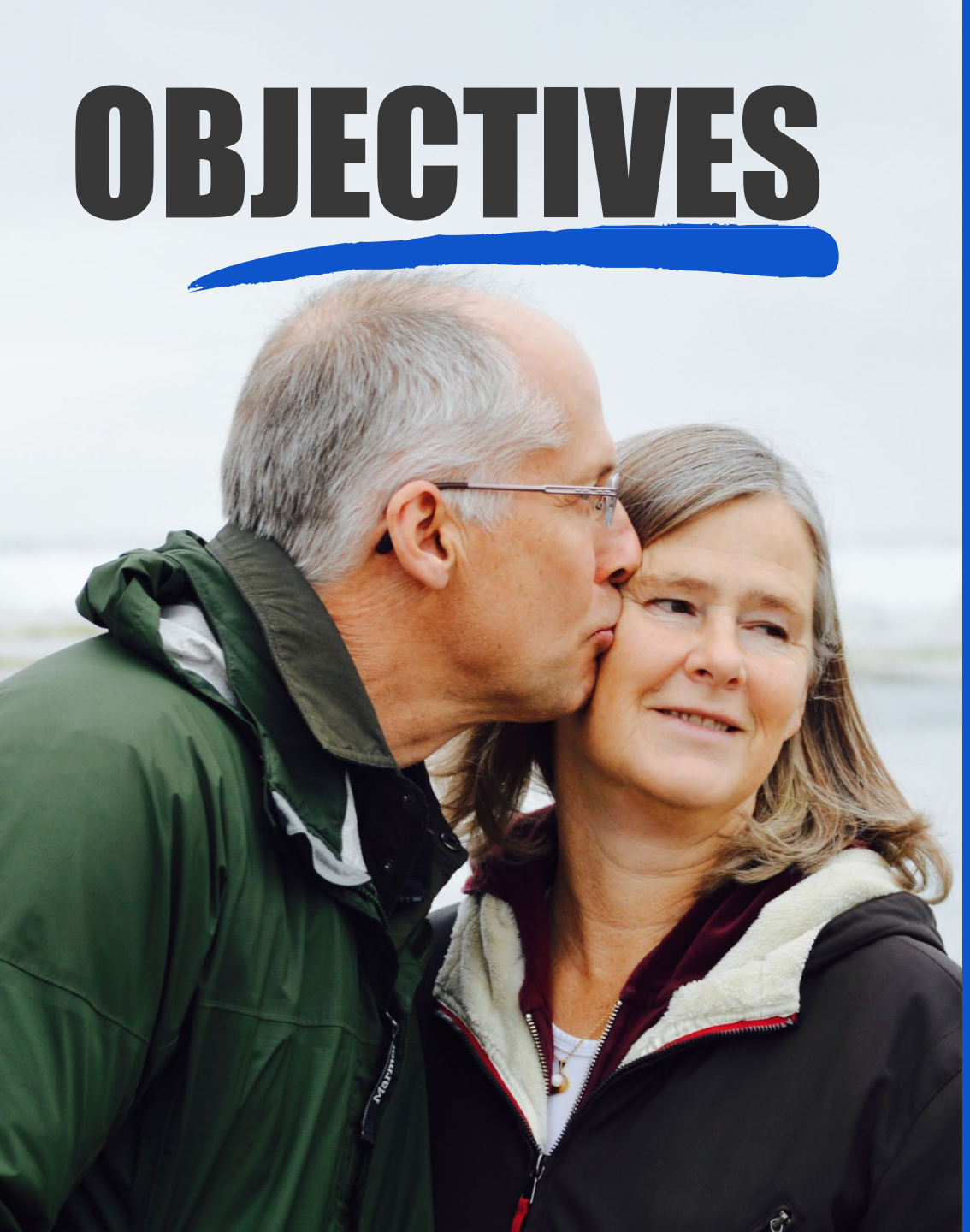
PROVIDER TRAINING

SPECIAL NEEDS PLAN (SNP) MODEL OF CARE (MOC)

Plan Year 2026

Alignment Health™

OBJECTIVES

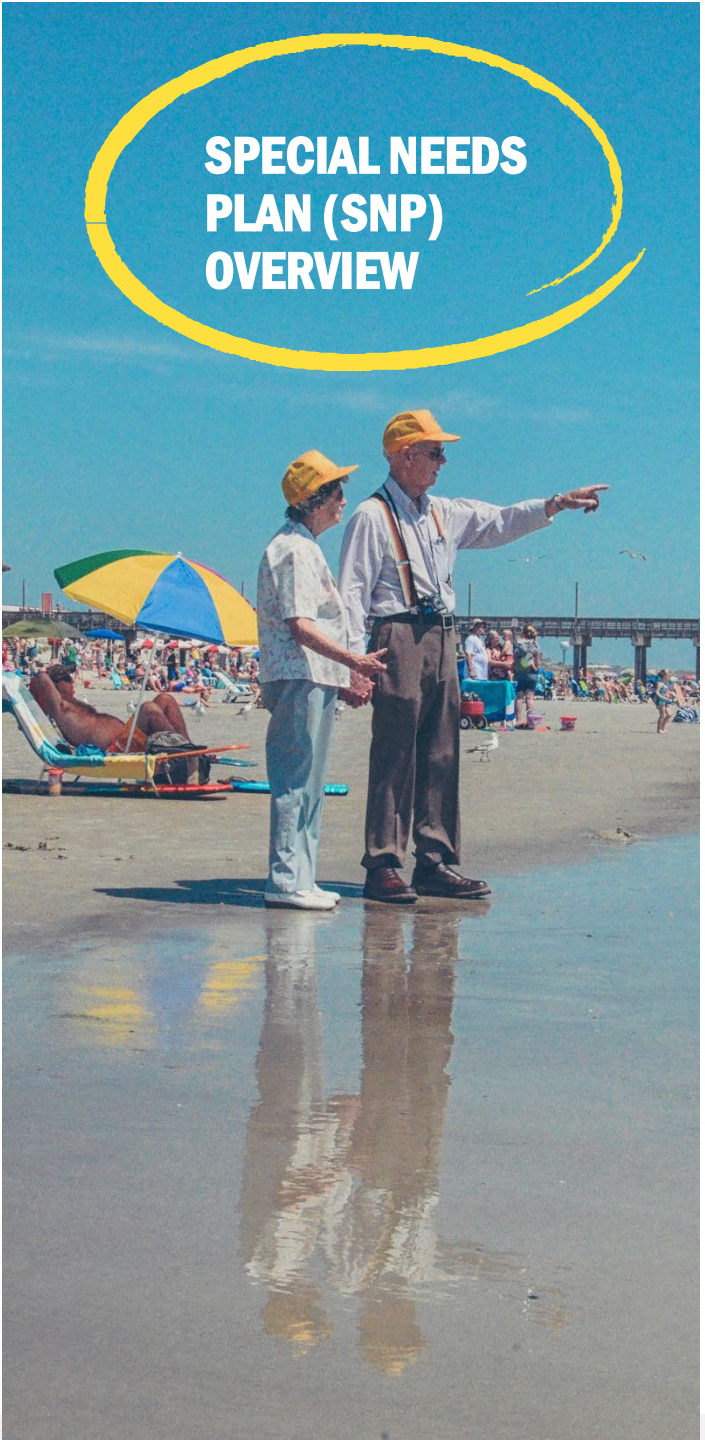


The 2026 SNP MOC Training will cover the following:

1. Overview of Special Needs Plans (SNPs)
    - Model of Care (MOC)
    - SNP Types
    - Eligibility Criteria
2. SNP Model of Care Requirements
    - MOC Requirements
    - MOC Goals
    - MOC Structure
        - SNP MOC Population Description
        - Care Coordination
        - Provider Network
        - MOC Performance and Quality Outcomes
3. Alignment C-SNP by State
4. Alignment D-SNP by State
5. Provider Responsibilities

Alignment Health™

SPECIAL NEEDS PLAN OVERVIEW



SPECIAL NEEDS PLAN OVERVIEW

- Established by the Medicare Act of 2003, **Special Needs Plans (SNPs)** are designed to provide targeted care to individuals with special needs and vulnerable Medicare beneficiaries.
- SNPs include Medicare **Part C (medical) and Part D (drug)** coverage, offering comprehensive healthcare services.
- SNPs can **be any type of Medicare Advantage Coordinated Care Plan**, including:
    - - Health Maintenance Organization (HMO)
    - - HMO Point of Service (HMO-POS)
    - - Local or Regional Preferred Provider Organization (LPPO or RPPO)
- SNPs serve **at-risk** populations with multiple health conditions and barriers to self-care management.
- SNPs provide members with guidance and resources to help them access benefits and important healthcare information.
- Medicare **mandates initial and annual training** for providers and employees who deliver care to SNP members.

SPECIAL NEEDS PLAN (SNP) TYPES

CMS OFFERS THREE TYPES OF SPECIAL NEEDS PLANS:

Dually Eligible (D-SNP or DE-SNP)	Beneficiaries who qualify for both Medicare and Medicaid coverage.
Chronic Condition (C-SNP)	Beneficiaries with specific severe or disabling chronic conditions such as cardiovascular disease, diabetes, congestive heart failure, osteoarthritis, mental disorders, ESRD, or HIV/AIDS
Institutional (I-SNP) *(Alignment currently does not offer I-SNPs)*	Beneficiaries who reside, or are expected to reside, for 90 days or longer in a long-term care facility – defined as skilled nursing facility (SNF) nursing facility (NF), intermediate care facility (ICF) or inpatient psychiatric facility OR those who live in the community but require an equivalent level of care to those who reside in a long-term care facility.

SPECIAL NEEDS PLAN ELIGIBILITY

DUAL ELIGIBLE SPECIAL NEEDS PLANS (D-SNPs)

A **Dual Eligible** Special Needs Plan (D-SNP) is available **to qualified seniors and individuals with disabilities** who meet the qualifying criteria listed below:

1. Reside within the D-SNP's identified service areas
2. **Meet dual eligibility** status requirements
   - ❑ enrollment in a federally administered Medicare program based on age and/or disability status
   - ❑ The state-administered Medicaid program based on low income and assets
3. Qualify for **BOTH** Medicare **and** Medicaid Benefits
4. Must verify Medicaid eligibility monthly after enrollment

CHRONIC CONDITION SPECIAL NEEDS PLANS (C-SNPs)

A **Chronic Condition** Special Needs Plan (C-SNP) is available to **eligible members** who meet the qualifying criteria listed below:

1. Must reside within the C-SNP's identified service areas
2. Must have a qualifying chronic condition confirmed by their Provider within 60 days of enrollment
3. Qualifying conditions for a C-SNP must include at least one eligible **confirmed** conditions such as a Chronic Lung Condition, Chronic Kidney Disease, Congestive Heart Failure or Diabetes Mellitus.

D-SNP MEDICAID ELIGIBILITY REQUIREMENTS

MEDICAID ELIGIBILITY CATEGORIES

QUALIFIED MEDICARE BENEFICIARY (QMB)

- Medicaid covers Medicare Part A and B premiums, deductibles, coinsurance and copayment amounts
- Not otherwise eligible for any Medicaid benefits
- Cost Share Protected

QUALIFIED MEDICARE BENEFICIARY PLUS (QMB+)

- Medicaid covers Medicare Part A and B premiums, deductible, coinsurance and copayment amounts
- Also eligible for full Medicaid benefits, secondary to Medicare coverage
- Cost Share Protected

SPECIFIED LOW INCOME MEDICARE BENEFICIARY PLUS (SLMB+)

- Medicaid covers Medicare Part B premiums
- Also eligible for full Medicaid benefits, secondary to Medicare coverage

FULL MEDICAID ONLY (OTHER FULL BENEFIT DUAL ELIGIBLE OR FBDE)

- Eligible for full Medicaid benefits but not for the QMB program
- Medicaid may provide some assistance with Medicare cost-sharing
- Generally, cost share is $0 when the service is covered by both Medicare and Medicaid. May be instances where member must pay Medicare cost-sharing if services/benefit not covered by Medicaid

DUAL ELIGIBLE SPECIAL NEEDS PLANS ELIGIBILITY (CONT)

DUAL ELIGIBLE SPECIAL NEEDS PLANS

- Medicare coverage is primary; Medicaid coverage supplements Medicare coverage
- D-SNP Members are “cost-share protected” meaning the state Medicaid program pays the Member’s Medicare (Parts A and B) cost share (copayments, deductibles, coinsurance).
- A D-SNP Member is not responsible for any costs and the Provider cannot balance bill the Member.
- Some D-SNPs are “integrated,” meaning the Health Plan administers both Medicare and Medicaid benefits
- D-SNPs must have a State Medicaid Agency Contract (SMAC) that lists all the requirements imposed by the state including at least certain federal minimum requirements
- All D-SNPs must assist Members with Care Coordination and accessing both Medicare and Medicaid benefits, even if the D-SNP does not administer the Medicaid benefit

SNP MODEL OF CARE (MOC) REQUIREMENTS

SNP MODEL OF CARE REQUIREMENTS

- The Model of Care (MOC) is a document that Alignment submits to Medicare to describe how Alignment works to successfully deliver care and services to the SNP Members
- The MOC is a fundamental component of SNP Quality Improvement, so CMS requires the National Committee for Quality Assurance (NCQA®) to review and approve all SNP MOCs based on standards and scoring criteria established by CMS.
- The Model of Care outlines extra, and unique services offered to the Special Needs population
- A Model of Care is required for each SNP type
- The Model of Care includes how Alignment measures the effectiveness of the MOC and the care provided to the SNP Members

SNP MOC STRUCTURE

THE SNP MOC REQUIREMENTS BY NCQA® AND CMS COMPRISE THE FOLLOWING CLINICAL AND NON-CLINICAL STANDARDS:

SNP Population

- Documentation of how the health plan will determine, verify and track eligibility
- Detailed profile of medical, social, cognitive, environmental conditions, etc. associated with SNP population
- Health conditions impacting beneficiaries & plan for especially vulnerable beneficiaries

Care Coordination

- SNP staff structure, roles and training defined
- Health Risk Assessment (HRA)
- Individualized Care Plan (ICP)
- Face-to-Face Visit (F2F)
- Interdisciplinary Care Team (ICT)
- Care Transitions (CT)

Provider Network

- Specialized expertise available to SNP beneficiaries & how health plan evaluates competency of network
- Use of clinical practice guidelines & care transition protocols by Providers
- MOC training for Provider network

Quality Measurement & Performance

- Quality Measure Monitoring
- Measurable goals & health outcomes for the MOC
- Measure patient experience of care surveys and analyze integrated results
- SNP Model of Care Program Evaluation (annual)
- Quality Improvement Plan

DESCRIPTION OF THE ALIGNMENT'S C-SNP POPULATION

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Most Vulnerable Members

- Alignment SNP focuses on the vulnerable sub-population of Members who are at highest risk of poor outcomes
- The Members are identified using Alignment Health Plan's proprietary software AVA™ and identifies gaps in care, census, pharmacy information and HEDIS® information, and predicts risk scores for Alignment Members

Overall SNP Population

- A Population Assessment was conducted to build a Model of Care that will properly serve Alignment Members' needs. Factors we identified include but are not limited to:
  - There are slightly more females than males enrolled in the Alignment C-SNPS
  - Hispanic, Caucasian, Asian and Indigenous Americans are top ethnicities within the Alignment C-SNPS
  - English and Spanish are preferred languages

THE HEALTH RISK ASSESSMENT (HRA)

THE HEALTH RISK ASSESSMENT (HRA)

- A Health Risk Assessment (HRA) is required for **all** Members enrolled in a SNP
- The HRA is a tool used to identify Member risk levels including but not limited to Health, Functional, Cognitive, Psychosocial / Mental Health
- Alignment uses HRA risk leveling to identify Member needs to provide better coordination of care and to improve health outcomes while reducing overall cost
- Alignment attempts to complete the HRA **within 90 days** of initial enrollment and annually, or when there is a change in the patient's condition
- Results of the HRA are communicated to the Member and Member's Provider (ICT)
- Patients have the right to refuse to complete the HRA
- HRA completion rates (initial and reassessments) are CMS STAR Measures!
- HRAs can be completed via telephone, e-mail, paper, virtually or in-person
- An HRA assesses needs related to:

HEALTH RISK ASSESSMENT KEY ELEMENTS

THE HEALTH RISK ASSESSMENT (HRA)

An HRA is a Medicare requirement for all C-SNP and D-SNP Members

HRA assessments must include:

- Demographic data (e.g., age, gender, race)
- Self-assessment of health status and activities of daily living (ADLs)
- Functional status and pain assessment
- Medical diseases/conditions and history
- Biometric values (e.g., BMI, BP, glucose)
- Psychosocial risks (e.g., depression, stress, fatigue)
- Behavioral risks (e.g., tobacco use, nutrition, physical activity)
- Social Needs assessment including housing stability, food insecurities and access to transportation

HRA SCORING

- HRA responses are entered into the AVA™ platform and scored.
- HRA scores in combination with the “at-risk” levels determine the Member’s outreach prioritization
- Members may receive calls from the CM team based on the members’ need and clinical judgment but could receive quarterly, biannually or annual CM team outreach.

CARE PLAN DEVELOPMENT

CARE PLAN DEVELOPMENT

- All members completing the HRA are initially sent an individualized care plan for review.
- An initial individualized care plan is developed from the HRA results within 30 calendar days of completion of the HRA and updated when a Member's health care needs change.
- All Members who agree to care coordination are referred for follow-up by the Care Team.
- Upon acceptance of care coordination, additional assessments are conducted as needed and an updated comprehensive individualized care plan (ICP) is created and ongoing engagement and support initiated.
- ICPs are tailored specifically to the needs of each Member and offers detail regarding the goals, interventions, barriers, and outcomes for each Member-centric element.

INTERDISCIPLINARY CARE TEAM (ICT)

The **Interdisciplinary Care Team (ICT)** is a Member-centric collaborative group focused on delivering comprehensive, coordinated care. The ICT plays a central role in managing care through:

- Initial and ongoing evaluation of the Member and their caregiver(s)
- Development, implementation, and modification of the Individualized Care Plan (ICP)
- Member advocacy and health education
- Support for Member self-management
- Regular review and updates to the ICP based on evolving needs

For both Chronic Special Needs Plan (C-SNP) and Dual Special Needs Plan (D-SNP) Members, the ICT must be tailored to address the Member's medical, behavioral, and social needs as identified through the Health Risk Assessment (HRA) and Care Plan.

ICT Composition includes the Member, the Care Team and the Primary Care Provider (PCP). Additional participants may include Social Workers, Pharmacists, Medical Directors, Specialists or other treating Physicians

Communication Methods- ICT information is shared through various channels, including:

- Documentation in the Care Management (CM) system
- Telephonic communication with the Member, caregiver, and Providers
- Written ICT meeting minutes
- Notes within the Member's ICP

ICT Meetings- ICT meetings are conducted at least annually, and more frequently as needed based on the Member's condition. Meetings may be held virtually, in-person or through care plan sharing via fax, email or regular mail

CARE TRANSITIONS

- A Care Transition is movement of a Member from one care setting to another when the Member's health status changes
- Care Transition settings include home, home health, acute care, skilled/custodial nursing facilities, rehabilitation facility, outpatient/ ambulatory care/ surgery centers
- Care Transitions are addressed by the Care Manager for both planned and unplanned transitions to maximize Member recovery and avoid preventable transitions
- All applicable ICT Members are informed of the Member's needs prior to, during and post transition from one care setting to another including the receiving facility

POST DISCHARGE CARE TRANSITION

The post-discharge program for C-SNP and D-SNP Members, includes phone calls or visits after being discharged home from the hospital.

Members receive post discharge follow-up based on the risk level assigned at the time of discharge.

Members identified as high risk may be referred to the CAW team where available.

During these calls, the CM or Provider:

- Helps the Member understand discharge diagnosis and instructions
- Facilitates follow-up appointments
- Assists with needed home health and equipment
- Resolves barriers to obtaining medications
- Educates the Member on new or continuing medical conditions

ALIGNMENT PROVIDER NETWORK

- The SNP provider network is made up of healthcare providers with specialized expertise to meet the needs of the SNP population.
- Collaboration of the ICT is primarily facilitated through communication of the ICP.

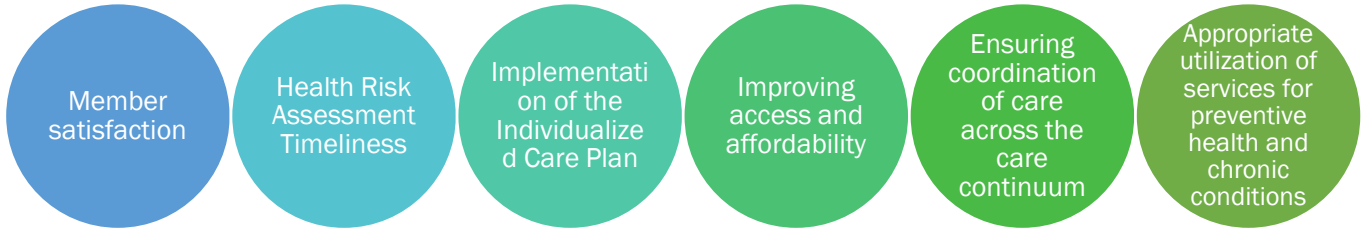
NETWORK OVERSIGHT:

- All Alignment Contracted Providers, Facilities and Ancillary Providers, undergo a Credentialing process to ensure they meet all Federal And State Credentialing Requirements
- All licensed Practitioners and Providers who have an independent relationship with Alignment Health Plan require credentialing
- Verification of credentialing information is performed by Alignment or its delegate initially prior to contracting and every 3 years after or sooner based on state requirements

QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

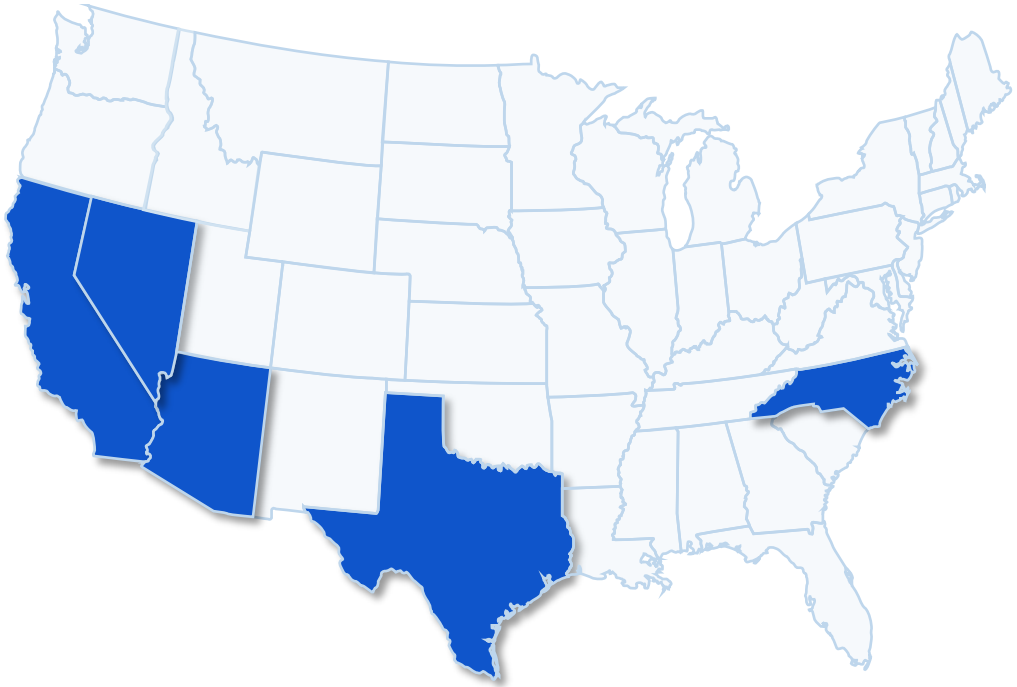
- The MOC requires the Alignment to have a Quality Improvement Program to monitor and evaluate its Model of Care performance. Alignment has established tailored measures and health objectives tied to coordination of care, appropriate delivery of services, affordability and member satisfaction.
- Alignment has a Quality Improvement Plan (QIP) that is specific to the C-SNP or D-SNP MOCs and designed to measure the effectiveness of each MOC
- Data is collected, analyzed and evaluated to report on the MOC quality performance improvement
- Specific HEDIS® health outcomes measures are identified to measure the impact the MOC has on all SNP Members
- Each year, an annual evaluation of the MOC is performed and the results shared with the stakeholders through the Quality Improvement Committee (QIC)
- Alignment establishes process and outcome measures tied to MOC goals, such as:



ALIGNMENT HEALTH PLAN SPECIAL NEEDS PLANS

SUMMARY OF THE ALIGNMENT SNP PLANS FOR 2026

SNP Type/ Condition	Approved Markets
Chronic Condition SNP ❖ Diabetes ❖ Congestive Heart Failure ❖ Cardiovascular Disorders	📍 California 📍 Nevada 📍 Arizona 📍 North Carolina 📍 Texas
Dual Eligible SNP ❖ Eligible for both Medicare & Medicaid	📍 California 📍 North Carolina 📍 Nevada 📍 Texas
Chronic Condition SNP ❖ Chronic Kidney Disease	📍 California
Chronic Condition SNP ❖ Chronic Lung Conditions	📍 California
Chronic Condition SNP ❖ Substance Use Disorder and/or Chronic Disabling Mental Health Conditions	📍 California



ALIGNMENT HEALTH PLAN CHRONIC SPECIAL NEEDS PLANS

(C-SNP)

ALIGNMENT'S HEART & DIABETES C-SNPS FOR CALIFORNIA

PLAN NAMES:

- Alignment Health Heart & Diabetes HMO C-SNP
- Alignment Health Heart & Diabetes CALPLUS HMO C-SNP
- Alignment Health Heart & Diabetes Choice HMO C-SNP

  Available in: Available in Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Clara, Stanislaus, Ventura, Yolo Counties

- Alignment Health Heart & Diabetes Access HMO C-SNP *(LA, Riverside and San Bernardino Only)*
- Alignment Health Silicon HMO C-SNP (*Santa Clara Only*)
- Alignment Health Heart & Diabetes Care HMO C-SNP *(Alameda, Fresno, Madera, Marin, Merced, Placer, Sacramento, San Francisco, San Joaquin, San Luis Obispo, Santa Clara, Stanislaus, Ventura, Yolo Only*)
- Alignment Health Heart & Diabetes Care HMO C-SNP (*LA, Orange, Riverside, San Bernardino And San Diego Only*)

ADDITIONAL ALIGNMENT C-SNPS FOR CALIFORNIA

CALIFORNIA

PLAN NAME:

- Alignment Health Balance – Chronic Kidney Disease

  (Los Angeles And Orange Counties Only)

- Alignment Health Breath Easy- Chronic Lung Disease

  Available in: Available in Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Ventura, Yolo Counties

- Alignment Health Clarity- Chronic Disabling Mental Health Conditions An/Or Substance Use Disorders

  Available in: Available in Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Ventura, Yolo Counties

ALIGNMENT'S HEART & DIABETES C-SNP FOR NEVADA

PLAN NAME:

- Alignment Health Heart & Diabetes HMO C-SNP (Clark County Only)

- Alignment Health Heart & Diabetes NVPlus HMO C-SNP (Clark and Washoe Counties)

ALIGNMENT'S HEART & DIABETES C-SNPS FOR ARIZONA

PLAN NAME:

- Alignment Heart & Diabetes HMO C-SNP
- Alignment Health Heart & Diabetes Plus HMO C-SNP
- Alignment Health Heart & Diabetes AZPlus HMO C-SNP

Available in: Maricopa, Pima and Santa Cruz Counties

ALIGNMENT'S HEART & DIABETES C-SNPS FOR NORTH CAROLINA

PLAN NAME:

- Alignment Health Heart & Diabetes NCPlus HMO POS C-SNP
- Alignment Health Heart& Diabetes Care HMO C-SNP

Available in: Avery, Buncombe, Chatham, Davidson, Davie, Forsyth, Guilford, Henderson, Johnston, Madison, McDowell, Mitchell, Orange, Transylvania, Wake, Wilkes Counties, North Carolina

ALIGNMENT'S HEART & DIABETES C-SNP FOR TEXAS

PLAN NAME:

- Alignment Health Heart & Diabetes HMO-POS C-SNP
- Alignment Health Heart & Diabetes Plus HMO-POS C-SNP

Available in: El Paso and Hudspeth

ADDITIONAL BENEFITS FOR C-SNPS MAY INCLUDE:

ALIGNMENT C-SNP BENEFIT SUMMARY
ADDITIONAL BENEFITS FOR D-SNPS MAY INCLUDE

- Care Anywhere Evaluations- Annual Wellness Examination
- Preventive and Comprehensive Dental Services
- Routine vision exams and glasses or contact coverage
- Routine preventive screening
- Hearing exams
- Transportation
- Chronic & Readmission Meal Benefit
- Personal Emergency Response System (PERS)
- Fitness Benefit
- Healthy Rewards Program
- Telehealth
- Caregiver Reimbursement
- In Home Support
- Pest Control
- Essentials For qualifying members to assist with Groceries, Gas, Utilities and Home Safety
- Access to Alignment's Virtual Care Center, which provides access to a licensed provider through video and/or phone for non-emergency medical care
- ACCESS On-Demand Black Card which includes 24/7 Concierge care, Telehealth and Over-the-Counter benefits
- Acupuncture & Reflexology
- Chiropractic Services
- Bonus Drug Coverage
- Supplemental Benefits for the Chronically Ill- (SSBCI)
    - Monthly Grocery Allowance for food
    - Air purifier or humidifier ($0 copay) per year
    - Limited pet services for boarding or walks
    - House cleaning

ALIGNMENT HEALTH PLAN DUAL ELIGIBLE SPECIAL NEEDS PLANS

(D-SNP)

ALIGNMENT'S D-SNP FOR CALIFORNIA

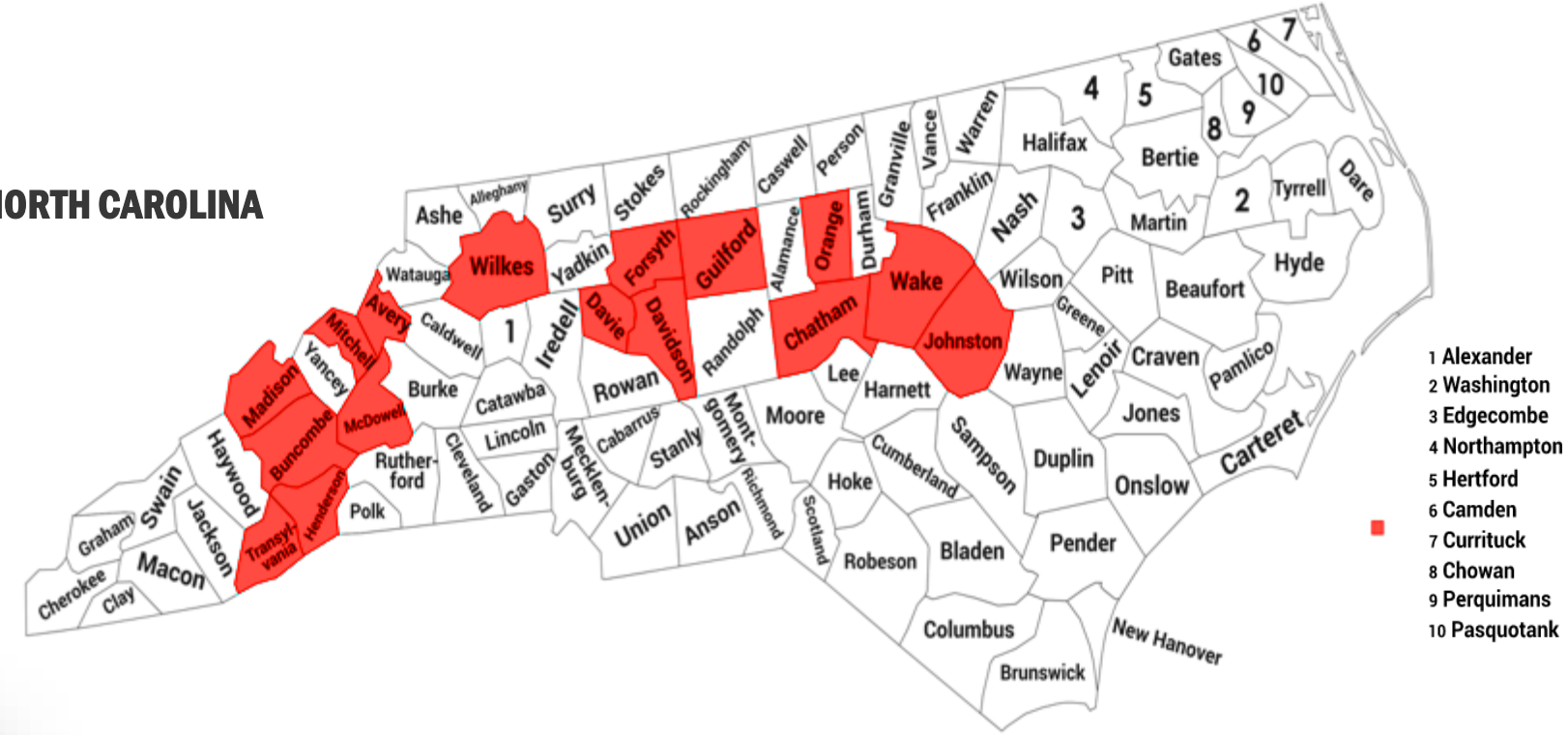
PLAN NAME:

- Alignment Cal Plus Duals HMO D-SNP

  Available in: Marin, San Francisco, San Joaquin, San Luis Obispo, Stanislaus, and Ventura Counties

ALIGNMENT'S D-SNP FOR NORTH CAROLINA

NORTH CAROLINA

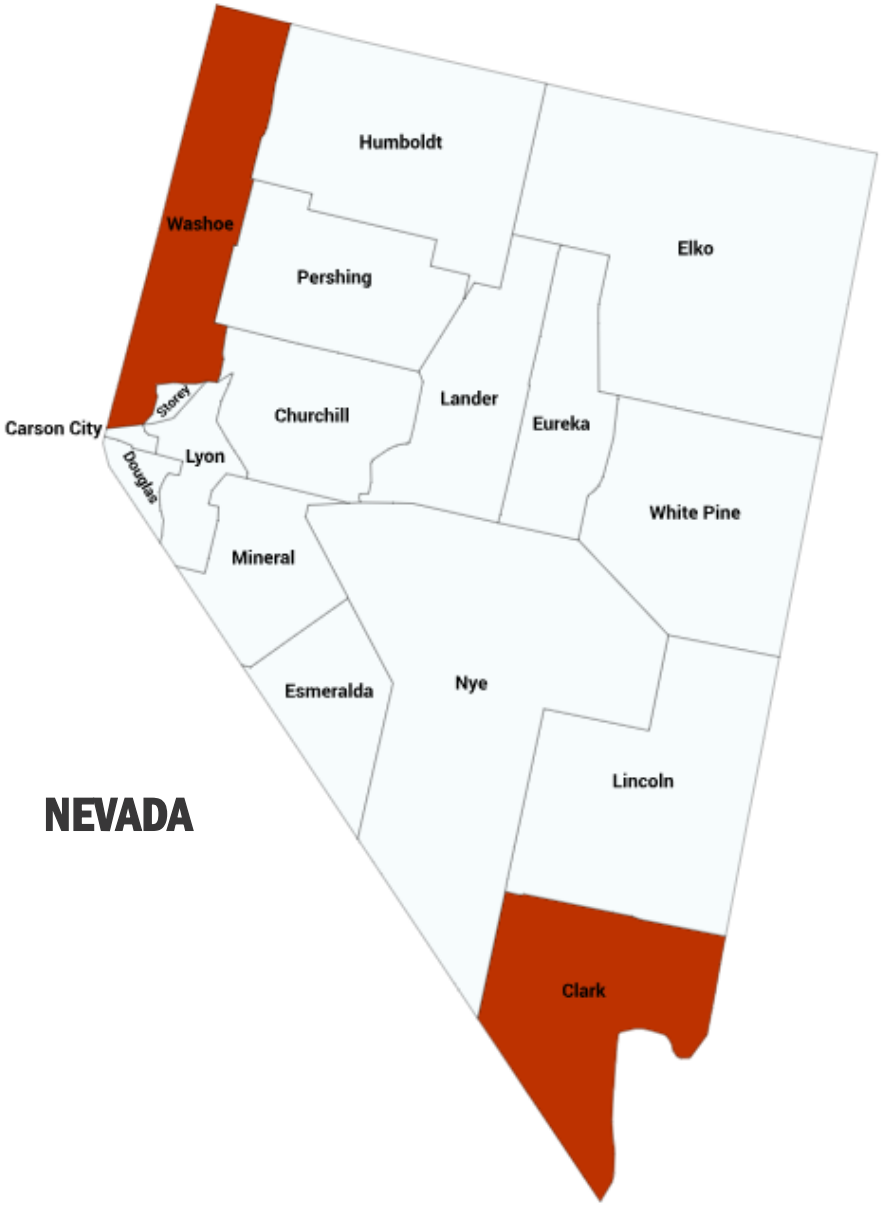


PLAN NAME:

- Alignment Health Nc Duals HMO POS D-SNP

Available in: Avery, Buncombe, Chatham, Davidson, Davie, Forsyth, Guilford, Henderson, Johnston, Madison, McDowell, Mitchell, Orange, Transylvania, Wake, Wilkes

ALIGNMENT'S D-SNP FOR NEVADA



NEVADA

PLAN NAME:

Alignment Health The One HMO D-SNP

Available in: Clark and Washoe Counties

ALIGNMENT'S D-SNP FOR TEXAS

PLAN NAME:

- Alignment Health Dual Select + HMO-POS D-SNP
- Alignment Health Total Dual+ HMO-POS D-SNP

Available in: El Paso and Hudspeth

ALIGNMENT D-SNP BENEFIT SUMMARY

ADDITIONAL BENEFITS FOR D-SNPS MAY INCLUDE

- Care Anywhere Evaluations- Annual Wellness Examination
- Preventive and Comprehensive Dental Services
- Routine vision exams and glasses or contact coverage
- Routine preventive screening
- Hearing exams
- Transportation
- Chronic & Readmission Meal Benefit
- Personal Emergency Response System (PERS)
- Fitness Benefit
- Healthy Rewards Program
- Telehealth
- Caregiver Reimbursement
- In Home Support
- Access to Alignment's Virtual Care Center, which provides access to a licensed provider through video and/or phone for non-emergency medical care
- ACCESS On-Demand Black Card which includes 24/7 Concierge care, Telehealth and Over-the-Counter benefits
- Acupuncture
- Chiropractic Services
- Bonus Drug Coverage
- Essentials For qualifying members to assist with Groceries, Gas, Utilities and Home Safety-Supplemental Benefits for the Chronically Ill-(SSBCI)
- Monthly Grocery Allowance for food
- Air purifier or humidifier ($0 copay) per year
- Limited pet services for boarding or walks
- House cleaning
- Pest Control
- Pet Services

WORKING WITH OUR MEMBERS AND PROVIDERS

PROVIDER RESPONSIBILITIES

- Collaborate with the Alignment Care Management and Care Anywhere teams, the Interdisciplinary Care Team (ICT), members, and caregivers.
- Review and respond to care plan development and invitations to participate in ICT meetings.
- Encourage members to:
  - Complete Health Risk Assessments (HRAs)
  - Engage with the ICT
  - Keep scheduled appointments
  - Follow prescribed treatment plans
- Participate in Alignment's quality improvement initiatives and member satisfaction surveys.
- Respond promptly to Alignment's requests for information related to:
  - Member complaints
  - Quality of care concerns
  - Medical record review requests
- Complete the annual Special Needs Plan (SNP) Model of Care (MOC) provider training and confirm completion.

For California Providers Only:

- Access and complete the Dementia Care Aware training. www.dementiacareaware.org/education-and-training/
- Utilize Dementia Care Aware resources during primary care visits to screen for cognitive impairment.
- Review and apply tools from the California Alzheimer's Disease Centers' "Assessment of Cognitive Complaints Toolkit" to support cognitive assessments.

FREQUENTLY ASKED QUESTIONS (FAQS)

- ❑ **Where can I Find Out About Alignment's Models of Care?**

Providers training includes a summary of all and can be located on the Alignment Health Plan Website - https://www.alignmenthealthplan.com/providers/special-needs-plan-training

- ❑ **Who Can Answer Questions Related to Any of the SNP Models of Care**

Please direct questions related to the content of the MOC to the Quality Management Department (qualitymanagement@ahcusa.com)

- ❑ **How Long Do the Models of Care Last?**

Chronic Condition SNP Models of Care are good for 1 calendar year. They are resubmitted to CMS/NCQA each February for the following year.

Dual SNP Models of Care can be good for 1- 3 years. Changes can be submitted in between renewals as required.

Alignment Health™

THANK YOU!