



2026 D-SNP Model of Care Training

Troy Medicare 2026 Model of Care Training Attestation



- In order to complete your annual MOC training, please click the link below to complete the attestation form.
- If the training was delivered in a group setting, an attestation form and an attendance roster must be submitted by the designated staff member with authority to sign on behalf of your provider group/clinic/facility.
- For assistance or questions: network@troymedicare.com

[Link to Complete the Training Attestation](#)

Special Needs Plan (SNP) History



2003

- SNPs were created as part of the Medicare Modernization Act

2008

- CMS contracted with the National Committee for Quality Assurance (NCQA) to develop a strategy to evaluate the quality of care provided by SNPs

2011

- The Patient Protection and Affordable Care Act (ACA) mandated further SNPs program changes: 1/ Requires all SNPs to submit Models of Care (MOCs); 2/ MOCs must meet CMS criteria; 3/ MOCs must be reviewed and approved by NCQA

Special Needs Plan (SNP) Features



- SNP programs were created to meet the need of Medicare Advantage members who have certain high-risk conditions or circumstances that necessitate care coordination beyond what customary care provides
- Three types of SNPs designed to meet member-specific health care needs
 - Individuals eligible for Medicare and Medicaid (D-SNP)
 - Individuals with specific chronic conditions (C-SNP)
 - Individuals who require an institutional level of care or equivalent (I-SNP)

D-SNP Population: Who Can Join a Dual-Eligible Special Needs Plan (D-SNP)?



Medicare Eligible

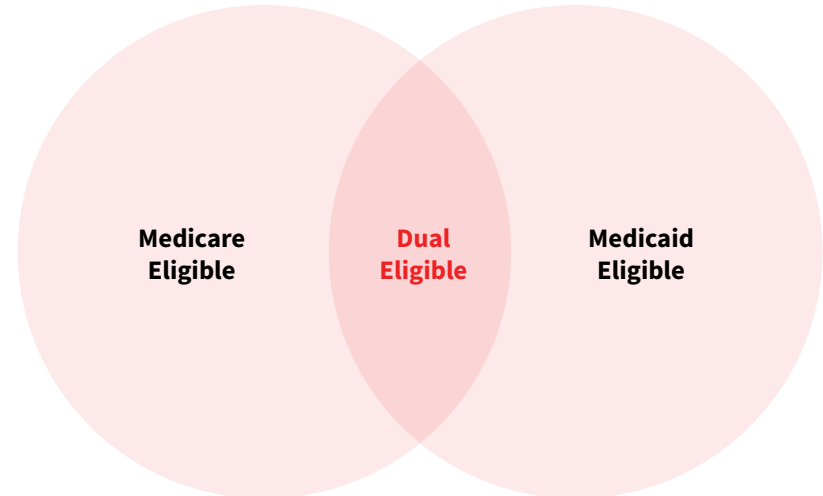
- People 65 and Older
- People of any age who have kidney failure or long-term kidney disease
- People who are currently disabled and unable to work

Dual Eligible

- Low income people who are disabled and cannot work
- Low income people 65+

Medicaid Eligible

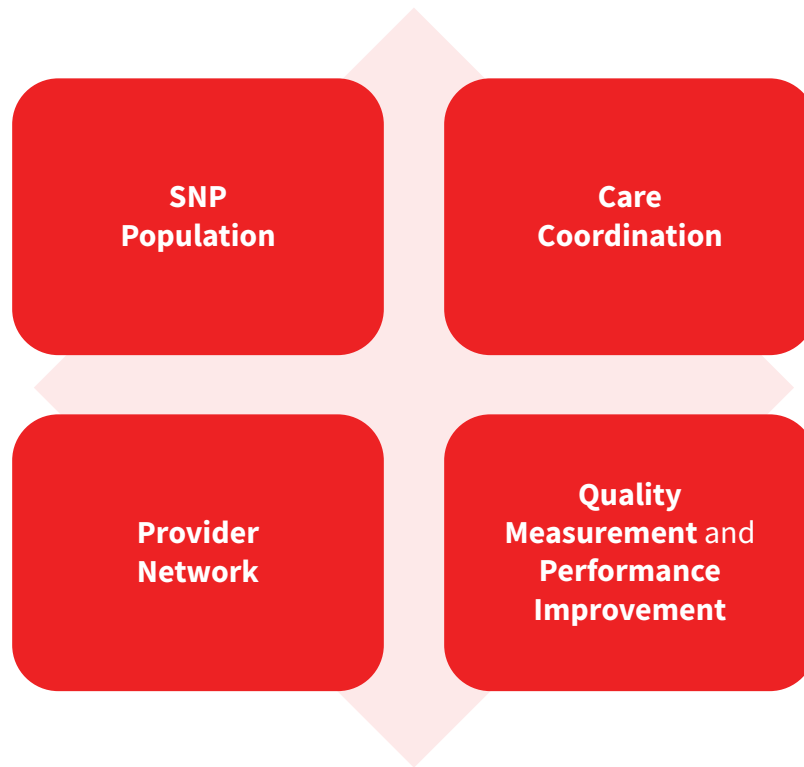
- Pregnant woman
- Children under 19
- People who are 65+
- People who are blind
- People who are disabled
- People who need nursing home care



Model of Care Goals



- Each plan must develop a Model of Care and a Quality Improvement program and evaluate the effectiveness
- The MOC is a plan for delivering care management and care coordination to:
 1. Improve quality
 2. Increase access to care
 3. Create affordability
 4. Coordinate care and Improve transitions across specialties
 5. Provide seamless transitions of care
 6. Improve use of preventative health services
 7. Improve member health
 8. Drive member satisfaction



Model of Care (MOC) Elements

Care Coordination Activities

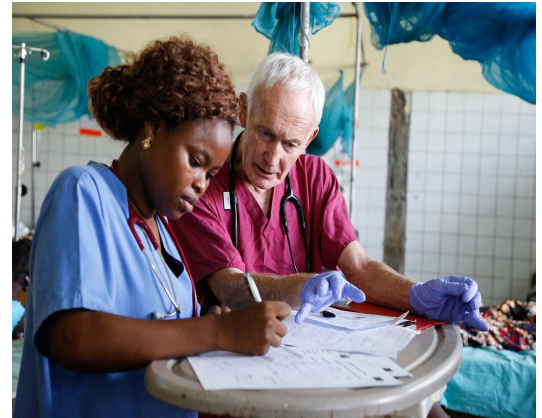


- Health Risk Assessment Tool (HRA)
- Interdisciplinary Care Team (ICT)
- Individualized Care Plan (ICP)
- Care Coordination of D-SNP benefits

Care Management



Care Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the patient and the caregiver's comprehensive health needs through communication and available resources to promote patient safety, quality of care and cost-effective outcomes.



Health Risk Assessment (HRA)



CMS regulation requires a Health Risk Assessment to be conducted for each member enrolled in the SNP

- Help identify members with most urgent care needs
- Are an important part of the member's care coordination
- Contain member self-reported information
- Completed within 90 days of enrollment
- Repeated every 365 days

Face-to-face encounters

- Face-to-face encounters encompass all encounters in which the member has in-person contact with a medical provider. This may include PCPs, specialists, and other providers.
- Members who may benefit from a face-to-face encounter are identified for outreach and scheduling for a face-to-face assessment with a Nurse Practitioner or Physician Assistants.

Health Risk Assessment



Assess the following needs of each member:

- Medical
- Social
- Psychosocial
- Functional
- Cognitive
- Mental Health

Member Acuity Level



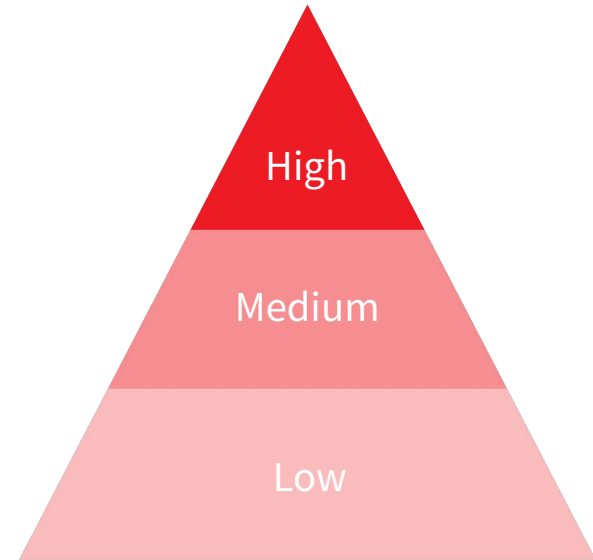
The Care Manager (CM) determines acuity based on:

1. Risk Stratification score calculated by HRA
2. Member preference for contact frequency
3. CM clinical judgment

High - represents our most vulnerable members and includes those with high utilization and multiple, unmanaged chronic conditions that put them at risk for unplanned transitions of care.

Medium - members generally have multiple conditions and may or may not be managed well

Low - these members are the most stable of the D-SNP members



Development of Individualized Care Plans



- CMS regulation requires an individualized care plan (ICP) to be developed for each member enrolled in the SNP
- An ICP is the mechanism for evaluating the member's current health status
- It is the ongoing action plan to address the member's care needs in conjunction with the ICT and member
- HRA responses are used to develop or update the ICP
- Develop member-specific goals for improving health outcomes
- Members that do not respond to the HRA will receive an ICP based in part on claims or encounter data

Individualized Care Plan



Troy Medicare works with each member to manage the ICP:

- Monitor implementation and barriers to compliance
- Develop impactful interventions
- Identify problems and manage crisis and act as a liaison between member and PCP
- Educate members about their conditions and medications and empower them to make good health care decisions

Individualized Care Plan



Individualized care plans include, but are not limited to, the following:

- Establishing patient-prioritized goals: what is important **TO** the patient and **FOR** the patient
- Identifying resources that might benefit the patient, including recommendations for the appropriate level of care
- Planning for continuity of care, including assisting the patient in making the transition from one care setting to another
- Collaborative approaches to health and care management which can include the PCP, pharmacy, family or patient representative
- Established timeframes for ongoing evaluation of patient's goals

Individualized Care Plans Model



PROBLEMS

Communicated by the patient regarding their life, health, worries and behaviours



GOALS

What the patient hopes to achieve regarding their health



BARRIERS

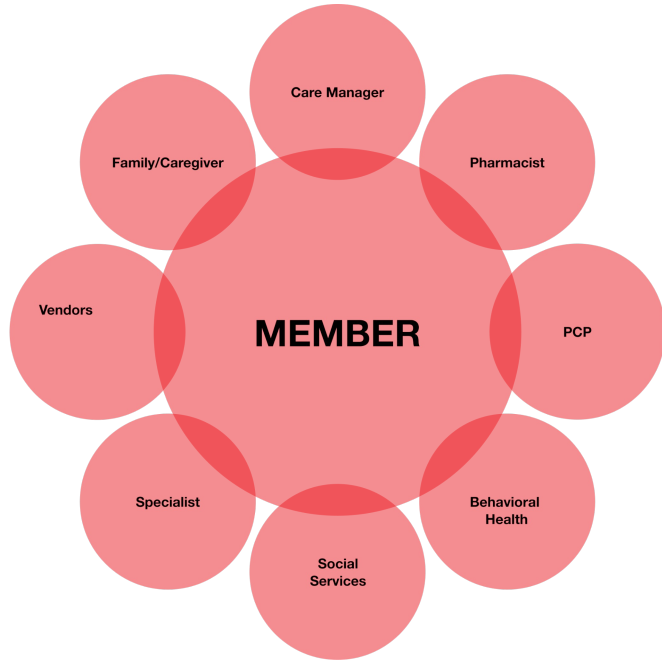
Ex. Lack of transportation, finances, housing, treatment side effects



INTERVENTIONS

Actions to support problem resolution and support goal decrease stress

Interdisciplinary Care Team (ICT) Staffing



- Each member is managed by an Interdisciplinary Care Team
- Participants are based on the member's needs - all members will be assigned a CM and a Pharmacist
- Care Managers will keep the team updated with information involving the member's care plan
- Formal meetings occur annually
- Smaller meetings occur as needed

Interdisciplinary Care Team (ICT)



- All care is per member preference.
- Family members and caregivers are included in health care decisions **as the member desires.**
- There is continual communication between all ICT Participants regarding the member's plan of care.
- All team meetings/communications are documented and stored within the CM documentation platform.
- All team participants are involved and informed in the coordination of care for the member.
- All team participants must be advised on ICT program metrics and outcomes.
- All internal and external ICT participants are trained annually on the current Model of Care.

Interdisciplinary Care Team (ICT) Roles



- Coach members to use their individualized care plan
- Prepare members/caregivers for their upcoming appointments
- Refer members to community resources
- Manage transitions
 - Prevent unplanned transitions
 - Identify problems that would cause transitions

Transitions of Care



- 30-day program available for all members who experience a transition in care.
- Designed to improve quality and health outcomes.
- During an episode of illness, members may receive care in multiple settings often resulting in fragmented and poorly executed transitions. Troy's Transitions of Care Program works to bridge these gaps and deliver more comprehensive, coordinated, and cost-effective care.
- Troy Medicare's staff manages transitions of care to ensure that members have appropriate follow-up care after a facility stay to prevent hospital readmissions.

Transitions of Care



- All members receive outreach prior to discharge and upon discharge
- Initial member outreach may include:
 - Assessment of Health Status and understanding of treatment plan post-discharge
 - Evaluate understanding of medication plan or changes
 - Ensure follow through with necessary appointments
 - Referral to pharmacy for full medication reconciliation, including evaluation for possible interactions, review of member's questions and education of possible side effects
 - Evaluate nutritional, functional, or social needs impacting care

Provider Network



The Model of Care describes the following:

- How the network corresponds to the target population
- How Troy Medicare oversees the network facilities
- How providers collaborate with the ICT and contribute to a member's ICP
- How Troy Medicare is responsible for maintaining a specialized provider network that corresponds to the needs of our members

Role of the Provider



Providers play an important role in managing the care of and responding to the member's needs by:

- Reminding the member of the importance of completing the HRA
- Communicating with the Troy Care Management Team
- Supporting care transitions
- Attending ICT meetings
- Contributing to the ICP
- Maintaining the ICP in the member record
- Monitoring and Encouraging medication adherence
- Completing the annual MOC training

CMS Expectations of Network Management



Prioritize contracting with Board Certified Providers



Monitor network providers to assure they use nationally clinical evidence-based guidelines.



Assure that providers are licensed and competent through a formal credentialing process



Coordinate the maintenance and sharing of member's health care information among providers and the ICT

Quality Measurement and Performance Improvement



- Troy Medicare determines goals for the MOC related to improvement of the quality of care that members receive.
- The 2026 goals are based on the following:
 - Stars Measures
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
 - Healthcare Effectiveness Data and Information Set (HEDIS)
 - Health Outcomes Survey (HOS)
 - Member Engagement in Troy's CM program



Thank You!

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