CareMore Health Plan, H0544, H2593
Institutional (Facility and Living in the Community) Special Needs Plan

Model of Care Score: 91.25%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

For this Special Needs Plan (SNP), CareMore Health Plan (CHP) is targeting members that live in the assisted living, board and care or group home setting with an institutional level of care. Its target population also includes institutional members living in contracted and qualified institutional facilities. The attributes of the community based members include increasing need for 24/7 assistance, significant physical and cognitive decline, assistance with multiple activities of daily living (ADLs), inability to thrive independently and complex medical management needs. Similarly, the attributes of extended care facility members include a large percentage of custodial dual eligible, significant physical and cognitive decline, assistance with ADLs, inability to live independently and complex medical management needs.

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 institutionalized members. CHP contracts with providers who provide services at the members' home environment, along with other allied health professionals as well as facilities including acute hospital, skilled nursing facilities, home health care agencies, hospice agencies, psychiatric hospitals, dialysis facilities, laboratory and radiology. Each member is assigned a nurse practitioner (NP), who visits their home or facility at least of weekly or more frequently as needed and acts as a gate keeper. Additionally, all members have a PCP who monitors and manages their care

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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 screening for chronic conditions, medical, functional, cognitive and psychosocial needs assessment, 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, pain assessment scale and Barthel Index of Activities of Daily Living. The assessment is performed by the NP at the member's home or facility within 30 days of enrollment and annually thereafter.

After the HRA is complete, the CHP's 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 and caregiver resources available. The ICP includes diagnostic test results, preventive screenings, medications, immunization history and needs, individual goals, nutrition and health management guidelines, referrals, sickness plan and other recommendations. The NP involves the interdisciplinary care team (ICT) based on the needs of the member. The ICT also discuss care plan completion and NP activities during ICT meetings, and monitors the details of the care plan for members who are not progressing toward goals. The ICP is completed within 90 days from the effective date, and is updated at least annually and more often as clinically indicated.

The ICT is led by the medical director and it includes NPs, family practice, care managers, hospitalists and other specialties. The ICT is determined based on the medical, psychosocial and care transition needs of the institutionalized members. The majority of the member interaction with the ICT is face to face, but may be by telephone depending on member's preference. The ICT meets monthly to evaluate and review members and oversee the performance of the program.

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