H0908 Buckeye Community Health Plan, Inc.
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 81.67%
2-Year Approval **January 1, 2015 – December 31, 2016**

Target Population

Buckeye Community Health Plan, Inc. (Buckeye) Dual Eligible Special Needs Plan (D-SNP) serves dually eligible individuals, those who have Medicaid eligibility and live in one of its 39 service areas in Ohio. Of the 1,359 members, sixty-three percent are age 59 or younger; the average age of members is 55 years old. The racial composition of Buckeye's membership is: White (36 percent), Black or African American (37 percent), unable to determine (29 percent), Asian (less than one percent) and American Indian or Alaskan (less than one percent).

Chronic conditions include but are not limited to diabetes, high blood pressure, chronic obstructive pulmonary disease (COPD), heart disease, obesity, arthritis, and mental health problems. The SNP population in Ohio tends to have a higher prevalence of mental health problems and substance abuse conditions which can impede the member's ability to achieve improved health outcomes. A significant percentage of the population has cognitive deficits resulting from their living conditions, historical life choices and/or disabilities.

Provider Network

Members have access to a wide range of credentialed and contracted providers that include physicians with specialties in: cardiac care, orthopedics, rheumatology, allergy, urology, dermatology, pathology, pulmonology, optometry, endocrinology, podiatry, neurology, rehabilitative therapy and oncology. The network also consists of but is not limited to: nursing specialists and physician assistants; dieticians and rehabilitative/restorative therapy specialists, mental health specialists, social service specialists; oral health specialists and surgeons; pharmacists and medical equipment suppliers. In rare instances when in-network services are not available, care managers (CM) coordinate members' access to out-of-network providers.

The types of facilities in the network encompass: hospitals and emergency departments, urgent and outpatient care centers, long-term care hospitals, laboratories and radiography facilities, skilled nursing and rehabilitative facilities, federally qualified healthcare centers, rural healthcare centers, pharmacies, dialysis centers, outpatient surgery centers, hospice, home health agencies and infusion centers.

Care Management and Coordination

Within 90 days of enrollment, the CM conducts an initial health assessment/risk stratification (HRA) with each member by telephone. The HRA identifies the member's medical, psychological, functional and cognitive needs. The assessment also gauges the member's medical and behavioral health history to coordinate his or her care. The CM conducts a reassessment annually or more frequently based on the member's health status. Buckeye uses HRA results, claims data and a predictive modeling tool to stratify each member into a low, medium or high priority risk status. The member's risk status determines the specific areas of focus, the frequency of contact, the intensity of interventions and the member's assignment to care coordination, care management or complex care management. The CM reviews the member's risk level during each contact.

The CM obtains input from the member, his or her caregiver and the interdisciplinary care team (ICT) to develop an individualized care plan (ICP) that includes prioritized goals, barriers to meeting those goals or complying with the ICP and possible solutions for the identified barriers. The CM modifies the ICP as needed based on the members needs/progress and modifies the goals based on the findings of on-going evaluation. The CM completes a re-assessment when the member has a significant change of condition or based on the member's stratification level. The CM shares the modified ICP with the ICT electronically within the care documentation system. Additionally, the CM shares it with the member, primary care practitioner (PCP), and/or other treating provider via fax or other appropriate communication modality.

A board certified medical director leads the multidisciplinary ICT comprised of clinical and nonclinical staff. It includes: a CM, social workers, behavioral health care managers, program coordinators, member representatives and pharmacists. Depending on the member's needs, the PCP and specialty care providers may join the ICT. Examples of these providers include: a nurse practitioner, a mid-level practitioner, a social worker, a registered nurse, an occupational, speech and/or physical therapist, a dietician, a pharmacist, a health educator, a disease manager, a behavioral/mental health provider, a community resources specialist, a dentist and pastoral services.

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.