



In partnership with:



We have a solution for that!

2026 Special Needs Plans (SNP) Model of Care (MOC) Provider Training

Training Regulatory Requirements

- The Centers for Medicare and Medicaid Services (CMS) requires that all SNP plans develop and implement a Model of Care (MOC) that describes how the Plan will coordinate care and design tailored services for the Plan's target population. [§ 422.101 \(f\)](#)
- As part of the MOC, CMS mandates that all SNP plans provide training on the MOC to all in-network providers and out-of-network providers who see SNP members routinely. [§ 422.101 \(f\)](#)

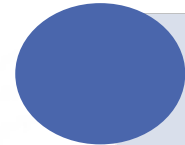
Goals of Training



Provide an overview of SNPs and how they differ from other types of Medicare Advantage (MA) plans



Show you how to identify Arkansas Superior Select, Inc. (ASSI) SNP members



Demonstrate how ASSI's MOC benefits you and your patients

What are SNPs?

- CMS defines a SNP as “a MA coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals.” Enrollment is limited to individuals with special healthcare needs due to:



Dual eligible status (receive Medicare and Medicaid benefits)

Certain CMS-specified chronic or disabling conditions

Long-term residence in an institutionalized setting or equivalent

- Established to improve quality of care for high risk/need beneficiaries
- Must meet all Medicare Part C and D requirements

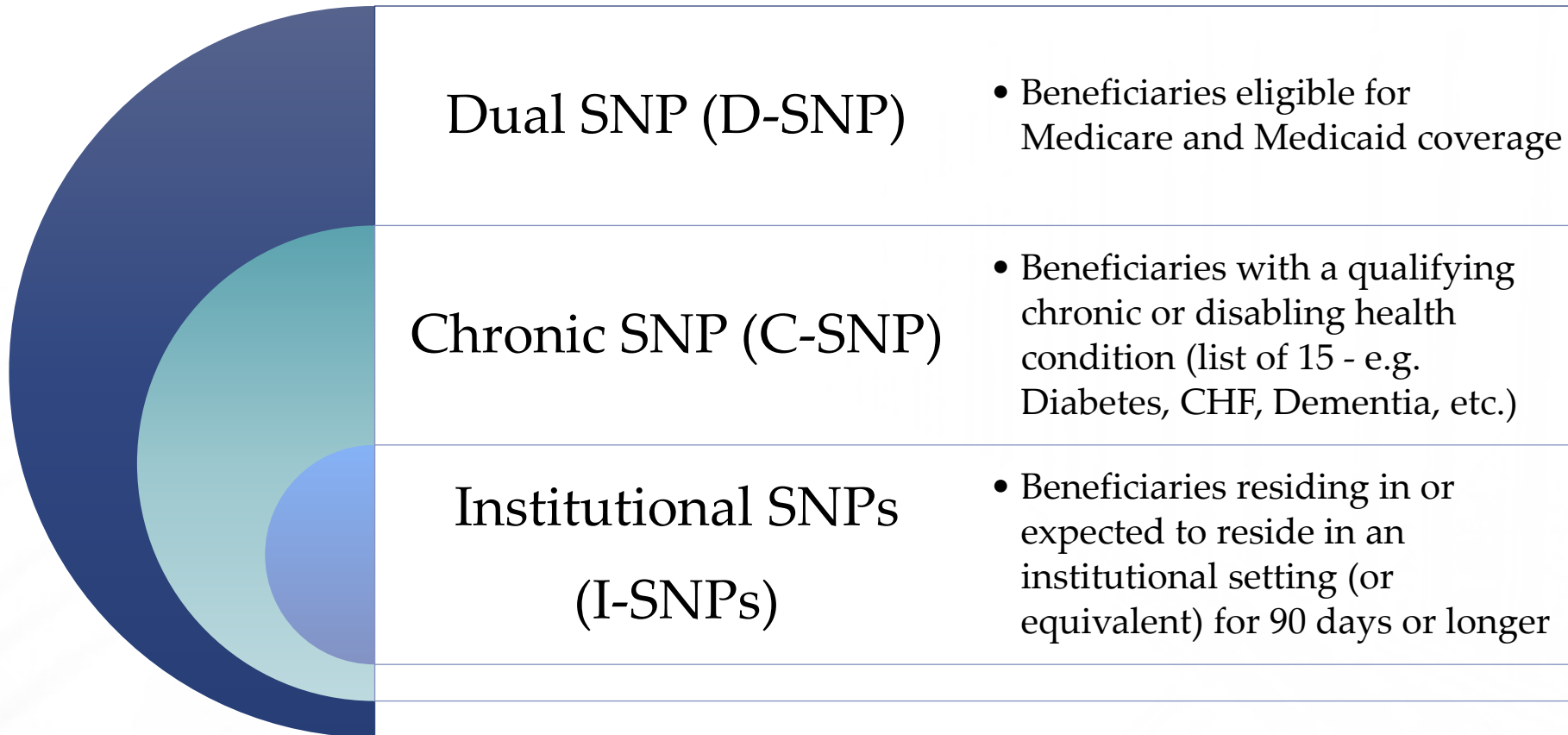


Enhanced care coordination and quality improvement program requirements via the MOC

Source: <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/index.html>

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SNP Types



SNPs at ASSI



D-SNP

- Beneficiaries eligible for Medicare and Medicaid coverage
- ~75 members
- Established 2015
- State-wide service area as of 2018



- Beneficiaries residing in or expected to reside in an institutional setting (or equivalent in community) for 90 days or longer
- ~2600 members
- Established 2018
- State-wide service area



The AIP Dual Advantage

- + **No Monthly Premium**
\$0 monthly plan premium for AIP Dual Advantage members with Medicare and Medicaid
- + **Durable Medical Equipment (DME)**
Covers medically necessary DME, such as walkers, wheelchairs and low-loss air mattresses
- + **Flex Card & Supplemental Benefits**
- + **Physical, Occupational and Speech Therapy**
No annual limit for Part B authorized therapy services
- + **Skilled Nursing Care**
No prior hospital stay requirement
- + **All-In-One Plan**
Covers original Medicare benefits plus Medicare Part D prescription drugs



| | |
|--------------------------|---|
| Monthly Premium | \$0 |
| Primary Care Visit | 20% coinsurance per visit |
| Specialist Visit | 20% coinsurance per visit |
| Inpatient Hospital Stays | \$0-\$1,736 deductible for each benefit period Days 1-60: \$0 coinsurance Days 61-90: \$0-\$434 coinsurance Days 91 and beyond: \$0- \$868 coinsurance per each "lifetime reserve day" (up to 60 days over your lifetime) Beyond lifetime reserve days: all costs |

+ Medical Services

Your cost for medical services match Original Medicare and may be less depending on your status under Arkansas Medicaid

+ Durable Medical Equipment (DME)

Covers medically necessary DME, such as walkers, wheelchairs and low-loss air mattresses

+ Physical, Occupational and Speech Therapy

No annual limit for Part B authorized therapy services

+ Skilled Nursing Care

No prior hospital stay requirement

+ All-In-One Plan

Covers original Medicare benefits plus Medicare Part D prescription drugs

How to identify your SNP patients



D-SNP:



AIP Dual Advantage (HMO D-SNP)

Toll-Free 1-866-488-5457 (TTY 711)

ISSUER ID: H1587-001 RxBIN: 012312
MEMBER ID: {{MemberNumber}} RxPCN: PARTD
MEMBER: {{MemberFullName}} RxGRP: H1587001

AIP DUAL ADVANTAGE (HMO D-SNP) CMS H1587 001

ENROLLEE INFORMATION
Member Services: 1-866-488-5457 (TTY 711)
8:00 a.m. to 8:00 p.m., 7 days a week
In emergency, call 911 or go to the nearest emergency room.

IMPORTANT PROVIDER INFORMATION
www.AIPCares.com
Provider Services: 1-866-488-5457 Pharmacists: 1-833-502-6756

Contracted and non-contracted providers may send claims to:

Medical: **Pharmacy:**
Access Health Services **MedImpact**
P.O. Box 3398 10181 Scripps Gateway Ct.
Little Rock, AR 72202-3398 San Diego, CA 92131
EDI #61184





I-SNP:



Tribute Select (HMO-POS I-SNP)

Toll-Free 1-877-372-1033 (TTY 711)

ISSUER ID: RxBIN: 012312
MEMBER ID: RxPCN: PARTD
MEMBER: RxGRP: H1587001


Tribute SELECT (HMO-POS I-SNP) CMS H1587 003

ENROLLEE INFORMATION
Member Services: 1-877-372-1033 (TTY 711)
8:00 a.m. to 8:00 p.m., 7 days a week
In emergency, call 911 or go to the nearest emergency room.

IMPORTANT PROVIDER INFORMATION
www.TributeMedicare.com
Provider Services: 1-866-225-8501 Pharmacists: 1-833-502-6756

Contracted and non-contracted providers may send claims to:

Medical: **Pharmacy:**
Access Health Services **MedImpact**
P.O. Box 3398 10181 Scripps Gateway Ct.
Little Rock, AR 72202-3398 San Diego, CA 82131
EDI# 61184



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SNP Model of Care (MOC)

*“As provided under section 1859(f)(7) of the Social Security Act, every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees. The MOC is a **vital quality improvement tool** and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan’s care management practices.” - CMS*

- Narrative filed with CMS AND process to be implemented

 **Plans audited against narrative = ASSI’s “Promise” to CMS**

Source: <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.html>

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Elements of the SNP MOC

The following topics must be addressed in the MOC narrative and process:

MOC 1: Description of the SNP Population

- Includes definition and description of most vulnerable

MOC 2: Care Coordination

- Staff structure and staff MOC training
- Health Risk Assessment (HRA)
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT)
- Care Transitions

MOC 3: SNP Provider Network

- Specialized network, Evidence-based guideline implementation, Provider MOC Training

MOC 4: MOC Quality Measurement & Performance Improvement

- Ongoing process for measuring and improving MOC performance including customer satisfaction; How results are communicated to stakeholders

SNP Care Coordination Requirements (all fulfilled by Case Managers)

| CMS MOC Regulatory Requirement | |
|--|---|
| Health Risk Assessment (HRA) §42 CFR 422.101 (f)(1)(i) | 1) All SNP members must have an initial HRA <u>within</u> 90 days of enrollment and at least annually thereafter <u>within</u> 365 days of the previous HRA |
| Individualized Care Plan (ICP) §42 CFR 422.101 (f)(1)(ii) | 2) All SNP members must have an ICP based on the needs identified in the HRA |
| Interdisciplinary Care Team (ICT) §42 CFR 422.101 (f)(1)(iii) | 3) All SNP members must have an ICT that collaborates in care plan development and implementation |
| Care Transitions §42 CFR 422.101 (f)(1)(iii) | 4) SNPs must support members who experience care transitions and ensure continuity of care across healthcare settings |

ASSI's SNP MOC



Each member is assigned to a dedicated Case Manager (CM)

CM supports member through care transitions.

- Conducts Transition Assessment, updates care plan, communicates with ICT

ICT composition varies but at a minimum includes the member, CM, Primary Care Provider (PCP)

- Communications regarding initial ICP; updates to ICP on an ad hoc basis.

Step 1

Health Risk Assessment

HRA is conducted for each member –within 90 days and annually thereafter by Case Manager

- Face-to-face or telephonically (or completed with responsible party/caregiver/POA, etc.)

HRA results incorporated into ICP. ICP shared with ICT.

Step 2

Risk Stratification

CM inputs HRA into care management system. High risk members identified.

- CM can change risk score

ICP mailed to member + PCP. Includes invitation to discuss.

Step 3

Individualized Care Plan

ICP is auto-generated from Care Management system based on HRA.

- If no HRA, care plan is developed from claims, medical records, etc.
- CM manages care plan follow up – monthly (high), quarterly (all others)

Step 4

Interdisciplinary Care Team

Step 5

Care Transitions Support

ASSI Case Managers



The Case Manager:

- Coordinates completion of HRA with the member, caregiver, POA, facility staff, etc.
 - The HRA is an assessment of the medical, functional, cognitive, psychosocial and mental health needs of the member.
- Coordinates and implements the member's care plan based on needs identified in the HRA
- Follows up with the member in accordance with their risk level (high=monthly, quarterly for all other members)
- Will contact ICT participants to review the member's care plan as well as updates and changes, as needed
- Supports and monitors the member through care transitions and coordinates follow up care
- Helps members obtain community resources to address social determinants of health

Interdisciplinary Care Team

“The ICT is primarily responsible for informing, maintaining and coordinating the member’s care plan. The ICT includes and collaborates with the member’s providers, specifically the member’s PCP and appropriate chronic condition specialists, as determined by the Care Manager.” – ASSI D-SNP MOC

Minimum participants


- Member/caregiver – input on care plan, self-manage conditions
- Case Manager (LPN, LCSW, RN, and/or APP) – primary POC, each member assigned to a CM (*some members’ care will be coordinated by more than one CM, working together)
- PCP – review and provide feedback on care plan, if needed

Additions based on need and increasing risk level

- Other network providers, Medical Director, specialists, behavioral health, pharmacists, nursing facility staff

What to expect and what we need from you...

- You might receive the Case Manager's created care plans via mail or fax for ASSI members that are your patients

 Please review and contact the CM if you have questions or if you disagree with the care plan.

- The Case Manager will invite you telephonically or via mail to participate in your patient's ICT meetings and discuss their care plans

 You are a critical member of your patients' ICTs. Please contact the CM on the care plan, if needed, as we can support the care you are providing for your patients.

- The Case Manager will monitor and support your SNP patients through transitions

 Please notify the CM or ASSI's Authorization team of transitions as soon as possible. We can't help our members/your patients unless we know about their transitions.

- Your ASSI SNP patients will be in touch with their Case Managers on at least a quarterly basis to track their care plan progress

 Contact the CM if you identify a high-risk patient who needs more frequent follow up.

Clinical Practice Guidelines

- As part of the MOC, ASSI identifies and approves clinical practice guidelines to promote internally and among network providers.
- ASSI monitors appropriate use of guidelines through the prior-authorization process and HEDIS® measures.

| Guideline | Adapted from: |
|--|---|
| Congestive Heart Failure (CHF) | American College of Cardiology/American Heart Association (ACC/AHA) guidelines |
| Chronic Obstructive Pulmonary Disease (COPD) | Global Initiative for Chronic Obstructive Lung Disease (GOLD), the American College of Physicians (ACP), and the American College of Chest Physicians. |
| Asthma | National Heart, Lung, and Blood Institute |
| Diabetes | AACE Diabetes Mellitus Clinical Practice Guidelines Task Force |
| Hypertension | Joint National Committee (JNC) VII- Prevention, Detection, Evaluation, and Treatment of High Blood Pressure |
| Osteoporosis | National Osteoporosis Foundation |
| Advanced Care Planning | Aging with Dignity's "five Wishes" and the Family Caregiver Alliance. |
| Palliative Care Guidelines | The Palliative Care program at Mt. Sinai Hospital in NYC; Decision support guidelines from the University of Ottawa and the University of Southern California Center for Medical Ethics |
| Preventive Care and Treatment | Agency for Healthcare Research and Quality, US Department of Health and Human Services, Massachusetts Quality Health Partners |

MOC Performance Measurement



- **Multiple performance measures are collected and used to evaluate MOC compliance and effectiveness:**
 1. MOC compliance/process measures:
 - Examples: HRA completion, Care Plan development, Members assigned to a CM, etc.
 2. Clinical and member health outcomes measures:
 - Examples: Network Adequacy, HEDIS®, Utilization, etc.
 3. Member satisfaction measures:
 - Examples: CAHPS and HOS surveys, complaints and grievances, adverse incidents



ASSI collects data on an ongoing basis and formally evaluates MOC performance annually. Contact ASSI if you would like to learn more about the Quality Improvement process.

ASSI MOC Benefits to Providers

- Dedicated case manager coordinates care for members, supports and extends the care that you are providing
- Improved member engagement and incorporation of member preferences in care plan
- Proactive identification of and support for at-risk members
- Reduced preventable admissions and readmissions
- Referrals to community-based programs to address social determinants of health (e.g. food, housing insecurity, safety, etc.)

Helpful Resources

- ISNP Website: [Home | Tribute Health Plans \(tributemedicare.com\)](https://www.tributemedicare.com)
- DSNP Website: [Home | AIP Dual Advantage \(aipcares.com\)](https://www.aipcares.com)
- Need Help? Call Provider Services at 1-866-225-8501 8:00 a.m. to 4:00 p.m. Monday - Friday
- Provider Portal: [Access Health Portal \(aproposystems.com\)](https://www.aproposystems.com)

Quick Contact Guide

Main Office

501-255-1784

networkops@accesshealth.services

Provider Claims Line

866-225-8501

ASSI and Access Health Services, LLC
thank you for your time and partnership!
Please feel free to contact us for assistance.