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2024 D-SNP Model of Care

Provider Training

Common Terms

D-SNP	**D**uals **S**pecial **N**eeds **P**lan	Plans providing coverage for those who are both Medicare and Medicaid eligible. **BlueRI for Duals is BCBSRI's D-SNP**.
Dual(s)	Beneficiaries	D-SNP members.
MOC	**M**odel **o**f **C**are	Plan roadmap, approved by CMS, defines BCBSRI's framework to support the D-SNP population.
ICP	**I**ndividual **C**are **P**lan	Reflects a Dual member's plan of care, developed by the member and BCBSRI care manager (CM), in support of the provider's plan of care.
ICT	**I**nterdisciplinary **C**are **T**eam	Comprised of the member and/or caregiver, providers, and BCBSRI care team. Required to meet annual.

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Housekeeping

✓**Virtual Sessions**: Keep cameras off and lines muted.

✓**Participant Credit**:

- Virtual/In-person: Provide Name and NPI to Trainer
- Self-guided Study: Complete the 2024 Provider Attestation form

✓**CMS Annual Requirement** for ALL providers, cannot be delegated.

✓**Printed Materials and Plan Specifics**: ProviderRelations@bcbsri.org

✓**Personalized Trainings**: Kathleen.Simon@bcbsri.org

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Training Objectives

1. **LEARN** core eligibility criteria and basic characteristics of the D-SNP Population.
2. **APPLY** D-SNP MOC framework components to your daily practice.

- ✓ Coordinate with D-SNP Care Team, care plans and annual ICT meetings
- ✓ Leverage plan benefits and team members to maximize patient supports
- ✓ Meet the Team – know who to contact when

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BCBSRI's Current D-SNP Population

Members

As of October 1, 2023, BlueRI for Duals care for **over 3,200 Rhode Islanders** across all 33 cities in RI. An additional 3,000 active BCBSRI Medicare Advantage members are D-SNP eligible.

Educate + Access

BENEFITS + RESOURCES

AWV: 91% of BlueRI for Duals members saw their PCP in the past 12 mths

In-home Companion Services: 21% utilized Papa Pals in 2022

Identify + Address

SDoH NEEDS

HRA Results:

33% ran out of food /$

28% need transportation

10% are worried about housing

Private Transportation:

Over 4,300 rides were provided in 2022

Advocate + Coordinate

MEDICAID BENEFITS

63 Medicaid Applications

44 LTSS Applications submitted

MedicaidInquiries@bcbsri.org

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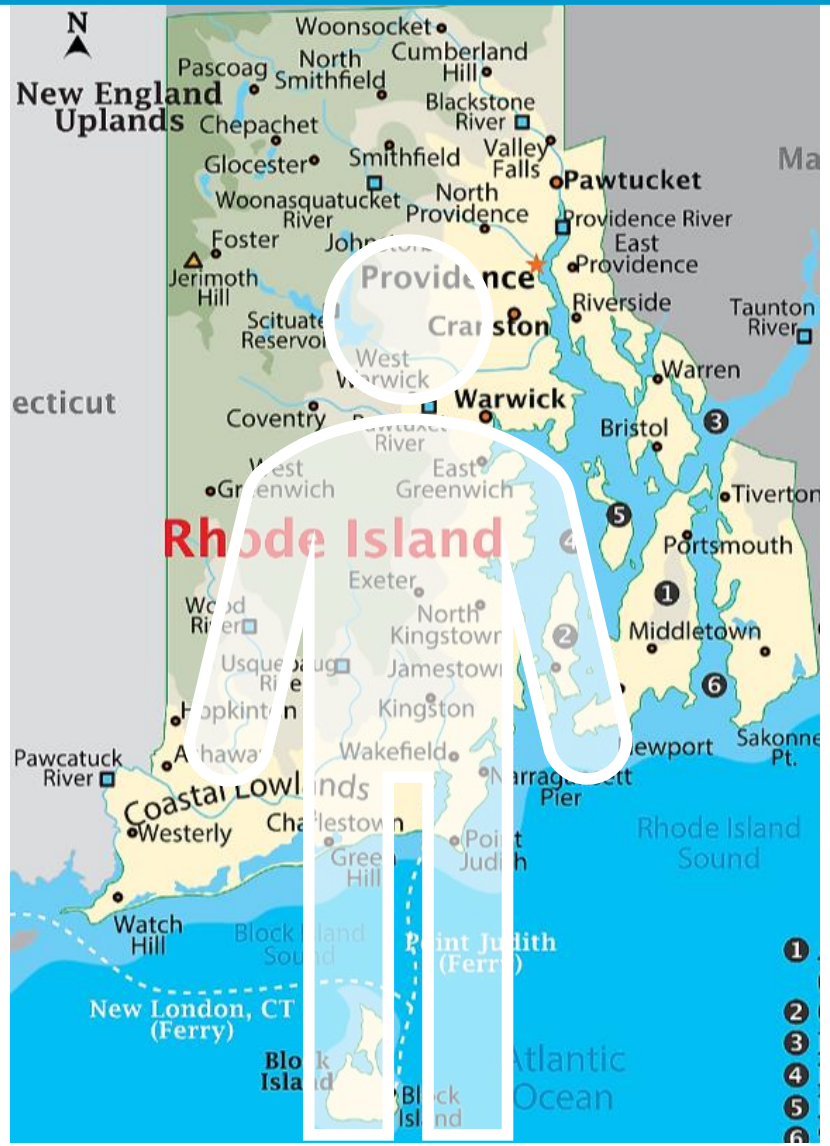
BCBSRI's Current D-SNP Population

Age
- ✓ 66 yo average age
- ✓ 33% are < 65 years old

Language Spoken
- ✓ 15% Spanish
- ✓ 85% English

Communities
- ✓ 37% Urban area
- ✓ 63% Suburb or rural area



Ethnicity
- ✓ 71% Caucasian
- ✓ 20% Hispanic
- ✓ 9% Other (Portuguese, Asian, Chinese, American Indian, Japanese)

Annual Income
- ✓ 66% < $50K

Housing
- ✓ 20% Rent
- ✓ 80% Own

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D-SNP Eligibility

BlueRI for Duals (HMO-D-SNP) beneficiaries must meet the following criteria:

1. **Enrolled** in **Medicare Part A and B.**

2. **Reside within** the services area, all **Rhode Island** counties.

3. **Have** one of the following **Medicaid Status Categories**:
   - ✓ **QMB+** (Qualified Medicare Beneficiary with Medicaid Coverage)
   - ✓ **SLMB+** (Specified Low-Income Medicare Beneficiary with Medicaid Coverage)
   - ✓ **FBDE** (Full Benefit Dual Eligible)
   - ✓ **QMB-Only** (Qualified Medicare Beneficiary without Medicaid Coverage)

Ineligible Medicaid Dual Status Categories:
QI (Qualifying Individuals),
SLMB-only (Specified Low-Income Medicare Beneficiaries without Medicaid Coverage), and
QDWI (Qualified Disabled Working Individuals)

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Special Needs Plan (SNP) Regulations & Plan Types

The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage (MA) Coordinated Care Plan (CCP) specifically designed to provide targeted care to individuals with special needs, known as a "Special Needs Plan" (SNP).

General Regulations

- SNPs follow existing MA program rules with respect to Medicare-covered services and Prescription Drug Benefit program rules.
- All SNPs must provide Part D prescription drug coverage because special needs individuals must have access to prescription drugs to manage and control their health care needs.
- All SNPs must submit and have approved a comprehensive Model of Care (MOC) plan.

Types of Coordinated Care Plans

1. A local or regional preferred provider organization (i.e., LPPO or RPPO) plan
2. **A health maintenance organization (HMO) plan**, or
3. An HMO Point-of-Service (HMO-POS) plan

TYPES of SNPs, Beneficiaries must meet eligibility criteria to enroll in the following types of Medicare Advantage SNPs

1. **Dual SNPs (DSNPs): Beneficiaries are eligible for both Medicare and Medicaid (defined subset of full & partial dual eligible categories).**
2. Fully Integrated Dual Eligible (FIDE) SNP: Beneficiaries are eligible for both Medicare and Medicaid; provides beneficiaries with access to Medicare and Medicaid benefits managed under one health plan.
3. Institutional SNPs (ISNPs): Beneficiaries have an actual or expected stay of 90 days or longer in a nursing facility or SNF.
4. Institutional Equivalent SNPs (IESNPs): Beneficiaries live in an ALF or community and require an institutional level of care.
5. Chronic Special Needs Plan (CSNP): Beneficiaries have specific severe or disabling chronic conditions specified by CMS.

Dual-Eligible Beneficiaries

Are low-income seniors or individuals with disabilities who qualify for benefits under both the Medicare program and their state Medicaid program but have different levels of eligibility.

Eligibility Categories

Partial Dual (4% of BCBSRI Duals)	**Full Dual** (96% of BCBSRI Duals)
• Qualify for financial assistance with Medicare premiums and in some cases cost-sharing. • Not entitled to other Medicaid-covered services.	• Qualify to receive all services covered by the Rhode Island Medicaid program. • Qualify for financial assistance with Medicare cost-sharing.

Care Characteristics

- ✓ Higher rates of chronic illness and co-morbidities, including diabetes, pulmonary disease and strokes.
- ✓ Higher rates of severe mental illness, Alzheimer's disease or related dementias.
- ✓ More likely to have functional limitations and require long-term care services than non-dual eligible Medicare beneficiaries.
- ✓ Have low incomes and relatively low levels of education and family and community support
- ✓ Dual eligible beneficiaries tend to have more complex care needs and higher health care spending than others without these conditions. They need a comprehensive range of medical, behavioral and social support services.

Most Vulnerable Beneficiaries (MVP)

Beneficiaries who are at a much higher risk of poor health outcomes* related *to medical, behavioral, and social health and have a higher likelihood of increased utilization and adverse health-related events. MVPs receive more frequent outreach from the care team and meet the criteria for at least one of the following cohorts:

Chronically Ill	Frail	Homeless	BH Afflicted
Population requiring significant attention with perpetual care needs.	*Population whose health will continue to deteriorate as they continue to age.*	*Population lacking the resources and support to maintain health and well-being.*	*Population with severe BH needs*
+ 1+ of the top 5 conditions: CHF, CAD,COPD, Diabetes, Asthma + 1+ BH Condition of depression, anxiety, schizophrenia, bipolar, dementia, personality disorder, or substance abuse + Social Vulnerability Index of 1 + 2+ ER visits and/or IP stays within the last 12 months	+ Aged 86+ + Social Vulnerability Index of 1 + 1+ condition of Diabetes, CHF, or COPD	+ Homeless population indicated by ICD-10 Code Z59.0 + Members identified as homeless by alternative mechanisms, such as the HRA, CM interactions, etc.	+ Any beneficiary who has had 1+ IP Admissions related to BH

MOC Goals

BCBSRI examines MOC effectiveness through analysis of population health outcomes and evaluation of the following core MOC goals:

1. Access to Needed and Affordable Care
2. Coordination of Care, including Transitions Across All Healthcare Setting and Providers
3. Appropriate Utilization of Services and Interventions for Acute and Chronic Conditions
4. Delivery of Preventive Care

- Achievement of goals is based upon meeting/ exceeding benchmarks within the defined timeframes.
- BCBSRI performs continuous evaluation of MOC performance and provides feedback to providers accordingly.

Blue RI for Duals Quality Program

Quality Management (QM) Program

Foundational structure for excellence, includes improvement processes and outcomes that address beneficiary needs, delivery system adequacy, and performance monitoring. This includes quality initiatives directed at major components of healthcare delivery:

- ❑ Delivery system access and adequacy is addressed
- ❑ Complaint and sentinel event management is included
- ❑ Beneficiary satisfaction with clinical and administrative services is measured
- ❑ Beneficiaries' self-rating of health over time is monitored
- ❑ Plan service is measured to ensure quality and drive improvements in health services for beneficiaries and providers

HEDIS Measure: Care of Older Adults
CY 2022 Completion Results:
- ✓ Pain Assessment 91%
- ✓ Functional Assessment 75%
- ✓ Medication Review 88%

Quality Performance Improvement Plan (QPIP)

Enterprise-wide program which objectively and systematically monitors and evaluates the quality, safety, and appropriateness of medical and BH services offered to beneficiaries. The QPIP identifies and acts on continuous improvement opportunities for the SNP population. QPIP improves our ability to deliver high-quality health care services and benefits to our DSNP beneficiaries.

- ❑ Integrates functional areas in decisions that affect the quality, safety, and services provided to DSNP beneficiaries: Ongoing review of care, assures demographic groups, races, ethnicities, special needs populations, care settings, and types of services are addressed.
- ❑ BCBSRI effectively monitors, reports, and analyzes the DSNP MOC, increasing organizational effectiveness and efficiency through quality measurement and performance improvement concepts.
- ❑ Cross-functional teams include BCBSRI Care Management, Behavioral Health, Utilization Management, Product, and Pharmacy teams.

Quality Improvement (QI) Work Plan

Cross-organizational Quality implementation plan includes goal accountability and key performance outcome monitoring (supporting the QPIP) for clinical, service, provider, and beneficiary experience improvement activities.

- ❑ All departments, units and organization-wide activities including clinical, service, provider, and beneficiary experience activities, including but not limited to HEDIS, BH Care, Quality of Care. Addresses drivers of higher utilization, e.g., frequent ED use.
- ❑ Monitors key departmental performance outcomes, quarterly review and update of each activity provided by the delegated business owners present to the oversight committee, as appropriate
- ❑ Staff and team performance for each activity, as indicated

Please see Appendix for complete program definition.

BCBSRI D-SNP Care Team

Nurse and Behavioral Health Care Managers, Pharmacists, Health Navigators, Medical Directors, Medicaid Specialists and **YOU!**

MOC Requirement	Description	Timeframe
HRA *Health Risk Assessment*	Identifies the member's medical, functional, cognitive, psychosocial, and mental health needs to inform and prioritize their care management and community service needs. **Expanded to include Advance Directives, Digital Health Literacy, Housing Security.**	Within **90 days** of enrollment and annually
ICP *Individualized Care Plan*	HRA informs the ICP, engaging and encouraging members to achieve their health goals.	Initial within **30 days** of HRA completion; per acuity level
ICT *Interdisciplinary Care Team*	Non/clinical professionals from different disciplines; work collaboratively with the member/caregiver, to uphold the member's comprehensive care plan.	**Annual** meeting
TOC *Transitions of Care*	TOC protocols facilitate continuity of care for D-SNP members, prevent fragmentation, reduce safety risks, and improve the member's experience of care.	Within **3 days** of transition notice
Face-to-face	**NEW 2024!** All D-SNP members are required to have a face-to-face encounter with a network provider and/or an ICT member.	**Annual**
Ongoing Care Management	D-SNP Care Managers and Health Navigators are responsible for management, maintenance, documentation, and communication of the ICP.	Per acuity level

Together, We Uphold D-SNP MOC Care Coordination Deliverables

Care Plan Update Frequency

The assignment of a member's primary point of contact (POC), as well as care plan updates are based on their HRA risk score. HRA risk scores are populated based on how the member completes the HRA. Members with more complex needs will primarily work with a Care Manager. Lower risk members will work with a Health Navigator.

<table>
<tr><th>Risk Level</th><th>HRA Score Threshold</th><th>Point of Contact</th><th>BCBSRI Outreach</th><th>ICP Update</th></tr>
<tr><td>Low</td><td><10</td><td>Health Navigator</td><td rowspan="2">Quarterly</td><td>Annually</td></tr>
<tr><td>Moderate</td><td>10-20</td><td rowspan="3">Care Manager</td><td>Semi-Annually</td></tr>
<tr><td>High</td><td>>20</td><td rowspan="2">Quarterly</td></tr>
<tr><td>MVP</td><td>N/A
See slide 7 for MVP criteria</td><td>Monthly</td></tr>
</table>

Quarterly outreaches are required for all, except MVPs which are monthly

BlueRI for Duals Differentiators

Additional Benefits; Enhanced Medicare and Medicaid Program Coordination; Enrollment and Eligibility Support.

$0 Premiums, No Referrals

Medicaid Benefit Coordination

- Health Navigator to help coordinate Medicaid services, such as:
  - Home care
  - Adult day health
  - Durable medical equipment, etc.
- Collaboration with community partners to impact social determinants of health
- Comprehensive care plans for members incorporating Medicaid-funded services

Medicaid Enrollment / Eligibility Support

- Medicaid specialists prepared to help BCBSRI members enroll in Medicaid or apply for LTSS eligibility
- Annual Medicaid recertification support
- 90-day grace period while BCBSRI supports Medicaid recertification

BlueRI for Duals 2024 Highlights

Each Blue RI for Duals member has an individualized ICT, comprised of clinical and non-clinical stakeholders collaborating to coordinate care and SDoH supports, helping members achieve their health goals.

SDoH* / Lifestyle Support Benefits

- *Private Transportation,72 one-way rides*
- *120 hrs. / year In-home companion services (Papa Pals)*
- *Glasses removed from OTC card, now covered with BCBSRI card and offers more discounts through EyeMed!*
- *$200 Wellness reimbursement; $100 Caregiver reimbursement*
- *PERS, personal emergency response system*
- *Flexible Benefit Card for OTC products and food $160/mth*

Community Supports

FREE fitness and educational classes at Your Blue Store locations:

- *Cranston*
- *East Providence*
- *Lincoln*
- *Warwick*
- *New! Narragansett*

Mobile Your Blue Bus, bringing service to you!

Ancillary Care Coverage

*$0 Part D Drugs**

Dental coverage: $3,000 annual benefit max including dentures, implants, crowns and so much more!

$1,500 / yr. for dental and hearing services above included benefits!

Hearing Aids: $0 on 2 hearing aids per year + batteries

$300/yr for glasses or contacts

CVS pharmacy · Walmart · shaw's · RITE AID · Walgreens

BMED-931490_2024_Blue_Difference_Brochure_Duals_EBOOK_FA.pdf (bcbsri.com)

BlueRI for Duals 2024 Highlights
Grocery Benefit Options

1. Order staples through Nations by calling or going online

2. Shop in person, wherever SNAP benefits are accepted

3. Fresh produce delivered at their doorstep by *Millonzi Fine Catering*
   - ✓ Choose from seasonal items and freshly prepared meals
   - ✓ *Millonzi* is also a SNAP distributor, if BCBSRI's monthly benefit is exhausted, members can use their SNAP benefits!

Beyond Monthly Grocery Benefit: Members can also access **14 prepared meals** (1 week of meals) via *Millonzi* post an IP or SNF discharge.

BCBSRI Clinical Programs

The following programs are available to BlueRI for Duals members who meet clinical criteria, outreach DSNPTriageGroup@bcbsri.org with questions.

In-home Programming

Services include coordinated care between NPs, SWs, RNs and other specialty staff dedicated to providing patients the right care in the least restrictive environment. Services do not include 24/7 in-home care.

PCPs receive reports from in-home visits.

- HouseCall By Blue
- Concerto Care
- Coastal @ Home
- Care @ Home (Prospect)
- Integra @ Home

Remote Patient Monitoring

Provides telehealth monitoring services for patients with COPD and CHF. NCM is provided with alerts for clinical values offering close to real time education and intervention. Program goal is to maintain ideal health and reduce avoidable ER and IP admission.

- AMC Health
- Coastal RPM
- Prospect RPM
- Southcoast RPM

Behavioral Health

Health Path: Home and community-based program for members with severe and persistent mental illness/substance use disorders. Program is available through Butler Hospital.

Medication Assisted Treatment

Dementia Care Coordination: Program administered through the Alzheimer's Association to support both caregivers and members with Alzheimer's or Dementia.

High-Risk Maternity

Telephonic Care Management for high-risk pregnancies. The goal of the BCBSRI Maternity Program is to reduce the risk of preterm births, low birth weights and pregnancy related complications by providing expectant mothers with information, tools and resources.

- 39% of pregnancies are high risk.
- 26% are in the top two quartiles for SVI due to SDoH needs.
- 36% are in HR ages.

Livongo, *Personalized Application + Health Coaching*

Diabetes Management:
Connected meter
Unlimited strips and lancets

My Strength: Digital program with proven tools and dedicated support to better manage behavioral health symptoms like stress, depression, sleep and more!

Provider Collaboration

- ✓ **Ask** for **BlueRI for Duals** and **Anchor** cards
- ✓ **Complete Quarterly Provider Attestation Requirements**
- ✓ Attend or complete self-led annual **2024 D-SNP Model of Care training**
- ✓ **Engage** in Care Management and **Annual D-SNP ICT meetings**
- ✓ Provide feedback – **We WANT to hear from YOU!**
- ✓ Leverage D-SNP member **Quarterly Special Elections**
  - October 15 – December 7, 2023, Annual Enrollment Period (AEP)
  - January through September 2024; Jan-March, April-June, July-Sept for enrollment the first of the month following enrollment.

Losing LIS vs. Losing Medicaid Coverage

Loss of LIS

Part D Drugs

Grocery Benefit

- Will have coinsurance on all medication Tiers
- May have a Part D premium of up to $35 per month
- Will have a pharmacy deductible of up to $545 for all medication Tiers
- Will not be able to use their Flexible Spending card for food/groceries (but will still be able to for OTC)

Loss of Medicaid

MA Cost Sharing

Medicaid Benefits

- Will have 20% coinsurance on some services such as PCP visits (apart from annual physical), dental, X-rays
- Will have copays on some services such as $100 for an ER visit, $55 for urgent care
- Will have no coverage for Medicaid-only services such as adult day health, homecare through Medicaid, dental through Medicaid

If a member loses Medicaid, they can **remain on BlueRI for Duals** for up to **90 days**.

BCBSRI Medicaid Specialists assist members to reapply for Medicaid and connect members with help to reapply for LIS

2024 New Cards and 20% Coinsurance

Effective January 1, 2024, all existing and new Blue RI for Duals (D-SNP) members will receive new ID cards and Flexible Spending Cards. The new ID cards will no longer display the copays or coinsurance. Consistent with 2023, **D-SNP members have a 20% coinsurance on some services such as PCP visits (excluding annual physical), medical services related to X-rays, specialist visits, and Part B DME supplies. Any D-SNP copay or coinsurance should be billed to Medicaid.** If you are not an approved Medicaid provider and are unable to submit your claim to Medicaid, you are **not** allowed to bill the member for the copay/coinsurance.

Please contact ProviderRelations@bcbsri.org if you have any questions.

Reminders will be shared in upcoming Provider Updates.

What's in it for me?

Patient Experience

- ✓ Patient preference honored: phone, in-person, timing
- ✓ D-SNP Care Team Composition
  - Patient / Caregiver
  - Clinical and Quality Teams
  - Health Navigators
  - Community Partners
  - Medicaid Specialists
  - Scheduling, coordination
  - LOCAL Customer Service
- ✓ Access to meaningful benefits

Provider Experience

- ✓ Fewer missed appointments
- ✓ More patient follow-through on your recommendations
- ✓ Personalized pharmacist consult
- ✓ Support for your Office staff
  - Coordinate appointments
  - Monitor and assist with Medicaid benefits
  - Focus on preventative screenings, quality needs, risk scores/revenue

BCBSRI members rated us #1 in member satisfaction among commercial health plans in the Northeast Region - J.D. Power - THREE years in a row.

Our company wide Net Promoter Score is on the rise and leading the market. Our multi-channel approach to service and meeting the needs of BCBSRI members where they are is invaluable to our customers

Contacts and Resources

Active D-SNP Member, CM Support: DSNPTriageGroup@bcbsri.org

Plan Overview: ProviderRelations@bcbsri.org

HEDIS Questions: QualityHEDIS@bcbsri.org

Schedule a D-SNP Training or general D-SNP questions: DSNP.Questions@BCBSRI.org

Link to D-SNP Materials: Medicare Advantage Plan Materials | Blue Cross & Blue Shield of Rhode Island (bcbsri.com)

Physician and Provider Service Center: (401) 274-4848 or 1-800-230-9050

Prospective Member Referrals, D-SNP Sales Line: (401) 459-5477

Webform for Referrals: www.bcbsri.com/medicare/duals (requires email)

Click on "Want some help?"

Appendix

1. MOC Deliverables
2. Interdisciplinary Care Team
3. Overview Health Risk Assessment Process
4. Individualized Care Plan
5. Ongoing Care Management
6. Transitions of Care, Processes
7. Transitions of Care, Personnel
8. MOC Quality Management Program
9. MOC Quality Performance Improvement Plan
10. MOC Quality Improvement Work Plan

Model of Care Key Deliverables	Overview	Objectives	Provider Role
Interdisciplinary Care Team, **ICT**	Each DSNP member has a dedicated ICT comprised of non/clinical professionals from different disciplines. ICT members work collaboratively with the member/caregiver, to uphold a comprehensive plan of care for the member	ICT members include the member or their representative, BCBSRI's DSNP care manager, health navigator, PCP, Medical Director, Specialists, other care providers	• Maintain required credentials for participation in the BlueRI for Duals (HMO-DSNP) network • Adhere to select national standard Clinical Practice Guidelines (CPGs) • Collaborate within the ICT • Complete MOC training upon onboarding and again annually
Health Risk Assessment, **HRA**	Assessment tool used to identify the member's medical, functional, cognitive, psychosocial, and mental health needs to inform and prioritize their care management services	• Annual requirement • Goal of 100% completion for all DSNP members • HRA results are shared with providers and drives the ICP • Goal of completion of HRA within first 90 days of plan enrollment • If the HRA is not completed by the member, the process restarts on day 366 • HRA results inform assignment of primary contact (Health Navigator or Care Manager) based on risk stratification	• Educate to the importance of HRA participation • Encourage HRA completion
Individualized Care Plan, **ICP**	HRA informs the ICP, engaging and encouraging members to achieve their health goals	• Completed within 30 Days of HRA completion • Updated when there is a change in health status • Minimum annual update • ICP is shared with ICT members and the member themself	• Provider feedback and ICT communication on the proposed ICP • Provider or provider representative participation in annual ICT meetings is requested
Ongoing Care Management	BCBSRI's DSNP Care Managers and Health Navigators are responsible for management, maintenance, documentation, and communication of the ICP	• Reflects evolving health status • Includes assessment of SDoH needs • Managed by BCBSRI DSNP clinical team	Consultation for ICP updates
Transitions of Care, **TOC**	Care transition protocols are used to facilitate continuity of care for DSNP members, prevent fragmentation, reduce safety risk, and improve the member's experience of care.	• For un/planned care transitions including overnight stays, home health care, home setting, urgent and emergency settings • Alerts via health information exchange (HIE), utilization management, beneficiaries, ICT members • Within 3 days of transition notice, BCSRI DSNP CM conducts the TOC assessment TOC assessments may not be appropriate if the transition is within a continuum of care, clinical discretion is applied • Coordinates and communicating members needs with ICT, conducts and documents assessments reflecting member health care preferences	Communicate with DSNP Care Managers, ICT members, members themselves, and caregivers

Interdisciplinary Care Team

Federal regulations require all SNPs to use an Interdisciplinary Care Team in the management of care for each individual enrolled in the SNP.

Purpose: Provide each DSNP beneficiary with access to a dedicated ICT comprised of clinical and non-clinical professionals from different disciplines and areas of expertise, working collaboratively with the beneficiary and caregiver, as well as others involved in the beneficiary's care, to support a comprehensive and coordinated plan of care for the beneficiary.

	Description
Beneficiary	• They are informed of their ICT role upon enrollment in the DSNP program via materials included in the enrollment packet and Informed of ICT and care management support during in-person and telephonic HRA process • Encouraged to participate in the overall ICT process through regular interactions with their Care Manager and the ICT and participate at ICT meetings
ICT Composition	• ICT expertise and capabilities align with the beneficiary's identified clinical and social needs, which are obtained through the HRA findings, as well as information obtained from other data sources such as claims and encounter data. The clinical and social needs identified informs composition of the ICT • Additional ICT members may be added at any time, based on changes in the beneficiary's health status and/or transitions of care
ICT Roles	• **Care Manager** serves as the primary point of contact, for all HRA risk levels except low, and communications for the beneficiary, the provider as well as internal and external ICT members • **PCP** actively participates in the development and maintenance of the ICT, coordinates and/or delivers needed care and services, communicates with the Care Manager and other members of the ICT, and attends the ICT meetings • **Medical Director** provides senior leadership to the ICT, facilitates and advises the ICT, partners closely with the beneficiary's providers to develop and strengthen relationships with the ICT, and addresses the barriers preventing or limiting the beneficiary's ability to access care • **All ICT** members analyze initial and annual HRA results and other assessment data, develop and maintain the ICP, monitor beneficiary outcomes and adherence to evidence-based guidelines through data/results (e.g., HEDIS, program evaluations, admissions/readmission rates, avoidable ED rates) • **Specialists** play a key role in the management of beneficiary complex and/or chronic conditions and collaborate with the ICT to care for the SNP beneficiary • **Health Navigator** serves as primary point of contact for low-risk HRA members and participates as a member of the ICT to provide information about the beneficiary's barriers, community resources, and preferences • **Pharmacist** provides medication guidance to the ICT, reviews the beneficiary medication profile, and advises on medication alternatives.
ICT Communications	• Care Manager sends electronic notification of availability of HRA results and initial ICP in the Clinical Care Management System • ICT meeting minutes are stored in the clinical system and are accessible to internal ICT members. External ICT members receive a copy of the minutes. • ICT is notified of beneficiary transitions of care, and when updates are made to the ICP • ICT is notified of key updates from interactions between the Care Manager and the beneficiary, as well as between Care Manager and PCP and Specialists • For beneficiaries who are deaf, hard of hearing, or speech impaired, TTY/TDD is used to facilitate communication

Overview of the HRA Process

Federal regulations require that all SNPs conduct an initial Health Risk Assessment and an annual health risk reassessment for each individual enrolled in the SNP.

Goals

1. Collect detailed information about the beneficiary's medical, functional, cognitive, psychosocial, and mental health needs to identify their unique health care needs to identify care management services that will be needed to support the beneficiary.
2. Conduct HRA on 100% of DSNP beneficiaries

Delivery

a) U.S.P.S. Mail

b) Phone call (IVR or with assistance from Health Navigator or Care Manager)

c) In-person

d) At least three attempts to complete HRA with beneficiary must be made

Timeframes

a) Must be completed within 90 days of enrollment in the DSNP

b) Must conduct reassessment within 365 days of most recent HRA

c) HRA results are entered in the clinical care management system w/in 3 days of receipt

Results

a) Identify Individual beneficiary health needs

b) Risk stratify beneficiary for care coordination

c) Identify beneficiaries' care management needs

d) Develop the initial care plan

e) Communicate with physicians, the Interdisciplinary Care Team (ICT), beneficiary, caregivers, and others involved in the beneficiary's care

Individualized Care Plan

Federal regulations stipulate that all SNPs must develop and implement a comprehensive individualized plan of care through an interdisciplinary care team in consultation with the beneficiary, as feasible, identifying goals and objectives including measurable outcomes as well as specific services and benefits to be provided

Essential Components of the ICP		
Beneficiary Self-Management Goals and Objectives	**Beneficiary Personal Healthcare Preferences**	**Services Specially Tailored to Beneficiary Health Needs**
• Care plans are mutually agreed upon between the beneficiary and the health plan • Goals are focused on the beneficiary activating their health through specific behaviors and actions that can be sustained • Goals relate to how beneficiary can improve their symptoms, level of functioning, physical and behavioral health, and overall wellbeing. • Care Manager engages the beneficiary using motivational interviewing techniques to develop goals • Care Manager and beneficiary collaborate to identify interventions to facilitate achieving the goals and identify and address any barriers that may make it difficult to be successful.	• Personal preferences may include beneficiary's: ○ Values ○ Culture ○ Abilities ○ Resources ○ Knowledge of options ○ Social networks • Essential that beneficiary understands their options and make decisions and choices about many aspects of their care. • Identified using information gathered from the beneficiary and caregiver(s) in the HRA and/or the comprehensive assessment	• The following services are tailored to the beneficiary and include, but are not limited to: ○ Complex case management (both medical and behavioral health) ○ Long term supportive service referral and collaboration ○ Health Navigator SDOH support ○ Resources and services available to assist homeless beneficiaries ○ House call by Blue program ○ Transportation support

ICP Ongoing Management

The Care Manager or Health Navigator are primary point of contact for management, maintenance, documentation, and communication of the ICP

Care Manager

- Maintains and makes ongoing updates in collaboration with the beneficiary and ICT
- Partners closely with the Health Navigator to address and resolve Social Determinants of Health (SDOH) barriers
- Reviews and updates the ICP at the cadence indicated by their risk level.

Change in Health Status

- ICP may be updated based on a change in beneficiary health status, based on clinical discretion.
- ICP updates will be made within ten days of completion of a reassessment.
- Transitions across the care continuum, such as an acute inpatient or skilled nursing facility admissions, prompt reassessment and ICP updates.

Health Navigator

- For low-risk members: Monitors beneficiary progress with goals, collaborates with beneficiary and ICT for goals not met
- Monitors data sources to identify any changes in health status as well as progress towards goals (e.g., beneficiary obtained recommended preventive health screening)
- Assists members with meeting any SDOH needs that have been identified

Clinical System Documentation

- ICP is documented and maintained in the clinical management system
- Internal BCBSRI ICT updates ICP with beneficiary specific information related to their role in supporting ICP
- Information is shared with ICT team members through the Clinical Care Management System and/or fax, mail, or secure email.

Transitions of Care (TOC) Process

Regulations require all SNPs to coordinate the delivery of care.

Purpose: Care transition protocols are used to facilitate continuity of care for SNP beneficiaries, prevent fragmentation, reduce safety risk, and improve the beneficiary's experience of care.

Healthcare Settings

Planned and unplanned care transitions may occur from various settings, to include:

- Beneficiary home
- Home health care
- Acute care facilities (e.g., hospital)
- Nursing facilities
- Rehabilitation facilities
- Outpatient care centers
- Emergency departments

Communication / Notification Mechanisms

BCBSRI may be notified of care transitions via the following:

- Alerts from the state's health information exchange (HIE).
- UM authorizations or notifications
- File feeds from facilities
- SNP beneficiary, caregiver, or provider notification to the ICT via phone or email.

Planned Transitions

Upon notification of a planned admission/transition, the Care Manager:

- Coordinates beneficiary care needs with the ICT
- Conducts Pre-admission Counseling Assessment
- Determines ICT and any relevant resources needed to support beneficiary needs
- Shares information with the external ICT
- Contacts beneficiary and/or caregiver to plan for the stay
- Shares beneficiary healthcare preferences with the admitting provider and team.
- Care managers complete three (3) follow up calls within 30 days following transition date. Fewer or additional calls can be made at Care Manager's clinical discretion based on member acuity or at member request.

Transitions of Care (TOC) Processes

Regulations require all SNPs to coordinate the delivery of care.

Purpose: Care transition protocols are used to facilitate continuity of care for SNP beneficiaries, prevent fragmentation, reduce safety risk, and improve the beneficiary's experience of care.

Beneficiary Access to PHI

The Health Navigator, in consultation with the Care Manager, assists beneficiaries and/or caregivers with accessing protected health information (PHI) via the following:

- Identifying the specific PHI needed and the sources of data for the beneficiary
- Contacting the provider or facility to facilitate release of needed PHI
- Completing the necessary steps to obtain the PHI, such as obtaining and completing forms or registering in a patient portal
- Tracking receipt of PHI and following up on information not yet received.

Sharing of Essential Elements of the ICP

- **Prior** to a transition, the Care Manager shares the most recent ICP with the admitting facility
- **During** the transition the Care Manager updates the ICP in collaboration with the facility and the ICT
- Updated ICP is sent to the beneficiary and caregiver.
- Internal ICT members receive a notification to alert them to review and provide any input into the updated ICP.
- External ICT members receive the updated ICP through preferred channels such as mail, fax or secure email.

TOC Assessment

TOC assessment is completed within 3 days of notification of admission or d/c unless otherwise clinically indicated. The Care Manager completes the TOC assessment via phone, virtual or face-to-face, which includes the following:

- Medication reconciliation
- Assessment of new and existing conditions
- Changes to any treatments
- Appointments with PCP/providers
- Reason for transition
- Overall rating of health
- Review of discharge instructions and any barriers/services needed to meet those barriers
- Evaluation of program support or ICT activation

After the initial TOC outreach, Care Managers will make three follow-up calls in the 30 days following a TOC. Clinical discretion is applied to discern if less or more frequent post-TOC follow-ups.

Care Transition Personnel

Care transitions are supported by the Care Manager, the UM nurse, and the Health Navigator.

Care Manager

The Care Manager is the primary contact for the beneficiary/caregiver and other members of the beneficiary's health care team and is responsible for leading and coordinating care transition processes. Specific roles include:

- Upon notification, the Care Manager sends a follow-up note electronically for the ICT to view describing the TOC
- Coordinates with each ICT team member to determine their role in management of the beneficiary.
- Shares the beneficiary's most recent ICP with the admitting facility upon notification of the admission and identification of the appropriate clinical contact at the facility.
- Facilitates medication reconciliation and identifies beneficiaries who would benefit from pharmacist intervention
- Updates the ICP in collaboration with the PCP, facility, outpatient providers, beneficiary, caregiver, and ICT to include information relevant to the TOC.
- Ensures that follow-up services and appointments are scheduled and performed.
- After the beneficiary's transition to home or other healthcare setting, the Care Manager completes the TOC assessment and contacts the beneficiary at least three times (or less or more based on clinical discretion).

UM Nurse

The UM Nurse is often the first team member made aware of a planned or unplanned transition of care. The UM Nurse plays a key role in care transition processes as follows:

- Shares applicable clinical updates with the Care Manager and the ICT
- Manages authorization requests
- Collaborates with the Care Manager on discharge planning needs and activities

Health Navigator

The Health Navigator assists the beneficiary by coordinating resources and support such as:

- Supports Care Manager in non-clinical related care transition processes
- Assists beneficiary/caregiver with accessing PHI
- Coordinates needed services such as transportation, linkage to community resources, scheduling appointments, etc.

BCBSRI Quality Management (QM) Program

The BCBSRI Quality Management (QM) Program sets a foundation for excellence, encompassing activities designed to improve processes and outcomes including but not limited to preventive care, acute care, chronic care, care coordination, behavioral health, and medication therapy management.

The QM Program addresses the needs of our beneficiaries and includes quality initiatives directed at major components of healthcare delivery:

- ❑ Delivery system access and adequacy is addressed
- ❑ Complaint and sentinel event management is included
- ❑ Beneficiary satisfaction with clinical and administrative services is measured
- ❑ Beneficiaries' self-rating of health over time is monitored
- ❑ Plan service is measured to ensure quality and drive improvements in health services for beneficiaries and providers

The QM Program is guided by the principles of continuous quality improvement and seeks to identify and remove barriers to accomplishing program goals. Utilizing a continuous quality improvement process, the QM Program establishes high standards of evidence-based clinical practice in the community, prioritizes beneficiary health and safety, and works to improve beneficiary and provider satisfaction. Additionally, the QM Program promotes the completion of the initial and annual HRA. This process serves to optimize beneficiaries' health and positively impact the overall health of our community.

MOC Quality Performance Improvement Plan (QPIP)

The MOC Quality Performance Improvement Plan (QPIP), as part of the QM Program, aims to improve our ability to deliver high-quality health care services and benefits to our DSNP beneficiaries.

- ❑ The MOC QPIP is designed to integrate all functional areas in decisions that affect the quality and safety of care and services provided to DSNP beneficiaries. The MOC QPIP enables ongoing review encompassing the full scope of care, assuring that all demographic groups, races, ethnicities, special needs populations, care settings, and types of services are addressed.

- ❑ The QM Program has the organizational infrastructure necessary to facilitate the MOC QPIP, ensuring BCBSRI can deploy effective monitoring, reporting, and analysis of the DSNP MOC, and enabling increased organizational effectiveness and efficiency through the incorporation of quality measurement and performance improvement concepts that drive organizational change.

- ❑ Cross-functional collaborations are an extremely important component of the MOC QPIP. The Quality Team works closely with the **Care Management, Behavioral Health, Utilization Management, Product, and Pharmacy teams** to ensure our DSNP beneficiaries are provided the appropriate services to support their unique needs.

DSNP Quality Improvement (QI) Work Plan

The identified health outcomes goals of the MOC are integrated into the DSNP Quality Improvement (QI) Work Plan which includes comprehensive tracking documents supporting the MOC QPIP.

The QI Work Plan Includes:

- All departments, units and organization-wide activities including clinical, service, provider, and beneficiary experience activities, including but not limited to:
  - ❑ HEDIS
  - ❑ Behavioral Health Care
  - ❑ Quality of Care.
- Staff member and performance goal accountability for each activity, as indicated
- Monitoring of key performance outcomes in departments supporting the MOC QPIP that correlate to specific components and objectives of the overall QM program. Monitoring is comprised of quarterly review and update of each activity provided by the delegated business owners and presentation of materials to the oversight committee, as appropriate.

All MOC goals are tracked interdepartmentally and presented to the EQC on at least a quarterly and annual basis. The quality committees that report up to the EQC have monthly or bimonthly meetings (or more often, if needed) to review health outcomes, patient safety information and to develop interventions for continuous quality improvement.