WellCare of Connecticut, H0712
Dual (Medicare Subset Zero Cost Sharing) Special Needs Plan

Model of Care Score: 98.75%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

The target population for WellCare's specific product is called Access $0 Cost Share and includes members who qualify for Medicare Part A and B and Medical Assistance from a State Plan under Title XIX (Medicaid). This includes members who are eligible for Qualified Medicare Beneficiary Comprehensive Medicaid Benefits (QMB+), Specified Low-Income Medicare Beneficiary with Comprehensive Medicaid Benefits (SLMB+) and Full Benefit Dual Eligibles (FBDE). The dual-eligible population tend to be frail, disabled, near the end-of-life, experience health inequality or health disparity, and co-morbidities or other multiple, chronic complex conditions.

Provider Network

WellCare has developed provider networks in each county that offer acceptable geographic access to dual-eligible enrollees throughout new and existing service areas, taking into account normal patterns of care and specialized treatment of chronic and disabling conditions. Dual-eligible members have access to primary care physicians (PCP), such as family practitioners, general practitioners and internal medicine providers. Based on the member's chronic or disabling conditions, a specialist can be chosen as the member's PCP. Members have access to a wide variety of specialists including endocrinologists, cardiologists, rheumatologists, and urologists. In stances where a member is in need of services outside of the network, a PCP authorization is required. WellCare is contracted with multiple behavioral health facilities that provide inpatient and outpatient mental health services. WellCare also holds direct Medicare contracts with at least one hospital in each county serving the special needs members. Ancillary services are primarily within counties where the hospital and most of the specialty services are located (e.g., skilled nursing facilities, diagnostic and therapeutic radiology facilities, dialysis centers, DME, and home health).

Care Management and Coordination

The health risk assessment (HRA) utilized by WellCare for gathering member information and assessing the level of risk covers medical, psychosocial, cognitive, and functional needs as well as collects member's medical and psychosocial history. The HRA begins with an overview of

plan services such as benefits, nurse advice line phone number, transportation, and available programs. The HRA is just the initial tool used by WellCare case managers to assess level of member risk for poor health outcomes and need for case management services. Member's that are engaged and agree are given a full health and functional assessment (HFA) which would be completed face to face in the member's home/community setting. The initial HRA is conducted within 90 days of enrollment, with annual re-assessments. Members may require more frequent re-assessment based on need and health status. The case manager or service coordinator reviews initial comprehensive HRAs and HRA stratification. The case manager/service coordinator analyzes and prioritizes member health care needs utilizing the care plan as the tool and includes all members of the interdisciplinary care team (ICT).

The case manager develops the individualized care plan (ICP) along with the member or caregiver after completion of the HRA and medical status assessments. The member and case manager set prioritized goals which include short and long term goals. Interventions for the care plan are varied and individualized based on member input, need and available benefits to the member. All areas of the member health and social status are taken into consideration while building the care plan including, community resources, available benefits, as well as those services that are not covered that the plan takes into consideration to expand as add-on benefits. The case manager/service coordinator is responsible for coordinating the input from all members of the ICT and sharing the information with the ICT via the care plan and/or by phone.

At a minimum the member, identified caregiver (if any), PCP and case manager will comprise the ICT. Other members of the ICT can include specialists, social service support, community case managers and others depending on the members' specific needs. The case manager is the single point of contact for the ICT and the member; they are responsible for updating the care plan in instances of health status changes. Most ICT meetings are done virtually or over the telephone, however, ICT meetings may be arranged face to face, as needed. These meetings are coordinated by the case manager and generally are arranged in a location that is convenient to ICT participants.

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.wellcare.com