

<<today\_date\_mmmm\_ddyyyy>>

<Doctor's Name>

<Clinic Name/Fax Number>

<Address>   
<City>**,** <State> <ZIP>

Re: <Member Name>, <DOB>

Dear <Doctocr's Name>,

My name is <CC Name> and I’m the Medica Care Coordinator for <Member Name>. I can help members:

* Navigate through health care systems, manage transitions, and access home care services and other community-based resources
* Identify and set up any non-medical services that can help the member maintain or improve their health and well-being
* Answer health care coverage questions
* Communicate and coordinate with their Interdisciplinary Care Team

The most recent Health Risk Assessment with <Member Name> indicates the following<Free text-HRA identified needs/concerns (or if no needs identified, unable to contact member, or member declines assessment document that here)>..

Currently, <Member Name> is receiving the following services:

* Care Coordination
* <free text for services received>
* <free text for services received>

We also see you as an integral member of the Interdisciplinary Care Team. Please contact me with questions or input about this member’s health care needs or plan of care.

<Free text-additional comments/concerns, etc.>

**My Contact Information:**    
Call me at <phone> <Monday – Friday> between <9 a.m. - 5 p.m.> TTY/TDD: 711.

Thank you,

<Care Coordinator Name>, <Credentials>

<County/Care System/Agency name>

<CC phone number>

cc: member record

CMS Special Needs Plans Model of Care Training

As a provider of member care within a Special Needs Plan (SNP), we want you to know about training available and required by the Centers for Medicare & Medicaid (CMS).

**SNP Model of Care Training Requirement**

* Learn about the CMS Model of Care requirements for Special Needs Plans such as Medica DUAL Solution (MSHO) and Medica AccessAbility Solution Enhanced (SNBC DSNP)
* Better understand Medica DUAL Solution (MSHO), Medica AccessAbility Solution Enhanced (SNBC DSNP) products, members and their needs as well as understanding the importance of your role as a member of the MSHO, SNBC DSNP interdisciplinary care team
* Learn more about the role of the Care Coordinator (CC); how you may interface with them and the benefits of coordinating with the Care Coordinator for your MSHO and SNBC DSNP members to better care for your member

**You’ll find more Medica benefit and plan information at Medica.com.**

**What’s a SNP? Who are SNP Individuals?**

CMS defines SNPs as coordinated care plans that provide targeted care and limits enrollment to special needs individuals. In the case of our members in a Dual Eligible Special Needs Plan (DSNP) this refers to someone who has both Medicare and Medicaid insurance.

**What’s the Purpose of the Model of Care?**

To ensure the unique needs of the each member are identified and addressed through the plan’s care management practices, and provide the foundation for promoting plan quality, access to services, care management, and care coordination processes.

**Model of Care: CMS-required elements**

* Identification of the target population and the members served through the SNP
* Description of the Care Coordination Model that ensures the SNP’s beneficiaries needs are met
* Identification of the provider network which includes the providers, services, and specialists available to members
* Quality Improvement Plan and Performance Measurement

**You’ll find the full SNP Model of Care Training in Provider Portal at Medica.com/Providers/Providers-training**.