Kaiser Permanente Health Plan, Inc. –California, H0524
Dual Eligible (Full Duals) Special Needs Plan

Model of Care Score: 87.50%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population

Kaiser Permanente California offers this Medicare Advantage Special Needs Plan (SNP) to members in separate programs for Northern and Southern California who are eligible for Medicare and full benefits under Medicaid. Members with SNP coverage are typically very frail or disabled, may have neurological disorders, mental health issues, end stage renal disease (ESRD) or other complex chronic conditions or are near the end of life. Approximately a third of the KP California SNP population is also under the age of 65.

Provider Network

Kaiser Permanente California contracts with individuals and groups to ensure comprehensive health care for its members. SNP members benefit from the services as part of the comprehensive Medical Care in place for all Kaiser Permanente Members. Its integrated health services delivery system is comprehensive and spans the ambulatory and emergency/hospital settings to include diagnostic, ancillary, laboratory and pharmacy services.

In Northern California, the healthcare delivery system includes 21 medical centers, 15 home health and 11 hospice locations, 2 skilled nursing facilities, 1 acute rehabilitation facility and over 100 ambulatory medical office buildings, its network of physicians is composed of over 7,000 physicians representing all specialties. In Southern California, the healthcare delivery system spans eight counties. There are 14 hospitals, 201 clinics, 10 Home Health and 10 Hospice locations with almost 6,000 physicians, covering all specialties. Throughout California, this is supplemented with an extensive network of contracted agencies and facilities to meet our members' needs.

The member's primary care physician (PCP) review and approve the SNP care plans created by the interdisciplinary care team (ICT) to ensure members are connected to the appropriate resources that support overall health and well-being. In Northern California, the members are assigned to an ICT based on the location of their PCP; in Southern California, members are assigned to an ICT based on proximity to the closest Medical Center. The physicians are supported by highly qualified clinician specialists and clinical teams in pharmacy, physical medicine and rehabilitation, nutritional care, care/case management, behavioral medicine, social services, home health, hospice, palliative care, skilled nursing facility care, health education and member services.

Care Coordination

Each SNP member will receive a health risk assessment (HRA) to support the development of a comprehensive individualized care plan (ICP). HRAs are conducted within 90 days upon initial

enrollment and on an annual basis. The health screen questionnaire (HSQ) survey tool is used to conduct the HRA, with the exception of members enrolled in hospice or a skilled nursing facility. The HSQ questionnaire is used to predict the risk of frailty, hospital admission and advanced illness or death. It is a well validated instrument developed by the Center for Health Research (CHR).

A comprehensive ICP is developed for each SNP member by the case manager using the HSQ information and risk stratification results to support care coordination and achieve member and care team goals. A thorough review of the member's medical record, consultation with clinical staff, along with member and caregiver interviews is used to develop the care plan. Case managers assess members in physical, functional, psychosocial, mental health, benefits coordination and advance care planning domains to ensure a comprehensive evaluation. Care plans include goals and outcome measures and are reflective of member preferences. Any add-on benefits or services for vulnerable members are included in the plan. ICPs are reviewed by the SNP case managers, in consultation with other members of the ICT. It is updated at least annually or during a significant change in health status.

The ICT provides care coordination services to support the member in achieving health care goals via an annual HRA, care planning and transition processes. ICT composition is based on the outcomes of the SNP member analysis. The ICT will include the SNP physician, SNP program manager, medical social worker and registered nurse case manager(s), behavioral health liaison and other members, to include pharmacists, case management, health educators

This Model of Care (MOC) summary is intended to provide a broad overview of the SNP's MOC. This summary provides a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to Kaiser Permanente's website at: www.kp.org