**H5422 Blue Cross Blue Shield Healthcare Plan of Georgia,**
**Dual Eligible Subset – Medicare Zero Cost-sharing Special Needs Plan**

**Model of Care Score: 100.00%**
**3-Year Approval** **January 1, 2015 – December 31, 2017**

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## Target Population

Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSGA) serves 36,000 Medicare members who are also eligible for Medicaid. The most prevalent conditions in the population are: diabetes, chronic obstructive pulmonary disease, psychiatric conditions (depression, bipolar) and renal disease. Fifty-three percent of members are under age 65 and 62 percent are female. English is the primary language (70 percent) spoken by members followed by Spanish (25.6 percent). The racial diversity of the population includes: White (37.16 percent), Black (33.51 percent), Hispanic (14.7 percent), Asian (8.62 percent) and other (4.91 percent). Approximately half of members have conditions or receive benefits that qualify them as having a disability.

BCBSGA'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

The facilities included in the network are: 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. BCBSGA members also have access to specialists trained to manage their conditions and special needs. These providers include cardiologists, endocrinologists, diabetic educators, geriatricians, nursing professionals, physical medicine physicians, physiatrists and social workers.

## Care Management and Coordination

Within 90 days of their enrollment, members complete a health risk assessment tool (HRA) that contains questions about their physical health, mental health, functional and cognitive and psychosocial status. Members complete the HRA telephonically, face-to-face (in-home or in a facility), by mail or by vendor. HRA responses identify a member's immediate needs or any changes since the last assessment to screen for potential referral to other programs, benefits and community resource needs. In addition to the initial and annual HRA, the care manager (CM) updates the HRA responses whenever there is a significant change in health status, or a diagnosis of new conditions.

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 the 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 to which all internal members of the interdisciplinary care team (ICT) have access. At a minimum, the ICT reviews the ICP annually, or when the member experiences a change in condition, when the member achieves a goal or the goals require revision. The CM communicates updates and modifications to the ICP either verbally, by hard copy or electronically with members, caregiver(s), 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, member and caregiver needs and other health care programs through which the member may receive benefits. While the ICT will always include the member, primary care physician (PCP) and CM, it may also consist of a medical expert, behavioral health (mental health/substance use) expert and social services expert. The PCP is responsible for coordinating the member's medical care with other disciplines and other providers; however, the CM works closely with the PCP via phone, fax, and/or in person during the care planning process to assist with the member's care coordination.

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.bcbsga.com/medicare