CareMore Health Plan, H0544
Dual Eligible (Dual Eligible Subset) Special Needs Plan

Model of Care Score: 91.88%
3-Year Approval January 1, 2013 to December 31, 2015

Target Population

CareMore Health Plan (CHP) is targeting dual eligible members that are eligible for Qualified Medicare Beneficiary (QMB), QMB Plus (QMB+), Specified Low-income Medicare Beneficiary (SLMB), SLMB Plus (SLMB+), full benefit dual-eligible (Medicaid only), Qualifying Individual (QI) and Qualified Disabled and Working Individual (QDWI). These members are mostly low income seniors who are typically on multiple medications, have multiple chronic conditions, are frail and most don't function independently. CHP's mean age of this SNP population is 70 years old, and a significant portion of these members have some of the risk factors associated with the elderly, such as cognitive impairment, functional impairment and varying ability in social and caregiver support.

Provider Network

In addition to a full contracted network of providers (e.g., primary care physicians (PCPs) and specialists), CHP employs clinicians with specialized expertise to provide additional services to the dual eligible population. CHP also sets up CareMore Care Centers (CCCs) in each geographic region it operates to provide a medical home for frail members, and to provide chronic care programs and preventative services for all members. In addition, CHP contracts with exercise and strength training centers to provide rehabilitative services, strength and balance training and activity in order to make members stronger and more mobile. Additionally, all members have a PCP who acts as a gate keeper.

Care Coordination

CHP uses standardized assessment questions, screening tools, guidelines and protocols as the health risk assessment (HRA) tool to identify members with specific conditions and determine appropriate interventions. The assessment includes collection of medical and psychosocial history, functional assessment, medical exam and a number of other screenings such as but not limited to: PHQ-9 Depression screening, miniCog, Community Assessment Risk Screen (CARS), fall risk screen, onsite lab testing, pain assessment scale and Barthel Index of Activities of Daily Living. Members are encouraged to come in to CCCs to get assessed within 30 days of enrollment and annually thereafter. However, if the member does not want to come in, the HRA can be performed at the member's house or over the phone.

After the HRA is complete, the CHP's nurse practitioner (NP) and the member go over the HRA results and develop the individualized care plan (ICP) to meet the specific needs of the member, considering the specific barriers, preferences and limitations. The ICP includes diagnostic test results, preventive screenings, medications and frequency, immunization history and needs, individual goals, nutrition and health management guidelines, referrals, sickness plan and other

recommendations. The care plan is reviewed and revised with the member during the annual health assessment or when the member is being seen by a NP or doctor for an uncontrolled chronic condition or frailty. Additional care planning revisions occur when the member is discharged from the hospital or skilled nursing facility.

CHP has multiple types of interdisciplinary care teams (ICTs); however, the main team that collaborates on dual eligible members is the neighborhood ICT. It is led by the local medical officer/director and includes a NP, internist/hospitalist, case manager, fitness trainer, social worker, registered dietician, mental health and other specialists as necessary. Their role is to identify and manage “frail” members and coordinate the use of all available resources to provide comprehensive care. The NP is responsible for leading the communication among other ICT members and determine which ICT members the member needs to see during the appointment. The majority of the member’s interaction with the ICT is face to face, but may be by telephone depending on member preference.

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.caremore.com