SecureBlue Special Needs Plan (SNP)

• A fully integrated Medicare and Medicaid product which includes Elderly Waiver Home and Community Based Services
• Also referred to as Minnesota Senior Health Option (MSHO)
• 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
Enrollment is voluntary

Different ways to enrollment
  • Member’s county financial worker
  • Blue Plus Enrollment: 1-866-518-844
  • Senior Linkage Line: 1-800-333-2433
MODEL OF CARE—Required for all Special Needs Plans (SNPs)

• Required by CMS

• Goal is to simplify access to healthcare for our members and reduce fragmentation of care delivery for our members

• Focus on coordinating access and delivery of all preventive, primary, specialty, acute, post acute and long term care services among different health and social service professionals and across settings of care
Model of Care Required Elements

• Comprehensive description of our SNP specific population
• Care Coordination model overview
• SNP Provider Network
  • Network of healthcare providers contracted to provide health care services to SNP members
  • Requires annual training of providers on Model of Care
• Quality Measurement and Performance Improvement
Model of Care must include an Interdisciplinary Care Team (ICT)

- Member and/or Authorized Rep
- Primary Care Physician
- Care Coordinator
- Blue Plus internal resources are part of the ICT within the Integrated Health Management area whose services are available to all members:
  - Medical Director
  - Integrated Health Management Director
  - Clinical Guides
  - Dedicated Clinicians—Case Management and Disease Management
  - Blue Plus Pharmacist
  - Utilization Management Specialist
• Care Coordinator is the central point person ensuring communication between members of the Interdisciplinary Care Team
• Care Coordinator is a social worker, public health nurse or registered nurse
  • Conducts health risk assessments and develops care plans
  • Connects our members to resources, care, and services
  • Coordinates the provision of all Medicare and Medicaid health and long-term care services among different health and social services professionals and across settings of care
SecureBlue Care Coordination

• Complex variety of contracting arrangements with local agencies providing face to face care coordination with enrollees across Minnesota
  • Blue Plus contracts with 60+ unique Care Coordination delegates
    • Clinics
    • Nursing facilities
    • Private case management agencies
    • County Public Health and Social Service Agencies
  • Blue Plus internal Care Coordinators (metro nursing facilities)
Model of Care must include Care Transition Protocols

• Blue Plus Care Coordinators assist our members moving between different health care settings (such as admission to the hospital and back home)
• Goal is to better coordinate the transition to reduce fragmented care and avoid rehospitalization
• Care Coordinators follow up with the member to discuss health status changes, ensure that follow up services and appointments are scheduled and performed, provide educational resources if needed, and review service needs
• Care Coordinators share applicable care plan information with key health care providers
Helpful Information Found in Blue Plus Policy Manual

Chapter 3 of the online Blue Plus Manual can be found at: www.providers.bluecrossmn.com

- Group numbers for this product begin with the letters PP are found in the Policy Manual

- Useful contact numbers are also found there including Customer/Member Services

  651-662-6013 or 1-888-740-6013
To locate your patient’s Care Coordinator, contact Integrated Health Management Intake:

651-662-5540 or 800-711-9868

Questions on Model of Care

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