Metropolitan Health Plan

CORNERSTONE SOLUTIONS (SNBC)

Stakeholder Conference

Managed Care Programs for Seniors and People with Disabilities

Metropolitan Health Plan

- Metropolitan Health Plan (MHP) was established as a nonprofit, state certified Health Maintenance Organization in 1983, as an enterprise initiative of Hennepin County.
- MHP is funded by contracts with the Department of Human Services (DHS) and Centers for Medicare and Medicaid (CMS).
- No taxpayer dollars are used for MHP’s operations.

MHP's Mission, Vision and Values

- Mission

Integrating health care and service to enhance the health and well being of our members and the community

- Vision

Be a leader in partnering with our members and community to improve health

- Values

Health. Care. Respect.

How is MHP Different?

- Serves only public programs in Hennepin County
- Conveniently located in downtown Minneapolis within blocks the Government Center, HCMC, Hennepin County's Century Plaza and other county services
- Gives back to the community by providing funding to community service organizations that serve the disabled adult population

Community Health Worker in Front Lobby

- MHP strives to deliver prompt, quality face-to-face services to members.
- MHP receives a high volume of member traffic in the front lobby, serving 30-40 members daily.
- Community Health Workers (CHW) located in the Front Lobby assist members by connecting them to
  - Health plan benefits
  - Care coordination
  - Social services and community resources

Community Health Worker in Front Lobby

- CHW's connect members to:
  - Transportation
  - YMCA memberships
  - Community cell phone programs
  - MHP cell phone programs
  - Care coordination and case management
  - Hennepin County Eligibility Assistance
  - Resources for housing, food, clothing and more

Community Health Worker in Front Lobby continued

- CHW's administer Health Risk Assessments to members who present in the Front Lobby
- Health Risk Assessments help the care coordination staff determine the level of care, the urgency and the type of care a member needs
- CHW's are key to gathering this data in a safe and confidential manner
- Members are then assigned a care guide that will best meet their needs

TRANSPORTATON

- CHW's help to arrange common carrier and special transportation for eligible MHP members to medical services and other health plan covered services in a courteous, efficient and cost effective manner.

- CHW's assist with providing special transportation and taxi rides via telephone and our Front Lobby Team provides monthly, ten ride and single ride bus passes to qualifying members.

YMCA & Touchstone Wellness Center

- MHP's partners with the YMCA and Touchstone Wellness Center for health club memberships

- MHP encourages healthy lifestyles by offering this benefit.

- CHW's in the Front Lobby are key to helping members access this benefit and encourage their regular attendance. Members simply present their MHP card to any YMCA or to the Touchstone Wellness Center and are able to gain access.

MHP Cell Phone Program

- CHW's assist qualifying members to access medical services and other health plan covered services by helping them access a working telephone.

- Members who are unable to access a landline or cell phone due to their medical status and limited financial resources will receive assistance obtaining either an MHP cell phone or cell phone from a federal Lifeline and state Telephone Assistance Plan program.

Care Coordination

- CHW's make sure that members are connected to care coordination. CHW's in the Front Lobby work closely with the care guides to ensure that members get the care they need.
- CHW's in the front lobby coordinate with care guides to provide a safe and secure meeting environment in MHP offices.
- CHW's get to know members and their needs and are an important part of the care member's receive.

Member Events

- Held twice a year (in the spring and fall)
- Members meet with providers, receive health education and meet with care guides
- Members provide feedback to MHP about the health plan through an anonymous written survey
- MHP updates and refines the program based on member feedback
- CHW's facilitate attendance and assist with the event

MHP's New Website

Visit www.mhp4life.org to check out MHP's new user-friendly website!

New features include:

- Separate member and provider pages
- A member news section
- Easy-to-access transportation and member ID card information
- Simpler navigation steps
- A more extensive provider search function (in progress)

THANK YOU!

Supportive Housing Programs

Partnerships with Medica Health Plan in Minnesota

Cindy R. Moe, MS,LP
Clinical Program Manager
Phone: (800)-548-6549 x 66282
Email: cindy.moe@optum.com

Project Summary

Initiative between Medica Health Plan and 2 Community Service Agencies (2012)

Hearth Connections*

- Housing Assistance and Supportive Services Agency
- Local Service Partners

St. Stephen's Human Services

- Human Service Agency
- Dedicated to Ending Homelessness

Services Provided

Supportive Services/Case Management

Rental Subsidies and/or Housing Vouchers

*http://www.hearthconnection.org/medica-project/

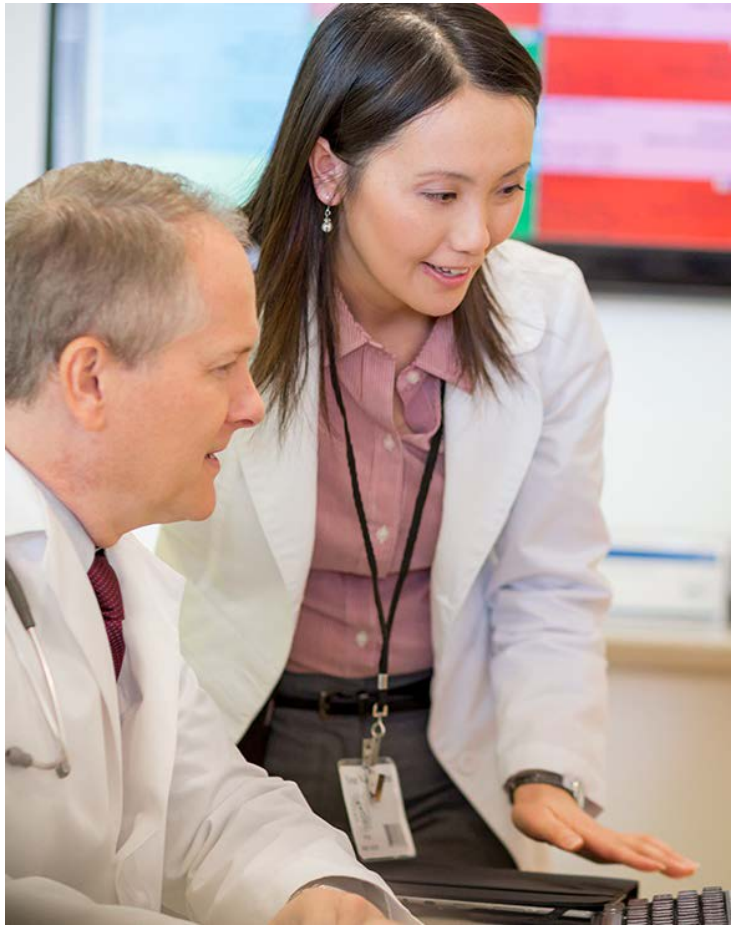
OPTUM™

Project Summary (cont.)

- Process Overview
  - Identification
  - Referral
  - Coordination
  - Placement and Supportive Services

Identification

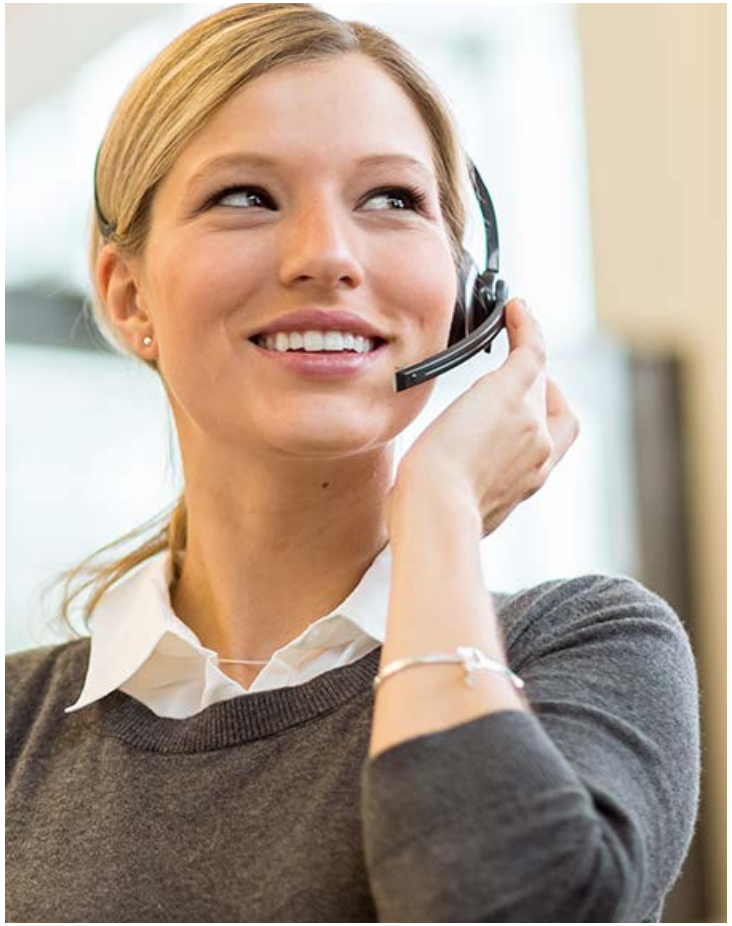
- Care Advocates (CA)/Coordinators (CC)
  - Identify members who may need assistance
  - Screen for homelessness
  - State and/or Federal definition*
- Internal Report
  - Members with “General Delivery” addresses



*https://www.nhchc.org/faq/official-definition-homelessness/

Referral

- Stratification of Identified Members
  - Direct referral
  - ER Visits/Claims Costs
  - Location (services vary by county)
- Referral List
  - Business Associate relationship
  - Referrals sent to Agency (secure email)
  - Member information
  - CA/CC information



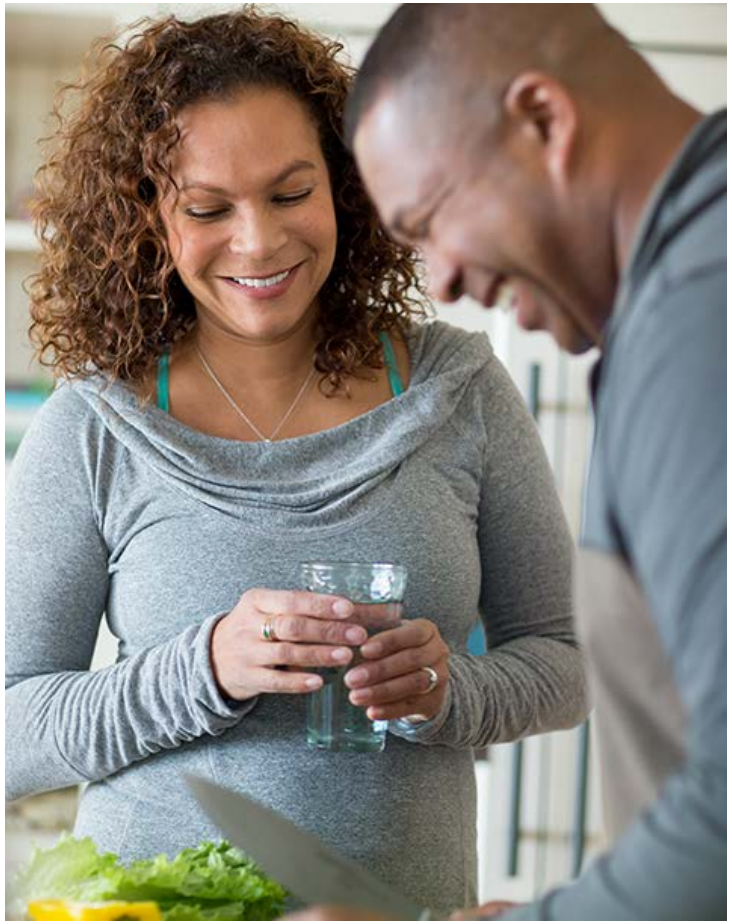
Coordination

- Locating the Member
  - Updating contact information
  - Notification of admissions
  - Provider contacts
- Screening/Assessment
  - Long-term Homeless
  - Self Sufficiency Matrix*
- Updates

*http://www.mnhousing.gov/get/MHFA_010880

Placement and Supportive Services

- Locate and Secure Housing
- Ongoing Supports
- Monthly Updates



Outcomes

- Hearth Connection
  - Three year project
  - Interim evaluation in 2014
  - Cost savings not identified (control matched)
  - Full evaluation in 2015
- St. Stephen's
  - Two grant periods
  - Initial results defined second year metrics
  - Final evaluation underway

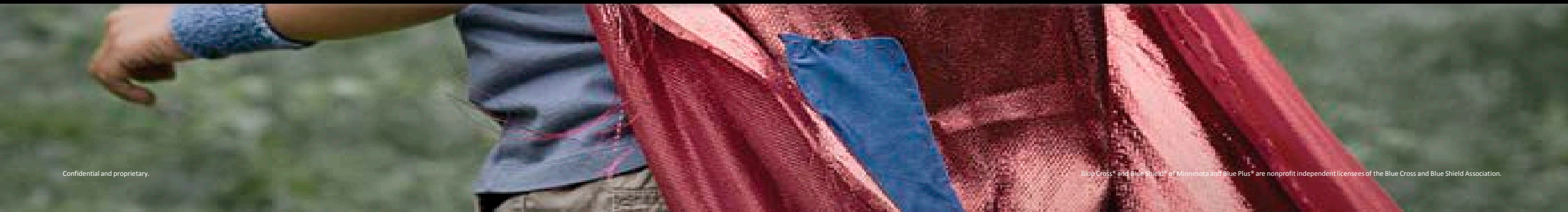
- Areas for Evaluation
  - Placement rates
  - Self-Sufficiency Matrix
  - Claims costs

Thank You

BlueCross BlueShield Minnesota

ACCESS MANAGEMENT: MN RESTRICTED RECIPIENT PROGRAM

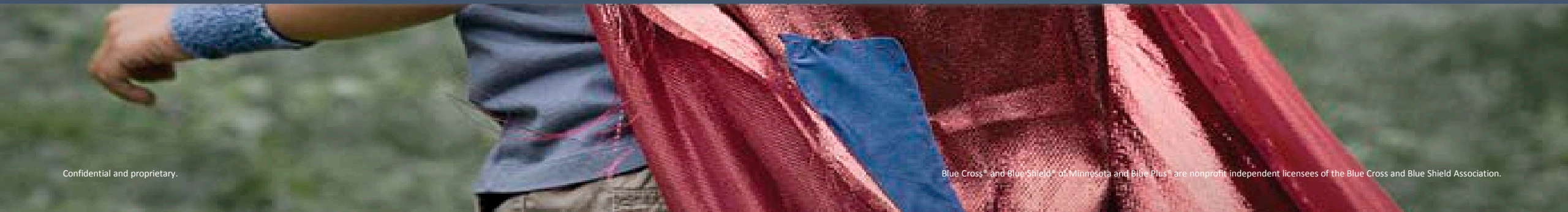
Ariel Johanna Cohen, EdD, RN, CARN, CLPP
Louise Clyde, Director of Behavioral Health Blue Cross Blue Shield of MN



BlueCross BlueShield Minnesota

ACCESS MANAGEMENT: MINNESOTA RESTRICTED RECIPIENT PROGRAM

Ariel Johanna Cohen, EdD, RN, CARN, CLPP
Louise Clyde, Director of Behavioral Health Blue Cross Blue Shield of MN



Access Management Team

BlueCross BlueShield Minnesota

NatalisOutcomes

- Access Management Specialists (AMS) manage MN Restricted Recipient members as well as members who are being monitored based on utilization data and claims
- Monitored members are contacted by AMS to offer case management. Utilization data and claims are continuously reviewed
- Restricted Recipients are PMAP or MNCare members that have demonstrated excessive over and/or dangerous utilization of health care, pursuant to the laws of the state of Minnesota
- The Access Management Team focuses on supporting healthcare needs of Restricted Recipients and monitored members for both behavioral and medical conditions

Hallmarks of AM

- Once it is determined that placement in the MN Restricted Recipient Program (MNRRP) is appropriate, the AMS will send an initial notice of placement to the member.
- The AMS contacts the member's primary care provider (PCP) to discuss the RR program and their role in the process.
- AMS sends a verification letter at least 30 days after notifying the member, if the member has not appealed placement within the thirty days
- AMS places a "claim stop" to pend all claims for review, except for home care, personal care attendant (PCA), durable medical equipment (DME), urgent care, behavioral health, chemical dependency, OB/GYN and labs.
- AMS notifies the medication vendor, pharmacy, and completes entry into MMIS.
- Any changes in providers must be completed through the AMS.
- AMS completes all required documentation in the electronic medical record.

NatalisOutcomes

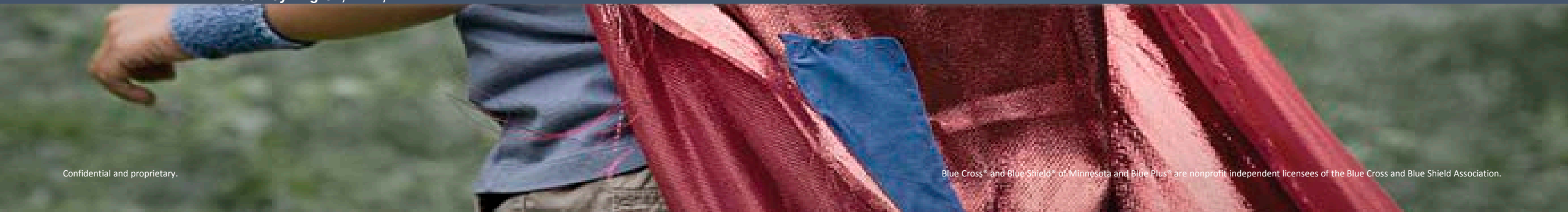
THANK YOU.

BlueCross BlueShield Minnesota

BLUE PLUS SPECIAL CARE PROGRAM

Ariel Johanna Cohen, EdD, RN, CARN, CLPP
Louise Clyde, Director of Behavioral Health Blue Cross Blue Shield of MN

NatalisOutcomes
Jonathan Hoistad, PhD
Jeffrey Wigren, MPH, MHA



Evidence-Based Strategies

- Transitional care with hospitalized consumers by a Nurse Practitioner, followed-up by intensive post-discharge support
- Self-management education with the client and their family to identify individual goals, improve health literacy and self-efficacy
- Care coordination about when to seek medical care, proper self-care, communication skills and available social supports. The client's symptoms, well-being and compliance with medical recommendations is monitored and reported to their PCP

Model Design

BlueCross BlueShield Minnesota

NatalisOutcomes

Main Goals

Use community care managers (CMs) to provide care coordination (CC) to (1) fill gaps in care, (2) resolve barriers to care and (3) reduce high-cost care, while (4) improving member's overall health. Ideally, the program will help members to address root issues, such as chemical, mental, behavioral and chronic physical health risks that may lead to overuse and abuse of health services

Pilot Scope Statement

Evaluate the effectiveness of a community based targeted care management pilot project serving 150-200 selected Blue Plus Minnesota Restrict Recipient Program enrollees to (1) ensure they receive appropriate support and the proper level of care, (2) increase use of preventive services (3) reduce the frequency of ER visits and hospitalizations and (4) improve their quality of life

Work Breakdown Structure & Project Management Plan

A detailed blueprint and set of pilot implementation tasks to ensure project fidelity

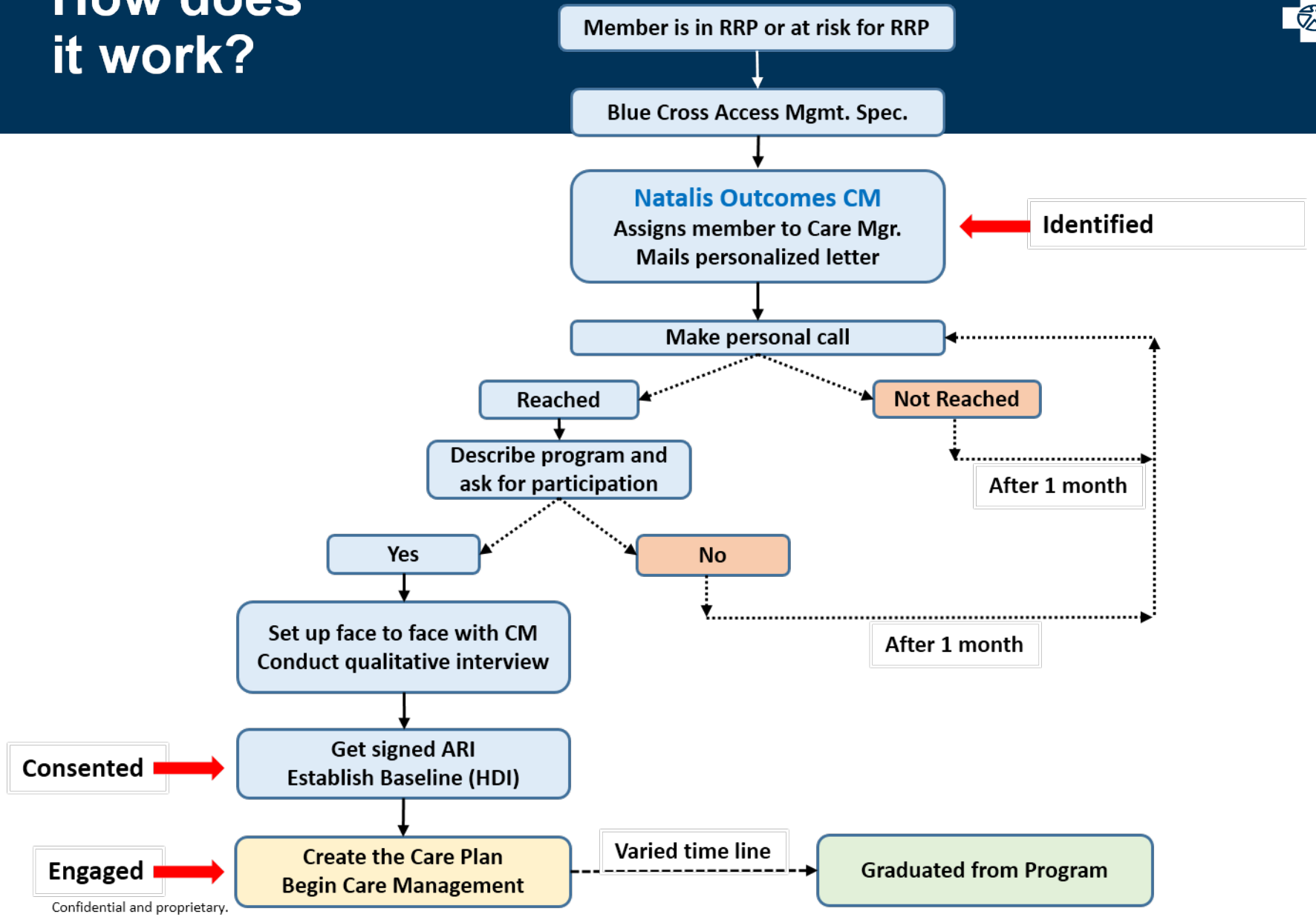
Model Design, continued

"We're encouraging people to become involved in their own rescue."

Population Demographics

- 168 members referred from Ramsey and Dakota counties to this date
- 50 members (29% of total referred) have consented to participate in the pilot
- 30 members (60% of consented) are actively engaged in program and have an active care plan
- 121 members (72%) are female
- 47 members (28%) are male
- Average age is 36 years
- Age range is from 19 – 61 years

How does it work?



Initial Talking Points to Member

BlueCross BlueShield Minnesota

NatalisOutcomes

Monitored:

- Member was referred from Blue Cross because the utilization patterns indicated that they member benefit from a face to face care coordinator to assist with their healthcare needs

Restricted:

- Member was referred from Blue Cross due to their placement on the MNRRP and the belief that they may benefit from a face to face care coordinator to assist with their healthcare needs

Benefits of care coordination:

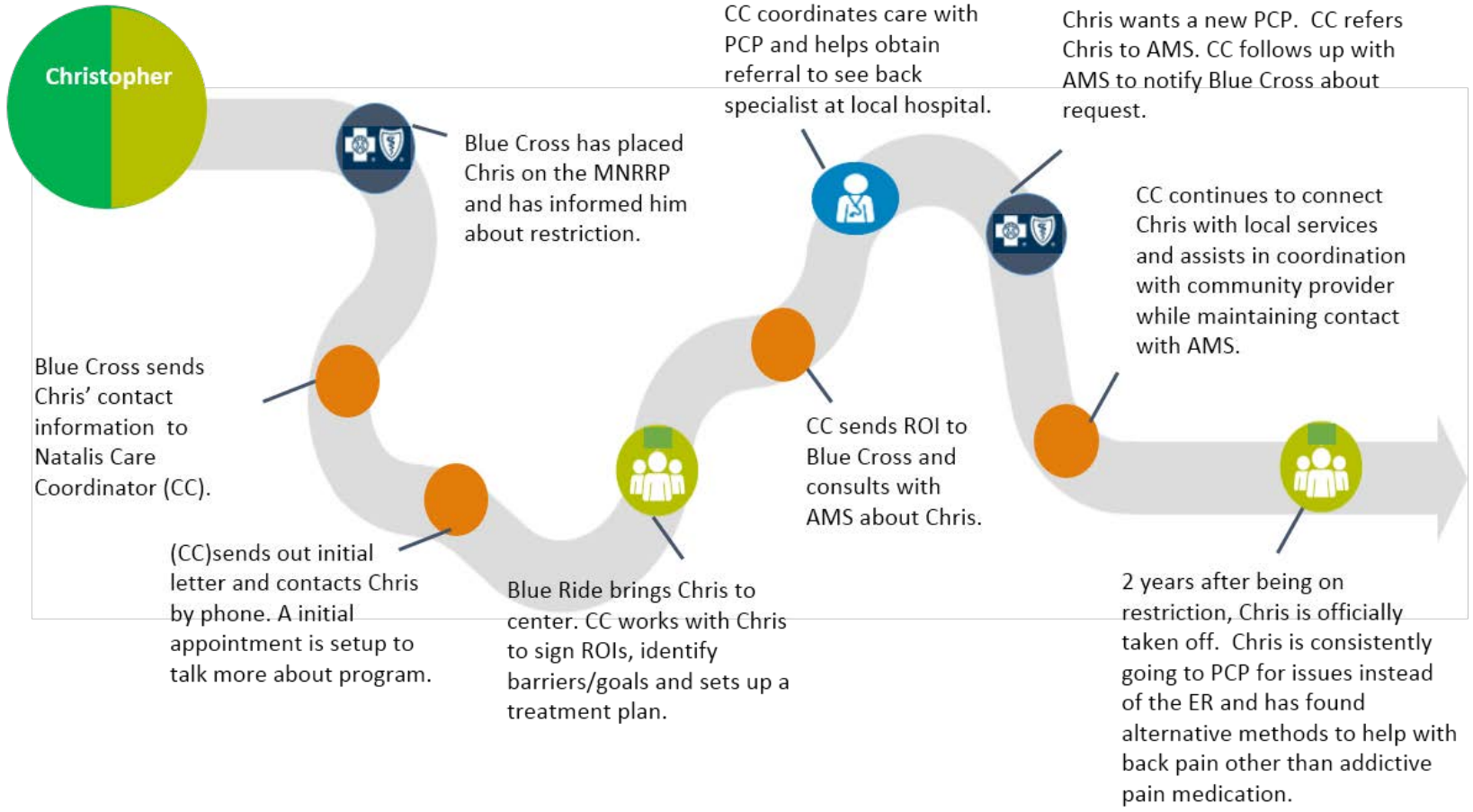
- Help member achieve their health goals
- Help with navigating the healthcare system
- Coordinate care with providers
- Connect member to community resources and supports
- Assist member with finding specialty providers
- Assist member with coordinating transportation
- Assist member with understanding their health plan benefits and how to work with health plan
- Assist member with maintaining active insurance

CHRIS

- 34 years old
- High ER visits for back pain
- Doctor shops for pain meds
- Lives in OtterTail

BlueCross BlueShield Minnesota

NatalisOutcomes



Outcomes of Pilot

BlueCross BlueShield Minnesota

NatalisOutcomes

- Not subject to restriction if member engaged while being monitored
- Reduction in amount of members re-enrolled in restricted program
- Decrease in emergency room visits and hospitalizations
- Increase in preventative visits
- Attendance of out-patient services on a consistent basis
- Improvement in quality of life
- 190 members referred
- 125 active members in the program

NatalisOutcomes

THANK YOU