Primary Care Provider (PCP) Model Of Care Training
The BlueCare Plus Special Needs Plan is designed to serve the unique needs of the dual eligible Medicare and Medicaid population, helping our members achieve better health in a cost effective manner. The Centers for Medicare & Medicaid Services (CMS) requires all Special Needs Plans (SNP) to have a Model of Care (MOC). The Model of Care is the architecture for care management policy, procedures, operational systems and interactions with our specialized provider network. The information contained in this training describes how the BlueCare Plus network of providers and staff ensure the success of the MOC and outcomes for members.
Learning Objectives

• **Recognize** the BlueCare Plus target population

• **Understand** the components of the BlueCare Plus Model of Care

• **Describe** the essential role of the contracted network of providers for a successful MOC

• BlueCare Plus measurements of performance
The BlueCare Plus target population is low-income elderly and low-income disabled individuals. Nationally, this population represents a higher cost subset of Medicare and Medicaid beneficiaries. We believe that effective execution of our Model of Care will successfully address these higher costs through better coordination of care for our members.
What is a Dual Special Needs Plan?

- A Medicare Advantage Plan specifically designed for low income elderly and low income disabled individuals

- There are several unique CMS requirements for D-SNP plans:
  - A MIPPA agreement with the Bureau of TennCare
  - A Model of Care that must be approved by NCQA for CMS
  - Provider training in the Model of Care
  - Provider participation in Interdisciplinary Care Teams

The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage (MA) coordinated care plan (CCP) that was specifically designed to provide targeted care to individuals with special needs. The Dual Eligible Special Needs Plans (SNPs) offer the opportunity to improve care for Medicare and Medicaid beneficiaries with special needs, primarily through improved coordination and continuity of care. CMS requirements for D-SNP plans include:

- A MIPPA agreement with the TennCare Bureau
- A Model of Care that must be approved by NCQA for CMS
- Provider training in the Model of Care
- Provider participation in the Interdisciplinary Care Teams
MIPPA

- Medicare Improvement for Patients and Providers Act of 2008
- Imposed new standards on Special Needs Plans, requiring more rigorous models of care management
- BlueCare’s MIPPA Agreement with the TennCare Bureau
- Requires D-SNPs and Medicaid MCOs to work together in an accountable manner to coordinate the delivery of Medicare and Medicaid covered services to beneficiaries
- Also has requirements pertaining to enrollment, member cost sharing, etc.

BlueCare Plus will work with BlueCare and other TennCare MCOs to coordinate Medicare and Medicaid benefits for our members through a MIPPA process defined by the Bureau of TennCare. This represents care coordination at the health plan level. Our members and the network of providers who care for them will have a better experience of care when BlueCare Plus and the TennCare MCOs follow the MIPPA process reliably.
CMS requires BlueCare Plus to provide an evidence-based model of care with an appropriate network of providers and specialists that meet the specialized needs of our target population. The second requirement is an array of care management services that includes a comprehensive initial assessment and annual reassessments of an individual’s physical, psychosocial and functional needs. The third requirement is an individualized plan of care that includes goals and measurable outcomes, including specific services and benefits to be provided with the Interdisciplinary Care Team to manage the care.

The diagram above offers a high-level overview of the BlueCare Plus care planning process after a member’s enrollment.

Our network of primary care providers and specialists are the cornerstone of our Model of Care, particularly the Interdisciplinary Care Team (ICT) process.

BlueCare Plus has a dedicated Quality Improvement program that monitors effectiveness of our Model of Care and provides feedback to members of the ICT concerning health status and receipt of essential services at the individual member level. This program is well supported by experts in health informatics, analysis and performance improvement.
At enrollment, BlueCare Plus assesses a member’s health status through an initial Health Needs Assessment (HNA). The assessment identifies the member’s medical and behavioral health history. The assessment is completed within 90 days of enrollment and again annually from the initial assessment date or more often if there is a significant change in medical and behavioral health status. BlueCare Plus staff review and analyze the HNA results, and stratify health care risks and communicates the results to the member, provider and Interdisciplinary Care Team (ICT). The HNA helps improve health outcomes by identifying patients with modifiable health risks and chronic conditions so that evidenced-based health improvement and disease management programs can be deployed effectively.
Every BlueCare Plus member is assigned a clinical Care Coordinator who is responsible for promoting member engagement in their own health and coordinating the work of the Interdisciplinary Care Team (ICT) in implementing an Individualized Care Plan (ICP) for each member.
BlueCare Plus uses an Interdisciplinary Care Team (ICT) to achieve member centric coordination of care. The ICT drives the care management process through analysis, communication and coordination of services. Each ICT is composed of health care professionals based on the member’s individual medical, behavioral and functional needs. The ICT develops and implements an individualized care plan to address the member’s needs. Consistent collaboration and analysis provide the foundation for providing on-going monitoring of the member’s health needs, progress and outcomes.

Participation by Primary Care Providers (PCPs) in Interdisciplinary Care Team (ICT) meetings is critical to the success of BlueCare Plus members in achieving better health and more stable lives. The BlueCare Plus Care Coordinator will facilitate the participation of all ICT members. The meeting may occur when the member is having a face-to-face visit with their PCP or may be done through a video or telephonic method. The Care Coordinator will strive to conduct the ICT process in a manner that is meaningful and efficient for the PCP.
BlueCare Plus in coordination with the member and treating providers develops a comprehensive individualized care plan (ICP) to meet the member’s needs. The care plan includes:

- Goals
- Objectives
- Specific services
- Outcome measures
- Preferences for care

The Interdisciplinary Care Team (ICT) reviews and revises the plan of care as needed based on the member’s health needs or at least annually. The Individualized Care Plan (ICP) is communicated to members, their designated caregivers and providers. This is done through mail, secure email or fax based on preference.
The provider role is **essential** in the success of the model of care. The following provider activities assist in the success of the model of care:

- Participation in the ICT for optimal coordination of care
- Review the Individualized Care Plan for each member for whom you provide medical or behavioral health services
- Care and coordination of services for the member
- Communication with the member, member’s family, other treating providers in the BlueCare Plus ICT
- Timely submission of documentation
- Modify care plan as necessary and communication with ICT regarding changes
- Perform annual health risk assessments during the annual wellness visit
- Preventive care and monitoring gaps in care
BlueCare Plus is responsible for maintaining a specialized provider network that corresponds to the needs of BlueCare Plus members. BlueCare Plus evaluates the provider network’s adequacy, accessibility, availability and credentialing standards on a quarterly basis to ensure compliance. The comprehensive network provides dual eligible members an adequate number of primary care physicians to access and monitor the member’s medical condition. Our primary care physicians have at their disposal a network of supporting services composed of board certified specialists, medical and behavioral health facilities, allied health professionals and in-home service providers to ensure that all member needs are met.

BlueCare Plus will monitor the use of clinical practice guidelines and protocols by the provider network to ensure that our members are receiving safe, evidence-based care.
The BlueCare Plus model of care is designed to meet the needs of a high risk, vulnerable population. Multiple methods are used to identify the most vulnerable members including:

- Initial indicator that the member qualifies as high risk during the Health Needs Assessment
- Members are considered at high risk with the following conditions:
  - End stage renal failure
  - Congestive heart failure
  - Chronic obstructive pulmonary disease with oxygen
  - Frail with limited functions
  - Behavioral, cognitive or physical disabilities
  - Multiple and chronic medical conditions complicated by behavioral health issues

- Provider referrals
- Claims analysis
- Utilization Management
- Member interaction
- Internal staff referrals
- Readmission reports
Integrated systems of communication are essential among plan personnel, providers and members. Our communication structure includes:

- Web-based training
- Web-based information
- Audio conferencing
- Face-to-face meeting
- Web conferencing
- Telephonic
- Secure Member Portal
- Secure Provider Portal

The communication network focuses on members and meeting their health care needs by assisting all parties involved to remain informed and of information necessary to provide efficient, medically necessary care. Communication is coordinated with the following:

- Member and caregiver
- Providers
- Internal Staff
BlueCare Plus uses national benchmarks to set and achieve care management goals and the structure of the Care Management program was designed based on the standards developed by the National Committee for Quality Assurance (NCQA) and The Centers for Medicare & Medicaid Services (CMS) Special Needs Plan model. The Interdisciplinary Care Team (ICT) periodically assesses and evaluates the rate of progression toward goals while identifying and addressing any barriers to meeting the goals.

The Quality Improvement Program provides the framework for the evaluation of the delivery of healthcare services and other services provided to our members. The program provides a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of care and service provided to our members.
BlueCare Plus provides an appropriate clinical and administrative staff with clearly defined roles. The teams possess the infrastructure necessary to coordinate the oversight of clinical services and improve health outcomes.
As described previously in this training document, following enrollment with BlueCare Plus a health needs assessment is implemented and the information is used to design coordinated care for the special needs members through the individualized care plan and the Interdisciplinary Care Team (ICT). The ICT consistently collaborates to solve a member’s health care issues that are too complex to be solved by one discipline in order to provide an efficient health care program. As a health care provider a BlueCare Plus member, your participation in the ICT process is essential and much appreciated. The ICT is responsible for analyzing the results of the initial and annual health risk assessments, incorporating those findings into an individualized care plan, collaborating to develop and update the member’s plan of care and manage the physical and behavioral health, functional and social support needs of the member.
At BlueCare Plus, customer service is more than just a name on a department door. Customer service is more than answering questions quickly and correctly. Customer service is the very heart of BlueCare Plus, talking personally, individually, to our members and providers.
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<th>Acronym</th>
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<tr>
<td>MIPPA</td>
<td>Medicare Improvements for Patients and Providers Act</td>
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Special Needs Plan (SNP)  
Primary Care Provider (PCP)  
Model of Care Training  
Attestation Form

Please complete form below and return

Mail:  BlueCare Plus  
Attn: Provider Outreach and Education  
1 Cameron Hill Circle  
Chattanooga, TN 37402

Fax:  1-888-725-6849

Email:  BCPProviderOutreach@bcbst.com (this should be a signed scanned document)

If you need additional, assistance or have questions please contact your Provider Network Manager or call the BlueCare Plus provider service line at 1-800-299-1407.

I, ______________________________________________________, acknowledge that I have  
Provider Signature  
completed the BlueCare Plus Model of Care Training.

Provider Name:  ____________________________________________________________  
Print Name

Provider NPI:  ____________________________________________________________

Provider Number  ____________________________________________________________

Practice Name:  ____________________________________________________________

Telephone:  ____________________________________________________________