

Medica **AccessAbility Solution**

Primary Care Clinic/ Provider

On enrollment the member must identify a Primary Care Provider. If the member does not choose a Primary Care Provider Medica will work with the member to find a provider that matches the member's needs.

A specialty provider may act as the member's primary care provider. Care Coordinator will provide support to the specialty provider to ensure members have access to preventive and acute care, disease management and chronic care management.

Creative options to primary care (i.e. visiting home Nurse Practitioner) will be available to those who meet criteria.

Care Coordination Model

Every member is assigned a care coordinator on enrollment based on which care system they choose to deliver their care. Medica's three care systems are: AXIS Healthcare, Medica Behavioral and Medica Care System

All care coordinators will work in cooperation with the county case manager, if the member has a county case manager.

Coordinators attend clinic visits with members at the member's direction.

Care coordination is a team based member centered approach. While each member will have only one Care Coordinator contact, Care Coordinators will have access to a wide range of resources to meet the unique needs of each member.

Comprehensive person centered care planning will include screening, risk assessment, advance directives, preventive focus, facilitating self monitoring and self management intervention, disease management and ongoing evaluation.

Members have the option to be extensively involved in the assessment and development of the care plan process.

After assessment and development of care plan members will receive a copy of the care plan, primary MD will receive copy of the care plan and additional case management based on identified needs of member.

Blue Plus **CareBlue Special Needs Basic Care**

On enrollment the member must identify a Primary Care Clinic that their personal physician is associated with. That personal physician may be a specialist.

A specialist may act as the member's primary care provider.

The member's Care Coordinator will provide support to the specialist to ensure communication and to support member access to preventive care, disease management, and chronic care management.

Every member is assigned a personal Care Coordinator who is a professional nurse or social worker.

Care coordinator delivery system is based on partnerships with counties.

The Care Coordinator can offer help to members with things like:

- Managing medications
- Answering health plan and benefit questions
- Assessing and improving safety
- Supporting members and their families with health care decisions
- Coordinating and integrating medical and social services
- Proactively preventing unnecessary illness/hospitalizations, whenever possible
- Navigating the system to effectively access resources and benefits
- Ensuring that the member receives care in the least restrictive setting and maintains the level of independence they desire
- Determining what additional services or medical coordination needs to be incorporated into the member's comprehensive treatment plan

Medica

Initial Health Risk Screening.

Members will receive telephonic contact upon enrollment to assist with selection of their care system.

Initial assessment contact will be completed within 30 days using assessment tools designed specifically for this program.

Care coordinators will work with members to build their care plan as a result of what is learned during the assessment

Care coordinators will also work with members at the initial contact to identify their care team, those people chosen by the member to be involved and/or kept informed of the member's health.

Initial and annual in person coordination assessment visits for AXIS and Medica Care System. Medica Behavioral Health will utilize in person visits when needed or requested by the member.

Subsequent contacts with members and their careteam are conducted face to face, telephonic or mail as per member need and desire.

For members at risk of or struggling with Depression, the PHQ-9 will be administered at least monthly as a monitoring tool. Members with other diagnosis will be offered appropriate risk screening

Medica will also place special focus on assessing the physical status of those with Mental Illness to assure that they are receiving appropriate physical care.

Blue Plus

Intensified case management is based on the identified needs of the member. A Blue Plus medical case manager and/or a Blue Plus behavioral case manager is available to work with the member and care coordinator.

Together, the care coordinator and the member determine and schedule follow up and evaluation of treatment plan. If is the member's decision to receive assistance from a care coordintaor

If a member's condition warrants a specialty provider currently not in the Blue Plus network, the care coordinator will coordinate access to a non contracted provider.

Care coordinators complete an initial face-to-face health assessment within 30 days of the member's enrollment, and then annually thereafter. The Care Coordinator, in concert with the member and member's providers, develops a comprehensive treatment plan. The treatment plan is based on member health status and respect for member choice. Medications, medical appointments, durable medical equipment and chronic care need will be identified and defined.

Medica Additional Benefits

There are NO Co-Pays for:

- Non-preventive office visits;
- eye glasses;
- emergency room visits;
- Medical Assistance prescription drugs (these drugs are considered Medical Assistance drugs because they are not covered by Medicare Part D but are covered at 100% by the health plan with no co-pays).

Waiving the following Medicare requirement for SNBC members: There are no requirements for a three – day hospital stay prior to a skilled nursing facility admission.

Fitness Program-

Access to Silver Sneakers program which provides a free membership to health clubs throughout the state and access to minimal impact exercises classes.

24 Hour Nurseline –

Access to a clinical nurseline 24 hours/day, 7 days/week

Smoking Cessation Program —Members get one-on-one telephone counseling and tools to help quit smoking

Disease Management —Case managers can help members with a major illness or injury to understand their medical condition and treatment

Disease Management Programs –

- Heart Disease
- Diabetes
- Asthma

Blue Plus

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- eye glasses;
- emergency room visits;
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Podiatry Services –

Up to 4 routine visits each year (2009) (12 in 2008)

~~Dental –In addition to Medical Assistance covered dental services, CareBlue will also cover:~~

- ◆ ~~Up to \$1,000 towards porcelain crowns each year; and~~
- ◆ ~~Up to \$3,000 towards bridge work each year (eliminated 2009)~~

Falls Prevention and Safety Program –

Coordination of member falls risk assessment and appropriate follow-up support services

Fitness Program –

Members may access a participating fitness center at no cost, or receive an at home exercise kit

Safety items-

Annual maximum allowance of \$500 for specified safety items not otherwise covered by Medicare & Medicaid.

24 Hour Nurseline –

Access to a clinical nurseline 24 hours/day, 7 days/week

Smoking Cessation Program —Members get one-on-one telephone counseling and tools to help quit smoking

Disease Management —Case managers can help members with a major illness or injury to understand their medical condition and treatment

Medica

Member Newsletter —

Mailed quarterly, the newsletter has health tips and ways to get the most from Medica.

Provider Network

Members may self refer for any covered service with any in network provider.

Medica has a large statewide provider network including over 96% of all practitioners in Minnesota.

Medica's Care Systems have experience in working with people with disabilities and can help members choose providers with a disability focus if that assistance is requested

No prior authorization needed for: SNF stays at contracted facilities, or for home care services.

Limited number of services that require prior authorization (e.g. bone growth stimulators, gastrointestinal surgery for morbid obesity)

We are working to support community partners on a tele-psychiatry initiative.

The goal is to have units deployed in greater MN quickly to increase access to psychiatry and psychology services to members.

Elevated contract requirements regarding the service and delivery of durable medical equipment.

Physical accessibility guidelines will be developed and shared with ALL provider types to educate providers regarding optimal accessibility.

Care coordinators have resources to help members obtain dental appointments.

Blue Plus

Member Newsletter — Mailed four times a year, the newsletter is packed with health tips and ways to get the most from the CareBlue plan

Disease Management Programs —

◆ Heart Disease

◆ Diabetes

◆ Asthma

◆ COPD

CareBlue is an Open Access plan, meaning members can access participating specialty care without the need for referrals. Some services may require prior authorization. Open Access helps members access the health care they need and helps providers to effectively advocate for their patients.

Blue Plus has one of the largest and most widely distributed provider networks in Minnesota. The CareBlue network includes 4,500 specialty providers statewide.

Dental Resources — Dental coordinator to assist members or their care coordinators with scheduling appointments when members encounter difficulty or need assistance, including assistance with scheduling transportation (as needed) and follow-up care appointments.

The Special Needs Dental coordinator has expanded understanding of the dental care challenges of the SNBC population and will work with members and care coordinators to assess each member's specific needs. The coordinator will also provide assistance with identifying and obtaining access to providers who are appropriately equipped and trained to work with people with disabilities.

DME Benefits — Ability to access durable medical equipment (DME) necessary for certain prescriptions right at the Pharmacy, e.g., certain diabetic supplies.

DME less than \$500 does not require prior authorization, e.g., humidifiers, Jobst stockings, lap trays, Ostomy bags and supplies, nebulizers and supplies, paraffin bath, smoking cessation products, splints, traction equipment, walkers, wound care supplies).

ARMHS, IRTs, ACTs

Medica

Medica Behavioral Health has pursued contracts with many ACT, IRTS and ARMHS providers throughout the state. A member receiving these services can either contact Medica Behavioral Health at 1-800-848-8327 or ask their provider to do so. If the provider is already contracted with Medica Behavioral Health, the provider can provide clinical information to us and we will move forward with the authorization. If the provider is not contracted with Medica Behavioral Health, at a minimum, we will authorize services for up to 120 days, as clinically needed, with the out of network provider. In addition, we may pursue a contract with the provider as we work to strengthen our network to support ACT, IRTS and ARMHS.

Formularies

AccessAbility Solution does not have separate medication formularies for dual eligible (Medicare/Medicaid) and Medicaid-only eligible members.

Part D:

<http://www.medica.com/C12/DrugFormularyPartD/default.aspx>

Over the counter:

[://member.medica.com/C15/DrugFormulary/default.aspx](http://member.medica.com/C15/DrugFormulary/default.aspx)

Access Survey

Information will be placed on our web site.

Who to call if interested in enrolling or if have additional questions.

1-800-266-2157

TTY:

1-800-234-8819

www.medica.com

Blue Plus

Blue Plus has an extensive network of behavioral health providers, so in many cases, transition of care will not be required. Services received from any provider that is not in the Blue Plus provider network will be approved as per our Continuity of Care/Transition of Care policy and procedure. Blue Plus will consider the individual enrollee's prior use of mental health services and develop a transitional plan to assist the member in changing mental health providers, if this is necessary. A plan shall be developed to assure the need for continuity of care for any member who is receiving ongoing mental health services. If care is not available within the behavioral health access and availability standards, services will be approved with available non network providers, if the provider is eligible (appropriate licensure and certification requirements).

Yes – 2 separate formularies for Dual and Single eligible only enrollees. bluecrossmn.com

Information will be placed on our web site.
bluecrossmn.com

1-866-477-1584

TTY: 1-888-878-0137

bluecrossmn.com