitees may participate in meeting or may decline
- Member care plan is reviewed and revised during ICT meeting, with or without member and/or external participants
- To reach Health Plan care coordination staff call: 800-822-6226 for assistance with member care issues



Care Transition Protocols

Care Transition Protocol	Designated Care Manager	Members provided with
• Applicable to all enrollees • Used to maintain continuity of care • Planned and unplanned transitions • In and out-of-network	• Coordinates care transition • Transfers elements of ICP between settings	• Information for accessing PHI • Education about health status and self-management tool • Information about point of contact through transition

MOC 3: Provider Network

Specialized Expertise

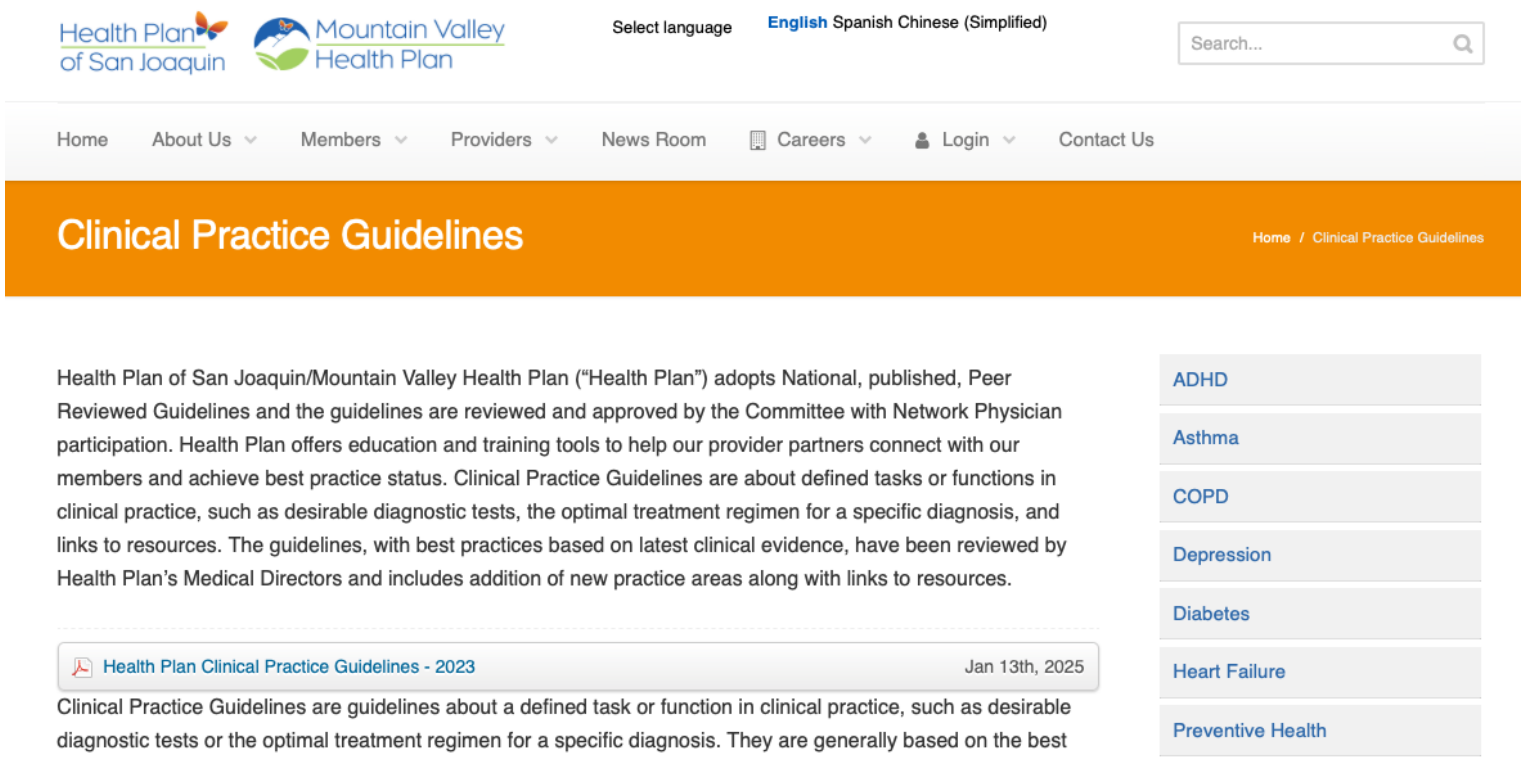
Network	• The network must include providers with specialized expertise that corresponds to target population (i.e., duals)
Oversight of Network	• The SNP credentials and recredentials practitioners and facilities
Provider Directory	• The SNP documents, updates, and maintains accurate provider information
Collaboration	• Providers are expected to collaborate with the ICT and contribute to the care plan

Clinical Practice Guidelines (CPGs) Care Transition Protocols (CTPs)

CPGs	Challenges to using CPGs	Communication of modified CPGs	CTPs
• The SNP adopts CPGs to promote evidence-based care, and monitors network provider use of CPGs	• The SNP modifies CPGs when they are inappropriate for the population or service area	• When CPGs are modified, changes communicated and acted upon	• The SNP ensures continuity of care across transitions (in and out-of-network)

Clinical Practice Guidelines

Available on Health Plan Website



MOC Training for Providers

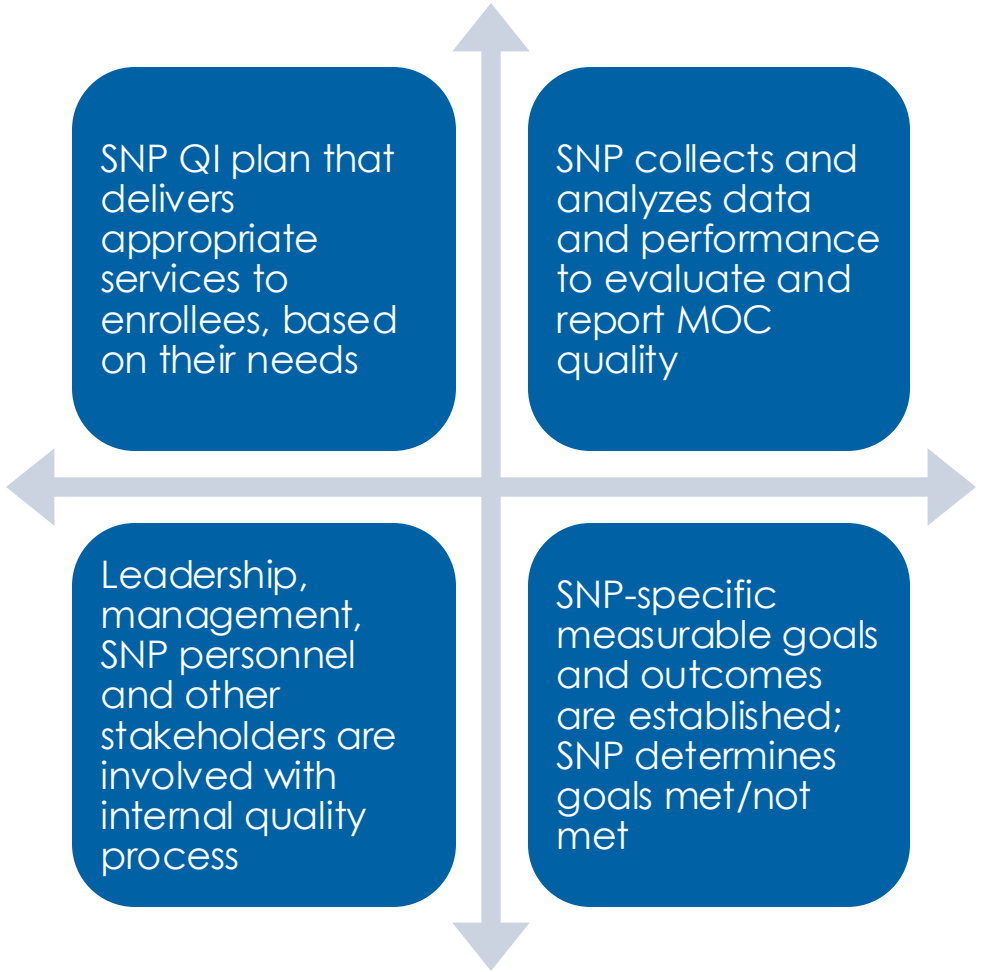
Training required for	Evidence of Training	Address challenges associated with training	Actions taken when
• Contracted providers • Out-of-network providers who see members on a routine basis	• SNP documents evidence of training delivery to providers	• Contracted providers, and • Out-of-network providers	• Training is deficient • A provider has not completed required

MOC 4: Quality Measurement & Performance Improvement

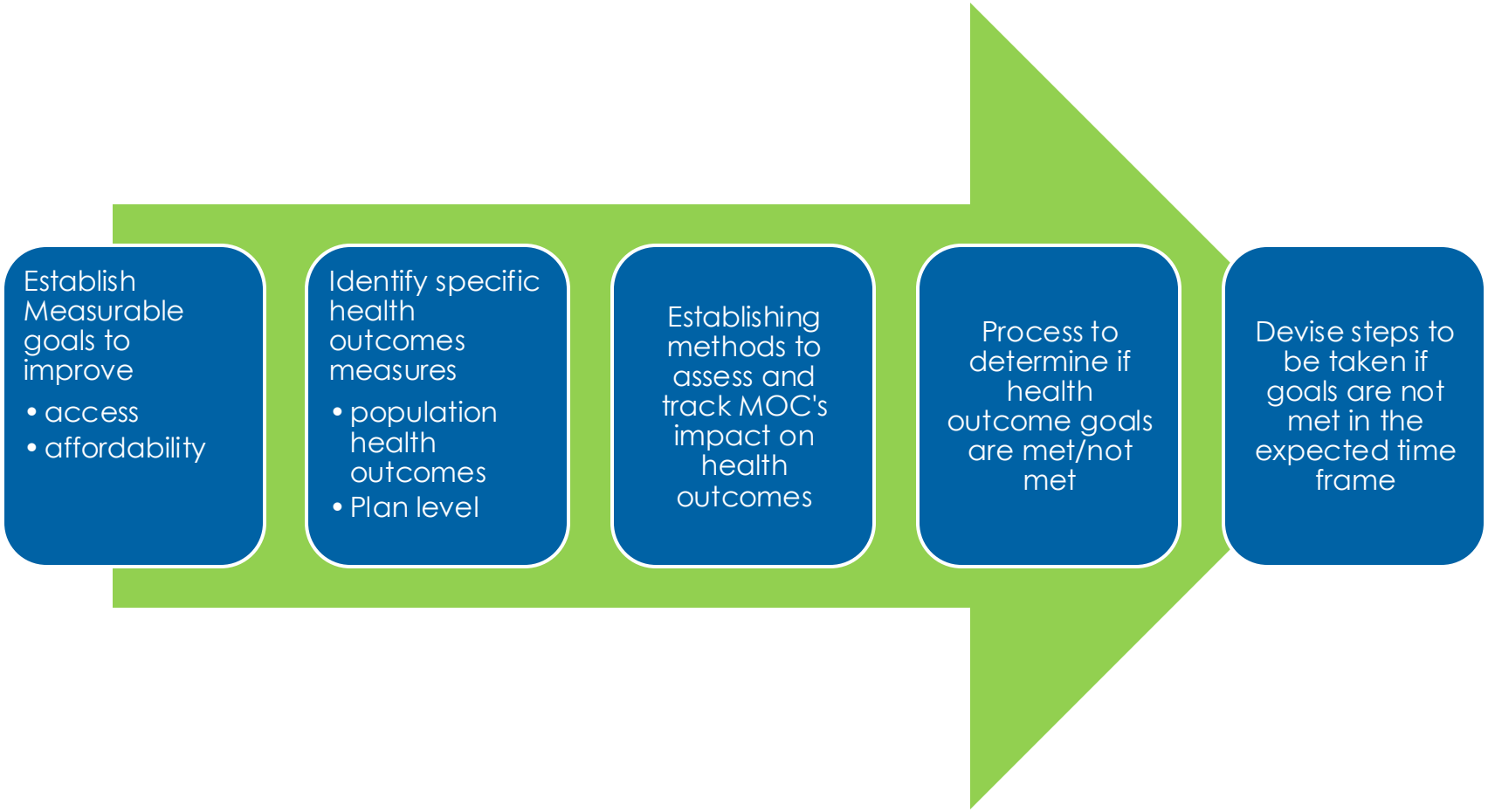
Quality Improvement Requirements

- SNP conducts a QI program that measures effectiveness of MOC
- Goal is to improve the SNP's ability to deliver high-quality services and benefits
- Leadership, managers and governing body evaluates performance, identifies improvement opportunities to modify systems and processes

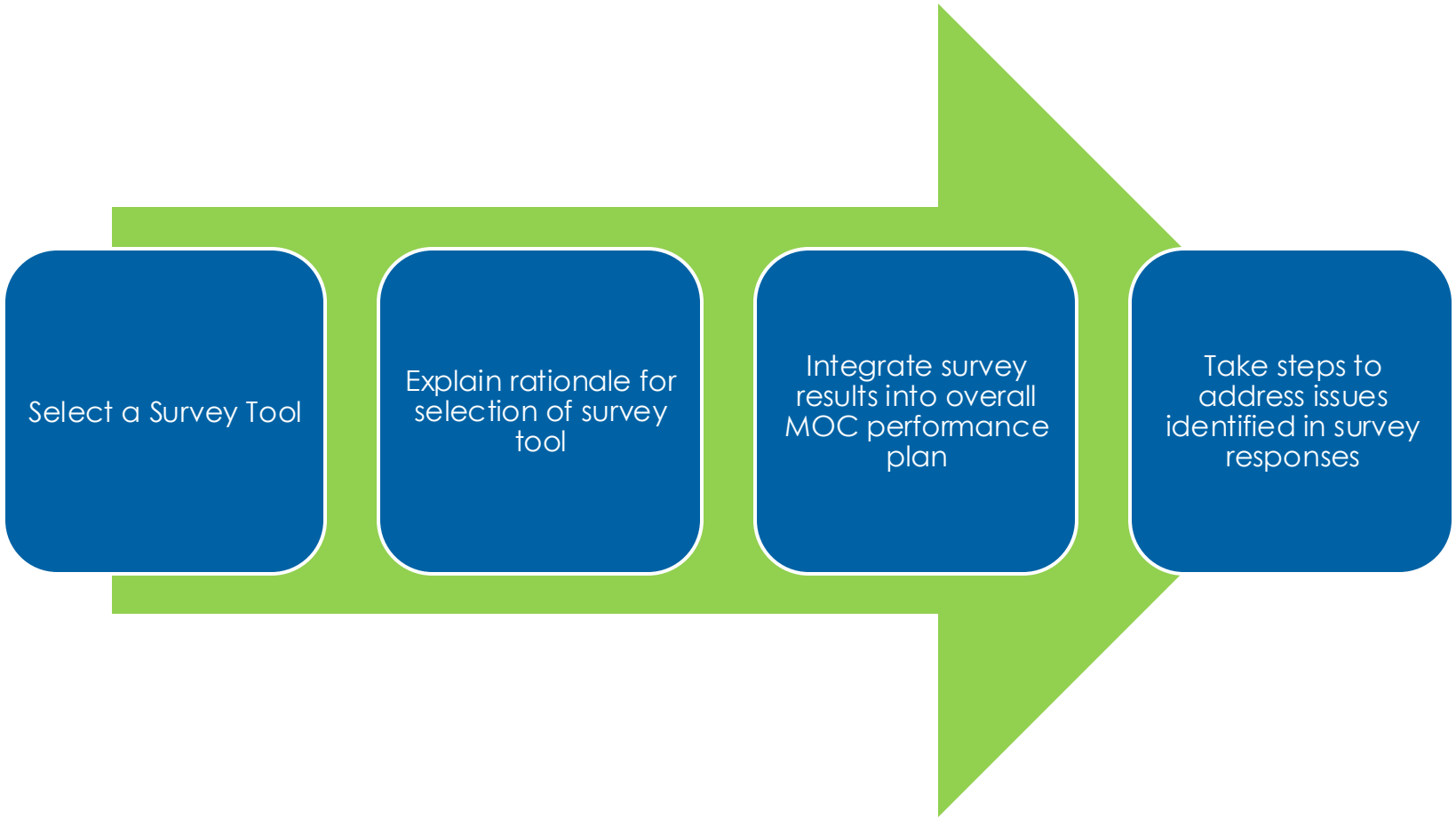
MOC Quality Performance Improvement Plan



Measurable Goals and Health Outcomes

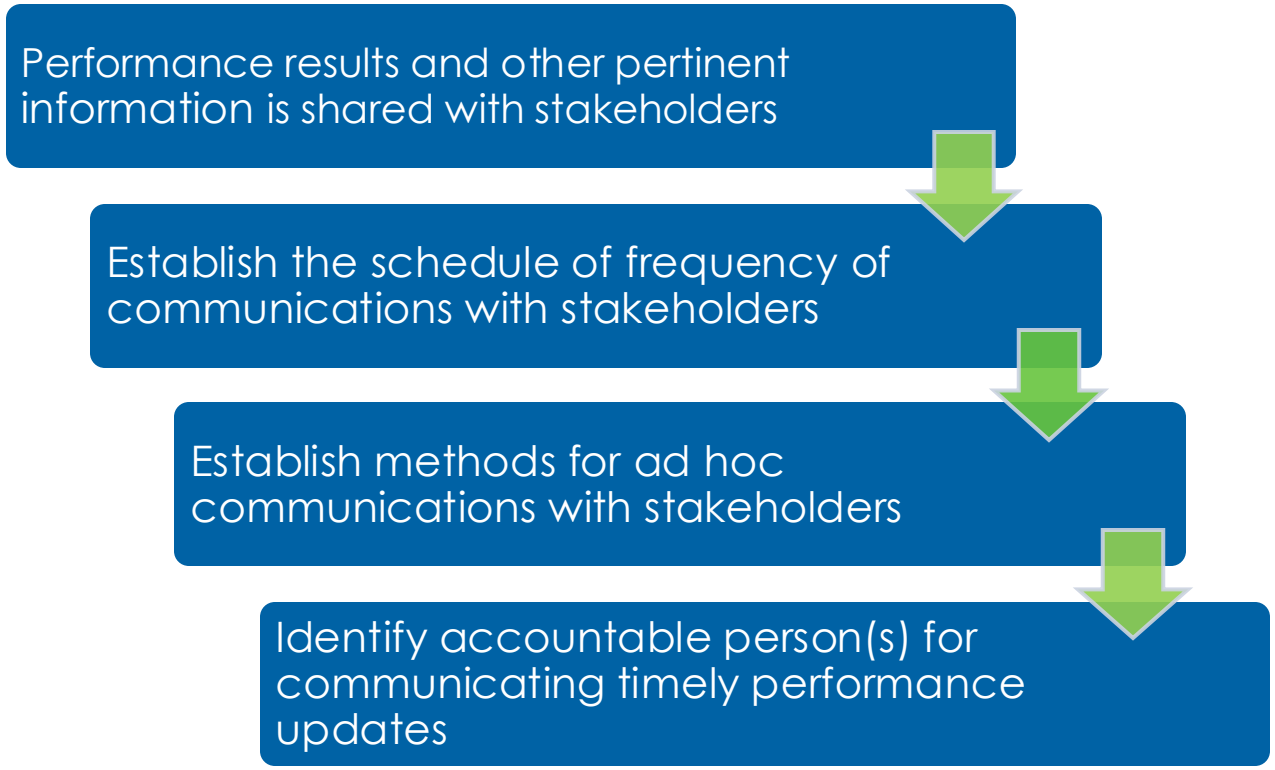


Measuring Patient Experience of Care (Satisfaction)



Ongoing Performance Improvement Evaluation of the MOC

Dissemination of SNP Quality Performance Related to the MOC



Congratulations!

You have completed the Model of Care Training

Next Steps

- Providers must track completion of annual Model of Care training
- Please follow your organization's guidance to ensure accurate training records are maintained

THANK YOU!

Health Plan of San Joaquin

Mountain Valley Health Plan

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