FamilyCare Health Plan, H3818

Dual-Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 83.13%
1-Year Approval **January 1, 2014 – December 31, 2014**

Target Population

This plan focuses on members that have full Medicare and Medicaid benefits. The majority of members are Caucasian, female, over age 65, live in the Tri County region of Oregon and speak English as their primary language. There are also a substantial number of members that are under-65 years of age. A large portion of the membership lives in Eastern Oregon. Spanish and Cantonese are the most common languages spoken by this population after English.

The plan focuses on identifying members with common or high-cost diseases and coordinating care for those members. The plan also focuses on members who are frail or disabled, have multiple chronic conditions or are near the end of life.

Provider Network

The plan has a network of licensed and credentialed providers, including primary care, specialists in a wide range of specialties, long-term care facilities, rehabilitation facilities, behavioral and mental health, hospice and hospitals. Providers receive education on coordination of care. Each member either chooses or is assigned a primary care provider (PCP) within 30 days of enrollment. The PCP acts as a "gatekeeper" to the member's healthcare. Members may self-refer to a specialist or work with the plan via a care coordinator for assistance finding specialized services.

Care Management and Care Coordination

All members receive a health risk assessment (HRA) within 90 days of enrollment and annually thereafter. The plan uses the HRA to assess the acuity of the members' needs and provides the stratification necessary to determine the appropriate level of care coordination. The member's care coordinator conducts the HRA primarily by phone, or face-to-face, if needed. The HRA includes a series of questions that evaluate the member's health and lifestyle, and is used for assessing, addressing and identifying risk factors that are known to predict the risk of potentially avoidable healthcare issues and identification of members who would benefit from follow-up and potential case management. It includes a list of providers, current diagnoses, medications, recent diagnostic tests and results, surgeries, hospitalizations and use of durable medical equipment and

a family health history. There is also an added focus on preventive screenings such as colonoscopies, mammograms and flu/pneumonia vaccination.

Following the completion of the HRA, the service coordinator develops the individualized care plan (ICP) with the member. The ICP addresses the following: knowledge and understanding of the member's disease or condition; development of interventions and goals; community resources; and target education. Results are also shared with the member, the member's PCP and the member's individualized care team (ICT) and any other health plan staff or providers involved in the member's care. Scheduled follow-up is set based on the level of need. The member is encouraged to actively participate in their care plan and the Plan provides health and wellness information, health behavior coaching and disease specific information/education.

Vulnerable members receive assistance with transportation, access to follow-up, transition planning, accessing DME, and assisting providers with interactions with other departments involved in the member's care (e.g., pharmacy, referrals and claims).

The ICP is reviewed annually or more often if needed based on stratification level or a change in health status such as a hospitalization. The service coordinator shares changes to the ICP with the PCP, ICT and any other providers involved in the member's ongoing care.

The Interdisciplinary Care Team (ICT) engages members with specialized needs in their care and treatment planning. The ICT develops and reviews care plans and recommends interventions and strategies to determine best practices in care to encourage good health outcomes for the member. The goals of the ICT are to use a member-centric approach that engages the member to take an active role in their care, coordinate and improve care and services across the health care spectrum, especially for members with special needs and complex health issues.

The ICT includes internal plan staff such as the medical director, manager of care management, service coordinator and quality coordinator as well as the member and their family or representative, if appropriate, the member's PCP and specialists, as appropriate. Additional providers are invited to participate based on member needs. The service coordinator serves as the consistent link between the member and the ICT.

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.familycareinc.org/