



**2026 Model of Care Training**

# Purpose of This Training

This training is designed to provide our valued provider partners with a detailed understanding of the Astva Health C-SNP Model of Care. Upon completion, you will be able to:

- Describe the unique characteristics of our C-SNP population.
- Detail the four core elements of our CMS-approved Model of Care.
- Understand your specific roles and responsibilities in the care coordination process.
- Collaborate effectively with the Interdisciplinary Care Team (ICT) to improve member health outcomes.
- Recognize the key quality measures we use to evaluate the MOC's effectiveness.

# What is a Special Needs Plan?

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A Special Needs Plan (SNP) is a Medicare Advantage plan offering focused care and services for individuals with specific needs. **Astiva Health's C-SNP (H1993)** is a **Chronic Condition SNP** for members with one or more of the following conditions:

- Diabetes Mellitus
- Chronic Heart Failure (CHF)
- Cardiovascular Disorders

**Our Goal:** To provide a superior, member-centric, and coordinated care experience that improves health outcomes, enhances quality of life, and manages the complexities of these chronic conditions effectively. This Model of Care is the blueprint for how we achieve that goal in partnership with you.

# C-SNP Enrollment and Verification Process

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## 1. Application Received

Applications are received from agents, online via CMS, or directly from potential members

## 2. Verification (Month 1)

Astiva contacts you, the provider, to confirm the member's qualifying chronic condition

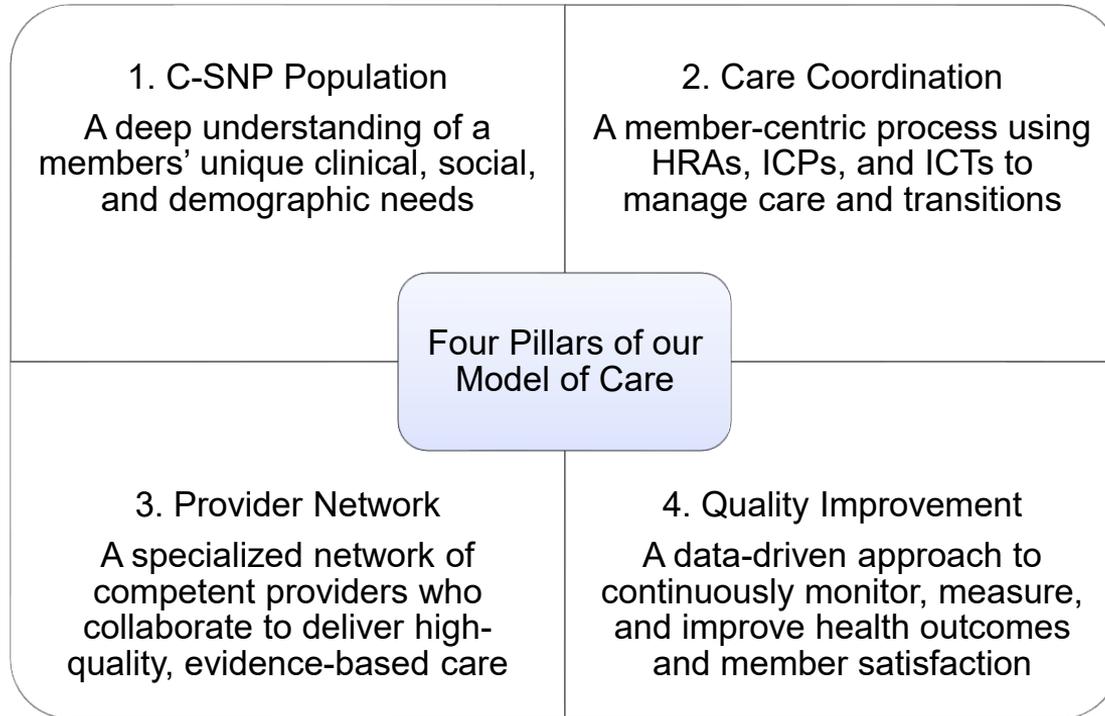
## 3. Enrollment Confirmed

If verified, enrollment is confirmed. If not, a disenrollment notice is sent for the end of Month 2

## 4. Grace Period (Month 2)

If verification is received anytime during the second month, the disenrollment is cancelled and the member is retained

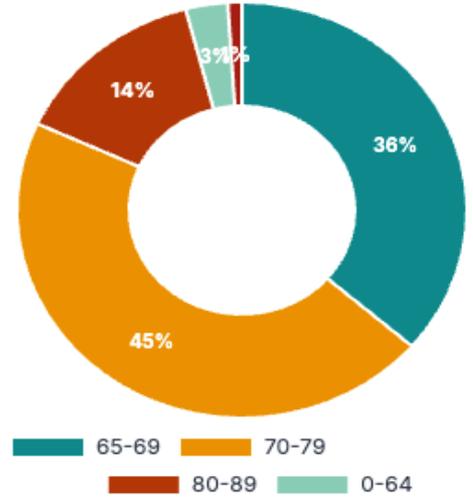
# Model of Care Elements



# MOC Element 1: Astiva's Population

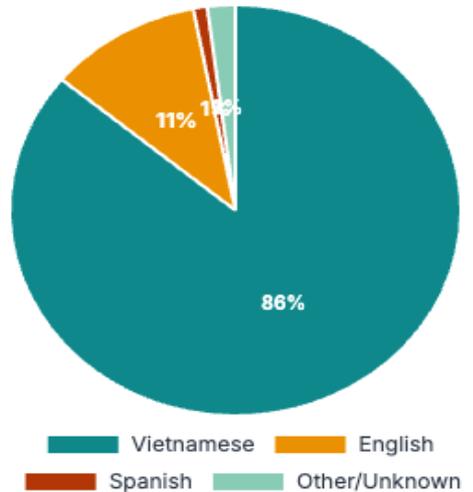
## Member Age Distribution

The 70-79 year age band is the most heavily enrolled, indicating a mature population with established chronic conditions requiring diligent management.



## Predominant Languages

An overwhelming majority of our members in Orange County speak Vietnamese, highlighting the critical need for culturally and linguistically competent care.



# MOC Element 1: Astiva's C-SNP Population

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Understanding our members is the foundation of our MOC. Our population has unique clinical, social, and demographic characteristics.

- **Health Status:** Many members experience frequent physical and mental distress. For example, in counties like Riverside and San Bernardino, 11% of adults report 14 or more days of poor physical health per month.
- **Prevalence of Conditions:** Within our service area, the prevalence of qualifying conditions among the eligible Medicare population is significant. For instance, Cardiovascular Disease prevalence is as high as 69% in Riverside County, and Diabetes prevalence reaches 58% in San Bernardino County.
- **Leading Comorbidities:** Our members often manage multiple conditions. The most common comorbidities are vascular disease, specified heart arrhythmias, and chronic obstructive pulmonary disease (COPD).

# MOC Element 2: Care Coordination

Our process ensures care is structured, proactive, and member-centric. Your participation is vital at every step.

## Health Risk Assessment (HRA):

- **What it is:** A comprehensive assessment (medical, functional, cognitive, psychosocial) completed within 90 days of enrollment and annually.
- **Your Role:** The results and summary will be shared with you. This information provides a holistic view of the patient beyond the clinical setting. Please review it to inform your treatment plan. The HRA helps stratify members by risk, allowing us to deploy resources effectively.

## Individualized Care Plan (ICP):

- **What it is:** A person-centered "living document" created collaboratively by the member, you, and the ICT. It outlines specific, measurable goals and interventions.
- **Your Role:** You are a key author of the ICP. You will be asked to review, provide input, and validate the plan. The ICP is not just a form; it is our shared roadmap for the member's care. It will be faxed or sent securely to you for review.

## Interdisciplinary Care Team (ICT):

- **What it is:** The team that implements the ICP. It **always** includes the Member, their PCP (you), and the Care Manager. It may also include specialists, pharmacists, or social workers.
- **Your Role:** Participate in ICT communications and case conferences (as needed) to provide clinical guidance, report changes in health status, and collaborate on solutions to barriers.

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## MOC Element 2: HRA

- **Purpose:** To conduct a comprehensive initial assessment that evaluates a member's medical, psychosocial, cognitive, and functional status.
- **Timeline:** Our goal is to complete the initial HRA within **90 days** of a new member's enrollment and conduct an annual reassessment thereafter.
- **Process:** We conduct telephonic outreach to new members. If a member cannot be reached after three attempts, the HRA is mailed to them.
- **Your Role:** Please encourage your patients to complete their HRA. The results are used to stratify members based on risk, identify the most vulnerable individuals for intensive management, and form the basis of the Individualized Care Plan.

## MOC Element 2: ICP

- **Purpose:** The ICP is a member-driven, person-centered "living document" that outlines prioritized goals, identifies barriers, and details specific interventions.
- **Essential Components:**
  - Member-specific short- and long-term goals (SMART goals).
  - Identification of barriers (e.g., language, transportation, health literacy).
  - A self-management plan with appropriate tools and education.
  - Coordination with the member-selected ICT.
- **Development & Updates:** The ICP is initiated by a Case Manager (CM) with the member upon HRA completion and further developed with input from the entire ICT, including you. It is updated at least annually, or more frequently for high-risk members and when a member's health status changes.
- **Your Role:** You are a key author of the ICP. The plan will be shared with you via fax, mail, or a secure portal, and it is designed to align with and support your treatment plan.

## MOC Element 2: ICT

- **Purpose:** To provide an integrated, holistic, and person-centered approach to planning care and coordinating services.
- **Composition:** The team is individualized to the member's needs and preferences and is led by the Astiva Case Manager. It always includes:
  - The Member and/or their Caregiver
  - The Primary Care Provider (You)
  - Specialists (e.g., Cardiologist, Endocrinologist)
  - Pharmacist
  - Behavioral Health Provider
  - Care Coordinator
- **Your Role as the PCP:** You are responsible for coordinating the member's medical care and treatment plan. The CM will work closely with you, sharing HRA results and the ICP, and facilitating communication to ensure the member's needs are met.

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# Provider & ICT Collaboration: A Partnership in Care

As a key member of the Interdisciplinary Care Team, your clinical expertise is vital. Astiva's Case Manager facilitates a seamless, bi-directional flow of information to ensure care is truly coordinated. **Contribute to the Individualized Care Plan (ICP):**

- Astiva's Case Manager will share the member's Health Risk Assessment (HRA) and a draft ICP with you.
- You are expected to review these documents and contribute your clinical expertise. This includes sharing the member's medical history, successful and unsuccessful treatments, and your insights into their health literacy and ability to self-manage.
- Your existing treatment plan is a foundational component that gets integrated directly into the comprehensive ICP.

## **Actively Collaborate and Communicate:**

- Astiva's Case Manager acts as the primary liaison to facilitate communication, but your active participation is crucial
- You are expected to engage in communications regarding your patient, especially when their health status changes or during care transitions (like a hospital discharge).

**Manage Transitions of Care:** You are considered the primary point of contact for managing a member's care as they move between different settings (e.g., hospital, skilled nursing facility, home), ensuring clinical continuity.

- In short, the model is designed as a partnership. Astiva's ICT provides the support structure and coordination, while you provide the core clinical direction and expertise to shape and guide the member's care.

## MOC Element 3: Provider Network

Astiva has built a network with the specialized expertise required to care for our C-SNP members.

- **Key Specialties:** Primary Care, Cardiology, Endocrinology, Ophthalmology, and Podiatry.
- **Provider Competency:** We ensure all network providers are competent and actively licensed through a rigorous credentialing process, which includes primary source verification and review of performance data.
- **Collaboration is Key:** Providers are expected to actively collaborate with the ICT and contribute to the member's ICP. Our Case Managers will be your primary point of contact to facilitate this engagement.

## **MOC Element 4: Quality Measurement & Performance Improvement (QIP)**

Our QIP is a formal process to monitor performance, measure outcomes, and continuously improve the quality and effectiveness of care.

- **Key Focus Areas:** We track access, utilization, member satisfaction, and clinical measures.
- **Data Sources:** We use HEDIS®, CAHPS®, HRA completion rates, and utilization data to evaluate MOC performance.
- **Measurable Goals for 2026:** We have set specific targets for key HEDIS measures, including:
  - **Controlling High Blood Pressure:** 80% Target
  - **Hemoglobin A1c Control for Patients With Diabetes (<8%):** 80% Target
  - **Eye Exam for Patients With Diabetes:** 80% Target
  - **Statin Therapy for Patients with Cardiovascular Disease:** 80% Target

Your documentation, accurate coding, and proactive management of these conditions are critical to achieving our shared quality goals

# Provider Expectations

## **Participate in the ICT**

Actively collaborate with the Case Manager and be responsive to communications regarding your patients

## **Contribute to the ICP**

Review, update, and return the member's ICP to ensure it aligns with your treatment goals

## **Partner in Care Transitions**

Ensure timely follow-up appointments and perform medication reconciliation after a member is discharged

## **Encourage HRA Completion**

Encourage your patients to complete their annual HRA with the Astiva Team

## **Use Clinical Guidelines**

Adhere to evidence-based guidelines and use the established process for modifications when clinical necessary

## **Focus on Quality**

Be mindful of HEDIS measures. Your proactive care is the primary driver of these important outcomes

# **Summary of Your Role and Key Responsibilities**

## **Annual MOC Training Actions**

- 1. Complete MOC training yearly** and submit attestation
- 2. Partner with us** to promote annual HRA completion
- 3. Participate actively in ICT** and offer clinical expertise
- 4. Communicate with Astiva Case Manager** during transitions
- 5. Use adopted Clinical Practice Guidelines** for care
- 6. Assist in closing care gaps** and meet quality goals



# Thank You!

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