Lesson Objectives

The purpose of this lesson is to provide an overview of the Dual Needs Population (DSNP) in relation to CMS Model of Care (MOC) requirements.

After completing this lesson, you should be able to:

- Describe the overall goal of the Dual Needs Population
- Identify the SNP Model of Care Requirements
- Recognize your role and responsibilities for SNP Model of Care
Dual Special Needs Plan

Dual Special Needs Plan (DSNP) is a service available to qualified seniors and individuals with disabilities.

Those individuals must also qualify for both Medicare and Medicaid benefits.
BCBSNM Dual Special Needs Population Model of Care

DSNP Coverage Options

DSNP Program members must first be eligible for New Mexico Centennial Care (NMCC) and be in the BCBSNM Centennial Care Program-Full Medicaid. Then they must be Medicare members, live in the 4 counties and elect to join BCBS MAPD DSNP.

BCBS Centennial (Medicaid) (NMCC) with Full Medicaid first

BCBSNM MAPD (Medicare)

If members have another Centennial Care MCO or Medicare offering, they are not eligible for the BCBS MAPD DSNP Program.

Meet Medicare requirements and live in our 4 Counties

Elect to join BCBS MAPD DSNP
Benefits to the Member for choosing DSNP

- Coordination of care between Medicare and Medicaid covered benefits
- One case manager to ensure all benefits are obtained
- Seamless transitions across various health care settings
- Individualized care plans and care teams to meet the member's specific needs.
What is DSNP Enrollment Process?
Members must be enrolled in BCBS Centennial Care with full Medicaid benefits.

Sales Office:
- Identifies possible DSNP candidates
- Contacts member, if eligible, Sales enrolls member
- BCBS Sales has contracted Senior Med Consulting
- Members may enroll on their own through CMS
- Current Membership –
What is the Model of Care?

For these dual members CMS requires additional case management and quality management programs to protect vulnerable populations.

The Model of Care requirements support the following:

- Improving access to essential services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions across healthcare settings
- Monitoring health status and improving access to preventative health services
- Assuring appropriate utilization of services
- Managing chronic disease and improving health outcomes
Do what’s right for the member by...

Meeting the requirements of Model of Care
BCBS performs a **Health Risk Assessment (HRA)** or **Comprehensive Needs Assessment (CNA)** within 90 days after MAPD DSNP enrollment and every year thereafter.

Within 14 days of the HRA completion – Care Managers develop an **Individual Care Plan (ICP)** with input from the member and key member supports.

Care Managers convene **Interdisciplinary Care Team (ICT)** meetings—including the PCP, the member and other key member supports.

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**Model of Care Requirements**

Care Coordinator – Primary Facilitator
Model of Care

Requirements (cont.)

- Update and review the care plan at least annually (3-5 goals) and with any change in status

Member Health

Monitor health status, manage chronic diseases and avoid hospitalizations

Member Care

Improve care through improved care coordination, and care team meetings (i.e., assist with needed DME, med refills, HHA or HCBS care)
DSNP HRA/CNA Requirements

**Must be completed within +/- 90 days of enrollment into MAPD D-SNP**

If completed while in NMCC 90 days before enrollment into the D-SNP Plan, no additional HRA/CNA is needed.

**Includes a comprehensive initial assessment of the member needs including the medical, psychological, cognitive, functional and mental health needs**

**HRA must be completed upon enrollment and annually within one year of the initial assessment or the previous HRA**

Three attempts to reach the member will be made after which, an Unable to Reach (UTR) Letter is sent. The UTR Letter includes the Care Coordinator team contact. If the Member or LAR refuses, this is documented in the member record.

HRA/CNA Assessment
MAPD DSNP HRA/CNA and Individual Care Plan Requirements

**Conduct HRA**: 90 calendar days from Enrollment in DSNP

**ICP Update**: Must update NMCC ICP, or complete new ICP if one not developed already, after DSNP HRA completed

**ICP Update**: After a change in members’ status or condition within 30 days

**ICP Update**: Updated after annual DSNP HRA completed

**HRA annually**: Must complete 365 days from last assessment
To have preventive and annual exams performed within 6 months from enrollment:

- results from the exam contribute to the ICP
- the PCP monitors and schedules age and gender appropriate screenings
- the PCP monitors all chronic conditions and schedules any appropriate tests and/or screenings, referrals and medications
Key Concept 1
Goal is to complete the ICP within 14 days after completion of the HRA

Key Concept 2
ICP must have specific interventions designed to meet all the needs identified in the HRA

Key Concept 3
ICP has least 3-5 long and short term problem goals and must include measurable outcomes

Key Concept 4
Must have barriers to care, educational, social/community support and cultural/language preference needs addressed

Key Concept 5
Must have input from the member and the member’s providers, including the PCP

PCP and member or LAR, must have a copy of the ICP signed by the member. PCP to add to member’s record

The ICP must be updated with any change in status or condition, such as unexpected hospitalization or ER visit, within 30 days of the adverse event.
Additional Clarifications

- If member refuses care coordination, it’s documented in the medical record.
- If member refuses, member is kept at Level 1 and an ICP is created.
- Short-term and long-term goals are developed (based on 3-5 problem goals).
- Only individuals nominated by the member (consented) are included for input into and distribution of the ICP.
- ICP is issued to the ICT, member and providers via mail, fax or secure email.
Interdisciplinary Care team - ICT

- Each member will have an **ICT meeting at least annually** and when there is a change in condition, as required.
- Internal monthly Integrated Team Rounds also occur with BH and Medical for care coordination as indicated per member plan of care.
Care Coordinator/Care Manager coordinates the ICT and will conduct a meeting at least annually or on any change of condition.

Care Manager meets with the member, caregivers, PCP and other member supports.

Additional Members of the Interdisciplinary Care Team (for example):
- Behavioral Health
- Waiver Case Managers
- Home Care Nurses
- Community Support Groups
- DME or Therapists
- Physician Specialists
- Hospital and SNF Physicians
1. HRAs Completed Timely
   - HRAs completed within +/-90 days effective enrollment
   - HRAs completed within 365 days of previous HRA

Also documented: HRAs NOT completed due to:
   - Unable to Reach or,
   - Refuse to participate
2. Member grievances by category, including quality of care/quality of service (access and availability)

3. DSNP-PCPs servicing this population who complete the MOC training (Target goal= 95% of members’ PCPs/office staff)
4. Members ranking satisfaction as high or very high with their providers, their Care Coordinators, their health care quality and their Health Plan (Via Modified CAHPS survey)
5. Hospitalizations/1000 members per year

Goal: Reduce the 2015 baseline of 13% by at least 15%
BCBSNM Dual Special Needs Population Model of Care- Health Outcomes

Process Outcomes Measured

6. Members with F/U after BH Hospitalization (within 30 days)

7. 30-Day All Cause Readmission
8. Medication Reconciliation Post-Discharge

- Documentation in the medical record **within 30 days of discharge** that medications prescribed or ordered upon discharge were **reconciled** with current medications

OR

- Notation that no medications were prescribed or ordered upon discharge.
Health Outcomes Measured

9. Members with medication adherence for oral diabetic medications, anti-hypertensive meds (ACE/ARBs), and Statins
10. Diabetic members who had evidence of blood sugar controlled (HbA1c ≤ 9)
Health Outcomes Measured

11. Flu Vaccine
   • Percent of members who report receiving the flu vaccine annually. Data collected by the Modified CAHPS survey.
Process Outcomes Measured

12. Members 66+ with documented evidence of being evaluated by their PCP on elements of Care of Older Adults (in the medical record) and completed Advance Directives discussion

- Functional Assessment
- Pain Assessment
- Medication Review
- Advance Directives
# DSNP MOC Requirements Summary

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time line</th>
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<tbody>
<tr>
<td>Conduct HRA or CNA–in Aerial</td>
<td>90 calendar days following Enrollment in DSNP</td>
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<tr>
<td>HRA annually</td>
<td>Must complete within 365 of the initial HRA the following calendar year</td>
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<tr>
<td>Complete ICP (or update)</td>
<td>14 calendar days from HRA completion</td>
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<tr>
<td>ICP Update</td>
<td>At each contact with the member for ongoing care coordination and within 30 days of all changes in condition</td>
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<tr>
<td>ICT meetings</td>
<td>ICT team meetings are to be held for each member annually and as needed, and are to include minimally, the PCP</td>
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<tr>
<td>Comprehensive BH assessment</td>
<td><strong>If HRA indicates</strong>, comprehensive BH assessment completed within 90 days of HRA</td>
</tr>
<tr>
<td>Integrated Team rounds PH–BH</td>
<td><strong>Co–Management with BH as needed</strong> and documented</td>
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<tr>
<td>Transition of Care –(CCEI) engagement</td>
<td>Inform Care Management and perform TOC prior to discharge from facility and post discharge visits (within 24–48 hrs)</td>
</tr>
<tr>
<td>Complex member Active Monitoring and Support –</td>
<td>Level 3 members –high risk will complete <strong>monthly assessments</strong> and ICP updates</td>
</tr>
<tr>
<td>Staff Education/Training Care Coordination/UM</td>
<td><strong>New Hire Training and annually</strong> Annual MOC testing–CBT IRR testing UM and CC annually</td>
</tr>
<tr>
<td>Education/Training Providers</td>
<td>Provider Manual–Online <strong>Annual</strong> training In–person and/or web–based (via BrainShark) with thirty days to complete.</td>
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<tr>
<td>Measure</td>
<td>Target</td>
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<tr>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>% of HRAs Completed within +/-90 days of enrollment (Initial HRA)</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>% of HRAs Completed within 365 days of the Initial Assessment (Annual HRA)</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>% of members with Individual Care Plans (ICP) signed by the member</td>
<td>≥80%</td>
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<tr>
<td>Member Complaints: Grievances and Quality of Care Issues</td>
<td>3 grievances/1000 members/yr (.003%)</td>
</tr>
<tr>
<td>% of D-SNP PCPs who service this population who completed the MOC training</td>
<td>90% of PCPs/Office Staff</td>
</tr>
<tr>
<td>CAHPS Survey to all DSNP members: provider satisfaction, Care Coordinator satisfaction, health care quality and health Plan satisfaction (Members&gt;600)**</td>
<td>85% overall sat on target questions</td>
</tr>
<tr>
<td>Number of Staff trained annually on DSNP</td>
<td>100% who work with members</td>
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<tr>
<td>Measure</td>
<td>Target (Overall and Improvement Goal)</td>
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<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Hospitalizations/1000 members per year (membership is only 380 as of 12.31.17)</td>
<td>↓ Baseline rate by at least 5% (2015 Baseline: 13%)</td>
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<tr>
<td>% of members who had a F/U after MH hospitalization within 30 days</td>
<td>Overall Goal: 70% Improvement Goal: ↑ Baseline by at least 10% (2015 Baseline: 25%)</td>
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<tr>
<td>30-day all cause readmissions</td>
<td>Overall Goal: &lt;15% Improvement Goal: ↓ Baseline by at least 10% (2015 Baseline: 17%)</td>
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<tr>
<td>% of members with medication reconciliation post-discharge</td>
<td>Overall Goal: TBD after Baseline Improvement Goal ↑ Baseline rate by at least 5% (2017 Baseline: 6%)</td>
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<tr>
<td>% members with medication adherence to oral diabetes medications</td>
<td>Overall Goal: 90% Improvement Goal: ↑ Baseline by at least 5% (2015 Baseline: 67%)</td>
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<tr>
<td>% members with medication adherence for antihypertensive medications (ACE/ARBs)</td>
<td>Overall Goal: 90% Improvement Goal: ↑ Baseline by at least 5% (2015 Baseline: 68%)</td>
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<tr>
<td>% members with medication adherence for statins</td>
<td>Overall Goal: 90% Improvement Goal: ↑ Baseline by at least 5% (2015 Baseline: 74%)</td>
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<tr>
<td>Measure</td>
<td>Target (Overall and Improvement Goal)</td>
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<tr>
<td>% of members with diabetes who had evidence of blood sugar controlled (HbA1c less than or equal to 9)</td>
<td>Overall Goal: 78% Improvement Goal: ↑ Baseline by at least 5% (2015 Baseline: 20%)</td>
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<tr>
<td>% members with flu vaccine</td>
<td>Overall Goal: 80%* Improvement Goal: ↑ Baseline by at least 10% (2015 Baseline: 17%)</td>
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<tr>
<td>% of members age 66+ who have documented evidence of being assessed and educated by their PCP on aspects of Care of the Older Adult (COA) and completed Advance Directives: discussion or Plan</td>
<td>Overall Goals listed below by element; Improvement Goal: ↑ Baseline by at least 10%</td>
</tr>
<tr>
<td>Medication Review</td>
<td>81% for Medication Review (2015 Baseline 85%)</td>
</tr>
<tr>
<td>Functional Assessment</td>
<td>72% for Functional Assessment (2015 Baseline: 80%)</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>84% for Pain Assessment (2015 Baseline: 84%)</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>75% for Advance Directives (2015 Baseline: 14.5%)</td>
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BCBS NM DSNP Card
Helpful websites:

- DSNP Overview
  http://www.bcbsnm.com/medicare/snp.html

- Provider directory
  https://www.bcbsnm.com/pdf/directories/cc_provider_directory_nm.pdf

- Eric Coleman Transition Model
  http://www.caretransitions.org

- Summary of Benefits
DSNP Program Contact Information

- Contact Customer Service for all ER admission notifications or Prior Authorization requests:
  - TTY/TDD: 711
  - Fax Number: 1–855–874–4711

- Care Coordination: 877–232–5518

Regarding any questions on coordination of care for the member, the Interdisciplinary Team Meeting or the Care Plan