Dual Eligible Special Needs Plan

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Blue adVantage (HMO) | Blue adVantage (PPO)

LOUISIANA BLUE

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What is a Dual Eligible Special Needs Plan?

A **Dual Eligible Special Needs Plan (D-SNP)** is a Medicare Advantage plan that has special benefits and services designed to improve care and manage costs for Dual Eligible enrollees. Blue Advantage offers this plan option named Blue Advantage Dual Plus (HMO-POS D-SNP).

The Centers for Medicare & Medicaid Services (CMS) has defined three types of special needs plans that service the following enrollees:

- Individuals with Chronic Conditions (C-SNP)
- Individuals who are Institutionalized or eligible for nursing home care (I-SNP)
- Individuals who are Dual Eligible and have Medicare and Medicaid (D-SNP)

D-SNPs provide focused care for members having Medicare and who are also entitled to medical assistance from a state plan under Title XIX (Medicaid) in contracted states.

This dual-eligible population contains some of our most vulnerable members. D-SNP is designed to provide specialized early intervention programs that focus on education, coordination of care and increased communication with providers, members and caregivers to improve overall health outcomes.

What is a Model of Care (MOC)?

All health plans that offer a D-SNP benefit plan are required by CMS to create a Model of Care (MOC). The **D-SNP MOC** is a guideline for delivering care management and services to members enrolled in the Dual Plus plan. It offers a detailed description of:

- Characteristics of D-SNP members
- Care Coordination through:
  - RN case management
  - LPN case management
  - Health risk assessments
  - Individualized care plans
  - Interdisciplinary care team
- Provider networking/adequacy
- Quality measurement and performance improvement

Model of Care Goals Include:

- Decrease in the rate of emergency department visits
- Decrease in unplanned hospitalizations and all-cause readmissions
- Improve access to preventative health services
- Improve access to services such as medical, behavioral health and social services
- Improve beneficiary health outcomes
- Improve coordination of care
- Improve medication adherence
- Improve member participation in the development of the Individualized Care Plan (ICP)
- Improve transitions of care
- Increase in the rate of follow-up physician visits post-hospitalization

Characteristics of D-SNP Members

D-SNP members frequently have chronic health conditions because they:

- Are frequently frail and/or disabled
- Have multiple chronic health conditions, which may include behavioral health needs
- Have adverse social determinants of health such as:
  - Low socio-economic status
  - Interpersonal safety
  - Financial (food insecurities, housing, utilities, medications, transportation, etc.)
  - Low health literacy rates
- Are usually aged
- Have mobility and cognitive constraints
- Have limited access to healthcare and/or limited involvement of caregiver(s)

Care Coordination

The primary difference between traditional Medicare plans and Blue Advantage Dual Plus is the inclusion of case management services as a plan benefit. Case managers provide care coordination across the many different services available to our members.

- Nutritional services
- Wound care services
- Physical and occupational therapy services
- Wellness program benefits
- Transportation
- Utilization management
- Interpretation services
- Diabetic foot screening/care
- Transitional care
- Educational and self-management materials

Case Management

D-SNP case managers provide an individualized, patient-centered array of services and act as the member's point-of-contact. Services include:

- Direct responsibility for the development and progression of member's care plans
- Managing care transitions across levels of care
- Linkage to internal and external community resources

Case managers are accountable for the implementation of the member's individualized care plans and case management goals through:

- Ongoing assessments
- Health risk assessments
- Interdisciplinary care team coordination
- Providing continuous education to the member/caregiver

Health Risk Assessment (HRA)

The health risk assessment (HRA) is an interactive and collaborative tool used to assess and identify factors that are known to predict the risk of potentially avoidable healthcare issues and to identify potential case management goals. The HRA includes an assessment of the following:

- Self-assessment of health status including frailty and physical functioning
- Medical history
- Medications
- Pain assessment
- Physical activity and needs
- Identification of barriers to care
- Psychosocial risks and needs
- Behavioral risks
- Cognitive function
- Functional assessments and needs
- Activities of daily living and instrumental activities of daily living
- Socio-economic needs

The HRA is used to determine frequency of contact with the member and is used in the development of the member's individualized care plan (ICP) based upon member goals, identification of gaps in preventive services and opportunities for improved self-management of chronic conditions.

Individualized Care Plan (ICP)

The case manager uses information obtained from the HRA to work with the member/caregiver and member's primary care provider (as available) to develop a plan of care. The member's strengths and needs are taken into consideration with an emphasis on member engagement in working towards their health goals.

The case manager will develop the individualized care plan with the member/caregiver and design a plan to address the following:

- Knowledge and understanding of their disease/condition
- Interventions and goals related to their disease/condition
- Community resources
- Self-management tools specific to the member's individual needs

The care plan is updated at least annually based on the member's HRA. However, updates can be made on a more frequent basis according to changes in the member's health status.

Interdisciplinary Care Team (ICT)

The Interdisciplinary Care Team (ICT) is comprised of multidisciplinary participants who share a common patient population, common patient care goals and have responsibility for complementary tasks.

The ICT membership takes an interdisciplinary approach to the member's healthcare needs and brings different areas of expertise to the care process. The team's approach is member-centric and provides access to care.

The participants may vary based upon the needs of the member and can include:

- Medical director
- Case manager
- Social services
- Behavioral health
- Pharmacy representative
- Member and/or member representative (if available to participate)
- Primary care provider (as available)
- Therapist (PT/OT/ST)
- Nutritionist
- Diabetes educator
- Wound care nurse

Provider Network

Development of a network sensitive to the needs of the dual eligible population. This specialized network will provide focused care for dual eligible beneficiaries.

- A large portion of the dual eligible population has chronic healthcare needs coupled with the need for social services. To ensure there are ample specialists to serve the dual eligible population, the networking team reviews the network adequacy for their assigned region. The networking team ensures that network providers utilize appropriate clinical practice guidelines and protocols.
- CMS requires MOC training to all employees and providers who coordinate the delivery of care to our Dual Plus members.

Quality Measurement & Performance Improvement

The Quality Improvement (QI) process promotes measurable improvement in the healthcare services provided and health status of our Dual Plus members.

By implementing an effective QI program, the balance of quality, efficient and improved clinical outcomes for members is achieved.

The QI program articulates our commitment to quality care and service to members, providers, management groups, executives and employees. Various leadership groups serve to support the quality improvement process. The Quality Improvement Committee (QIC) is composed of executive staff, medical directors and departmental leaders from the following areas:

- Integrated care
- Appeals and grievances
- Quality improvement
- Member services
- Enrollment
- Compliance
- Pharmacy
- Medical management
- Marketing
- Provider relations

Quality Measurement & Performance Improvement (continued)

The D-SNP Quality Committee (QC) is an extension of the QIC. The D-SNP QC is responsible for oversight of the D-SNP program through monitoring and evaluation of the MOC's effectiveness including discussing potential opportunities for improvement, sharing ideas for possible actions and giving feedback on any actions implemented during a QI initiative.

If the D-SNP QC identifies an opportunity for improvement, the following actions are performed:

- Processes are defined
- Goals are developed
- A timeline is set with a target date for completion
- Actions are taken and reviewed
- Remeasurement is done to assess success or failure

If the goals are not achieved, alternative actions for improvement are reviewed and implemented, as appropriate, with continuous monitoring.

Thank You!

You have completed the 2026 Dual Eligible Special Needs Plan Training.