H1903 WellCare of Louisiana Inc.
Dual Eligible (Subset- Medicare Zero Cost Sharing) Special Needs Plan

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

Target Population

As of December 2013, WellCare of Louisiana's Dual Eligible SNP target population included 5,688 members, of whom 54 percent were younger than 65 years old and 58 percent were female. The majority of members speak English as their primary language. Hypertension is the most prevalent diagnosis among members using outpatient services. WellCare's overall D SNP membership faces multiple medical, cultural, socioeconomic and linguistic challenges. Many members have multiple chronic and debilitating conditions, which have a direct impact on their quality of life and ability to obtain needed care.

Provider Network

WellCare maintains a comprehensive network of multidisciplinary practitioners and ancillary providers to meet the extensive acute, chronic and preventive medical, surgical, behavioral and psychosocial needs of the dual-eligible special needs population. Specialist providers are available to serve the clinical needs of the member populations. Services are available in the home, community and hospital settings.

Care Management and Coordination

The health risk assessment (HRA) assesses risk and provides an opportunity to offer case management services to D SNP members. HRAs are conducted for all members within 90 days of enrollment and again annually, within 365 days of the previous HRA, or more frequently as needed. Based on the initial HRA, WellCare stratifies its members according to level of need from Level 1 to 4. The most vulnerable members are stratified into Level 4.

The case manager (CM), with the active involvement of the member and caregivers/member representatives, works with the member's primary care physician (PCP) and a variety of specialist(s) and ancillary care providers, when applicable, to identify and prioritize a problem list and comprehensive treatment plan. The CM is responsible for organizing all input into a comprehensive and actionable plan of care.

The case manager (CM) completes a comprehensive assessment with the member and uses the results of the assessments to select a stratification level and develop the initial individualized

care plan (ICP). The ICP identifies self-management goals and services that reflect the member's unique needs. Members and their caregivers are provided guidance and education which includes verbal instructions and feedback from the CM as well as standardized educational materials. These activities help to improve the member's health literacy in order to alleviate the disparities in this population, while reducing the likelihood of a health crises or continued deterioration. Members' self-management knowledge is assessed regularly by the CM, and the ICP is updated as necessary. The ICP is the primary vehicle for communicating HRA information along with information from other sources and interactions. All ICPs are shared with the interdisciplinary care team (ICT), which reviews the ICP and provides member specific feedback.

The CM, in consultation with the medical director, as needed, determines the membership of the ICT based on member specific needs and requests for additional specialists. The composition of the ICT varies for each member, and at a minimum will include: the member, CM, primary care physician (PCP) or usual practitioner, and caregiver(s) as applicable. Additional members may include specialists, social service support and behavioral health specialists.

The CM ensures that the ICT has the appropriate clinical and psychosocial participants with the required level of authority and resources to execute recommended interventions that meet the needs of the member. The CM shares the ICP with members of the ICT for review, and goals/targets are updated accordingly based on new information. This occurs, at a minimum, during initiation of the ICP and at any significant change in the member's health status. When an ICP is updated it reflects changes in a member's health status, which coincides with a change in stratification level. This may be triggered by a hospitalization notification or authorization for other transitions that may indicate a change in the member's health status.

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: https://www.wellcare.com/medicare/snps