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Model of Care

2026 Provider Training

Welcome to Ultimate Health Plans 2026 Model of Care Training for Providers

We value your partnership in caring for our members.

This course will provide you with information to help you care for your patients with special needs.

Training Overview

This training will provide you with an overview of the Model of Care (MOC).

By the end of this course, you will be able to:

- Describe the different types of Special Needs Plans (SNPs)
- Define a SNP and characteristics of the SNP population
- Recognize the key components of the Model of Care
- Understand responsibilities as a network provider for SNP members
- Define your role in supporting the Model of Care

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What is a Model of Care (MOC)?

As provided under section 1859(f)(7) of the Social Security Act (the Act), every Medicare Special Needs Plan (SNP) must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA).

The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees.

The MOC 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 UHP's care management practices.

The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes. (CMS.gov)

(CMS.gov) https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/model-care

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What is a Special Needs Plan (SNP)?

A Special Needs Plan (SNP) is a Medicare Advantage coordinated care plan specifically designed to provide targeted care and limit enrollment to special needs individuals.

SNPs have specially designed Plan Benefit Packages (PBPs) that go beyond the provision of basic Medicare Part A and B services and care coordination, including, but not limited to:

- Supplemental Health Benefits
- Specialized Provider Networks
- Appropriate Enrollee Cost Sharing

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Types of SNP Plans

A special needs individual could be any one of the following:

- An individual residing in institutional setting such as SNF, NH, etc.,
- A dual eligible, or
- An individual with a severe or disabling chronic condition, as specified by the Centers for Medicare and Medicaid Services (CMS)

There are 3 types of SNP Plans:

- **Institutional SNP (I-SNP):** For people in certain institutions (like a nursing home) or who require nursing care at home
- **Chronic SNP (C-SNP):** For people who have specific chronic or disabling conditions
- **Dual SNP (D-SNP):** For people who are eligible for both Medicare and Medicaid

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** Please note that UHP does not offer I-SNP.
UHP does offer certain C-SNPs and D-SNP **

Chronic Special Needs Plans (C-SNP)
Eligibility

All the following eligibility criteria must be met for enrollment in a C-SNP:

- Individual must be enrolled in Medicare Part A (Hospital)
- Individual must be enrolled in Medicare Part B (Medical)
- Individual must live in a plan service area

UHP offers the following 4 major SNP categories:

- Diabetes Mellitus (DM)
- Cardiovascular Disorders (CVD)
- Congestive Heart Failure (CHF)
- Chronic Lung Disorders (CLD)

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Chronic Special Needs Plans (C-SNP)

Eligibility

A potential UHP C-SNP member must have at least one of the following qualifying diagnoses:

Diabetes Mellitus (021,029,033,050,051,052)

Cardiovascular Disease (021, 029, 033, 050, 051, 052)

- Cardiac Arrythmia
- Coronary Artery Disease
- Peripheral Vascular Disease
- Chronic Venous Thromboembolic Disorder

Congestive Heart Failure (022, 029, 033, 050, 051, 052)

Chronic Lung Disorder (023, 025)

- Asthma
- Chronic Bronchitis
- Emphysema
- Pulmonary Fibrosis
- Pulmonary Hypertension

Dual Special Needs Plans (D-SNP)
Eligibility

Medicare-Medicaid Dual Eligible Program (D-SNP) (035,036)

Medicaid Eligibility Criteria

- Meet income and asset requirements
- Member of an eligible group such as:
  - Adults with disabilities
  - Older adults
  - Children and families
  - People who are pregnant
  - End Stage Renal Disease *this diagnosis encompasses any age member*

Medicare Eligible Criteria

- Age 65 or older or under 65 with a disability such as:
  - Intellectual/ Developmental
  - Cognitive
  - Physical
  - Behavioral health needs
  - Chronic medical conditions
  - End Stage Renal Disease *this diagnosis encompasses any age member*

Individuals must meet both Medicare and Medicaid eligibility

Types of Dual Eligible SNPs

May Receive Financial Assistance with Medicare Premiums

(and cost sharing, in many cases)

- **Partial Benefit** Dually Eligible Individuals (036)
  - Qualify for Medicare
  - Don't qualify for full state Medicaid benefits
- **Full Benefit** dually eligible individuals (035)
  - Qualify for Medicare
  - Qualify for full state Medicaid benefits

**All claims need to be submitted through UHP only.
Do Not Bill Medicaid Directly**

Model of Care Goals

Determining MOC goals:

- UHP determines goals for the Model of Care related to improvement of the quality of care our members receive.

MOC goals have regulatory alignment with:

- Medicare Star Ratings
- CAHPS - Consumer Assessment of Healthcare Providers and Systems
- HEDIS - Healthcare Effectiveness Data and Information Set
- HOS - Health Outcomes Survey

MOC goals may include:

- Access to care
- Member satisfaction
- Access to preventive health services
- Chronic care management
- Risk Stratification

Specific UHP Model of Care Goals

Quality	• Improve the quality of care and services received by members.
Access	• Support access to essential services, including medical, mental health, and social services. Address social determinants of health such as food, housing and transportation.
Coordination of Care	• Support coordination of care between care settings.
Outcomes	• Improve beneficiary health outcomes.
Transitions	• Enhance transitions of care across health care settings and providers.
Preventive Services	• Promote access to preventive services.
Appropriate Utilization	• Facilitate appropriate utilization of services.
Affordability	• Improve access to affordable care.

SNP Benefits

Benefits are designed to consider the specific needs of the target population.

Specific benefits are listed in the Evidence of Coverage for the specific plan.

Examples of Benefits:

- $0 Primary Care visit copays and $0 - low copays for Specialists
- Hearing Benefit – no cost for routine hearing exams
- 24-Hour Nurse Triage Line – designed to provide members with a resource when they have questions pertaining to their health
- Transportation to plan approved destinations including PCPs, Specialists, dialysis, pharmacies, imaging centers, food pantries, and more.
- Silver Sneakers® Fitness Program
- Meal delivery services following a hospital stay (2 meals/day for 7 days)

SNP Model of Care Elements

SNP Model of Care addresses SNP structure, processes, resources, and requirements.

Th Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to develop and implement a Model of Care.

The MOC is evaluated and approved by NCQA according to the CMS guidelines.

MOC 1 **Description of the SNP Population**	MOC 2 **Care Coordination**	MOC 3 **SNP Provider Network**	MOC 4 **Quality Improvement**
• Eligibility • Health Conditions • Limitations and Barriers • Most Vulnerable Population	• Health Risk Assessment Tool (HRAT) • Face-to-Face Encounter • The Individualized Care Plan (ICP) • The Interdisciplinary Care Team (ICT) • Care Transition Protocol	• Specialized Expertise • Clinical Practice Guidelines • MOC Training	• Improvement Plans • Measurable Goals and Outcomes • Measuring Member Experience • Ongoing Performance Improvement

MOC 1: Target Population

SNP MOCs must identify and describe the target population, including health and social factors, and unique characteristics of each SNP type.

Specifically, within the C-SNP, the most vulnerable members are those with one or more qualifying C-SNP diagnosis(es) in poor control, with any of the following factors or combination of factors:

- Sedentary or debilitated lifestyle
- Non-adherent to treatment plan
- Uncontrolled or poorly managed behavioral health conditions
- Advanced age/frailty and solo living situation
- Limited or complete lack of social support system/caregiver
- Inadequate housing/transportation
- Low health literacy
- Low socioeconomic status
- Low English language proficiency
- Visual problems
- Hearing problems
- Short and long-term memory deficits
- Excessive or inappropriate use of hospitalization and/or ER visits

MOC 2: Care Coordination

SNP MOCs must provide Care Coordination to its members.

Care Coordination ensures that members healthcare needs, preferences, and information sharing are met successfully over time.

Care Coordination maximizes the use of effective, efficient, safe, and high-quality patient services that lead to improved outcomes.

The following elements are essential components in the development of comprehensive care coordination:

- Health Risk Assessments (HRA)
- Face-to-Face Encounter
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT) Meetings
- Care Transition Protocols

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MOC 2: Health Risk Assessment (HRA)

The Health Risk Assessment is the starting point for member assessment and care planning. It is also an annual checkpoint for reassessment of key health metrics.

Our HRAs are used to:

- Identify individual health needs (self-reported)
- Identify members, based on risk stratification, who require transportation or translation services
- Recommend members for Disease or Case Management Programs
- Initiate care plans
- Communicate with physicians, Interdisciplinary Care Team (ICT), members, caregivers, and ancillary providers

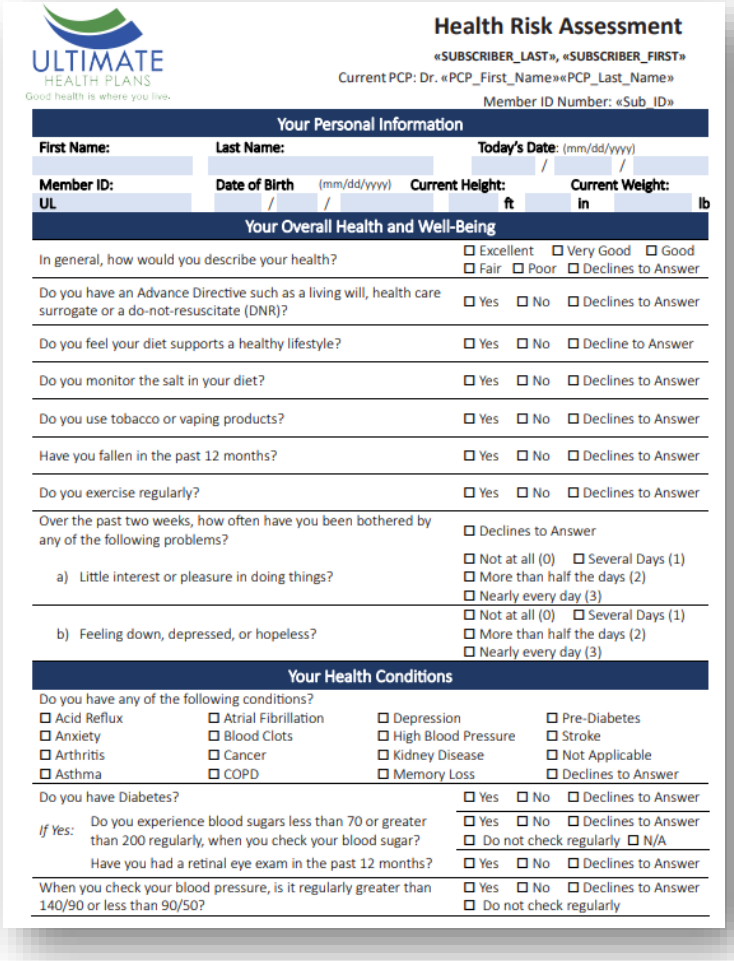
Our HRAs are completed by:

- Mail
- Phone call
- Member portal
- PCP offices
- Sales representatives

MOC 2: Health Risk Assessment (HRA)

A comprehensive initial assessment is completed within 90 days of the completion of the HRA.

An annual reassessment of the member's medical, physical, cognitive, psychosocial, functional, and mental health needs is also conducted.



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Health Risk Assessment

«SUBSCRIBER_LAST», «SUBSCRIBER_FIRST»
Current PCP: Dr. «PCP_First_Name»«PCP_Last_Name»
Member ID Number: «Sub_ID»

Your Personal Information

First Name: | Last Name: | Today's Date: (mm/dd/yyyy) / /
Member ID: UL | Date of Birth (mm/dd/yyyy) / / | Current Height: ft | Current Weight: in lb

Your Overall Health and Well-Being

In general, how would you describe your health?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Declines to Answer
Do you have an Advance Directive such as a living will, health care surrogate or a do-not-resuscitate (DNR)?	☐ Yes ☐ No ☐ Declines to Answer
Do you feel your diet supports a healthy lifestyle?	☐ Yes ☐ No ☐ Decline to Answer
Do you monitor the salt in your diet?	☐ Yes ☐ No ☐ Declines to Answer
Do you use tobacco or vaping products?	☐ Yes ☐ No ☐ Declines to Answer
Have you fallen in the past 12 months?	☐ Yes ☐ No ☐ Declines to Answer
Do you exercise regularly?	☐ Yes ☐ No ☐ Declines to Answer
Over the past two weeks, how often have you been bothered by any of the following problems?	☐ Declines to Answer
a) Little interest or pleasure in doing things?	☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
b) Feeling down, depressed, or hopeless?	☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Your Health Conditions

Do you have any of the following conditions?

☐ Acid Reflux	☐ Atrial Fibrillation	☐ Depression	☐ Pre-Diabetes
☐ Anxiety	☐ Blood Clots	☐ High Blood Pressure	☐ Stroke
☐ Arthritis	☐ Cancer	☐ Kidney Disease	☐ Not Applicable
☐ Asthma	☐ COPD	☐ Memory Loss	☐ Declines to Answer

Do you have Diabetes?		☐ Yes ☐ No ☐ Declines to Answer
If Yes:	Do you experience blood sugars less than 70 or greater than 200 regularly, when you check your blood sugar?	☐ Yes ☐ No ☐ Declines to Answer ☐ Do not check regularly ☐ N/A
	Have you had a retinal eye exam in the past 12 months?	☐ Yes ☐ No ☐ Declines to Answer
When you check your blood pressure, is it regularly greater than 140/90 or less than 90/50?		☐ Yes ☐ No ☐ Declines to Answer ☐ Do not check regularly

MOC 2: Face to Face Encounter

The Primary Care Physician will conduct an initial member Face-to-Face encounter annually.

- Face-to-face encounters may be completed in person or via telehealth.
- If a face-to-face encounter is performed via telehealth by UHP, the Plan will obtain Member and/or caregiver verbal consent and document the consent in the Care Management platform.
- If the PCP does not complete the Face-to-Face encounter, UHP may use third party vendors.

The intended outcome of the Face-to-Face encounter.

- To establish and/or further enhance the relationship between the Member and their care team.
- To elicit additional concerns that may not be achieved by telephonic contact alone to promote successful coordination of care and improve health outcomes.

MOC 2: Individualized Care Plan (ICP)

An Individualized Care Plan (ICP) is developed by a participant of the Interdisciplinary Care Team (ICT), mainly the nurse case manager.

The ICP can be developed in collaboration with the member and the member's caregiver (with consent).

If the member is not reached, an ICP is created using HRA information, claims data, and/or their electronic medical records.

The Plan's Care Management Team works closely with the member to create, implement, and evaluate the ICP.

The ICP is a fluid document, ever-changing based on the member's changing health care needs. The ICP is updated at least annually and/or if a significant change in status occurs.

MOC 2: Individualized Care Plan (ICP)

The ICP must include, but is not limited to:

- The beneficiary's self-management goals and objectives
- The beneficiary's personal health care preferences
- A description of services specifically tailored to the beneficiary's needs
- Identification of measurable goals and action taken if goals are not met

The ICP is shared with members of the ICT using various methods such as, but not limited to:

- verbal communication during face-to-face or telephonic activities
- written communication delivered in person, mail, email, facsimile
- the member portal

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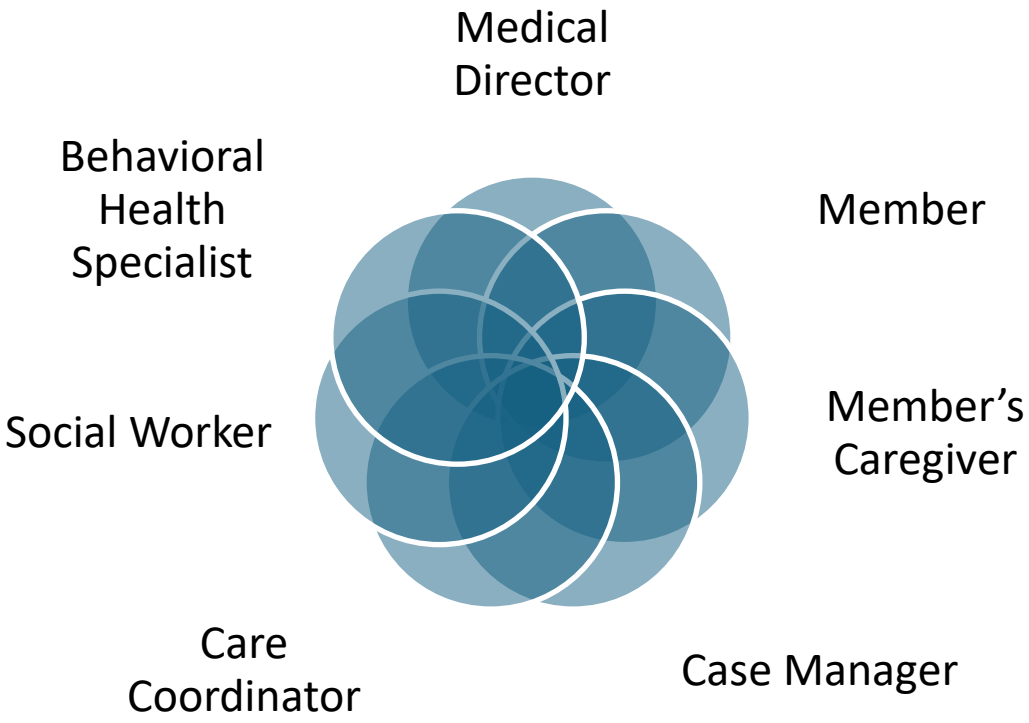
MOC 2: Interdisciplinary Care Team (ICT)

The composition of the ICT is based on the SNP member's needs and can include the following individuals:



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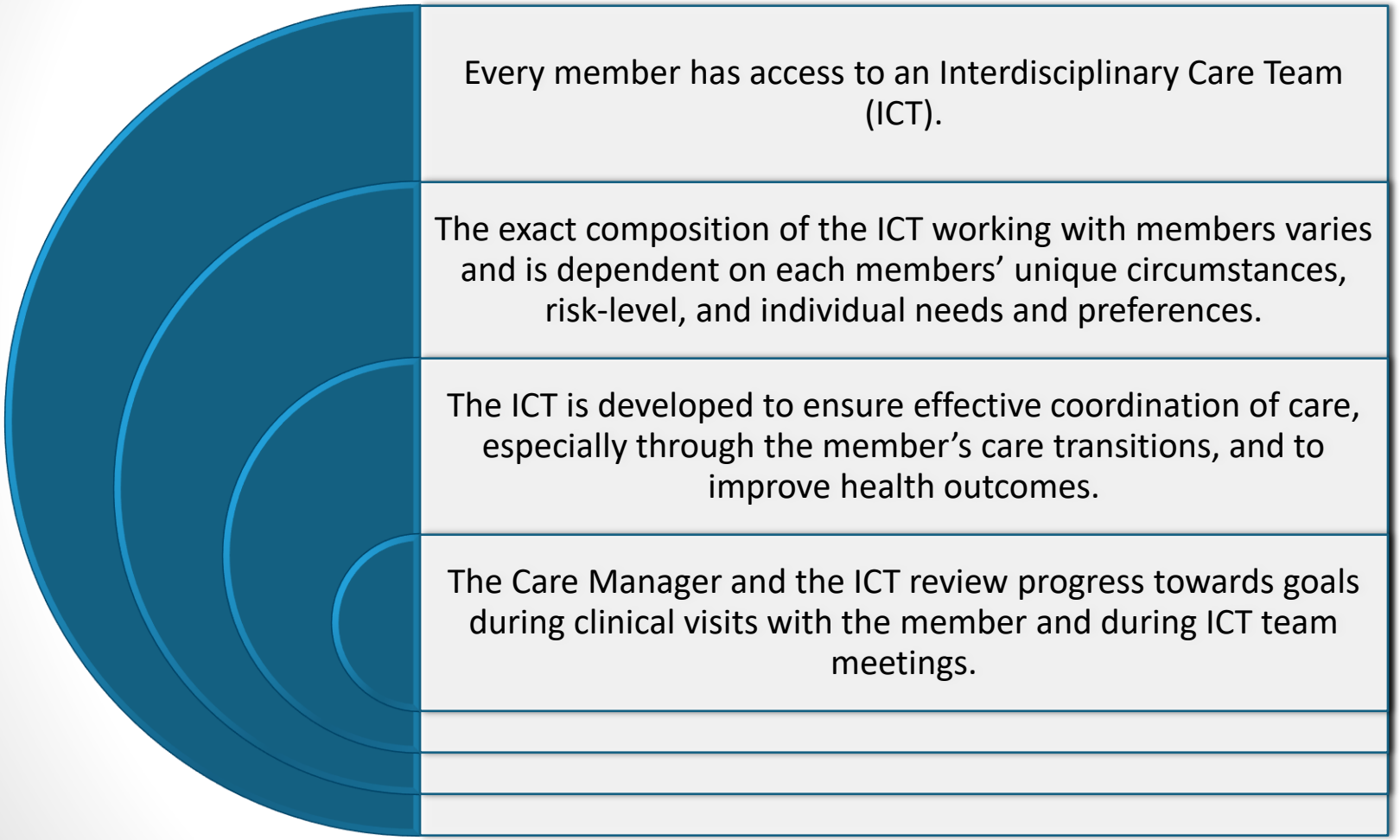
MOC 2: Interdisciplinary Care Team (ICT)



MOC 2: Interdisciplinary Care Team (ICT)

Member / Caregiver	PCP (MD or DO)	Care Manager (RN)	Other Medical Professional / Specialist
ICT process revolves around the member	Participates in the development of the ICP and ensures progress is being made to meet ICP goals	Ensures that needs or gaps in care are identified by assessing the HRA, Claims, and electronic medical records (EMRs) Subsequent visits are also addressed in the ICP	Each member of the ICT shares the responsibility for ensuring the member's needs in relation to their specialty are met
Participates in all HRAs	Communicates with member and the Interdisciplinary Care Team (ICT)	Provides input to the ICT for the ICP development and ongoing updates	Communicate updates regarding changes in treatment/ recommendations
Participates in the development of the ICP **when applicable**	Conducts oversight for all transitions of care events	Ensures access to, and coordination with, other services provided through strategic partnerships and alliances	Provide input to the ICT regarding the development and ongoing updating of the member's ICP
Communicates needs, barriers, and prioritizes goals		Participates in the development of the ICP and ensures progress is being made to meet ICP goals	Attends formal ICT meetings and/or provides meaningful input as appropriate

MOC 2: Care Transition Protocols

Transition of Care:

- Improves the care of its vulnerable population
- Provide an integrated, proactive approach to safely transition the member between levels of care and across care settings
- Uses evidence-based clinical practices and targeted strategies
- Members are called within 7 days of discharge

During Outreach, the Care Manager:

- Helps the member understand discharge diagnosis and instructions
- Facilitates follow-up appointments
- Helps schedule transportation
- Helps with home health care and required medical equipment that were arranged prior to discharge from a facility
- Resolves barriers to obtaining medications
- Educates the member on new or continuing medical conditions
- Refers appropriate members to Complex Case Management

**Members may opt out of case management; however, PCPs, caregivers or treating providers may refer members to case management at any time. Members may also self refer. **

MOC 3: SNP Provider Network

Expertise

- The UHP provider network is comprised of providers with expertise in specialized care corresponding to our target population.

Onboarding

- UHP oversees its provider network and facilities and ensures that they are onboarded through a valid credentialing process.
- During the new and annual provider orientations, in which providers are given the Model of Care training, providers complete the attestation of training.
- Similarly non-network providers are also provided the MOC training and asked to review the information.

Training Requirements

- Regulations at (42 CFR§422.101(f)(2)(ii)) require that SNPs conduct MOC training for their network of providers.
- UHP complies with the network training requirements: Requiring initial and annual trainings for network providers

Tracking MOC Training

- Documenting evidence that the organization makes available and offers MOC trainings for network providers
- Monitoring challenges associated with completion of MOC trainings for improvement opportunities
- UHP has implemented action plans when the required MOC training is deficient or has not been completed
- UHP does not track the completion of non-network provider attestations.

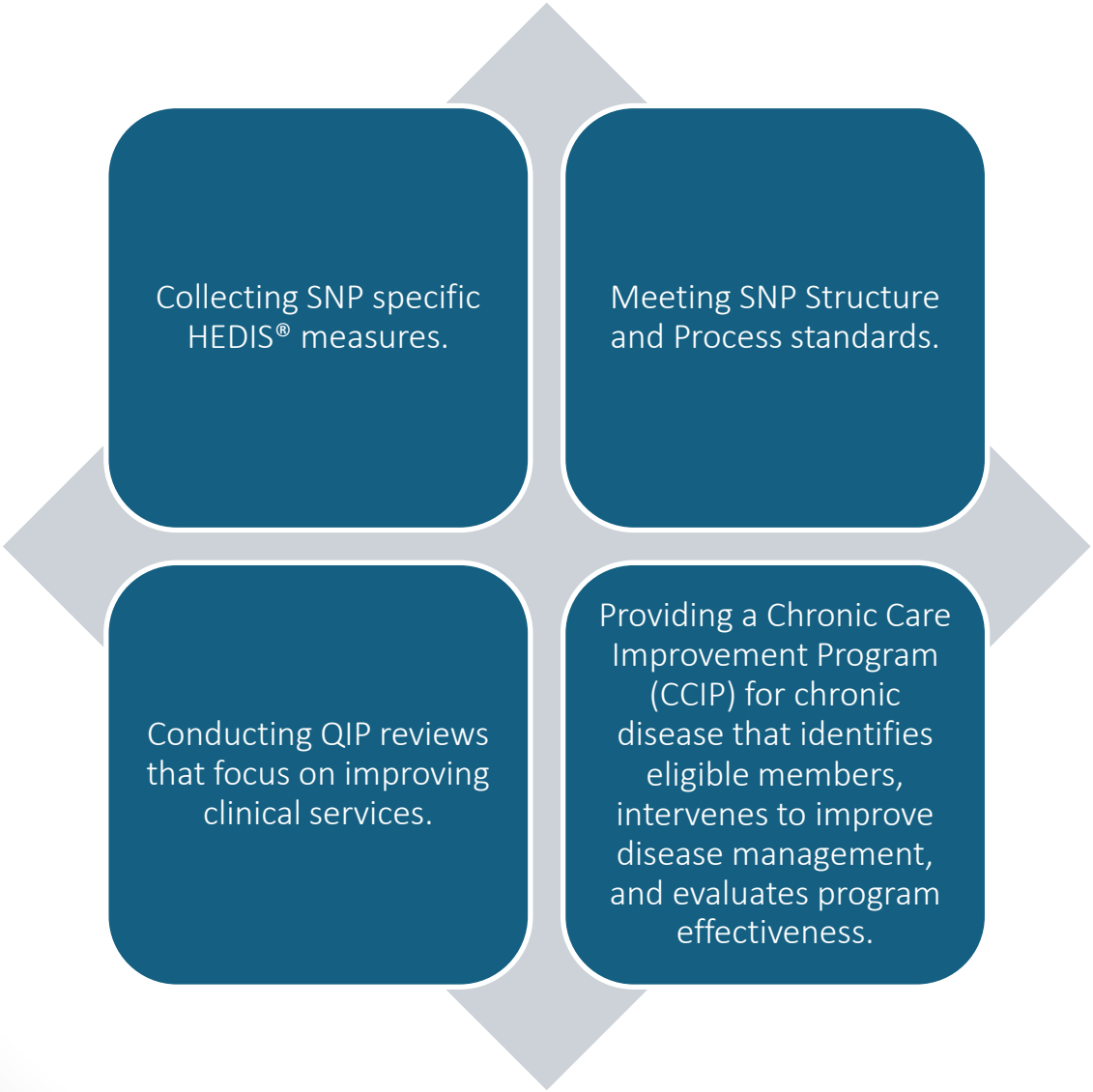
MOC 4: Quality Improvement Program (QIP)

Code of Federal Regulations (42 CFR §422.152(g)) require that all SNPs conduct a Quality Improvement Program (QIP) that measures the effectiveness of its MOC.

The purpose of the Plan's Quality Improvement Program (QI Program) is to continually take a proactive approach to improve the way the Plan provides care and engages with its members, partners, and other stakeholders so that it may fully realize its vision, mission and commitment to member care.

MOC 4: Quality Improvement Program (QIP)

UHP Quality Improvement Program (QIP) monitors health outcomes and implementation of SNP MOCs by:



MOC 4: Quality Improvement Program (QIP)

UHP Quality Improvement Program (QIP) monitors health outcomes and implementation of SNP MOCs by:

Ultimate Health Plans Contact Information

Need to reach Ultimate Health Plans:

- to obtain a member's care plan?
- to refer a patient for additional services?
- to request an interdisciplinary care team meeting for a member?
- to obtain additional information about the Ultimate SNP Model of Care?

By Phone or Fax:

• Member Services	(888) 657-4170 (TTY 711)
• Provider Services	(888) 657-4171
• Provider Relations	(352) 515-5963
• Provider Relations Fax	(352) 515-5976
• Care Management Team	(866) 967-3430

By Email:

- caremanagement@ulthp.com

By Provider Portal:

- http://providerportal.uhp.health

SNP MOC Training Completion

2025 Annual Provider Training Attestation

Thank you for your review and completion of the
2026 Annual Provider Training.
Please attest to the receipt and completion of the 2026 SNP MOC Training by going to the following link: Provider Training Attestation

Thank you for participating in the
MOC Training Program.