Advantage by Buckeye Community Health Plan, H0908
Dual Eligible (All Duals) Special Needs Plan

Model of Care Score: 85%
3-Year Approval **January 1, 2013 to December 31, 2015**

Target Population

Buckeye targets all Medicare beneficiaries who are also eligible for Medicaid at any level in four regions (30 counties) in Ohio. A large percentage of the current membership (74 percent) is 59 years old or younger. The average age is 51, so most of the population qualifies for Medicare because of a disability. There is a high prevalence of substance abuse and mental health issues, particularly depression. The membership has housing and income issues and tend to struggle with the complexities of having to manage two sets of benefits and systems (Medicare and Medicaid).

Provider Network

Buckeye provides enrollees access to a wide range of credentialed and contracted providers that include: physicians; nurse practitioners; physician assistants; dietitians; acute care facilities such as hospitals, emergency departments, urgent care centers and some long-term care hospitals; laboratories; skilled nursing facilities; federally qualified healthcare centers (FQHCs); rural healthcare centers (RHCs); pharmacies, radiography facilities; rehabilitative facilities; dialysis centers; outpatient surgery centers; hospices; home health agencies; infusion centers; durable medical equipment suppliers; behavioral health practitioners; oral/dental specialists and vision specialists.

Buckeye only contracts with providers that accept both Medicare and Medicaid. Primary care physicians (PCPs) are responsible for supervising, coordinating and providing all primary care to members as well as coordinating/initiating referrals to specialists and coordinating care among other network providers.

Care Management and Coordination

The health risk assessment (HRA), a standardized assessment tool created by Buckeye, is designed to identify the needs of the most vulnerable members by evaluating medical, psychological, functional and cognitive needs. HRAs are conducted by Buckeye care managers (a licensed nurse) within 90 days of the member's enrollment, usually by phone. In-person assessments are done when warranted. Assessments are then conducted annually or more frequently if needed based on the members' health status. Buckeye uses the results of the HRA,

claims data and a predictive modeling tool to stratify each member into low, medium or high priority risk status. The risk status determines the specific areas of focus for the member and the frequency of contact and intensity of interventions and assignment to care coordination, care management or complex care management.

The care manager is the primary person responsible for developing the plan of care (POC) for each member based on HRA results and claims data. The POC includes information on prioritized problems, barriers, interventions and goals. Care managers contact members by phone to discuss the POC and explain the care manager's role, the role of care management, and then ask if members are willing to participate in the care management program. Members are informed that they may decline to participate or disenroll (opt out) from the program at any time. If the member agrees to participate, an in-depth assessment is done to more closely identify and prioritize the member's individual needs, including assessment of activities of daily living, barriers to meeting goals, including social barriers (e.g., transportation, childcare needs, safety), mental health status, alcohol or drug dependency, health literacy, personal and caregiver resources and other factors that may impact the member's health and ability to meet their care plan goals.

The care management team, known as the interdisciplinary care team (ICT), reviews the gathered information and begins to build a complete care management POC within 30 days of the assessments and identification of the member as appropriate for care management. The ICT is generally comprised of multidisciplinary employed clinical and nonclinical staff. The non-medical personnel perform non-clinical based health service coordination and clerical functions, and licensed professional staff focus on the more complex and clinically based service coordination needs. The ICT also includes a PCP and specialty care providers pertinent to the member's needs that may include, a nurse practitioner, mid-level provider, social worker, registered nurse, occupational/speech/physical therapist, dietician, pharmacist, health educator, disease manager, behavioral/mental health specialist, community resources specialist, dentist, pastoral services, and others.

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:

http://advantage.bchpohio.com