



**SPECIAL NEEDS PLAN
MODEL OF CARE NETWORK
PROVIDER TRAINING**

2026



WHAT IS INCLUDED IN THE TRAINING

- Annual Training Requirements
- Who is SCAN Health Plan?
- What is a Special Needs Plan (SNP?)
- The SCAN SNP Footprint
- What is a Model of Care?
- MOC 1: SNP Population
- MOC 2: Care Coordination
- MOC 3: Network
- MOC 4: Quality Metrics & Performance
- CALIFORNIA PROVIDERS ONLY: FIDE SNP
- Attestation Reminder



ANNUAL TRAINING REQUIREMENTS

CMS requires annual Model of Care (MOC) training for all staff and providers involved in the care of Special Needs Plan (SNP) members.

What's expected of you



COMPLETE

Complete annual SNP Model of Care (MOC) training and submit [attestation of completion](#)



UNDERSTAND

Understand the unique clinical, functional, and social needs of a SNP member



PARTICIPATE

Participate in coordinated, team-based care delivery

Completion of this training is required for participation in SCAN SNP networks

WHO IS SCAN HEALTH PLAN

1977 – A BOLD BEGINNING

In 1977, twelve determined seniors in Long Beach, California refused to accept a healthcare system that was not working. Instead of complaining, they organized and built something new.

COMMUNITY FIRST

Senior Care Action Network, SCAN, became a true network of community partners providing everything from healthcare to housing, transportation to culturally relevant programs. It reflected the diversity of the people it served.

1984 – LEADING INNOVATION

SCAN launched its first Medicare Advantage plan, proving a nonprofit health plan could set the standard for care.



Our refreshed logo is the SCAN *"heart on display"*

adding twelve radiant beams, one for each of our original founders.

This is a daily reminder of the people who inspired us to build something better over four decades ago and who still inspire us to keep going today.



| SPECIAL NEEDS PLANS AND THE MODEL OF CARE



Special Needs Plans (SNP) are Medicare Advantage plans designed for individuals with defined needs:

- Chronic conditions (C-SNPs),
- Institutional or nursing-level care needs (I-SNP), or
- Dual eligible Medicare-Medicaid (D-SNP).

These types of plans provide coordinated, targeted care to meet each member's unique needs.

CMS requires each Special Needs Plan to submit and operate under an approved **Model of Care (MOC)** document. The MOC is the plan's framework that outlines how the plan:


1. Identifies member needs,
2. How care is coordinated,
3. How the network is structured and,
4. How quality and performance is measured



YOUR ROLE: All medical office staff and providers serving SNP members are expected to understand and apply the Model of Care elements in daily practice

2026 SCAN SPECIAL NEEDS PLANS

SCAN OFFERS 3 TYPES OF SNPs:

1  **CHRONIC CONDITION (C-SNP)**


For members with qualifying chronic conditions

Balance, Strive

- Chronic Heart Failure
- Cardiovascular Disease
- Diabetes


Village health:
SCAN partners with DaVita Integrated Kidney Care to serve members with

- End Stage Renal Disease (ESRD)
- Chronic Kidney Disease (CKD)
- Post-Renal Transplant.

2  **INSTITUTIONAL SNP (HI-SNP & FI-SNP)**

For members in facilities needing institutional level of care

Embrace & Embrace together:
A plan that serves beneficiaries who are eligible for Medicare who choose to reside in a qualifying institution or the community.

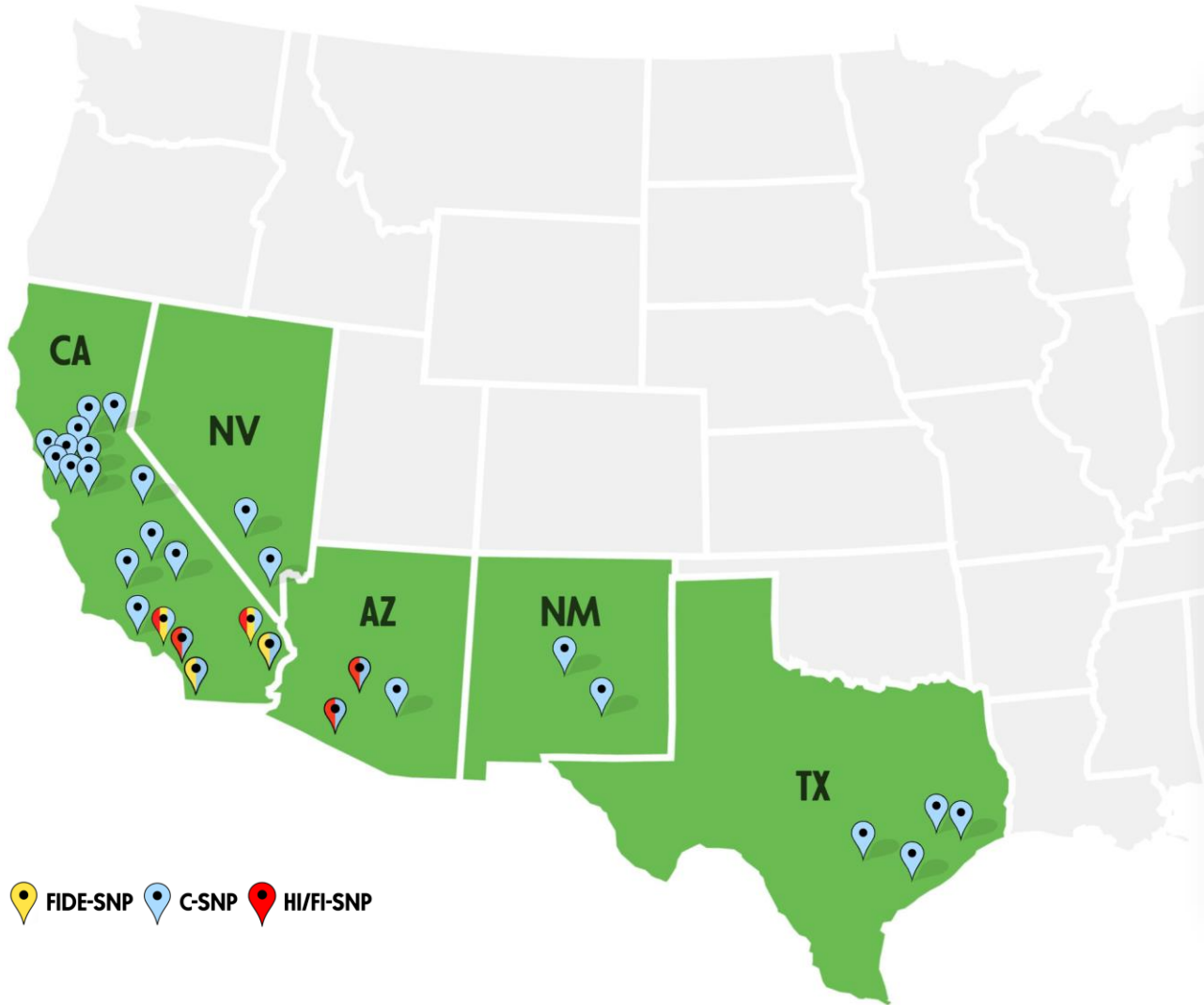
3  **DUAL-ELIGIBLE SNP (FIDE-SNP)**

For members eligible for both Medicare & Medi-Cal - California Only

Connections:
These members are eligible to receive both Medicare and Medi-Cal benefits

Connections at Home:
Members are eligible to receive all Medicare and Medi-Cal benefits and meet Nursing Facility Level of Care (NFLOC) which qualifies them for home and community-based services.

2026 SCAN SNP FOOTPRINT



 FIDE-SNP
  C-SNP
  HI/FI-SNP



CALIFORNIA

- Alameda •
- Fresno •
- Kings •
- Los Angeles •••
- Madera
- Orange ••
- Placer •
- Riverside ••
- Sacramento
- San Bernardino •••
- San Diego ••
- San Francisco •
- San Joaquin •
- San Mateo •
- Santa Clara •
- Stanislaus •
- Tulare •
- Ventura •
- Yolo •



ARIZONA

- Maricopa ••
- Pima ••
- Pinal •



NEVADA

- Clark •
- Nye •



TEXAS

- Bexar •
- Fort Bend •
- Harris •
- Montgomery •



NEW MEXICO

- Bernalillo •
- Sandoval •

ELEMENTS OF A CMS MODEL OF CARE

The Model of Care is organized into four segments:

MOC 1

● SNP Population

Defines the SNP population, its most vulnerable members', and diagnosis verification requirements.

MOC 2

● Coordination of Care

Explains how the plan connects the right services to the right member at the right time (e.g. HRA, ICP, ICT).



MOC 3

● Network

Outlines the network provider expertise that supports consistent, high-quality care for complex populations

MOC 4

● Content Gap Analysis

Describes how the plan measures outcomes to continuously improve SNP care

MOC 1: THE SNP POPULATION



Know your whole patient – not just the diagnosis

UNDERSTAND YOUR PATIENTS

Demographics: Age, disability, geography

Clinical Profile: Conditions, comorbidities, risk level

Social Risk Factors: Housing, food, transportation, language preferences/translation needs

High-Risk Patients: Identify the most vulnerable

CARE NEEDS AND CHALLENGES

High Needs: Multiple chronic conditions

Functional limitations: cognitive, behavioral health needs

Social Drivers: Impacting outcomes

DIAGNOSIS VERIFICATION REQUIREMENTS

Confirm: qualifying conditions within first two months of enrollment

Timely: Submit to avoid involuntary disenrollment

Accurate: provider documentation for compliance and coordinated care

MOC 1: DIAGNOSIS VERIFICATION

Diagnosis Verification

Diagnosis (Dx) Verification is the process of confirming that a member has the chronic condition required to qualify for enrollment in a Chronic Special Needs Plan (C-SNP).

CMS requires this verification to make sure members are only enrolled in plans that match their health needs, which helps ensure they receive the right benefits, care, and coordination.




✓ **Verify** diagnosis within the first 2 months of enrollment. CMS requires Special Needs Plans (SNPs) to verify that each enrollee meets the chronic condition eligibility criteria through the member's treating provider to stay enrolled in a CSNP.

✓ **Documentation** of verification is required and maintained by SCAN for compliance and audit purposes

✗ **If not verified or confirmed not to have a qualifying condition** → member must make a plan change or will be involuntarily disenrolled

✗ **Claims** submission is no longer allowed by CMS for C-SNP chronic condition verification.

 **Treating Provider Definition:** The verifying provider must have an ongoing relationship with the members to ensure they are familiar with the health status. This ensures that the provider can accurately confirm the presence of the qualifying condition(s) as required by CFR 422.52(f)(1)(i).
Eligible provider credentials: MD, DO, PA, NP
Not eligible: Pharmacists, RNs, and office staff are not included as eligible providers for this purpose

New Announcement
DX VERIFICATION MADE EASY! ☀️

Did you know SCAN Health Plan now allows you to provide diagnosis verification 3 ways!

- 1. Fax the signed Dx Verification form to:** (562) 308-3679
- 2. Email the signed Dx Verification to:** C-SNPDXVerification@SCANHealthPlan.com
- 3. NEW! PAPERLESS OPTION**
Phone verification is available prior to a patient's effective date.

NEW CONTACT US
☎️ 1-877-778-7226 option 6

PLEASE LEAVE THE FOLLOWING INFORMATION AFTER THE TONE:

1. Name & Callback Number
2. Treating Provider's full name & NPI
3. Member's full name & DOB
4. Chronic conditions being confirmed

24 HOUR AVAILABILITY
scan

MOC 2: COORDINATION OF CARE



HEALTH RISK ASSESSMENTS (HRA) & INDIVIDUALIZED CARE PLANS (ICP)

- HRA's assess clinical, functional, psychosocial, and social risk factors.
- Results are used to develop and update an individualized care plan (ICP) aligned to the member's goals and needs
- PCPs are expected to review and support the ICP during routine and episodic care

CARE TRANSITIONS & CARE COORDINATION

- Support safe transitions across care settings
- PCPs are expected to collaborate to ensure timely follow-up, medication reconciliation, and timely continuity of care
- Members and caregivers must be informed of a clear point of contact throughout the transition process

FACE-TO-FACE VISITS

- At least one face-to-face encounter annually, conducted in person or via real-time interactive telehealth
- PCPs are expected to document identified needs, care plan updates, and follow-up actions resulting from the encounter

MOC 2: INDIVIDUALIZED CARE PLAN

The individualized Care Plan (ICP) is developed for each SNP member using input from but not limited to the member, caregivers, providers, and care team. It reflects the member's health needs, preferences, and goals.

When to Update the Care Plan:

At least annually or:

- ✓ New concern is identified during outreach
- ✓ Change in Health Status
- ✓ After ICT review
- ✓ Transition event (admit or discharge from the hospital)

STEP 1

REVIEW HRA, TRIGGERS & ICP

Upon receipt of SCAN documents via MFT: Review HRA/ICP for triggered members

STEP 2

CLINICAL REVIEW

Complete a clinical review of all available member medical records to identify any new concerns and document

STEP 3

PATIENT OUTREACH

Outreach to member, documenting attempts and outcome within 30 days of receipt of trigger report

STEP 4

REVIEW AND ASSESS TRIGGERS

Review all triggers with the member on your outreach and assess for any other concerns, determine acuity level and need for case management

STEP 5

REVIEW FINDINGS WITH CARE TEAM

Review all findings in your Interdisciplinary Rounds, update care plan, and return to SCAN

Document if you failed to contact the patient or if the member declined

MOC 2: CARE TRANSITIONS

Goal to reduce readmissions and ensure safe recovery

PCP Responsibilities

1. NOTIFICATION OF DISCHARGE

RECEIVE & REVIEW DISCHARGE

- Review the discharge summary
- Identify any new risks

2. PATIENT FOLLOW-UP

COMPLETE POST DISCHARGE VISIT

- Ensure follow-up services and appts are scheduled timely
- Assess acuity

3. MEDICATION RECONCILIATION

ENSURE MEDICATION ACCURACY

- Perform a comprehensive medication reconciliation
- Educate patient on potential issues that could lead to readmission

4. UPDATE CARE PLAN

UPDATE INDIVIDUALIZED CARE PLAN (ICP)

- Changes in condition
- New Diagnosis
- Functional/Social Needs

Communicate relevant updates to ICT as needed

5. COORDINATE CARE

ENGAGE WITH CARE TEAM

- Specialists
- Hospital discharge planners
- SNFs and/or home health
- SCAN CM Team-when appropriate

MOC 2: FACE TO FACE VISITS



Visit Frequency

SNP members should be offered at least one face-to-face visit within the first 12 months of enrollment and annually thereafter, when feasible



Visit Format

Visits may be conducted in person or via real-time interactive technology, when appropriate



Purpose of the Visit

Face-to-face visits help identify clinical, functional, cognitive, and social needs that may not be fully captured through other interactions



Supporting Care Planning

Information from the visit supports the Health Risk Assessment (HRA), Individualized Care Plan (ICP), and Interdisciplinary Care Team (ICT) collaboration



If Not Completed

If a visit is declined or not feasible, the reason should be documented

Why this matters:

- ✓ Face to face visits strengthen care planning and coordination
- ✓ Improve alignment of care goals with member needs
- ✓ Supports better outcomes for high needs SNP members

MOC 2: ADVANCE CARE PLANNING



Advance Directives are an ongoing, documented conversation that supports shared decision-making of a patient's end of life wishes, preferences, and goals for future medical care.

Primary care providers should educate Members on Advance Directives and encourage completion.

Advance Directive discussions and completion status must be documented in the Member's medical record.

MOC 3: NETWORK



Your role in the SNP provider network

As a network provider, you deliver care tailored to members with complex and specialized needs, supported by a coordinated care team.

SPECIALIZED EXPERTISE

- Providers must have specialized expertise aligned to the SNP target population.
- The SNP ensures licensed, credentialed providers and maintains accurate network records.
- Providers must collaborate with the ICT and contribute to each enrollee's ICP.

USE OF CLINICAL PRACTICE GUIDELINES (CPGS)

- Use appropriate clinical guidelines and protocols
- Identify when guidelines require modification for vulnerable or clinically complex Members.
- Document, communicate, and implement approved modifications through the ICP and ICT, including continuity of care during transitions.

ANNUAL MOC TRAINING

- MOC training required for all providers who provide care to SNP members (in and out of network)



It is the responsibility of the provider and/or Medical Groups to maintain proof of training completion

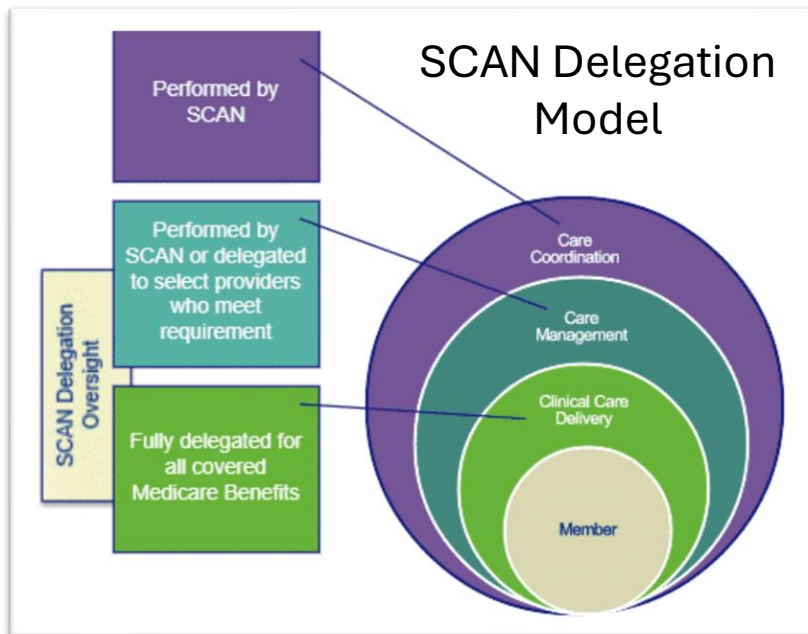
MOC 3: WHO CARES FOR OUR MEMBERS

Provider Network The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP enrollees.

The SNP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized health care needs of the



target population identified in MOC 1 and provide oversight information for all its network types.



SCAN's delegation model defines which functions are retained by SCAN or delegated to qualified providers, with SCAN maintaining oversight to ensure compliance across care coordination, care management, and clinical care delivery.

MOC 4: HOW WE MEASURE SUCCESS



Your role in the SNP provider network

SCAN does not delegate quality improvement however, SCAN requires contracted provider organizations to have a quality improvement program and support the SCAN QIP activities including but not limited to providing access to information systems and/or information sharing, access and availability reporting, provision of requested medical records and/or documentation and HEDIS reporting

QUALITY METRICS

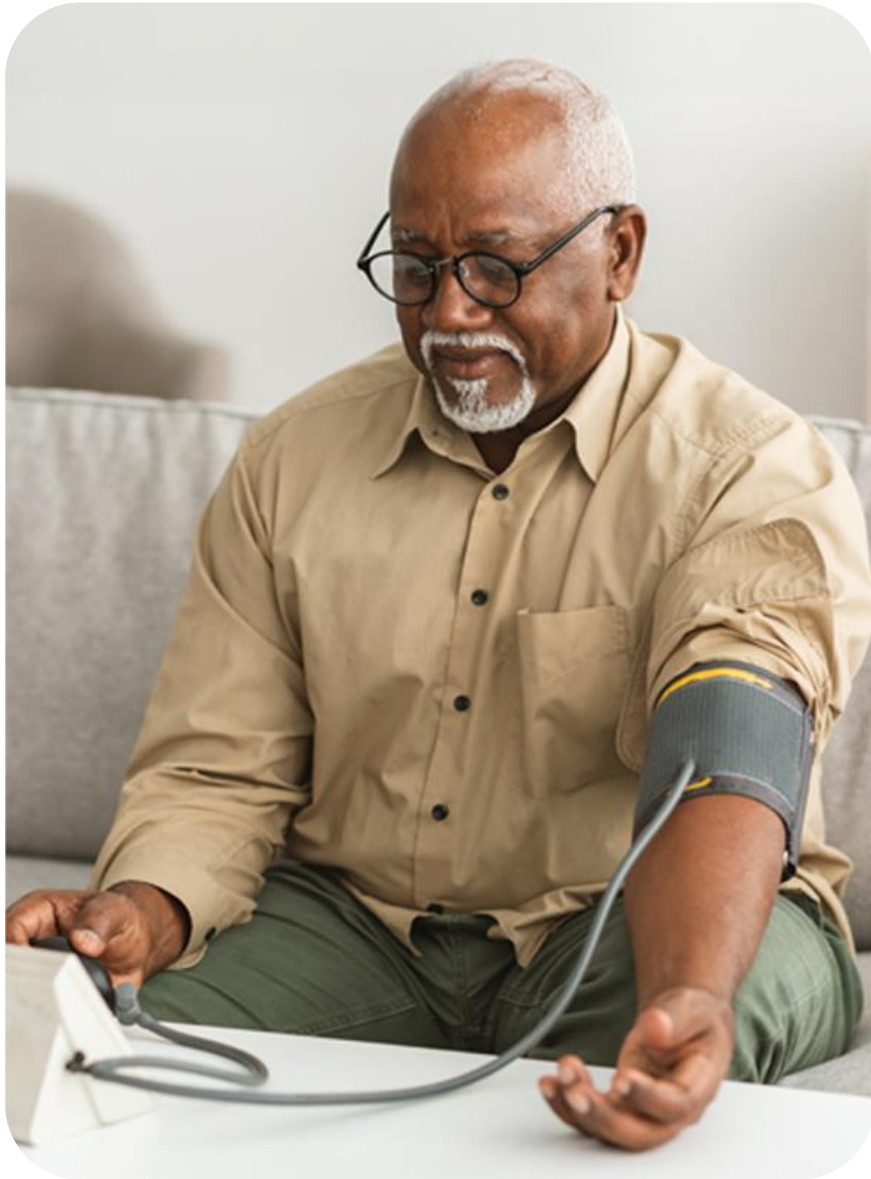
- Quality metrics are used to measure care quality, outcomes, and member experience.
- Performance is monitored and reviewed regularly to identify gaps and improvement opportunities.
- Results drive targeted actions and improvements aligned with SNP MOC and CMS requirements.

QUALITY IMPROVEMENT PROGRAM

- SCAN's Quality Improvement (QI) Program oversees and evaluates the quality, appropriateness, and outcomes of clinical and non-clinical care delivered to SNP enrollees.
- The QI Program drives continuous improvement, addresses enrollee needs (including SNP subpopulations), and supports safe, equitable, and coordinated care.

MEMBER EXPERIENCE

- Collaboration with medical groups and providers on quality measures (i.e., CMS5Star, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS))
- SCAN monitors member experience (grievance trends and quality investigations)



CALIFORNIA PROVIDERS ONLY
**UNIQUE SERVICES OFFERED
THROUGH THE SCAN FULLY
INTEGRATED DUAL-SNP PLAN
(FIDE-SNP)**

CALIFORNIA PROVIDERS ONLY: FIDE-SNP



SCAN fully integrates a beneficiary's Medicare and Medi-Cal services to create a seamless, coordinated care experience:

- **One** health plan serves as a single point of coordination for all Medicare and Medi-Cal services
- **One** enrollment once both Medicare and Medi-Cal coverage are aligned with SCAN
- **One** Member Services call center supports questions and needs across both programs
- **All** Medicare and Medi-Cal benefits are administered through one integrated plan

FOR MORE INFORMATION READ MORE ON THE [SCAN WEBSITE](#)

CALIFORNIA PROVIDERS ONLY - DHCS REQUIREMENTS

What's expected of you

DEMENTIA TRAINING

The California Department of Health Care Services (DHCS) requires all providers participating in FIDE-SNP plans to complete Dementia training

While SCAN does not mandate a specific training we recommend and support Dementia Care Aware as an excellent option.

LINK: [Dementia Care Aware](#)

DHCS CICM

SCAN's California Integrated Care Management (CICM) program provides whole-person, interdisciplinary care coordination for eligible dually enrolled members with complex medical, behavioral health, and social needs and meet one of the four populations of focus.

LINK: [SCAN CICM](#)

THANK YOU FOR SUPPORTING OUR SNP MEMBERS



**PLEASE REMEMBER TO
COMPLETE THE REQUIRED SNP
MODEL OF CARE ATTESTATION AND
RETAIN A COPY FOR YOUR RECORDS
TO SUPPORT COMPLIANCE AND
AUDIT REQUIREMENTS**

[LINK TO ATTESTATION](#)

QUESTIONS OR SUPPORT NEEDED?

Please contact Provider Relations or the Delegation Oversight team for assistance.