H2425 Blue Plus
Dual Subset Medicare - Zero Cost Sharing Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

In order to enroll in Blue Plus (BP) individuals must: 1) have Medicaid eligibility, 2) receive services under Medicare Parts A and B, 3) be age 65 or older and 4) reside within the approved service area of 62 counties within Minnesota which encompasses urban and rural areas. Of the 36,000 Medicare and Medicaid eligible individuals age 65 and over living in Minnesota, 8,579 are Blue Plus members.

The average age of members is 81.6 years old with 92 percent identifying themselves as White. English is the primary language of 94.4 percent of members. Fifty-two percent of members are widowed, 30 percent are divorced, separated or currently single and 18 percent are married. The most prevalent conditions among members are diabetes, coronary artery disease and asthma.

Barriers such as lack of transportation, social isolation, and limited community support and cognitive and sensory impairments limit members' access to healthcare providers. Consequently, members experience declines in their physical and mental health; these declines may lead to an increased need for specialized care and eventually to decreased assistance from the community to a long-term care setting.

Provider Network

The BP network includes over 96 percent of providers in Minnesota as well as additional providers in contiguous border counties in North Dakota, South Dakota, Iowa and Wisconsin. The network includes providers who have clinical expertise serving individuals with multiple and complex care needs. This provider network is "open access" meaning members may see any network provider for a covered service without a referral. The plan also has procedures in place to authorize out-of-network services when the contracted network does not meet a member's needs, as determined by the member's care plan. BP regularly tracks and trends out–of–network referrals for potential network expansion follow–up.

Care Management and Coordination

Within 30 days of enrollment, a care coordinator (CC) must complete a health risk assessment (HRA) and a face-to-face long-term care consultation (LTCC) / MNChoices assessment to

determine nursing facility level of care and eligibility for elderly waiver home and community-based services. Annual face-to-face reassessments are provided annually and more frequently if there are significant changes in the member's health status.

Needs identified in the assessments are addressed in the individual plan of care (ICP) summarized and sent to the member's primary care physician (PCP) annually and shared with informal and formal support providers as appropriate. The ICP includes, but is not limited to: member's strengths, choice of personal goals, preferences related to preventive health screening and a self-identified personal risk management plan. At a minimum, ICP are developed within 30 days of the initial HRA and reviewed semi-annually for members receiving home and community based elderly waiver services and annually for all SB based on assessed needs.

The interdisciplinary care team (ICT) is composed primarily by the member, CC and the applicable network provider specialties focused on the member's medical or social needs. Based on the member's need for medical and social services or home and community based services, clinicians from the integrated health management and government programs departments, who focus on integrated case and disease management services as well as benefits and member management, may be added to the ICT. A copy of the signed care plan is given to the member and ICT members as needed. The member's community PCPs also receive an annual care plan summary and are contacted as needed for care transitions, assessments and planning.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.bluecrossmn.com.