H5859 Health Plan of CareOregon, Inc.
Dual Eligible Full Benefit Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Health Plan of CareOregon, Inc. (CareOregon) enrolls members who are fully dual eligible, having Medicare (Parts A and B) and Medicaid coverage living in Oregon. With over 8,500 full dual members, 52 percent of members are over age 65, 57 percent are female, 77 percent are English speaking and a majority (69 percent) identify as Caucasian. Eighty-five percent of the members served live in the three most populous counties: Washington (15 percent), Multnomah (54 percent) and Clackamas (16 percent). The top five conditions impacting members by prevalence include: diabetes without complication (18.9 percent), chronic obstructive pulmonary disease (14.7 percent), renal failure (10.7 percent), congestive heart failure (9.9 percent) and polyneuropathy (9.6 percent).

The CareOregon population suffer from higher rates of medical, behavioral health and substance abuse. By definition, as a dual eligible plan, 100 percent of the population lives below the federal poverty limit. Members are more likely to qualify for Medicare due to disabling conditions versus age qualification. Co-morbid conditions, poverty and lower health literacy frequently occur together which creates a complex set of factors and barriers for members.

Provider Network

CareOregon's provider network includes, but is not limited to, major specialty and subspecialty services such as allergy, cardiology, dermatology, endocrinology, general surgery, gastroenterology, oncology, orthopedics, otolaryngology, pathology, radiology and urology. A cornerstone of their contracted specialty services is Oregon Health Science University whose services consist of all major sub-specialties, including a major trauma center and transplant services. Additionally, CareOregon contracts with every major hospital and health system within the communities served to ensure that all specialized services are available to members at participating network facilities. Lastly, the plan is tied to contractors with expertise in working with vulnerable populations that are very linguistically and ethnically diverse and work closely with the local community to coordinate social services for members.

Care Management and Coordination

CareOregon uses a health risk assessment tool (HRAT) to evaluate beneficiaries' medical, behavioral, psychosocial, cognitive and functional needs. The HRAT also determines the member's frailty and current health risk levels. The information captured in the HRAT assists in member risk stratification and supports the creation of individualized care plans (ICPs). HRATs

are distributed via mail to members within 90 days of enrollment and can be completed online, by telephone or by mail. A new HRAT may be conducted earlier than the annual reassessment period should clinical information from claims, pharmacy or other data used to monitor member's health status indicate that their health risks have increased.

CareOregon combines data from the HRAT and internal data on medical diagnoses and pharmacy usage to develop an ICP for each member at all stratification levels. The ICP includes: measurable short and long-term goals, prioritized, based on beneficiary needs and preferences; planned interventions to achieve goals, including resources and collaborative approaches to be utilized; planning for continuity of care, including transition of care and transfers; anticipated beneficiary results/outcomes and timeframes for follow-up contact and re-evaluation of goals. The ICP is updated and revised annually, or sooner if there are changes in the member's health status.

The internal interdisciplinary care team (ICT) consists of physicians (primary care and geriatric specialist), clinical pharmacists, case managers, care coordinators, social workers and mental health care providers. Other healthcare providers are involved as needed. When the ICT convenes together, their aim is to: improve the member's medical status and stability; establish and strengthen the medical home; facilitate the member's access to necessary durable medical equipment, medications and specialty or ancillary services; encourage and support the member's self-management knowledge, skills, and ability; and assure the member's receipt of adequate caregiver, social and community support.

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.careoregon.org