H5649 Central Health Plan of California
Chronic or Disabling Condition (Diabetes Mellitus) Special Needs Plan

Model of Care Score: 85.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Central Health Medicare Plan (CHMP) operate a chronic condition special needs plan (C-SNP) for members who have a diagnosis of Diabetes Mellitus and reside in Southern California. CHMP estimates that there are 4,284 members who had a diagnosis of diabetes as of December 31, 2013. This represents 30.1 percent of the entire CHMP membership. Of the 4,284 identified diabetics, 474 (11.1 percent) have been stratified into the highest risk category, 2,294 (53.5 percent) into the medium risk category, and 1,516 (35.4 percent) into the lowest risk category.

Demographically, 83.65 percent of CHMP members identify as non-White, while 62.02 percent identify as African American, Asian, Hispanic, or Native American. Out of the entire membership, 40 percent of adults with diabetes have less than a high school education, compared with only 20 percent of the general population. Extrapolated from a small sample, the plan estimates that less than 20 percent of the CHMP membership completed high school.

Provider Network

CHMP contracts with specialist and specialty facilities that correspond with the target population. Some of these specialists include, medical, pharmacist, mental health, nephrologists, dialysis facilities and specialty outpatient clinics. CHMP also contracts with acupuncture providers and registered dietitians that focus on the diabetic membership. Additionally, CHMP holds contracts with 32 delegated physician groups that included more than 1,900 primary care physicians and over 3,600 specialist providers.

The plan has working relationships with over 60 hospitals, which includes tertiary care, located throughout the Southern California service area. The network includes a comprehensive ancillary network for physician groups and members to access. CHMP monitors the adequacy of its network through quarterly GeoAccess reports to identify any gaps in the service area. In addition, CHMP has compiled community resources that are available to support the member needs not covered under the plan's benefit structure.

Care Coordination

CHMP provides care coordination services to all SNP members, which begins with completion of an initial or annual health risk assessment (HRA). The HRA tool allows for validation of pre-populated data, while collecting member reported information. The HRA captures medical, psychosocial, functional, cognitive needs, medical and mental health history. Once results are entered into the case management system, the tool stratifies each member's risk level. CHMP uses the case management system to pair HRA data with claims and encounter information

including medical, pharmacy, and lab data. This allows the case management team to develop and update an individual care plan (ICP) for each member based on risk.

CHMP assigns a case manager to each member according to stratified risk level (low, moderate or high). The case manager develops the ICP for each member in order to deliver appropriate care. Case managers then incorporate individual care and treatment goals into the ICP. Each member's care plan identifies goals and objectives that reflect the member's unique needs, are realistic and measurable, include a time frame for achievement, identify services and care to meet member's care goals and connect the member/caregiver with add-on benefits and services.

After a care plan is built, CHMP identifies an interdisciplinary care team (ICT) based on the ICP. The ICT consists of the family/caregiver, member, administrative and management staff, case managers, primary care physician, social workers, pharmacists, board certified physicians, ancillary services and providers. The plan reserves the ability to change the composition of the ICT based on the evolution of the member's care plan and prioritized goals. Ultimately, CHMP determines the composition of the ICT by the member's medical condition, psychosocial and/or behavioral needs.

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.centralhealthplan.com/