Dual-Eligible Special Needs Plans (DSNP) Model of Care

TRAINING FOR PROVIDERS
NEW MEXICO 2020
Overview and Objectives

Define the characteristics of the DSNP population and its special needs

Identify the benefits and requirements of the DSNP Model of Care

Recognize each team member’s role and responsibilities in serving DSNP members
DSNP is…

- **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
DSNP is also…

- A model of care that requires actions from the members, the care coordinator, and the provider and medical team
- A system of accountability that measures healthcare quality and proposes interventions to improve those services
The DSNP Model of Care is…

- The *written plan* for delivering this integrated care management program to members with special needs
- The CMS-approved document outlining requirements, including case management and quality management
- Written to protect members with more complex, special needs
- Designed to foster communication among enrollees, caregivers, BCBSNM care managers, providers/PCPs and their teams
DSNP overview

A BCBSNM care coordinator acts as a central point of contact for the patient/member.

Care coordinator completes holistic health risk assessment and repeats annually (HRA).

Quality outcomes data are collected and shared with the team (QI).

A complete physical exam is performed at least annually by the PCP (PE).

The interdisciplinary care team meets at least annually to discuss the member’s progress (ICT).

The whole team and the member’s PCPs are trained on the Model of Care annually (MOC).

An individualized care plan is made with the team and member at least annually (ICP).
Member Characteristics

• Members must be enrolled in Medicaid AND be dually eligible to receive Medicare benefits. If eligible for both, they can enroll in BCBSNM SNP.

• Qualifying members usually have significant medical or behavioral health conditions, disabilities and/or impairments. There is a high prevalence of chronic and/or cognitive conditions. This population qualifies for Medicare benefits based on these.

• DSNP members often have unmet financial and/or social determinants of health in addition to their significant medical needs. Members are culturally and linguistically diverse, and many are older adults.

• Many DSNP members have significant utilization of Long Term Supports and Services (LTSS), such as Home and Community Based Services (HCBS).
Member characteristics: Counties served

Bernalillo
Dona Ana
Sandoval
Santa Fe
Torrance
Valencia

Many have significant rural tracts within them
### Member characteristics:
Common conditions affecting DSNP members

<table>
<thead>
<tr>
<th>Medical Conditions</th>
<th>Behavioral Health</th>
<th>Social Determinants</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD/asthma</td>
<td>Depression</td>
<td>Poverty</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Dementia/Alzheimer’s</td>
<td>Housing insecurity</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Developmental</td>
<td>Living in facilities</td>
</tr>
<tr>
<td>Heart disease/failure</td>
<td>PTSD</td>
<td>Transportation issues</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>Traumatic brain injury</td>
<td>Social/family concerns</td>
</tr>
<tr>
<td>Stroke</td>
<td>Bipolar disorder</td>
<td>Education deficits</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Substance abuse</td>
<td>Language barriers</td>
</tr>
<tr>
<td>Cancer</td>
<td>Schizophrenia</td>
<td>Cultural considerations</td>
</tr>
</tbody>
</table>
Member characteristics:
Key services utilized

- Long and Short Term Services and Supports (LTSS)
- Home and Community-Based Services (HCBS) waiver
- Personal Care Services (PCS)
- Nursing
- Therapies: physical, occupational, speech, other specialized therapies
- Core Service Agencies (CSA)
- Community-based services
- Durable Medical Equipment (DME)
Member characteristics: Services to keep members in their homes

- Adult Day Care
- Assisted Living
- Attendant Care
- Emergency alert monitoring devices
- Meal delivery providers
- OTC oral nutritional supplements
- Community transition services
- Meals delivered after hosp stay
- Home health services
- Homemaking services
- Psychosocial rehabilitation
- Home modifications and safety
- Transportation
- Respite care transitional living
- Silver sneakers fitness program
Member characteristics: Additional challenges may include:

• Lack of coordination between their Medicaid and Medicare benefits which results in fragmented and uncoordinated care

• Poor health literacy which results in lack of member understanding, engagement and follow-through

• Unmet social and functional needs which results in the health care activities relegated as low priority activities

• High use of emergency rooms and lack of preventive care
Services to be coordinated

Medicare Covers:

Part A:
- Hospital Care
- Skilled Nursing Care
- Nursing Home Care (not custodial care)
- Hospice
- Home Health Services

Part B:
- Physicians visits
- Preventive Care
- Outpatient Care
- Emergency Room (ER)
- Clinical Research
- Ambulance Service/Emergency Ground Transportation
- Durable Medical Equipment (DME)
- Mental Health services (inpatient, outpatient, partial hospitalization)
- Getting a second opinion prior to surgery
- Limited Outpatient Pharmacy Prescription Drugs

Part D
- Medicare Covered Prescription Drugs

Medicaid Covers: *
Must confirm with NM contracts

- Adult Day Health
- Adult Psychological Rehab Services
- Anesthesia Services
- Assisted Living
- Behavioral Health Professional Services: Outpt and Substance Abuse Services
- Care Coordination
- Community Health Workers
- Dental Services
- Dialysis Services
- Durable medical equipment (DME)
- Diagnostic Tests: X-rays, labs and radiology
- Emergency Services
- Environmental Modifications
- FQHCs
- Hearing Aids and Related Evaluations
- Home Health Services
- Hospice Services
- Hospital Inpatient and Outpatient
- Indian Health Services
- Vision Care Services
- Podiatry Services
- Medical & Non-medical Transportation Services
- Pharmacy Services
- Private Duty Nursing for Adults

*If not covered by Medicare or if Medicare benefit is exhausted. Please note this is a general benefit overview by BCBSNM, not comprehensive.
Identification and enrollment of DSNP members

• The Sales office identifies possible DSNP candidates
• Outreach is conducted by local agents who specialize in DSNP
• Member may also enroll on their own through CMS
• Once enrolled, a care coordinator is notified and makes the initial clinical outreach
• Members can also be identified by their insurance cards:
# DSNP advantages

**Goal:** To assist members and their care teams to keep the member at home and as healthy as possible

<table>
<thead>
<tr>
<th>Benefits to member</th>
<th>Benefits to providers and team</th>
</tr>
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<tbody>
<tr>
<td>Improves access to affordable, primarily free, healthcare</td>
<td>Provides comprehensive member health information in one place</td>
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<tr>
<td>Improves two-way communication with a single point of contact</td>
<td>Provides feedback about success in providing care to hard-to-reach patients</td>
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<tr>
<td>Improves access to prevention interventions</td>
<td>Increases the frequency of member contact</td>
</tr>
<tr>
<td>Improves frequency and quality of team communication about member</td>
<td>Provides more member support and coordinated care from non-office-based resources</td>
</tr>
<tr>
<td>Improves management of chronic disease through goal-setting</td>
<td>Provides reinforcement and encouragement for the Plan of Care</td>
</tr>
<tr>
<td>Improves access to prevention interventions</td>
<td>Keeps member engaged</td>
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DSNP requirements

• HRA—Health Risk Assessment: Care coordinator completes within 90 calendar days of enrollment, unless member cannot be reached or refuses. Must be revisited within 365 calendar days and also after notification of change in health status or transitions in care.

• ICP---Individualized Care Plan: Completed after HRA completion, with input from patient and provider, share with both.

• ICT---Interdisciplinary Care Team: choose members, meet at least annually.

• PE--Complete physical exam by PCP: as soon as possible after enrollment.

• QI---Quality Improvement: Process and Health Quality Outcomes are monitored and must be met, or improvement plans made.

• MOC---Model of Care: Providers and staff train annually on program updates.
DSNP responsibilities

• **Patient responsibilities**
  • Cooperate with telephone interviews and creating an Individualized Care Plan (ICP)
  • Try to adhere to the ICP and reach goals

• **Plan responsibilities**
  • Care Coordinator contacts patient within 90 days and immediately with any transitions of care
  • Care Coordinator completes a initial HRA and repeats at least annually
  • Care coordinator develops an Individualized Care Plan (ICP) in collaboration with the PCP, shares with member and care team for inclusion in the patient record
  • Care coordinator initiates, coordinates, facilitates an Interdisciplinary Care Team (ICT) which meets at least annually to discuss the member’s ICP

• **Provider and staff responsibilities**
  • Give input for the ICP
  • Attend ICT meetings
  • Take an annual DSNP MOC training module (such as this one)
  • Perform a complete physical exam as soon as possible and then at least yearly
  • Receive data from Quality Improvement measurements and act on the results
Care Coordinator

- A BCBSNM care coordinator acts as a central point of contact for the patient/member (HRA)
- Care coordinator completes holistic health risk assessment and repeats annually
- An individualized care plan is made with the team and member (ICP)
- A complete physical exam is performed at least annually by the PCP (PE)
- A BCBSNM care coordinator acts as a central point of contact for the patient/member
- The interdisciplinary care team meets at least annually to discuss the member’s progress (ICT)
- The whole team and the member’s PCPs are trained on the Model of Care annually (MOC)
- Quality outcomes data are collected and shared with the team (QI)
Components of the Health Risk Assessment Tool (HRA)

• Extensive medical information
• Mental health/behavioral health
• Social Determinants of Health
  • (housing, food, education, employment, safety, transportation, disability)
• Barriers to effective medical care
• These are used to make the Individualized Care Plan (ICP)
Components of the Individualized Care Plan (ICP)

- **Identified needs**, both clinical and non-clinical, and specific services, referrals, and care coordination required to address them.

- **Goals and objectives**: *measurable* outcomes with dates for achieving, arrived at together with the member, their support network, and the interdisciplinary care team.

- **Outcomes** measures: whether or not goals have been met and plans for the future.

- **Barriers** to care or to meeting goals and plans to address them.

- **Educational needs**: addressing knowledge deficit and encouraging self-management, crisis plan.

- **Social/community** support needs including living arrangements and food.

- **Preferences** for care, agreeing to the options within the Care Plan.

- **Cultural** and language preferences.

- **Schedule** for future follow-up and updates.
Individual Care Plans (ICP)
MOC Requirements

- Complete the ICP shortly after the HRA

- ICP must include interventions specifically designed to meet the needs identified in the HRA

- ICP should have short and long-term goals related to each of the 1-2 problems selected, must include measurable outcomes

- ICP must include any barriers to care, plus any education, social/community and cultural/language needs addressed

- ICP must have input from the member or legal representative

- ICP must be updated after an event, or any change in status or condition such as hospitalization or ED visit
  - Providers can help by notifying the Care Coordinator if the member was hospitalized or had a change in condition

- Care management must send the ICP to the PCP’s office to add to the member’s record
  - Providers must add the Care Plan sent by BCBSNM to the member’s records
Individual Care Plans (ICP)

• **How are they made?**
  • Based on member’s answers and problem list as found in the HRA
  • Together with member choose 1-2 problems to work on and set measurable goals

• **How are they shared?**
  • Made available to all members of the ICT and support network as nominated by member
  • Written notification or secure electronic transmission, must be entered into the record

• **How do others give input?**
  • ICT members can contact the care coordinator directly or wait until the team convenes

• **How often are they reviewed?**
  • At least yearly, but more often as the risk level dictates, or when new medical situations arise, such as hospitalizations, worsening of or new conditions, change in living situation

• **What if the member doesn’t reach the goals?**
  • Work together with member and ICT to modify activities to support goal achievement
Interdisciplinary Care Team (ICT)

- The whole team and the member's PCPs are trained on the Model of Care annually (MOC)
- A BCBSNM care coordinator acts as a central point of contact for the patient/member (ICT)
- Quality outcomes data are collected and shared with the team (QI)
- Care coordinator completes holistic health risk assessment and repeats annually (HRA)
- An individualized care plan is made with the team and member (ICP)
- A complete physical exam is performed at least annually by the PCP (PE)
- The interdisciplinary care team meets at least annually to discuss the member's progress (ICT)
Interdisciplinary Care Team (ICT)

- The composition of the ICT is defined by the needs of the member as identified in the HRA and other assessments, and as requested by the member and/or their family, provider and clinical teams.

- The ICT meets on an annual basis or upon significant changes to the member’s health status. Meetings may be telephonic or electronic.

- 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.

- The ICT should have participation from the member’s PCP and/or other key healthcare providers.

- As the member achieves desired goals and the ICP changes, the composition of the ICT team may change.
Possible members to include in the ICT

- Member (Patient)
- Member’s caregiver/legal representative
- Family and extended support network
- Primary Care provider and team
- BCBSNM SNP LTSS personnel
- Utilization Management
- PCMH/health homes
- Hospital and post-acute physicians
- Certified health educators
- Behavioral health specialists
- Home care nurses
- Physician specialists
- Community support groups i.e. churches
- Justice personnel
- Protective service personnel
- Patient advocacy groups
- Institutional facility staff
- Waiver case managers
- Community health workers
- Therapists
Providers and office staff

- The whole team and the member's PCPs are trained on the Model of Care annually (MOC)
- Care coordinator acts as a central point of contact for the patient/member (HRA)
- A BCBSNM care coordinator completes holistic health risk assessment and repeats annually (HRA)
- An individualized care plan is made with the team and member (ICP)
- A complete physical exam is performed at least annually by the PCP (PE)
- The interdisciplinary care team meets at least annually to discuss the member’s progress (ICT)
- Quality outcomes data are collected and shared with the team (QI)
- The interdisciplinary care team meets at least annually to discuss the member’s progress (ICT)
Providers direct expectations

- MOC requirements: Annual physical exam, ICT, ICP, QI, MOC
- Collaborate with the Interdisciplinary Care Team (ICT)
- Assist with developing and updating the ICP
- Sign and file the ICP
- Document the process for linking member to services
- Provide clinical and pharmacotherapy consultation
- Complete surveys and evaluations
- Complete MOC training annually
Providers indirect expectations

- Monitor network providers to assure they use nationally recognized clinic practice guidelines when available
- Assure that network providers are licensed and competent through a formal credentialing process
- Coordinate the maintenance and sharing of member’s health care information among providers and the ICT
- Attend and complete annual compliance training
- Review written communications
Provider requirements

<table>
<thead>
<tr>
<th>ICP</th>
<th>Individualized Care Plan</th>
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<tbody>
<tr>
<td></td>
<td>• Contribute, advise, record in patient chart</td>
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<tr>
<th>ICT</th>
<th>Interdisciplinary Care Team</th>
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<tbody>
<tr>
<td></td>
<td>• Meet with and participate, at least annually</td>
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<tr>
<th>PCP PE</th>
<th>Physical exam</th>
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<tbody>
<tr>
<td></td>
<td>• Perform complete exam annually</td>
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<table>
<thead>
<tr>
<th>QI</th>
<th>Quality Improvement</th>
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<tbody>
<tr>
<td></td>
<td>• Review and respond, record in chart</td>
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<table>
<thead>
<tr>
<th>MOC</th>
<th>Model of Care Training</th>
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<tbody>
<tr>
<td></td>
<td>• Annual training on the DSNP Model of Care</td>
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## Five QI Process Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Goal/Target</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Initial Health Risk Assessments (HRAs)</td>
<td>• Initial HRAs completed within 90 days of enrollment</td>
<td>TBD after CY2020</td>
<td>BCBSNM Care Coordinators</td>
</tr>
<tr>
<td></td>
<td>• For reachable members who do not refuse</td>
<td></td>
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</tr>
<tr>
<td>2. Annual Health Risk Assessments (HRAs)</td>
<td>• Follow-up HRAs completed within 365 days of the previous one for reachable patients who do not refuse.</td>
<td>TBD after CY2020</td>
<td>BCBSNM Care Coordinators</td>
</tr>
<tr>
<td>3. Annual Interdisciplinary Care Team meeting (ICT)</td>
<td>• ICT meets to discuss patient within 365 days of enrollment and once per calendar year after that if member does not refuse. Document in chart. May meet if condition changes</td>
<td>TBD after CY2020</td>
<td>BCBSNM Care Coordinators Providers Rest of team</td>
</tr>
<tr>
<td>4. Annual Primary Care Providers DSNP Model of Care Training (MOC)</td>
<td>• PCPs servicing this DSNP population who complete the MOC training (such as this one) once per calendar year</td>
<td>TBD after CY2020</td>
<td>Providers When prompted by BCBSNM</td>
</tr>
<tr>
<td>5. Member Experience and Satisfaction (Modified CAHPS Survey)</td>
<td>• Survey questions include satisfaction with providers, care coordinators, health care quality, Plan. Ability to adhere to Plan of Care, received and understood written medical information about condition</td>
<td>TBD by Modified CAHPS Benchmarks Survey is conducted ~ 6-8 months after CY2020</td>
<td>BCBSNM Program Staff</td>
</tr>
</tbody>
</table>
# QI Health Outcomes Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>What providers can do</th>
</tr>
</thead>
</table>
| 1. Hospitalizations | Number of inpatient hospitalizations per member month (annualized). Goal is to reduce. | • Add-on (or inform BCBSNM) re patients who feel their conditions worsening.  
• Encourage “Call Us First” before ER use.  
• Check in with members to make sure they are following their Plans. |
| 2. Medication reconciliation post-discharge | Increase documented reconciliation in the medical record (even if there are no changes) with medications from hospitalization within 30 days after discharge | • Code for the reconciliation when done, CPT II code: 1111F, document notice of med rec in the member’s record.  
• May be done at office visit or by telephone  
• Provider, RN, or licensed pharmacist must document  
• Note that meds prescribed or ordered on discharge, were reconciled with current meds  
• Discharge summary medication list with note of reconciliation with current meds (permissible)  
• If no meds ordered upon discharge, make notation in member record |
| 3. 30-Day All-Cause Readmissions | Reduce the rate of readmissions to the hospital | • Active outreach after admission or observation.  
• Follow-up office visit 1-2 weeks after discharge.  
• Perform proper discharge planning |
| 4. Medication adherence  
Oral diabetes medications  
ACE/ARBs for HTN  
Statins  
Anti-depressants | Percentage of those prescribed medications who continue them for a prescribed period, usually 80% of the time they should have been on them. Over all goal: 85% | • Make it easy to adhere  
• Order 90-day prescriptions where indicated  
• Home delivery if helpful  
• Education about importance of medication adherence |
# QI Health Outcomes Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>What providers can do</th>
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</thead>
</table>
| **Controlling Blood Pressure**               | Percentage of people 18-85 yrs. with a diagnosis of hypertension whose documented BP was adequately controlled <140/90. Documentation is judged by the last recorded BP of the calendar year. Final Overall Goal: 74% | • Use CPT II Codes for documentation (see slide 27 for all CPT II HTN codes):  
  - 3074F (systolic < 130 mmHg)  
  - 3078F (diastolic < 80 mmHg)  
 • Have patients return every 2 weeks for medication adjustment until well-controlled  
 • Take measurement properly: not through clothes, arm resting on table at heart level  
 • Document BPs that patients bring from home such as, from a recorded Self Monitoring BP (SMBP) device  
 • Allow patient to drop in just for BP check then document in member’s record  
 • Educate on risks of high BP |
| **Flu Vaccination**                          | Percent of members who report receiving the flu vaccine annually. Data is collected by the annual modified CAHPS survey to member. Final Overall Goal: 75%                                                                                   | • Encourage members to get a flu shot wherever they can and remember to report it when asked on the survey in the spring  
 • Educate on its importance if there is a chronic condition |
| **Care of the Older Adult series**           | Member age 66 or older with specific documentation in the medical record of these measures:  
  • Functional assessment  
  • Pain assessment  
  • Medication review  
  • Advance directives  
 Final Overall Goal: 90% for medication review, functional and pain assessments | • Perform all 4 and make specific mention of these 4 aspects of care in the medical record.  
 • Make an addition to the annual exam template  
 • See specific requirements in the following slide |
Care of the Older Adult Documentation Requirements

**MEDICATION REVIEW**
- A medication list in the medical record, and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
- Notation that the member is not taking any medication and the date when it was noted.

**FUNCTIONAL ASSESSMENT**
- Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.

**PAIN ASSESSMENT**
- Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).
- Result of assessment using a standardized pain assessment tool, not limited to numeric rating scales (verbal or written).

**ADVANCE DIRECTIVE**
- The presence of an advance care plan in the medical record on or before December 31 of the measurement year.
- Documentation of an advance care planning discussion with the provider and the date when it was discussed. The documentation of discussion must be noted during the measurement year.
- Notation that the member previously executed an advance care plan. The notation must be dated on or before December 31 of the measurement year.
Getting QI credit for your hard work: using CPT II codes

- The AMA has developed “supplementary” diagnosis codes to assist with performance measures.
- CPT Category II codes are tracking codes which facilitate data collection for performance measurement.
- They are recorded in the CPT portion of the billing ticket.
- They are used in addition to the ICD-10 code for the diagnosis and the CPT code for level of care.
- CPT II codes do not generate revenue and are not required for processing claims, which may be why they are underutilized.
- Now that Quality measures play a role in reimbursement, there is an incentive to use them, rather than to rely on the results of chart abstraction for “credit” in meeting Quality requirements.
### CPT II codes for the DSNP metrics

<table>
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<tr>
<th>Controlling BP Measure: Hypertension diagnosis</th>
<th>Last reading</th>
<th>CPT II code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic</td>
<td>&lt;130</td>
<td>3074F</td>
</tr>
<tr>
<td></td>
<td>130-139</td>
<td>3075F</td>
</tr>
<tr>
<td></td>
<td>≥140</td>
<td>3077F</td>
</tr>
<tr>
<td>Diastolic</td>
<td>&lt;80</td>
<td>3078F</td>
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<tr>
<td></td>
<td>80-89</td>
<td>3079F</td>
</tr>
<tr>
<td></td>
<td>≥90</td>
<td>3080F</td>
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</tbody>
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<thead>
<tr>
<th>Care of Older Adults: Over 66 year old</th>
<th>Annual assessments</th>
<th>CPT II Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication review</td>
<td>Pain</td>
<td>1125F</td>
</tr>
<tr>
<td>Functional assessment</td>
<td>No pain</td>
<td>1126F</td>
</tr>
<tr>
<td>Pain assessment</td>
<td>Plan document in record</td>
<td>1157F</td>
</tr>
<tr>
<td>Advance care planning</td>
<td>Discussion in record</td>
<td>1158F</td>
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Summary: DSNP Model of Care Requirements

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<thead>
<tr>
<th>HRA</th>
<th>ICP</th>
<th>ICT</th>
<th>PCP PE</th>
<th>QI</th>
<th>MOC</th>
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</thead>
<tbody>
<tr>
<td>Health Risk Assessments</td>
<td>Individualized Care Plan</td>
<td>Interdisciplinary Care Team</td>
<td>Physical Examination</td>
<td>Quality Improvement</td>
<td>Model of Care training</td>
</tr>
<tr>
<td>Comprehensive questionnaire administered to members within 90 days of enrollment and at least yearly after that. May be modified with changes in health status with input from the team.</td>
<td>Developed from the HRA by the care coordinator with input from the member, the care team, and providers. Distributed to all who are approved by the member and should be included in the medical record.</td>
<td>Comprised of medical and behavioral health providers, nurses, pharmacists, the care coordinator, the patient, any supports s/he designates and meets at least yearly to discuss the member’s progress and make plans/goals for the future.</td>
<td>Preventive and annual exam performed soon after enrollment and at least annually. The PCP monitors all chronic conditions and schedules any appropriate testing, referrals, and/or medications.</td>
<td>Measures are monitored and must be met: medication reconciliation, preventing readmissions, medication adherence, HTN, and Care of Older Adult measures. An improvement plan required if not meeting.</td>
<td>Providers and staff involved in caring for these members must complete annual training on the DSNP MOC, much like this one, to keep up with changes in the program.</td>
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For more information:

Overview for patients

- [https://www.bcbsnm.com/medicare/blue-cross-medicare-options/snp](https://www.bcbsnm.com/medicare/blue-cross-medicare-options/snp)

Blue Medicare Advantage Dual-Care (HMO-SNP)sm Plans

Customer Service

- **1-877-688-1813** TTY/TDD 711
  - Press 2, have member ID card available

- Nurse line 24/7: **1-800-631-7023**/TDD 711