H0838 Universal Care, Inc.
Chronic or Disabling Condition (Chronic Heart Failure) Special Needs Plan

Model of Care Score: 88.33%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Universal Care operates as a chronic care special needs plan (C-SNP) under the name Brand New Day (BND) that specializes in patients with chronic heart failure (CHF) within the State of California. To qualify for the C-SNP, members must have a diagnosis of CHF from a qualified medical professional.

Brand New Day has 2,804 members who are currently dually eligible for Medicare and Medicaid benefits and are enrolled in a C-SNP as well as members who have Medicare only. The most common comorbidities for these members include, diabetes, heart disease, COPD, dementia, and mental illness. Other than English, the most common language in all California counties is Spanish. BND also has other languages represented which include, Khmer (Cambodian), Vietnamese, Korean, Armenian, Russian, and Tagalog. BND also serves members that are hearing impaired, blind and mute.

Provider Network

BND contracts with providers across multiple counties and service areas within California. The BND network includes providers who match their assigned members' language and culture needs. The plan also has contracts with providers who go out to the patient's home for those who have trouble traveling to appointments. The basic network BND contracts with includes, primary care providers, facilities, specialists, ancillary services, allied health and mental/behavioral health providers.

BND contracts to provide CHF members with a 2-way scale which communicates daily weights to a call center, and reports if the member has a weight gain of more than 2 pounds in a day or 5 pounds in a week. If this occurs, BND either sends the member to a cardiologist or a properly trained PCP. When necessary, these providers may go to a member's house to deliver care.

Care Management and Coordination

BND uses a health risk assessment (HRA) as the basis for all care coordination activities. The plan builds the tool to act as a multidisciplinary instrument to collect data on the medical, psychosocial, functional capabilities and limitations of the membership. The plan designs the HRA to identify continuity of care issues for new enrollees and those members in need of referral or continuation of Medicaid (Medi-Cal in California) coordinated services. The tool allows both the plan and its providers/care managers to, organize and facilitate the process of care management/coordination, determine long-term care requirements and placement and to

make use of health care resources. Each BND member the plan identifies as eligible and enrolled in the CHF program receives an HRA. In addition, BND assesses its members according to a CHF tool that specifically addresses preventative care, labs, testing and physiological assessment

The results of the HRA and CHF assessment are used to build an individualized care plan (ICP) for all members. A BND care manager creates the care plan for each member and incorporates information for developing needs and goals of the care plan. The development process of the ICP includes, HRA results, CHF assessment tool results, claims data or history, information from provider (including specialist) or member and clinical assessments. The results of the care planning process for each member's ICP, at a minimum includes, the beneficiary's self-management preferences, the beneficiary's personal healthcare preferences and the identification of goals.

BND uses the results of the member's HRA, the CHF assessment tool and ICP to determine the composition of an interdisciplinary care team (ICT) for each CHF member. The plan assigns each member to an ICT that's reflective of the final care plan, but at a minimum includes, primary, ancillary and specialty providers. The ICT oversees coordinating, reviewing, modifying and evaluating the care that is delivered to assigned CHF members. Required ICT participants for higher risk CHF members include, a medical expert, social services expert, care manager, pharmacist, mental/behavioral health expert (when necessary), the member and/or family/caregiver (when possible) and a cardiologist.

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.BNDhmo.com.