Sample MOC Summary for Public Display
Special Needs Plan Organization Name

HealthCare for All Z0000 Dual Eligible SNP (Medicaid Subset)
Health Care for Some Z0010 Dual Eligible SNP (Medicare Zero-Cost Sharing)

Model of Care Score: 85%
3-Year Approval **January 1, 2014 – January 1, 2017**

Target Population:
The D-SNP target population is Qualified Medicare Beneficiaries (QMB) and Full Benefit Dual Eligibles (FBDEs) who also qualify for community-based long-term care according to the Medicaid Advantage Plus contract with State. The D-SNP has a large Medicaid and Medicare population and works with a population who face barriers to healthcare access and health status improvement including: health literacy, economic disadvantage, disability, and chronic medical and/or behavioral conditions. The current population in its D-SNPs includes a mix of age ranges, with 30 percent of members under 65 years of age. This SNP serves members throughout the major metropolitan areas of the State including, name of county, name of county, and name of county.

Provider Network:
The D-SNP provider networks are constructed to meet the unique needs of high risk and potentially vulnerable populations. The D-SNP seeks to include a culturally diverse network of providers who are experienced with the target population and located in geographic proximity to where the members live. Further, the D-SNP contracts with specialists that focus on the most prevalent medical and behavioral conditions of the target population.

If a member is unable to utilize a network provider to obtain medically covered services, the D-SNP will provide and cover these services with out-of-network providers and the member would pay at an in-network rate.

The D-SNP attempts to contract with Federally Qualified Health Centers (FQHC) throughout its service areas. These providers, in particular, are especially relevant to the dual-eligible population as most of these members have limited income sources. These centers have strong programs for Diabetes and cholesterol management as well as cardiovascular care.

Care Management and Coordination:
After enrollment, the Member is assigned to a case manager. The case manager conducts a comprehensive member assessment, including a health risk assessment (HRA). The HRA is conducted in-person at the member's home and assesses the member's medical, physical, cognitive, psychosocial and functional need, as well as current caregiver and community resources. This information is used to develop an individualized care plan (ICP) and determine the frequency and intensity of interventions for each member.

The case manager, with the member and their caregivers, work with the member's Primary Care Provider (PCP) to develop the individualized care plan (ICP). Each member's care plan identifies goals that reflect the member's unique needs, are realistic and measurable, include a time frame for achievement, when appropriate, identifies services and care to meet member's goals and connects the member/caregiver with add-on benefits and services such as community resources. The ICP also includes member self-management plans and information.

Once the ICP is developed, the case manager is responsible for assembling the appropriate members of the interdisciplinary care team (ICT). The ICT at a minimum includes the member, caregiver, PCP and the D-SNP Case Manager. Other members of the ICT can include specialists, social service support, behavioral health specialists, and others depending on the members' specific needs. The care plan is shared with the members of the ICT who are involved with the member's care. The member is integrated in the ICT and receives a copy of the care plan.

The PCP serves as a gatekeeper and orders services for the member via the case manager who coordinates the use of participating providers and services. The case manager is the single point of contact for the ICT, and is responsible for all communication to all the members of the ICT including updating any changes in Member health status via the care plan.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at:

HealthCare for All Z0000: HCfA@org.com
HealthCare for Some Z0010: HCfS@org.com