BCBSRI 2023 DSNP TRAINING

CMS Required Annual Provider Training

Blue Cross Blue Shield of Rhode Island

BlueRI for Duals

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

Current Membership

As of October 1, 2022, BlueRI for Duals supports 1,375 dual members.

With over 2,500 additional BCBSRI members who are currently D-SNP eligible.

Achieving Our Vision

Building relationships with providers, office staff, community business organizations to best support this unique population. Direct insight in workstreams, direct contacts has resulted in tighter collaboration which results in a higher standard of patient care.

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**

Provider + Community Partner **Engagement**

Advocacy and policy efforts aimed at affordability

Learning Objectives

1. **Reference eligibility criteria** and **basic characteristics** of the DSNP population

2. **Define components of the BCBSRI DSNP Model of Care** including
   - Role and responsibilities of D-SNP network providers
   - Primary goals of the MOC
   - Roles of and members within the interdisciplinary care team (ICT)
   - Services within, i.e., transition of care, pharmacy, unique benefit support

3. **Access and apply 2023 BlueRI for Duals benefits to your daily practice**

Note: MOC training is a CMS 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 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 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:

BlueRI for Duals

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

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)

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 (92% of current membership)	**Partial Dual-Eligible** (8% of current membership)
Qualify to receive all 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 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 meets 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

Model of Care (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.

Overview: BlueRI 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

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.

Each Member has an Individualized Care Team

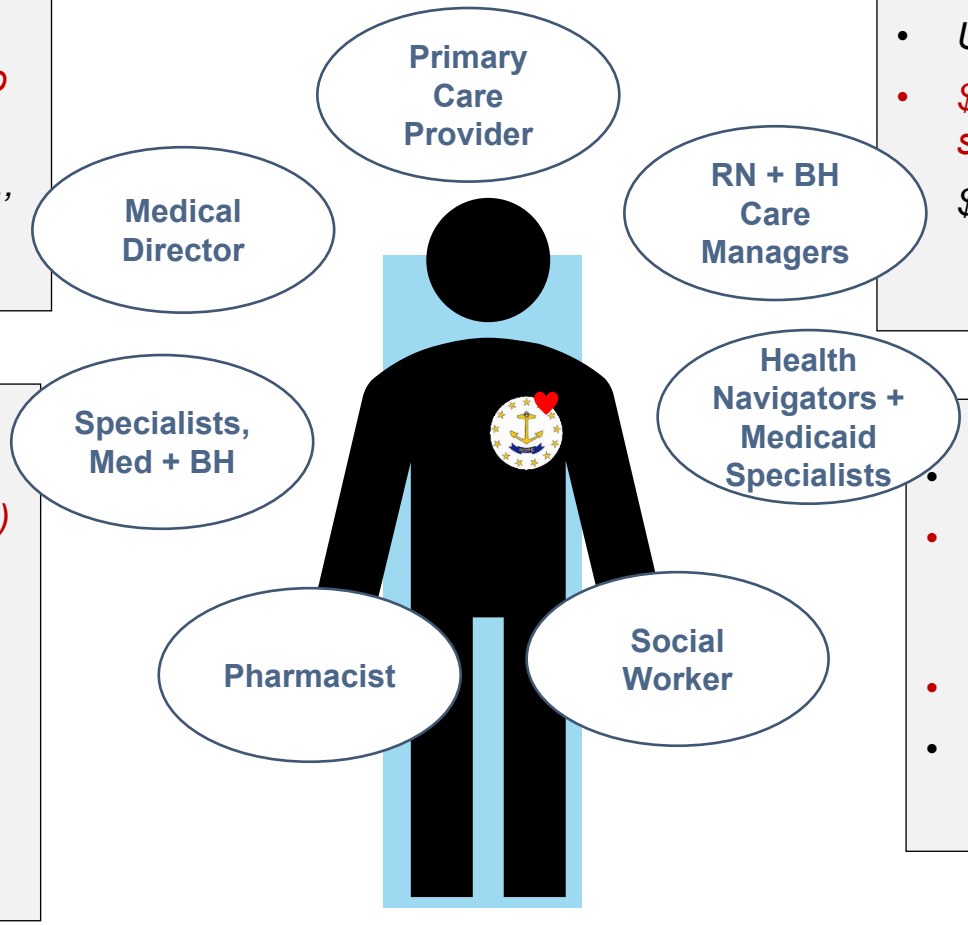
Clinical and non-clinical stakeholders collaborating to coordinate care and SDoH supports, helping members achieve their health goals.

Community Supports

- *Your Blue Store fitness and educational classes*
- *Mobile Your Blue Bus, bringing service to you!*
- *Community Business Organizations (e.g., United Way, Clinica Esperanza, RI Free Clinic, CAP agencies)*

SDoH* / Lifestyle Support Benefits

- *72 one-way rides*
- *Flexible Benefit Card (groceries**+ OTC**)*
- *$200 Wellness reimbursement*
- *$100 Caregiver reimbursement*
- *120 hr. / Papa Pals per year*
- *PERS, personal emergency response system*
- *14 Post IP and SNF discharge meals, wk. following discharge*



Interdisciplinary Care Team, ICT

Ancillary Care Coverage

- *Dental coverage: $3,000 annual benefit max + dentures, implants, crowns and so much more!*
- *Up to 2 hearing aids for $0 + batteries*
- *$1,500 / yr. for dental, vision and hearing services above included benefits!*
- *$300/yr for glasses*
- $0 Part D Drugs**

Advocacy / Support

- *BCBSRI Health Navigator*
- *BCBSRI Medicaid Specialists (e.g., Medicaid application / redetermination, Long Term Services and Supports)*
- *Non-skilled Home Care Providers*
- *Community Partnerships (i.e., RIPIN, Progreso Latino)*

IT'S WHAT WE LIVE FOR

*Social Determinants of Health **For duals members with LIS

Blue Cross Blue Shield of Rhode Island

MOC 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

Frequency of Care Plan Updates

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>

Minimum outreach requirements remain; quarterly outreaches are required for all, except MVPs which are monthly

BlueRI for Duals Differentiators

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

Additional Benefits

All Medicare and Medicaid benefits **PLUS:**

- $0 Part D Prescription Drugs*
- Flex Card
  - ✓ $150/mth for groceries* & OTC, including FREE delivery
  - ✓ $300/yr vision hardware
  - ✓ $1,500/yr vision, hearing, dental services

- Clinical Programs for Medicare Advantage members, including Duals. Participants must meet clinical criteria:
  - ➢ HouseCall by Blue
  - ➢ Remote Patient Monitoring
  - ➢ HealthPath and HealthPath Connect, *bundled BH services provided via Butler*

Integrated Care Team and Medicaid Benefit Coordination

As the primary insurer, BCBSRI provides:

- Personal Health Navigator for each dual member
- Either BH or RN Care Manager as lead CM
- Coordination of Medicaid services, i.e., Home care
  - Adult day care
  - Durable medical equipment, etc.
  - Letter of non-coverage from primary
- Collaboration with community partners to impact social determinants of health

Medicaid Enrollment / Eligibility Support

- Expanded Team, including bilingual English/Spanish staff
- Alleviates burden of application to critical services
  - ✓ Medicaid application for active members
  - ✓ Proactive Annual Medicaid recertification
  - ✓ Long term services and supports (LTSS) eligibility and application
- 90-day grace period to allow for assistance in regaining eligibility

Impact of Losing LIS v. Losing Medicaid

If a member of BlueRI for Duals loses Medicaid they may remain on the plan for up to 90 days.

Loss of Medicaid

- 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 $95 for an ER visit, $60 for urgent care
- Will have no coverage for Medicaid-only services such as adult day health, homecare through Medicaid, dental through Medicaid

Loss of LIS

- Will have copays on Tiers 3 through 5 medications
- ★ May have a Part D premium of up to $36.30 per month
- ★ Will have a pharmacy deductible of up to $505 for Tiers 3, 4, and 5
- Will not be able to use their Flexible Spending card for food/groceries (but will still be able to for OTC)

BCBSRI Medicaid Specialists help members reapply for LIS and Medicaid

New ID Cards and 20% Coinsurance

As of January 1, 2023

Effective January 1, 2023, all existing and new Blue RI for Duals (D-SNP) members will be receiving new ID cards. The new ID cards will no longer display the copays or coinsurance. This year D-SNP members will have a 20% coinsurance on some services such as PCP visits (excluding annual physical), dental, and X-rays. Any D-SNP copay or coinsurance should be picked up in full by Medicaid. If you are not an approved Medicaid provider and are unable to submit your claim from BCBSRI to Medicaid, you will not be allowed to bill the member for the copay/coinsurance.

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

Reminders will be shared in the November, December and January Provider Updates.

What's in it for me?

PATIENT Experience

- Patient preference honored: phone, in-person, timing
- DSNP Clinical Care Composition
  - Patient / Caregiver
  - Clinical and Quality Teams
  - Health Navigators
  - Community Partners
  - Medicaid Specialists
  - Scheduling, coordination
  - LOCAL Customer Services
- 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

Two Years in a Row!
Rated 5-Stars
BY MEDICARE FOR 2022 & 2023

Only MA plan in the market with CMS' 5 Star designation for two years in a row, allows for enrollment year-round into the top quality and customer service plan in RI

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

Contact Us

BlueRI for Duals QUESTIONS:

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

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

Patient Referrals to the BlueRI for Duals plan:

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

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

Click on "Want some help?"

Website: BlueRI for Duals - 2023 | Blue Cross & Blue Shield of Rhode Island (bcbsri.com)

Appendix

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

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	Communication / Notification Mechanisms	Planned Transitions
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	**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.	**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.