BlueCross BlueShield of New Mexico

Dual-Eligible Special Needs Plans (D-SNP) Model of Care

Training for Providers

Version ed. 2022.10.26

Background

The Model of Care (MOC) is considered a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed.

In 2010, the Patient Protection and Affordable Care Act (ACA) reinforced the importance of the MOC as a fundamental component of SNP quality improvement by requiring the National Committee for Quality Assurance (NCQA) to review and ensure the MOC meets requirements set by The Centers for Medicare & Medicaid Services (CMS).

CMS requires all contracted and out-of-network providers seen by members on a routine basis to receive training on the SNP MOC. This training is required for new providers initially and annually thereafter.

SOURCES: SNPMOC.NCQA.ORG, CMS.GOV, CHAPTER 42 OF THE CODE OF FEDERAL REGULATIONS, PART 422 (42 CFR 422.101 (F)(2)(II))

Course Objectives

- Explain Dual Eligible Special Needs Plans (D-SNPs)
- Describe the goals of the Model of Care and its benefits
- Recognize the care coordination model and components
- Understand a provider's role
- Learn about the MOC Quality Measurement and Performance Improvement goals
- Find resources available to you and our D-SNP members

SNP Overview

- A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals.
- A special needs individual could be any one of the following:
  - An institutionalized individual,
  - An individual with a severe or disabling chronic condition, as specified by CMS, or
  - A dual eligible.
- Therefore, there are three different types of SNPs:

Institutional SNP (I-SNP)	Chronic Condition SNP (C-SNP)	Dual Eligible SNP (D-SNP)
•Membership limited to those who live in certain institutions such as nursing homes or long-term facility	•Membership limited to those with specific chronic conditions such as HIV/AIDs, diabetes, heart failure	•Membership limited to those who are eligible for both Medicare and Medicaid.

D-SNP Overview

- Of the three types of SNPs, BlueCross BlueShield of New Mexico has a D-SNP.
  - **Dual-Eligible**: A program for those who qualify for both Medicare and Medicaid.
  - **Special Needs**: An integrated care model to improve the health of our most vulnerable members.
  - **Plan**: An insurance vehicle to insure coordination of benefits in a non-duplicative, synergistic manner.

Common Conditions Affecting D-SNP Members

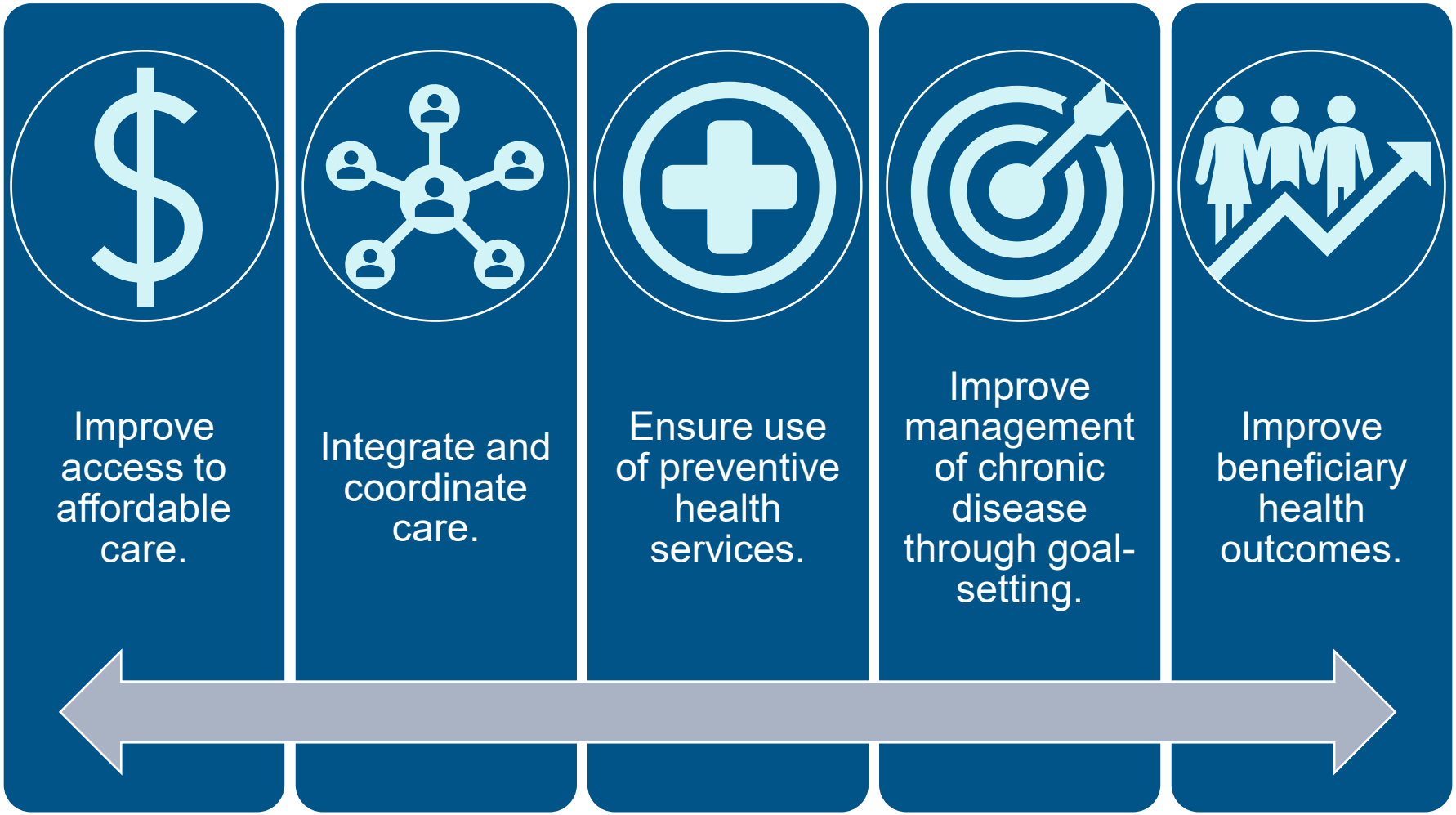
Medical Conditions	Behavioral Health	Social Determinants
Hypertension	Alzheimer's Disease/Dementia	Poverty
Hyperlipidemia	Depression	Housing insecurity
Arthritis	Schizophrenia	Availability of transportation
Diabetes	Bipolar Disorder	Social/family concerns
Heart Disease & Heart Failure	Alcohol Use Disorder	Education
Chronic Kidney Disease	Substance Use Disorder	Language barriers

SNP MOC Elements

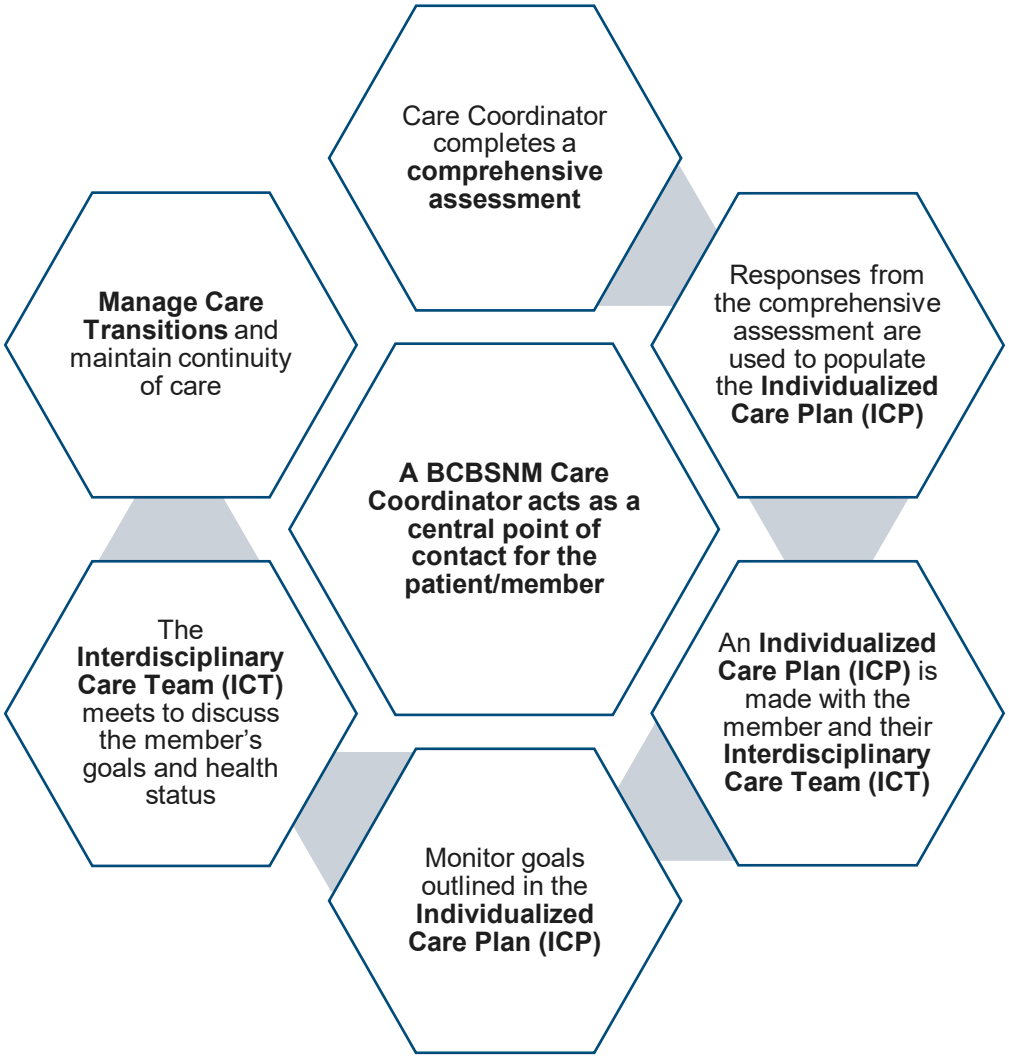
The MOC requirements comprise the following clinical and non-clinical standards:

Description of the SNP Population	• Description of Overall SNP Population • Subpopulations – Most Vulnerable Beneficiaries
Care Coordination	• SNP Staff Structure • Health Risk Assessment (HRA) Tool • Individualized Care Plan (ICP) • Interdisciplinary Care Team (ICT) • Care Transitions Protocols
SNP Provider Network	• Specialized Expertise • Use of Clinical Practice Guidelines and Care Transition Protocols • MOC Training for the Provider Network
MOC Quality Measurement & Performance Improvement	• MOC Quality Performance Improvement Plan • Measurable Goals and Health Outcomes for the MOC • Measuring Patient Experience of Care • Ongoing Performance Improvement Evaluation of the MOC • Disseminate of SNP Quality Performance Related to the MOC

MOC Goals


Improve access to affordable care.
Integrate and coordinate care.
Ensure use of preventive health services.
Improve management of chronic disease through goal-setting.
Improve beneficiary health outcomes.

Care Management Model



Care Coordinators

- A Care Coordinator acts as a **central point of contact** for a member.
- Care Coordinators help ensure that our D-SNP beneficiaries' health care needs, preferences for health services, and information sharing across health care staff and facilities are met over time.
- Care coordination maximizes the use of effective, efficient, safe, high-quality patient services that ultimately lead to the goal of improved health outcomes.

Comprehensive Assessments:

Health Risk Assessment (HRA)

Comprehensive Needs Assessment (CNA)

- Care Coordinators conduct comprehensive assessments initially upon enrollment.
  - These assessments are then conducted annually and/or after change in health status or transitions in care.
- These assessments look at the member's:
  - Medical,
  - Functional,
  - Cognitive,
  - Psychosocial, and
  - Mental Health Needs
- Responses from the assessment are used to populate the ICP.

Individualized Care Plan (ICP)

- An ICP is developed and includes information such as:
  - Goals and objectives
  - Outcome measures
  - Barriers to care and/or meeting goals
  - Educational needs
  - Social/community support needs
  - Preferences for care
  - Cultural and language preferences
  - Services for vulnerable members or those near end-of-life
- Monitoring activities are performed by the Care Coordinator to ensure the member's ICP goals are being achieved.
- Progress towards the goals in the ICP is shared with the provider and discussed at the ICT.

Individualized Care Plan (ICP)

- The ICP is shared with the member's provider in order to keep the provider up to date on the member's progress.
- Providers should review the ICP and provide the Care Coordinator with any necessary updates.
  - For example: If the member's goal is to control their high blood pressure, then blood pressure readings and recent lab results should be included in the ICP.

Interdisciplinary Care Team (ICT)

- The composition of the ICT is defined by the needs of the member as identified in assessments, and as requested by the member and/or their family, provider and clinical teams.
- The ICT meets to discuss the member's goals and health status.
- The ICT works in a proactive manner designed to prevent adverse outcomes and avoidable episodes of care, and act as a support team for the member.
- ICT meets on an annual basis or upon significant changes to the member's health status.
  - Outcomes from these meetings are documented in the member's records.

Care Transitions

Care Coordinators manage Transitions of Care (TOC) for members in order to facilitate continuity of care and promote member safety. During Care Transitions, members can be provided with:

- Discharge care coordination, episodic case management and pre-admission/post-discharge counseling
- Education and guidance to mitigate condition risks and support for behavior change
- Personalized outreach and engagement based upon attitudes, behaviors, and assessments
- Reinforcement of provider instructions for care, diet, and activity
- Assistance in finding a provider and helping schedule appointments

Our Provider Network

- Our provider partners respond to our members needs by:

Communicating with care coordination and others in the member's care team	Attending ICT meetings	Supporting care transitions for our members	Assisting with development and updates to the ICP
Reviewing and responding to patient-specific information	Completing physical exams	Involving family members and caregivers in health-care decisions, as the member chooses	Encouraging medication adherence
	Promoting quality improvement	Understanding the MOC for our members by completing this training	

MOC Quality Measurement and Performance Improvement

- The goal of performance improvement and quality measurement is to deliver high-quality health care services and benefits to our members.
- The BCBSNM QI Program is committed to:
  - Measuring, monitoring, and continually improving performance of physical and behavioral health care in key aspects of clinical and service quality for members and providers;
  - Continually measuring and monitoring plan performance to define and act on opportunities for improvement of the QI program; and
  - Focusing Continuous Quality Improvement (CQI) efforts on those priority areas defined in the annual QI Work Plan for improving member experience, member satisfaction, and member health and wellness.
- BCBSNM is monitoring multiple process measures and health outcomes measures as part of the MOC for our members.

Process and Health Outcomes Measures

Measure	Description
Initial Health Risk Assessments (HRAs)	• Initial HRAs completed within 90 days of enrollment
Annual Health Risk Assessments (HRAs)	• Follow up HRAs completed within 365 days of previous HRA
Annual Interdisciplinary Care Team meeting (ICT)	• The ICT meets at least annually to address the unique member needs.
Annual Individualized Care Plan (ICP)	• An ICP is completed/updated every year. It includes a description of services and goals tailored to the member's needs.
Annual Primary Care Providers D-SNP Model of Care (MOC) Training	• Providers servicing the D-SNP population who complete the MOC training annually
Member Experience and Satisfaction Survey	• The data source is the CAHPS® or Modified CAHPS® Survey

Process and Health Outcomes Measures (cont.)

Please note - depending on which plan your members belong to you may be responsible for one or more items below

Measure	Description	What providers can do
Acute hospital admits	Rate of acute hospital admits.	• Follow up with patients to confirm that they are following their plan of care • Open communication with ICT
Readmissions within 30 days	Ratio of all-cause readmission within 30 days (observed vs expected)	• Early and comprehensive discharge planning • Active outreach after discharge • Follow-up visit after discharge
Transition of Care – Member Engagement	Members who had a provider visit within 30 days of an inpatient discharge.	• Early and comprehensive discharge planning • Active outreach after discharge • Follow-up visit after discharge
Transition of Care: Medication reconciliation post-discharge	Members who had a medication reconciliation on the date of inpatient discharge through 30 days after the inpatient discharge.	• Document in the patient's medical record even if no medications were prescribed or ordered upon discharge • Use CPT II Code (see slide 21)
Follow up after a Mental Health Hospitalization	Members who had a follow-up visit with a mental health provider within 30 days of a mental health hospital discharge.	• Early and comprehensive discharge planning • Active outreach after discharge • Follow-up visit after discharge with a mental health provider

Process and Health Outcomes Measures (cont.)

Please note - depending on which plan your members belong to you may be responsible for one or more items below

Measure	Description	What providers can do
Medication adherence for non-insulin diabetes medications, anti-hypertensive medications (ACEs/ARBs), and statins	Improving prescribed medication adherence.	• Encourage adherence and provide education on medications • Order 90-day refill on prescriptions and discuss home delivery
Antidepressant Medication Management	Improving prescribed medication adherence	• Encourage adherence and provide education on medications
Controlling Blood Pressure	Members 18-85 years old with a diagnosis of hypertension whose documented BP was adequately controlled < 140/90	• Educate on risks of elevated BP. • Document BPs taken at home from a digital blood pressure device • Take a second BP reading at the end of the visit if the first reading is elevated • Use CPT II Codes (see slide 21)
Flu Vaccination	Members who report receiving the flu vaccine annually. Data source is the annual CAHPS® or modified CAHPS® survey.	• Encourage patients to get a flu vaccination • Educate on the importance of an annual flu vaccination
Care for Older Adult	Members age 66 or older who had each of the following: • Functional assessment • Pain assessment • Medication review	• Document all components in the medical record • Documentation of a medication review should include a medication list in the medical record • Use CPT II codes (see slide 21)

Helpful CPT II Codes

Controlling Blood Pressure: Hypertension diagnosis	Reading	CPT II Code
Systolic	<130	3074F
	130-139	3075F
	≥140	3077F
Diastolic	<80	3078F
	80-89	3079F
	≥90	3080F

Care for Older Adults:	Annual assessments	CPT II Code
Functional assessment		1170F
Medication review Medication list in record		1160F 1159F
Pain assessment - Pain		1125F
Pain assessment - No Pain		1126F

Transition of Care	Assessment	CPT II Code
Medication reconciliation post-discharge		1111F

Summary

- The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in our D-SNP are identified and addressed.

- We can improve health outcomes for our members by:
  - Aligning on coordination of care
  - Collaborating on plans of care
  - Ensuring lines of communication are open
  - Participating in the ICT and care transitions
  - Improving quality measure performance

Contact Us

- Websites
  - For members: www.getbluenm.com/dsnp
  - For providers: www.bcbsnm.com/provider
- Phone Numbers:
  - For members:
    - 1-877-688-1813 (TTY 711)
    - We're open 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you're calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
  - For providers:
    - Refer to the options available at www.bcbsnm.com/provider/contact-us

Thank you for participating in our D-SNP MOC Training