Health Care Service Corporation, H-3822
Dual Eligible (Medicare Zero Cost-Sharing) Special Needs Plan

Model of Care Score: 96.88%
3-Year Approval **January 1, 2014 – January 1, 2017**

Target Population

Enrollment into Health Care Service Corporation (HCSC)'s plan will be limited to seniors and individuals with disabilities who are Medicare Zero Cost Share (QMB and QMB+) Dual Eligible and reside in the service areas of Bernalillo, Sandoval, Torrance or Valencia County, New Mexico. The unique needs of dual eligibles include not only their underlying health conditions, but also the challenges of having to navigate both the Medicare and Medicaid benefits and payment systems. In New Mexico, 43% of dual eligibles have one or more behavioral health issues or cognitive impairments and 60% have multiple chronic conditions. In addition, two-thirds are seniors aged 65 and older and more than half have incomes below the poverty line.

Provider Network

HCSC's provider network includes primary care physicians (PCP), physician specialists, acute care hospitals, inpatient mental health hospitals and nursing facilities, home and community based services network, allied health professionals, physical/occupational/speech therapy specialists, lab and radiology specialists, Federally Qualified Community Health Centers and home health physicians/providers. In addition, HCSC's network includes skilled nursing facilities, adult daycare centers and rehabilitation centers. To better serve the target population, HCSC has also increased its provider network in the areas of substance abuse, home and community based services as well as Indian Health Services/Tribal/Urban Indian Facilities and critical access providers.

Care Management and Coordination

Within 10 calendar days of enrollment and annually upon membership renewal, the care coordinator will contact the member to conduct an initial health risk assessment (HRA) by phone. During the assessment, the care coordinator will obtain basic physical health, behavioral health, demographic information and transition of care information to determine the level of care coordination the member needs. If the member cannot be reached after 3 attempts, a care coordinator, community health worker or community support worker will visit the member at his/her home in an effort to perform the HRA. The HRA will determine whether the member requires Level I care coordination or a comprehensive needs assessment for assignment to Level

II or Level III care coordination. The comprehensive assessment in-person visit is scheduled within 2 weeks from the initial HRA.

The individualized care plan (ICP) is developed from the specific needs of each member using the HRA and additional comprehensive plan of care assessments. Each member's ICP includes a clear statement of needs and the specific services and care coordination required to address those needs. The ICP also includes goals with targeted timelines and dates for achieving those goals. It also takes into account the member's existing care and support network in the community, including community based providers and the member's care givers. The ICP is developed by the interdisciplinary care team (ICT) with input from the member.

The composition of the ICT is defined by the needs of HCSC members and the level of prominence of individual clinical and behavioral health members of the ICT varies significantly depending on the level of members' health needs. The care manager leads the team and is supported by the health coordinator. The care manager is responsible for performing the in-depth assessment of each member's needs, coordinating with stakeholders in the member's care and incorporating member's desires. If the member's HRA indicated that a behavioral health diagnosis was primary, a behavioral health care manager may lead the team in the ICP development and implementation. Community based resources will also become a key component of the member's care team and will often be responsible for service delivery as directed by the ICP. Each member will have an ICT meeting annually via teleconference, at a minimum, as well as when there is a change in condition or services needed.

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:
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