Model of Care (MOC) Training

Chronic Condition Special Needs Plan (C-SNP)

Dual Special Needs Plan (D-SNP)



of Tennessee

2026 Provider Education

Objectives

- Define key SNP terms, including MOC, SNP, D-SNP, C-SNP, FIDE-SNP
- Understand CMS MOC requirements
- Recognize how providers support the MOC
- Understand differences between D-SNP and C-SNP



SPECIAL NEEDS PLANS: MODEL OF CARE TRAINING

Training Requirements

- CMS requires annual MOC training for all providers and staff, including out-of-network providers regularly used by our members.
- Must be completed by Dec 31
- 95% Tax Identification Number compliance required for D-SNP incentive eligibility
- Plan monitors and reports participation
- Staff training includes additional clinical workflow guidance

What is a SNP?

- SNPs are Medicare Advantage plans designed for individuals with specific needs.
- Types: D-SNP, C-SNP, FIDE-SNP, I-SNP
- Our offerings: BlueCare Plus Tennessee (D-SNP/FIDE)℠; BlueAdvantage Total Diabetes & Heart (C-SNP)℠
- We've designed each plan to provide targeted care and services to individuals with special needs.

Our SNP Options for 2026

- BlueCare Plus and BlueCare Plus Choice (HMO FIDE)℠
- BlueCare Plus Select (HMO D-SNP)℠
- C-SNP: BlueAdvantage Total Diabetes & Heart ℠



Plan Overview

SPECIAL NEEDS PLAN MODEL OF CARE

BlueCare Plus Tennessee Plans

- **BlueCare Plus and BlueCare Plus Choice** are Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP) for beneficiaries who are eligible for both Medicare and Medicaid.
  - Aligned with BlueCare Medicaid TennCare MCO
  - Medicare + Medicaid services are coordinated
  - **Choice plan** serves members with long-term services and supports (LTSS) and Employment and Community First (ECF)
  - Certain LTSS and ECF CHOICES under the TennCare program as part of CHOICES groups 1-8.
- **BlueCare Plus Select** is a Dual Special Need Plan (HMO-DSNP) designed for beneficiaries who are also eligible for both Medicare and Medicaid.
  - **Non-aligned** TennCare Medicaid members with a different Medicaid MCO, (e.g., UHC, Amerigroup)
  - Includes **QMB-Only** members who do not qualify for full TennCare Medicaid benefits; but cost share amounts are paid by TennCare qualifying them for a DSNP plan. (Premiums, deductible, coinsurance)
- Members are medically complex with multiple chronic conditions and comorbidities.

**Some benefits may vary by plan*

SPECIAL NEEDS PLAN MODEL OF CARE

Blue Advantage Total Diabetes and Heart

- Blue Advantage Total Diabetes and Heart is a Chronic Condition Special Needs Plan (C-SNP) for Medicare beneficiaries diagnosed with diabetes, chronic cardiovascular disease (*cardiac arrythmias, CAD, PVD and chronic venous thromboembolic disorder*) and/or chronic heart failure.
- The plan covers benefits under the Medicare Advantage plan.
- Plan members may have any co-morbidities with diabetes, chronic cardiovascular disease and/or chronic heart failure.
- Provides targeted clinical support, screenings and coordinated benefits.

Model of Care

What's the SNP Model of Care?

CMS requires all **SNPs** to have a **Model of Care** that is based on guidelines developed by the National Committee of Quality Assurance (NCQA). It's a document reviewed and approved by CMS that describes:

- Basic framework to support the SNP in meeting the needs of each of its enrolled beneficiaries
- Infrastructure to promote and evaluate quality, care management and care coordination processes for the SNP

Models of Care are considered a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in an SNP are identified and addressed.



The Four Core MOC Elements

- Quality Measurement & Performance
- Description of the SNP Population
- Coordination of Care
- SNP Provider Network

SPECIAL NEEDS PLANS: MODEL OF CARE TRAINING

MOC Elements 1 & 2

MOC 1: SNP population

We analyze data to identify and describe the population:

- Health risks
- Common conditions
- Demographics
- Disparities
- Identify and describe the most vulnerable population and their risk factors



MOC 2: Care Coordination

We describe staff structure and core responsibilities:

- Health Risk Assessment (HRA)
- Face-to-Face encounters
- Individualized Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- Care transitions

As providers and staff, you are a MAJOR component of successful care coordination.

SPECIAL NEEDS PLANS: MODEL OF CARE TRAINING

MOC Elements 3 & 4



MOC 3: Provider Network

Within the MOC, we describe requirements and actions regarding the provider network:

- Maintaining a robust and specialized network
- Ensuring appropriate licensing and credentialing is up to date on all providers
- Actions taken to involve providers in the ICT and use your expertise to care for members



MOC 4: Quality Measurement and Performance Improvement

As part of our MOC requirements, we must:

- Develop and maintain a QI Program Plan
- Collect and monitor data
- Develop goals and monitor progress
- Identify barriers to meeting goals, and take actions to improve the care provided to our members

Our high-quality provider network is essential to providing the best care to our members.

Provider Responsibilities

You are a key member of the Interdisciplinary Care Team (ICT).

- Your **active** participation as a member of the ICT is crucial to members' health.
- The ICT is composed of:
  - Member and/or designated family/caregiver
  - Care Coordination Team (Case Managers, Health Navigators and Pharmacy Technicians and any individual assisting with the patient's coordination of care. i.e., member services, claims)
  - Treating providers (based on member's expressed need and preferences, the team may expand to include other specialists and community support)

Provider Responsibilities

As an active member of the Interdisciplinary Care Team (ICT), providers support the following:

- Implement the Individualized Care Plan (ICP) with goals tailored to the member's medical conditions and personal preferences.
- The plan's Care Coordination Team will share ICP updates through secure communication (mail, fax, provider portal).
- Conduct Annual Wellness Visits, preventive screenings, and address prioritized, condition-specific goals.
- Review member goals, provide clinical input, and acknowledge the care plan using the Patient Assessment and Care Planning Form (PACF).
- Identify members who are vulnerable, fragile, or at risk.
- Perform face-to-face or virtual visits at least annually, or more frequently based on the member's needs.

Determining the Right Care Setting

As a Provider, **we need your input**:

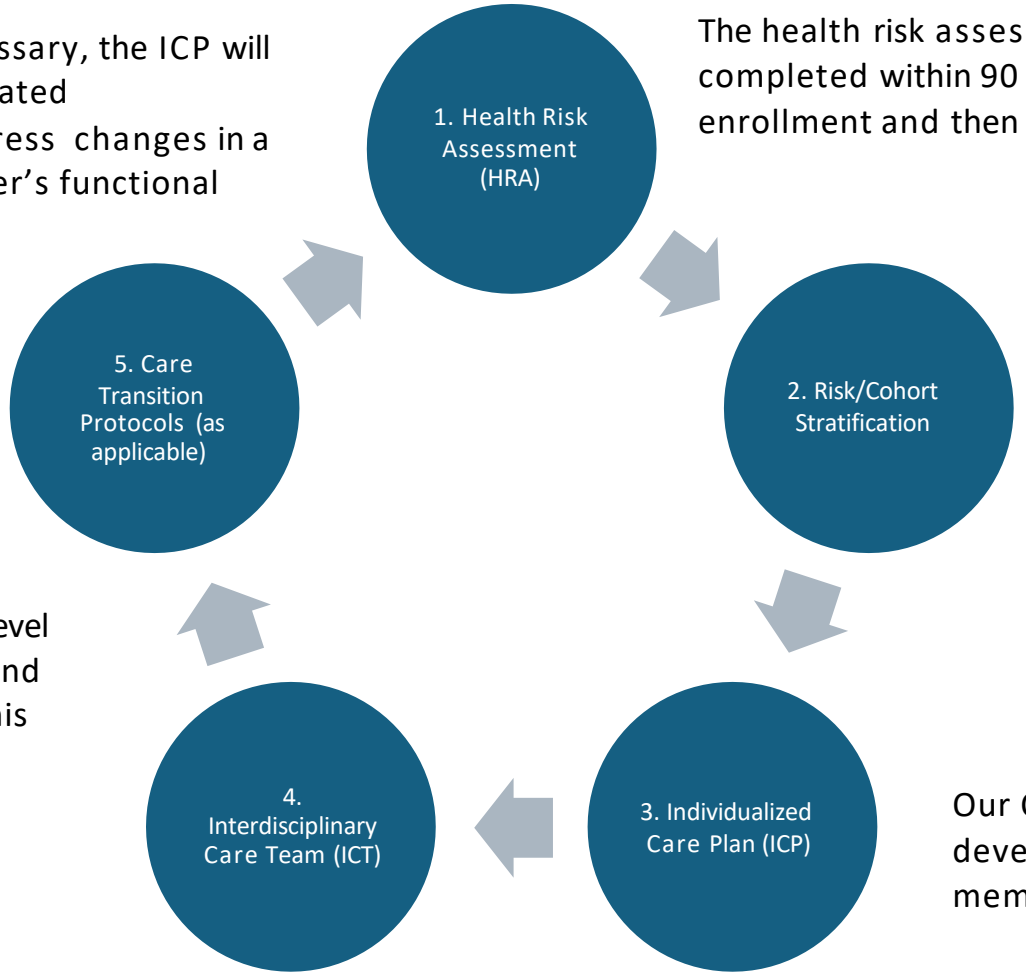
- Through the **Nursing Facility Diversion Program**, the care coordination team works to allow members to continue living safely in the home and community-based settings
  - Members in home settings, inpatient settings and nursing facilities are all screened to determine the most appropriate setting for their care.
- Providers may receive requests for medical records or input regarding the most appropriate setting for the member.
- As the member's provider you have the chance to assess components of the member's living situation that are key to making the best decision (Caregiver situation, home environment, ADL's, etc.)

Staff Integration

As an active participant caring for our members you can help by:

- The plan's Care Coordination Team will share ICP updates through secure communication (mail, fax, provider portal).
  - Make sure those are communicated with providers and nurses
- Providers conduct Annual Wellness Visits, preventive screenings, and address prioritized, condition-specific goals.
  - Ensure appropriate coding, so that information is communicated back to the plan
- Review member goals, provide clinical input, and acknowledge the care plan using the Patient Assessment and Care Planning Form (PACF).
  - Help get the PACF back to BlueCare Plus

MOC Clinical Processes



The health risk assessment must be completed within 90 days of enrollment and then annually.

HRA results and other data is used to stratify members and determine risk and cohort levels.

Our Care Coordination Team develops an ICP for each member to facilitate their care.

The MOC requires an intensive level of communication between us and the physicians and their staff. This occurs through the ICT process.

If necessary, the ICP will be updated to address changes in a member's functional status.

Your Role on the Interdisciplinary Care Team (ICT)

How does the team work together?

- PCPs are integral members of the ICT coordinating care with the plan and other health providers, pharmacy, behavioral health, etc.
- Review, provide feedback, and acknowledge/attest member care plan goals documented within the PACF (D-SNP & C-SNP).
- Communicate clinical changes and relevant health information to support care coordination.
- Contribute updates to the member's Individualized Care Plan as warranted by a health status change.
- Partner with the plan to support safe and effective care transitions.

Your Role on the Interdisciplinary Care Team (ICT)

- **Clinical Provider *(MD, DO, PA, NP)***
  - *Review the ICP*
  - *Provide any comment or updates based on the member's needs*
  - *Communicate back to the plan*

- **Provider's Nurse *(RN, LPN, MA, CNA)***
  - *After provider review and updates:*
    - *Submit the PACF to BlueCare Plus*

- **Office Administration Staff *(Front Office, Office Manager, Coordinators, Scheduling, Billing & Coding, etc.)***
  - *After providing review and updates:*
    - *Submit the PACF to BCP*

ICT Activities

As a provider serving Special Needs Plans members, you're considered part of the ICT. Compensation is provided for provider participation in ICT activities.

› PCPs are encouraged to complete PACF during the member's Annual Wellness Visit and bill the following codes:

Activity	Code	Fee
Interdisciplinary Care Team (ICT)	99366 - 99368	$54
DSNP Administration of Patient Assessment and Care Planning Form (PACF)*	96160 - 96161	$155
CSNP Administration of Patient Assessment and Care Planning Form (PACF)*	96161	$225

**Claim must be filed with appropriate codes for reimbursement. Submitting PACF alone is not sufficient for reimbursement.*

BlueCare Plus Tennessee (DSNP/FIDE)

ICT Activities: How to Participate (Providers & Staff)

- In accordance with CMS DSNP Model of Care (MOC) requirements, please review and acknowledge the member's individualized Care Plan (ICP) completed by the health plan, or acknowledge care plan goals within your equivalent medical plan.
- The PACF is available at: https://bluecareplus.bcbst.com/docs/providers/BlueCare_Plus_Patient_Assessment_and_Care_Planning_Form.pdf

PACF can be submitted by:

- Upload via Availity® under the Quality Care Rewards Tool, or
- Fax to (423) 591-9504
  - Medical records containing all required PACF elements may be submitted in lieu of the PACF.
  - Remember timely submission supports CMS MOC compliance, coordinated care, and reduces follow up outreach.

BlueAdvantage Total Diabetes and Heart (C-SNP)

ICT Activities: How to Participate

Complete the BlueAdvantage Patient Assessment and Care Planning Form (PACF):

- Complete online in Availity® under the Quality Care Rewards Tool
  - Forms may be exported and completed, then uploaded to the QCR or faxed to 1-877-922-2963
  - Medical records and office notes are not accepted in lieu of a PACF for C-SNP

- If you need training or help with the PACF or ICT processes, contact our Care Coordination Team at **MA_ProviderOutreach@bcbst.com**

Quality Improvement

We annually select pertinent quality improvement measures to track and trend throughout the year to improve and monitor member health outcomes.

- Data is collected, analyzed and evaluated to measure the overall program performance.
- As a provider, and part of the ICT, you are expected to participate in quality improvement efforts to improve measures, such as:
  - Annual Wellness Exams
  - Care for Older Adults (COA) measures; medication review, pain assessment, and functional status screening
  - Completion of care transition support i.e., timely follow-up visits with members post Emergency Department visit and/or inpatient hospital discharge
  - Compensation is offered for participation in ICT activities (mentioned in previous slides)

We're Right Here

- If you have questions about **BlueCare Plus Tennessee**, our Dual Special Needs Plan, please contact us at MOC_PRV_TRNG@bcbst.com

- For questions about **BlueAdvantage Total Diabetes and Heart** (C-SNP), please contact us at MA_ProviderOutreach@bcbst.com

- **Website**: https://provider.bcbst.com/tools-resources



Thank You

Thank you for participating in the BlueCross network of providers. The Medicare Advantage SNP population is characterized by both medical and social complexity. We're committed to helping you coordinate service and care for this special population we're privileged to serve together.

of Tennessee