L.A. Care Health Plan, H2643
Dual Eligible (Medicaid Subset-$0 Cost Sharing) Special Needs Plan

Model of Care Score: 85.00%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population

In 2008, L.A. Care implemented a special needs program for Medicare/Medi-Cal dual eligible members. Dual eligible members tend to have more serious and complex medical health needs than the broader Medicare or Medicaid population. Data has shown that they are three times more likely to be disabled, to have multiple complex medical conditions and one third of all dual eligible members have difficulty completing three to six activities of daily living. L.A. Care's care management program focuses on the following illnesses: diabetes, chronic obstructive pulmonary disease, congestive heart failure, depression, dementia, frail, developmental disabilities and end of life.

Provider Network

L.A. Care's provider network is comprised of primary care physicians (PCPs), geriatricians, endocrinologists, cardiologists, specialized mental health network, inpatient and outpatient facilities, skilled nursing facilities, dialysis centers, home health providers, durable medical equipment (DME) and transplant facilities in order to meet the specialized needs of the target population who may be affected by multiple chronic conditions. In addition, L.A. Care assessed primary care practice sites for certain physical accessibility requirements and addressed inadequacies in access by providing grant-funding to safety-net practices to enhance physical access. As a result, the grant program supplied height-adjustable exam tables, wheelchair accessible weight scales and assistive-listening devices.

L.A. Care uses the traditional managed care model of assigning members to a PCP of their choice to coordinate the entire gamut of care. PCPs are responsible to directly provide primary care services and refer members for specialty care.

Care Coordination

The health risk assessment (HRA) is a standardized screening tool used for all members upon enrollment. The HRA tool is administered by non-clinical staff members over the telephone with the member or the member's caregiver. The initial HRA is completed within the first 90 days of enrollment and an annual reassessment of the HRA is completed within 12 months of the last risk assessment or adjusted to coincide with health status changes when necessary.

The HRA identifies medical, psychosocial, functional and cognitive needs and documents medical and mental health history. The HRA also includes the Patient Health Questionnaire (PHQ-9) with automated scoring. The PHQ-9 is a brief, 9 item self-reported depression

assessment and has demonstrated usefulness as an assessment tool for the diagnosis of depression in primary care.

The individualized care plan (ICP) incorporates the results from the HRA, measureable goals/objectives, specific services and benefits, outcome measures, preferences for care, barriers identified and add-on benefits and services for vulnerable members, such as the disabled or those near the end-of-life. It is developed by the care manager, in collaboration with the PCP and input from the member, family and caregiver as appropriate, using information provided by the member or the caregiver through the HRA and follow-up telephone calls. Care managers must develop an initial care plan within 90 days of the initial referral and discuss results with the interdisciplinary care team (ICT) within 14 days of completion. Care managers update the care plan based on the ICT recommendations and review/revise the care plan annually or whenever a change in health status is identified.

The ICT is consists of medical directors, registered nurse care managers, nurse practitioners, clinical pharmacists, social workers, health educators and non-clinical support staff. Additional ad hoc members of the team may include representatives from various operational areas that include Medicare operations, customer service, claims and provider network operations and representatives from community based organizations. A behavioral health expert, social services specialist or other health care specialists are available when the members need is identified through the health risk assessment.

The ICT also includes participation of PCP, members and/or caregivers whenever feasible. Meetings are held face to face and/or by telephone on a weekly basis to review care plans, resolve barriers to long and short term goals, plan interventions and update supportive services needed by the members.

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.lacare.org/members/medicareadvantageplan