Healthy Blue

Missouri | Healthy Blue | Medicare Advantage

2026 Medicare Advantage

Special Needs Plans and Model of Care overview

Learning objectives

- Describe the different types of Special Needs Plans (SNP)
- Understand the impacts of the state Medicaid agency contract on Dual Eligible Special Needs Plans (D-SNP) plans
- Understand the key components/requirements of the Model of Care:
  - Description of the SNP
  - Care coordination
  - Provider network
  - Quality measurement and performance improvement
- Understand your responsibilities as a provider
- Availability of resources and references
- Complete Attestation

Types of SNP plans

- **Dual Eligible Special Needs Plans (D-SNP):** For members eligible for Medicare and Medicaid
- Chronic Condition Special Needs Plans (C-SNP): For members with disabling chronic conditions (categories defined by CMS). Vendors or providers are contracted in some markets to administer some of the maintenance of certification (MOC) requirements and/or are requested to confirm diagnosis.
- **Our organization currently provides the following CSNP plans in various markets:**
  - Group 4 conditions - Includes, one or more of the following conditions to qualify: Diabetes, Congestive Heart Failure, and/or Cardiovascular disease
  - Chronic Kidney Disease (CKD) and/or End-Stage Renal Disease (ESRD) with or without dialysis;
  - Lung Conditions - Includes, one or more of the following conditions to qualify: Asthma, Chronic Obstructive Pulmonary Disease, Chronic Bronchitis, Emphysema or Pulmonary Fibrosis
- **Institutional/Institutional Equivalent Special Needs Plan (I-SNP/IE-SNP):** For beneficiaries expected to reside for 90 days or longer in a long-term care facility (e.g., skilled nursing facility, intermediate care facility, or inpatient care facility, etc.) or meet equivalent institutional level of care (LOC) criteria but living in the community.

D-SNP plans

- Members are eligible for both Medicare and Medicaid.
- Plans may be *full benefit duals* or *partial benefit duals*:
  - Full benefit duals are eligible for Medicaid benefits.
  - Partial benefit duals are only eligible for assistance with some or all Medicare premiums and cost-sharing.
- A member may change plans once during the first three quarters of the year.
- Providers must adhere to coordination and cost share requirements, which may vary by D-SNP type (refer to your provider manual).
- D-SNP types include data coordination, highly integrated dual eligible (HIDE), and fully integrated dual eligible (FIDE).

D-SNP State Medicaid Agency Contracts (SMACs) always include clinical elements

CMS requires each approved D-SNP to have a State Medicaid Agency Contract that includes defined requirements.

Who is eligible to enroll:

- Medicaid eligibility categories as defined by CMS: QMB (+), SLMB (+), QI, QDWI, FBDE
- Alignment requirements and limitations
- Subpopulation to be served (limited to LTSS or BH); the Medicaid landscape also informs this
- Age limitations
- Waiver populations

This informs if there is potentially a Medicaid plan that is also supporting the member. The Medicaid plan may not be ours

Responsibility to coordinate:

- D-SNPs must coordinate overlapping Medicare and Medicaid benefits to ensure that Medicaid remains the payer of last resort
- D-SNPs are always required to navigate care not limited to Medicaid MCO, FFS, waiver programs, State case management agencies, community-based organizations (CBOs), and others
- The model of Care is the foundation for how care is coordinated
- When D-SNP supplemental benefits overlap traditional Medicaid benefits, the D-SNP must first exhaust the Medicare supplemental
- Coordination of care transitions

When you participate in the ICT, the D-SNP will help identify the Medicaid benefits being coordinated.

Medicaid benefits:

- All D-SNPs are aware of Medicaid benefits regardless of who administers these benefits
- A member may have their Medicaid managed under another Managed Care Organization (MCO)
- When the enrollee has Medicaid benefits available under this health plan for both Medicare and Medicaid, you only have to submit your claim and authorization once

*** For FIDE, the D-SNP authorizes everything for you.**

Integration types:

- FIDE: Integrated clinical model to include integrated benefit coverage
- HIDE: Integrated and coordinated model with partial benefit carve-in or specific coordination/ connection requirements
- CO: Coordination only
- Admissions, discharge, transfer requirements

SMAC informs the D-SNP type (model)

D-SNP model types	Provider impact
FIDE (Fully Integrated Dual Eligible)	• A single ID card is used. • There is a single determination that includes Medicare and Medicaid criteria. • There is a Single Care Management contact. • It must cover Medicaid primary and acute care services and LTSS, including at least 180 days of nursing facility coverage. • It must use specialized care management and network methods to coordinate care for high-risk beneficiaries. • D-SNP provides coverage for Medicaid benefits the same as the aligned Medicaid plan. • All members are exclusively aligned, and D-SNP covers additional Medicaid benefits. • D-SNP covers the entire service area of the aligned Medicaid. • There is a single *Provider Manual.* • There is no separate Medicaid contact
HIDE (Highly Integrated Dual Eligible)	• It must cover Medicaid behavioral health benefits, long-term services, and supports (LTSS), or both. Contract for coverage of Medicaid benefits may be with the D-SNP, the D-SNP's parent company, or another entity owned and controlled by the D-SNP's parent company. • The D-SNP service area aligns with or may be greater than Medicaid. • We coordinate with our affiliated Medicaid partners for aligned members to reduce duplication and overlap. • The members' Medicaid services continue to be provided by Medicaid. • Some services may remain excluded based on the state landscape. • The ICT assists in coordination, including Medicaid.
CO (Coordination Only)	• The D-SNP only administers the D-SNP and D-SNP supplemental benefits. • The D-SNP CM attempts to coordinate with Medicaid; however, Medicaid services remain excluded from the D-SNP. • Some members may have a cost based on their level of Medicaid. Review coverage to ensure compliance with federal balance billing.

States may require data coordination and HIDE models to maintain exclusively aligned enrollment. These plans are referred to as *Applicable Integrated Plans (AIPs)*.

FIDE D-SNP

- The plans provide Medicare and Medicaid benefits.*
- They include long-term services and supports (LTSS) benefits (eligibility rules apply).*
- One identification card is used to access both Medicare and Medicaid services.*
- Materials and processes are integrated.*
- States may carve out Medicaid behavioral health benefits from the contract.
- Coordination between Medicare and Medicaid plans or other agencies is required if unaligned.

* Applicable only in an aligned FIDE

Additional requirements for FIDE D-SNP

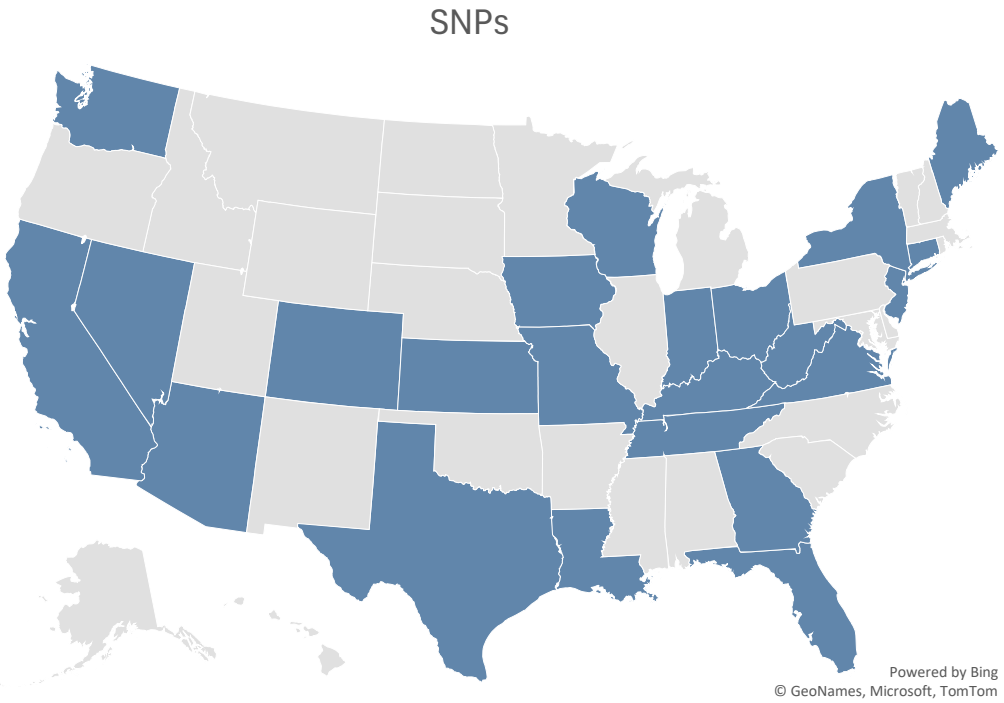
Per 42 CFR 422.2, fully integrated D-SNPs (FIDE SNPs) are also required to:

"[coordinate] the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods of high-risk beneficiaries"

"[employ] policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievances and appeals, and quality improvement"

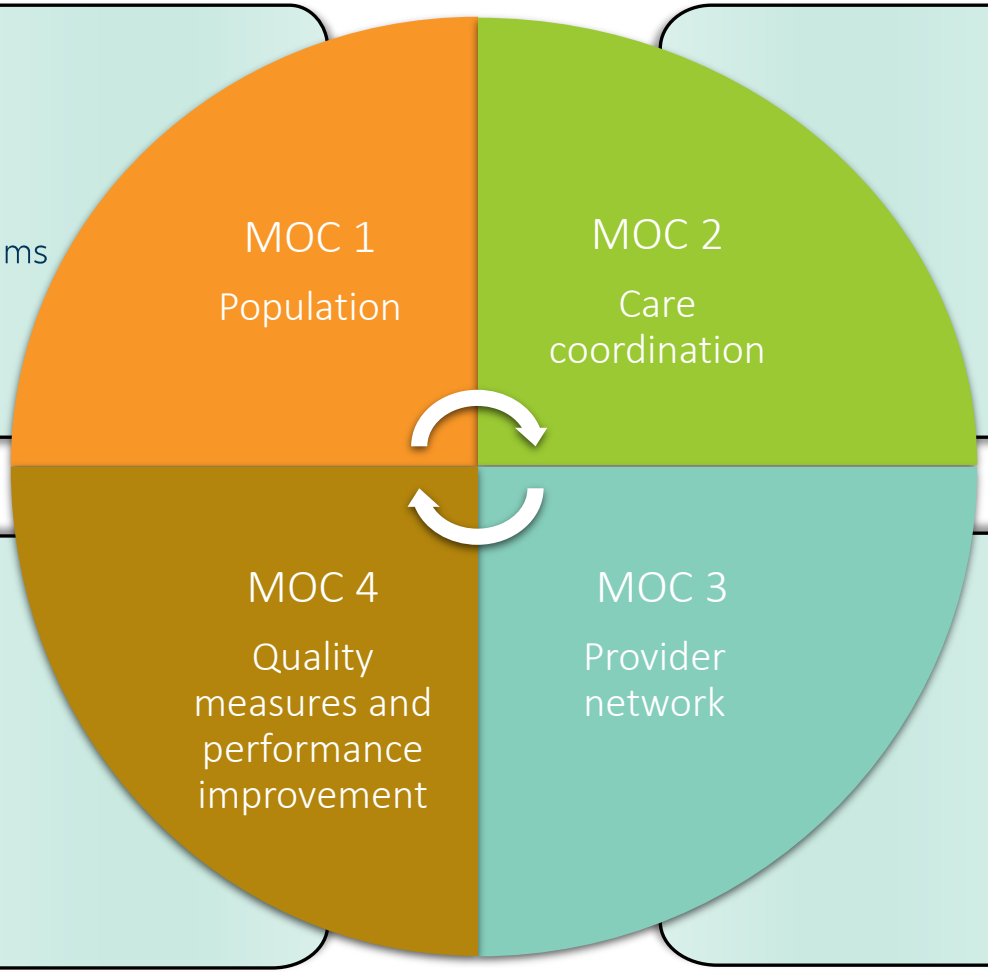
2026 SNP footprint

State	CO DSNP	HIDE DSNP	FIDE DSNP	Group 4 C-SNP	Lung C-SNP	CKD C-SNP	I-SNP
AZ				✓	✓	✓	✓
CA	✓			✓	✓		✓
CO	✓						
CT	✓					✓	
FL		✓		✓			
GA	✓					✓	
IA		✓					
IN	✓		✓				
KS		✓					
KY						✓	
LA	✓						
ME	✓						
MO	✓			✓			
NJ			✓			✓	
NV	✓			✓	✓	✓	✓
NY		✓	✓				
OH	✓		✓	✓			
TN	✓		✓				
TX	✓	✓		✓	✓	✓	
VA	✓		✓	✓		✓	
WA	✓	✓					
WI	✓	✓					
WV	✓						



MOC elements

- SNP population description
- Eligibility requirements
- Define the most vulnerable members and clinical programs
- Describe relationships with community partners



- Staff structure and oversight
- Associate annual training
- Health risk assessment
- Individualized care plan
- Interdisciplinary care team
- Transition management

- Quality performance improvement plan
- Identifying, defining, and measuring goals and health outcomes

- Expertise of provider network
- Provider annual training
- Use of practice guidelines and care transition protocols

Care coordination strategies

Health Risk Assessment (HRA):

- The member HRA is completed within 90 days of enrollment and repeated within 365 days of the last HRA or sooner based on significant changes in heath.
- Physical, behavioral, cognitive, psychosocial, and functional areas are assessed, and the results are used to create an individualized care plan (ICP).
- It assists in care coordination and identifies urgent needs.
- Additional assessment tools are used as needed for condition-specific focus, or as part of other program requirements.
- Members and the providers can access the HRA securely on the website/portals.

Interdisciplinary Care Team (ICT):

- Care was coordinated with the member, PCP, and other participants.
- Providers are key members of the ICT and are responsible for coordinating care and managing transitions.
- ICT role-based actions may include diagnosing/treating, communicating treatment and management options, advocating, informing, and educating members, completing assessments, reviewing HRA results and ICP, collaborating with providers, coordinating with other carriers (Medicaid), and arranging community resources.

Individualized Care Plan (ICP):

- This includes member-specific goals and interventions, issues identified during the plan HRA process, and other interactions.
- Members we cannot reach or do not complete the HRA will receive an ICP based on claims or other information available to the case manager.
- It is updated annually or as the member's needs change.
- The ICP is available on the website for the members and the providers.

Provider access to the member HRA and ICP in Availity is under the Total Member View (TMV) dashboard Care Management tab.

Our SNP is designed to optimize the health and well-being of our aging, vulnerable, and chronically ill members.

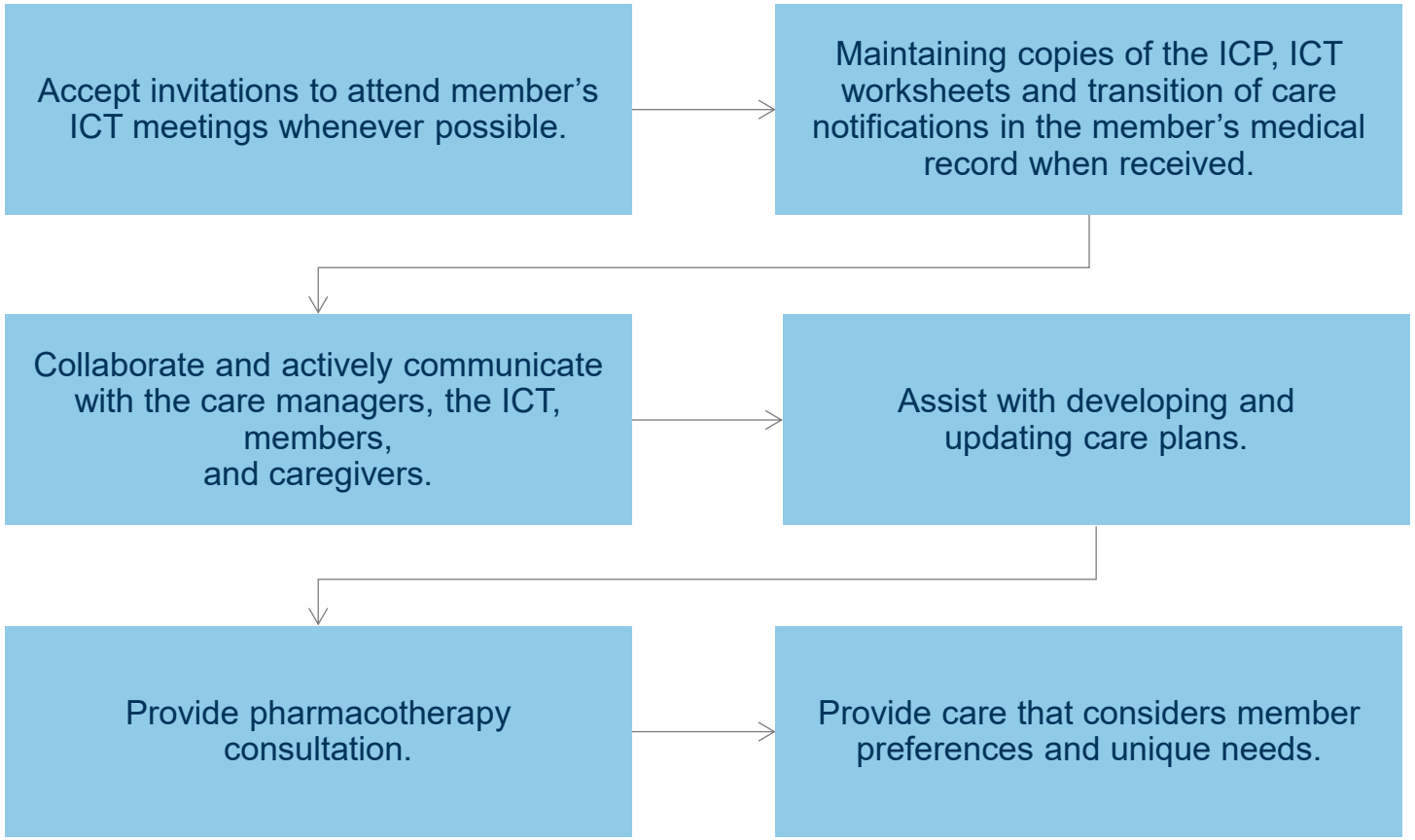
Interdisciplinary Care Team (ICT)

- Each member has an ICT developed based on assessment results, identified needs, and complexity.
- Each member's ICT consists of the member, the case manager/coordinator, and the PCP.
- Additional ICT participants are added based on assessment results, identified needs, complexity, involvement in care, and member preferences.
- A member's ICT may include specialty care providers and our health care team in meetings, including behavioral health or pharmacy representatives.
- ICT meetings or reviews are held at a frequency determined by patient needs and complexity.

The ICT:

- Develops or contributes to a comprehensive individualized care plan.
- Coordinates care with the member, the member's providers, and between members of the ICT.
- Collaborates through ongoing communication that can occur by mail, phone, through the provider website, emails, fax, or meetings.
- If a formal meeting occurs, the care manager will inform your office of the details on a case-by-case basis.

ICP provider responsibilities

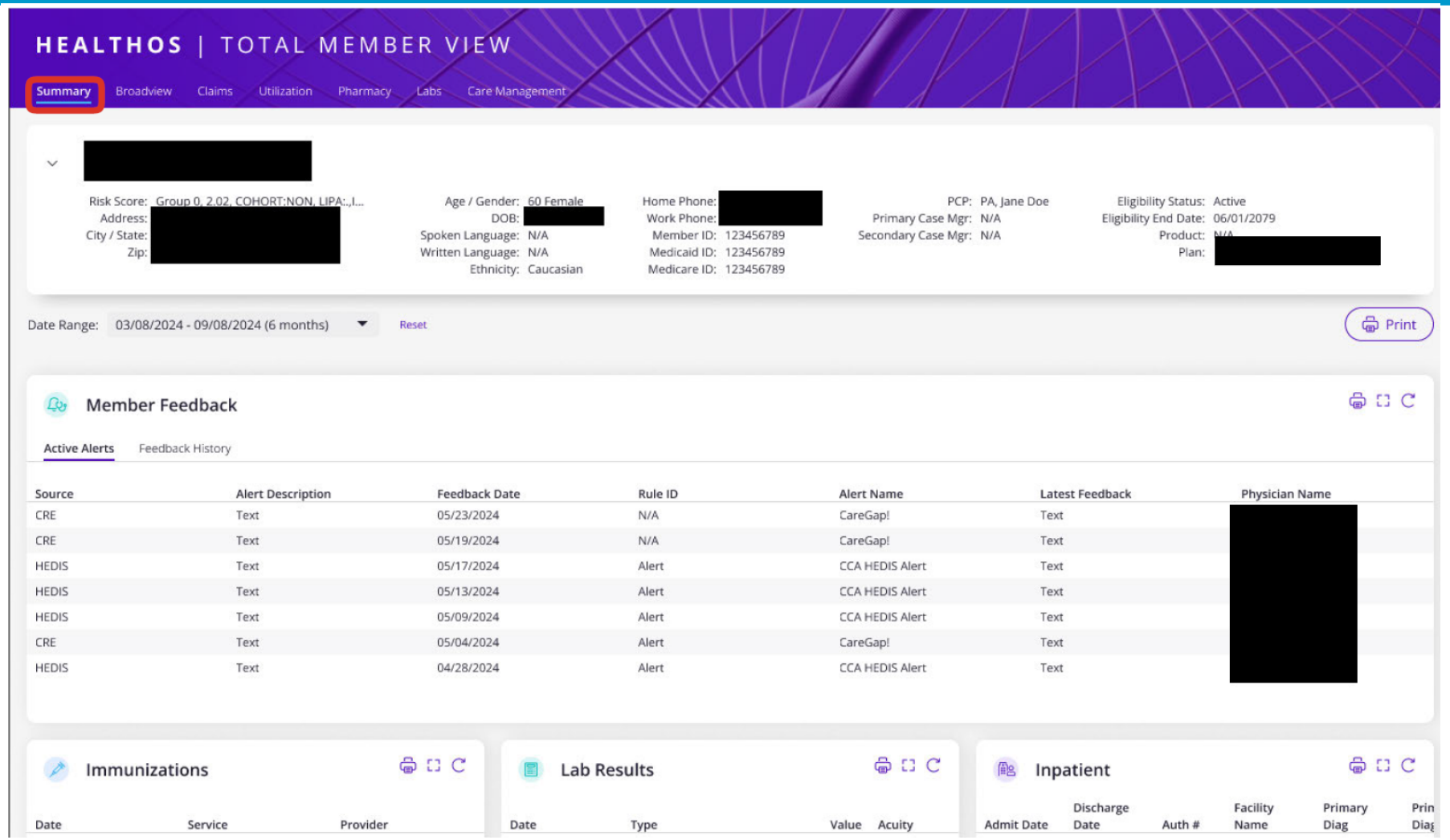


- Review the member ICP plan available on the provider website:
  - ICPs are updated and must be reviewed annually at a minimum.
  - ICPs are updated with significant changes in member health status.
  - Providers will review ICP post-member transitions from a hospital or other skilled setting.
  - Providers enroll through Availity Alerts Hub to receive reporting for HRA and ICP updates to facilitate review.
  - Providers may review before, during, or after office visits with members before ICT meetings.
- Provide feedback to the case manager/coordinator if changes to the ICP are recommended.
- Support the ICP in collaboration with the ICT.

Care transitions and provider communication

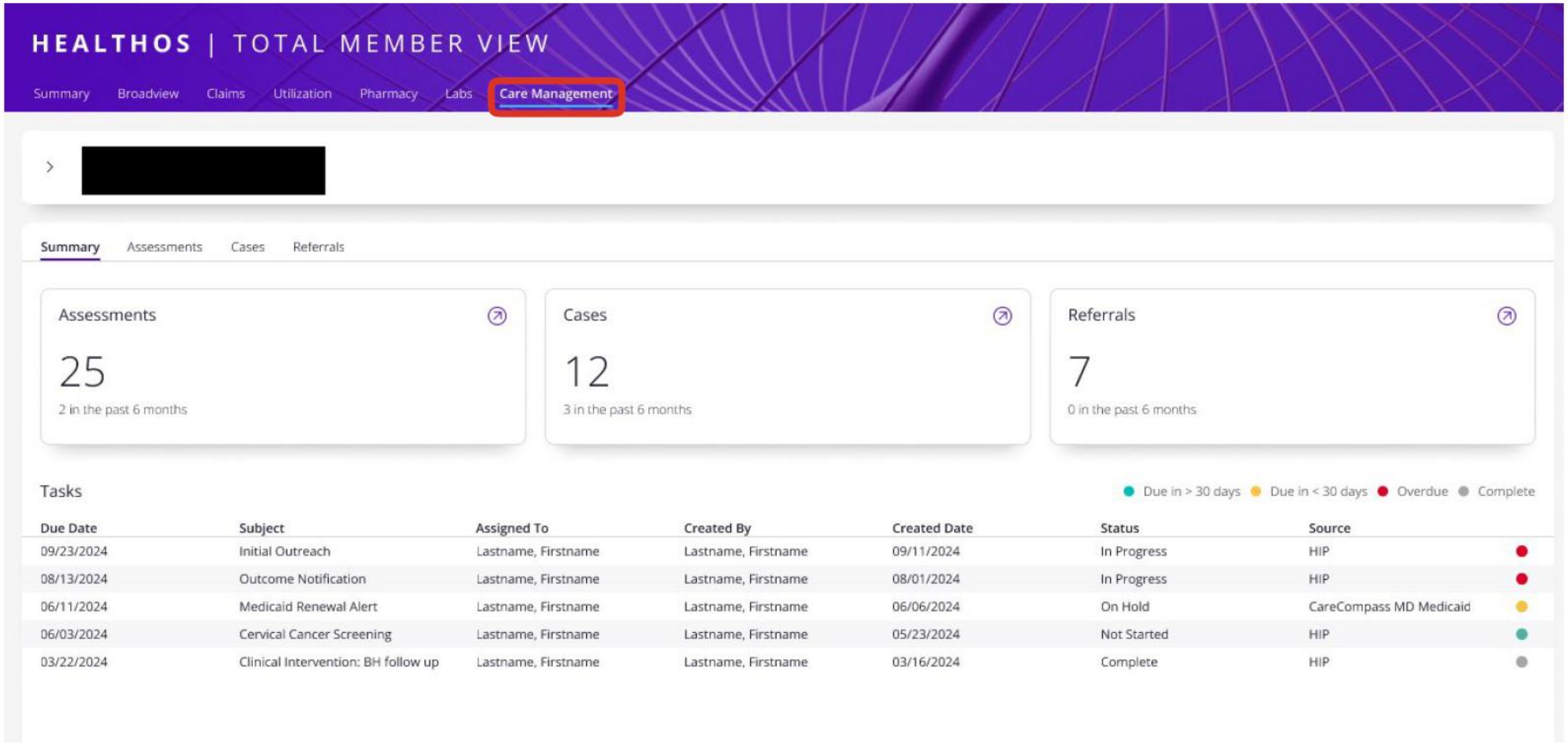
- Our goal is effective, efficient communication with our providers:
  - Valuable information on member utilization, transitions, and care management is available on the secure provider website.
  - You may reach the care team by calling the number provided to you in any correspondence from us or the number on the member's identification card.
- SNP members have many providers and have multiple transitions. You are the key to successful coordination of care during transitions:
  - Contact us if you would like our team to assist in coordinating care for your patient.
  - Our care team may be contacting you and your patient at times of transitions to ensure needs are met, services are coordinated, prescriptions are filled, and medications are taken correctly.
  - Care transition protocols are documented in the provider manual.
  - Members may also contact customer service for assistance.

Total Member View (TMV) in Availity Payer Spaces — Located under the Application tab



TMV has replaced P360

Total Member View (TMV) > Care Management > Summary



Availity alerts

Receive real-time email notifications, including recommended follow-up actions:

- Know when patients are admitted to a facility or have been discharged from inpatient care against medical advice.
- Identify patients who need outreach after a transition in care.
- Track your patients' behavioral health visits and prescriptions to guide follow-up.
- Identify patients with HRA and ICP updates.

Benefits:

- Signing up for alerts reduces Care Management outreach via other avenues and demonstrates collaboration as part of the ICT. Care managers work with members and the ICT to engage them in care and facilitate coordination of needs.
- Delivering the right care can also result in higher HEDIS® measures, potentially boosting your financial performance. When you view patient-level details in Alerts Hub, you get credit for the notice of admission measures.
- Key measures include: Transitions Of Care (TRC); Follow Up After Hospitalization for Mental Illness (FUH); Follow Up for People with Multiple Chronic Conditions (FMC); Plan All-Cause Readmissions (PCR)

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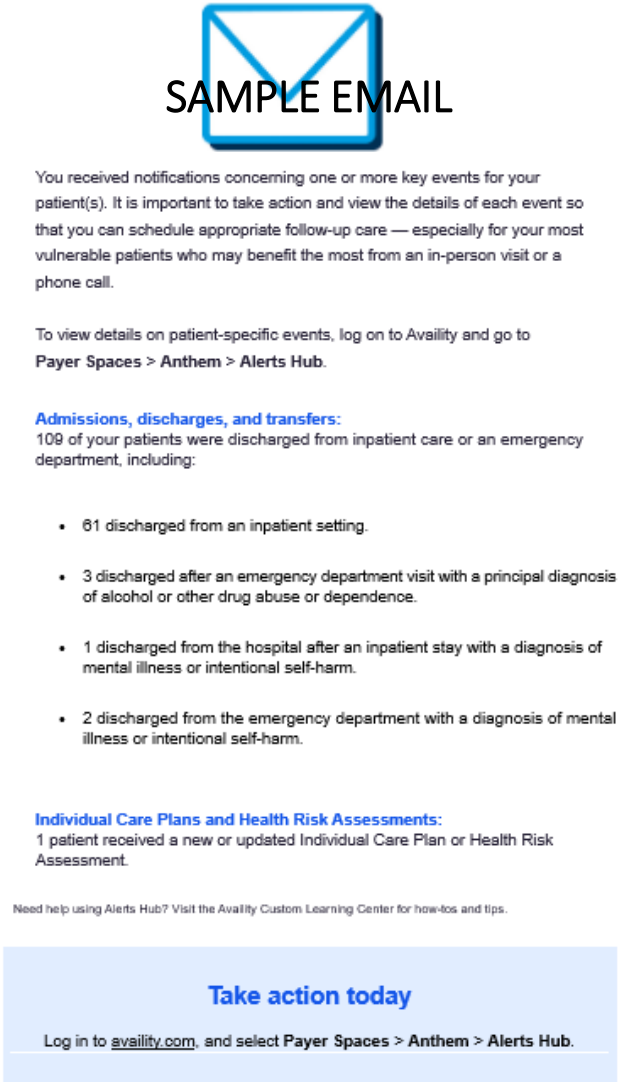

Availity Alerts Hub Organizational access

Stay up to date with member HRA's, ICPs, patient admissions, discharges, and transfers and deliver the right care at the right time.

First, ensure that all users needing access to Alerts Hub are registered. In your organization's Account menu, select Manage My Teams:

- Then, under Select User Roles, select Admin and Reporting, followed by Alerts Hub > Clinical > Total Member View.
- Then, define access for all users.
- Log on and select Payer Spaces. Select the appropriate payer/Plan.
- Select Preference Center, then select your organization > Alerts Hub > View and Configure Preferences
- Select the provider tax ID expansion arrow, select Add Additional Recipients, search for the user, confirm the recipients' information, then select Finish.*
- The Alerts Hub tile should appear in your available applications in Payer Spaces.

* Registering at the TIN level will give the user access to all alerts for each of the care providers associated with the TIN. Users can also choose to register at the NPI level to see individual care providers' alerts only.

Performance and quality outcomes

The health plan has a Quality Improvement (QI) Program designed to assess whether the overall MOC structure effectively accommodates members' unique healthcare needs. The SNP MOC goals include but are not limited to:

- Improving access to affordable medical, mental health, and social services.
- Improving health outcomes and the use of preventive health services.
- Improving coordination of care.

Additional SNP MOC goals may be included based on the state or MOC type. MOC goals are measured using a combination of clinical outcome metrics, care coordination performance, member experience and satisfaction, and quality improvement metrics. These may include HEDIS and Star ratings; completion of HRAs, ICTs, ICPs, CAHPs survey results, and utilization goals, such as reducing ER and admission rates.

Model of Care Training Attestation

- The plan is required to maintain a record of your annual Model of Care training.
- Select **Begin Attestation** and follow the instructions to receive credit for completing this course.
- Thank you for your time in participating and completion of this training.

Begin Attestation