H5209 Care Wisconsin Health Plan, Inc.
Dual Eligible (Dual Eligible Subset - Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 83.33%
2-Year Approval **January 1, 2015 – December 31, 2016**

Target Population

Care Wisconsin Health Plan, Inc. (Care Wisconsin) is a Dual Eligible Special Needs Plan (D-SNP) serves individuals who; are enrolled in Medicare (Parts A, B and D), are eligible for Medicaid, require a nursing home level of care and reside within Dane County.

Care Wisconsin provides Medicare members with acute and primary health services while coordinating their care across the continuum under a contract with the Wisconsin Department of Health Services. This contract, as part of the Partnership Program, covers the following target groups: frail elders and adults with physical disabilities, Alzheimer's disease, a terminal illness or developmental disabilities.

Provider Network

Care Wisconsin's network includes primary care providers (PCPs) in family practice, internal medicine and geriatrics; specialists with experience treating traumatic brain injury; psychiatrists specializing in geriatric or developmentally disabled needs; residential providers with specific training in complex behaviors and dental providers. Its service areas include long-term care facilities, medical centers with dialysis services and outpatient clinics with physicians that specialize in therapy for heart and vascular conditions. In the event that a member must obtain care outside of the network, Care Wisconsin enters into member-specific agreements with other providers to support the unique needs of that individual.

Care Management and Coordination

Within three days of enrollment, the care coordinator (CC) contacts the new member by telephone to gather pertinent information for the rest of the interdisciplinary care team (IDT) and to ensure that his or her needs can be addressed immediately, if necessary. Within 10 days of enrollment and annually thereafter, the social worker (SW) conducts a face-to-face visit with the member to complete a psychosocial assessment. Within that same time frame, a registered nurse (RN), in conjunction with the SW, completes a comprehensive assessment; subsequent reassessments occur every six months. Within 90 days of enrollment and annually thereafter, the nurse practitioner (NP) or physician assistant (PA) completes a face-to-face initial comprehensive history and physical assessment. Care Wisconsin staff document the information collected during the assessments in the electronic care management system. During their

quarterly visits with the member, the RN and/or SW may complete additional assessments as needed.

The IDT develops a member-centered plan (MCP) for each new member within 30-60 days of enrollment. Elements of the MCP include: member needs, strengths and preferences; short and long-term care outcomes, informal and formal supports to support the care outcomes; the specific period of time covered by the MCP and frequency of contact between the IDT and the member. The IDT updates the MCP every six months and when there is a significant change in the member's condition, living arrangements or support system.

Core IDT participants consist of: a NP or PA, a RN, a SW and a CC. Other providers may join the IDT based on the member's needs. Examples of these providers include, but are not limited to: PCPs, specialists, behavioral health providers, restorative therapists, medical director, a pharmacist and nursing home or residential providers.

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.carewisc.org/.