San Mateo Health Commission (CareAdvantage), H5428
Dual Eligible (Medicare Zero Cost-Sharing) Special Needs Plan

Model of Care Score: 96.25%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

CareAdvantage is a Medicare Advantage Dual Eligible Special Needs administered by the Health Plan of San Mateo (HPSM). The target population for enrollment in CareAdvantage is dual eligible beneficiaries who reside in San Mateo County and have their Medi-Cal benefits administered through the HPSM. CareAdvantage beneficiaries are culturally and ethnically diverse as reflected in the following language breakdown: English 59%, Spanish 15%, Mandarin/Cantonese 10%, Tagalog 9%, Russian 3% and other 4%. Characteristics of the CareAdvantage target population include members with: mental health diagnosis 44%, diabetes 43%, disabled under age 65 28%, and developmental disabilities 7%. Moreover, 47% of CareAdvantage beneficiaries are 75 years old or older, reflecting a population that face many challenges seen in an elderly population.

Provider Network

HPSM contracts with an extensive network of health care providers with specialized expertise to meet the healthcare needs of the CareAdvantage population, such as hospitals and other health care facilities, medical specialists, behavioral specialists, nursing professionals, allied health professionals, and pharmacies. HPSM's provider network also includes a wide range of safety net providers, including the San Mateo County public hospital and clinic system. Additionally, CareAdvantage members have access to a primary care network with nearly 850 primary care physicians, hundreds of pharmacies, 150 skilled and long term care nursing facilities, over two dozen contracted acute care facilities and a tertiary care acute care facility within the San Francisco greater Bay Area. CareAdvantage members also have access to a multitude of specialty allied health providers, which include home health agencies, outpatient rehabilitation facilities, chiropractic, multi-specialty clinics, radiology, surgery centers, audiology, medical transportation, hospice, durable medical equipment and orthotics and prosthetics providers.

Care Management and Coordination

HPSM has a variety of health risk assessment (HRA) tools that it uses for determining the level of severity of members' risk for an adverse health outcome. Specifically, the plan uses a comprehensive HRA tool to identify the medical, psychosocial, functional, and cognitive needs of beneficiaries, in addition to capturing medical and mental health histories. Other pertinent data collected includes demographics, health service usage, especially preventive care. The initial HRA assessment is conducted within 90 days of their enrollment effective date and HPSM reviews the assessment form on an annual basis to ensure that it remains effective in identifying member needs.

Results from the assessments are used to develop individualized care plans (ICP) for each member on an annual basis, or when the members' health status changes. Assessments are analyzed in order to stratify members as high, medium, or low risk, as well as identify the most vulnerable beneficiaries including frail or disabled individuals, individuals with end-stage renal disease, members near the end-of-life, or with multiple or complex chronic conditions. Individuals identified as high risk receive additional outreach and assessment from the nurse case manager. HPSM's care management philosophy and policy is to engage the patient, whenever feasible, in care planning efforts. Evaluating member social needs and personal preferences can drive activities, supports and case management services. Social and practical needs can include transportation, shelter and food. HPSM strives to understand the member's social needs and preferences in an effort to develop care plans that address the member's issues and barriers to participating in their care.

The composition of an interdisciplinary care team (ICT) for a member varies, depending on the intensity of services that the member needs. The basic composition of the team includes: member and caregiver (if member concurs), physician, nurse case manager, medical social worker or social services representative, behavioral health representative and other identified professional, as appropriate. This composition is determined by looking at the overall services a member generally needs, beyond clinical services, and finding a suitable representative for the team whose activities address that need.

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.hpsm.org