H2643 L.A. Care Health Plan
Dual-Eligible (Dual Eligible Subset-Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 100.00 %

1-Year Approval[1] **January 1, 2015 – December 31, 2015**

Target Population

L.A Care's target population are individuals with Medicaid who also receive services under Medicare Part A and Part B and reside in Los Angeles County. Members may have diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular disease, behavioral health conditions, dementia, frailty, developmental disabilities or are at the end of life. Of the 6,183 members, eighty percent are over the age of 65 and 20 percent are between 46 and 64 years. The majority of the members are female (54 percent). Spanish is the primary language spoken by 60 percent of members, while 37 percent of members speak English.

Provider Network

L.A. Care is comprised of Medicare and Medicaid healthcare providers to meet the specialized needs of the target population. The network includes primary care physicians (PCP), endocrinologists, cardiologists, nephrologists, dialysis centers, home health providers, durable medical equipment (DME), geriatricians, specialized mental health network, inpatient and outpatient facilities, skilled nursing facilities and transplant facilities.

Care Management and Coordination

The health risk assessment (HRA) is completed within 90 days of enrollment and at least annually thereafter and upon significant change in the member's health status. The HRA is administered by specially trained non-clinical staff members, who conduct telephone interviews with the member or the member's caregiver. When staff is unable to reach a member by telephone, a written HRA tool is mailed. The HRA identifies medical, psychosocial, functional and cognitive needs. It documents medical and mental health history and cultural and linguistic needs are also assessed. L.A. Care uses HRA responses and a thorough review of member's claims and authorization history to develop the initial individualized care plan (ICP). Goals form the ICP and drive discussion in the initial interdisciplinary care team (ICT) meeting.

Organization of the ICT is based on the member's risk level, care management needs and prioritization of the issues to be addressed. The member is encouraged to participate so L.A.

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[1] Per CMS guidance, plans that use the cure process receive a one-year approval, regardless of their final score.

Care makes available a convenient time and place, provides interpreter services and a location that meets disability accommodations if needed. The ICT consists of medical directors, registered nurse care managers, nurse practitioners, clinical pharmacists, social workers, health educators and non-clinical support staff (i.e. care coordinators and health navigators). Additional members may include Medicare operations, customer service, claims and provider network operations, and representatives from community based organizations. The care manager (CM) is responsible for updating the care plan based on the ICT recommendations or when there is a change in the member's health status. Meetings are held face-to-face or telephonically on a weekly basis.

The essential elements incorporated in the individualized care plan (ICP) are the results from the HRA responses and member's diagnosis, prognosis, care needs, barriers to attaining goals, identified short term and long term goals and alternative approaches to problem solving as needed. The ICP includes outcomes that are specific, measurable and goal-oriented which are developed along with the member. The CM develops the ICP within 30 days of the completion of the Health Risk Assessment (HRA) reviews the care plan at least annually and according to the set follow up schedule. The ICP is revised based on ongoing follow up and contact with the member, especially high risk members, whose condition may warrant multiple changes throughout the year. The member is central to the care planning process and the member's changing goals and desires shape the care plan.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://www.lacare.org/members/medicareadvantageplan