McLaren Health Plan, H0141
Dual-Eligible (Dual Eligible Subset - Medicare Zero Cost-sharing)
Special Needs Plan

Model of Care Score: 85.63%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

The target population for this SNP is dually eligible individuals who qualify for Medicare and Medicaid and are enrolled in McLaren Health Plan's (MHPs) MA-SNP (D-SNP). Several of these members have a high incidence of multiple needs and lack support systems. Many face barriers to healthcare access and health status improvement such as a lack of primary care services and preventive health screenings or socio-economic disadvantage. Co-morbidities such as heart disease, Chronic Obstructive Pulmonary Disease (COPD), hypertension (HTN), diabetes (DM), depression, and cellulitis are prevalent. Among these members, 50% have documented depression.

Provider Network

MHP recognizes that members who are dually eligible for Medicare and Medicaid and enrolled in its MA-SNP (D-SNP) have specific needs and may require the services of many different types of specialists and various other physicians and providers. The provider network includes primary care, specialty, ancillary, skilled and non-skilled, and facility types including but not limited to medical specialists, dialysis facilities and specialty outpatient clinics.

Due to the multifaceted, chronic, and relapsing nature of substance use disorders, the care management focus is to increase the member's treatment participation and retention, maximize greater use of services, and improve drug-related outcomes. MHP uses a team approach in conjunction with integration of a comprehensive network of services though the interdisciplinary care team (ICT) process.

Care Management and Coordination

The initial health risk assessment (HRA) is completed within 90 days of enrollment. MHP's HRA is based on the targeted population characteristics. Questions are aligned with what needs could be present with the members and if a member answers "yes" to two or more mental health questions, the PHQ-9 form becomes available. If the member is not reached to schedule an HRA, a letter is sent requesting the member contact the plan. The complex case manager (CCM) nurse assigned to the member makes every attempt to complete an HRA and care plan. If the member

cannot be reached by phone and/or they refuse, MHP will contact the PCP to get information or get the basic information the member provides at the time of enrollment from the application. A basic care plan is developed and includes the identified goals and is shared with the member. Reassessment occurs annually or after any transitions of care. Prior to the reassessment, the CCM reviews the member's claims, medication list, care plan, and pending referral request.

Members of the MHP SNP ICT are carefully chosen to include both experienced and highly dedicated internal staff members, external community partners, and providers. The SNP member and the member's needs are at the core of the ICT. The core ICT may include case management nurses who perform case management and utilization management, pharmacists, a disease management nurse, chief medical officer and/or primary care and non-clinical staff. Other members may include PCPs, specialists, community pharmacists, behavioral health providers, support agencies such as the Area Agencies on Aging, home health providers, community resource providers, faith based organizations, and others identified as stakeholders by the member/caregiver and members of the team. The member/caregiver is always invited to participate in the ICT.

Each member enrolled in the SNP program will have an individualized, prioritized care treatment plan which is developed by the case manager, in collaboration with the ICT. The ICT is led by the CCM RN case manager. The case manager monitors, updates and evaluates member progress toward the care plan goals on an ongoing basis through member, family, caregiver, PCP, specialist, and ICT contact. Modifying the plan as needed helps to accurately reflect the prescribed care plan of the provider, incorporating additional information such as activities that are the result of an unplanned or planned transition, the Care Plan becomes the key repository of all care and service provided to support the member's clinical, behavioral, and psycho/social needs across the continuum.

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.McLarenHealthPlan.org.