H0564 Blue Cross of California
Dual Eligible (Subset - Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 86.67%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Blue Cross of California (BCC) serves dual eligible Medicare and Medicaid members who reside in one of the plan's service areas in California. Fifty-three percent of members are under age 65 and 62 percent of the total membership is female. English is the primary language (70 percent) spoken by members followed by Spanish (25.6 percent). The racial diversity among members includes: White (37.16 percent), Black (33.51 percent), Hispanic (14.7 percent), Asian (8.62 percent) and other (4.91 percent). The most prevalent conditions in the population are: diabetes, chronic obstructive pulmonary disease, psychiatric conditions (depression, bipolar) and renal disease. About half of members have conditions or receive benefits that qualify them as having a disability.

BCC's most vulnerable members are those who have multiple chronic and complex medical and behavioral conditions, complex medication regimens, multiple hospital re-admissions or experience functional, social and environmental issues that limit their understanding of health issues and access to medical services.

Provider Network

BBC's provider network includes, but is not limited to: behavioral health (mental health and substance use) facilities, skilled nursing facilities, ancillary providers and facilities, dialysis centers, federally qualified health centers and rural health care systems. Members also have access to specialists trained to manage their conditions and special needs that include: cardiologists, diabetic educators, endocrinologists, geriatricians, nursing professionals, physical medicine physicians, physiatrists and social workers.

Care Coordination and Management

Within 90 days of enrollment and annually thereafter, members complete a health risk assessment tool (HRA) that contains questions about their physical and mental health as well as their functional, cognitive and psychosocial status. Identification of the member's cultural preferences is also part of the HRA process. Members complete the HRA telephonically, by mail, via the member portal, by interactive voice response or utilizing home care providers. Additional assessment tools are utilized to assess specific member needs and include the following: disease specific tools, additional behavioral health assessments, post discharge

assessment tools and a universal assessment tool for members who require long term services and supports. A screening tool may also be used to further stratify the members and to determine if a more comprehensive assessment is required. In addition to the annual reassessment, the care manager (CM) completes reassessments based on a significant change in a member's status, such as after a transition or a change in the stratification level.

The CM develops the individualized care plan (ICP) using information gathered through the assessment process, along with a review of the relevant evidence-based clinical guidelines. The ICP includes prioritized, short and long-term goals that consider the member's self-management goals, target dates for goal completion, personal healthcare preferences and desired level of involvement in their case management plan. The ICP also includes services designed to meet the member's needs.

The CM documents the ICP in the electronic case management system where it is accessible to all internal members of the interdisciplinary care team (ICT). The ICT reviews the ICP annually, at a minimum, when the member experiences a change in condition or status, achieves their goals or the goals require revision. The CM communicates ICP updates and modifications either verbally, by hard copy or electronically with the member and/or caregiver, primary care physician (PCP) and other ICT members as needed.

The composition of the ICT is based on the complexity of the member's condition, results of the HRA, the member's needs and other health care programs through which the member may be receiving benefits. The ICT will always include the member, CM and PCP, but it may also consist of a medical expert, behavioral health (mental health/substance use) expert, social services expert and other practitioners. The PCP, with the CM's assistance, coordinates the member's medical care with other providers and disciplines.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.anthem.com/ca/medicare