H9954 Anthem Health Plans, Inc.
Dual Eligible (Subset - Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 86.67%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Anthem Health Plans, Inc. (Anthem) serves members who have full benefit dual eligibility. Across all Anthem plans, English is the primary language (70 percent) with Spanish being the next most prominent (25.6 percent) language spoken. The review of racial diversity of the population reveals: White (37.16 percent), Black (33.51 percent), Hispanic (14.7 percent), Asian (8.62 percent) and other at 4.91 percent. Sixty-two percent of members are female and 53 percent are under age 65. The top healthcare diagnoses include: diabetes, major depressive, bipolar and paranoid disorders, chronic obstructive pulmonary disease, vascular disease, congestive heart failure and renal failure. Approximately 50 percent of this population have conditions or received benefits that would qualify as having a disability.

The major challenges members face include the following: lack of financial resources, homelessness or unstable home environment, access to care issues due to transportation barriers or living in rural areas, variations in education, poor health literacy, comorbid conditions, communication difficulties including language, hearing and cognitive issues. Additionally, dual eligible members must navigate the Medicare and Medicaid systems which is especially challenging given complex needs and can lead to fragmented, costly care and poorer health outcomes.

Provider Network

Anthem's provider types include but are not limited to: geriatricians, physical medicine physicians and physiatrists; behavioral health (mental health and substance use) providers and facilities, skilled nursing facilities, ancillary providers and facilities, dialysis centers, federally qualified heath centers, rural health centers, cardiologists, endocrinologist, diabetic educators, social workers and nursing professionals. Anthem also contracts with vendors to provide telemonitoring services, transportation, personal emergency response systems and home safety assessments for its members.

Care Management and Coordination

Within 90 days of enrollment, the member completes a health risk assessment (HRA) to assess their physical, mental, functional, cognitive and psychosocial needs. The member can complete the HRA telephonically, face-to-face (in-home or in a facility), by mail, or by vendor.

Additional assessment tools may be utilized to assess specific member needs and include the following: disease specific tools, additional behavioral health assessments, post discharge assessment tools, and a universal assessment tool for members who require long term services and supports. Certain HRA questions generate a risk score (0 = low risk, 1-3 = moderate risk, level of 3 = high risk) which allows the case manager (CM) to better determine members' needs and the interdisciplinary care team (ICT) composition. At a minimum, the HRA is conducted annually, whenever there is a significant change in health status, or after transitions of care.

In developing the individualized care plan (ICP), the CM reviews the HRA results as well as detailed clinical information on each member including history, a list of medications, authorizations, claims and lab work results. The ICP includes prioritized goals (short and long-term) that consider the member/caregiver's self-management goals, personal healthcare preferences and desired level of involvement in the case management plan. The ICP is stored in the case management system and is available electronically to all internal members of the ICT. Updates or modifications to the ICP are communicated either verbally, by hard copy or electronically. The ICP is reviewed annually at a minimum, whenever the member experiences a change in condition or status, or when ICP goals are achieved or require revision.

The core composition for ICT is the member, CM and primary care physician (PCP). Members with more complex care needs have an ICT that may include additional members such as: a social worker, clinical pharmacist, behavioral health specialists, dietitians, transitional care nurses, treating specialists and case managers from other programs, such as Medicaid home and community-based services waiver programs. With the CM's assistance, the PCP coordinates the member's care with other disciplines and with other providers. The ICT meetings may take place telephonically, electronically or in person.

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.anthem.com\medicare\