**Marion Polk Community Health Plan Advantage Inc. H5995**
**Dual-Eligible (Full Duals) Special Needs Plan**

**Model of Care Score: 88.13%**
**3-Year Approval** **January 1, 2012 – December 31, 2014**

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## Target Population

Marion Polk Community Health Plan Advantage's (MPCHP Advantage) target population includes all members who are enrolled in or are eligible to participate in a dual-eligible SNP (D-SNP). These individuals meet the criteria for enrollment if they: reside in Marion and Polk Counties of Oregon, are entitled to Medicare Part A, are enrolled in Medicare Part B and do not have end stage renal disease (ESRD) (with limited exceptions, such as if they develop ESRD when they are already a member). They must also be eligible for full Medicaid benefits via one of the following categories: Full Benefit Dual Eligible (FBDE), Qualified Medicare Beneficiary Plus (QMB+) and Specified Low-Income Medicare Beneficiary Plus (SLMB+). MPCHP Advantage stratifies the target population according to vulnerability in the following categories: members who are stable, frail/disabled members, members with multiple chronic illnesses (including those who develop ESRD after enrollment) and members near the end of life.

## Provider Network

The MPCHP Advantage provider network contains over 500 local physicians representing the majority of primary and specialty care available to members. In addition to the primary and specialty care provider network, the plan also has a network of ancillary providers who provide services such as: physical therapy, occupational therapy, speech therapy, radiology, and licensed clinical social workers. These networks allow the plan to provide care to members who may have difficulty accessing primary and specialty care as well as therapists and social work services.

MPCHP also contracts with a managed behavioral care network through a group of mental health providers consisting of approximately 73 mental health specialists. MPCHP Advantage employs durable medical equipment (DME) coordinators and contracted mobility clinics staffed by a physical therapist and physiatrist care coordinators to develop appropriate solutions for the DME needs of frail and disabled members. In addition to the these services, the plan also offers home care coordination, case management services, access to licensed nurses, pain management clinics, specialty services such as skilled nursing facilities and sub-acute care facilities.

## Care Management and Coordination

MPCHP uses a comprehensive health risk assessment (HRA) to identify the specialized needs of individual members. It gives members the opportunity to describe their health status through the HRA, which includes areas such as cognitive, social, and behavioral needs. MPCHP uses the results of the HRA to develop an individualized care plan (ICP) for each member. The care plan utilizes various elements of a medical home model and enables the plan to develop,

communicate, and act upon patient goals and objectives while taking individual preferences into consideration. In addition to facilitating the execution of a comprehensive ICP, the care planning process also allows the plan to monitor interactions with the member through goal setting. These goals include: increasing member access to preventive health services, improving the coordination of care through an identified case manager and improving seamless transitions of care across healthcare settings. Additionally, the electronic health records (EHR) system also acts as an essential element in developing ICPs. The EHR system communicates member needs and determines the composition of the interdisciplinary care team (ICT).

The plan's case management and utilization management staff, along with an adult comprehensive care team, are the primary parts of the ICT that MPCHP utilizes. This care team acts as a "hub" to coordinate services for all members. The ICT consists of practitioners and providers, integrates areas of clinical expertise in order to maximize health outcomes for all SNP members. The ICT also focuses on recognizing members with high medical risks or needs. Specifically, this team coordinates clinical expertise to provide comprehensive care based on the ICP.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at:

http://www.atriohp.com/