

BLUE PLUS MODEL OF CARE TRAINING

Government Markets Partner Relations Team



MODEL OF CARE

MODEL OF CARE (MOC)



SecureBlue MSHO is a Special Needs Plan (SNP) for members dually eligible for both Medicare and Medicaid (D-SNP)

CMS requires that all Special Needs Plans have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA)

MOC addresses MN DHS elements related to MN's Managed Long-Term Care Services and Supports requirements

Annual required MOC training ensures that providers and staff (including Care Coordinators) are educated, aware and will leverage the MOC to deliver care and services to SecureBlue MSHO members.

WHAT IS A MOC?



The MOC provides the framework for how the SNP will identify and address the unique needs of its members. It promotes quality, care management, and care coordination processes.

- Goals of the MOC:
 - Ensure access to affordable healthcare services.
 - Ensure coordination of care across payers and care settings
 - Improve health outcomes
 - Reduce avoidable hospitalizations
 - Facilitate appropriate use of services
- Submitted to CMS (and DHS) at least every 3 years: SecureBlue MSHO MOC is currently 2024 - 2026

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WHAT IS A MOC?



The MOC covers 4 areas:

Description of the SNP population:
medical, social,
cognitive,
environmental
conditions, member
eligibility, and the
unique characteristics
of the population

Care Coordination:
staff structure,
assessment tools,
Interdisciplinary Care
Team, care plan
development and
care transition
protocols

Provider Network:
specialized expertise
available to members,
how the plan
evaluates the
network, clinical
practice guidelines
and care transition
protocols

and Performance
Improvement:
 performance
improvement plans, goals
 and outcomes of the
MOC, and dissemination
of plan performance data
 to stakeholders,
regulatory agencies and
 general public)

Quality Measurement

CARE COORDINATOR ROLE IN THE MOC



Some examples of the Care Coordination elements in the MOC are:

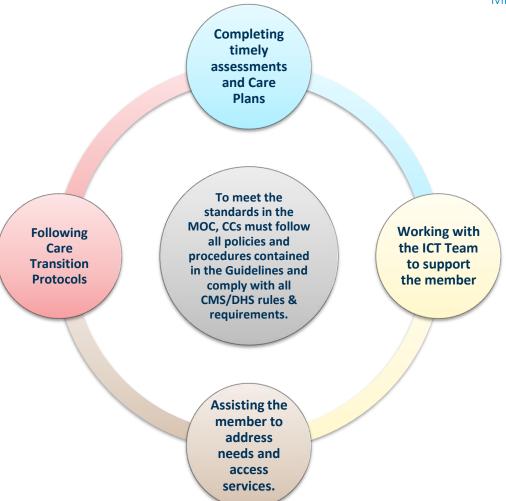
- Provide a detailed description of how the organization conducts the initial HRA and annual reassessment. (Element 2B)
- Explain how the organization disseminates the HRA information to the Interdisciplinary Care Team (ICT) and subsequently how the ICT uses that information. (Element 2E)
- Describe transition protocols for enrollees as they move from different settings of care. The description should include care coordinator roles and responsibilities and protocols for assessments and provision of LTSS. (Element 2F)

These are all core tasks you do as the Care Coordinator!

CARE COORDINATOR ROLE



Our MOC is the foundation for our CC Guidelines and delivery of our Care Coordination model.



MODEL OF CARE



CMS requires all staff working with our MSHO members complete SNP-MOC training upon hire and annually thereafter:

- For Newly hired CC's/staff review the most recent fall training slides.
- CC's who did not attend fall training should review the slides.
- Each Delegate should maintain all records of attendance. Do not send to Blue Plus.

