H3259 Volunteer State Health Plan
Dual Eligible (Dual Eligible Subset) Special Needs Plan

Model of Care Score: 98.33%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Volunteer State Health Plan (VSHP) serves dual eligible members receiving Medicare and Full Medicaid benefits and living in Tennessee; membership includes low income seniors and non-elderly adults with disabilities. Currently, 16 percent of its members receive long-term services and support, 80 percent are aged 46 and above, 35 percent are below the 100 percent federal poverty line and approximately 37 percent are affected by circulatory, respiratory and/or musculoskeletal system disorders. This population is at increased risk for high disability rates, high risk scores, high utilization rates including prescription drugs due to their low literacy, home isolation, language or cultural barriers, and end of life planning and/or hospice services.

Provider Network

The network consists of over 11,000 physicians, of whom approximately 76 percent of the primary care physicians (PCPs) and 58 percent of the specialists are board certified. It also includes nursing professionals, allied health professionals, health care facilities, community mental health centers/outpatient facilities, crisis intervention/psychiatric emergency services and ancillary services. To ensure that the provider network coordinates with the interdisciplinary care team (ICT) the plan relies on the care coordinator, other members of the ICT, the individualized care plan (ICP) and network management as the primary mechanisms to oversee this process.

Care Management and Coordination

The member education specialist conducts a health needs assessment (HNA) for all members who agree to participate within 90 days of enrollment and completes a reassessment annually or upon changes in the member's health status. The HNA collects medical, behavioral health, psychosocial, functional and cognitive information on the member. Upon completion of the HNA, the assessment results are systematically forwarded to the care management system for a care coordinator (CC).

The CC reviews the responses gathered during the HNA process as well as information obtained during an in-depth assessment to develop goals and interventions for the ICP. Goals include both short and long-term objectives, detail the services and benefits to be provided based on a member's individual needs, are measurable, are attainable, and have timely outcome measures

specific to each goal and intervention. The CC discusses the appropriate level and meaning of care stratification, assessment analysis and the ICP with the member and/or caregiver.

The interdisciplinary care team (ICT) includes the following individuals: medical and behavioral health clinical professionals, member, the member's caregiver(s), PCP, specialty physicians and other providers. While the frequency of meeting is determined by a member's health status, ICT meetings occur at least annually for members in level 1 (low or moderate risk) and twice a year for members in level 2 (high risk). ICT communication occurs by phone to members, followed by written communication of the ICP or through the PCP, depending on member's acuity level.

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: http://bluecareplus.bcbst.com