

Special Needs Plan Provider Model of Care Training 2026



Florida complete care

Institutional Special Needs Plan (HMO I-SNP)
Institutional Equivalent Special Needs Plan (HMO IE-SNP)
Dual Eligible Special Needs Plan (D-SNP)

Who is Florida Complete Care (FC2)



Florida Complete Care Overview

- Florida Complete Care (FC2) is a Medicare Advantage HMO with a Medicare contract and a Florida Medicaid contract.
- FC2 offers three Special Needs Plans (SNPs) designed to support members with complex medical and functional needs:
 1. **Institutional Special Needs Plan (I-SNP)**
 2. **Institutional Equivalent Special Needs Plan – In the Community (IE-SNP)**
 3. **Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP / D-SNP)**

Enrollment Requirements

- Enrollment is dependent on annual CMS contract renewal.

To Join Florida Complete Care, a Member Must:

- Be entitled to Medicare Part A and be enrolled in Medicare Part B
- Live in FC2's service area
- For D-SNP: Receive Medicaid assistance from the State of Florida
- I-SNP: Live in an institutional setting; long term care facility for at least 90 days'
- IE-SNP: Live outside of an institution but require the same level of care that would be provided at a facility
- D-SNP: Receive Full Medicaid assistance from the State of Florida (FBDE, QMB+, SLMB+)



Model of Care Goals

1. Target Population

- Understand the characteristics, needs, and eligibility requirements for Florida Complete Care's I-SNP, IE-SNP, and D-SNP members.
- Recognize vulnerable sub-populations and SDOH factors impacting care.

2. Care Coordination

- Apply Florida Complete Care's care management model: HRA, ICP, ICT, and Transitions of Care (TOC).
- Clearly understand provider responsibilities in assessments, communication, and safe transitions.

3. Provider Network

- Understand expectations for delivering culturally and linguistically appropriate care, closing care gaps, and supporting quality outcomes.
- Collaborate effectively with Care Managers and the Interdisciplinary Care Team (ICT).

4. Quality Measurement

- Support HEDIS, CAHPS, HOS, STAR, and internal KPI performance through timely documentation, screenings, and follow-up.
- Recognize how provider engagement drives quality scores and MOC effectiveness.



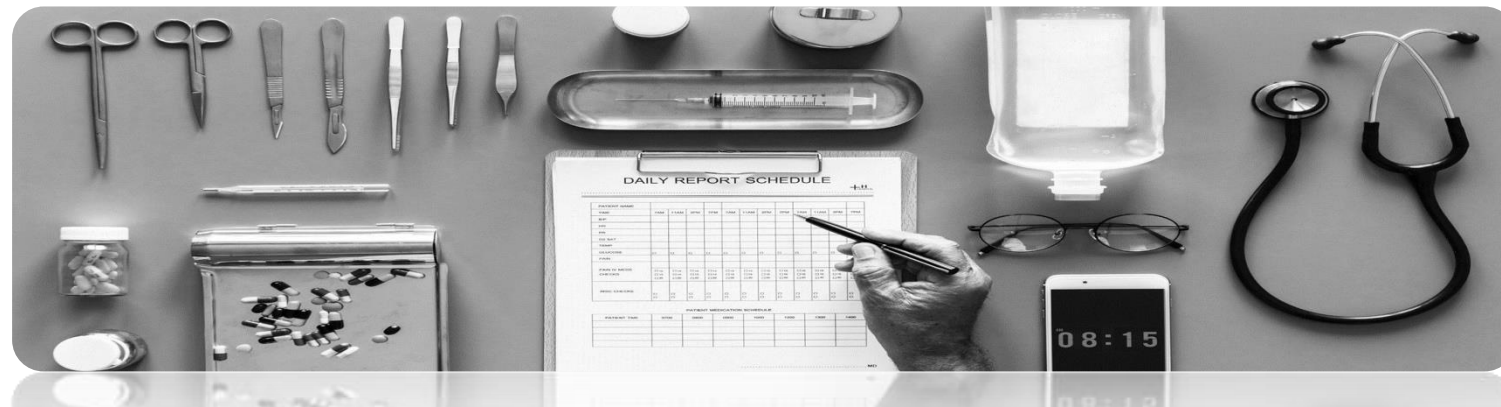
Model of Care Overview

Why It Matters

- The MOC is a CMS-required framework approved by NCQA under the Social Security Act.
- Under Section 1859(f)(7) of the Social Security Act, every Special Needs Plan (SNP) must maintain a Model of Care (MOC) approved by NCQA.
- It ensures individualized, high-quality care for SNP members.
- Providers play a key role in care coordination and quality improvement.
- The MOC is more than a requirement—it's the foundation for delivering high-quality, person-centered care.

What the MOC Promotes

- Individualized Care – Services tailored to each member's health and social needs.
- Integrated Care Management – Coordinating medical, behavioral, and long-term services.
- Quality & Accountability – Measurable goals and continuous improvement.
- Collaboration Across Disciplines – Providers, care managers, and community resources working together.
- Member-Centered Approach – Education, engagement, and shared decision-making.



Learning Goals for Providers

Understand

Understand the 2026 Requirements

- Describe new CY 2026 CMS and NCQA Model of Care requirements, including the 50% minimum element score, SDOH HRA domains, and annual face-to-face encounter requirements.
- Understand how MOC requirements impact clinical documentation, assessments, and transitions of care.

Recognize

Recognize the SNP Populations Served

- Identify the eligibility criteria and population characteristics for FC2's I-SNP, IE-SNP, and D-SNP plans.
- Understand the needs of vulnerable members, including SDOH considerations and high-risk subsets.

Apply

Apply Care Coordination Standards

- Explain provider roles in completing assessments, participating in ICT meetings, updating care plans, and supporting safe transitions of care.
- Understand expectations for collaborating with FC2's Care Managers.

Navigate

Navigate FC2's Benefits and Services

- Recognize key 2026 benefits and supplemental services available under each plan and how they support member well-being.
- Understand how benefit design supports clinical outcomes, independence, and chronic condition management.

Support

Support Quality & Performance Requirements

- Understand FC2's quality strategy, including HEDIS, CAHPS, HOS, STAR, and internal KPIs.
- Know how provider engagement influences quality performance and member experience outcomes.

Meet

Meet Compliance Obligations

- Complete MOC training and attestations under CMS SNP regulations.
- Understand how adherence to MOC processes helps maintain compliance and plan accreditation.

Our Training Objectives

1

Explain Florida Complete Care (HMO I-SNP), Florida Complete Care In the Community (HMO IE-SNP) and Dual Eligible Special Needs Plans (D-SNP).

2

Describe Florida Complete Care's MOC goals and care management program.
Describe what Florida Complete Care offers.

3

Describe how Medicare and Medicaid benefits are integrated and coordinated under the plans.
Discuss the completion of the MOC attestation.

4

Describe which members qualify for (HMO I- SNP), (HMO IE-SNP) and Dual Eligible Special Needs Plans (D-SNP).



CMS Requirements

The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff to complete basic training on the Special Needs Plans (SNPs) Model of Care (MOC).

What is the SNP Model of Care?

The Model of Care is the framework for delivering coordinated care and care management to special needs members. It ensures that each member receives personalized, high-quality services through collaboration among providers and care teams.

Purpose of the Course:

This course explains how Florida Complete Care and its contracted providers collaborate to successfully deliver the Model of Care (MOC) program for Special Needs Plans (SNPs).



Eligibility Requirements



Florida Complete Care (HMO I-SNP) and Florida Complete Care In the Community (HMO IE-SNP) are Medicare Advantage and prescription drug plans. Our plans include hospital, medical and prescription drug benefits in one plan.

To join our plans, members must:

- Be entitled to Medicare Part A
- Enrolled in Medicare Part B
- Live in our service area
- Live in one of our nursing homes or plan to move into one soon
- Live at home but need the same level of care as someone in a nursing home



D-SNP Eligible Medicaid Categories Overview



Medicaid Eligibility Categories

The Medicaid eligibility categories encompass all levels of Medicaid eligibility, including:

- Full Medicaid
- Qualified Medicare Beneficiary (QMB)
- QMB Plus
- Specified Low-Income Medicare Beneficiary (SLMB)
- SLMB Plus
- Qualifying Individual (QI)
- Qualified Disabled and Working Individual (QDWI)



Our Special Needs Plans (SNPs)

Three (3) segments within the plan

HMO-I-SNP Institutional Special Needs Plan

- Plan 001
- Individuals who live in the plan's service area and either reside (or plan to reside) in a network nursing home or live in the community but require a nursing-home level of care.

HMO-POS-IE-SNP Institutional Equivalent Special Needs Plan

- Plan 002
- Individuals who live in the plan's service area and remain in the community but require a nursing-home level of care, including those residing in assisted living facilities.

HMO-POS D-SNP (Duals VIP) Special Needs Plan

- Plan 004
- Individuals who reside in the plan's service area and receive Florida Medicaid as a dual eligible, specifically Full Benefit Dual Eligible (FBDE), Qualified Medicare Beneficiary Plus (QMB+), or Specified Low-Income Medicare Beneficiary Plus (SLMB+).

POS (Point of Service) plans allow members to receive covered specialist care from providers both in and out of the Florida Complete Care network anywhere in Florida. This is called an open network.



Plan Eligibility Requirements

Institutional Special Needs Plan (HMO I-SNP)

- Medicare recipients living in a nursing home long-term, more than 90 days or recent move-ins that are expected to stay longer than 90 days.
- Plan qualifies for a Special Enrollment Period.

Institutional Equivalent Special Needs Plan (HMO-POS-IE-SNP)

- Medicare recipients living in the plan service area that meet level of care (LOC) based on state assessment.
- Level of Care assessments:
 - 701B Comprehensive Assessment
 - 701T Non-Community Placement Assessment
- Plan qualifies for a Special Enrollment Period.

HMO-POS D-SNP (Duals VIP) Special Needs Plan

- Medicare recipients living in the plan service area that are entitled to Medicare Part A and enrolled in Medicare Part B Must qualify for Medicaid assistance as a Full Benefit Dual Eligible (FBDE), Qualified Medicare Beneficiary Plus (QMB+), or Specified Low-Income Beneficiary Plus (SLMB+).



Identifying our Members



**Florida
complete care**

1-833-FC2-PLAN
3 2 2 7 5 2 6

HMO I-SNP
Member ID: **123-223-8888**
Member Name: **John Doe**
Health Plan: **80840 1023789567**
Effective Date: **01/01/2026**

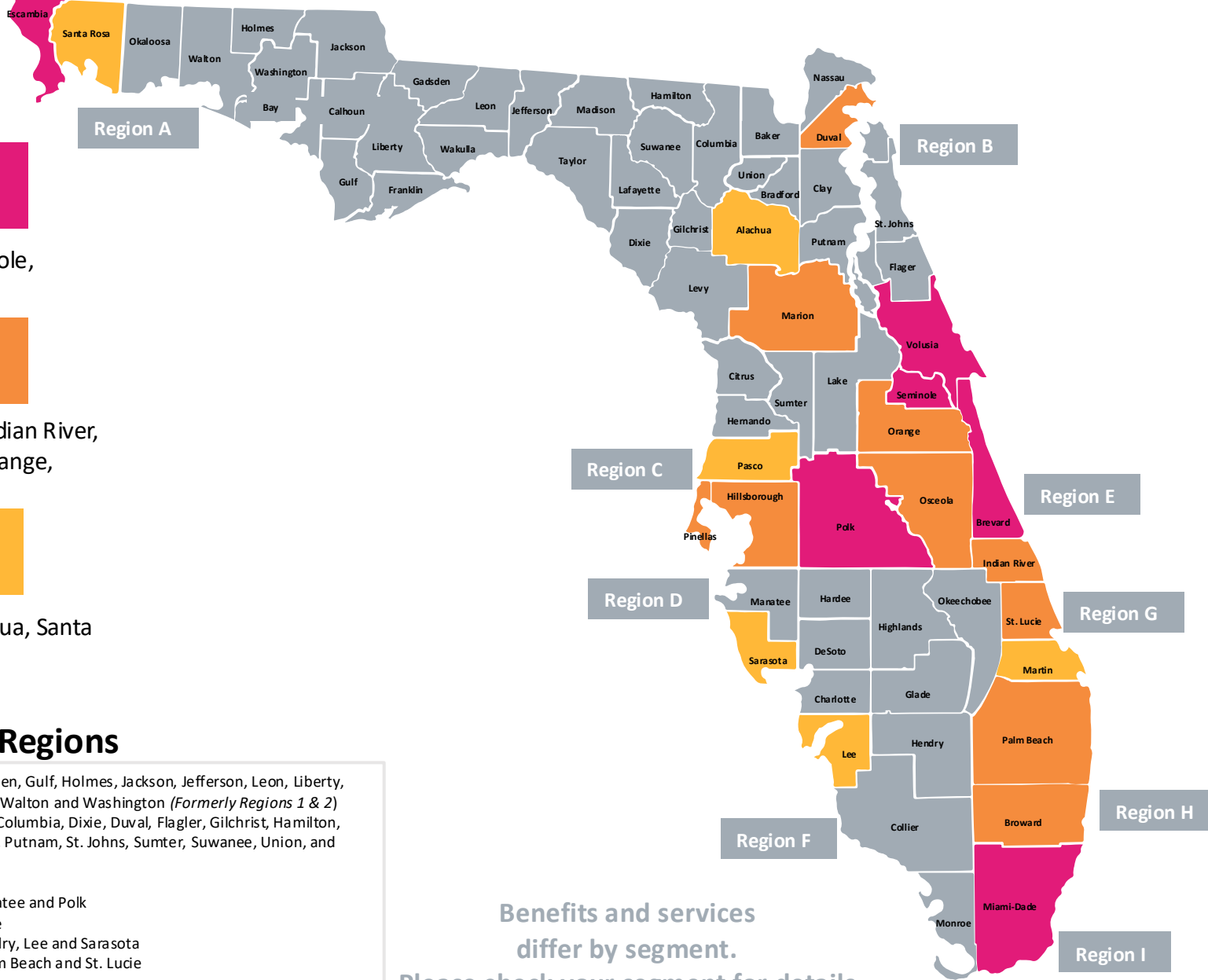
PRIMARY DOCTOR
PCP: **Mr. Hopper**
Phone: **(305) 222-3333**
CMS#: H9986-001 (PBP)

MedicareRx
Prescription Drug Coverage X

RxBIN: 004336 RxPCN: MEDDADV RxGRP: RX21BK
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Service Area & Segments



Segment One (1)

Miami-Dade, Brevard, Polk, Seminole, Volusia and Escambia

Segment Two (2)

Broward, Palm Beach, St. Lucie, Indian River, Pinellas, Hillsborough, Osceola, Orange, Marion, Duval

Segment Three (3)

Martin, Lee, Sarasota, Pasco, Alachua, Santa Rosa

SMMC 3.0 Regions

- Region A:** Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton and Washington (*Formerly Regions 1 & 2*)
- Region B:** Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwanee, Union, and Volusia (*Formerly Regions 3 & 4*)
- Region C:** Pasco and Pinellas
- Region D:** Hardee, Highlands, Hillsborough, Manatee and Polk
- Region E:** Brevard, Orange, Osceola and Seminole
- Region F:** Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota
- Region G:** Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
- Region H:** Broward
- Region I:** Miami-Dade and Monroe

Benefits and services differ by segment. Please check your segment for details specific to your location.

Supplemental Benefits



I-SNP

- Emergency Preparedness Meals
- Dental: \$912.50 per quarter
- OTC: \$350 per quarter
- Emergency Preparedness Meals
- Legal Aid: \$250 per lifetime for assistance with power of attorney for healthcare decisions (SSBCI)

Benefits and services differ by segment location.

IE-SNP

- Flex Card OTC: \$40 per month
- Flex Card Healthy Food Assistance: \$60 per month
- Dental: \$862.50 per quarter
- Emergency Preparedness Meals
- Post-Discharge Meals
- Medically Tailored Meals (SSBCI)
- Fresh Produce Box (SSBCI)
- Specialty House Calls
- Legal Aid: \$250 per lifetime for assistance with power of attorney for healthcare decisions (SSBCI)

For additional information about FC2's Supplemental Benefits, visit us at: www.FC2healthplan.com

HMO-POS D-SNP (Duals VIP)

- Flex Card OTC: \$75-\$100 per month*
- Flex Card Healthy Food Assistance \$170-\$210 per month
- Hearing, Vision & Dental Services: \$5,500 - \$6,060 per year
- Emergency Preparedness Meals
- Post-Discharge Meals
- Medically Tailored Meals (SSBCI)
- Fresh Produce Box (SSBCI)
- Unlimited Routine Transportation
- Specialty House Calls
- Legal Aid: \$250 per lifetime for assistance with power of attorney for healthcare decisions (SSBCI)
- Advance Care at Home
- Arthritis Program at Home

Target Population

Who We Serve	Key Population Characteristics	Most Vulnerable Sub-Populations	Social Determinants of Health (SDOH)
<ul style="list-style-type: none">• I-SNP: Individuals residing in, or requiring, nursing-home level of care.• IE-SNP: Individuals living in the community who meet nursing-home level of care.• D-SNP: Individuals eligible for both Medicare and Florida Medicaid.	<ul style="list-style-type: none">• Multiple chronic conditions, functional limitations, cognitive or behavioral health needs.• Higher risk for falls, hospitalizations, and care fragmentation.	<ul style="list-style-type: none">• Limited caregiver support, socially isolated, or homebound individuals.• Individuals with complex medication regimens or frequent ER use.	<ul style="list-style-type: none">• Housing instability, food insecurity, transportation barriers, low health literacy.



CMS Star Ratings

Florida Complete Care will monitor the following quality measures:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers (CAHPS)
- Health Outcome Survey (HOS)
- STAR Ratings

New Medicare Advantage Plans are not rated their first year

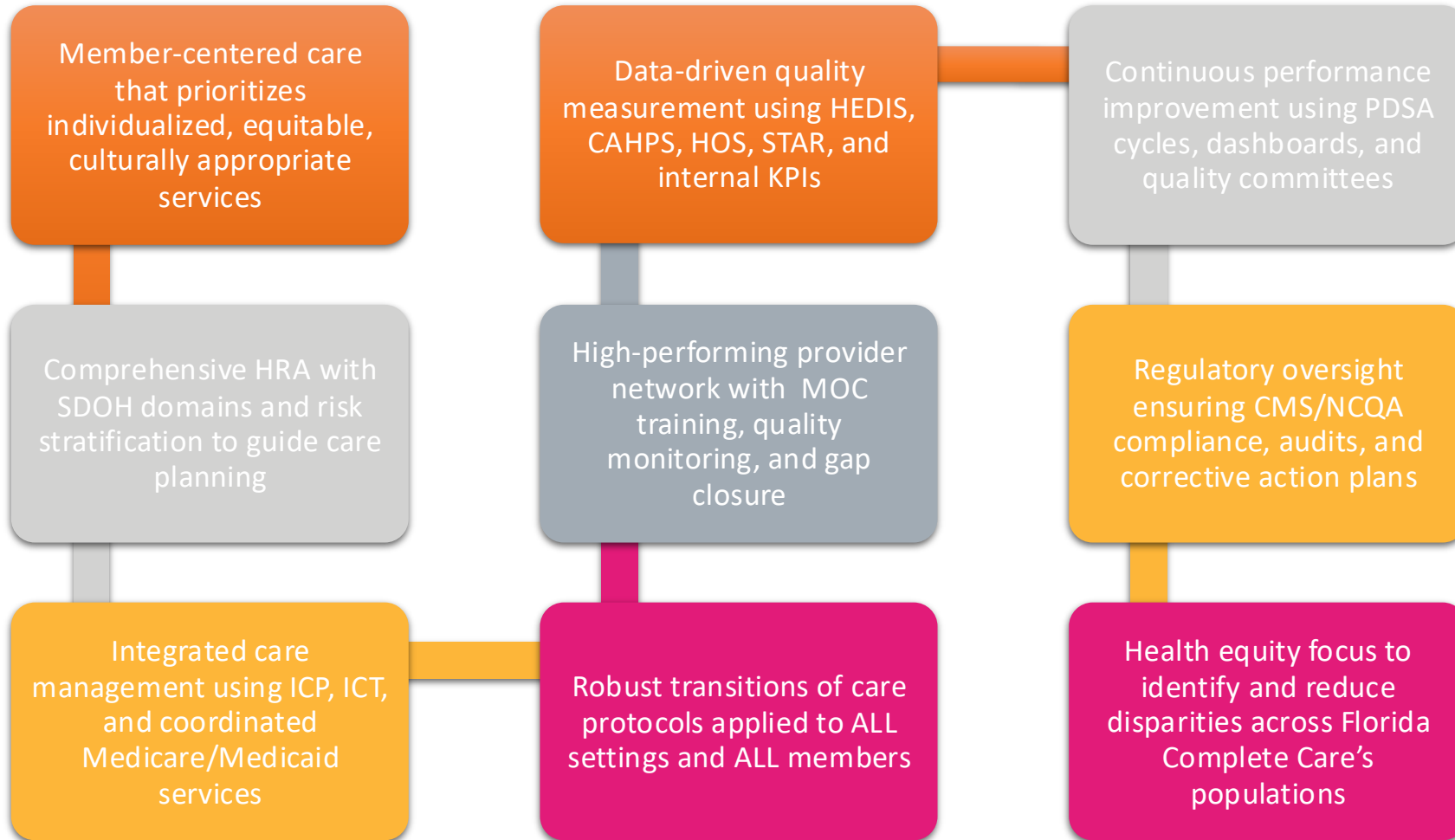
The Centers for Medicare & Medicaid Services (CMS) evaluates all Medicare Advantage Plans to ensure that our members have:

- Access to care and benefits
- Wellness and preventive programs
- Chronic Condition management
- MOC and HRA completion rate

Note: Florida Complete Care is an HMO I-SNP with a Medicare contract. Enrollment in Florida Complete Care depends on contract renewal.



Quality Measurement



Integrating and Coordinating Care

Florida Complete Care integrates and coordinates member care across the entire continuum through a centralized point of contact, ensuring seamless communication and collaboration among providers.



How We Support Your Care

Primary Care Provider (PCP): Every SNP member is assigned a PCP who helps assess your health needs and guides the member's overall care.

Care Manager: The care manager coordinates services, including home health therapies, skilled nursing visits, and planned hospital stays.

Coordinated Care: The care manager makes sure Medicare and Medicaid benefits work together seamlessly for comprehensive support.

Team Approach: The care manager works closely with the member or caregiver, the PCP, specialists, and other members of the Interdisciplinary Care Team (ICT) to keep all care organized and connected.



Ensuring Smooth Care Transitions

Critical Transitions of Care

Covers **planned and unplanned hospital admissions** and **discharge planning** from hospitals, rehab centers, and nursing facilities.

Care Manager = Central Point of Contact

Ensures continuity and coordination during every transition.

Communication is Key

Care Manager shares updates and notifications with your Interdisciplinary Care Team (ICT) and Primary Care Provider (PCP) through your updated Individualized Care Plan (ICP).



Elevating the Member Experience



Enhancing Quality of Life

- Supported by an Interdisciplinary Care Team (ICT) to help every member stay in the least restrictive setting.
- Individualized Care Plan (ICP) addresses needs like fall prevention, bladder control, physical activity, and behavioral health.
- Care Transitions Program ensures safe, coordinated transitions with follow-up after hospital or facility discharge.

Delivering Quality of Service

- Care guided by CLAS principles (Culturally and Linguistically Appropriate Services), including translation and interpreter support.
- Prompt resolution of inquiries, complaints, grievances, and appeals.
- Access to specialized services, extra benefits, and a tailored provider network.



Care Management Approach

Our care management approach is led by a dedicated Care Manager who provides personalized, comprehensive support for 100% of our members through an integrated care team.



Care Manager Primary Point of Contact



Coordination of D-SNP, Medicaid and Medicare Services



Navigate PA Process



Provide Education on Various Health Topics



Facilitate Communication Between Providers



One Individual Conducting Assessments



Provider Responsibilities



- **Review** and contribute to the Individualized Care Plan (ICP) for all SNP members, ensuring care aligns with goals, needs, and risk stratification.
- **Support** safe and timely transitions of care (TOC) and post-discharge follow-up.
- **Provide** clinical updates and participate in assessments.
- **Participate** in the member's Interdisciplinary Care Team (ICT) meetings.
- **Deliver** culturally and linguistically appropriate care.
- **Completion** of HRA SDOH domains (housing, food, transportation) by supplying timely clinical information and awareness of barriers.
- **Complete** Model of Care (MOC) attestation.



Model of Care Attestation



This training and completion of an attestation are for appropriate D-SNP and I-SNP in-network and out-of-network providers at least once during the MOC's period of approval.

- ❑ After completing the training, please complete the Attestation form by clicking the link:

[Model of Care Training Attestation](#)

- ❑ You can also submit a copy of the signed form by emailing it to: FC2_MOC@ilshealth.com

- ❑ If you have any questions about the Model of Care or Completing the Attestation Form, please call Provider Relations Training at [1-866-962-6186](tel:1-866-962-6186)

As a Medicare Advantage Special Needs Plan, The Centers for Medicare & Medicaid Services (CMS) requires us to train you on our Model of Care and keep record of the completed training.



Model of Care Attestation Form Sample

Attestation to be completed at the completion of this training.

Model of Care Attestation

Provider Model of Care Training Confirmation

1. This form is to be completed by the provider or a representative of the provider group who completed the Model of Care training. To document completion of this training, please complete the form to be submitted to the provider group. If the training was delivered to a group setting, one attestation form should be submitted by the designated staff member with authority to sign on behalf of your group.

2. This form is to be completed by the provider or a representative of the provider group who completed the Model of Care training. To document completion of this training, please complete the form to be submitted to the provider group. If the training was delivered to a group setting, one attestation form should be submitted by the designated staff member with authority to sign on behalf of your group.

1. Provider Name/Group**
Enter your answer

2. Phone**
Enter your answer

3. Fax**
Enter your answer

4. Tax Identification Number (TIN/EIN)**
Enter your answer

5. Tax Identification Number (If you add additional TIN/EIN)
Enter your answer

6. National Provider Identifier (NPI)
Enter your answer

7. Name Completed By**
Enter your answer

8. Title**
Enter your answer

9. Date**
Please input date (MM/DD/YYYY)

10. The Provider Model of Care training has been completed by the Provider Group above. I consent as a digital signature attesting to the accuracy of the information.**
 Agree
 Disagree



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