2025 Blue Plus SecureBlue MSHO Model of Care

Provider training

MODEL OF CARE

Welcome to the SecureBlue MSHO Model of Care provider training

- SecureBlue (MSHO) is a Fully Integrated Dual Eligible Special Needs (D-SNP) plan 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)
- The MOC also addresses MN DHS elements related to MN's Managed Long-Term Care Services and Supports requirements

MODEL OF CARE

- Annual required MOC training ensures that employees and providers are educated, aware and will leverage the MOC to deliver care and services to SecureBlue MSHO members.
- CMS requires that in network and out of network providers who see enrollees on a regular basis complete Model of Care Training annually.
- Model of Care is submitted to CMS (and DHS) at least every 3 years
- Current SecureBlue MOC is approved for 2024-2026

MODEL OF CARE

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

MODEL OF CARE

The MOC approval is based on NCQA's evaluation, which uses scoring guidelines and criteria established by CMS and is organized around four standards:

MOC 1 Description of the SNP population – demographics, health conditions, unique characteristics and services for our most vulnerable beneficiaries

MOC 2 Care Coordination – staff structure, MOC training for internal/contracted staff, Health Risk Assessment (HRA), Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT) and care transition protocols

MOC 3 SNP Provider Network – specialized expertise, clinical practice guidelines and provider MOC training

MOC 4 Quality Measures and Performance Improvement – program goals, outcomes, improvement plans and member satisfaction

SECUREBLUE MSHO POPULATION

SECUREBLUE POPULATION

SecureBlue (MSHO) is a fully integrated Medicare (Parts A, B, and D) and Medicaid product which includes Long-Term Services and Supports

Members must:

- Be Medicare and Medicaid eligible (dual eligible)
- Be 65+ years or older
- Reside within service area approved by Minnesota Department of Health and Centers for Medicare & Medicaid Services

SECUREBLUE POPULATION

Enrollment is voluntary

Different ways to enroll:

- Member's county financial worker
- Blue Plus Enrollment: 1-866-477-1584
- Senior Linkage Line: 1-800-333-2433

Visit the SecureBlue MSHO member website for information about benefits and enrollment

https://www.bluecrossmn.com/members/shop-plans/minnesota-health-care-programs/secureblue-minnesota-senior-health-options

https://www.bluecrossmn.com/members/shop-plans/minnesota-health-care-programs/secureblue-minnesota-senior-health-options#apply

SECUREBLUE POPULATION

Average age: 79 yrs

20% of members live in a Nursing Facility, 40% of members are Community Well and 40% of members live in the community with Elderly Waiver supports

Gender

- 68.5% female
- 31.5% male

Geographic location

- 77.7% Rural
- 22.3% Metropolitan

SECUREBLUE POPULATION

Race

- 71.4% White
- 4.7% Asian or Pacific Islander
- 2.3% Black
- 0.5% Native American or Alaskan Native
- 7.8% Multiple races
- 1.0% Some other race
- 12.2% Did not report

Language

- 74% speak English
- 1.5% speak Spanish
- 1.1% speak Hmong
- 1% Vietnamese
- 3.3% Other languages

SECUREBLUE POPULATION

The top clinical health conditions for SecureBlue members include:

- heart and vascular conditions, including hypertension, heart disease, coronary artery disease (CAD), congestive heart failure (CHF) and atherosclerosis
- psychiatric conditions such as depression, anxiety and dementia
- alcohol or drug abuse
- diabetes (with and without complications)
- chronic kidney disease (CKD) and renal failure
- chronic obstructive pulmonary disease (COPD)

Top co-morbidities include:

- hypertension
- diabetes
- depression
- morbid obesity

SECUREBLUE POPULATION

- Frail and vulnerable
  - Older, live alone, approx. 80% of members live in the community
- High need for social supports
  - 40% are eligible for Home and Community Based Services
- Poor socioeconomic status
  - 34.5% income level less than $10,000 per year
- Low health literacy
  - 23% did not complete high school
- Complex medical needs and chronic condition management
- Cognitive and sensory impairments

SECUREBLUE STAFF STRUCTURE AND CARE COORDINATION

CARE COORDINATION - ROLES

Every MSHO member is assigned a Care Coordinator upon enrollment

The Care Coordinator will:

- Offer Health Risk Assessment (HRA): Identify member's medical, functional, cognitive, psychosocial, and mental health needs
- Develop person-centered Care Plan: Address the needs identified in the HRA
- Connect members to resources, care, and services
- Support smooth care transitions between care settings
- Ensure communication between members of Interdisciplinary Care Team (ICT)
- Monitor and document progress toward health goals and changes in health status

HEALTH RISK ASSESSMENT (HRA)

All members will be offered an HRA within 30 days of enrollment (completed by the assigned Care Coordinator)

Annual reassessments are conducted within 365 days of previous HRA

Assessments must include Social Determinants of Health (SDoH) questions to address food, transportation and housing

FACE TO FACE ENCOUNTER

All special needs plans (SNPs) must provide for face-to-face encounters for the delivery of health care, care management or care coordination services. The face-to-face encounter must be between each enrollee and a member of the enrollee's ICT, the plan's case management and coordination staff or contracted plan healthcare providers.

Intended outcomes of the face-to-face encounters completed by the Care Coordinator include:

- ensuring the member's primary, acute, social, and long-term care needs are identified and addressed through relationship building, assessment and care planning and

- collaborating with the member to develop a person-centered care plan that includes formal and informal supports, member preferences, and goals.

INDIVIDUALIZED CARE PLAN (ICP)

- Within 30 days of completing and HRA, the Care Coordinator develops Support Plan (i.e. care plan/ICP)

- The ICP is developed and shared with the member and/or designated representative, primary caregiver and other members of the Interdisciplinary Care Team (ICT) based on the needs identified in the HRA and the member's preferences.

- The ICP should:
  - Include the member's assessed needs and health and/or personal goals
  - Identify supports for and barriers to member achieving needs and goals
  - Document discussion of preventive care, health and safety risks, emergency plans, advanced directives, health education, case/disease management
  - Facilitate member access to culturally sensitive choices for supports/services

- ICPs are reviewed (at minimum) semi-annually by Care Coordinators and whenever there's a significant change

INTERDISCIPLINARY CARE TEAM (ICT)

- At a minimum, the ICT includes:
  - Member and/or Authorized Representative
  - Care Coordinator
  - Primary Care Provider, if known and reported by the member
- Based on the member's clinical and social needs, ICT may also include:
  - Specialists
  - Psychiatrist or other behavioral health clinician
  - Local or social service agency case managers, financial workers
  - Blue Plus Clinical Case and/or Disease managers
  - Others as needed

CARE TRANSITION PROTOCOLS

- Detailed Transition of Care (TOC) protocols are included in the Care Coordinator Guidelines for both planned and unplanned transitions.
- The goal of the protocols is to reduce incidents related to fragmented or unsafe care and to reduce readmissions for the same condition.
- Protocols focus on regular engagement and clear and timely communication between the Care Coordinator, the member/authorized representative, the receiving facility and members of the ICT.
- Post transition protocols follow the Four Pillars for Optimal Transition:
  - Timely follow up appointments scheduled
  - Medication self management review/instruction
  - Knowledge of warning signs/symptoms and actions to take to prevent unplanned transitions/readmissions
  - Use of a personal health record (medical history and medication regimen)

BCBSMN STAFF STRUCTURE

BlueCross BlueShield Minnesota

Medicare and Medicaid

- Member Services
- Case Management
- Utilization Management
- Behavioral Health
- Stars Center of Excellence
- Quality
- Product
- Community Engagement
- Network
- Provider Support
- Many more departments and teams support the MSHO population

BLUE PLUS PROVIDERS

BLUE PLUS PROVIDER NETWORK

Blue Plus' open access network includes:

- 100 percent of hospitals in MN
- over 95 percent of practitioners in MN
- providers in contiguous border counties in North and South Dakota, Iowa and Wisconsin
- all Minnesota nursing facilities that accept Medicaid and/or Medicare as a payment source
- all non-federal hospitals in the state and along the bordering states

Our network includes providers who have clinical expertise serving geriatric individuals with multiple and complex care needs, such as: Internists/Primary Care Providers, Endocrinologists, Dietitians, Podiatrists, Eye Doctors, and Urologists and primary care practices with a targeted focus on geriatric/elder care.

PROVIDER CREDENTIALING AND TRAINING

- Providers are required to follow the care protocols established in the Provider Policy & Procedure Manual and Blue Plus Manual.
- Model of Care training is encouraged initially and annually for all providers. MOC training is given to SecureBlue MSHO supplemental benefit providers annually.
- MOC training is housed on Availity and completion reporting can be requested at any time.
- Blue Plus' provider agreement describes our right to audit for failure to complete training and a CAP or other remediation may be developed to address non-compliance.

PROVIDER ROLES & RESPONSIBILITIES

- Complete MOC Provider training annually
- Work with the Care Coordinator to:
  - Develop, monitor, and update the member's care plan
  - Support the member reaching their health care goals
- Inform the Care Coordinator of:
  - Changes in the member's heath care service needs and supports
  - Planned or unplanned transitions of care
- Maintain effective and ongoing communication with other care providers
- Adhere to Blue Plus Policies & Procedures

SECUREBLUE QUALITY MEASURES AND PERFORMANCE IMPROVEMENT

QUALITY PERFORMANCE IMPROVEMENT PLAN

The Blue Cross Quality Program Mission is to deliver enterprise and member value by ensuring health plan services and operations increase the likelihood of achieving desired health outcomes for individuals and communities.

1. Improve member and community health across the continuum of care by removing barriers to preventive and chronic condition care; improving social factors that contribute to health; and decreasing total cost of care.
2. Enhance the member experience by ensuring ease and understanding throughout the member journey by intentionally building a member journey that makes health care easy to understand.
3. Eliminate health inequities in health outcomes by building an enterprise culture of equity and inclusion.

SECUREBLUE MOC GOALS

SecureBlue Population Goals are determined by evaluating which measures are:

- most appropriate for the SecureBlue population and
- most in need of improvement

Goals are collaboratively set by:

- Stars, Risk Adjustment, and Quality Center of Excellence
- SecureBlue Program Management and
- Population Health teams

May be population specific or focus on operational improvements

May be related to HEDIS or other quality measures (i.e. DHS Performance Improvement Plan PIP)

SECUREBLUE MOC GOALS

Goal examples:

- All SecureBlue members will have a:
  - Health Risk Assessment,
  - Care Plan and
  - Interdisciplinary Team
- Reducing the risk of falling
- Reducing readmissions
- Increasing optimal care for SecureBlue members and improving access to essential services

QUALITY MEASURES: ONGOING PERFORMANCE IMPROVEMENT

If goals are not achieved in a given year, Blue Plus:

- completes a barrier analysis,
- identifies opportunities for improvement,
- adjusts initiatives as appropriate

The barrier analysis is used when determining activities to implement for the following year. New interventions may be identified, or existing interventions may be refined through analysis of lessons learned.

QUALITY MEASURES: MEMBER SATISFACTION

SecureBlue members are surveyed on their satisfaction with the care they receive through the following survey mechanisms:

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
    - Medicare Advantage & Prescription Drug Plan CAHPS (Medicare CAHPS)
        - Required for CMS Star Ratings Program
        - Comprised of the standard CMS instrument plus six CMS-approved supplemental items used to collect information needed by DHS to produce an annual integrated report of all MSHO plans.
    - Adult Medicaid CAHPS
        - Required for NCQA accreditation

2. Blue Plus Care Coordination Satisfaction survey
    - Asks members (or their caregivers) about their experience and satisfaction with the Care Coordinator
        - Courtesy and respect
        - Timeliness of response
        - Help offered to make informed decisions about health care
        - Frequency of contact with members

RESOURCES

Blue Plus Provider site: https://www.bluecrossmn.com/providers

Blue Plus Manuals: www.bluecrossmn.com/providers/forms-and-publications

- The Blue Plus Provider Manual (Chapter 3: Government Programs)
- Provider Policy and Procedure Manual (Chapter 6: Blue Plus)

NCQA Model of Care resources

https://snpmoc.ncqa.org/

MSHO SUPPLEMENTAL BENEFIT PROVIDERS

How can you help?

- Care coordination and plan awareness
- Aligning outcomes
- Social Determinants of Health

THANK YOU!