



Provider Model of Care Training

Medica AccessAbility Solution Enhanced[®]

Medica DUAL Solution[®]

Medica Advantage[®] Dual

Objectives

- Special Needs Plan Description
- Model of Care Overview and Requirements
- Complete training attestation

Why do I need Model of Care Training?

- Centers for Medicare & Medicaid Services (CMS) Requirement
 - All Medicare Advantage Special Needs Plans (SNPs) must have a Model of Care (MOC) that describes the care and services to be provided to SNP members
 - The MOC is a detailed document (>100 pages) that provides the framework for how Medica identifies and addresses the unique needs of its SNP populations
 - CMS carefully reviews the MOC during an audit to make sure we are implementing all processes as described, including MOC training
- The Centers for Medicare and Medicaid Services (CMS) requires Medica providers who serve Medicare Advantage SNP members to complete annual training on the SNP Model of Care
- MOC training helps you:
 - Understand the unique characteristics and needs of SNP members
 - Understand the importance of your role as a member of the Interdisciplinary Care Team
 - Learn more about the role of the Care Coordinator (CC), including how you may interface with them and how they can help with the management of your SNP patients

What is a Special Needs Plan (SNP)?

- A type of Medicare Advantage Plan that focuses on certain vulnerable groups of Medicare beneficiaries
- Three types of SNPs:

I-SNP

- Institutional Special Needs Plan
- Enrolls beneficiaries who are institutionalized or require an institutional level of care (LOC)

D-SNP

- Dual Eligible Special Needs Plan
- Enrolls beneficiaries who are eligible for both Medicare and Medicaid

C-SNP

- Chronic Condition Special Needs Plan
- Enrolls beneficiaries with certain chronic and disabling conditions

Medica's Special Needs Plans: D-SNPs*

Plan Name	SNP Type	State	CMS Contract & Plan #
Medica DUAL Solution® (Minnesota Senior Health Options or MSHO)	D-SNP	MN	H2458-002
Medica AccessAbility Solution Enhanced® (Special Needs BasicCare (SNBC) Special Needs Plan or SNBC D-SNP)	D-SNP	MN	H9952-001
New in 2025: Medica Advantage® Dual (ND D-SNP)	D-SNP	ND	H8889-016

*See the appendix for additional plan related information

Model of Care

What is the Purpose of the Model of Care (MOC)?

To ensure the unique needs of each member are identified and addressed through the plan's care management practices, and provide the foundation for promoting plan quality, access to services, care management, and care coordination processes.

- MOC must meet all CMS requirements
- CMS awards approval of MOC for 1 to 3 years
- CMS requires MOC Training be completed annually



Model of Care: CMS Required Elements



Element 1: Description of SNP Population

*see the appendix for product specific demographics



Element 2: Care Coordination



Element 3: Provider Network



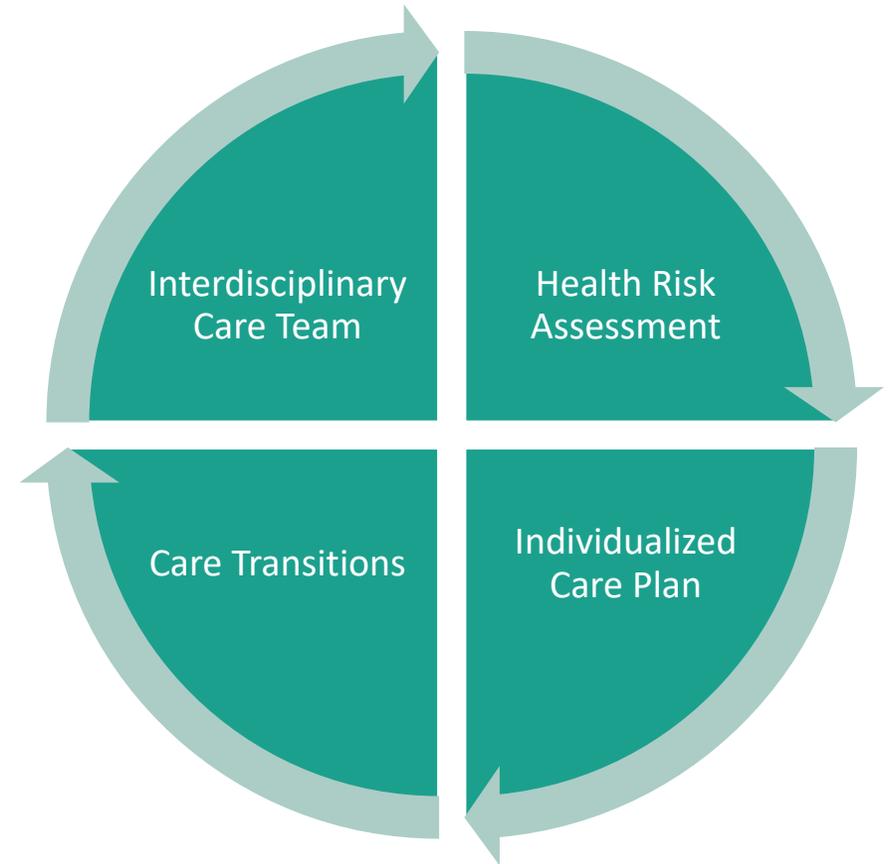
Element 4: Quality Measurement & Performance Improvement

MOC 2: Care Coordination

*All SNP members are assigned a Medica care coordinator/case manager**

The Care Coordinator's role:

- Main point of contact ensuring there is collaboration and communication among the member and the member's care team
- Complete Health Risk Assessment and Individualized Care Plan with member
- Assist member and providers with navigating benefits
- Coordinate care across providers and settings of care



*Referred to as “care coordinator” throughout this training

Care Coordination Role

Care Coordinator Responsibilities

Conduct Health Risk Assessment and develop an Individualized Care Plan with the member based on their identified needs and preferences

Ensure the member's healthcare needs and preferences are shared with the Interdisciplinary Care Team

Provide ongoing monitoring and updating of care plan

Connect the member to resources, health care, and services

Collaborate with different health and social services professionals and across settings of care

Work with the member to live in the least restrictive setting possible and that is the member's choice.

Identifying a Care Coordinator



- All SNP members are assigned a Care Coordinator who is familiar with the area where the member lives
- The Care Coordinator could be employed by Medica, or by one of our County, Care System, or Agency partners
- To identify your patient's Care Coordinator:
 - MN Providers Call 1-800-458-5512
 - ND Providers Call 1-866-905-7430

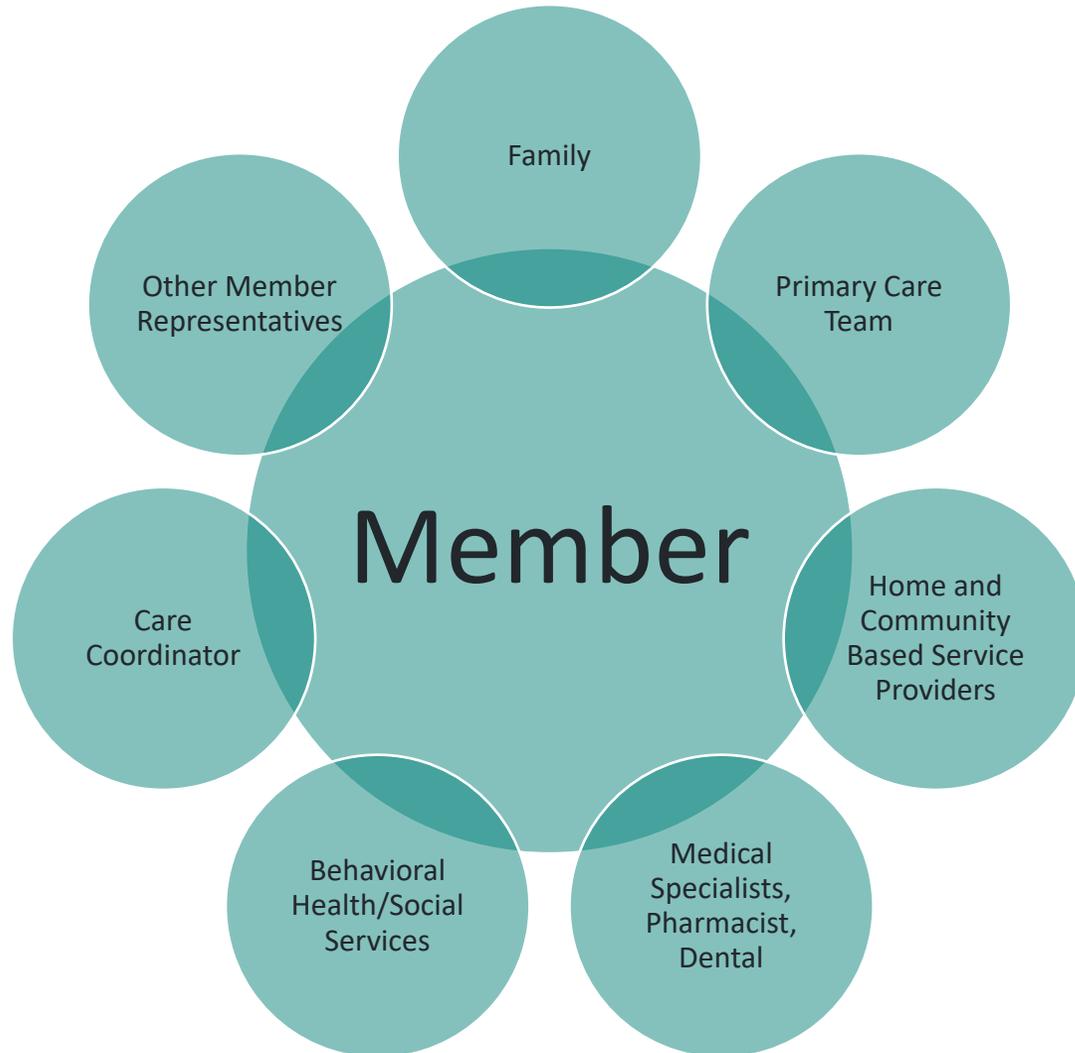
Health Risk Assessment (HRA)

- Completed by Care Coordinator with Member
 - Within 30 days of enrollment (MSHO); within 60 days of enrollment (SNBC D-SNP); within 90 days of enrollment (ND D-SNP)
 - Annually within 365 days of the last HRA completed
 - With significant change of condition
- An HRA provides the Care Coordinator with pertinent information about a member's medical, functional, cognitive, psychosocial, mental health, and Social Determinants of Health (SDoH) needs.
- The HRA drives the Individualized Care Plan by identifying a member's needs, wants, and concerns

Individualized Care Plan

- Required for every member
- Person centered, addresses needs and concerns identified during HRA
- Includes person centered SMART goals
- Completed by Care Coordinator and sent to member within 30 days (MN D-SNPs) or 60 days (ND D-SNP) of HRA
- Summary shared with Primary Care Provider (PCP) and other members of care team per member discretion
- Ongoing monitoring throughout the year with documentation of goal progress based on member-specific follow-up schedule

Interdisciplinary Care Team



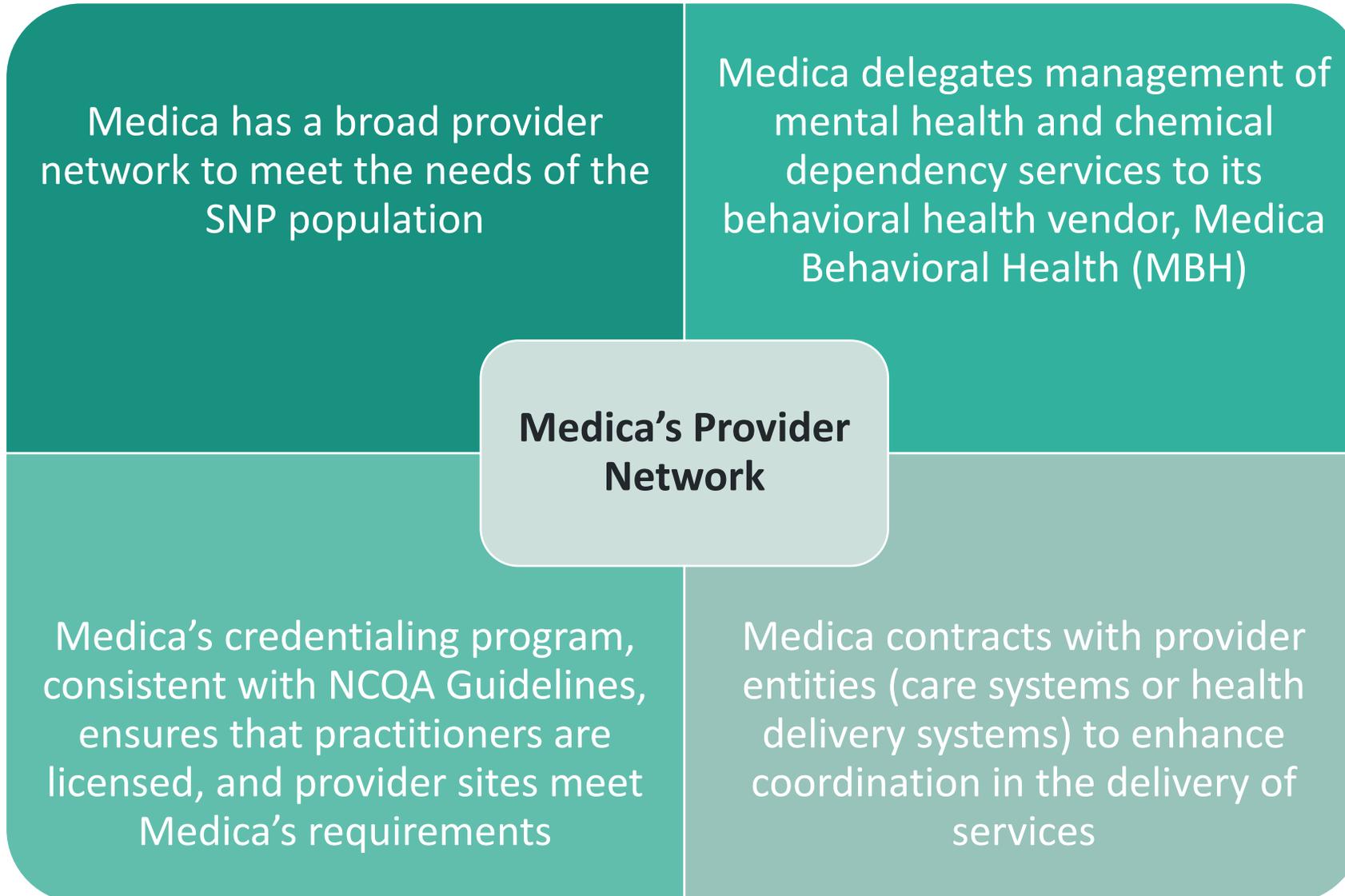
- Collaborative communication between the Care team members and the Medica Care Coordinator is essential to best serving the member and their needs
- Primary Care providers (PCPs) are integral members of the ICT who can provide valuable input on the member's care plan
- Care Coordinators communicate with the PCP at least annually with information about the member's care plan and CC contact information.
- Each member of the ICT has a role in providing the most effective and efficient care for the member

Transitions of Care

**The movement of a patient from one setting of care to another (e.g., hospital to home or nursing facility)*

- When members move from one care setting to another, they are at risk of adverse outcomes due to fragmented care
- Care Coordinators follow up with the member throughout the transition:
 - Discuss their health status changes and discharge instructions
 - Ensure that follow up appointments have been scheduled
 - Ensure member understands any changes in their medication regimen
 - Address social determinants of health issues the member may be facing
 - Determine if member needs any new services or supports upon discharge
- The communication between the Care Coordinator, providers and the member is critical to ensuring an effective transition from one care setting to another or back to home.
- As a provider, your role providing follow-up care and communicating information back to the Care Coordinator regarding transition needs of the member is important to a successful transition plan.
- Care Coordinator updates the member's care plan as necessary and shares information with the member and their Interdisciplinary Care Team, as applicable

MOC 3: Provider Network



MOC 4: Quality Measurement and Performance Improvement

- CMS requires SNPs to have a comprehensive Quality Improvement Program that evaluates the effectiveness of the MOC
- For each of the SNPs, Medica establishes process and outcome measures tied to MOC goals, such as:
 - Improving access and affordability
 - Ensuring coordination of care across the care continuum
 - Appropriate utilization of services for preventive health and chronic conditions
 - Implementation of the MOC
 - Improving member satisfaction

Examples of measures include:



Model of Care Training Attestation

- To document completion of this training, please complete the attestation form **for your state**.
- We ask that one person sign the attestation on behalf of your organization to receive credit for this training.
 - Although we ask for a representative to complete one attestation on behalf of their provider organization, all organizations must maintain evidence of each individual provider's completion of annual MOC training and provide such evidence to Medica upon request.

[Minnesota](#)

[North Dakota](#)

Appendix



Demographic, Product, and Benefit Info

Description of MN D-SNP Population*

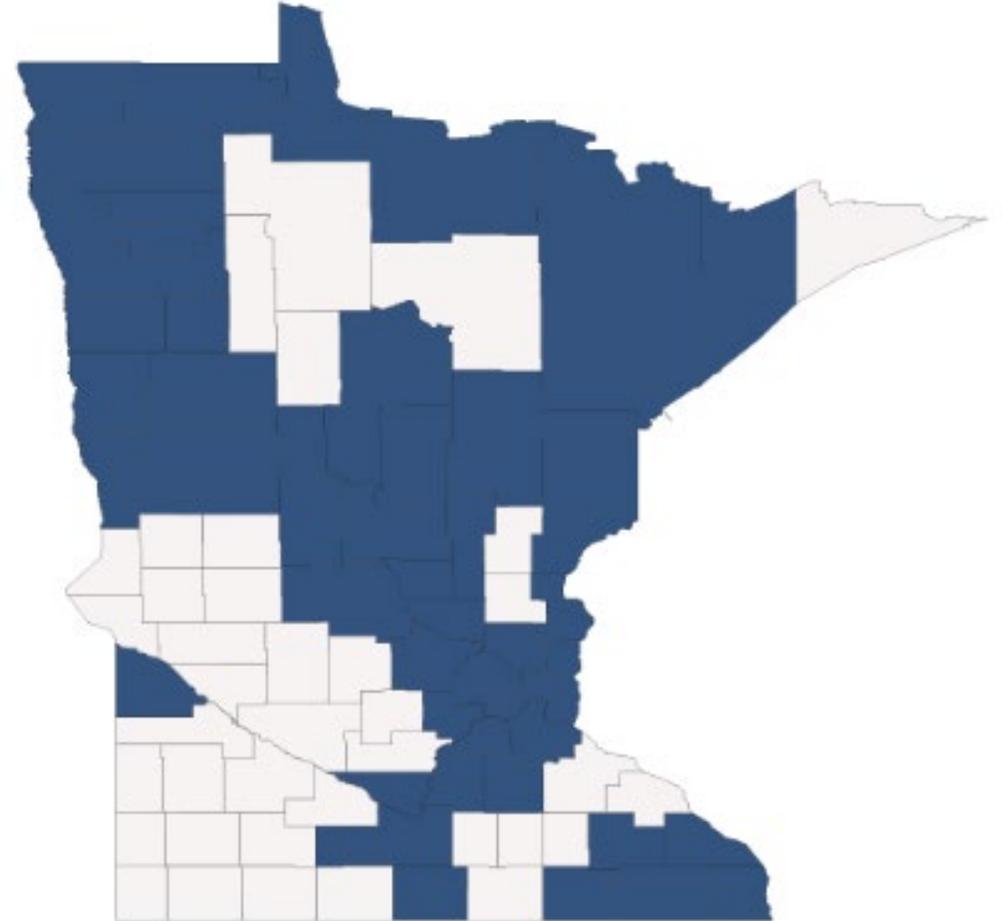
Medica AccessAbility Solution® Enhanced (SNBC D-SNP)	Medica DUAL Solution® (MSHO)
Gender: 57% female and 43% male	Gender: 66% female and 34% male
Average age: 50	Average age:77
Race breakdown: 69.3% White; 24.5% Black; 3.6% Asian; 2% American Indian or Alaska Native; 0.0% Native Hawaiian or Other Pacific Islander; 0.6% Unknown/Other	Race breakdown: 73.0% White; 14.5% Black; 10.0% Asian; 2.0% American Indian or Alaska Native; 0.2% Native Hawaiian or Other Pacific Islander; 0.5% Unknown/Other
% with Chronic Conditions: 96%	% with Chronic Conditions: 95.9%
Top Chronic Conditions: Depression, Hypertension, Hyperlipidemia, Low Back Pain, Diabetes, Persistent Asthma	Top Chronic Conditions: Hypertension, Hyperlipidemia, Depression, Diabetes, Low Back Pain, Chronic Renal Failure
88% live in the community; 12% live in an institutional setting	87% live in the community; 13% live in an institutional setting

*The North Dakota D-SNP will be a new product in 2025 so detailed member information is not yet available.

MSHO Eligibility Criteria

**Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at www.medica.com*

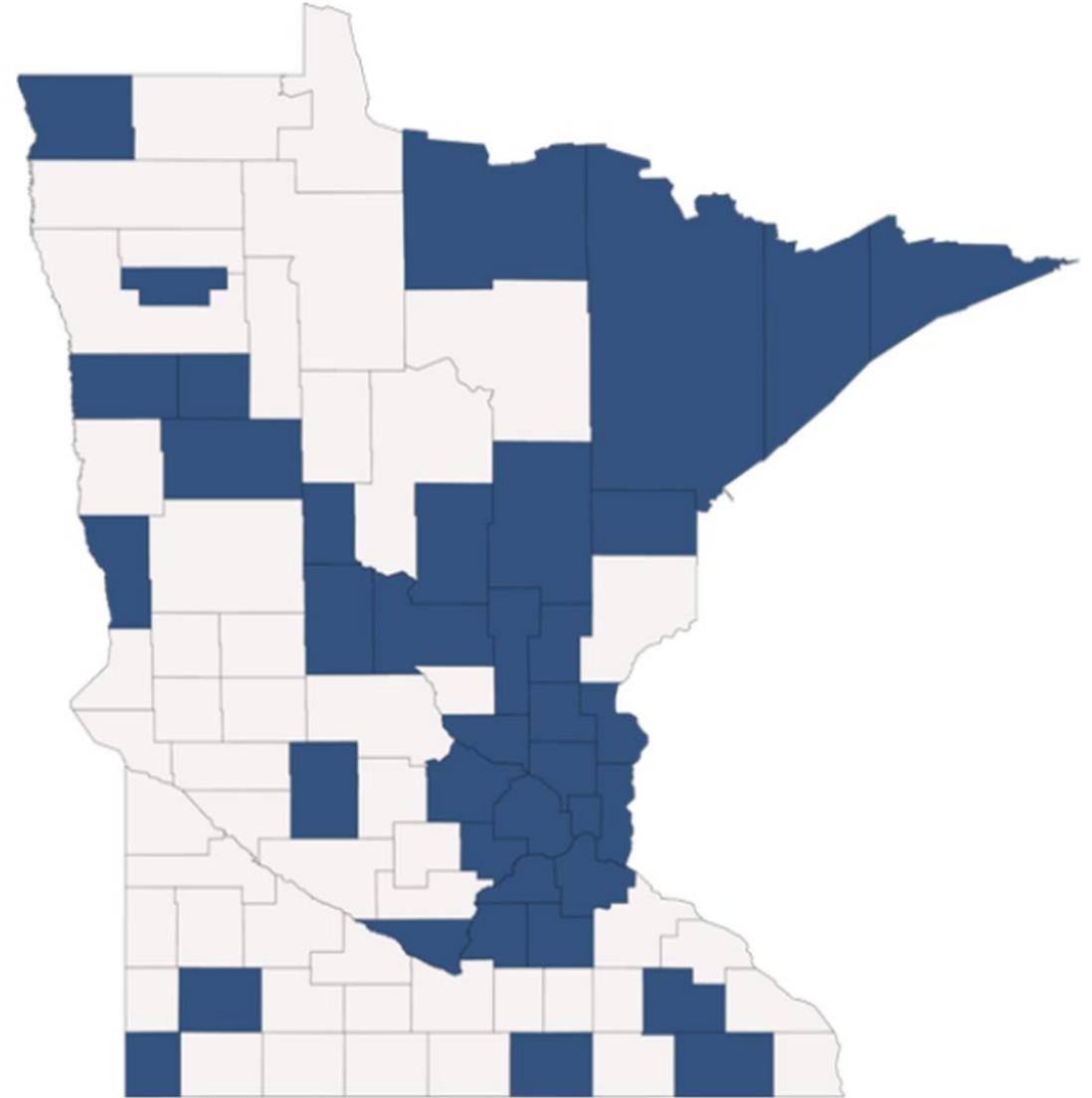
- 65 years or older
- Enrolled in Medicare Parts A & B
- Eligible for Medical Assistance
- Live in the plan's service area



SNBC D-SNP Eligibility Criteria

**Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at www.medica.com*

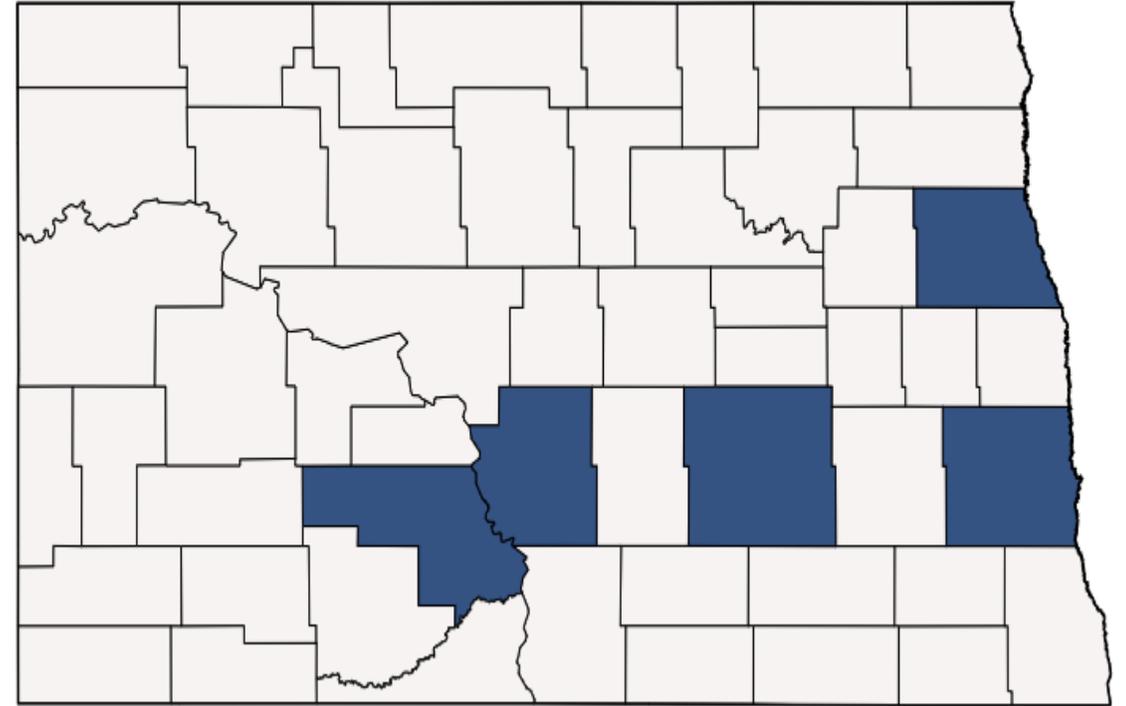
- Age 18-64 with a certified disability
- Enrolled in Medicare Parts A & B
- Eligible for Medical Assistance
- Live in the plan's service area



Medica Advantage[®] Dual Eligibility Criteria **(new in 2025)**

**Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at www.medica.com*

- Age 18+
- Enrolled in Medicare Parts A & B
- Eligible for Medical Assistance
- Live in the plan's service area



Sales and Enrollment Process

<p>SNBC D-SNP</p>	<p>Members or Authorized Reps can complete an application through Medica’s sales dept. (Paper, Telephonic, Online)</p>	<p>Enrollment Telephone Number: 1 (800) 266-2157 (TTY for the hearing impaired at 711) 8 a.m. to 8 p.m., seven days a week.</p>	<p>Members or Authorized Reps can reach out to their county financial worker</p>	<p>Disability Hub MN</p>
<p>MSHO</p>	<p>Members or Authorized Reps can complete an application through Medica’s sales dept. (Paper, Telephonic, Online)</p>	<p>Enrollment Telephone Number: 1 (800) 266-2157 (TTY for the hearing impaired at 711) 8 a.m.-8 p.m. CT, 7 days a week.</p>	<p>Members or Authorized Reps can reach out to their county financial worker</p>	<p>Senior Linkage Line</p>
<p>Medica Advantage® Dual (ND D-SNP)</p>	<p>Members or Authorized Reps can complete an application through Medica’s sales dept. (Paper, Telephonic, Online)</p>	<p>Customer Service Telephone Number: 1 (866) 476-7431 (TTY for the hearing impaired at 711)</p>	<p>Members or Authorized Reps can connect with their county Human Service Zone</p>	<p>North Dakota Center for Persons with Disabilities</p>

❖ *Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at www.medica.com*

Model of Care Questions?

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THANK YOU