Hometown Health Plan H3672
Dual Eligible (Full Benefit D SNP) Special Needs Plan

Model of Care Score: 85.00%
3-Year Approval **January 1, 2014 to December 31, 2016**

Target Population

Hometown Health Plan's target population for its two SNP contracts with the product name 'Here for You' consists of dual-eligible members in the QMB only, QMB+, SLMB+, and FBDE Medicaid eligibility categories. The service area includes the following Ohio counties: Ashland, Carroll, Columbiana, Coshocton, Holmes, Mahoning, Medina, Portage, Stark, Summit, Trumbull, Tuscarawas and Wayne. Currently, 74 percent of the dual eligibles in the organization's existing MA plan are over 75 years of age and 43 percent are over age 85. Females account for 80 percent of the membership and males 20 percent.

Although a number of members have multiple chronic conditions, the top three conditions for the target population are vascular disease, congestive heart failure and chronic obstructive pulmonary disease. In addition to the complex clinical needs, members in this population include the impoverished, elderly and disabled.

Provider Network

Health Plan actively recruits Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to provide comprehensive services to members. It also contracts with state and county health departments to ensure members have greater access to preventive services.

Members have access to primary care physicians (PCPs), consisting of family practitioners, internal medicine practitioners, pediatricians and general practitioners. This includes practitioners like gynecologists, nephrologists, medical oncologists and endocrinologists who are actively involved in members' care and serve as PCPs for individuals with specific conditions. The network contains a wide range of specialists including psychiatrists, psychologists, and behavioral health counselors.

Health Plan makes a broad range of facilities available that include hospitals, skilled nursing facilities, dialysis centers and behavioral health centers. It offers physical, speech and occupational therapy through contracted facilities. The plan also provides access to a comprehensive network of pharmacies and pharmacists.

Care Management and Coordination

Health Plan conducts an initial health risk assessment (HRA) by phone within the first 90 days of members' enrollment and annually thereafter. It uses a tool to assess their medical and behavioral health status, utilization of services, use of inpatient, home health and durable medical equipment, caregiver resources, activities of daily living, social needs and lifestyle risk factors. Living arrangements and caregiver questions help identify the level of caregiver involvement and questions about frequency of PCP visits, emergency room utilization and inpatient stays help the care/case/disease manager understand how members manage their conditions.

Care/case/disease managers review the results of the HRA and calculate a numeric risk score from the responses. After receipt of the completed HRA, the care/case/disease manager contacts members in the highest risk levels by telephone and performs a comprehensive assessment that provides greater detail about their needs.

The care/case/disease manager with active involvement of the member or caregiver works with the PCP and other providers to identify a plan of care. The key components of the care plan are the problems, interventions and goals. As the care/case/disease manager works with the member to address knowledge regarding his or her condition/disease, community resources and provide education, they develop short and long term goals, interventions and identify barriers.

The member care team is the responsibility of the care/case/disease managers. At a minimum it includes the care/case/disease manager, member or caregiver and a PCP. The care/case/disease manager may add a pharmacist, behavioral health coordinator, clinical specialist, community case worker, dietician or physical, occupational, or speech therapist, as appropriate.

From the initial outreach, care/case/disease managers encourage members to take an active role in their health care. Care/case/disease managers facilitate member participation by forming a trusting relationship with him or her.

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.HEALTHPLAN.ORG