Metropolitan Health Plan (MHP), H2457
Dual Eligible (Medicaid Subset - $0 Cost Share) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population

Metropolitan Health Plan created a Minnesota Senior Health Options (MSHO) plan that is an alternative delivery system for acute and long-term care. The target population consists of members age 65 and over who receive benefits under Medicare Parts A and B and Medicaid. Members must live in Hennepin County, MN. The Special Needs Plan's members may live in the community or in an institutionalized setting. Currently, 85% of the population lives in the community and they are divided almost equally between those members that are non-nursing home certifiable and those that are at-risk for nursing home placement. Members at risk of institutionalization need multiple formal or informal supports to remain in the community. In addition, there are twice as many females in this population and the majority of them are between 76-80 years of age. These members tend to be widows living at or below the poverty line.

Provider Network

MHP contracts with an extensive provider network that includes primary care providers (PCPs), physician specialists, hospitals and nursing homes. The Special Needs Plan (SNP) does not have a gatekeeper model. It allows members to work with their medical providers and care coordinator to determine services they wish to receive within the covered benefits.

Care Management and Coordination

MHP uses two types of health assessment tools for community-based members, the long term care consultation (LTCC), which is a comprehensive assessment, and a condensed health risk assessment tool (HRA) for members that cannot be reached by phone or refuse a long term care consultation (LTCC).

Care coordinators administer the HRA by phone, mail or face-to-face. It minimally addresses medical, social, environmental and mental health factors. This tool also has questions about: safety, chronic health conditions, whether the member needs special equipment, aids, or therapy, when they last had certain preventive visits or vaccines, whether they need assistance with activities of daily living or instrumental activities of daily living and their medical history.

It is administered within 30 calendar days of enrollment for new members and annually for all members. The care coordinator stratifies the information from the HRA as high, medium or low risk. For institutional members, the care coordinator relies on the geriatric assessment done by the nurse practitioner or registered geriatric nurse at the nursing home facility.

The LTCC is more comprehensive than the HRA. The State of Minnesota's Department of Human Services developed the LTCC and MHP must use it when a member wishes to access Elderly Waiver services (home and community based services). The LTCC has domains that cover ADLs, IADLs, mental health, developmental disabilities, traumatic brain injury, medical history, other supports and caregivers, end of life planning, other social services and basic needs. MHP administers LTCCs face-to-face within 30 calendar days of a new member's enrollment. It must also review the LTCC in-person with the member annually.

Care coordinators, under the direction of their clinical supervisors, and members develop the individualized care plan (ICP) to address risks identified in the assessments. The ICP identifies medical, behavioral health and community services and supports tailored to the member's unique needs. It contains an initial demographic section and areas for: the primary medical provider, emergency contact, previous assessment dates and the type of assessment, mental health diagnoses, advance directives, members' strengths, personal goals and spoken language. The ICP has sections to develop goals for annual exams, breast exams and colorectal exams. The ICP is reviewed twice a year or more frequently if a member experiences a transition in care or a sentinel event.

The interdisciplinary care team (ICT) consists of the member or responsible party, PCP and other service providers and supports, as needed. Types of providers that might serve on the ICT include: a nurse practitioner, physician's assistant, social worker or community resource specialist, a registered nurse, a physical, occupational or speech therapist, a behavioral health specialist a dietician, a disease management specialist and a preventive health/health promotions specialist.

This Model of Care (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.mhp4life.org.