Special Needs Plan Model of Care Education

2026 Provider Training

Learning Goals

- Background of Medicare Advantage and HealthTeam Advantage (HTA)
- What a Chronic Special Needs Plan (C-SNP) is and how it's different from traditional Medicare Advantage (MA) plans
- How beneficiaries qualify for a C-SNP plan
- What a Special Needs Plan (SNP) Model of Care (MOC) is
- Understanding care coordination for SNP members and the development of an individual care plan (ICP)
- Membership and function of the interdisciplinary care team (ICT)
- HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP) coverage area

Medicare Advantage and HealthTeam Advantage

Medicare Advantage (MA), also known as "Part C", is a type of health plan that provides all the benefits of Original Medicare (Part A and Part B) and often includes prescription drug coverage (Part D).

HealthTeam Advantage incorporated in 2015 and entered the Greensboro Medicare Advantage marketing in 2016 offering plans in 4 North Carolina counties. Since then, the company has grown and now provides coverage for more than 22,000 members throughout 33 North Carolina counties based on plan selected.

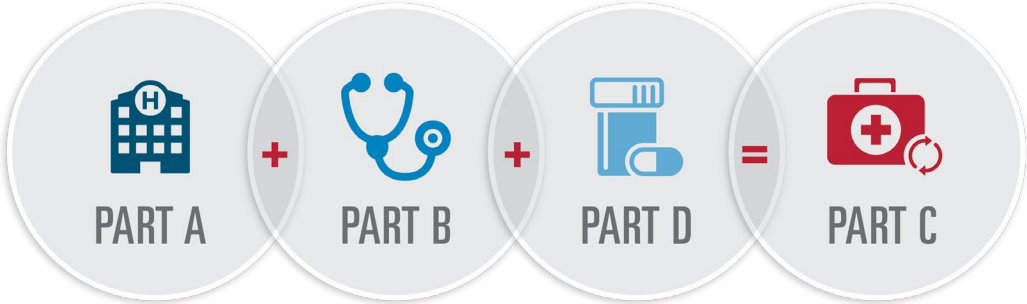
Conducting business as HealthTeam Advantage, Care N' Care Insurance Company of North Carolina, Inc., is owned by Cone Health. Cone Health became a part of Risant Health, a nonprofit organization created by Kaiser Foundation Hospitals at the end of 2024.

HealthTeam Advantage offers 5 Medicare Advantage plans. 4 Medicare Advantage Preferred Provider Organization (PPO) plans and one Medicare Advantage Health Maintenance Organization Chronic Special Needs (HMO C-SNP) Plan with membership more than 19,000 in our PPO plans and more than 3,600 HMO C-SNP plan members.

HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP) plan is currently available in 7 North Carolina counties: Alamance, Davidson, Davie, Forsyth, Guilford, Randolph, and Rockingham counties.

What is a Chronic Special Needs Plan?

- A Chronic Condition Special Needs Plan (C-SNP) is a type of Medicare Advantage (MA) plan that provides extra support for people with chronic or disabling conditions.
- Congress created Special Needs Plans (SNPs) as a new Medicare Advantage (MA) plan type in 2003.
- The Center for Medicare & Medicaid Services (CMS) approves three types of SNPs:
  - **Dual-eligible SNPs:** enroll only beneficiaries dually entitled to Medicare and Medicaid
  - **Chronic SNPs:** enroll only beneficiaries who have certain chronic or disabling conditions
  - **Institutional SNPs:** enroll only beneficiaries who reside in institutions or are nursing-home certified



Characteristics of Special Needs Plans

- Limited enrollment: Members must have a qualifying condition
- Members tend to have multiple comorbid conditions and are more challenging, complicated, and costly to manage
- Plan benefits are customized to better meet the needs of the chosen population
- Enrollment options are year-round for those with qualifying conditions
- There must be a comprehensive SNP Model of Care (MOC) that provides a detailed road map for care management, policies, and clinical operations (The MOC must be approved by NCQA)

CMS List of 22 SNP-specific Chronic Conditions

Medicare Advantage plans target benefits for persons with one or more of the following severe or disabling chronic conditions:

- Chronic Alcohol Use Disorder and other Substance Use Disorders (SUDs)
- Autoimmune Disorders
- Cancer
- Cardiovascular Disorders
- Chronic Heart Failure
- Dementia
- Diabetes Mellitus
- Overweight, Obesity, and Metabolic Syndrome
- Chronic Gastrointestinal Disease (CGD)
- Chronic Kidney Disease (CKD)
- Severe Hematologic Disorders
- HIV/AIDS
- Chronic Lung Disorders
- Chronic and Disabling Mental Health Conditions
- Neurologic Disorders
- Stroke
- Post-organ Transplantation Care
- Immunodeficiency and Immunosuppressive Disorders
- Conditions associated with cognitive impairment
- Conditions with functional challenges that require similar services
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning

HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP)

To join HealthTeam Advantage's Chronic Special Needs Plan (CSNP) Medicare-eligible beneficiaries must meet the special eligibility requirements of a diagnosis of diabetes mellitus, chronic heart failure (CHF), and/or a cardiovascular disorder (CVD).

Eligibility requirements:

- Eligible beneficiaries must be entitled to Medicare Part A and enrolled in Part B as of the effective date of coverage
- Prospective members must have a verified diagnosis of diabetes mellitus, chronic heart failure (CHF), and/or a cardiovascular disorder (CVD)
- Prospective members must live in Alamance, Davidson, Davie, Forsyth, Guilford, Randolph, or Rockingham County

Eligibility will be <u>verified</u> by the following:

- Enrollees must attest to having the chronic condition at the point of enrollment. Verification of a member's diagnosis for enrollment in the CSNP will be confirmed through a provider verification form. Provider verification is <u>required within 30 days</u> of the member's effective date. Failure to return the verification form timely could cause the member's disenrollment from the plan.

HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP)

Our Member Value Proposition

"To partner with beneficiaries in management of their chronic conditions, reduce acute exacerbations of heart failure, improve diabetic control, and generally improve care, outcomes, and the experience of care."

- Disease-specific education
- $0 copayments for primary care provider visits and certain specialist visits
- Specially tailored formularies ($0 copayments for key medications)
- Care plans directed by local expert physicians
- Latest technologic advances to improve monitoring and compliance

- Individualized member care plan
- Care coordination between primary care and specialty services
- Healthcare Concierge model for personalized member services
- Integrated pharmacist support

Targeted Care Models Improve Outcomes for Diabetic Members

A study by Avalere Health found diabetic Medicare beneficiaries who are enrolled in C-SNPs experience better outcomes than they would in non-specialized Medicare Advantage plans.

Using a claims-based approach to compare beneficiary outcomes on five clinical and utilization measures, Avalere found that enrollees in a diabetes-focused C-SNP were:

- 22% more likely to have a primary care visit
- 10% more likely to receive appropriate diabetes testing
- 38% less likely to have an inpatient hospital admission
- 32% less likely to have a readmission
- 6% more likely to fill (and refill) a prescription for an antidiabetic medication

These findings held true when controlling for expected differences in enrollees' demographics and health status. The analysis suggests that C-SNPs can improve outcomes for beneficiaries with diabetes compared to non-SNPs.

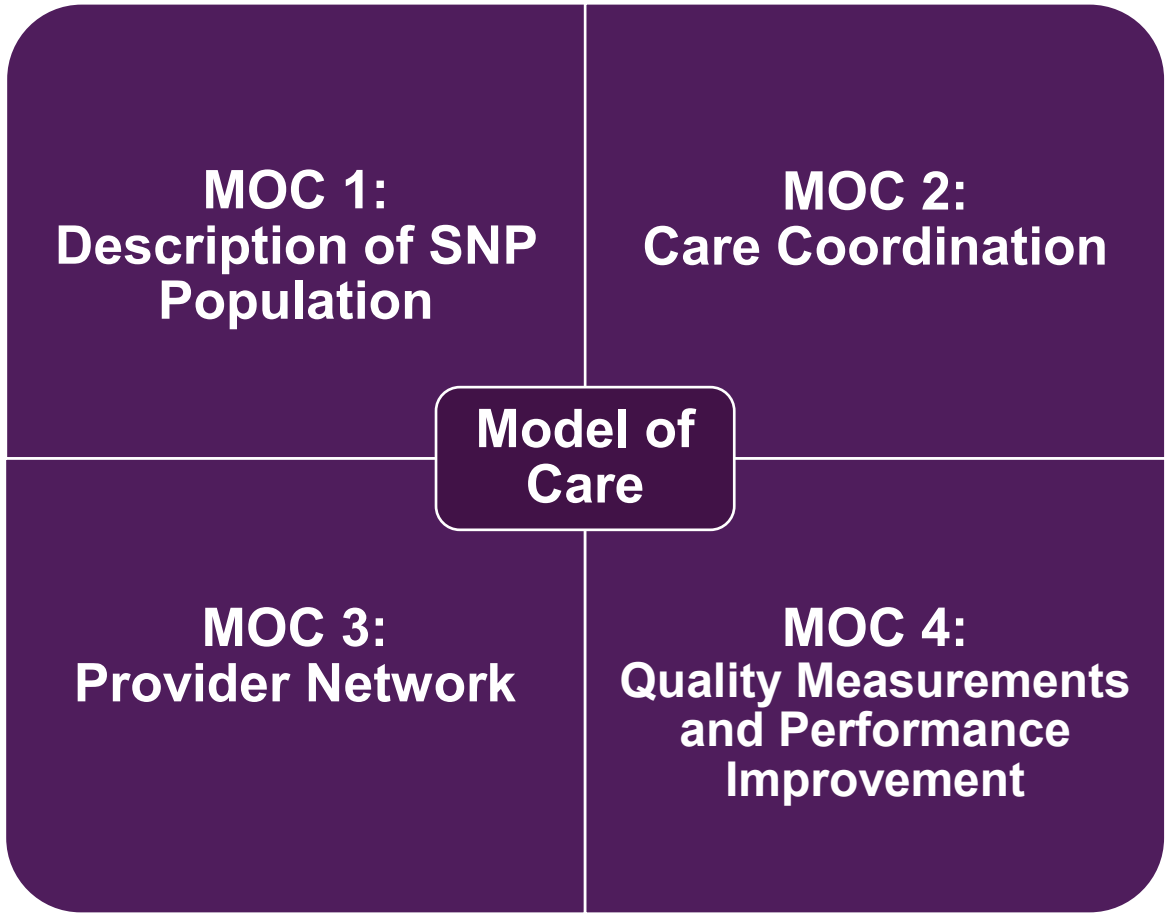
CMS Model of Care (MOC) Training

Centers for Medicare & Medicaid Services (CMS) Model of Care training is an annual, mandatory requirement for providers, staff, and contractors working with Medicare Advantage Special Needs Plans (SNPs). This training ensures healthcare teams understand how to deliver coordinated, high-quality care tailored to vulnerable Medicare beneficiaries.

CMS Model of Care (MOC) Training

Special needs plans (SNPs) are required to develop and implement a Model of Care (MOC) for each type of SNP offered.

The MOC provides the structure for care management and coordination for special needs individuals and includes 4 elements.



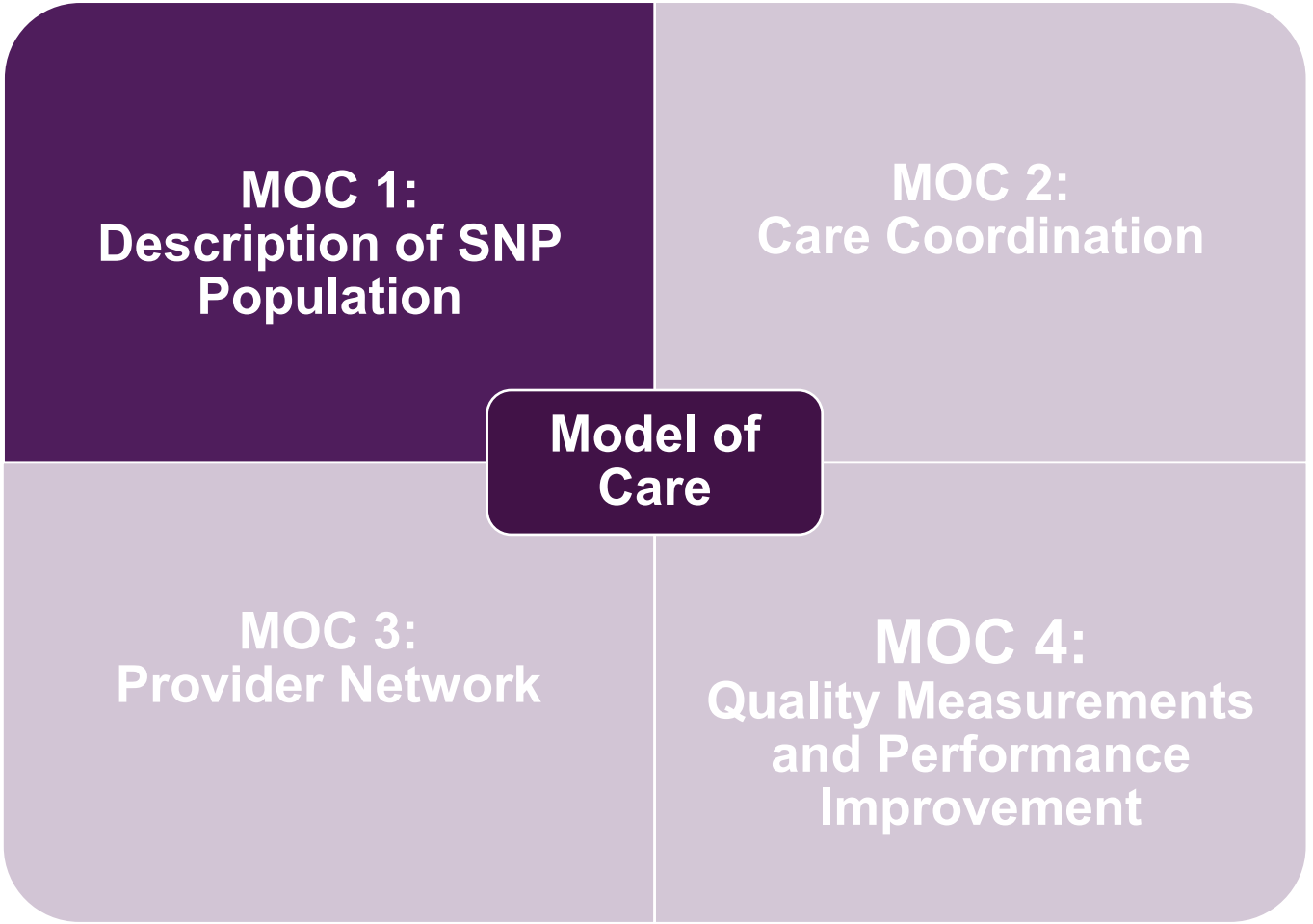
Model of Care Element 1

Special Needs Plan (SNP) Population

Model of Care Element 1

Description of SNP Population

Understanding of the intended population with methods to identify the most vulnerable members of this population.



Model of Care Element 1

Description of the CSNP Population

HTA's C-SNP targets Medicare beneficiaries with **diabetes, chronic heart failure (CHF), and/or cardiovascular disorders (CVD)**

Cardiovascular disorders include cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorders

Eligible members must be **entitled to Medicare Part A and enrolled in Part B** and meet **Medicare Advantage eligibility requirements**

Members must have a **verified qualifying diagnosis** to enroll

HTA's C-SNP **operates in seven Piedmont Triad North Carolina counties** (as CMS-approved)

Population is characterized by **complex chronic conditions** requiring coordinated, specialized care

Defined eligibility criteria guide the plan's **care coordination, provider network, and quality improvement strategies**

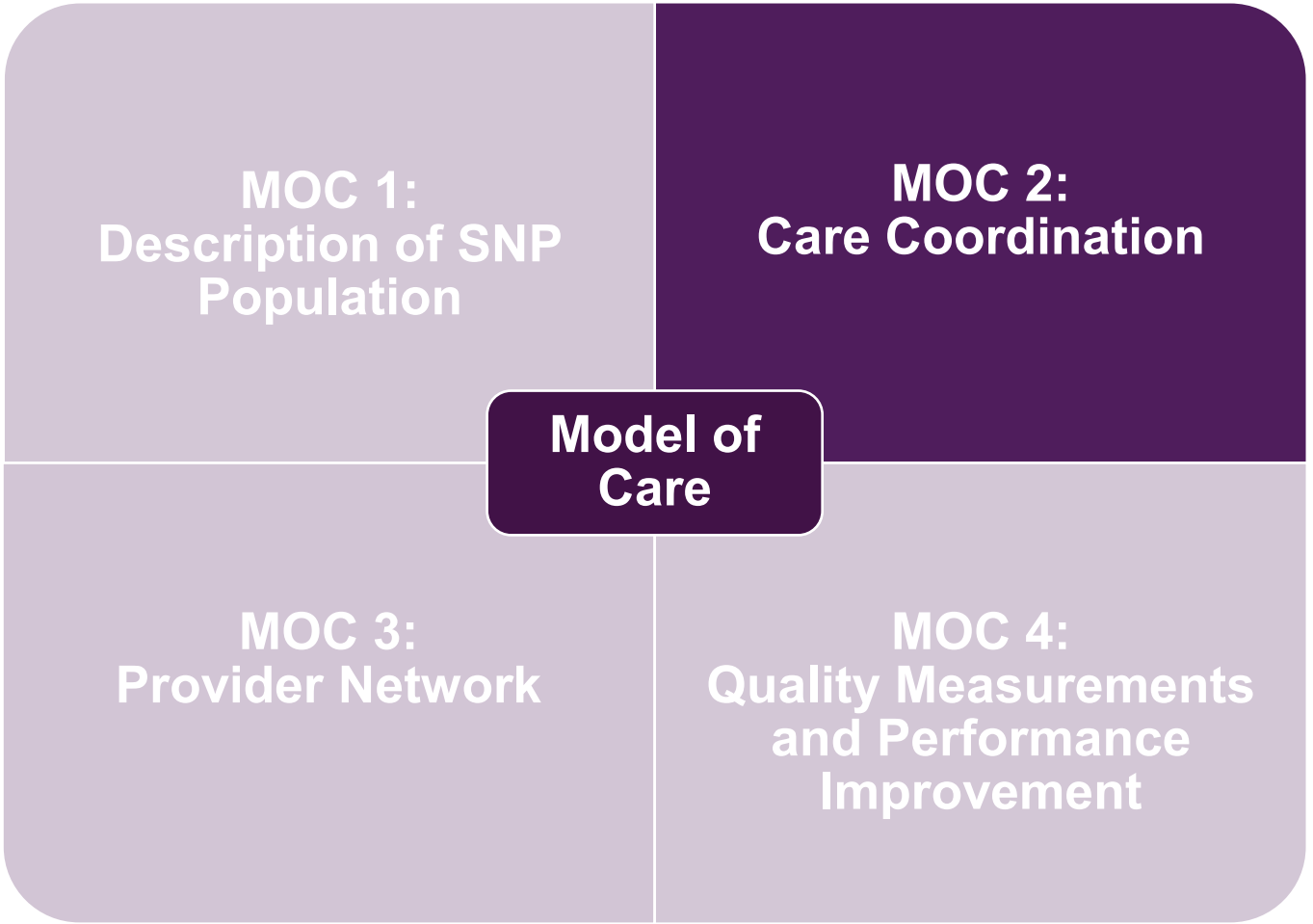
Model of Care Element 2

Care Coordination

Model of Care Element 2

Care Coordination

Detailed plan for care coordination utilizing the PCP and the member as the center of the care team.



Model of Care Element 2

Care Coordination (Overview)

Purpose of Care Coordination

- Ensure seamless, member-centered care for individuals with severe and disabling chronic conditions
- Address medical, behavioral, and social needs
- Reduce fragmentation across providers and settings

Interdisciplinary Care Team (ICT)

- Member and/or caregiver
- Primary Care Provider (PCP)
- Specialists relevant to chronic conditions
- Care manager
- Behavioral health providers
- Pharmacist and ancillary providers (as needed)

Care Coordination Model

- Centralized care management led by designated care coordinator
- Collaboration across all ICT members
- Ongoing engagement with the member and caregiver

Model of Care Element 2

Health Risk Assessment Tool

Sample Questions

Does one of your medical conditions significantly overwhelm your ability to take care of yourself?

____ Yes ____ No Which condition? _____

Do you have trouble obtaining food on a frequent basis?

____ Yes ____ No

Do you need assistance with the following? Check one response for each task.

Task	Able to do this without help	I have some help with these	I need help and I have no one to help me.
Bathing			
Dressing			
Eating			
Using the restroom			
Walking			
Taking medications			
Meal preparation			
Housekeeping chores			
Shopping and errands			
Transportation			
Money management			

If you smoke, are you thinking about quitting smoking and interested in receiving some information?

____ Yes ____ No

____ I do not smoke

Do you take more than 10 medications?

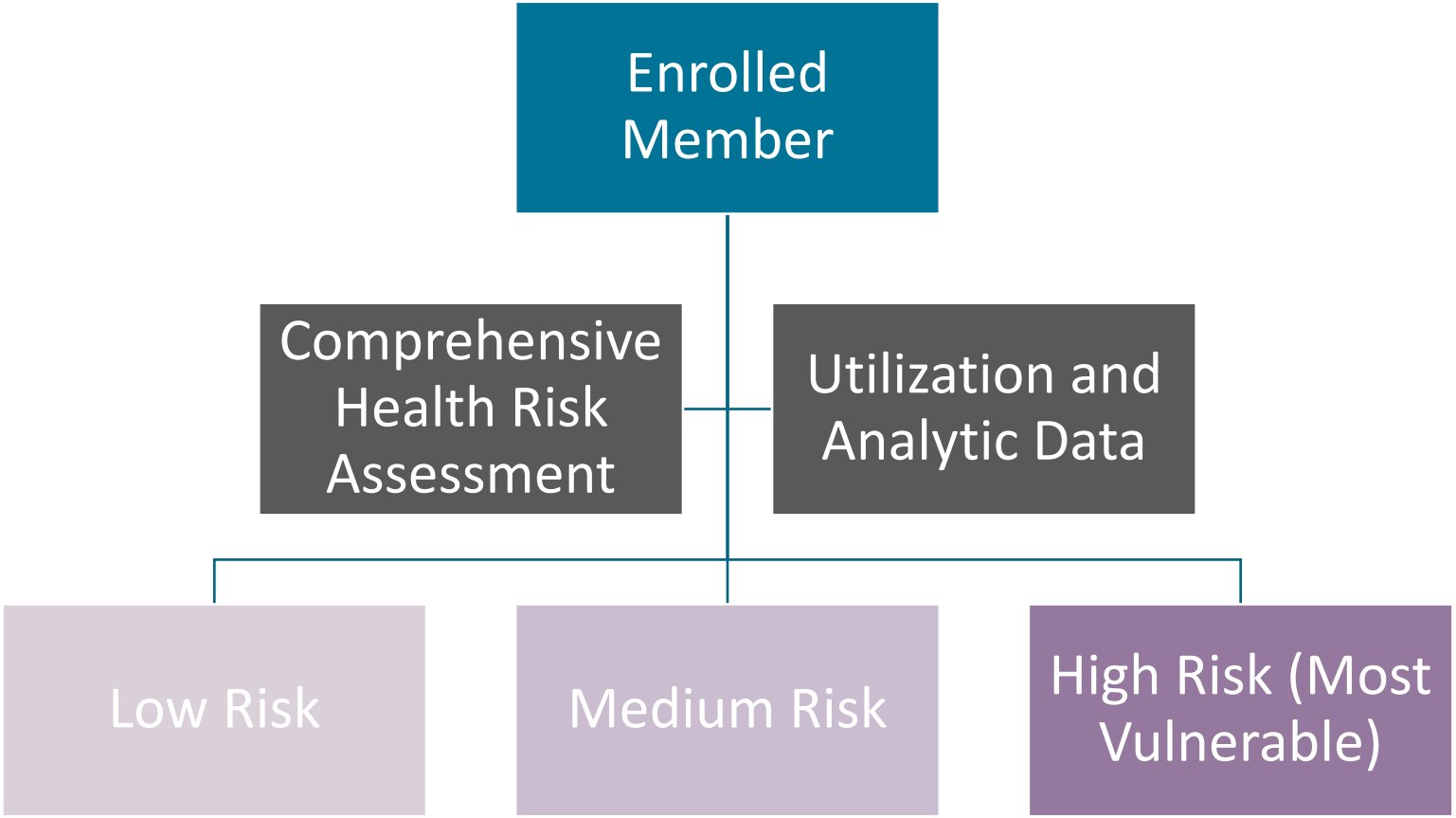
____ Yes ____ No

Do you sometimes go without your medications due to cost?

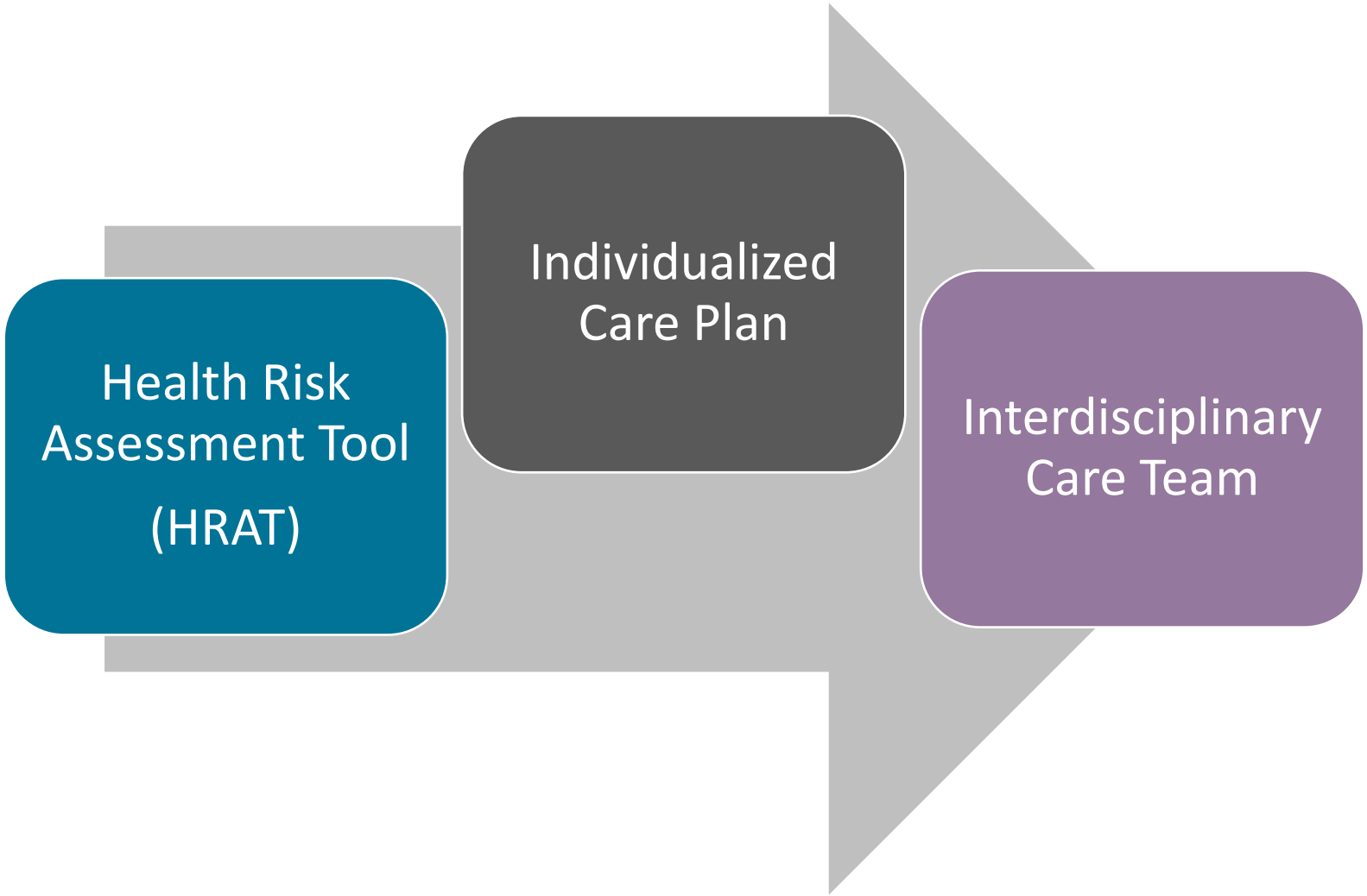
____ Yes ____ No

Model of Care Element 2

Health Risk Assessments (HRAs) and Individual Care Plans (ICPs)

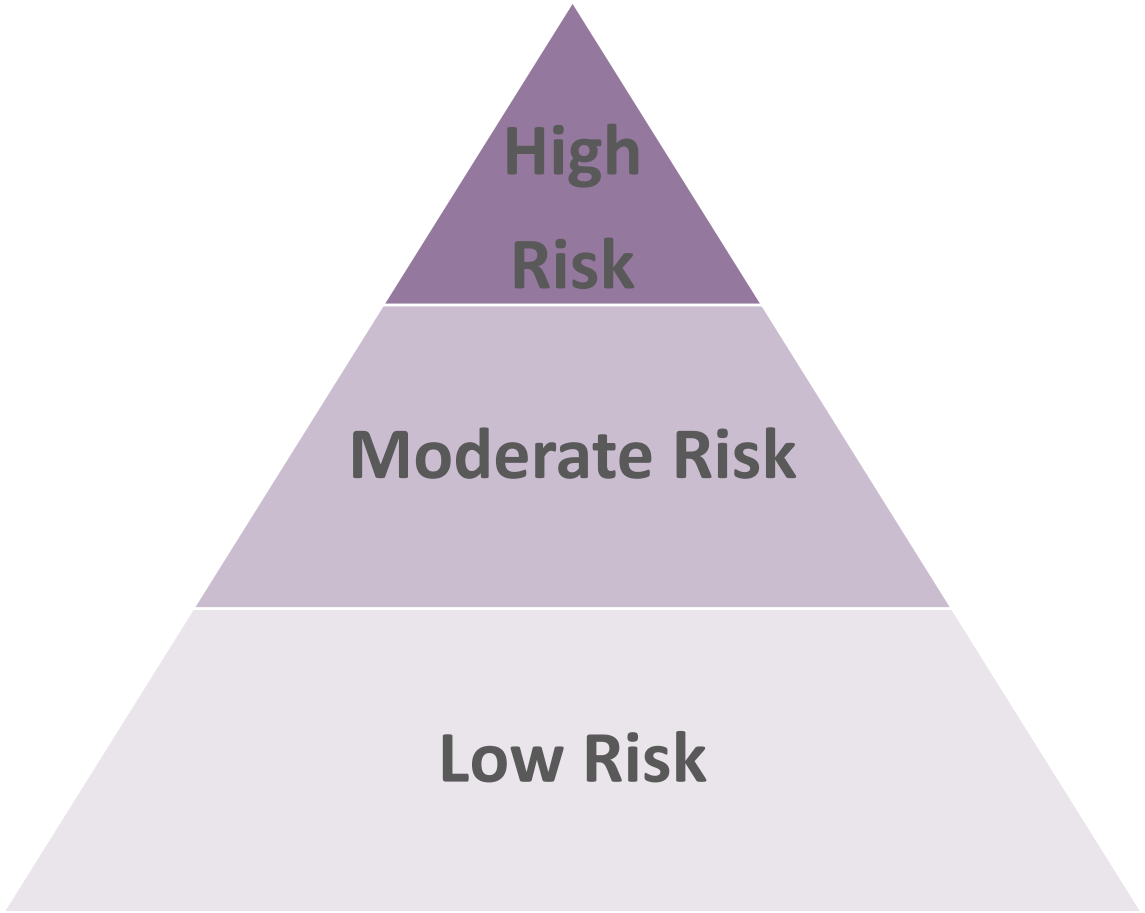


Model of Care Element 2



Model of Care Element 2

Individualized Care Plans (ICPs)



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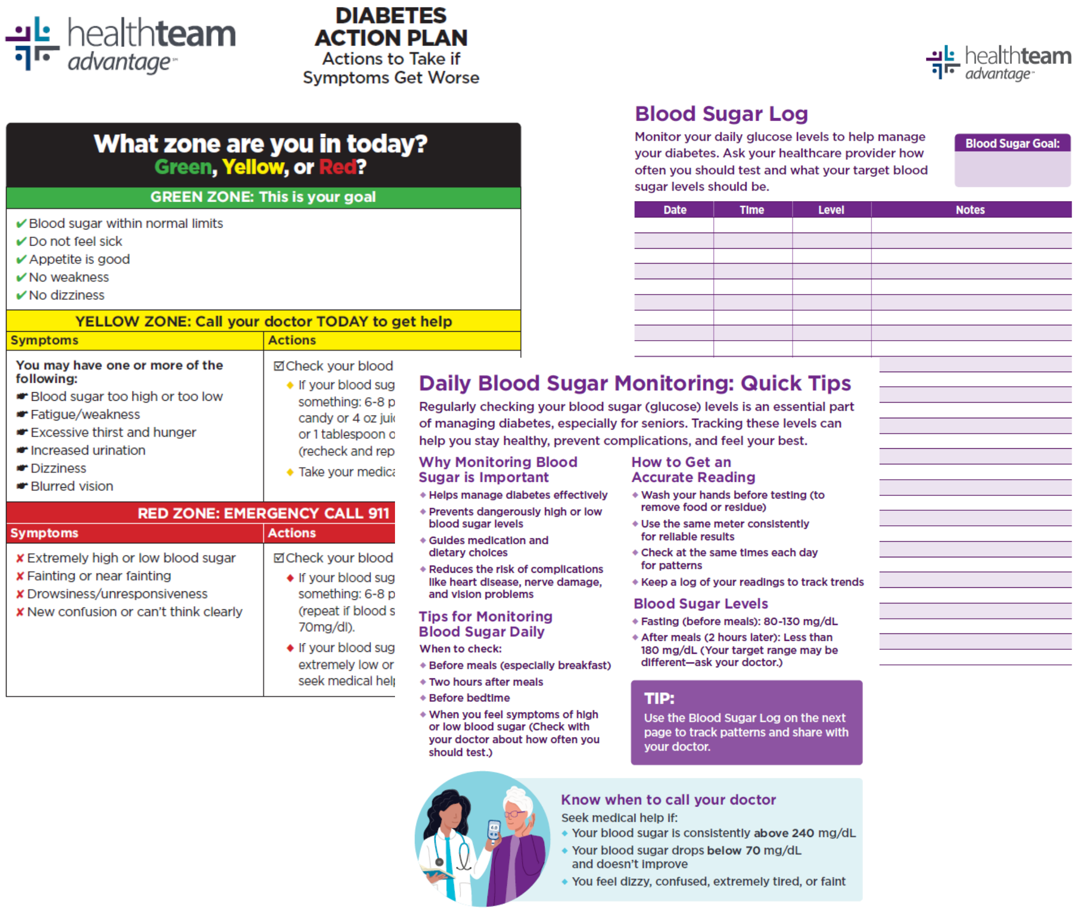
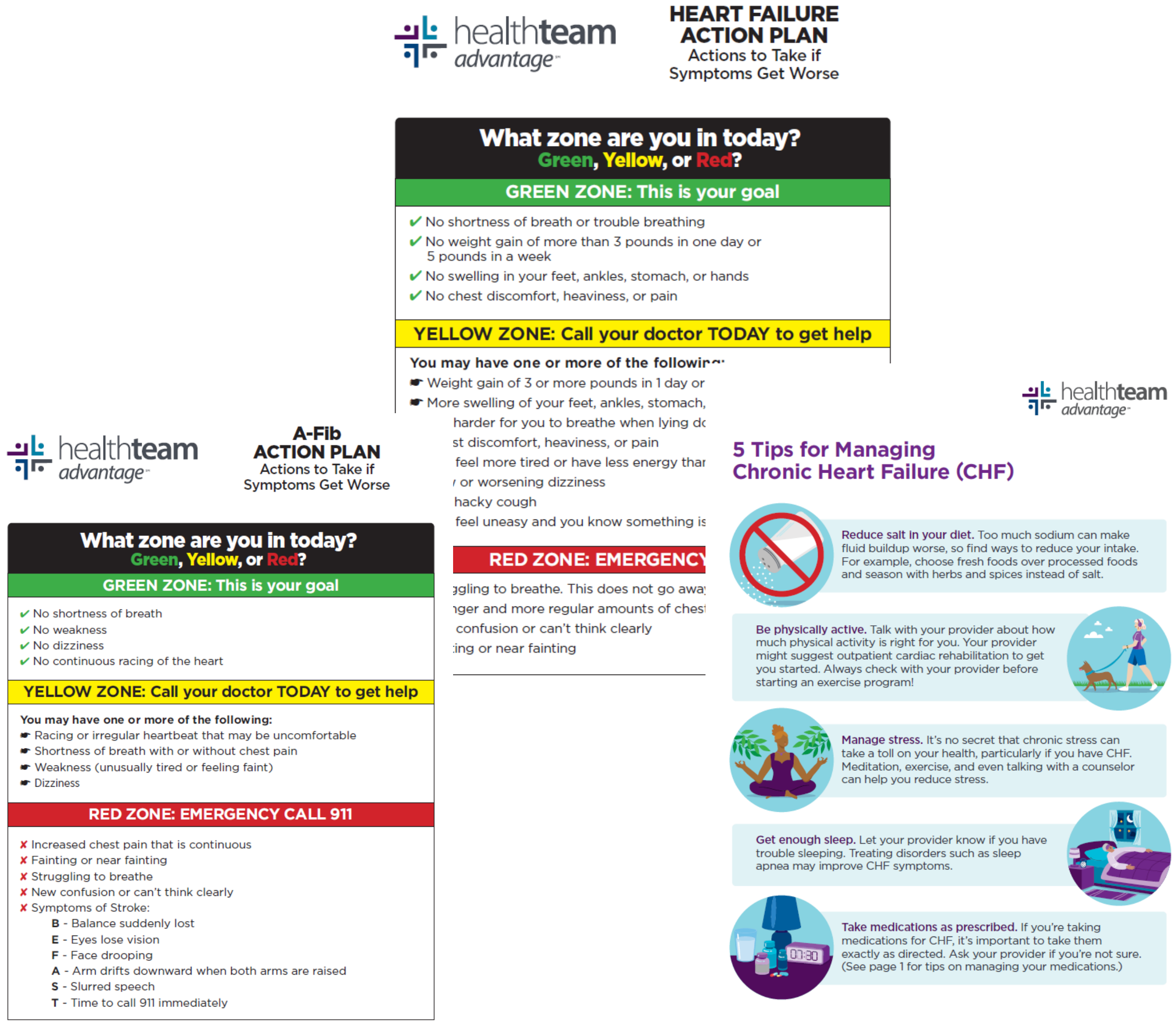
DIABETES CARE PLAN
PROBLEMS
1. Member identified as diabetic through attestation and HbA1c value
INTERVENTIONS
1. Educational outreach via member newsletter and mailings a. Medication adherence b. Annual eye (retinal) exam c. Foot care d. Appropriate lab testing e. Dietary compliance
2. Recommended Guidelines and Physician Monitoring for Compliance a. 2021 American Diabetes Association Guidelines: https://care.diabetesjournals.org/content/44/Supplement_1/S1 b. Monitor gap closure of annual HEDIS diabetic measurement set c. Appropriate lab testing for monitoring including: HbA1c, LDL-C and renal function panels d. Monitoring of utilization metrics including annual wellness visits, emergency room utilization, and hospital admissions e. Monitoring abnormal results for further interventions
3. Additional monitoring a. Medication reconciliation b. Functional status assessment
GOALS
1. HbA1c <7% 2. Monitor HbA1c at least 2 times per 12 months 3. Medication adherence of 90% + 4. Annual wellness visit annually 5. At least one additional PCP visit/year 6. Annual retinal exam 7. Annual foot exam 8. Annual lipid profile

Member Education and Outreach





Model of Care Element 2

Interdisciplinary Care Team

HealthTeam Advantage sends an invitation to the primary care provider along with the care plan.

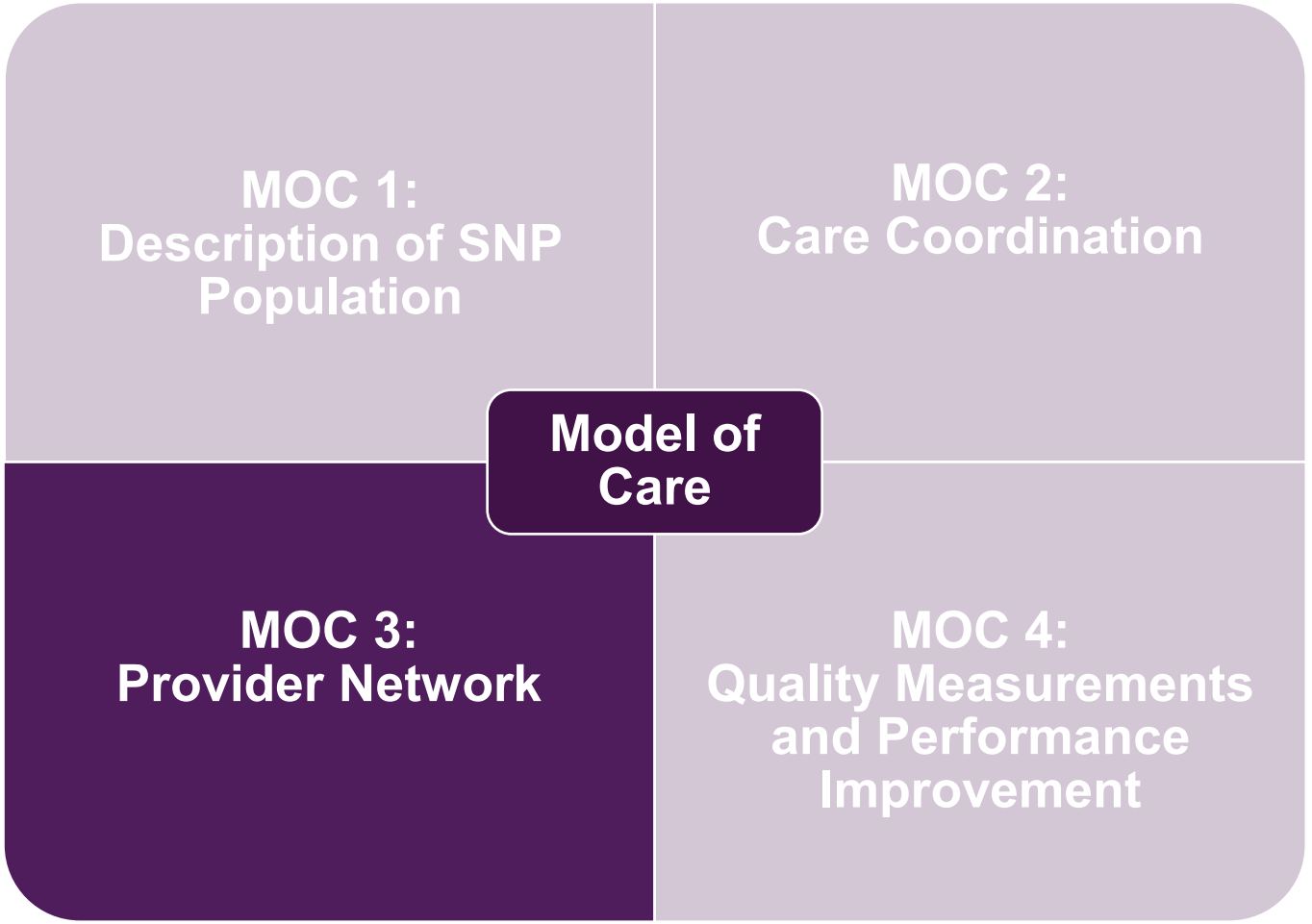
Model of Care Element 3

Provider Network

Model of Care Element 3

Provider Network

The SNP provider network is made up of healthcare providers who are contracted to offer healthcare services to SNP members. The PCP is responsible for primary care and care coordination for beneficiaries.



Model of Care Element 3

Provider Network

Purpose of the Provider Network

- Ensure access to specialized, coordinated care for C-SNP members
- Support members with severe and disabling chronic conditions
- Deliver care that is accessible, culturally competent, and evidence-based

Network Composition

- Primary Care Providers (PCPs) with experience in chronic condition management
- Specialists relevant to the target conditions (e.g., cardiology, endocrinology)
- Behavioral health providers
- Ancillary providers (labs, imaging, rehab, DME, home health)
- Pharmacists and medication therapy management support

Model of Care Element 3

Network Management & CMS Expectations

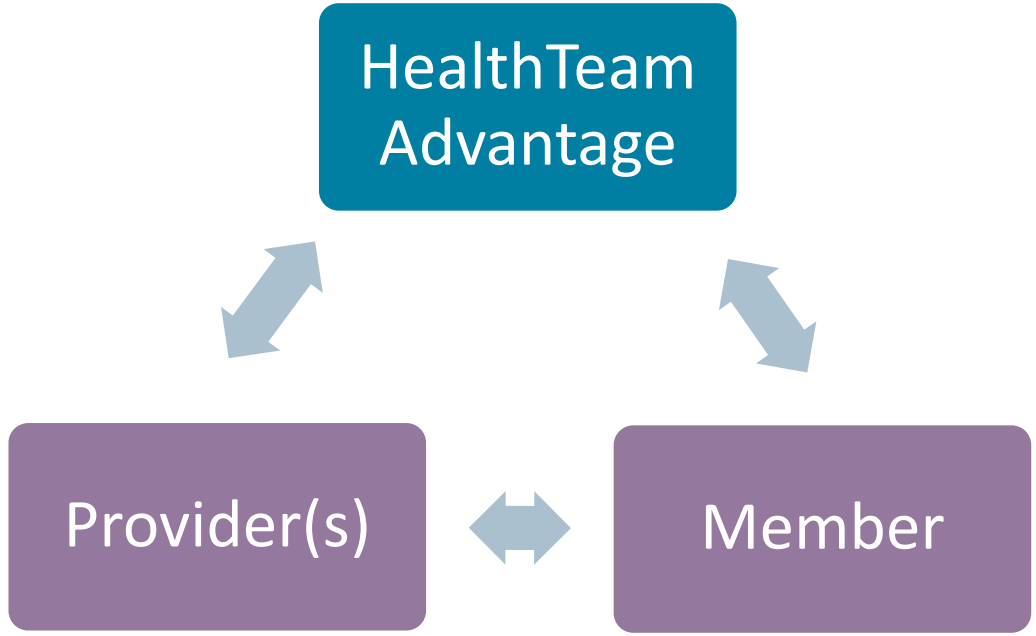
Provider Selection & Credentialing	• Providers selected based on expertise with target populations • Credentialing and re-credentialing per CMS and state standards • Ongoing evaluation of provider performance and quality outcomes
Care Coordination & Communication	• Defined processes for PCP–specialist communication • Use of care plans, referrals, and transitions of care • Shared responsibility for timely information exchange
Access & Availability	• Network meets time, distance, and appointment wait-time standards • Access to after-hours care and urgent services • Ensures continuity of care, especially during transitions

Provider Training & Oversight	• Training on:
	  • C-SNP Model of Care requirements
	  • Chronic condition management
	  • Cultural competency and health equity
	• Ongoing monitoring to ensure CMS MOC compliance

Model of Care Element 3

Communication Channels

- Provider Portal
- Provider Manual
- Provider Phone Line
- Faxes and Emails
- HTA Website
- *Provider Connections* (HTA monthly Provider eNewsletter)
- Provider Concierges
- *Member Connections* (HTA monthly member eNewsletter)
- Committee Meetings



Clinical Practice Guidelines

HealthTeam Advantage has adopted the following nationally accepted and locally vetted evidence-based guidelines:

Diabetes:

American Diabetes Association: Standards of Medical Care in Diabetes 2025

Chronic Heart Failure:

2022 ACC/AHA/HFSA Guideline for the Management of Heart Failure

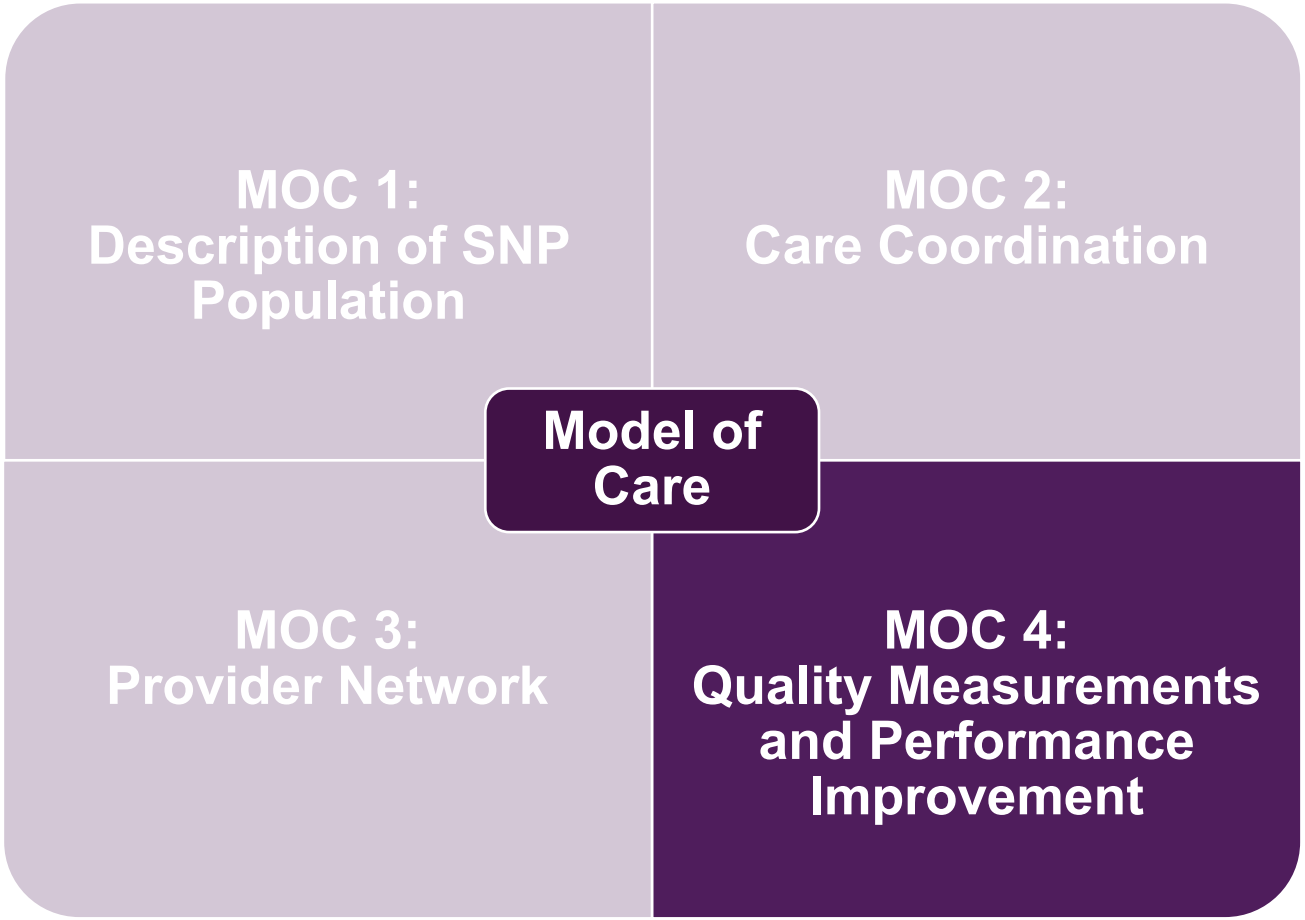
Model of Care Element 4

Quality Measurements and Performance Improvement

Model of Care Element 4

Quality Measurements and Performance Improvement

Continuous monitoring of process, performance, and quality outcomes with detailed reporting and improvement strategies.



Model of Care Element 4

Quality Measurement Overview

Purpose of Quality Measurement

- Evaluate effectiveness of the **C-SNP Model of Care**
- Ensure services meet the needs of members with **severe and disabling chronic conditions**
- Drive **continuous quality improvement (CQI)**

Quality Measurement Framework

- Measures aligned with:
  - CMS Star Ratings
  - HEDIS
  - CAHPS
  - C-SNP-specific clinical outcomes
- Use of structure, process, and outcome measures

Key Performance Domains

- Clinical quality and health outcomes
- C-SNP-specific clinical outcomes
- Member experience and satisfaction
- Access to care and service utilization

Model of Care Element 4

Measurable Goal Examples

Process Measures

- HRA completion rate
- IDT meeting rates
- Percentage of members with ICPs
- Complaints about the plan
- Percentage of staff and providers that complete annual MOC training
- CAHPS survey results around getting needed care and care quickly

Outcome Measures

- HEDIS scores for diabetes and hypertension measures
- Medication adherence rates
- Plan's all-cause adjusted readmission rate
- ED utilization rates
- Generic medication dispensing rate
- Percentage of members with an assigned PCP

We're Here for You!

If you have questions or concerns about this training, please contact HealthTeam Advantage.

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Your Provider Concierge

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844-806-8217, Option 5

Attestation

Thank you for completing our Special Needs Model of Care Training.

To acknowledge your completion of this training, you must complete and submit the attestation form.

CLICK HERE for Provider Attestation Form

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