**Comprehensive Care Management Corp. H5989**
**Dual Eligible (Full Duals) Special Needs Plan**

**Model of Care Score: 87.50%**
**3-Year Approval** **January 1, 2012 to December 31, 2014**

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## Target Population

The population of this SNP consists of full dual eligible members who are elderly or disabled and require a nursing home level of care, but live in the community, that is, they do not reside in an institutional setting. The State of New York must approve them to participate in the program.

## Provider Network

Comprehensive Care Management Corp. (CCM) employs and contracts with a variety of physicians with appropriate expertise. The cornerstone of its care management program is collaboration with participating primary care physicians (PCPs) who, along with care managers, serve as the gatekeeper for services.

CCM has contracts with facilities that are necessary for the care of its members and include: inpatient, psychiatric and rehabilitation hospitals, skilled nursing facilities, dialysis facilities, laboratories and radiology/imaging facilities. The SNP also contracts with numerous medical specialists that include: allergy and immunology, ambulatory surgery, cardiology, chiropractor, dermatology, ENT, endocrinology, gastroenterology, general surgery, geriatric specialist, gynecology, hematology, infectious disease, nephrology, neurology, oncology, ophthalmology, orthopedics, pain management, physical medicine and rehabilitation, podiatry, pulmonology, radiation oncology, rheumatology and vascular surgery. In addition, CCM contracts with behavioral and mental health specialists and clinical psychologists, as well as physical therapists, occupational therapists, speech pathologists, certified home care agencies, nurse practitioners, RN care managers, and pharmacists.

## Care Management and Coordination

To qualify for this program, members must be evaluated using the state approved Semi Annual Assessment of Members (SAAM) tool that provides a complete functional assessment. If a member scores a level 5 on the tool then it is determined that they require a nursing home level of care. An additional screening tool encompasses psychosocial needs, medical and rehabilitation needs and identifies members at significant risk who require more comprehensive assessment. The health risk assessment (HRA) includes questions to identify those members who are likely to: be frail/disabled, have multiple chronic illnesses or be near the end of life.

The community health nurse (CHN) completes the initial SAAM at the member's home before the member is effective to determine his/her eligibility for the program and initial care plan. The

care manager completes the HRA by phone within 30 to 90 days of enrollment. CCM repeats the administration of the SAAM every six months and the HRA annually.

The care manager conducts a more comprehensive care management assessment in addition to the HRA and the SAAM for moderate and high risk members. This assessment includes a complete medical history, mental health history, depression screening, nutrition screening, additional activities of daily living questions, financial status, transportation needs and barriers to following the physician's plan of care.

The care manager reviews, analyzes and stratifies members based on their responses to the HRA, SAAM and care management assessment and develops an individualized care plan (ICP). The ICP includes a problem list, goals, interventions and a time frame for reevaluation. The care manager consults with the member or family when reviewing goals and works together with them to identify achievable, measurable goals. The care manager consults with the member on the interventions and encourages them to verbalize their own goals for care, which are incorporated into the ICP. The care manager works with the CHN to ensure that the ICP has been implemented appropriately and assesses progress on a routine basis. If the member experiences a significant event based on a set of triggers (e.g., a fall, hospitalization or other major health-related event), the care manager conducts a reassessment, by phone or in-person, to determine the member's level of risk and need.

The interdisciplinary care team (ICT) consists of the care manager, PCP, CHN and the member. CCM will add other members to the team if the member's condition requires additional expertise. The core members of ICT team are an integral part of the member's care and therefore, most appropriate for participation.

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.centerlight.org/