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

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

CareMore Health Plan (CHP) targets members that live in assisted living (66 percent), board and care or group home settings (23 percent) with an institutional level of care. Its target population also includes members living in contracted and qualified institutional facilities such as nursing homes (11 percent). The attributes of the community based and extended care facility 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.

Among the overall CHP population, the ethnic breakdown is: Hispanic (31 percent), Non-Hispanic Caucasian (27 percent), Asian (21 percent) and African American (11 percent). English is the primary language in all of the CHP plans with Spanish being the next most prevalent language among members. CHP's I-SNP population includes 2,530 members of which 69 percent are female and the average age is 83 years old. Members have the following conditions: dementia (52 percent), diabetes (27 percent), asthma (7 percent), congestive heart failure (6 percent), coronary artery disease (5 percent), chronic obstructive pulmonary disease (4 percent) and severe mental illness (3 percent).

Provider Network

CHP's network includes skilled nursing facilities, long-term acute psychiatric, short–term placements/shelters, psychiatric partial hospitalization, rehabilitation and dialysis units. CHP's ancillary services include transportation, home health, durable medical equipment, hospice, dental, vision, physical, occupational, and speech therapy, as well as exercise and strength training centers.

In addition to primary care physicians (PCP), CHP employs specialists in the following areas: pain management, behavioral health, cardiology, pulmonology, vascular surgeon, nephrology, psychiatry, geriatric specialists, immunologists, speech pathologists, laboratory specialists, radiology specialists and podiatry. Each member is assigned a mid-level provider (MLP) who visits the member's place of residence, at least weekly, or as frequently as necessary and acts as a gatekeeper.

Care Coordination and Management

CHP uses a health risk assessment (HRA) that is integrated into the member's electronic health records to identify specific conditions and determine appropriate interventions. The assessment includes screening for chronic conditions, medical, functional, cognitive and psychosocial needs as well as a number of other screenings which include: PHQ-9 Patient Depression Questionnaire, mini-Cog, mini–mental state examination, community assessment risk screen, fall risk screen, pain assessment scale and Barthel Index of ADLs and long-term services and support. The MLP administers the HRA at the member's place of residence within 30 days of enrollment, annually thereafter and whenever there is a change in health status and/or after a care transition.

After discussing the HRA results with the member, the MLP, the medical director and the interdisciplinary care team (ICT), if necessary, develops an individualized care plan (ICP) that considers the member's preferences, limitations, barriers, caregiver support and available resources. 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 MLP completes the ICP within 90 days from the effective date of enrollment and updates it at least annually or more often as clinically indicated.

The ICT is determined based on the medical, psychosocial and care transition needs of institutionalized members. The ICT is led by the medical director and it includes MLPs, family practice physicians, care managers, hospitalists and other specialties (e.g. home health therapists, ophthalmologists, social worker, registered dietician, podiatry and mental health). The majority of the member interaction with the ICT occurs face-to-face through their MLP's weekly home visits, but it may also occur via 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: http://www.caremore.com