# BCBSRI 2022 DSNP TRAINING

## Provider Portal MOC Training

Blue Cross Blue Shield of Rhode Island

# Introducing: BlueRI for Duals

***BlueRI for Duals: Passionately leading a state of health and well-being across Rhode Island***

**Our Vision**

To passionately lead a state of health and well-being across Rhode Island.

**Achieving Our Vision**

We are launching a D-SNP plan so that we can extend the benefits, high quality medical care, and individualized services that come with being Blue to the approximately 37,000 Rhode Islanders who are dual eligible.

**Keys to Success**

Continuing to address the **social determinants of health**

Helping members to **access and coordinate** Medicaid benefits

Supporting members to make the **best decisions for their health**

Simplifying the **member experience**

**Engaging community partners**

**Advocacy** and policy efforts aimed at affordability

# D-SNP Differentiators

***BlueRI for Duals provides additional benefits and supports to both members and providers***

## Additional Benefits

All Medicare and Medicaid benefits **plus**:

- Ancillary Benefits:
  - Dental services up to $3,000
  - $300 for glasses
  - Hearing aids and batteries
- Private Transportation
- OTC ($275/Quarter)
- $200 Wellness Reimbursement
- Monthly Food Box (for those who qualify)

## Care Team and Medicaid Benefit Coordination

- Health Navigator & RN Care Manager working with member on their care plan and goals
- Help accessing Medicaid services, such as:
  - Home care
  - Adult day care
  - Durable medical equipment, etc.
- Collaboration with community partners to impact social determinants of health

## Medicaid Enrollment / Eligibility Support

- Medicaid specialists prepared to help BCBSRI members enroll in Medicaid or apply for LTSS eligibility
- Annual Medicaid recertification support (proactive outreach based on state report)
- 90-day grace period while BCBSRI supports Medicaid recertification (no premium charged during this time)

# BlueRI for Duals PROVIDER Perspective

***BlueRI for Duals patients will have access to more resources compared to Medicare / Medicaid FFS***

***Every D-SNP Member will have an RN Care Manager and a Health Navigator who will:***

Assist each member at the level that they desire and require, whether it be over the phone or in their home

Set up medical appointments, transportation, one on one companions, or connection with housing support, a grocery benefit, fuel assistance, and more

Tie together the member's care plan incorporating support from behavioral health agencies, homecare vendors, community-based organizations, caregivers, and the member.

Resulting in fewer missed appointments, more follow through on your recommendations, and the members' access to Medicaid benefits that YOUR practices will NOT have to coordinate.

# Learning Objectives

***After the training, you will be able to describe the following:***

1. Eligibility criteria and basic **characteristics of the DSNP population**
2. **Components of the BCBSRI DSNP Model of Care**
3. How we **coordinate care for DSNP beneficiaries**, including the most vulnerable beneficiaries
4. Role of the **Interdisciplinary Care Team in supporting the beneficiary's health care needs**
5. How **care and services are coordinated for a beneficiary during a transition of care**
6. Role and responsibilities of DSNP network providers
7. Primary goals of the MOC and key components of the quality oversight program

***Note: MOC training will be an annual requirement***

# Special Needs Plan (SNP) Regulations

***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 are expected to follow existing MA program rules with regard 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 Plans

**A SNP may be any type of Medicare Advantage Coordinated Care Plan, to include:**

a) A local or regional preferred provider organization (i.e., LPPO or RPPO) plan

b) A health maintenance organization (HMO) plan, or

c) An HMO Point-of-Service (HMO-POS) plan

## Types of SNPs

**SNP beneficiaries must meet eligibility qualifications to enroll in the following types of MA SNPs:**

a) Dual SNPs (DSNPs): Beneficiaries are eligible for both Medicare and Medicaid (defined subset of full and partial dual eligible categories).

b) Fully Integrated Dual Eligible (FIDE) SNP: Beneficiaries are eligible for both Medicare and Medicaid. This type of DSNP provides beneficiaries with access to Medicare and Medicaid benefits managed under one health plan.

c) Institutional SNPs (ISNPs): Beneficiaries have an actual or expected stay of 90 days or longer in a nursing facility or skilled nursing facility.

d) Institutional Equivalent SNPs (IESNPs): These beneficiaries live in an assisted living facility or community and require an institutional level of care.

e) Chronic Special Needs Plan (CSNP): Beneficiaries have specific severe or disabling chronic conditions specified by CMS. SNPs are a type of MA plan

We are offering this type of MA SNP

# Dual Eligible Beneficiaries

***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 | |
|---|---|
| **Full Dual-Eligible** | **Partial Dual-Eligible** |
| Qualify to receive all of the services covered by the Rhode Island Medicaid programs in addition to financial assistance with Medicare cost-sharing | Qualify for financial assistance with Medicare premiums and in some cases cost-sharing but are not entitled to other Medicaid-covered services. |

## Care Considerations

- 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.

# BlueRI for Duals (HMO-DSNP) Eligibility Criteria

***Beneficiaries must be eligible for Medicare and full Medicaid benefits to qualify for BlueRI for Duals***

In order to be eligible to enroll in BlueRI for Duals (HMO-DSNP), beneficiaries must meet the following conditions:

1. Members must be eligible for/enrolled in Medicare Part A and B
2. Members must reside within the plan service area (includes all Rhode Island counties)
3. Members must have one of the following Medicaid Dual 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)

# Model of Care (MOC) Goals

***BCBSRI will ensure our DSNP MOC is effective and continuously improves the health of our DSNP beneficiaries through ongoing evaluation of the following core MOC goals***

**Core MOC goals:**

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

Achievement of goals will be determined based upon meeting or exceeding the benchmarks, within the defined timeframes, for the health outcome measures associated with each of the MOC goals. The plan will perform continuous evaluation of MOC performance and provide feedback to providers accordingly.

# Key Model of Care Deliverables

- ❑ Health Risk Assessment (HRA)
- ❑ Individualized Care Plan (ICP)
- ❑ Ongoing Care Management
- ❑ Interdisciplinary Care Team (ICT)
- ❑ Management of Transitions of Care (TOC)

# Most Vulnerable Beneficiaries

***The most vulnerable population (MVP) consists of those 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. These members will receive more frequent outreach from the care team. BCBSRI defines the MVP as members that 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<br>+ 1+ BH Condition of depression, anxiety, schizophrenia, bipolar, dementia, personality disorder, or substance abuse<br>+ Social Vulnerability Index of 1<br>+ 2+ ER visits and/or IP stays within the last 12 months | + Aged 86+<br>+ Social Vulnerability Index of 1<br>+ 1+ condition of Diabetes, CHF, or COPD | + Homeless population indicated by ICD-10 Code Z59.0<br>+ 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 |

# 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) MVP members will be prioritized for completion of HRAs within 30 days of MVP identification

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

d) 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<br>• Goals are focused on the beneficiary activating their health through specific behaviors and actions that can be sustained<br>• Goals relate to how beneficiary can improve their symptoms, level of functioning, physical and behavioral health, and overall wellbeing.<br>• Care Manager engages the beneficiary using motivational interviewing techniques to develop goals<br>• 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:<br>○ Values<br>○ Culture<br>○ Abilities<br>○ Resources<br>○ Knowledge of options<br>○ Social networks<br>• Essential that beneficiary understands their options and make decisions and choices about many aspects of their care.<br>• 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:<br>○ Complex case management (both medical and behavioral health)<br>○ Long term supportive service referral and collaboration<br>○ Health Navigator program for SDOH support<br>○ Resources and services available to assist homeless beneficiaries<br>○ House call by Blue program<br>○ Transportation support |

# Individualized Care Plan

***The Health Risk Assessment informs baseline development of an Individualized Care Plan, which seeks to engage and equip the member to achieve their health goals***

## Requirement:

An Individualized Care Plan (ICP) will be completed within 30 Days of HRA completion and updated when there is a change in health status, with a minimum of one update annually. The Individualized Care Plan will be shared with all members of the Interdisciplinary Care Team (ICT) and the member.

### What to Expect

1. BCBSRI RN or BH care Manager will complete a comprehensive assessment with the member, reach out to you to understand the PCPs goals/plan for the member, finalize care plan and send it to you

### What we Need from You

1. Review care plan to be sure it is consistent with the goals the PCP has for the member and includes all relevant providers, CBOs etc.
2. The BCBSRI care manager will act as the quarterback/coordinator-the care manager will coordinate who will perform what interventions with the member. We will look to you to carry out interventions that are part of the care plan for example:
    1. A member with diabetes needs education on monitoring blood sugars. The PCMH care manager will provide the teaching and provide updates on the progress to the BCBSRI care manager.
3. Help coordinating and attendance at an annual meeting with entire care team and member

# ICP Ongoing Management

***The Care Manager will be the primary point of contact for management, maintenance, documentation, and communication of the ICP***

| Care Manager | Change in Health Status | Health Navigator | Clinical System Documentation |
|---|---|---|---|
| • Maintains and makes ongoing updates in collaboration with the beneficiary and ICT<br>• Partners closely with the Health Navigator to address and resolve Social Determinants of Health (SDOH) barriers<br>• Reviews and updates the ICP at least every 90 days non-MVP beneficiaries and every 30 days for MVP beneficiaries | • ICP is updated based on a change in beneficiary health status.<br>• ICP updates will be made within ten days of a change in health status and completion of the reassessment.<br>• Transitions across the care continuum, such as an acute inpatient or skilled nursing facility admissions, will also prompt reassessment and ICP updates. | • Monitors beneficiary progress with goals, collaborates with beneficiary and ICT for goals not met<br>• Monitors data sources to identify any changes in health status as well as progress towards goals (e.g., beneficiary obtained recommended preventive health screening)<br>• Assists members with meeting any SDOH needs that have been identified | • ICP is documented and maintained in the clinical management system<br>• Internal BCBSRI ICT updates ICP with beneficiary specific information related to their role in supporting ICP<br>• Information is shared with ICT team members through the Clinical Care Management System and/or fax, mail, or secure email. |

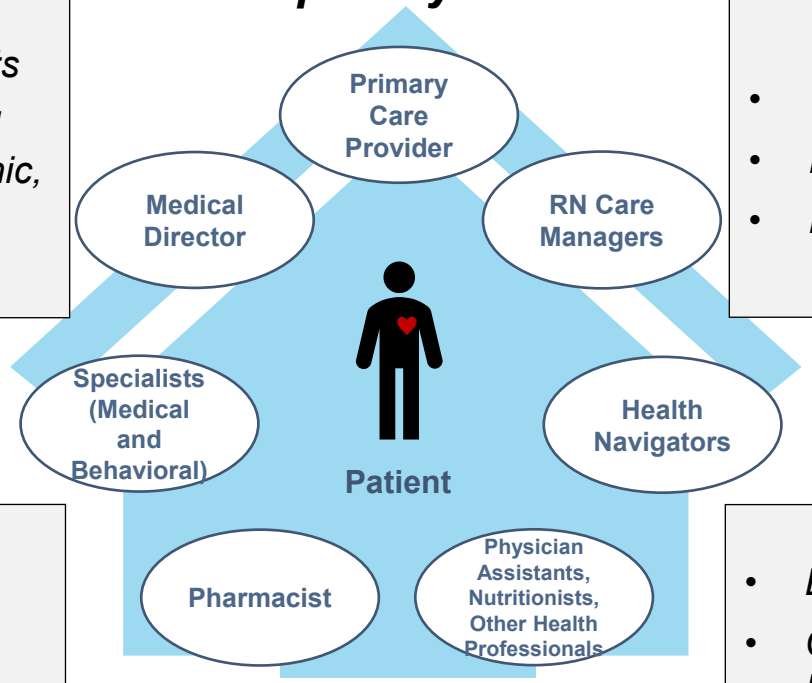
# Member Centric Clinical Model and Supporting Benefits

***The Interdisciplinary Care Team consists of clinical and non-clinical stakeholders collaborating to coordinate care and SDoH supports to help members achieve their health goals***

**Community Supports**

- *Local community and wellness events*
- *Community partnerships (e.g. United Way, Clinica Esperanza, RI Free Clinic, CAP agencies)*

***Interdisciplinary Care Team***




**Ancillary Care Coverage**

- *Vision coverage*
- *Dental coverage*
- *Hearing coverage*

**SDoH* / Lifestyle Support Benefits**

- *Transportation*
- *Food / meal*
- *Wellness reimbursement*
- *Fitness tracker*
- *OTC*

**Advocacy / Support**

- *BCBSRI Navigator*
- *Community partnerships (e.g. RIPIN, Progreso Latino)*
- *Medicaid application / redetermination*

# 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<br>• 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<br>• 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 and communications for the beneficiary, the provider as well as internal and external ICT members<br>• **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<br>• **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<br>• **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)<br>• **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<br>• **Health Navigator** participates as a member of the ICT to provide information about the beneficiary's barriers, community resources, and preferences<br>• **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<br>• 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.<br>• ICT is notified of beneficiary transitions of care, changes in health status and when updates are made to the ICP<br>• ICT is notified of updates from interactions between the Care Manager and the beneficiary, as well as between Care Manager and PCP and Specialists<br>• For beneficiaries who are deaf, hard of hearing, or speech impaired, TTY/TDD is used to facilitate communication |

# 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.

| Healthcare Settings | Communication / Notification Mechanisms | Planned Transitions |
|---|---|---|
| **Planned and unplanned care transitions may occur from various settings, to include:**<br>• Beneficiary home<br>• Home health care<br>• Acute care facilities (e.g., hospital)<br>• Nursing facilities<br>• Rehabilitation facilities<br>• Outpatient care centers<br>• Emergency departments | **BCBSRI may be notified of care transitions via the following:**<br>• Alerts from the state's health information exchange (HIE).<br>• UM authorizations or notifications<br>• File feeds from facilities<br>• SNP beneficiary, caregiver, or provider notification to the ICT via phone or email. | **Upon notification of a planned admission/transition, the Care Manager:**<br>• Coordinates beneficiary care needs with the ICT<br>• Conducts Pre-admission Counseling Assessment<br>• Determines ICT and any relevant resources needed to support beneficiary needs<br>• Shares information with the external ICT<br>• Contacts beneficiary and/or caregiver to plan for the stay<br>• Shares beneficiary healthcare preferences with the admitting provider and team.<br>• Continues to contact beneficiary at least once per week for one month following the transition |

# Transitions of Care (TOC) Processes

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**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

**Within 3 days of notification of the beneficiary's transition, 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

# Care Transition Personnel

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

## Nurse 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 once per week for one month.

## 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.

# Provider Role

***Provider partners are an invaluable part of the Interdisciplinary Care Team. BlueRI for Duals (HMO-DSNP) network providers are expected to fill the following roles.***

**Network Provider Roles and Responsibilities:**

- ❑ Communicate with DSNP Care Managers, ICT members, beneficiaries, and caregivers
- ❑ Collaborate with the DSNP care team on the ICP
- ❑ Review and respond to patient-specific communication
- ❑ Maintain required credentials for participation in the BlueRI for Duals (HMO-DSNP) network
- ❑ Adhere to select national standard Clinical Practice Guidelines (CPGs)
- ❑ Participate in the ICT
- ❑ Remind DSNP members of the importance of the HRA and assist with completion upon request
- ❑ Encourage DSNP members to work with their care management team
- ❑ Complete MOC training upon onboarding and again annually

# Quality Program Overview

## Quality Management (QM) Program

- Program and structure providing foundation for excellence, encompassing activities designed to improve processes and outcomes, address beneficiary needs, ensure delivery system adequacy, and monitor performance

## Quality Performance Improvement Plan (QPIP)

- An ongoing, comprehensive, enterprise-wide program which objectively and systematically monitors and evaluates the quality, safety, and appropriateness of medical and BH care and services offered to beneficiaries. **The QPIP identifies and acts on opportunities for continuous improvement for the SNP population**.

## Quality Improvement (QI) Work Plan

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

# 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:

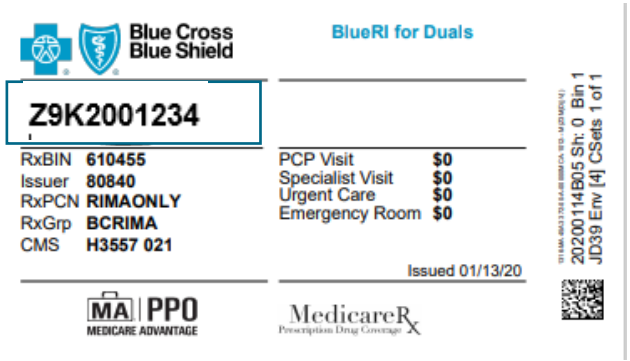
- All departments, units and organization-wide activities including clinical, service, provider, and beneficiary experience activities, including but not limited to:
  - ❑ HEDIS
  - ❑ Behavioral Health Care
  - ❑ Quality of Care.
- Staff member and performance goal accountability for each activity, as 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.

# DSNP Prefix/Card Info

**The DSNP product has a special prefix for only this product: Z9K**

**The member ID cards will also state BlueRI for Duals in the top right hand corner.**



# Contact Us

**For Questions:**

**D-SNP Mailbox**: DSNP.Questions@BCBSRI.org

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

**If you have a patient who you think would qualify for D-SNP please use the following resources:**

**D-SNP Sales Line**: (401) 459-5477

**Webform for Referrals**: www.bcbsri.com/medicare/duals

Click on “Want some help?”